COMMUNITY SOLUTIONS

PURPOSE: Health care organizations will make a meaningful, measurable, and transformative contribution to end chronic homelessness across a community with a focus on building racially equitable systems.

COMMITMENT: Build Sustained Belief in and Commitment to Ending Chronic Homelessness at the Population Level

WITHIN THE HEALTH SYSTEM

- Establish this work as a strategic priority that aligns to a broader journey towards population health and well-being and an "anchor mission" for the health system in the community
- Identify and engage key internal leaders to champion the effort and sustain their belief in the goal and the path to achieving it
- Identify and articulate the levers and roles for the health system to address homelessness, from physical and mental health services to community benefit and relations in order to believe in the opportunity and obligation
- Build a case using relevant data that resonates with health system leaders and links ending chronic homelessness to health, cost, and quality outcomes

TOGETHER WITH THE COMMUNITY

- **Create and sustain buy in for shared population level aim, timeline and measurement framework**
- Build trust and partnership with housing/homeless system partners, relevant government actors as well as key mainstream agencies
- Develop, tap into and/or refine existing ongoing community-wide communications strategy and infrastructure
- Build a case using relevant data that resonates with health system leaders and links ending chronic homelessness to health, cost, and quality outcomes

GOVERNANCE: Establish shared language and mechanisms for collaboration, measurement and governance

WITHIN THE HEALTH SYSTEM

- **Establish clear internal oversight, project management, measurement, and reporting structure from line staff to leadership that includes internal measures to align and integrate efforts**
- Identify leaders at different levels of the health system who will engage in internal and external efforts
- Reframe how people experiencing homelessness are perceived, treated and talked about within the health system at all levels
- Develop and implement a longitudinal internal communications strategy and infrastructure that builds and sustains will for local, regional and national health system staff

TOGETHER WITH THE COMMUNITY

- Build capacity and capability to partner with people with lived experience as key stakeholders in the improvement process
- Work with cross-sector stakeholders (including public health) to map assets and levers for the most appropriate role for health care
- Use population needs and community assets data to create and pursue a common policy platform on the local/regional level
- Commit to the shared goal of ending chronic homelessness and create a path toward achieving it
- Create clear and simple language and shared definitions for key terms and concepts across sectors
- Tap into and add to governance and decision-making mechanisms that align with existing coordinated efforts to end homelessness

HOUSING PLACEMENTS: Increase housing placements and retention rates for those experiencing chronic homelessness

WITHIN THE HEALTH SYSTEM

- **Understand and optimize the health system's role in the identification to housing placement process so that people don't fall through the cracks between steps in the process**
- Invest organizational funds in housing unit and subsidy gaps for high utilizers of the health system
- Focus organizational assets (funds, people, infrastructure, policies etc) to fill community-wide service and provider gaps

TOGETHER WITH THE COMMUNITY

- Engage in improvement of the identification to housing placement process
- Develop data-sharing mechanisms to target and prioritize high utilizers of the health care system that are on the By-Name list
- Identify and close community-wide housing unit and subsidy gaps
- Identify and close community-wide service and provider capacity gaps

FINANCING: Establish and build upon financial mechanisms aligned to reducing and ending chronic homelessness

WITHIN THE HEALTH SYSTEM

- **Map current funding mechanisms for care delivery within the health system to identify ways to fund coordinated service delivery and fill provider gaps (e.g., 1115 Medicaid Waiver; MSSP participation)**
- Develop internal policy and practice to align allocation of Community Benefit, foundation, and/or Corporate Social Responsibility funds
- Track organizational investments against monthly metrics for reducing, ending or sustaining an end to chronic homelessness
- Quantify and project financial value to the institution associated with savings (productivity, utilization, resources) for achieving the aim

TOGETHER WITH THE COMMUNITY

- **Build, tap into, refine and/or add to the community-wide mechanism for multi-stakeholder flexible funding to incentivize achieving and sustaining an end to chronic homelessness**
- Quantify the economic and social value of getting to and sustaining an end to homelessness across the community
- Develop and implement strategies/tools to support reinvestment/reallocation of cost savings into upstream solutions

