Baltimore, MD

May 15-18

#HCH2023

Toward Justice:

Leading With Lived Expertise

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

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Membership

The National Health Care for the Homeless Council is the premier national organization working at the nexus of homelessness and health. We unite thousands of health care professionals, people with the lived experience of homelessness, and advocates. Our 200+ Organizational Members include HCH programs, medical respite care programs, and housing and social service organizations from across the U.S.

Organizational Members of the Council have unique opportunities to network, collaborate, and advocate alongside an expansive group of leaders and professionals that work every day at the intersection of homelessness and health care. Additionally, you will be afforded special cost savings opportunities. Dues start as low as $500.

Join us as an **Individual Member** to access our communications, get involved in advocacy and research, help guide our strategic direction, and develop professionally through our three membership networks — the HCH Clinicians' Network, National Consumer Advisory Board, and Respite Care Providers Network.

POTENTIAL PHOTOGRAPHY, FILMING, & RECORDING

Please be aware that by attending HCH2023 and its related events, you consent to be photographed, filmed, and/or otherwise recorded. Your entry constitutes your consent to the capture of your image and/or statements for any purpose by the National HCH Council, whether now known or hereafter devised, in perpetuity. If you do not agree to the foregoing, please register your objection at the conference registration desk so we can try to accommodate your desire.

Welcome

Welcome to the 2023 National Health Care for the Homeless (HCH) Conference & Policy Symposium! The National Health Care for the Homeless Council is privileged to host the largest gathering of practitioners of homeless health care, medical respite care, advocates, people with lived experience of homelessness, and researchers about homelessness in the country. For many of us, the Conference is easily one of the highlights of the year. The National HCH Conference is a tremendous opportunity to learn, grow professionally, reconnect with colleagues, and make new connections with our loving community.

This year's theme is "Toward Justice: Leading with Lived Expertise." I don't remember who first said it, but the saying is true, so it's stuck with me over the years: Justice is what love looks like in action. Justice is organizing our individual actions and our society's structures to reflect how we would want to be treated if we had fewer advantages, or when we make mistakes, or experience hardship. The theme was chosen with recognition that we are not operating with justice if we only have compassion to serve, but don't listen and use the wisdom of the communities we want to serve. It was also chosen with a deep note of appreciation for the 20th anniversary of the National Consumer Advisory Board (NCAB).

NCAB is made up of those who have the lived experience of homelessness and are using that hard-won expertise to help HCH programs, medical respite programs, other service providers, and the Council improve our services. Simply put, if an agency wants to improve its services, it can only succeed but so much until it listens to and incorporates insight from those it is trying to serve. One of the many ways NCAB serves the HCH community is to help HCH programs establish, sustain, and maximize local Consumer (or Client) Advisory Boards (CABs) or find other ways to ensure that the knowledge of people with the lived experience of homelessness is incorporated into the agencies' decision-making. Consumers serve on the Council's Board of Directors and every Board committee and have helped the Council serve our HCH community in invaluable ways over the past 20 years. THANK YOU, NCAB!!
My sincere hope is that you will be equipped and energized through your participation in the #HCH2023 Conference & Policy Symposium to better advance justice through your life-saving, life-changing, and society-changing work in the HCH movement in your communities.

In solidarity,

Bobby Watts
CEO, National Health Care
for the Homeless Council

LET'S CONNECT

Share your conference experience on social media and connect with other attendees using the hashtag **#HCH2023**

Conference Overview

MONDAY, MAY 15 PRE-CONFERENCE INSTITUTES

7 a.m.-4:30 p.m.	Registration and Check-In Open
7-8:30 a.m.	Breakfast
8:30 a.m.-4:30 p.m.	Pre-Conference Institutes

TUESDAY, MAY 16 MAIN CONFERENCE DAY 1

7 a.m.-6 p.m.	Registration and Check-in Open
7 a.m.-6 p.m.	Exhibitor Hall Open
7-8:30 a.m.	Breakfast (including Clinicians' Network, RCPN, & VAP breakfasts)
7:30-8:30 a.m.	Site Visit Registration
8:30-9:30 a.m.	Opening Plenary and Keynote Presentation
9-11:30 a.m.	Mobile Medical Units On-Site
9:45-11 a.m.	Concurrent Breakout Sessions, Oral Presentations, Federal Panel
11 a.m.-12:30 p.m.	Lunch *(including Governing Membership Annual Meeting/Lunch)*
11:45 a.m.-3 p.m.	Site Visits
12:30-5 p.m.	Concurrent Breakout Sessions, Oral Presentations
5-6:30 p.m.	Welcome Reception and Poster Presentations

WEDNESDAY, MAY 17 MAIN CONFERENCE DAY 2

7 a.m.-6 p.m.	Registration and Check-in Open
7 a.m.-6 p.m.	Exhibitor Hall Open
7-8:30 a.m.	Breakfast
7:30-8:30 a.m.	Site Visit Registration
8:30-11:15 a.m.	Concurrent Breakout Sessions, Oral Presentations
7 a.m.-2 p.m.	Mobile Medical Units On-Site
11:15 a.m.-12:45 p.m.	Awards Luncheon (Ceremony,11:50 a.m.-12:35 p.m.)
11:45 a.m.-3 p.m.	Site Visits
12:45-3:30 p.m.	Concurrent Breakout Sessions, Oral Presentations
4-5 p.m.	Closing Plenary
5:15-6:30 p.m.	Rally

THURSDAY, MAY 18 LEARNING LABS

7-8:30 a.m.	Breakfast
8:30 a.m.-1:30 p.m.	Learning Labs

Keynote Speakers

DR. NAHEED DOSANI

Founder, Palliative Education and Care for the Homeless Program

As a palliative care physician and health justice activist, Dr. Naheed Dosani is dedicated to advancing equitable access to healthcare for people experiencing structural vulnerabilities like poverty and homelessness. These efforts include founding the Palliative Education and Care for the Homeless (PEACH) Program at the Inner City Health Associates, serving as the Medical Director of Kensington Hospice in downtown Toronto, a Health Equity Expert Advisor at the Canadian Partnership Against Cancer and as a palliative care physician at St. Michael's Hospital at Unity Health Toronto.

Dr. Dosani shares his passion for palliative care and health equity with learners as an Assistant Professor with the Department of Family and Community Medicine at the University of Toronto. His research interests include improving care models for people experiencing structural vulnerabilities and access to palliative care for culturally diverse communities.

Dr. Dosani has received many prestigious honours for his trailblazing work, including the Meritorious Service Cross for Humanitarianism from Canada's Governor General in 2018, a humanitarian award from the Canadian Society of Palliative Care Physicians in May 2019, and the Early Career Leader award from the Canadian Medical Association in 2020. He received an Honorary Degree (Doctor of Laws) from Ontario Tech University in 2022.

Tuesday, May 16 | 8:30 a.m. | Grand Ballroom

DENISE OCTAVIA SMITH

Founding Executive Director
National Association of Community Health Workers

Denise Octavia Smith, MBA, CHW, PN a woman of African descent, Community Health Worker, and survivor of a rare chronic disease is the founding Executive Director of the National Association of Community Health Workers. During the COVID-19 pandemic Denise partnered with global and US organizations to center CHWs' expertise, racial equity and authentic community-based partnership. Mrs. Smith is a Visiting Scholar at the Harvard Medical School Center for Primary Care, an Aspen Institute Healthy Communities Fellow, and a Robert Wood Johnson Culture of Health Leader. In 2013, Denise partnered with hundreds of CHWs to achieve historic community engagement and enrollment of 30,000 residents into her state's ACA Health Insurance Marketplace. Her research interests include building trust and relationship, patient and community-level health system governance, health insurance literacy and CHW policy leadership.

Wednesday, May 17 | 4 p.m. | Grand Ballroom

Award Winners

Philip W. Brickner National Leadership Award

Philip W. Brickner, MD (1928-2014), established Health Care for the Homeless (HCH) as a national model of care for severely disadvantaged persons. In 1983, Dr. Brickner was chosen to direct the HCH Demonstration Program of the Robert Wood Johnson Foundation (RWJF), the Pew Charitable Trust, and the U.S. Conference of Mayors. With his team from St. Vincent's Hospital, he selected projects in 19 cities and oversaw their implementation of multidisciplinary primary care efforts that were based upon his own work in New York City. The program was replicated by the 1987 Stewart B. McKinney Homeless Assistance Act and now includes approximately 300 federally-funded HCH programs nationally. In 2015, the Council's Board of Directors established the Brickner Award to honor annually an individual from our field who exemplifies Dr. Brickner's commitment to social justice, compassion, humility, inclusiveness, innovation, intellect, and persistence.

Brian Bickford

Brian Bickford is a licensed mental health counselor in Worcester, Mass. He began his career working with children in residential treatment facilities. He worked in various roles that led to the discovery of different engagement and clinical styles. His work with children taught him about himself personally and professionally. Later, Brian found himself aiding different populations in different organizational roles (i.e. clinician, manager, director, etc.). It became Brian's passion to assist and serve people experiencing homelessness in his community in Worcester. The Worcester Healthcare for the Homeless program led Brian to adopt an integrated team model for caring for people experiencing homelessness. He has a great appreciation for those we all serve. His sense of belonging and commitment to community change inspires the work he does today.

Currently, Brian is the Regional Manager for Eliot Community Human Services PATH team. He has found the perfect mixture of engaging with community members, providing direct care, supporting team members, and advocating at state and national levels for human rights. Brian is completing his sixth year on the National HCH Council Clinicians' Network Steering Committee and is the immediate past Chair. He has served on NHCHC's Board of Directors and Administrators Committee, has been involved in many local and national task forces, committees, and has lectured and provided training focused on Harm Reduction, Outreach Practices, and Housing and Homelessness. Brian advocates for community members who have been silenced, abused, and neglected by families, communities, organizations, institutions, and policy makers. He carries the voice of those he serves and aspires to support, nourish, and call for human rights, dignity, respect and community connections.

Ellen Dailey Consumer Advocate Award

The National Consumer Advisory Board's (NCAB) annual Ellen Dailey Consumer Advocate Award honors the spirit and strength of founding member Ellen Dailey, a passionate champion of consumer voices in the provision of homeless services who was instrumental in starting the Consumer Advisory Board at the Boston HCH Program in Boston, MA, and NCAB.

Albert Miller

Albert Miller is grateful that he is alive and has the opportunity to help with the goals of Health Care for the Homeless everyday which is the elimination of homelessness. Albert says his small part is dealing with inspiration, hope, and always giving a helping hand anywhere and anytime. His goal is to be an ambassador of Health Care for the Homeless for the rest of his life. He is thankful for all who have helped him – seen and unseen, and now he is back to work in the streets.

Award Winners

Karen Rotondo Award for Outstanding Service

The HCH Clinicians' Network's annual award celebrates the memory of the Network's "Founding Mother," Karen Rotondo. This award recognizes hands-on caregivers who demonstrate vision and creativity in advancing the goals of ending and preventing homelessness, and who have made a significant contribution to improving the health and quality of life of people without homes.

Jackie Alba-Nguyen

Jackie Alba-Nguyen, MD, is Assistant Medical Director at Valley Homeless Healthcare Program in San Jose, Calif. Jackie practices primary care, street medicine, trans care, and addiction medicine. In 2016, Jackie and VHHP opened the Gender Health Clinic for people experiencing homelessness, which later expanded to the Gender Health Center serving the entire county, regardless of housing status. Jackie has fiercely advocated to halt encampment sweeps in her community and for initiatives to decriminalize homelessness. A colleague says, "Dr. Alba-Nguyen does not simply provide medical services for her patients. She is inspired to create lasting systemic changes to improve the way her patients and future generations are treated. She has a genuine way of getting people to look at systemic inequities through a human lens which is her superpower."

Willie J. Mackey National Medical Respite Award

In tribute of the service and dedication of Council advocate and Respite Care Providers' Network member Willie J. Mackey, this award honors the outstanding contribution to the field of medical respite by a person, team, or agency, as determined by their efforts to improve the health and lives of people without homes.

Monte Hank

Monte has worked with the homeless population for the last 30 years, first providing Client Services/Case Management at Wasatch Homeless Health Care, Inc./ Fourth Street Clinic for 26 years. While there he created and developed Case Management/Care Coordination, a Recuperative Care Program, a Dental Referral Project, a TEAM approach (CPI) to address potentially violent situations and a Drug Assistance Program. He is one of the founders for the original idea of "Recuperative Care & Hospice Care" which became The INN Between. Monte was also a member of the original group who met in Chicago in 1999 to help form the Respite Care Provider Network. He has been at The INN Between for over 4 years, first working as the Administrator for the Assisted Living side and now as Client Services Director. Prior to this career (at 41) he returned to school to obtain an AS degree in Ethnic Minority Health & Human Services and a BA in Organizational Business. His prior education was from the "school of hard knocks."

Scholarship Winner

John N. Lozier Scholarship for New Members

The Lozier Scholarship supports one individual from an Organizational Member to attend the Conference for the first time. Meant to inspire new leaders in the HCH movement, this award honors John Lozier, the Council's founding executive director who shepherded the Council from a single staff and a handful of members to more than 20 staff and 220 members before his retirement in December 2016. We are grateful this scholarship furthers John's mission of broadening the HCH community.

Jessica Ward

Jessica Ward is the Data Manager for Albuquerque Health Care for the Homeless. Jessica Analyzes data and provides important insights for the organization. These insights allow her to identify patterns and trends that are used to directly aid in policy and programming decisions. The improved policies and programming that has evolved from Jessica's assistance has helped create positive outcomes for not only the staff, but the community she has passionately served for 7 years. Jessica focuses her career goals around advancing her skill-set and knowledge through continued education. She believes that she can always find more ways to improve the lives she influences by being a perpetual student.

Gender-Affirming Care 101: Clinical Competencies

britt walsh; **Paula M Neira**, Program Director of LGBTQ+ Equity and Education, Johns Hopkins Medicine Office of Diversity, Inclusion and Health Equity; **Vib Gonzalez**; **Andrew Spiers**, Director of Training & Technical Assistance, Housing First University, a program of Pathways to Housing PA

Gender-affirming care is a life-saving intervention, especially for gender-diverse individuals experiencing homelessness. This full-day training is intended for clinical providers who are new to gender-affirming health care and are seeking to gain foundational clinical competencies in hormone therapy (i.e. estrogen therapy, anti-androgen and testosterone therapy), surgical referrals, and gender-affirming primary care. Speakers include leading experts from The Fenway Institute and other nationally recognized trainers.

Laurel AD

Consumer Engagement: How Consumer Leaders Advance Health Care Systems

National Consumer Advisory Board

Consumers make unique and invaluable contributions to governance and advocacy, and their voices are vital to the continuous advancement of high-quality and accessible health care. Consumers from various parts of the country and with a wide range of consumer engagement expertise, in partnership with NHCHC staff, will explore various elements of consumer engagement at HCH programs, including promising practices, emerging issues, and current challenges during this full day training.

