



NEXT STEPS IN PUBLIC HEALTH | MENTAL & BEHAVIORAL HEALTH
Power in Partnership: Bridging from crisis to community for people experiencing housing insecurity and serious mental illness

MARCH 2024

Event Summary

Keynote and Panelists

The Next Steps in Public Health event welcomed more than 80 attendees to the Delmar Divine for a day-long session focused on hospital-community partnerships to address the major health and social issues facing individuals experiencing housing insecurity and serious mental illness. Following an opening by Institute for Public Health Director, William Powderly, MD, and President of Barnes-Jewish Hospital, John Lynch, MD, Katherine Koh, MD with Massachusetts General Hospital, Boston Healthcare for the Homeless, and Harvard Medical School gave a keynote presentation entitled *Strengthening Hospital-Community Partnerships for People Experiencing Homelessness and Mental Illness*.

Dr. Koh's presentation told the story of the founding and growth of Boston Healthcare for the Homeless, and she focused on the degree to which shared humanity and a commitment to meeting patients where they are truly informs the organization's work. She emphasized the importance of longitudinal relationships, team-based care, and empathy. She also spoke about a few specific hospital-community partnerships that have been particularly helpful for their organization, including having drop-in clinic space located adjacent to the Massachusetts General Hospital emergency department, on-site pharmacy access, shared data infrastructure for clinical needs, and a large medical respite facility.

An expert panel consisting of Kelli Braggs, M. Div., MSW, Bridge of Hope Ministries; Julie Gary, PhD, MPH, City of St. Louis Health Department; Angela Martin-Davis, MBA, BSN, RN, BJC Behavioral Health; Vontrice McDowell, MSW, St. Louis Housing Authority; and Yusef Scoggin, MD, Covenant House followed to provide a local perspective on ongoing and aspirational efforts to address these issues here in St. Louis. Their comments emphasized both the urgent need in St. Louis for solutions to specifically improve care and outcomes for people experiencing housing instability and serious mental illness, as well as the ways in which many organizations are actively working to meet those needs. Their comments provided crucial background and context for the breakout sessions that followed.

Breakout Sessions

Breakout sessions, aimed at brainstorming around partnerships and promising interventions, focused on the following topics:

- Programs to facilitate direct linkage to housing or other resources in the emergency department (facilitated by Jonathan Belcher, MSW, St. Patrick Center and Diane Howard, MSW, LCSW, Barnes-Jewish Hospital)
- Creating or augmenting street medicine or other outreach programs (facilitated by Nathan Nolan, MD, MPH, MPHE, Washington University in St. Louis)
- Partnerships with federally qualified health centers and other local medical and behavioral health partners (facilitated by Devin Banks, PhD, Washington University in St. Louis)

- Growth in medical respite care (post-acute short-term housing and support) (facilitated by Callan Montgomery, MPH, Haven Recovery)

This document will summarize each breakout session, and then conclude with a series of themes and takeaways that arose across sessions and may suggest potential for broader, policy-based solutions.

Breakout Session 1: Programs to Facilitate Direct Linkage to Housing or Other Resources in the Emergency Department

Participants in this session focused on ways in which programs that were located in acute-care clinical settings could directly provide linkage to key services, including but not limited to housing.

Current strengths in this area included multiple existing programs and networks aimed at providing services; barriers included a lack of collaboration or coordination between these programs and networks. Participants shared that a housing coordinator in the emergency department might need to make dozens of phone calls to different organizations to determine whether shelter space or other housing options were available for any given patient, indicating that the linkage process itself was extremely time consuming and inefficient.

Challenges include: 1) a lack of cooperation between Saint Louis City and County governments, including resistance to cooperating on the part of both elected and unelected officials; 2) duplication of services from nongovernmental public and private organizations within and across the City and County; 3) lack of a centralized data repository to track available housing options across the region in real time; 4) lack of venues and initiatives to facilitate regional planning and cooperation between the City and County.

Potential advances included:

- Centralized coordinator to track shelter and housing availability
- Data sharing system to help keep shared longitudinal records of clients and easily match back to resources that had previously been successful, or avoid ones that had not been successful or had not matched with client needs
- Creation of a venue or entity to conduct, facilitate, and advocate for greater regional planning and cooperation across the City, County, and other municipalities – such as building on the existing Regional Business Council and Greater St. Louis Inc organizations

Broad policy changes needed to support these innovations were also noted; these are reviewed in the final section of this document.