INFLOW: Prevent the inflow of individuals into chronic homelessness

WITHIN THE HEALTH SYSTEM

- **Invest organizational funds in housing, services and/or navigation gaps for patients at risk of experiencing homelessness**
- Improve early identification and support of patients at risk of homelessness to reduce their inflow into homelessness

TOGETHER WITH THE COMMUNITY

- Understand and overcome barriers (e.g. privacy barriers) to data-sharing across housing & homelessness and health care systems
- Work with key community partners in building an "At Risk" list and data/measurement infrastructure
- Identify and close community-wide service, provider capacity, housing units and subsidy gaps
- Create an integrated pathway to connect at-risk individuals with diversion/prevention resources
- Identify, understand and work to eliminate institutional and systems barriers (including structural racism)

COMMITMENT: Build sustained belief in and commitment to ending chronic homelessness at the population level

STRATEGIES

WITHIN THE HEALTH SYSTEM

- Establish this work as a strategic priority that aligns to a broader journey towards population health and well-being and an "anchor mission" for the health system in the community
- Identify and engage key internal leaders to champion the effort and sustain their belief in the goal and the path to achieving it
- Identify and articulate the levers and roles for the health system to address homelessness, like physical and mental health services and relations, in order to believe in the opportunity and obligation
- Build a case using relevant data that resonates with health system leaders and links ending chronic homelessness to health, cost, and quality outcomes

STRATEGIES

TOGETHER WITH THE COMMUNITY

- **Create and sustain buy in for shared population level aim with a racial equity lens**
- Build trust and partnership with housing/homeless system partners, relevant government actors as well as key mainstream agencies
- Develop, tap into and/or refine existing ongoing community-wide communications strategy and infrastructure
- Build a case using relevant data that resonates with health system leaders and links ending chronic homelessness to health, cost, and quality outcomes

COMMITMENT: Build Sustained Belief in and Commitment to Ending Chronic Homelessness at the Population Level

STRATEGIES

WITHIN THE HEALTH SYSTEM

- Establish this work as a strategic priority that aligns to a broader journey towards population health and well-being and an "anchor mission" for the health system in the community
  - *Review the current or draft Strategic Plan and identify where this work might advance key priorities*
  - *Build a compact/agreement with the board of directors around community accountability via homelessness efforts*
  - *Include homelessness outcomes as a measure on the health system dashboard that is reported on and reviewed at the Board level*
  - *Explore "what matters" and how this work impacts health system employees (e.g., staff experience, the housing status of health system employees) to shape messaging*
- Identify and engage key internal leaders to champion the effort and sustain their belief in the goal and the path to achieving it
  - *Identify who in the health system works with/touches/services those experiencing homelessness*
  - *Do a power mapping exercise of leaders and other individuals within the health system to identify their potential losses and gains.*
  - *Celebrate work and successes at all stages*
  - *Create succession planning to ensure consistency in mission is carried over despite turnover*
- Identify and articulate the levers and roles for the health system to address homelessness, from physical and mental health services to community benefit and relations in order to believe in the opportunity and obligation
  - *Use the Pathways to Population Health (P2PH) Compass to assess what work the health system is doing to work on overall population health and well-being more broadly*
  - *Brainstorm the ways the health system has influence in the community*
  - *Review the current or draft Strategic Plan and identify where this work might advance key priorities*
- Build a case using relevant data that resonates with health system leaders and links ending chronic homelessness to health, cost, and quality outcomes
  - *Understand the types of business cases that have already been made and build upon them in a way that speaks to your context/values/mission*
  - *Collect data and stories- interview ED patients, clinical staff and case managers using video and other media- to show the link between chronic homelessness and the effect on the health system (e.g. how many people experiencing homelessness you touch through patient care over the course of a week)*
  - *Use change management and organizing approaches to tap into the psychology of behavior change*
  - *Create list of datasets that would be good for in the system and with the community (including CHNA)*