Essex ABC

Building a Healthier Foundation for Justice: The BIPOC Collective Experience

Kevonya Elzia, Director of JEDI, National Health Care for the Homeless Council**; Chante Gamby,** Founder, Housing Director, Fringe Counseling, Coaching, & Consulting LLC, Cook County Health

Consumers make unique and invaluable contributions to governance and advocacy, and their voices are vital to the continuous advancement of high-quality and accessible health care. Consumers from various parts of the country and with a wide range of consumer engagement expertise, in partnership with NHCHC staff, will explore various elements of consumer engagement at HCH programs, including promising practices, emerging issues, and current challenges during this full day training.

Harbor E

Harm Reduction and HCH: Supporting People Who Use Drugs Across the Spectrum of Care

Dr. Catherine Crosland, Director of Homeless Outreach, Unity Health Care, Inc.; **Hillary Miller** Project HOME-Street Medicine; **Devora Keller**, San Francisco Department of Public Health; **Joelle Puccio**, Academy of Perinatal Harm Reduction; **Jose Martinez**, National Harm Reduction Coalition; **Tanagra Melgarejo**, National Harm Reduction Coalition; **Molly Greenberg**, Baltimore Health Care for the Homeless; **Mishka Terplan**; **Nayeli Spahr**, Project HOME; **Rajani Gudlavalleti**, Baltimore Harm Reduction Coalition; Emma Roberts, National Harm Reduction Coalition; **Shawn Westfahl**, Overdose Prevention and Harm Reduction Coordinator, Prevention Point; **Will Miller, Jr.**, BMore Power

Harbor ABC

Co-sponsored by the National Harm Reduction Coalition and the National Health Care for the Homeless Council, this full-day session will focus on harm reduction practices to support people experiencing homelessness who use drugs. Taught by expert faculty from both the harm reduction and health care for the homeless communities, the day will include practical strategies for dismantling stigma, explore language and policies that support people who use drugs, examine the role of Federally Qualified Health Centers and Health Care for the Homeless health centers in syringe service programs, and highlight where the harm reduction movement is headed. The session will offer three breakout tracks in reproductive health, frontline service delivery, and meeting the needs of the Latinx community.

Medical Respite 101: Building a Sustainable Program

Angie Matthis, Greater Waterbury Health Partnership; **Leslie Swiderski**, Waterbury Hospital; **Brooks Ann McKinney**, Cone Health; **Laurel Nelson**, Center for Respite Care; **Julia Gaines**, COTS Recuperative Care; **Leta Davis**, Joseph's House; Mari Lowe, Christ House; **Annie Nicol**, Director of Homeless Services Petaluma Health Center, COTS Recuperative Care (consultant); **Robert Fulton**, Recuperative Care Program, Greater Portland Health; **Britt LaShier**, Recuperative Care Program, Greater Portland Health

Harbor D

Medical respite care is an essential service for people experiencing homelessness. While the number of medical respite programs has increased drastically over the last 5 years, there are still not enough beds to meet the growing needs of our vulnerable neighbors without homes. This PCI will focus on planning, developing, and piloting a medical respite program. Through panel presentations, interactive discussions, and virtual site visits, attendees will have an opportunity to learn how to define your program model, determine admission criteria, create a trauma-informed environment, build community partnerships, train and support staff, and negotiate with funders. Additionally, information will be provided on identifying outcome measures, policy implications for medical respite, and new resources available for communities as they create their medical respite services. Participants will have the opportunity to engage in information sharing and networking with providers from across the country.

Session Descriptions

Breakout Sessions
Tuesday, May 16 9:45-11 a.m.

Leading with lived experience: Empowering clients and residents in advocacy and decision making

Lara Pukatch, Director of Advocacy, Miriam's Kitchen; **Tony Burns**

Harbor A

Many homeless service and advocacy organizations, governments, and funders are committed to empowering leaders with lived experience of homelessness. But the roadmap for realizing this goal is not always clear. How and where to begin? What advice do clients have for organizations improving their commitment to this work? How can your organization move beyond checking the box and/or tokenizing community leaders? How can we meaningfully incorporate client leadership across all facets of an organization? What challenges come with building trauma-informed programs that maintain client choice and require extra resources? How can client leadership thrive in a hybrid or virtual work environment? How are can organizations understand and commit to this work in the context of their racial equity priorities? What are lessons learned from both organizations and individuals engaged in these partnerships? This session will feature an advocate with lived experience of homelessness, advocacy staff from a homeless services organization, and a DEI practitioner to discuss all these questions and more.

Site Visits

This year you have the opportunity to tour two sites that are part of the Health Care for the Homeless Baltimore program. Each day, 30 individuals will tour two of HCH's programs. Signups will begin at 7:30am on Tuesday and Wednesday outside of the Grand Ballroom (3rd floor).

During the site visits you will see:
Downtown Baltimore Clinic - 421 Fallsway is HCH's largest clinic location and offers comprehensive, interdisciplinary care on a walk-in and scheduled basis.

Sojourner at Oliver - HCH's newest housing project which was their first co-developed affordable housing project.

Site visits will be:
Tuesday, May 16 from 11:30-2: *please grab a quick bite to eat before meeting for the shuttle
Wednesday, May 17 from 1:30-4

Attendees are asked to wear a mask throughout the site visit.

Housing First for Health: Making Life Saving Medical Home Visits a Priority in Supportive Housing

Christy Respress, Pathways to Housing DC; **Carolyn Summer**, Unity Health Care

Harbor B

Primary care home-visit services are an essential and sorely lacking component needed in supportive housing programs serving formerly chronically homeless adults. There is no "one size fits all" approach to healthcare and services need to be tailored to meet the individual needs of the people we serve. While Healthcare for the Homeless (HCH) practitioners conduct "home visits" to people residing on the streets and in shelters, this service does not follow people once they move into housing. A collaboration between a large Housing First services organization and an HCH provider changed that paradigm with their innovative, sustainable, and replicable "Housing First for Health" pilot project.

Enormous health inequities are found amongst people experiencing homelessness as a result of systemic racism. In our community, 93% of adults experiencing homelessness are Black, compared to 47% of city residents as a whole. Black men can expect to live 17 years less than their White counterparts. The percentage of Black residents living with diabetes is nearly 6x higher, and the percentages of those living with high blood pressure and dying from heart disease are more than 2x higher. These outcomes are unacceptable and we MUST change them by changing how we deliver healthcare. Bringing healthcare to the homes of our clients is one way of bringing about health justice.

Our organization is dedicated to ending homelessness for people with disabilities using the Housing First model. From our inception, we've partnered with our local HCH provider to connect people with primary healthcare both on the streets and at HCH clinic sites. Even though we have a HCH clinic onsite, a percentage of our Housing First clients with the most complicated health challenges still weren't accessing primary care. In 2021, we received a significant contribution from a large healthcare company and we used it to create a Medical Home Visiting program called "Housing First for Health". The primary barriers to creating such a program in the past were a lack of flexible funding.

The first step of the pilot was prioritizing tenants with the most serious health conditions that put them at risk of premature death. Partnership and collaboration is key to the success of this pilot. Tenants in the Housing First program are assigned to a case manager and/or mental health support team who help them adjust to their new home, connect with healthcare, and achieve their individual goals.

Federal Panel

Emily Mosites, Special Populations Senior Advisor, Deputy Director for Infectious Diseases (DDID), CDC; **Barbara DiPietro**, Senior Director of Policy, National Health Care for the Homeless Council; **Erika Jones-Haskins**, Policy Director, U.S. Interagency Council on Homelessness (USICH); **Emily Rosenoff**, Director, Office of BHDAP; HHS Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services (HHS); **Jemine Bryon**, Deputy Assistant Secretary, Office of Special Needs, U.S. Department of Housing and Urban Development (HUD)

In this session, staff from federal agencies will discuss priority issues, funding opportunities, and other issues pertinent to the HCH community. This session will provide a forum for open discussion about programs and issues vital to health center operations. Time will be reserved for Q&A.

Harbor C

Using Point-of-Care Ultrasound as a Diagnostic and Engagement Tool in HCH Settings

Jennifer Nunes, Physician Assistant, Boston Health Care for the Homeless Program; **Rebecca Lee**, Boston Health Care for the Homeless Program; **Ryan Dono**, Medical Director of GLFHC Health Care for the Homeless Program, Greater Lawrence Family Health Center; **Jason Reinking**, Associate Medical Director, LifeLong Trust Health Center

Waterview AB

This workshop will consist of several case studies presented in a brief lecture followed by four rotating hands-on demonstrations featuring mobile, handheld ultrasound devices. We will show how specific point-of-care ultrasound (POCUS) techniques can be an attainable skill for both new and seasoned medical providers working in the field of homeless health care and offers another clinical datapoint for patients who often have major barriers to accessing traditional medical imaging modalities. The cases will highlight examples when POCUS was instrumental in making a diagnosis, determining a treatment plan, or as a clinical engagement tool to build patient trust. They will be drawn from examples when point-of-care ultrasound was used both in traditional clinical settings as well as on a mobile clinic or during street outreach. We will highlight how new technology allows POCUS to be more affordable and portable.

During the practice part of the workshop, participants will be exposed to the following ultrasound techniques: lung ultrasound for diagnosis of pleural effusion or lung consolidation; cardiac & inferior vena cava ultrasound for the evaluation of pericardial effusion, ejection fraction and fluid status; abdominal ultrasound for evaluation of ascites; soft tissue ultrasound for differentiating between cellulitis versus abscess; and ultrasound-guided venous blood draw. We will also provide equipment for participants to practice these techniques during the second half of the workshop.

Building a Data Bridge Between the Healthcare and Homeless Response System

Shawn Baker, Michigan Department of Health and Human Services; **Paula Kaiser Van Dam,** Director, Bureau of Community Services, Michigan Department of Health and Human Services; **Lynn Hendges**, Manager — Housing & Homeless Services, Michigan Department of Health & Human Services

Laurel CD

This workshop session will explain a new innovative and promising practice created to improve services to the homeless. This approach is relevant to a very real, current issue. Homeless service providers do not have a clear picture of their client's health history e.g. visits to the emergency room or to a mental health provider. Health plan workers often know little about their clients housing status.

This session will explain two new data matching projects that will present homeless service providers a clearer picture as they prioritize very limited housing resources for the most vulnerable. It also provides an opportunity to consider agency policies for the exchange of data to improve health and housing.

The first project is the Homeless Vulnerability Indicator in Care Connect360 (CC360). The CC360 platform is a system used by Medicaid Health Plan and Prepaid Inpatient Health Plan workers and managers to record and track the health information of their members. With the Homeless Vulnerability Indicator, they will now be able to see when one of their members is facing homelessness. A specified homeless agency contact will be provided to ensure the facilitation of collaboration for the benefit of the member.

The second data project is the Medical Fragility Score. This score gives homeless service agencies and their Housing Case Managers limited access to the CC360 system. Once the Medical Fragility Score is put into CC360, it will give Housing Case Managers an indicator of the level of health issues a homeless individual is dealing with. Participants will learn how these initiatives work, what the process includes, how they may assist in their work, and steps for implementation and replication.

Oral Presentation: Harm Reduction

Kara Cohen, Associate Director of Street Medicine, Project HOME Healthcare Services; **Maire St. Ledger**, Project HOME; **Katie Burk**, Managing Consultant, Facente Consulting

Location: Kent ABC

Oral Presentation: Gendered Experience of Homelessness

Ruthanne Marcus, Centers for Disease Control & Prevention; **Leah Warner**, San Francisco Department of Public Health

Location: Essex ABC

"More Than Healthcare": Using Direct Patient Feedback to Create a Measurement Tool for SDOH

Sarajane Brittis, The Floating Hospital; **Igda Martinez**, The Floating Hospital; **Meghan Miller**, Director of Health Education, The Floating Hospital

Harbor E

Health can be directly impacted by social determinants, such as access one's to care and physical environment. Because individuals living in temporary housing are often disproportionately affected by these Social Determinants of Health (SDoH), our organization created a study to assess the risk factors related to socio-environmental conditions. The study utilized a 34-item questionnaire that was developed and pilot tested through direct feedback from patients living in an urban shelter system.

Through an iterative research process that involved nearly 400 patients, results identified several SDoH that disproportionately affected our patients. Lack of food, clothing, social support, and adequate housing were the most often cited needs of our respondents, with many stating that they didn't know where to go to find information or acquire necessities. The results of this study directly informed the development of our life-skills programming and expansion of the health-education department.

Building on the enthusiasm and investment of our patients, we created evidence-based, innovative programs that are "more than healthcare." Our life-skills team builds upon patient strengths to help resolve and address patients' barriers and stressors. Our education department has introduced relevant programming such as financial literacy, personal advocacy and nutrition as well as individualized goal-setting sessions.

While innovative, these programs are not one-of-a-kind and can be replicated by other organizations with policy implications. The expectations of this workshop will be to help organizations identify SDoH among the unhoused populations and discuss ways in which they can build similar programs to mitigate adverse and elevate beneficial SDoH for their patients through the "more than healthcare" approach.

Building Service Capacity Through a Model Workforce Development Program

Kelly Bruno Nelson, CalOptima Health; **Danielle Cameron**, Director, Program Development, Medi-Cal and CalAIM, CalOptima Health; **Mia Arias**, Director of CalAIM Operations, CalOptima Health; **Adam Hirsch**, Director of Business Development, CHRYSALIS

Dover ABC

In late 2022, a managed care plan began a partnership with a community-based organization that had an impressive history of partnering with local employment partners to effectively meet staffing needs, while also providing opportunities for individuals with lived experience and other barriers to integrate into the workplace. Together they sought to address several regional concerns: lack of employment opportunities for people with lived experience and other employment barriers; lack of trained job applicants for positions that would ultimately increase capacity of the homeless services continuum; the improvement of job opportunities (e.g. living wage adjustments) for this population; and increasing the diversity of the staff within homeless service provider organizations so that they might better reflect the diversity of the population being served. Ultimately these partners collaborated to offer a workforce training program that made progress on all those regional concerns. This session will review work done to-date on this project, successes achieved, barriers faced along the way, and the work left to be accomplished.

Innovative Solutions: Leading with Lived Experience

Sketch Oppie, Executive Committee member Lived Experience Advisory Board, LEABsv; **Marti Phillips**, Senior Project Manager, Bitfocus; **Maureen Damrel**

Laurel AB

The Customer Facing Portal provides opportunities for individuals with lived experience of homelessness to inform and test new technology designed to expand client access and choice. The program included Lived Experience Advisory Board members and other individuals with lived experience of homelessness, working in collaboration with other organizations to create the Customer Facing Portal. The Customer Facing Portal is a new tool that provides clients access to components of their HMIS record. It includes a suite of features to empower clients with increased choice and personal agency in their journey to permanent housing. Centering Lived Experience in the collaborative approach to technology advancements is leading to a shift in power from information only being available to the providers to a customer facing portal that empowers the consumer to access their own information and provides a model for other communities to follow. The customer facing portal eliminates many of the barriers currently that an unhoused individual faces when beginning to access resources. The customer-facing portal allows the consumer to pin their location, provides a resource guide showing them what nearby resources are, they can message their case manager, able to receive notifications on upcoming appointments, able to sign ROIs electronically, are able to upload important documentation so as to have access to it without it being lost or stolen and are able to login from anywhere to do all of this.