Breakout Session 2: Creating or Augmenting Street Medicine or Other Outreach Programs

Participants in this session focused on the potential for street medicine or similar programs to expand in order to meet individuals where they are, establish long-term relationships, and provide broader services.

Participants agreed that there is a major gap for people who are in a mental health crisis who either may not need or may not want formal emergency department care, but who are clearly in need. There is also a gap in chronic preventive care among the unhoused population.

Current strengths in this area include a lot of passion, dedication, and true mission-driven work among the people currently providing care in this space, and an interest in working together and collaborating in order to change the landscape for people experiencing both housing instability and serious mental illness.

Challenges include a lack of centralized coordination or communication among the groups and people working in this area, which prevents sustained collaborations. A deep lack of trust of the medical establishment is also a major barrier. Existing rules for where paramedics can transport, how 911 calls are handled, etc. also impede flexible and individual-centered care delivery. There is also a lack of sustainable funding, since most of the

services provided by current outreach groups are not reimbursed or reimbursable due to current Medicaid billing rules.

Potential advances included:

- Creating a centralized plan or organization in this space, including to coordinate philanthropy; could start with a directory and community calendar, as well as a monthly regional check-in with a needs-based approach
- Data sharing system to help keep shared longitudinal records of clients – needs to explicitly cross hospitals and clinics since many individuals seek care in multiple locations. Better data could also provide evidence for program effectiveness, which in turn could facilitate obtaining funding.
 - Street medicine build within Epic, or via FQHC build (OCIN)?
- Appropriately funded, appropriately staffed street medicine or outreach team based on the following principles:
 - Trust is crucial; should not be branded as Wash U or SLU per se, but rather as a trusted independent clinic / group of clinicians
 - People need to feel like they belong – clinician continuity crucial (people can identify “my doctor”)
 - Longitudinal care is crucial for relationship building – need to not just treat the acute crisis, but also check in before a crisis occurs and after one is addressed
 - Care team should include a prescriber (doctor, NP, PA), caseworkers, community health workers, people from faith communities, peer workers, occupational and physical therapists
 - Funding should be diversified and come from multiple stakeholders who ultimately benefit from the existence of this organization
 - Telemedicine should be utilized as feasible and appropriate
 - Having a brick-and-mortar physical location is also important so that privacy and safety can be ensured for care delivery once trust is established
 - Physical location should have a “living room” or “walk-in” component so that people can seek care whenever it is most feasible and acceptable for them
 - [Power4Stl](#) was shared as an example
- Community paramedicine, either as part of the above or as a separate locally-driven approach, is underutilized but has the potential to match capable clinicians with at-risk patients for a more longitudinal relationship for basic care and triage
- Creating opportunities to personalize stories in this space, to humanize our unhoused peers, raise awareness of their needs, alleviating the negative perception of unhoused people so that more shelters and housing can be put in new neighborhoods that may have different resources

Broad policy changes needed to support these innovations were also noted; these are reviewed in the final section of this document.

Breakout Session 3: Partnerships with federally qualified health centers and other local medical and behavioral health partners

Participants in this session focused on care provision, both for medical and behavioral health, outside the hospital. The group recognized that nontraditional care provision likely needs to play a major role in reaching people who are either acutely or chronically unhoused, so there was overlap between this group’s discussion and the street medicine / outreach discussion outlined above.

Current strengths in this area included multiple existing FQHCs and hospital-based community clinics providing medical care, behavioral health care, or both. Barriers included major issues with collaboration and coordination between care sites due to the complexity of client needs and the lack of available data sharing as well as the complex nature of the partnerships required to meet individuals’ needs. Workforce was also

recognized as a major barrier, with FQHCs struggling to meet staffing goals and therefore either having post-hospital appointments 4-8 weeks post-discharge or patients being diverted to hospital-based clinics because of availability. Payment models were another barrier, with discussants noting that low levels of reimbursement and a volume-based approach preclude the kind of deep and longitudinal relationships required to do the “hard” parts of the work that could ultimately be most efficacious in truly changing someone’s life for the better. A lack of a clear role for community paramedicine was also identified as a barrier, as were issues with ongoing stigma around substance use disorder.