TOGETHER WITH THE COMMUNITY

- Create and sustain buy in for shared population level aim, timeline and measurement framework
  - *Create data-sharing agreements*
  - *Match chronic BNL with health system clients to show percentage overlap*
  - *Share CoC case conferencing/case management infrastructure to illustrate supports available in community that provide more than physical healthcare*
  - *Celebrate work and successes at all stages*
  - *Be able to articulate the timeline and measurement framework*
- Build trust and partnership with housing/homeless system partners, relevant government actors as well as key mainstream agencies
  - *Work directly with community boards that include individuals with lived experience to build understanding*
  - *Do an asset mapping exercise to understand what work is already going on around homelessness*
  - *Meet regularly with local Continuum of Care (CoC) leaders to understand work to date and opportunities for collective impact*
  - *Work closely with local partners and racial equity experts to speak out historical and current inequities created by structure racism and own up to their role in perpetuating those inequities & commit to prevent them moving forward*
- Develop, tap into and/or refine existing ongoing community-wide communications strategy and infrastructure
  - *Meet with local Continuum of Care (CoC) leaders to understand ways stakeholders have framed the issue in the past, including news coverage*
- Build a case using relevant data that resonates with health system leaders and links ending chronic homelessness to health, cost, and quality outcomes
  - *Create a list of datasets that would be good for in the system and with the community (including CHNA)*
  - *Look at homelessness/housing insecurity among health system employees*

GOVERNANCE: Establish shared language and mechanisms for collaboration, measurement and governance

STRATEGIES

WITHIN THE HEALTH SYSTEM

- **Establish clear internal oversight, project management, measurement, and reporting structure from line staff to leadership that includes internal measures to align and integrate efforts**
- Identify leaders at different levels of the health system who will engage in internal and external efforts
- Reframe how people experiencing homelessness are perceived, treated and talked about within the health system at all levels
- Develop and implement a longitudinal internal communications strategy and infrastructure that builds and sustains will for local, regional and national health system staff

STRATEGIES

TOGETHER WITH THE COMMUNITY

- Build capacity and capability to partner with people with lived experience as key stakeholders in the improvement process
- Work with cross-sector stakeholders (including public health) to map assets and levers for the most appropriate role for health care
- Use population needs and community assets data to create and pursue a common policy platform on the local/regional level
- Commit to the shared goal of ending chronic homelessness and create a path toward achieving it
- Create clear and simple language and shared definitions for key terms and concepts across sectors
- Tap into and add to governance and decision-making mechanisms that align with existing coordinated efforts to end homelessness

GOVERNANCE: Establish shared language and mechanisms for collaboration, measurement and governance

WITHIN THE HEALTH SYSTEM

- Establish clear internal oversight, project management, measurement, and reporting structure from line staff to leadership that includes internal measures to align and integrate efforts
- Identify leaders at different levels of the health system who will engage in internal and external efforts
- Reframe how people experiencing homelessness are perceived, treated and talked about within the health system at all levels
- Develop and implement a longitudinal internal communications strategy and infrastructure that builds and sustains will for local, regional and national health system staff

- *Identify a Senior Sponsor for the work (a member of the C-Suite)*
- *Identify 1-2 staff who will coordinate the multi-disciplinary team internally and externally*
- *Define and write down policies and commitments to efforts to generate sustainability independent of staff*
- *Establish key care delivery process measures that align with reducing or ending chronic homelessness*

- *Assess what other initiatives are happening and look for a line of sight to a strategic priority and if possible, at the board level*
- *Convene a multi-disciplinary team within the health system that includes physical and mental health services, admissions and discharge staff, case/care managers, Community Benefit/Population Health department staff, as well as senior leaders*
- *Set an expectation that senior health system leaders will serve on boards and committees to represent the role of the hospital (i.e. land use, housing etc)*
- *Identify and analyze key levels and associated local public policy actions that could address and build a common platform for CEO advocacy*
- *Start with interns and med students and pitch it as "it's not going to get any harder than working with this population, so if you can do this, you can do anything"*
- *Segment homeless population by care type (i.e. senior homeless population with gerontology) to target diff. Hospital teams and rally them around a cause*
- *Establish that community boards for each hospital are required to conduct Community Health Needs Assessment (CHNA)*