Building the Plane while Flying: Applying Lessons Learned during COVID to the Migrant Crisis

Mary Tornabene, FNP, Manager of Shelter Base Care Services, Heartland Alliance Health; **Colleen Ryan**, Nurse Practitioner, Heartland Alliance Health

Harbor D

Our organization is a federally qualified health center in the Midwest with a focus providing integrated health care to the individuals experiencing homelessness. We have a long history of serving refugees and migrants that are new to the country, thus providing care to persons seeking asylum and those with refugee status is second area of expertise for us. We currently work collaboratively with refugee resettlement agencies and provide care for torture victims through a dedicated team and a network of local partners.

Our city is an established sanctuary city and recently we received several busloads of migrants from South America and Western Africa that appeared with little or no warning. We were called upon to rapidly respond to this humanitarian crisis and address the medical and behavioral health needs for this group of people. After two years of work providing care in the midst of the COVID pandemic, we were well suited to quickly pivot and respond to this request.

This presentation will discuss how we rapidly shifted to offer medical and behavioral health care built on a city wide network of individuals and organizations who had already come together to address the pandemic. Our organizations' history of working with those experiencing homelessness and the refugee community allowed us to be successful. We will describe the workflows created in collaboration with asylum seekers and the special tools we modified to offer screenings and referrals for specialty care. We will talk about our efforts to engage other organizations in our existing network to share the load. The presentation will also summarize the clinical services that we provided and the lessons learned about providing care to this special population.

Providing Equitable & Effective Addiction Care for People Experiencing Homelessness

Fabiola Arbelo-Cruz, Assistant Professor of Psychiatry, Yale School of Medicine; **Dr. Jeremy Weleff**, Addiction Psychiatrist; Yale School of Medicine; **Nicholaus Christian**, Yale Program in Addiction Medicine

Harbor D

People experiencing homelessness (PEH) have increased rates of polysubstance use and more than 12x the risk of overdose mortality compared to the general population (Fine, 2022). Being homeless makes it difficult to meet basic biological needs, and shelters often utilize congregate living arrangements that can be challenging for people seeking recovery. The Housing First approach has been effective at providing PEH with rapid housing that can stabilize medical conditions without increasing substance use (Baxter, 2019). However, housing is only one step towards improved health, and an addiction treatment gap persists along the continuum of unsheltered homelessness to stable housing. Primary care providers that serve PEH are uniquely positioned to deliver low-threshold addiction care to combat the escalating rates of homelessness and associated overdoses. This workshop will cover the core components of addiction care, including the basics of medications to treat addiction in low-threshold settings, trust-building practices and harm reduction approaches to engage PEH in addiction treatment. An addiction medicine/internal medicine clinician and two addiction psychiatry physicians with extensive experience in homeless mobile outreach will lead the session. Small group discussions based on videos of people with lived experience of homelessness (PLEH) will be used to demonstrate the barriers that patients face in getting addiction care, and open dialogue on how to address these barriers. The session will end with case-based discussions to model complex medication management needs for PEH, and teach a framework for creating an addiction care plan for a patient experiencing homelessness. This workshop will better equip providers to provide equitable and evidence-based addiction care for patients experiencing homelessness.

Oral Presentation: Medical Respite Operation and Evaluation

Marc O Griofa, City of Las Vegas; **Greg Morris**, CEO, Ascending to Health Respite Care; **Devin Miller,** Program Manager, Colorado Department of Health Care Policy & Financing

Location: Harbor A

Oral Presentation: Mobile Outreach

Hugh Silk, Road to Care; **Rebecca Stauffe**r, CohnReznick; **Brian Bickford**, Central Mass PATH Regional Manager, Eliot CHS Homeless Services; **Jillian Joseph**, Road to Care; **Erik Garcia**, Road to Car**e**

Location: Kent ABC

Oral Presentation: Replicable Trauma-Informed Outreach

Caroline Waddell, CDC; **Tyler Gray**

Location: Essex ABC

Minnesota Homeless Mortality Study, 2017-2021

Katherine Diaz-Vickery, Medical Director, Clinician-Investigator, Hennepin County Health Care for the Homeless; **Jonda Crum**, Certified Peer Recovery Specialist — Forensic Endorsed, Minnesota Recovery Connection; **Josh Leopold**, Minnesota Department of Health

Laurel CD

The Minnesota Department of Health recently collaborated with the Health, Homelessness, and Criminal Justice Lab at the Hennepin Healthcare Research Institute to conduct the first systematic examination of mortality among people experiencing homelessness (PEH) who die in Minnesota (Minnesota Homeless Mortality Report, 2017-2021 (state.mn.us)). The researchers merged Minnesota state death data, Minnesota Homeless Management Information System data, and Minnesota population data from the Census from 2017-2021 to compare sociodemographic differences and causes of death among PEH and the general Minnesota population. The analysis showed that PEH have mortality rates three times higher than the general Minnesota population and American Indian PEH have mortality rates 5 times higher than the general Minnesota population. Substance use was the leading cause of death among people experiencing homelessness, accounting for more than one in three of all deaths observed during the study period. PEH were 10 times more likely to die from a substance-use related cause than the general Minnesota population. This work was done through MDH's Center of Excellence on Public Health and Homelessness with funding by the CDC Foundation. The Center's Advisory Group, which includes people with lived experience, clinicians, public health officials, and homeless service providers, informed the study design, data interpretation, and public engagement of the results. MDH also conducted interviews with people with lived experience to better understand the stories behind the data. The interviews demonstrate the importance of trauma and adverse childhood experience in people's life trajectories.

Expanding on Alcohol Harm Reduction: The San Francisco Managed Alcohol Program

Alice Moughamian, Nurse Manager, San Francisco Department of Public Health; **Michelle Nance**, Nurse Practitioner, San Francisco Department of Public Health; **Bryce Bridge**, UCSF

Harbor E

The San Francisco Department of Public Health (SFDPH) created a Managed Alcohol Program (MAP) as part of the COVID-19 response to curb emergency care utilization among at-risk people with severe alcohol use disorder (AUD). MAP is a residential program that provides motel rooms, three meals a day, community activities and programming, and nurse administered standard dose equivalents of vodka or beer to program participants. This workshop will describe all aspects of Managed Alcohol as a harm reduction model for providing care to those experiencing homelessness with severe AUD. This workshop will start with an overview of Managed Alcohol as a care model, how we include harm reduction in the program's philosophical framework, how the program was developed and now sustained in terms of staffing and funding. Presenters will then share special considerations for program development such as identifying community stakeholders, working with special populations such as the LatinX/Indigenous community, and incorporating participant feedback into program policies and protocols. We will then discuss the updated clinical outcomes and measures of program success. Finally, presenters will discuss and facilitate a discussion on a complex case study to address the ethics the program has faced when harm reduction and client autonomy meet the core clinical tenet of non-maleficence or "do no harm" for program clinical staff.

Managing Controlled Medications in Homeless Patients: A Framework Informed by Lived Experience

Libbi Cox, Prevention Point Pittsburgh; **Dr. Liz Frye**, Street Psychiatrist, Center for Inclusion Health at Allegheny Health Network; **Katherine Koh**, Boston Health Care for the Homeless Program

Harbor B

Managing controlled medications in patients experiencing homelessness (PEH) is one of the most common clinical challenges faced by providers. Patients often ask for controlled medications like benzodiazepines and stimulants to survive "the rigors of homelessness." Prescribers are often torn between prescribing to maintain alliance or reduce suffering in the patient vs. not prescribing due to concerns for addictive potential or safety risk of overdose and death. As a person with lived experience and two street psychiatrists practicing for a total of 15 years, we have found this to be one of the most significant challenges in the provider-patient relationship in caring for PEH.

This presentation will a) provide novel, original research conducted by one of the presenters on the rates of benzodiazepine prescribing for PEH (n = 244,113) vs. housed patients (n = 2,763,513) with mental illness in the VA, revealing the high rates of prescribing multiple benzodiazepines at once, and high rates of co-prescriptions with opioids (31.0% vs. 25.5%, $p < .001$) and other sedatives (55.1% vs 38.0%, $p<.001$) in PEH; b) review the existing literature on controlled medication prescribing for PEH; c) provide the perspective of a person with lived experience of mental illness and describe the reasons that patients may want these medications; d) outline a framework for how to assess the risks and benefits of prescribing controlled medications for PEH and e) solicit audience participation regarding challenges and effective approaches for managing controlled medications in PEH.

We will consider this topic through the lens of this year's conference theme, justice, balancing both justice in giving the patient relief from suffering and also justice by minimizing medical harm to patients through thoughtful clinical decision-making.

HRSA Panel

Barbara DiPietro, Senior Director of Policy, National Health Care for the Homeless Council; **James Macrae**, Associate Administrator, Bureau of Primary Health Care; **Jennifer Joseph**, Director, Office of Quality Improvement, Bureau of Primary Health Care; **Sue Lin**, Deputy Director, Office of Quality Improvement, Bureau of Primary Health Care

Harbor C

In this session, staff from HRSA's Bureau of Primary Health Care (BPHC) will discuss priority issues, funding opportunities, and other issues pertinent to the HCH community. This session will provide an opportunity to hold conversation and ask questions related to issues specific to health center operations. Time will be reserved for Q&A.

The Health and Housing Impact of the Flexible Housing Pool Program of Chicago & Cook County

Keiki Hinami, Director of Applied Research, Center for Health Equity, Cook County Health; **Peter Toepfer**, Executive Director, Center for Housing and Health; **Kayla Wallace**

Dover ABC

In an interactive workshop format, we propose to present our evaluation of the Flexible Housing Pool program of Chicago and Cook County (FHPCC). FHPCC expands the supply of permanent supportive housing (PSH) units and lowers eligibility barriers to PSH for high-risk individuals and families experiencing homelessness in the region. FHPCC's innovative features comprise (1) a public escrow fund that collects contributions from regional government agencies, private foundations, and healthcare organizations; (2) a cross sector data-driven approach to identifying candidates with justice-involvement and chronic conditions that contribute to higher use of crisis systems; (3) deep partnership between housing and healthcare organizations to deliver comprehensive support services; and (4) a commitment to alleviate racial disparities in housing. Since 2019, FHPCC housed over 500 adults, youths, and families, 93% of whom remain in the program or graduated into independently supported stable housing as of 2022. When the pandemic and the response to it ushered an alarming rise in all-cause mortality among the region's people experiencing homelessness – driven primarily by drug- and alcohol-related causes – clients housed in FHPCC was associated with a 30% reduction in the risk of premature death compared to matched controls. We also detected PSH-attributable reductions in the risk of jail registrations and hospital encounters. In an interactive format, we will share details around establishing, operating, and evaluating the FHPCC for jurisdictions seeking to replicate this successful program model.

Developing a Model of On Site Geriatric Care for People with Lived Experience of Homelessness

Dr. Van Yu, Chief Medical Officer, Janian Medical Care

Laurel AB

In an interactive workshop format, we propose to present our evaluation of the Flexible Housing Pool program of Chicago and Cook County (FHPCC). FHPCC expands the supply of permanent supportive housing (PSH) units and lowers eligibility barriers to PSH for high-risk individuals and families experiencing homelessness in the region. FHPCC's innovative features comprise (1) a public escrow fund that collects contributions from regional government agencies, private foundations, and healthcare organizations; (2) a cross sector data-driven approach to identifying candidates with justice-involvement and chronic conditions that contribute to higher use of crisis systems; (3) deep partnership between housing and healthcare organizations to deliver comprehensive support services; and (4) a commitment to alleviate racial disparities in housing. Since 2019, FHPCC housed over 500 adults, youths, and families, 93% of whom remain in the program or graduated into independently supported stable housing as of 2022. When the pandemic and the response to it ushered an alarming rise in all-cause mortality among the region's people experiencing homelessness – driven primarily by drug- and alcohol-related causes – clients housed in FHPCC was associated with a 30% reduction in the risk of premature death compared to matched controls. We also detected PSH-attributable reductions in the risk of jail registrations and hospital encounters. In an interactive format, we will share details around establishing, operating, and evaluating the FHPCC for jurisdictions seeking to replicate this successful program model.

Session Descriptions

Breakout Sessions
Tuesday, May 16 2-3:15 p.m.

Centering lived experience and justice with people navigating homelessness and substance use

Maureen Sumner, House of Hope; **Megan Smith**, House of Hope

Harbor C

Our organization's street outreach program comprises case managers (many of whom are social workers), physicians (psychiatry, internal medicine, and emergency medicine), interns (including social work and public health), students (including medicine, undergraduate, and social work), residents (internal medicine, family medicine, triple board), and people with lived experience with homelessness and intersectional concerns (not as discrete from these other constituent groups). Within the last year, we have seen a significant upsurge in the number of people who are talking with us about their use of fentanyl, crystal meth, and pressed pills, among other substances. This has led us as a program to deepen our thinking about how to best support and advocate for these individuals in the manner of their choosing. Most fundamentally, these conversations have underscored the deep connection between individuals' use of substances and their experiences of trauma, marginalization, and disaffection. We have aimed to center this lived expertise both in how we talk about substance use with those we meet on outreach and those learners with whom we do outreach. We have also utilized it to guide our resourcing and networking, including by bolstering our connections with local peer-led harm reduction initiatives, the buprenorphine hotline, and the state's comprehensive toxicology pilot.

We have continued to reckon with the burden of stigma placed on people who use drugs, pervasively from outside and quite often from within the homeless service provider network and homeless community itself. We follow the work of the Vancouver Area Network of Drug Users and other drug user activist organizations, but do not have this resource locally.

Oral Presentation: Behavioral Health Access and Therapy

Joseph Morrison, University of California, Davis; **Helen Dang**, University of California, Davis; **Ritz Tolentino**, University of California, Davis; **Kirsten Dickins**, Rush University Medical Center

Location: Harbor A

Oral Presentation: Changing Climates — Climate resilient housing and workforce burnout

Rachel Maas, Central City Concern; **Kristina Gunhouse-Vigil**, Director of Workforce Transformation, San Francisco Community Health Center; **Richard Bruno**, Central City Concerne

Location: Kent ABC

Oral Presentation: Addiction Recovery and Sober Living

Michael Mayer, Boston Healthcare for the Homeless Program; **Dr. Mary Lashley**, Professor, Towson University Department of Nursing; **Dr. Jason Worcester**, Medical Director, Boston Accountable Care Organization; **Andrew Maier**, Executive Assistant, Boston Healthcare for the Homeless Program Consumer Advisory Board

Location: Essex ABC

Addressing the Needs of Immigrant Patients with Experiences of Homelessness: Tools for Best Practice

Aura Obando, Family Team Medical Director, Boston Healthcare for the Homeless Program; Massachusetts General Hospital; **Margaret (Maggie) Sullivan**, Director, Oasis, Boston Healthcare for the Homeless Program | FXB Center for Health & Human Rights at Harvard

Harbor D

Immigration status is a well recognized social determinant of health and can compound the social and medical needs of HCH immigrant patients. Immigration law directly influences non-citizens' eligibility for a wide array of benefits and services, including health insurance. The health consequences of limited access to care are particularly magnified for those experiencing homelessness.