Potential advances included:

- Starting workforce development in high school in the health professions broadly
- Addressing specific training needs in college level across the health professions broadly (training programs, certificates, associate’s degrees, four-year degrees)
- Providing training to paramedics and other professionals to increase comfort with substance use and mental health crises, reduce stigma, and understand options to emergency department transport
- Leveraging the Medicaid funding that is flowing through MCOs to direct funds to FQHCs that can provide whole-person, wraparound care – one idea is to embed MCO care coordinators in FQHCs instead of having care coordination in both places
- Changing funding for FQHCs to allow deeper levels of support for clients who need it
- Creating better systems for referral as well as tracking whether referrals can meet client needs, to be able to advocate for additional resources where they are most needed
- Allowing cross-municipality collaborations to serve people more broadly – too many small districts to have their own resources, but limited ability to share resources due to structural and legal barriers

Broad policy changes needed to support these innovations were also noted; these are reviewed in the final section of this document.

Breakout Session 4: Growth in medical respite care (post-acute short-term housing and support)

Participants in this session focused on ways in which medical respite care can contribute to the care continuum for people with serious mental illness and housing insecurity. The group covered the broad range of needs that should be addressed by respite care, including psychiatric care, developmental and degenerative care needs, traditional clinical care, long-term or hospice care, perioperative care, and substance use disorder care; basic needs like food, clothing, hygiene; and case management and care coordination needs.

Current strengths in this area include new respite programs here in St. Louis, and a great deal of energy and work that has gone into creating them. Barriers include the large number of resources, sectors, and dollars required to sustain respite care, and a lack of sustainable funding specifically targeted to this type of care.

Potential solutions included:

- Data regarding the savings to hospitals and other sectors that could support efforts to find sustainable ways to fund respite care
- Data regarding the outcomes of respite care to understand where and how it can be best used, and where it is positive for patient outcomes, to support its reimbursement
- Partnerships with Medicaid managed care organizations, which do have some flexibility in covering portions of the care provided, e.g. many navigational services could potentially be billed as “targeted case management” services
- Waivers to allow Medicaid to cover the non-medical components of respite care (skilled services are usually covered, but state Medicaid programs are prohibited from covering room and board unless this rule is waived at the federal level)
- Coordination and collaboration for a safe discharge from respite to stable housing

Broad policy changes needed to support these innovations were also noted; these are reviewed in the final section of this document.

Key themes and takeaways across all four sessions

1. There is a broad need for cross-sector collaboration and coordination.

All four groups noted the lack of collaboration and coordination between the many groups working to provide services for people with serious mental illness and housing instability. Suggestions included creating a working group or task force, creating a formal network with a paid staff member to specifically focus on coordination, and creating regular meetings for people to share projects and progress. However, there was also concern about creating yet another organization and yet another silo, so most participants felt that any new structure would need to explicitly focus on coordination rather than service delivery. One area of collaboration that was universally supported was in the area of data sharing; while appropriate privacy and consent would need to be prioritized, participants were strongly in favor of better data infrastructure that would allow coordination of care for clinical and service needs. Participants noted the [Unite US Community Information Exchange \(CIE\)](#) as an example on the service side.

2. Policy change, both in Medicaid payment policy and in City and County policy, is needed to facilitate the kind of work that needs to be done.

Many of the innovations that were suggested by each breakout group would be most successful and sustainable in the setting of policy change. Major types of policy change that were sought included payment reform within Medicaid, such that important services like respite care, care coordination, mental health care, etc. could be covered with sustainable rates. There was a good deal of interest in pursuing an 1115 Demonstration Waiver in Medicaid, which would allow Medicaid to cover housing services – the cost of room and board – rather than being limited to navigation efforts and short-term assistance, as long as the activities are budget neutral to the state.

At the City and County level, there was interest in policy change that would support the development of affordable housing, ideally in a variety of neighborhoods, as well as policy change that might facilitate better coordination between City and County resources. There were also suggestions to examine fire and emergency response policies in order to optimize responses and collaborate across geographies where feasible.

3. Specific investment in workforce is needed in order to sustain the work going forward.

Participants in every group identified key workforce issues that could only be addressed with broad intervention, such as training programs ranging from high school to certification programs to associates degrees to four-year degrees and beyond. There was also mention in many groups of the need to prioritize retention of staff, given that people who work in this space are doing emotionally challenging, intense work. Implementing self-care programs, flexible work schedules, peer support, equitable compensation and benefits packages, and a move towards salaries and sustainable employment rather than billable hours and grant-funded positions, were recommended approaches.

Wrap-up and Next Steps

The event concluded with a presentation from Meaghan Bailey, MPH from the Washington University Center for Community Health Partnerships and Research, who provided best practices for community partnership. Leah Kemper, MPH, Institute for Public Health Associate Director, thanked participants and announced a funding opportunity aimed at supporting pilot studies related to the topics addressed at the event; a formal announcement is forthcoming.