- *Assess the understanding of the homeless condition/provide opportunities for helping people understand*
- *Use data and stories- interview ED patients and case managers using video and other media*
- *Partner with homelessness sector experts and people with lived experience to educate key internal staff on social determinants of health (SDOH), homelessness/housing, community-wide change*

- *Tie this work to creating joy in work for frontline staff*
- *Create a clear plan and process for communication that includes strategies for front line staff, middle managers, and senior leaders*
- *Outline savings to healthcare system and tie that to internal messaging*
- *Identify and share NPS score / community perception of health system*
- *Link this work to Corporate Social Responsibility and other initiatives*
- *Celebrate work and successes at all stages*

TOGETHER WITH THE COMMUNITY

- Build capacity and capability to partner with people with lived experience as key stakeholders in the improvement process
- Work with cross-sector stakeholders (including public health) to map assets and levers for the most appropriate role for health care
- Use population needs and community assets data to create and pursue a common policy platform on the local/regional level
- Commit to the shared goal of ending chronic homelessness and create a path toward achieving it
- Create clear and simple language and shared definitions for key terms and concepts across sectors
- Tap into and add to governance and decision-making mechanisms that align with existing coordinated efforts to end homelessness

- *Intentionally spend time building and refining relationships and create space for continuous co-design meeting of meeting norms, processes and overall work with all stakeholders at meetings*
- *Compensate people with lived experience for their time and expertise*
- *Ask and be explicit about power, privilege, racism, sexism etc. (now and historically in this setting/community)*

- *Use the Pathways to Population Health (P2PH) Compass to assess what work the health system is doing to work on overall population health and well-being more broadly*
- *Meet with local Continuum of Care (CoC) leaders to understand ways stakeholders have framed the issue in the past, including news coverage*

- *Work with public health/other sectors so community leaders can identify priorities and develop integrated plan of action with clearly defined notes*

- *Articulate a "how much" and "by when" AIM for ending chronic homelessness*
- *Understand what the current path is (e.g. process maps, FMEAs, journey mapping to bring in tools of QI to this process and allowed for communicating with a path OUT/ending could look like)*
- *Use asset map to identify additional services and supports that would support housing stabilization AND that healthcare sector could provide (i.e. behavioral health, SUD treatment)*

- *Catalog different existing language and how it is utilized to create a cross-sector glossary of terms, acronyms, and locally used jargon within health care and housing/homelessness*
- *Partner with those with lived experience to create person-centered, de-jargoned language*

- *Understand who in the community currently convenes efforts to reduce/end chronic homelessness and see what role health care can play in that coalition, along with the most appropriate leader to represent their health system in the coalition efforts*
- *Identify and engage best leaders to join local homelessness case conferencing meetings (likely case managers or discharge planners)*
- *Understand what measurement systems currently exist and where the health system might support or tap into those systems (e.g., health system using HMIS data, support for data collection)*

HOUSING PLACEMENTS: Increase housing placements and retention rates for those experiencing chronic homelessness

STRATEGIES

WITHIN THE HEALTH SYSTEM

- **Understand and optimize the health system's role in the identification process to housing placement so that people don't fall through the cracks between steps in the process**
- Invest organizational funds in housing unit and subsidy gaps for high utilizers of the health system
- Focus organizational assets (funds, people, infrastructure, policies etc) to fill community-wide service and provider gaps

STRATEGIES

TOGETHER WITH THE COMMUNITY

- Engage in improvement of the identification to housing placement process
- Develop data-sharing mechanisms to target and prioritize high utilizers of the health care system that are on the By-Name list
- Identify and close community-wide housing unit and subsidy gaps
- Identify and close community-wide service and provider capacity gaps

HOUSING PLACEMENTS: Increase housing placements and retention rates for those experiencing chronic homelessness