This workshop will employ case-based discussions to describe and address common barriers to care immigrant patients face. We will specifically address how to optimize health care delivery for immigrant patients experiencing homelessness by ensuring appropriate language access, developing policies on law enforcement requests to enter the premises, and use of welcoming signage, among other tools. In small groups, we will discuss the importance of understanding our patients' immigration journeys, how to elicit such histories in a trauma-informed way, and how this information may be useful in revealing previously unidentified medical and mental health needs. Additionally, we will discuss how disclosure of certain kinds of trauma such as torture and domestic violence, may provide the patient a path toward a more permanent legal status, emphasizing the role of the health care worker in facilitating referrals to immigration attorneys.

In this workshop we will share some of the steps we have taken at BHCHP to inform and empower our immigrant patients, including: Know Your Rights trainings, creating a clinic dedicated to immigrant health, forging Medical Legal Partnerships, and more. We will also share staff capacity-building opportunities that have helped close gaps in care across patients of various language backgrounds, including trainings, hiring practices that prioritize cultural and language diversity, enhanced access to interpreter services, and more. We will also discuss the value of coalition building in enabling the sharing of best practices and prioritizing advocacy opportunities. One potential outcome from the workshop may be to generate a working group amongst HCHs interested in immigrant health and policy. establishing, operating, and evaluating the FHPCC for jurisdictions seeking to replicate this successful program model.

Thriving Beyond Recuperative Care: Navigation & Support for Graduates

Monica Ray, Population Health Strategic Development Manager, Cottage Health;
Salvador Robledo, Cottage Health; Marguerite Pak-Greeley, Cottage Health

Dover ABC

As one of only a few health system-led medical respite programs in the nation, our recuperative care program (RCP) supports patients during their stay in the program and continues with wrap-around care after exiting the program. As a ten-bed respite care for those experiencing homelessness and medical needs, the RCP offers up to 90 days in a local shelter with intensive supportive services. Patients graduating from the program continue to receive services, including case management, nursing, and healthcare navigation.

Since launch in 2018, the RCP has cared for more than 100 unique patients, with more than half of these patients entering permanent housing. Operating in a housing-scarce environment, this RCP's approach for graduates is instrumental in their securing and retaining permanent housing. Individuals exiting the program have a dedicated registered nurse, community health navigator, and social worker helping to address their basic and clinical care needs. Advantages to this model include increased connections to permanent housing and lower rates of graduates falling out of housing. A Patient Advisory Committee and developmental and participatory evaluation provide process improvement and programmatic guidance. In addition, the health system's leadership here ensures access to coordinated care with electronic medical record documentation, connection to the health system's recuperative care workforce development program, clinical resources, and a high level of buy-in and collaboration from community partners, including funders. This workshop will share this model of health system-led recuperative care and follow-up support, identify strategies for partnership between health systems, shelters, and patients for implementation and evaluation, and facilitate conversation to share learnings and experiences from participants.

Lifting up the Expertise of People with Lived Expertise in Program Design: Implementing MAT Services

Adam Woodruff, Highland Hospital; **Dr. Aislinn Bird**, Psychiatrist, Alameda County Health Care for the Homeless; **Catherine Hayes**, Cardea Health

Laurel CD

In our community, nearly one person dies of a suspected overdose every day. In 2021, over half of the overdose deaths were people currently or formerly homeless. Many unhoused people were granted much needed housing during the COVID-19 pandemic. However, this has led to many people being isolated from their community, who now find themselves engaging in substance use alone, which places them at higher risk of accidental overdose. This is the case at a large supportive housing site in an urban setting. We recognize the need to bring harm reduction services and substance use disorder (SUD) treatment to people where they live, whether in the street, shelter, or supportive housing. People with lived expertise working in harm reduction/ MAT programs is another critical way to meet people where they are at. With this in mind, we are developing a harm reduction/MAT program that will be embedded in this supportive housing site—developed and led by peer harm reduction specialists.

As part of the development of this pilot program, we have partnered with a MAT program in a busy, urban emergency department where peer substance use navigators are integral to the success of their program. We are working closely with their peer specialists in designing our pilot program. The presentation will highlight the importance of having people with lived expertise participate in the program design, how to best support peers through this process, and how SUD treatment can and should be offered in non-traditional settings.

It Takes a Village: An Integrated Safety Net for Housing Insecure Older Adults in a Health Plan

Rosaneli Loza, Manager, Connecting Provider to Home, SCAN Health Plan; **Aiko Tan**, SCAN Health Plan; **Michael Jordan**, Healthcare in Action

Laurel AB

A health plan developed programs to serve as an integrated safety net for older adults experiencing housing insecurity. The program included interventions to address whole-person care, what matters to the member, and the root causes of housing insecurity -- social needs, economic hardship, interpersonal concerns, and health conditions within the healthcare system. This includes housing navigation, retention, and upstream homelessness prevention (allowing older adults to remain safely housed or get re-housed in safe and accessible dwellings).

A two-year retrospective study (2020-2021) was completed for 71 housing insecure members who completed the intervention. Post-intervention, the team helped 83% of members get re-housed or prevent homelessness and connected all members with housing programs by performing a constellation of interventions to ensure members did not need to choose between rent and other necessities. Implications and findings demonstrate that older adults need personalized one-on-one assistance to navigate the housing support system and that it's critical to address older adults' medical needs to help members stay housed. For example, many members identified as homeless due to interpersonal issues often had untreated cognitive decline/behavioral concerns that benefited from medical treatment. Accordingly, the team was able to connect 95% of members to their healthcare team for appropriate care, including specialties, behavioral and mental health, pain management, vision and dental.

This initiative has evolved with the state's Medicaid efforts to provide community supports through partnering and contracting with vendors and has housed and prevented homeless for 58 members in 2022 YTD.

The why behind MMI2-SWC, murdered & missing 2-spirit individuals, women & children it's an epidemic

Bridie Johnson, Senior Director of Behavioral Health Services, Colorado Coalition for the Homeless

Waterview AB

Points of Care: Creating an Emergency Department That Effectively Serves the Unhoused

Sophia Druffner, PhD student, Vanderbilt University Community Action Research Program

Harbor E

People experiencing housing instability are at higher risk for emergency department admissions, poor health outcomes and shorter life-expectancies. In September 2022, a major hospital in the mid-South implemented a two-question housing screening tool within the Emergency Department as a standard part of registration and triage. When the patient is identified as housing unstable, a social worker consultation is requested. Interviews are currently taking place with social workers, healthcare providers, and registration staff in the ED as to their experience with the two-question screening criteria. A separate qualitative study, consisting of individual and focus group interviews, will be conducted in January 2023 to determine themes in the experiences of unhoused persons in the ED of this hospital. Results from both studies will be available and ready for presentation at the NHCHC conference.

Ensuring the Wheels Keep Turning for Mobile Health Clinics to Provide Health Care for The Homeless

Rebecca Stauffer, CohnReznick; **Miranda Von Dornum**, Chief Medical Officer, Project Renewal; **Jermaine Pope**, Project Renewal

Harbor B

How does a health center create and launch a mobile health clinic and maintain a sustainable, viable mobile service delivery program? This session will provide best practices to create a sustainability plan for a mobile health clinic with a financial model and best practices for clinical operations, workforce, and vehicular management and maintenance.

The most critical aspect of delivering health care to individuals experiencing homelessness is to meet them where they are – and a mobile clinic is the perfect modality in which to bring needed health care services to those who are in most need of compassionate medical care. Mobile health units can be customized to deliver a variety of health care services, such as primary care, dental, behavioral health, and drug user health services.

The key to developing a successful mobile health unit is understand the environmental factors, population's needs for services, and the staff structure the organization can develop to deliver services. Each mobile problem is unique and customized to the environment, the patient population, and the services delivered. Therefore, health centers need to be able to assess opportunities to build a mobile health program that fits their organization and the patient populations' needs.

This session will be presented in partnership by a clinical and operational staff from a homeless health care provider in a large urban environment that runs a multi-fleet mobile health program serving the complex needs of unhoused and chronically ill individuals and a national consulting firm with experience in strategic planning and business development for FQHCs.

Improving Outcomes and protecting from compassion fatigue by learning Motivational Interviewing

Rafael Martinez, LCSW, Director of Behavioral Health, Circle the City

This presentation will focus on encouraging clinical excellence of helpers as they provide care to our most vulnerable while providing a framework that not only protects the helpers from compassion fatigue, but promotes a worldview of partnership, optimism and empowerment.

Harbor A

Motivational Interviewing (MI) can be defined as a particular way of talking with people about change and growth to strengthens their own motivation and commitment to making changes in their lives. It is true that nobody can make anybody do anything. Be it flossing, exercise, working with housing navigators or substance use treatment. Often, in our desire to help, our "fixing impulse" is activated and we tell people what they should be doing. Even in the most client centered manner, this strategy may have the opposite effect of helping, instead causing people to be defensive, not trusting and turning away from us. MI provides an evidenced based set of strategies that evokes that internal motivation creating space for people to create their own arguments for change.

It is common for helpers to feel it is our responsibility to "save" the patient by healing wounds, obtaining housing or entering treatment. And if the patient does not change, it is because we did something wrong. This can lead to compassion fatigue. Our job is to provide the best services possible that promote change, and that is all the control we have. MI provides evidence-based interventions that allows a helper to definitely say, "I did the best I could in this situation." Additionally, the spirit of MI which is partnership, empowerment, acceptance and compassion supports a perspective that does not support the "It is up to me to save this person." It is up to the help and the person.

Oral Presentation: Transitions to Hospitals and Hospice

Stephen Hwang, St. Michael's Hospital, Unity Health Toronto; **Br. James Hall**, Executive Director, Rocky Mountain Refuge

Location: Essex ABC

Oral Presentation: Trauma-informed Sex Safety

Meghan Miller, Director of Health Education, The Floating Hospital; **Karen Hudson**, Program Leader, Homeless Health Initiative, Children's Hospital of Philadelphia; **Erica Pugh**, Temple University

Location: Kent ABC

Hopeless to Homeless to Hired to Housing: Getting the right veteran for the right job

Jeffrey Walsh, Illinois State, UNICEF, Polish Red Cross

Waterview AB

Beyond 'Treatment as Usual': Adapting the Primary Care Behavioral Health model

Sydney Fontanares, County of Santa Clara; **Anthony Moore**

Harbor C

Often, people who are homeless face multiple barriers to accessing behavioral health care and adhering to treatment recommendations. At the Valley Homeless Healthcare Program, the typical primary care behavioral health model has been modified to address these unique mental health needs. Instead of using an appointment based schedule, at our clinics, it utilizes a "walk in" model to help encourage patients to come in when they can (missed appointments are usually due to limited resources, such as finances, transportation, and childcare). Interdisciplinary teamwork is an essential component of providing healthcare for homeless clients and is also heavily used at VHHP, thus using "warm hand offs: and informal team collaboration between the psychology team and other disciplines has been useful in addressing the spectrum of psychosocial needs of the homeless client. Psychotherapy with the homeless population is not "treatment as usual." The clinician serves as a stable contact person who invests time to help them locate and secure necessary resources, reconnecting them with supportive communities, and being an advocate on their behalf when appropriate. Homelessness is a complex, interdisciplinary issue and one that psychology can help provide solutions for.

Leveraging Resources to Build Partnerships between Health & Homeless Systems

Gillian Morshedi, Directing Attorney, Homebase; **Gaya Amirthavasar**, Social Determinants of Health Manager, Santa Clara Family Health Plan

Laurel CD

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Using Lived Expertise to Address the Communication Barrier

Charlotte Garner, Regional Representative Regions 6 & 8, NHCHC; **Valarie Dowell**, Community Health Navigator, Cincinnati Health Network/NHCHC

Harbor B

Confronting Collective and Cumulative Grief: Self-care as an Institutional Responsibility

Deirdre Hoey, Behavioral Health Therapist, Health Care for the Homeless; **Lauren Ojeda**, Pediatric and Family Case Manager, Health Care for the Homeless; **Veronica Johnson**, Behavioral Health Therapist, Health Care for the Homeless

Harbor D

Homelessness is a socially engineered trauma, rooted in systems of oppression and violence, with measurable health disparities. Compared to their housed counterparts, individuals experiencing homelessness are 3-4x more likely to die prematurely, 2x as likely to have a heart attack or stroke, and 3x more likely to die of heart disease; the life expectancy of a person experiencing homelessness is only 48 years. Homelessness is a traumatic experience, and individuals experiencing homelessness often have histories of trauma prior to homelessness. While larger systemic work is required to upend the underlying systems of oppression, staff encounter these realities while trying to collaborate with clients to navigate these structures and provide equitable, high-quality, person-centered health care.

In order to adequately provide these services, the health and well-being of staff must be an institutional priority. Staff experience the cumulative effects of stress, burnout, and vicarious trauma, each with well-documented physical, mental, and emotional manifestations. The passing of clients can be a particularly challenging time marked with grief. Regardless of the duration of engagement with a client, grief is a natural reaction to the loss of a client, and acknowledging these feelings are essential. In a whole-person health care model with wrap-around support, it's common for various staff to engage with the same client, leading to a collective grief that is felt more broadly and communally.

This workshop will provide attendees with a framework for understanding grief as a collective and cumulative process. Attendees will develop a praxis of addressing shared grief to combat the harms of unacknowledged, successive loss. Additionally, this workshop will include a history of one organization's intermittent attempts at addressing shared loss, and how COVID-19 led to a coalition of staff reviving the creation of a space for grieving through storytelling. The value of storytelling as a coping strategy for grief, death, and bereavement is well-established as an effective form of processing, allowing staff to reflect on the full humanity of clients. The power of collective healing demonstrates the need to reconceptualize self-care from a solely individual practice, to an institutional responsibility. Attendees will recognize the roles of white supremacy in the workplace and how they are antithetical to collective grief.

Elevating Medical Respite to a Statewide Medicaid Benefit: Successful State Approaches

Rachel Biggs, Chief Strategy Officer, Albuquerque Health Care for the Homeless; **Rhonda Hauff**, CEO, Yakima Neighborhood Health Services; **Pooja Bhalla**, Executive Director of Healthcare Services, Illumination Foundation; **Barbara DiPietro**, Senior Director of Policy, National Health Care for the Homeless Council

Harbor E

Medical respite care programs are expanding at the same time state Medicaid programs are looking to address social determinants of health through non-traditional care approaches. Recently, a number of states have incorporated (or are actively moving to add) statewide reimbursements for medical respite services. Not only do these payments help create and sustain programs, but they also integrate medical respite care into the larger healthcare system. This panel discussion will feature HCH leaders from three states who will talk about how their state is paying for medical respite care, and the lessons learned that others can replicate.