WITHIN THE HEALTH SYSTEM

- Understand and optimize the health system's role in the identification to housing placement process so that people don't fall through the cracks between steps in the process
  - *Clearly articulate health systems role in the ID to housing placement process and Identify and train appropriate staff to engage in progressive engagement with patients who are homeless or at risk of homelessness*
  - *Co-create process map and identify pain points/bottlenecks with people with lived experience*
  - *Utilize a screening tool to identify patients experiencing housing instability/literal homelessness*
  - *Connect hospital data on people experiencing housing instability/homelessness with CES access points/community BNL and share report with housing experts*
  - *Review patient utilization data by race/ethnicity, gender, age to see where there may be opportunities to address specific barriers to subpopulations such as immigration status, language, gender*
  - ***Look at geographic location (neighborhood, census tracts, etc) to help get work and investments***
  - *Celebrate successes along the ID to housing continuum (ex: like: VI-SPDAT)*
  - *Include discharge planning in ID to housing placement process*
- Invest organizational funds in housing unit and subsidy gaps for high utilizers of the health system
  - *Create housing preferences for specific populations (at-risk of chronic, chronic, etc.)*
  - ***Track utilization rates of those prioritized for housing to determine/show benefit of housing as a social determinant of health.***
- Focus organizational assets (funds, people, infrastructure, policies etc) to fill community-wide service and provider gaps
  - *Conduct a gaps analysis to understand where to focus organizational assets*
  - *Create housing preferences for specific populations (at-risk of chronic, chronic, etc.)*
  - *Place housing navigators, community health workers, resource nurses, or any number of "navigator positions" that can be deployed to assess and refer patients for SDOH needs in hospitals*
  - *Include hospice care within Permanent Supportive Housing (PSH)*
  - *Create a long term care assisted living facility that is housing first and has staff trained in medical care and also assertive, progressive engagement*
  - *Use medical students/interns to staff some of the housing facilities that need specific healthcare services (opportunity for them to learn and will be less expensive)*
  - *Optimize and deliver adequate mental health service*
  - *Use health system real estate to create additional, targeted housing*

TOGETHER WITH THE COMMUNITY

- Engage in improvement of the identification to housing placement process
  - *Develop mechanisms/MOUs to support cross sector data sharing and practice*
  - *Create process map and identify pain points/bottlenecks with people with lived experience*
  - *Include discharge planning in ID to housing placement process*
  - *Co-create process for identifying high utilizers of medical system and prioritize these individuals for housing*
  - *Embed mental health savvy case managers/navigators in the ID to housing process*
  - *Increase and facilitate flow of communication and information sharing between hospital case managers and homeless system case managers.*
- Develop data-sharing mechanisms to target and prioritize high utilizers of the health care system that are on the By-Name list
  - *To be added with learning*
- Identify and close community-wide housing unit and subsidy gaps
  - *Conduct gaps analysis*
  - *Create asset map of housing resources dedicated to coordinated housing placement system, baseline delta between supply & demand*
  - *Advocate for dedicated subsidies from Public Housing Authority*
  - *Invest in master leasing of existing units*
  - *Invest in the near-term and long term development of new affordable housing units & advocate for the protection & preservation of existing affordable housing*
  - *Convene and incentivize landlord community to dedicate market units*
  - *Include other affordable housing strategies such as land trusts, innovative housing (tiny homes, shipping containers), etc.*
- Identify and close community-wide service and provider capacity gaps
  - *Conduct gaps analysis & determine a process for who is best positioned and how to close the community service and provider gaps*
  - *Have internal team work with community board members to help understand link between homelessness and health; they use a "social influencer of health"*
  - *Co-locate mental and physical health services within permanent supportive housing*
  - *Actively tie health system efforts on mental health, substance use disorders, and SDOH screening to reductions in chronic homelessness*

FINANCING: Establish and build upon financial mechanisms aligned to reducing and ending chronic homelessness

STRATEGIES

WITHIN THE HEALTH SYSTEM

- **Map current funding mechanisms for care delivery within the health system to identify ways to fund coordinated service delivery and fill provider gaps (e.g., 1115 Medicaid Waiver; MSSP participation)**
- Develop internal policy and practice to align allocation of Community Benefit, foundation, and/or Corporate Social Responsibility funds
- Track organizational investments against monthly metrics for reducing, ending or sustaining an end to chronic homelessness
- Quantify and project financial value to the institution associated with savings (productivity, utilization, resources) for achieving the aim

STRATEGIES

TOGETHER WITH THE COMMUNITY

- **Build, tap into, refine and/or add to the community-wide mechanism for multi-stakeholder flexible funding to incentivize achieving and sustaining an end to chronic homelessness**
- Quantify the economic and social value of getting to and sustaining an end to homelessness across the community
- Develop and implement strategies/tools to support reinvestment/reallocation of cost savings into upstream solutions

FINANCING: Establish and build upon financial mechanisms aligned to reducing and ending chronic homelessness

WITHIN THE HEALTH SYSTEM

- Map current funding mechanisms for care delivery within the health system to identify ways to fund coordinated service delivery and fill provider gaps (e.g., 1115 Medicaid Waiver; MSSP participation)
- Develop internal policy and practice to align allocation of Community Benefit, foundation, and/or Corporate Social Responsibility funds
- Track organizational investments against monthly metrics for reducing, ending or sustaining an end to chronic homelessness
- Quantify and project financial value to the institution associated with savings (productivity, utilization, resources) for achieving the aim

- *Invest in wrap-around services and other supports*
- *Incentive pay: tie executive benefits to mental health outcomes/readmissions/transitions and test at a small scale tying executive benefits to homelessness outcomes*

- *Create a checklist of geographically specific funding mechanisms to use in conversation with hospitals about whether they are eligible for funding, if they use it and if not, how they can get it*
- *Map funding mechanism (i.e. medicaid waiver in Hennepin county: used medicaid funds and used it to rent apartments and support case management*
- *Partner with local Community Development Financial Institution (CDFI) efforts*
- *Establish a % for Community Benefit investments*

- *Align measures with current or draft Strategic Plan priorities for the health system*
- *Align system level run charts on reductions in homelessness with community benefit investment over time*

- *To be added with learning*

TOGETHER WITH THE COMMUNITY

- Build, tap into, refine and/or add to the community-wide mechanism for multi-stakeholder flexible funding to incentivize achieving and sustaining an end to chronic homelessness
- Quantify the economic and social value of getting to and sustaining an end to homelessness across the community
- Develop and implement strategies/tools to support reinvestment/reallocation of cost savings into upstream solutions

- *Develop measurement framework and infrastructure*
- *Use community health and wellbeing department funds*
- *Pursue collaborative funding opportunities such as grant opportunities, affordable housing opportunities etc.*

- *Develop measurement framework and infrastructure*
- *Outline savings to healthcare system and tie that to internal messaging*
- *Develop different messages for different audiences*
- *Tie this work to creating joy in work for frontline staff*
- *Identify and share NPS score / community perception of health system*
- *Link this work to Corporate Social Responsibility or social justice mission*

- *To be added with learning*

INFLOW: Prevent the inflow of individuals into chronic homelessness

STRATEGIES

WITHIN THE HEALTH SYSTEM

- **Invest organizational funds in housing, services and/or navigation gaps for patients at risk of experiencing homelessness**
- Improve early identification and support of patients at risk of homelessness to reduce their inflow into homelessness

STRATEGIES

TOGETHER WITH THE COMMUNITY

- Understand and overcome barriers (e.g. privacy barriers) to data-sharing across housing & homelessness and health care systems
- Work with key community partners in building an "At Risk" list and data/measurement infrastructure
- Identify and close community-wide service, provider capacity, housing units and subsidy gaps
- Create an integrated pathway to connect at-risk individuals with diversion/prevention resources
- Identify, understand and work to eliminate institutional and systems barriers (including structural racism)