NIMRC has been actively working with several states on their plans to integrate medical respite care into their Medicaid program. Additionally, staff have been creating reimbursement principles and publishing updates on states' status of this work, as well as updating models of care and other programmatic resources to assist in these efforts. Each state is different in how it is approaching reimbursements, which offers an opportunity to evaluate lessons learned and be more proactive in guiding future work in this area.

It is essential to have HCH program leadership discuss how they have worked with their states to develop policies and practices that support statewide recognition and reimbursement in order to engage the broader HCH community in the advocacy needed to further expand medical respite care in all communities.

What Happens When Short-Term Medical Respite Is Not Enough?

Dr. Catherine Crosland, Director of Homeless Outreach, Unity Health Care, Inc.; **Dena Hasan**, Director, Policy and Program Support, DC Department of Human Services; **Jennette Hathorn**, Medical Respite Lead, Unity Health Care, Inc.

Dover ABC

We in the Health Care for the Homeless community are aware of the need for and benefit of medical respite to adequately address the acute medical needs of people experiencing homelessness. We often think of medical respite as a short-term service where someone experiencing homelessness can recover from an illness before being discharged all too often back to shelter or the street and too infrequently to permanent housing.

But what happens when a short-term stay is not enough, and when the medical needs of an individual are so complex and persistent that there is no foreseeable time when discharge to shelter or the street would be reasonable? With an aging and more medically vulnerable population experiencing homelessness, a longer-term intervention is necessary.

During the pandemic, our HCH partnered with the city to create non-congregate hotel-based shelters to protect those most at risk for complications or death from COVID-19 (ie people who are older and with significant medical co-morbidities). These shelters have medical services embedded (including nursing care scaled to meet the needs of the most vulnerable patients) and have significantly increased the number of "medical respite" beds in our community. And, unlike typical medical respite beds, individuals can stay until an appropriate housing resource is available to them. While many people have moved quickly through this program to permanent housing – we have served over 2,000 individuals and have housed over 800 in the past three years – we have consistently served a subset of older, medically vulnerable individuals who have been difficult to place because of their significant needs. Many have been with us for upwards of a year or more, far longer than most medical respite programs could allow. The challenge now is to make this model of longer-term medical respite for an older and medically complex population sustainable beyond the pandemic, whether in the form of a medical shelter or even site-based bridge or permanent housing with medical supports and meals.

In addition to sharing about our program (the nuts and bolts of developing a long-term, shelter-based medical respite, the delivery care model, and the interdisciplinary care coordination), we welcome the opportunity to have a robust discussion with the audience about how their communities are meeting the needs of an aging and more medically vulnerable population experiencing homelessness.

Emerging Health Care Concerns Among People Experiencing Homeless Who Use Xylazine

Maire St. Ledger, Project HOME; **Monique Taylor**, Project HOME; **Jovan Cosby**

Laurel AB

Xylazine ("Tranq") first appeared in the opioid drug supply over a decade ago, however, it has now infiltrated over 90% of the drug supply in one large city. This presentation will discuss how the increase in xylazine has impacted the health care concerns among people experiencing homeless (PEH) in several areas: pregnancy/prenatal care, wounds, and MOUD treatment. We will also discuss how we have pivoted our model of care delivery, including increased utilization of Certified Recovery Specialists and people with lived experience , development of inreach resources in hospital settings, increased outreach and street medicine resources, and educating local health care and non-profit entities regarding these emerging health care needs.

Background: Xylazine ("tranq") has been found in over 90% of the opioid and fentanyl supply in our large city. With the increasing contamination of the opioid supply by novel substances, our street medicine and outreach teams have noticed several emerging health trends.

1) Delayed access to prenatal and pregnancy care, including an increased number of people delivering babies on the street, and not accessing postpartum care.

2)Increasing severity, size, and complications of wounds and soft tissue infections.

3)Challenges completing inpatient medical and substance use treatment due to insufficient withdrawal management or fear of inadequate management.

Our CRS has been essential in connecting with participants who are fearful or reticent to accept care.

We have developed several programmatic innovations to decrease negative health outcomes and improve healthcare engagment.

We have also developed inreach resources in our city's various hospital systems, including increasing involvement of CRS's who work in inpt settings to help facilitate the plans of care.

Promoting Safe and Stable Housing for Children and Youth: A Call to Action

Janna Gewirtz O'Brien, Department of Pediatrics at the University of Minnesota; Hennepin Healthcare; The Bridge for Youth; **Emma Hartswick**, Medical Student, SHEEP Program Coordinator, Harvard Medical School; **Aura Obando**, Family Team Medical Director, Boston Healthcare for the Homeless Program; Massachusetts General Hospital

Harbor C

Safe and stable housing is foundational for child and adolescent health. When children and youth do not have a place to call home, their physical and psychological health suffers. In this talk we will seek to: (1) describe the impact of stable housing, housing instability, and homelessness on child and adolescent health, (2) outline the clinician's role in addressing housing instability and homelessness in clinical practice, and (3) promote clinician advocacy for key policy interventions that address housing instability and homelessness locally and nationally. We describe clinical interventions clinicians could implement in practice including: proactively identifying housing instability and other social drivers of health, mitigating associated health risks, reducing barriers to care, engaging in individual advocacy to prevent eviction and support healthy housing, and forging partnerships with community resources. Several promising policy level interventions to improve child and adolescent health will be discussed, including: solutions that promote housing affordability and choice, strategies that support families experiencing homelessness and facilitate exit into housing, and cross-sector approaches that address the complex drivers of homelessness. Through case-based discussions, we will highlight the role clinicians can have as advocates. This talk is a call to action, to not only meet the needs of current HCH patients, but also to inspire clinicians to engage in advocacy for homelessness prevention efforts. Clinicians can have quite a powerful role in addressing the health impacts of homelessness through direct patient care, institutional-level activism, and advocacy for policy changes that improve the lives of families and youth. medical respite, the delivery care model, and the interdisciplinary care coordination), we welcome the opportunity to have a robust discussion with the audience about how their communities are meeting the needs of an aging and more medically vulnerable population experiencing homelessness.

Oral Presentation: Pregnancy and Post-partum Planning

Hillary Miller, Project HOME-Street Medicine; **Annalynn Galvin**, Cizik School of Nursing, UT Health Science Center (UTHealth) Houston; **Elijah Parks,** Lead Outreach Worker, Project HOME

Location: Essex ABC

Oral Presentation: Scope and Quality of Medical Mobile Services

Elyssa Rosen, Clinical Project Manager, LA County Department of Health Services, Housing for Health; **Absalon Galat**, DHS HFH; **Pia Valvassori**, Health Care Center for the Homeless

Location: Kent ABC

Treating Alcohol Use Disorder in the Primary Care Setting

Sarah Meyers, MD, Brown Addiction Medicine Fellowship

Harbor A

People experiencing homelessness experience high rates of alcohol use disorder, estimated to be as high as 40%, and increased morbidity and mortality from alcohol use, as well as increased barriers to treatment including limited financial resources, limited insurance coverage, photo ID requirements, comorbid physical and mental health conditions, and stigma. The most accessible place for treatment is frequently low barrier, primary care clinics that provide homeless healthcare sources, but these treatments are underutilized. This session will provide a clinical overview of the indications and uses of evidence-based treatments for alcohol use disorder, such oral and injectable naltrexone, acamprosate, disulfiram, gabapentin, and topirimate. We will review the conditions under which outpatient treatment of alcohol withdrawal syndrome can be medically managed, and the available treatments, primarily chlordiazepoxide, diazepam, and gabapentin. We will additionally review supportive care for patients for whom abstinence is not the goal, including appropriate screenings, supplementation, and vaccinations. Finally, we will review the evidence base for non-abstinence based treatment, which has been shown to be superior to abstinence-based treatment. Participants will have the opportunity to integrate their knowledge through collaborative case discussions. This session will be presented in the context of the upcoming Adapted Clinical Guidelines for substance use disorders.

Beyond dope: recognizing and treating lesser-known substance use disorders

Elise Paquin, Physician, Project Home; **Amy Summer**, Project Home; **Ivel Morales,** Assistant Residency Program Director, Thomas Jefferson University and Project Home

Harbor B

Over the last decade, a number of new illicit drugs have become available in Philadelphia. These novel psychoactive substances appear in the drug supply as new drugs, or are added to traditional drug preparations such as heroin, fentanyl or cocaine. Some of the most prominent new substances on the rise are sedatives, amphetamines, synthetic cannabinoids, and cathinones. One of the most concerning of these substances, from the prospective of health care providers, is the veterinary sedative xylazine (also known as "tranq"). Tranq has been increasingly used as an additive and/or enhancer in other drugs, particularly opioids such as heroin or fentanyl. The incidence of fatal opioid overdose in Philadelphia is rising, and in 2021 xylazine was detected in 34% of all overdose deaths, a 39% increase from 2020.

Stimulants such as amphetamines were detected in 82% of Philadelphia overdose deaths in 2021. Synthetic cannabinoids (also regionally known as "K2") and synthetic cathinones ("bath salts") have also become easily available in the Philadelphia drug market. This poses a challenge because the chemical compositions of these substances vary widely and the clinical presentations of acute intoxication are poorly understood, making treatment difficult. It is imperative that our clinicians and care teams become familiar with recognizing and treating substance use disorders involving these newer and less studied drugs.

We aim to provide an overview of these emerging synthetic compounds, specifically xylazine, amphetamines, synthetic cannabinoids, and synthetic cathinones. With mixed methods including case presentations, patient testimonials, literature review and small group exercises/discussions, our audience will gain valuable information for the diagnosis and treatment of these less know substance use disorders.

Using Research to Advocate for Housing as a Better Solution

Sarah Gillespie, Associate Vice President, Urban Institute; **Cathy Alderman**, Chief Communications and Public Policy Officer, Colorado Coalition for the Homeless

Dover ABC

Our workshop team includes a housing researcher, advocate, and consumer who have collaborated on a rigorous evaluation of a supportive housing initiative for over 7 years. Recently we have worked together to provide evidence from the evaluation alongside consumer stories to other practitioners and advocates seeking to make a strong case for housing first as a solution in the face of growing policy efforts to prioritize ineffective "rehab-first" or involuntary treatment approaches. As detailed in the abstract, our workshop will provide key data points and myth-busting evidence others seeking to advance housing as a solution can use for compelling advocacy.

Housing the "impossibles": how to house the medically frail homeless population

Alexis Chettiar, Cardea Health; **Catherine Hayes**, President Cardea Health

Harbor D

Across the United States the homeless population is growing older and sicker. Homelessness results in an accelerated aging process and the rapid worsening of chronic medical conditions that could be treated with consistent access to quality care and shelter. Additionally, being unhoused carries an increased risk of disability and traumatic brain injury. As the health of chronically homeless individuals deteriorate, they often cycle between the unsheltered environment, inpatient hospitalization, and skilled nursing facilities, often ending up back on the street without proper care or accommodation. Often the only housing option for medically frail people experiencing homelessness is limited to institutionalization. Conversely, many people who have experienced homelessness value their independence and autonomy and desire to be housed in the community. The lack of housing options for the medically vulnerable has grown into a gap in which some of the most vulnerable unhoused people fall through.

An organization in an urban area has piloted a novel and sustainable program to house medically frail homeless individuals by leveraging existing federal Medi-Caid Home and Community Based Alternatives (HCBA) wavier programs. HCBA waivers provide for personal care, skilled nursing and medical case management services that flex to meet the beneficiaries needs, up to 24-hour of skilled nursing care. Through these federal waivers the medically frail Homekey program is permanent housing where individuals can live with autonomy up to and including end of life care. The organization has successfully housed and stabilized some of the "sickest of the sick" homeless people in the County, including individuals with medical, social, and behavioral complexities that have historically compromised their ability to be housed in the community.

Social Justice and Healthcare Solutions for Families Experiencing Homelessness

Pooja Bhalla, Executive Director of Healthcare Services, Illumination Foundation; **Geeta Grover**, The Center for Autism and Neurodevelopmental Disorders

Harbor E

Social justice and healthcare are inextricably linked, and an important aspect of social justice is the ability to have fair access to healthcare. Healthcare is not equitable if it is not accessible, and there are still immense gaps in terms of coverage and access for underserved populations, particularly for individuals experiencing homelessness who face many barriers to care. This presentation outlines how we have set out to remove those barriers.

Our innovative Children and Families Program (C&F) healthcare model provides primary care and behavioral health services and wraparound case management to approximately 200 vulnerable children and families experiencing homelessness. All of the children and families we serve are connected with our emergency family shelters; most have experienced high levels of trauma and need intensive services to address their interrelated health, mental health, substance use, developmental, and academic issues. Our C&F healthcare program partners with two physicians: a Clinical Professor of Pediatrics and Developmental and Behavioral Pediatrician specializing in Autism and Neurodevelopmental Disorders; and a board-certified Pediatrician specializing in underserved populations.

Our program also includes healthcare collaborations with local hospitals and medical groups to help provide our families with vital healthcare services they might not otherwise receive. These include a local university mobile eye clinic; a dental mobile clinic; and parenting health classes. In a new partnership with a local children's hospital primary care plan, we are now able to refer children to pediatric care. We have also implemented on-site health and wellness educational sessions provided by student nurses.

Expanding Medical Respite Care: Breaking Down Silos through Multi-Sector Collaboration

Julia Dobbins, Director of Medical Respite, NHCHC; **Ashley Brand**, System Director, Community Health, Integration and Housing, CommonSpirit Health; **Jesse Gelwicks,** Kaiser Permanente

Laurel AB

Collaborative partnerships are crucial to the delivery of high quality, equitable community-based care. While these partnerships are essential, it can be difficult for funders, large health systems, and smaller nonprofits/social service organizations to navigate, understand one another, and to build mutual partnerships that create a lasting impact. As we continue to work to de-silo our complex and convoluted health care system, this presentation will focus on how to build cross-sector collaborative efforts that address the needs, geographies, and priorities across the health care continuum. In this presentation, we will highlight how a health system and a health plan have partnered with a national institute to expand medical respite care capacity in 10 states. Through the framework of learning collaboratives and peer cohorts, these multidisciplinary partnerships have opened the door to more creative problem solving, the creation of accessible new resources, and continued development of best practices in medical respite care. We will discuss how we work together to develop shared definitions and measures of success. Presenters will share strategies for building systemic partnerships to expand access to medical respite care that attendees can take back to their local communities. This workshop will include a presentation and group discussion. There will be time for questions, answers, and networking at the end.

Building partnerships and power to end homelessness: How DC won historic PSH funding

Jesse Rabinowitz, Miriam's Kitchen; **Wesley Thomas**

Laurel CD

Homelessness is the epitome of injustice. This is perhaps best visualized by a growing tent encampment in eyesight of the White House in Washington, DC. Not only is DC the capital of the wealthiest nation in the world, but it also has one of the highest rates of homelessness in the United States. In DC, nearly 90% of individuals experiencing homelessness are Black, compared to only 45% of the general population.