INFLOW: Prevent the inflow of individuals into chronic homelessness

WITHIN THE HEALTH SYSTEM

- Invest organizational funds in housing, services and/or navigation gaps for patients at risk of experiencing homelessness

- *Create mechanism (at risk screening questions) to determine reasons for housing instability/homelessness and invest dollars in targeted prevention, including housing options for people with disabilities*
- *Invest in education of frontline hospital staff around diversion/prevention resources currently available*
- *Situate case managers in hospitals for warm referrals to resources and invite housing experts into the health system to inspire/educate*
- *Clear medical debt for at risk patients*

- Improve early identification and support of patients at risk of homelessness to reduce their inflow into homelessness

- *Screen for social determinants of health and medical vulnerabilities and provide housing, mental health, and substance use care in response to need*
- *Continually learn and characterize what makes people at risk in your community through means like holding focus/community groups of lived experience/peers to determine people who are at risk of homelessness and at risk of chronic homelessness to further segment population including provider subjective assessment*
- *Document patients that meet disability criteria for chronic homelessness at first point of contact and document date homelessness began*
- *Review patient utilization data by race/ethnicity, gender, age and geographic location to see where there may be opportunities to address specific barriers or subpopulations such as immigration status, language, gender, collection status etc.*
- *Implement best practices and discharge planning to prevent people from exiting the hospital to homelessness*
- *Create shared prioritization assessments between health, housing, and benefits systems*
- Utilize expertise of local health department team of epidemiologists to help collect, analyze and present data. Identify subpopulation at risk.

TOGETHER WITH THE COMMUNITY

- Understand and overcome barriers (e.g. privacy barriers) to data-sharing across housing & homelessness and health care systems

- *Implement a standardized screening tool for homelessness prevention/rapid resolution across all agencies that serve as access points*
- *Ensure community is able to regularly case conference list of individuals at risk of chronic homelessness and match with housing resources*
- *Create data sharing agreements between HMIS and health system*
- *Hold focus/community groups of lived experience/peers to help identify 'at risk'*
- *Support housing system in responding to medical elevated medical risks*

- Work with key community partners in building an "At Risk" list and data/measurement infrastructure

- Identify and close community-wide service, provider capacity, housing units and subsidy gaps

- *Conduct client interviews to understand pathways into homelessness/chronic homelessness and invest in resources that are data informed*
- *Advocate to address predatory landlords & improve conditions to achieve safe, affordable quality housing stock*
- *Add investments in prevention (rental assistance, etc.)*
- *Use health system power to advocate for policies that eliminate structural racism around housing and economics*
- *Develop and implement trauma informed practices and policies and coordination with housing sector to address high levels of trauma in chronic homeless populations.*
- *Partner with community development corporations for community improvement and infrastructure to reduce inflow due to poverty*
- *Extend care and initial touchpoints out to the community -- street medicine outreach*

- Create an integrated pathway to connect at-risk individuals with diversion/prevention resources

- *Engage in environmental/economic landscape analysis to know where to educate around diversion/prevention resources*
- *Process and resources mapping across and between systems, including health and housing systems*

- Identify, understand and work to eliminate institutional and systems barriers (including structural racism)

- *Support and participate in service and advocacy coalitions to address systems barriers*

Strategies that Apply Across Pillars

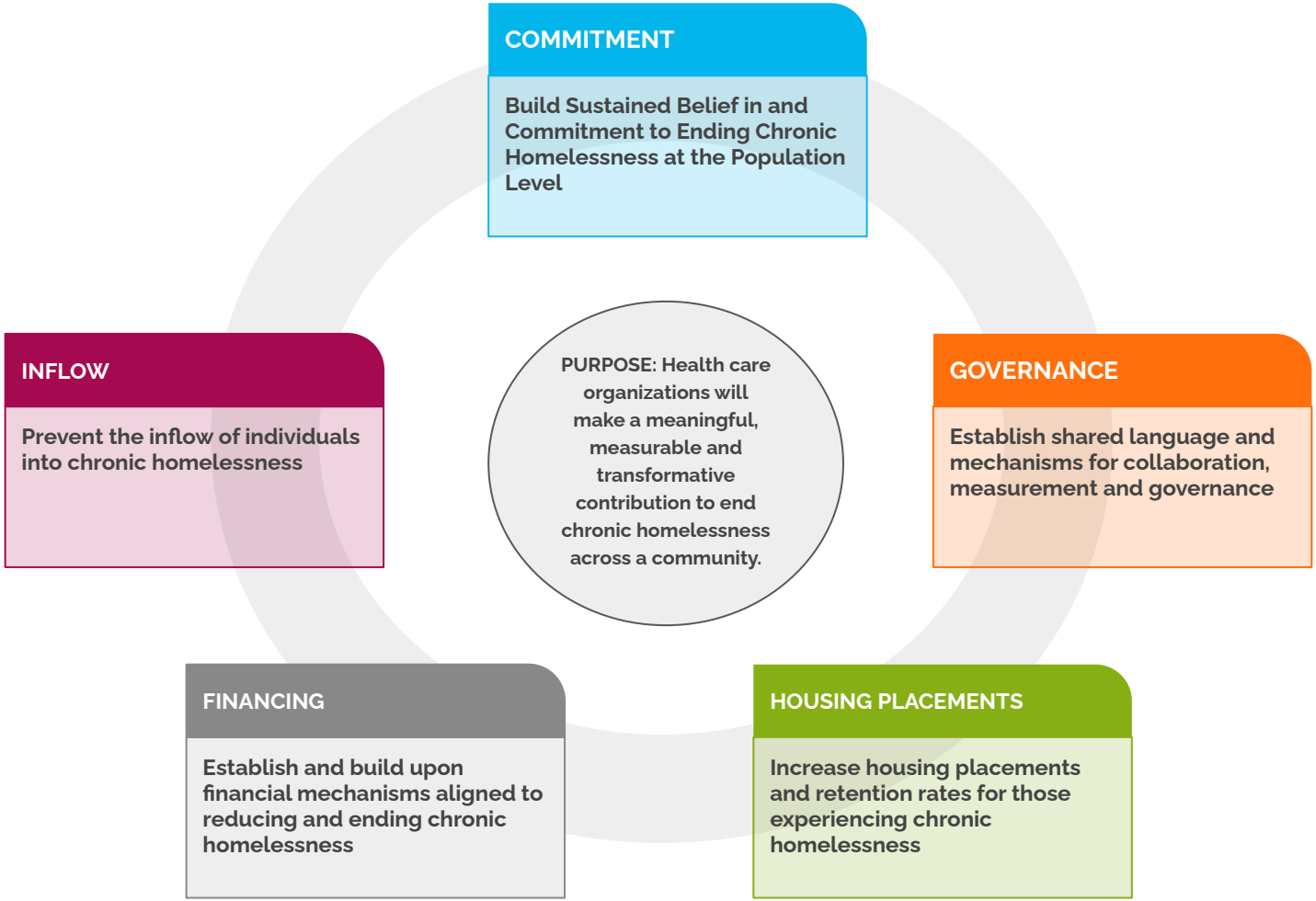
- Commit to the shared goal of ending chronic homelessness and create a path toward achieving it

Actions that Apply Across Pillars

- *Tap into why people do this work and why working to end chronic homelessness is better for people who are currently or at risk of being part of that population*

Terms to Define

- Mainstream agencies
- Inflow definition: shouldn't be inflow to "chronic" homelessness-->just "homelessness"
- Anchor Mission


COMMITMENT
Build Sustained Belief in and Commitment to Ending Chronic Homelessness at the Population Level
INFLOW
Prevent the inflow of individuals into chronic homelessness
PURPOSE: Health care organizations will make a meaningful, measurable and transformative contribution to end chronic homelessness across a community.
GOVERNANCE
Establish shared language and mechanisms for collaboration, measurement and governance
FINANCING
Establish and build upon financial mechanisms aligned to reducing and ending chronic homelessness
HOUSING PLACEMENTS
Increase housing placements and retention rates for those experiencing chronic homelessness