Driven by this injustice and the knowledge that homelessness is caused by systems such as racism and capitalism, and not individual choices, a grassroots advocacy campaign recently won funding to put ending long-term homelessness within reach. This session will equip participants with the tools to build similar coalitions in their communities and win funding to end homelessness.

In 2021, a broad coalition leveraged both grassroots power with "insider" advocacy to create a budget that levied a small tax on those who have benefited most from capitalism- DC's very wealthy- to fund 2,000+ PSH vouchers. Through the successful use of relationship-based organizing & deep partnership, a multi-year campaign secured the funding needed to end chronic homelessness in DC. Using this victory as a case study, we will explore how to meaningfully engage clients in advocacy, build local power to fund housing, & leverage growing concern about unsheltered homelessness into funding & away from criminalization. Learn how advocacy focused on utilizing the same methods that caused homelessness- namely purposeful policy and budgetary choices- are being used to reverse centuries of disinvestment in housing and to fund housing that ends homelessness. Justice oriented campaigns must center the voices of people closest to injustice. Hear directly from a leader with lived experience of homelessness about their role in this historic victory.

Oral Presentation: Pregnancy and Post-partum Planning

Hillary Miller, Project HOME-Street Medicine; **Annalynn Galvin**, Cizik School of Nursing, UT Health Science Center (UTHealth) Houston; **Elijah Parks,** Lead Outreach Worker, Project HOME

Location: Essex ABC

Oral Presentation: Scope and Quality of Medical Mobile Services

Elyssa Rosen, Clinical Project Manager, LA County Department of Health Services, Housing for Health; **Absalon Galat**, DHS HFH; **Pia Valvassori**, Health Care Center for the Homeless

Location: Kent ABC

Putting "Community" into a Community Clinic

Julie Han, Senior Program Coordinator, The Center in Hollywood; **Kristian Melby**, Saban Community Clinic; **Christine Stellino**

Harbor E

This workshop will share the administrative, clinical, and consumer perspectives of launching and operating a Community Clinic at the Organization. The Organization is a nonprofit that ends isolation and homelessness through radical hospitality. It's an inclusive space for anyone experiencing homelessness to feel welcome, feel safe, and receive services. By partnering with the Clinic and tailoring its services to fit the community's needs, the Organization is able to provide robust, wrap-around health care to consumers where they feel safe, valued, and are encouraged to take the lead on their health journey.

The partnership between the Organization and the Clinic brings together critical services under a shared roof including primary and behavioral healthcare, infectious disease care, substance use counseling, community engagement, and housing support. Because of the discrimination and other practical barriers to care that persons experiencing homelessness face, combining these vital services is not just best practice but a matter of justice and equity.

This workshop will share the successes and challenges of the project from the consumer and staff perspectives. Attendees will hear from consumers about their experiences of accessing care at the Community Clinic. The team will share the challenges of building new processes and adapting existing workflows to the needs of the community. The team will also share the impact that rooting care in a community-driven, inclusive, and low-barrier setting has had on 1) consumers' longitudinal access to full-person care; and 2) optimization of treatment goals and morbidity metrics in comparison to pre-enrollment patient data. This workshop will provide lessons learned for other agencies seeking to incorporate true community-based and community-led healthcare services into their offerings.

Diabetes Cardiovascular Disease Oral Health Integration

Carol Niforatos, Colorado Coalition for the Homeless; **Carol Rykiel**, Colorado Coalition for the Homeless

Harbor D

Breaking down barriers and creating timely access to care is paramount when patients have co-morbidities that sometimes require urgent care. Oral health care team members are a vital component to the patients team. In a patient-centric endeavor, our team helped create manageable, sustainable cross-departmental workflows that empower the patient to improve their overall health outcome by providing tools and services to help manage and eliminate disease.

Returning to Intention – sharing yoga practices justly with people experiencing homelessness

Albert Miller, Board Member, Health Care for Homeless; **Deirdre Hoey**, Behavioral Health Therapist, Health Care for the Homeless

Harbor C

Yoga practices are 5000 years old and originated in India. Early yoga was accessible, inclusive, and diverse — offering a wide variety of ways to free the mind, body, and spirit from pain and suffering related to human existence. When the British colonized India in the late 1700s, yoga became illegal due to oppression/control. Later in the late 1800s, yoga was re-introduced into Western societies as an exclusive activity that required money, physically-abled bodies, and societal power to access.

Taking the history and philosophy of yoga into consideration, this conference presentation offers attendees practical ways to teach yoga to people experiencing homelessness justly without falling into the traps of cultural appropriation. For yoga practices to be available and accessible for anyone regardless of race, ethnicity, gender identity, or physical ability, service-oriented yoga classes/instruction need to address social justice issues regarding how people are welcomed and invited into the practice. Discussions of humility, authenticity, and balance will highlight ways to disrupt societal power dynamics that are disproportionately harmful to people experiencing homelessness.

This workshop will include a detailed history of how an HCH behavioral health therapist started a group yoga practice in a health clinic setting 7 years ago which serves homeless consumers. The history will also discuss how that group yoga program was adapted in response to a global pandemic to relaunch in an innovative way to serve consumers in a combined on-site and virtual class format. An HCH consumer will share his experience – both as an attendee of the health clinic class (in-person and online) and as a yoga teacher himself at an emergency overnight homeless shelter, at a daytime harm-reduction drop-in center, and on city benches during his street outreach efforts.

Finally, a portion of this workshop will include a demonstration of a yoga class as it would be presented to consumers with lived experience of homelessness. The yoga practice portion will be co-led by the HCH behavioral health therapist and the HCH consumer – both of whom are yoga teachers to people experiencing homelessness in their community. The experiential section of the workshop will allow participants to feel the benefits of yoga in a memorable way.

Oral Presentation: Housing impact and solutions

Priya Srikanth, OHSU; **Sarah Strang**, The Road Home; **Meg Devoe**, Central City Concern, OHSU; **Jeniece Olsen**, Chief Operating Officer, Fourth Street Clinic; **Eileen Vinton**, Summit Team Complex Care Manager, Central City Concern; **Brian Chan**, Oregon Health & Science University, Central City Concern

Location: Kent ABC

California Statewide Study of People Experiencing Homelessness: Results and Next Steps

Priest Martinez, Lived Expertise Advisory Board member, The Benioff Homelessness and Housing Initiative; **Margot Kushel**, The Benioff Homelessness and Housing Initiative; **Kara Ponder**, The Benioff Homelessness and Housing Initiative

Laurel CD

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Oral Presentation: Barriers to and Prioritization of Housing

Ben King, Clinical Assistant Professor, University of Houston Collage of Medicine; **Megan Leubner**, Medical Student, Quinnipiac University School of Medicine; **Ann Nguyen**, Graduate Student, UT Houston School of Public Health; **Sophia Druffner**, Vanderbilt University Community Action Research Program

Location: Harbor A

Progression, Not Perfection An Introduction to Harm Reduction in Medical Respite Care Settings

Sherri Downing, Senior Program Manager II, Advocates for Human Potential

Dover ABC

Alcohol, heroin, fentanyl, and a host of other substances compound the complexity of healing without having a place to call home. Substance use disorders are epidemic; overdoses are at an all-time high. The effects frequently lead to cycling from the streets to the hospital to jail to shelter to the streets and back to the hospital. The time between the revolving doors goes down with each repetition. Heath continues to decline, and even though hospitals are reluctant to discharge people to the street, at some point they must.

Harm reduction strategies coupled with medical respite care can begin to reduce the impact of inequity across socio-economic status, race, gender identification, trauma, and class, using practical, non-judgmental strategies, one person at a time. Coming from backgrounds that include recovery, the presenters believe the results are indisputable: health is improved,

Medical respite providers see the results of this cycle every day. Harm reduction is an evidence-based practice that can be used to provide the opportunity and support people need to begin moving toward healthier lives.

Weaving a Tapestry of Data

Claire Burrus, Ending Community Homelessness Coalition (ECHO); **Lyric Wardlow**, Community Training Manager, ECHO; Akram Al-Turk, ECHO

Laurel AB

Proposed Session Outline:

1. The CoC presents on the WHY and HOW of incorporating qualitative projects into homelessness response systems' work.
2. Facilitators encourage participants from the same geographic regions to join one another in in breakout groups.
3. Facilitators prompt the groups:
    a) Identify a specific issue/area your local community is focusing on improving.
    b) Write down three questions you have about your issue.
    c) Write down the sources of data your system currently has access to that would answer any of these questions.
    d) Consider what other information is needed to fully understand the issue.
4. Facilitators ask groups to report out to the room what they had written down.
5. Briefly co-design 1-2 qualitative projects inspired by the groups' report-outs.

Impact of a data-driven centralized care coordination program in a large urban shelter system

Jessie Schwartz, Clinical Coordinator, New York City Department of Homeless Services; **Eve Cleghorn**, New York City Department of Homeless Services; **Dr. Fabienne Laraque,** Medical Director, NYC Department of Homeless Services

Waterview AB

Impact of a data-driven centralized care coordination program in a large urban shelter system for single adults

Purpose

A pilot program of centralized data-driven care coordination integrated within a large urban shelter system was guided by Hawk's et al. (2017) principles of universal harm reduction. This conceptual approach was hypothesized to improve effective health service utilization and reduce harmful incidents in shelter in this highest need population with little existing social support.

Background

Approximately 52,000 people per day received shelter services in 2021 in this urban center. Of those, about 16,000 were single adults. Of single adults with Medicaid who had healthcare visits and were unhoused in 2016-2018, based on data analyzed by an academic partner, 62% had chronic mental illness, 66% had a substance use disorder and 41% had an alcohol use disorder. The same analysis found highly elevated rates of chronic medical conditions. In addition, the population has high rates of incarceration, with 1,045 arrests in this shelter system in 2021.

Program Description

An initial group of 50 very high-risk clients were identified using administrative data from the shelter case management system, followed by outreach and coordination of services through a centralized care management team with medical and social work backgrounds; multiple local and state agencies participated. The program focused on reducing harms associated with health conditions, addressing client preferences and needs, and providing structured engagement plans that followed clients across multiple settings, including shelters, hospitals, and jails.

Results

After six months, there was an average 46% reduction in reported negative incidents in shelter, followed by an additional 30% reduction in months six through twelve. In the first year of the intervention, 20% of clients moved to permanent housing, 28% were incarcerated, and 6% died.

Conclusion

Centralized care coordination for people experiencing homelessness with complex health conditions that prioritized humanism, pragmatism, incrementalism, and accountability without termination of services was associated with a decrease in shelter-reported negative incidents among these clients.

Wound care in the Age of Xylazine: Practical and Ethical Considerations for Wound Treatments

Kara Cohen, Associate Director of Street Medicine, Project HOME Healthcare Services;
Lydia Williams, Family Nurse Practitioner, Project Home Healthcare Services

Harbor B

People who inject substances have long been at risk for soft tissue infections and wounds. However, with the increasing presence of the novel substance xylazine ("tranq") in the opioid/fentanyl supply, there has been a drastic uptick in wound size, severity, and complexity, with people who use tranq more frequently experiencing such complications as cellulitis, necrosis, sepsis, and limb loss. Our nurse-led street medicine team, under the guidance of an Family Nurse Practitioner who is also a Certified Wound Ostomy Continence Nurse, has worked to engage and educate participants regarding wound care and harm reduction practices. This workshop is targeted for clinicians who are licensed to provide wound care, and will review basics of wound care evaluation and referrals, how to provide wound care via a harm reduction lens, and address some of the complex questions of medical ethics including beneficence, non-maleficence, justice, and autonomy as it pertains to providing wound care to people experiencing homelessness who use substances.

Background: Xylazine is currently present in over 90% of the opioid/fentanyl supply in our city. Consequently, our area has seen a drastic increase in the amount of people with severe necrotic ulcerations, which can often occur even on body parts where people are not injecting, or even with snorting tranq. These wounds have led to hospitalizations, sepsis, and limb loss. Our team noticed that people were refraining from showing these severe wounds to their providers because they were embarrassed by the appearance and odor, and they were afraid they were going to be recommended for hospitalization and amputation. However, our FNP/CWOCN began to develop certain wound techniques that facilitated participants' abilities to more safely manage their wounds, and reduce harm, promote healing, and prevent hospitalizations even while people are still actively using substances. However, with the explosion of these new wounds among people living on the streets of our city, there also was an increased demand for wound care, which led people who are inexperienced or unlicensed to provide wound care to begin offered supplies and wound services. We noted that in some cases the dressing selections were inappropriate and caused more harm than good. We worked to develop methods to educate our patients on what is beneficial and harmful in wound care so they can advocate for themselves.

Oral Presentation: Integration Mental Health Services

Emma Tasini, Healthcare in Action; **Marjorie Momplaisir-Ellis**, NYC Health and Hospitals

Location: Essex ABC

Developing an Integrated Healthcare and Housing Facility

Lisa Thompson, Chief Operating Officer, Colorado Coalition for the Homeless; **Miriah Nunnaley,** Director of Recuperative Care, Colorado Coalition for the Homeless; **Jennifer Cloud**, Chief Real Estate Officer, Colorado Coalition for the Homeless

Laurel AB

This presentation will provide an overview of a new one of a kind, innovative development project that will help to meet the needs of our state's most vulnerable and underserved communities. The new facility will provide safe, dignified, and quality spaces for people experiencing homelessness to heal and stabilize from medical issues. The facility will provide 75 medical respite beds on the first three floors of the building targeted towards people experiencing homelessness with acute medical or behavioral health conditions who have been hospitalized and cannot safely be discharged to the streetsor shelters. For people experiencing homelessness, recovery "at home" is not an option, and the Recuperative Care Facility helps to rectify this ongoing challenge.

Amenities of the Facility will include a commercial kitchen and dining room, commercial laundry, medical exam suites, and "step-down" hospital beds in semi-private spaces for medical observation. Recuperative Care will be provided for 30 to 45 days, depending on the needs of the patient. During that time, housing counselors will work with these patients to arrange for post-respite supportive housing including at the Housing Development located above the facilty.

In addition to recuperative care, the development project is also providing supportive housing above the Recuperative Care Center and will target people experiencing homelessness who are "high utilizers" of emergency rooms and expensive hospital care. The intention of such a project is to reduce avoidable health care costs through on-site supportive services and linkage to ongoing integrated care at the adjacent health center.

This new Housing Development project features 81 one-bedroom apartments and 17 studio apartments with full bathrooms and kitchens, a business center, case management and counseling services, bike storage, laundry facilities, a community room with kitchen, and a fourth-floor terrace. Architectural services for the mixed-use project mimic market rate housing in the neighborhood, Construction of the project was completed in October 2022.

Residents will receive individualized support through case management in order to create a stable environment and to keep those who were once homeless in housing. On-site staff will provide or assist residents in obtaining any medical care, behavioral health care or substance treatment services through the adjacent Health Center, as well as peer support, and job training.their role in this historic victory.

Session Descriptions

Breakout Sessions
Wednesday, May 17 12:45-2 p.m.

Collecting SOGI Data in a HCH Setting- a Multi-Pronged Approach

Sanju Nembang, Boston Health Care for the Homeless Program; **Pam Klein**, Boston Health Care for the Homeless Program

Harbor D

Collecting patients' Sexual Orientation and Gender identity (SOGI) information is recognized as a key aspect of providing holistic, patient-centered health care. It is an intervention that fosters retention in care for gender and/or sexual minority patiensts who often feel unconnected and invisible to health care providers who have no knowledge of their patients' gender identity and/or sexual orientation. It also enables health care practices to identify health care disparities among gender and/or sexual minority patients as compared with those of their cisgender heterosexual counterparts and then to tailor interventions to address these disparities. For health care entities that receive federal funds, collecting SOGI information is now mandatory. However, there may exist multiple barriers that negatively impact the ability to reliably collecting SOGI information in a health care setting, especially in the setting of serving a population experiencing homelessness. This presentation aims to describe a multi-pronged approach to addressing low SOGI data collection rates within a federally qualified health center serving a population experiencing homelessness. Some examples of the strategies we discuss include adding SOGI data collection to our quality measures, sending patient messages via the EMR portal, staff education, utilizing volunteers for patient outreach, and offering patients the option to fill out a SOGI form on their own in the waiting room. We present our best practices in hope that the information is applicable in other HCH settings.

Oral Presentation: Living Through an Encampment Sweep: Community and Uncertainty

Yesenia Mejia Urieta, Boston University School of Social Work, Boston Healthcare for the Homeless Program; **Avik Chatterjee**, Boston University School of Medicine, Boston Medical Center, Boston Healthcare for the Homeless; **Michael Mayer**, Boston Healthcare for the Homeless Program

Location: Kent ABC

Oral Presentation: Approaches to Street Outreach

Marc O Griofa, City of Las Vegas; **Brian DeGrafenreid**, Old Pueblo Community Services; **Marketa Jansky**, Advanced Practice Practitioner-Family Nurse Practitioner, El Rio Community Health Center; **Joshua Decker**, El Rio Health; **Deirdra Goeth**, Lead Outreach Navigator, OPCS; **Kim Hunter**, BHC, El Rio Health; **Dana Arnold,** Navigator II, OPCS; **Will Nieves**, Navigator II, Old Pueblo Community Services

Location: Essex ABC

Oral Presentation: Public Health Awareness and Response Approaches to Street Outreach

Ashley Meehan, PhD Student, Johns Hopkins University; **Emily Mosites**, Special Populations Senior Advisor, Deputy Director for Infectious Diseases (DDID), CDC; **Megan Schoonveld**, Centers for Disease Control and Prevention; **Claire McKeown**, Philadelphia Dept of Public Health, DDC BT-PHP; **Kashiki Harrison**, Philadelphia Dept of Public Health, DDC BT-PHP

Location: Harbor A

Reimagining A Racially Equitable and Just Coordinated Entry System

Regina Cannon, Founder, President & CEO, ARC4Justice

Harbor C

Many communities have begun to challenge traditional assessment and prioritization tools that have been proven to be inequitable. Instead, they are creating processes that speak to the specific experiences of those disproportionately experiencing homelessness in their communities. That work must continue, and we must retool our coordinated entry systems to become racially equitable and just: a Coordinated Entry System where we are no longer satisfied with having a shared anti-racist vocabulary but strive to have shared anti-racist practices. In such a system, the people and communities that have experienced housing and resource discrimination will be able to make fair decisions about where resources are allocated, what policies are developed and approved, and how services and housing are provided. This session is an opportunity for communities to share with and learn from their peers, people who have faced homelessness, TA providers, federal government partners, health care and housing partners, and funders to reimagine and rebuild Coordinated Entry System with more equitable and just processes, practices, policies and cultures.

Community Organizing: A Winning Strategy to Improve Public Transit Access

Yosha Singh, UT Austin Dell Medical School; **Paulette Soltani**, Texas Harm Reduction Alliance; **Barry Jones**, Texas Harm Reduction Alliance

Laurel CD

Many communities have begun to challenge traditional assessment and prioritization tools that have been proven to be inequitable. Instead, they are creating processes that speak to the specific experiences of those disproportionately experiencing homelessness in their communities. That work must continue, and we must retool our coordinated entry systems to become racially equitable and just: a Coordinated Entry System where we are no longer satisfied with having a shared anti-racist vocabulary but strive to have shared anti-racist practices. In such a system, the people and communities that have experienced housing and resource discrimination will be able to make fair decisions about where resources are allocated, what policies are developed and approved, and how services and housing are provided. This session is an opportunity for communities to share with and learn from their peers, people who have faced homelessness, TA providers, federal government partners, health care and housing partners, and funders to reimagine and rebuild Coordinated Entry System with more equitable and just processes, practices, policies and cultures.

Improving Reentry for Homeless Veterans with Peer Support: The Post-Incarceration Engagement Model

Beth Ann Petrakis, Center for Healthcare Organization and Implementation Research; **Kristian Smith**, Little Rock VAMC; **Jessica Blue-Howells**, Deputy National Director, Veterans Justice Programs, Veterans Health Administration (VHA) Homeless Programs Office; **Jennifer Yanez**, Healthcare for Reentry Veterans Specialist, VA Southern Nevada Healthcare System

Dover ABC

This is based on a quality improvement project in a large healthcare system. The model was designed to help justice-involved individuals who face many challenges after incarceration, including finding stable and safe housing, addressing physical and behavioral health needs, and meeting financial needs. This novel intervention adds specially trained peer specialists who team with reentry social workers in a healthcare system to support individuals as they transition back to community settings after incarceration. The peer specialists provide hope, guidance, and support as they tailor services to meet the needs and goals of their clients. The peer specialists help individuals move from temporary to transitional to permanent housing programs. They also assist with linkage and continued engagement in healthcare, mental health, and substance use programs. The model has been pilot tested in two sites and is currently being implemented in six additional sites nationwide.

Hospital and Housing Partnerships

Myra Nagy, Chair of CCH CAB, CCH; **Jenny Dearing**, Director of Housing First and ACT Services, Colorado Coalition for the Homeless; **Dr. Sarah Stella**, Associate Professor of Medicine, Denver Health; **A.K. Kopperud**, Project Manager, UCHealth's Housing Transitions Team (HTT)

Waterview AB

From homelessness to housing to health! This panel of community partners will cover how Denver used innovating healthcare partnerships to launch initiatives which provide supportive housing to chronically homeless individuals who frequently use emergency services like jails, emergency rooms and detox facilities. Panelist will share details of the Denver SIB lead to the development of Denver's second Social Impact Bond project focused on homelessness - the Denver SIPPRA project. Denver SIPPRA launched July 1, 2022 to provide supportive housing to an additional 125 participants who have high levels of interactions with the healthcare and justice systems. Panelists will share early learning from this project and discuss the benefits of interagency collaboration on an organizational, financial and clinical level. Panelists will further discuss the impact of investing in these programs on client success. This will included an exploration of modalities used, program structure and consumer narrative.

Lessons in Palliative Care: Examples and Promising Practices from San Francisco and Toronto

Tanya Majumder, Physician, San Francisco Department of Public Health Street Medicine, Shelter Health, and Urgent Care; **Donna Spaner**, Inner City Health Associates; **Shannon Ducharme**, Health Worker Extraordinaire, Street Medicine; **Melanie Bien**, Sr. Psychiatric Social Worker, Street Medicine; **Trevor Morey**, Physician, Inner City Health Associates; **Naheed Dosani**, Inner City Health Associates

Harbor B

Consumer Perspective: Behavioral Health Services and C19 Lessons Learned

Presenter?

Laurel CD

In 2021, the National Consumer Advisory Board created, administered, and interpreted the data from a national survey on behavioral health and behavioral health care services during the pandemic. Consumers will share the data and recommendations, stories, and lessons learned.partners, health care and housing partners, and funders to reimagine and rebuild Coordinated Entry System with more equitable and just processes, practices, policies and cultures.

"What's new in homeless health care?" A no-jargon summary of the latest research

Katherine Diaz-Vickery, Medical Director, Clinician-Investigator, Hennepin County Health Care for the Homeless; **Alaina Boyer**, Director of Implementation Research, National Health Care for the Homeless Council; **Travis Baggett**, Massachusetts General Hospital, Boston Health Care for the Homeless Program; **Stefan Kertesz**, Professor of Medicine, Attending Physician, University of Alabama at Birmingham, Birmingham, Alabama VA Health Care System

Dover ABC

Staying up-to-date on the growing field of homelessness research presents a considerable challenge for the busy clinician or administrator. This workshop will present a plain-language summary of selected scientific studies on the health of homeless people that have been published since January 1, 2022. The presentation will focus on scientific contributions in the following domains of homeless health: 1) health status, 2) health care delivery, 3) interventions and implementation, and 4) housing. The presenters will highlight the practical implications of each study and provide attendees with an annotated bibliography containing take-home points. No expertise in research methods is required.

When Clinicians and Policy Advocates Join Forces

Rachel Biggs, Chief Strategy Officer, Albuquerque Health Care for the Homeless; **Nadia Fazel**, Chief Clinical Officer, Albuquerque Health Care for the Homeless

Harbor E

Increasing access to care is a cornerstone to community health centers and safety net clinics. Often, access to care includes making policy changes that drive diverse care models. A recent example of this includes the movement to allow Advanced Practice Providers (APPs) to work at the top of their licensure to ensure a larger pool of primary care staffing candidates. APPs are now the backbone of primary healthcare in Federally Qualified Health Centers. A current movement involves incorporating Dental Health Aid Therapists (DHATs) in the dental care team. A DHAT is a midlevel dental provider whose practice is limited to basic dental treatment and expands on the functions of a dental hygienist and expanded function dental assistant. Physicians and dentists should collaborate with policy advocates to make these changes at a legislative level. Clinician involvement in policy work increases job satisfaction by reducing the care burden away from solely physicians and dentists. This workshop will discuss how these policy movements are enhanced when clinician leaders work in partnership with policy advocates and how the outcomes can be hugely beneficial for providers and patients, particularly those patients experiencing homelessness.

Oral Presentation: Vision and Dental Care among People Experiencing Homelessness

James Miller, Physician, Allegheny Health Network; **Mehdi Mohammadi**, Associate Clinical Professor of Dentistry, Herman Ostrow School of Dentistry of USC

Location: Kent ABC

Oral Presentation: Disparities in Mortality and Dying with Dignity

Ben King, Clinical Assistant Professor, University of Houston Collage of Medicine; **Jillian Olmsted**, Executive Director, The INN Between, Emily Curran, UT Houston School of Public Health; **Maria Alegria**, UT Houston School of Public Health

Location: Essex ABC

Mobile Hygiene to Engage Unsheltered PEH

Rhonda Hauff, CEO, Yakima Neighborhood Health Services

Waterview AB

The Covid pandemic put a spotlight on the lack of available public hygiene facilities in our communities for people experiencing homelessness. There are no public facilities for washing, toileting, or showers. During the pandemic, people steered away from communal shelters, some in fear of catching Covid and others annoyed by the restrictions created by Covid. As a result, many more people were literally left out in the cold, and outreach teams needed new incentives to engage those who isolating in private and unsanctioned encampments and in need of medical, behavioral health, and other lifesaving supports (food, warm clothes and clean water).

This presentation showcases an interdisciplinary team effort, centered around a highly visible hygiene trailer, branded by an organization recognized as a trusted provider of services for people experiencing homelessness. Starting with the outreach workers who get the word out about the availability and location of the showers, team members are available with real-time resources for Coordinated Entry, housing applications, rental assistance, health insurance applications, clinical triage, behavioral health care and warm handoffs to medical, dental, and ongoing behavioral health. Participants leave the experience with a fresh set of clothes, a snack, and meals to go.

In the first months of the program, most participants are new patients to the organization (outreach goal) and connected to multiple services from this effort (service goal). Housing placements were made (ending homelessness goal). We will present successful linkages, desired services, and funding strategies.data from a national survey on behavioral health and behavioral health care services during the pandemic. Consumers will share the data and recommendations, stories, and lessons learned.partners, health care and housing partners, and funders to reimagine and rebuild Coordinated Entry System with more equitable and just processes, practices, policies and cultures.

Falling Through the Cracks: LGBTQ+ Disparities in Homelessness

Andrew Spiers, Director of Training & Technical Assistance Housing First University

Harbor C

Staying up-to-date on the growing field of homelessness research presents a considerable challenge for the busy clinician or administrator. This workshop will present a plain-language summary of selected scientific studies on the health of homeless people that have been published since January 1, 2022. The presentation will focus on scientific contributions in the following domains of homeless health: 1) health status, 2) health care delivery, 3) interventions and implementation, and 4) housing. The presenters will highlight the practical implications of each study and provide attendees with an annotated bibliography containing take-home points. No expertise in research methods is required.

Strengthening Partnership and Improving Health Outcomes Among Persons Experiencing Homelessness

Alicia Rossiter, University of South Florida; **Latiena Williams**, Assistant Professor, USF College of Nursing; **Kumar Jairamdas**, University of South Florida

A unique partnership between a College of Nursing and a homeless shelter was created to provide onsite medical oversight and coordination of care for individuals experiencing homelessness. Nursing leaders understand that in order to better address social determinants of health and to improve health outcomes among persons who are experiencing homelessness, it is imperative to integrate awareness and hands on experience to better understand the root of social factors and social justice.

Harbor A

"Why don't you go see your doctor?" Barriers to accessing healthcare among Portland's houseless

Sara Fujii, Mobile Clinic Coordinator, Outside In; **Mandi Ruscher-Haqq**, Family Nurse Practioner, Outside In; **Seanie Chien**, Outside In

A unique partnership between a College of Nursing and a homeless shelter was created to provide onsite medical oversight and coordination of care for individuals experiencing homelessness. Nursing leaders understand that in order to better address social determinants of health and to improve health outcomes among persons who are experiencing homelessness, it is imperative to integrate awareness and hands on experience to better understand the root of social factors and social justice.

Harbor D

Trauma Informed, ADA-Approved Behavioral Health Services by the National Consumer Advisory Board

National Consumer Advisory Board

Harbor D

Patients may face many internal and external barriers as they address their behavioral health. Trauma and physical and mental disabilities can complicate behavioral health care and make it almost impossible for patients to find the help they need. Health centers can examine policies, programs, patient flow, and environmental factors to alleviate some of these barriers and to support patients as they courageously pursue the help they need.

Discover principles and promising practices that align with trauma informed care and the Americans with Disabilities Act to ensure that patients who have experienced trauma and patients with physical and mental disabilities can comfortably and safely access care at HCH health centers.

Wound Care Management Across Health Care for the Homeless Settings

Kara Cohen, Associate Director of Street Medicine, Project HOME Healthcare Services; **Lydia Williams**, Family Nurse Practitioner, Project Home Healthcare Services; **Elizabeth Spradley**, Maryland Department of Health — Center for Harm Reduction Services

Essex ABC

Staying up-to-date on the growing field of homelessness research presents a considerable challenge for the busy clinician or administrator. This workshop will present a plain-language summary of selected scientific studies on the health of homeless people that have been published since January 1, 2022. The presentation will focus on scientific contributions in the following domains of homeless health: 1) health status, 2) health care delivery, 3) interventions and implementation, and 4) housing. The presenters will highlight the practical implications of each study and provide attendees with an annotated bibliography containing take-home points. No expertise in research methods is required.

Developing an organizational Justice, Equity, Diversity, Inclusion (JEDI) language

Kevonya Elzia, Director of JEDI, National Health Care for the Homeless Council

Laurel AD

The American Healthcare system has been reckoning with the effects of twin pandemics since 2020. Although health inequalities existed long before Covid-19, as a healthcare system we have failed to do our part of the root work required to truly address why these inequalities persist despite advancements in science & technology. "In order to treat me you need to know who I am" & my socialized lived experiences. We cannot provide patient-centered care if we do not fully see our patients. In didactic lecture, we will work together to develop a plan for starting the process of curating a shared JEDI language for your organization. Kevonya Elzia, MA, BS, RN Director of Justice Equity Diversity Inclusion at the National Healthcare for the Homeless Council, will guide participants in developing invitations, strategies & statements, that can be used to introduce and/or move the work of justice, equity, diversity, inclusion forward in your organization. Our time will be split with the first half of the session dedicated to foundation JEDI concepts and the second half of our time together spent in small groups working on tangible actions that you can use immediately. Kevonya will share her antidotes from her experience doing this will a mid-size {700 employees} community health clinic.

Preventing Suicide: Resources for Assessment, Intervention, and Coping with Loss

Bridie Johnson, Senior Director of Behavioral Health Services, Colorado Coalition for the Homeless; **Lawanda Williams**, Chief Behavioral Health Officer, Health Care for the Homeless, Baltimore, MD; **Jen Elder**, Director, SAMHSA Homeless and Housing Resource Center, Policy Research, Inc; **Lynea Seiberlich-Wheeler**, Associate Director of Behavioral Health, West County Health Centers

Harbor E

A unique partnership between a College of Nursing and a homeless shelter was created to provide onsite medical oversight and coordination of care for individuals experiencing homelessness. Nursing leaders understand that in order to better address social determinants of health and to improve health outcomes among persons who are experiencing homelessness, it is imperative to integrate awareness and hands on experience to better understand the root of social factors and social justice.

Self-Care Strategies

The National HCH Council acknowledges conferences can be stressful for attendees emotionally, mentally, and physically. In addition, we acknowledge that the material discussed in sessions might be emotionally challenging for some attendees. Because of this, we are providing the following self-care strategies:

- **Know Your Limits and Step Away.** Consider your own emotional well-being when choosing which sessions to attend. If at any time you feel increasingly uncomfortable in a session, take a step away from the conference. The Burnham room will serve as a Recharge Lounge for all attendees. The Recharge Lounge has a sign at the entrance and is open between 8 a.m. and 5 p.m. on Thursday, May 23, and Friday, May 24. Please use this room, your hotel room, or other quiet places to help you relax.
- **Eat and Sleep Well.** Maintaining healthy eating and sleeping habits can be difficult when you are in an unfamiliar space. We encourage you to eat well, stay hydrated (drink plenty of water, at least 8 glasses a day), and get enough rest (8 hours or more of sleep). This will give you the chance to be your best self.
- **Stay Active.** Find ways to move your body throughout the conference. If you would like, use the fitness center at your hotel or take a walk with others.
- **See Council Staff or Call if You Need Help.** Council staff are available throughout the venue and specifically at the Registration Desk to help refer you to individuals who can provide assistance. If you need additional help, you may also call the National Suicide Prevention Lifeline at 1-800-273-8255.

RELAXATION LOUNGE

Stop by the Relaxation Lounge in **Waterview CD on the lobby level** to enjoy a quiet and relaxing space featuring sofas, charging capabilities, and light snacks from 7 a.m.-6 p.m.

Continuing Education Information

HOW TO GET YOUR CERTIFICATE

1. Go to http://nhchc.cmecertificateonline.com

2. Click on the "2023 National Health Care for the Homeless Conference & Policy Symposium" link.

3. Evaluate the meeting and click the hyperlink provided on the last page to claim your credit certificate.

4. Save/Download/Print all pages of your certificate for your records.

Questions? Email Certificate@AmedcoEmail.com

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CHCF is working to improve the delivery of health and social services to people experiencing homelessness, with the goal of promoting care that is responsive, person-centered, and focuses on the patient's emotional, physical, and psychological needs.

Learn more at www.chcf.org

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Baltimore Marriott Waterfront

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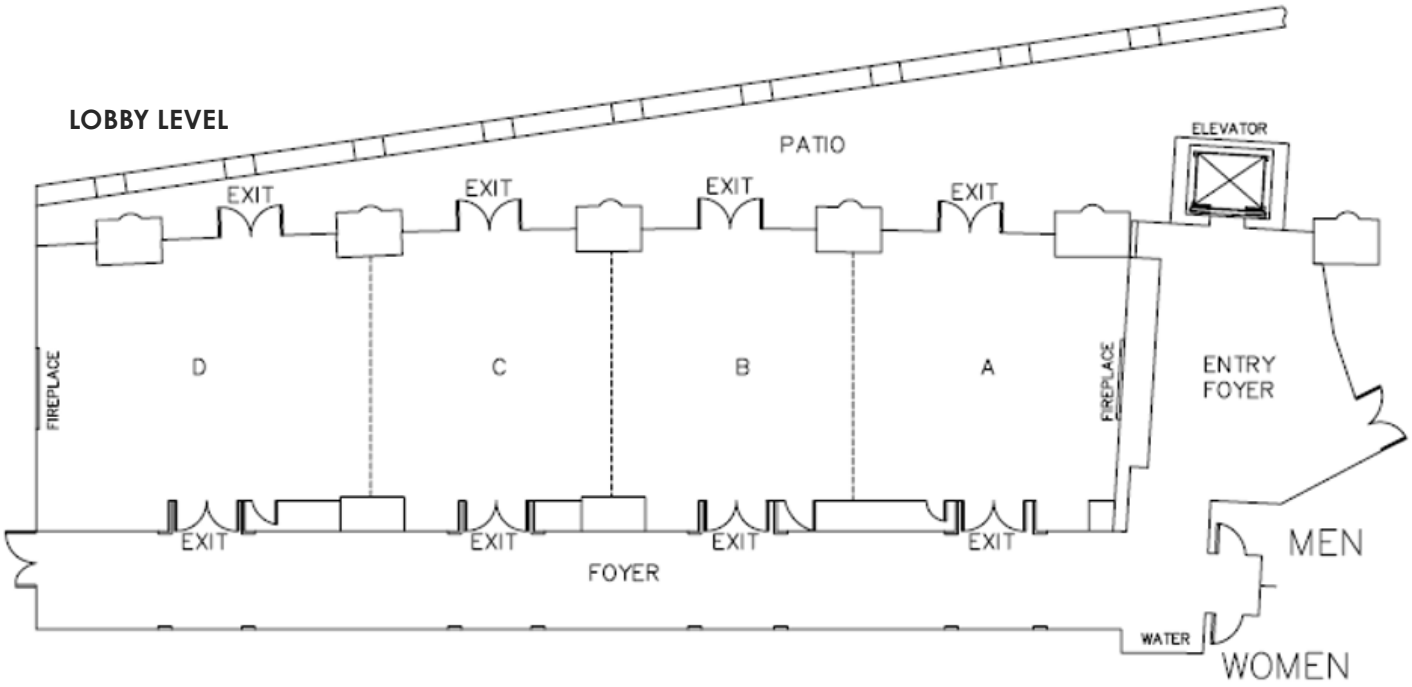

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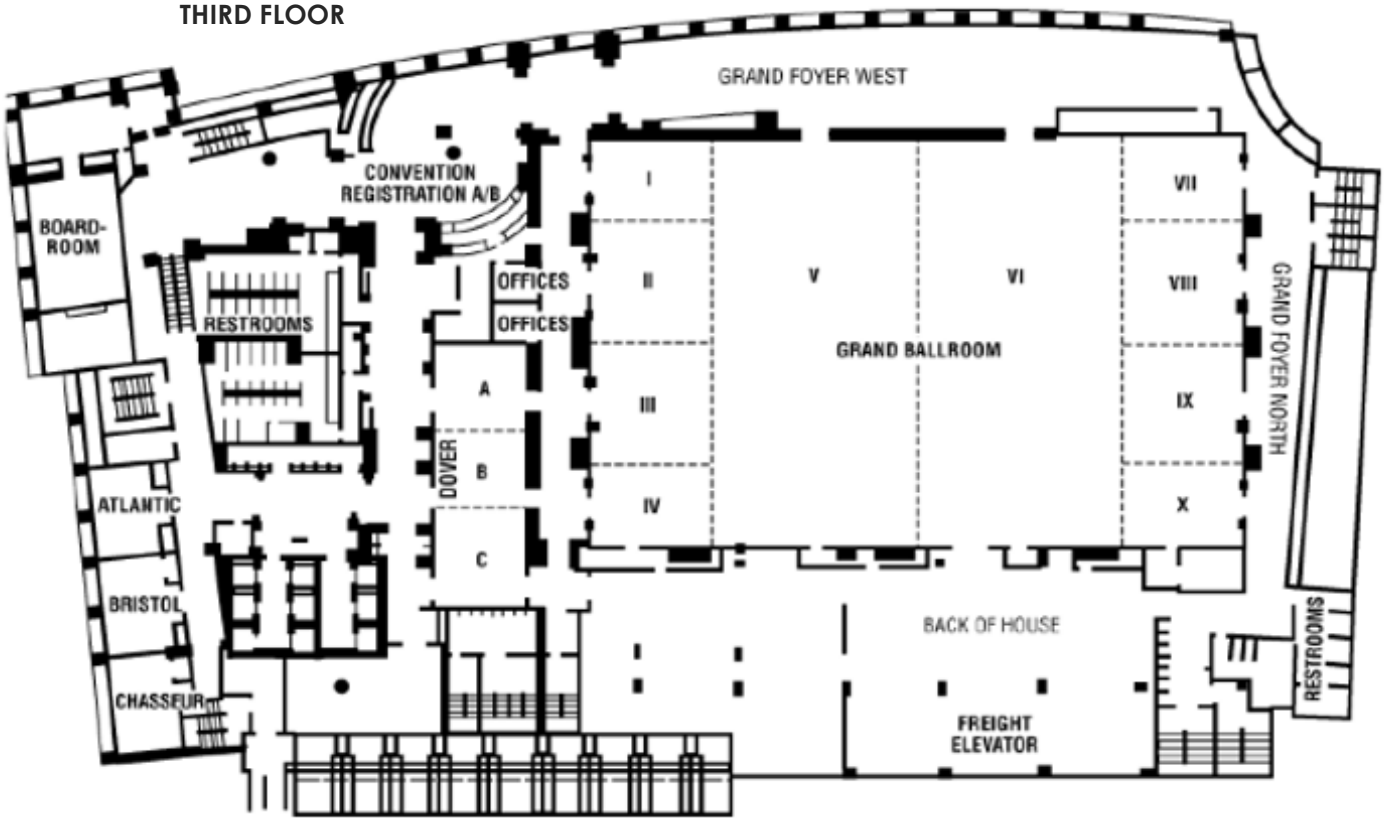

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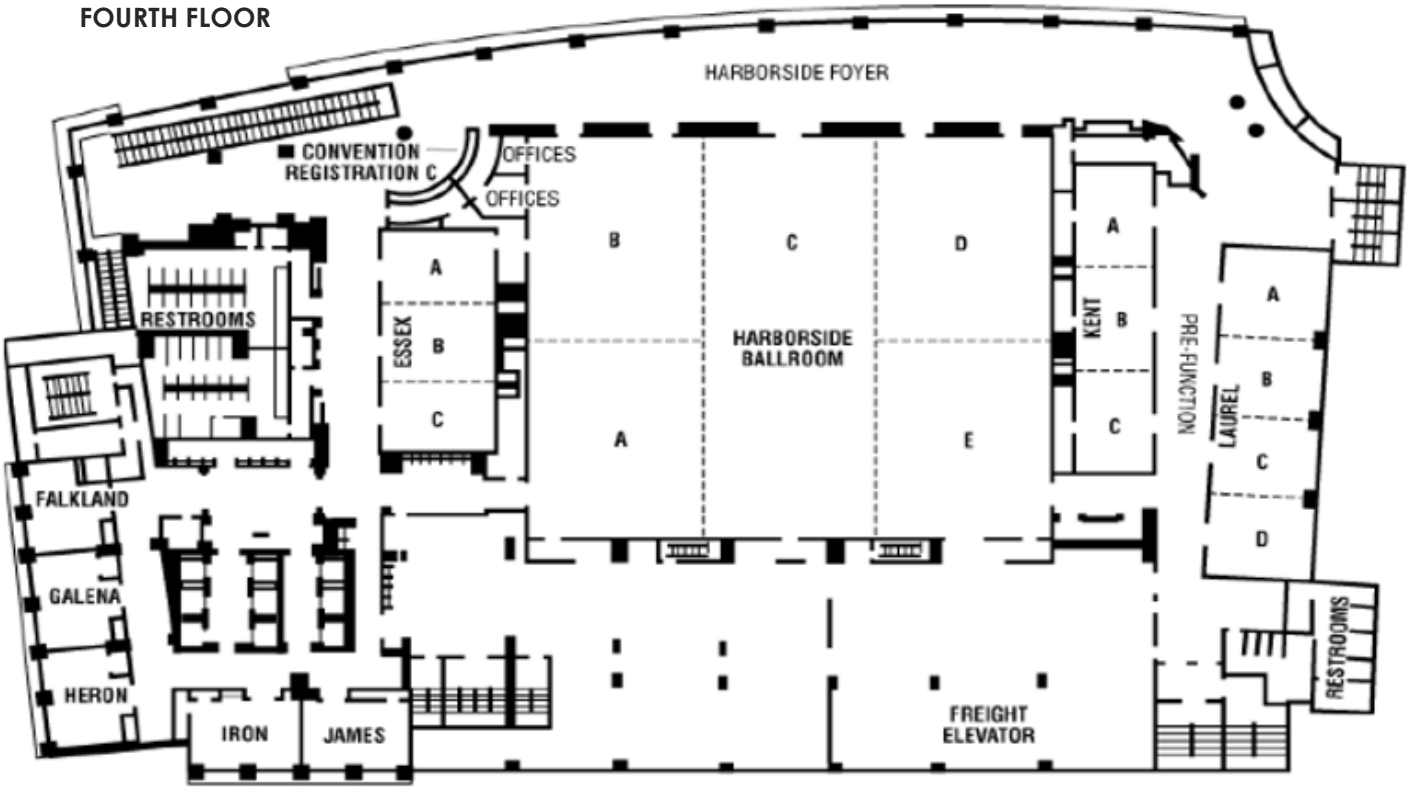

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