NATIONAL HEALTH CARE FOR THE HOMELESS

HCH2026 ORLANDO

JUNE 8-11

CONFERENCE & POLICY SYMPOSIUM

CommonSpirit

PRESENTING HOPE SPONSOR

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

nhchc.org

RISING TOGETHER:

COMMUNITY, COURAGE & CARE

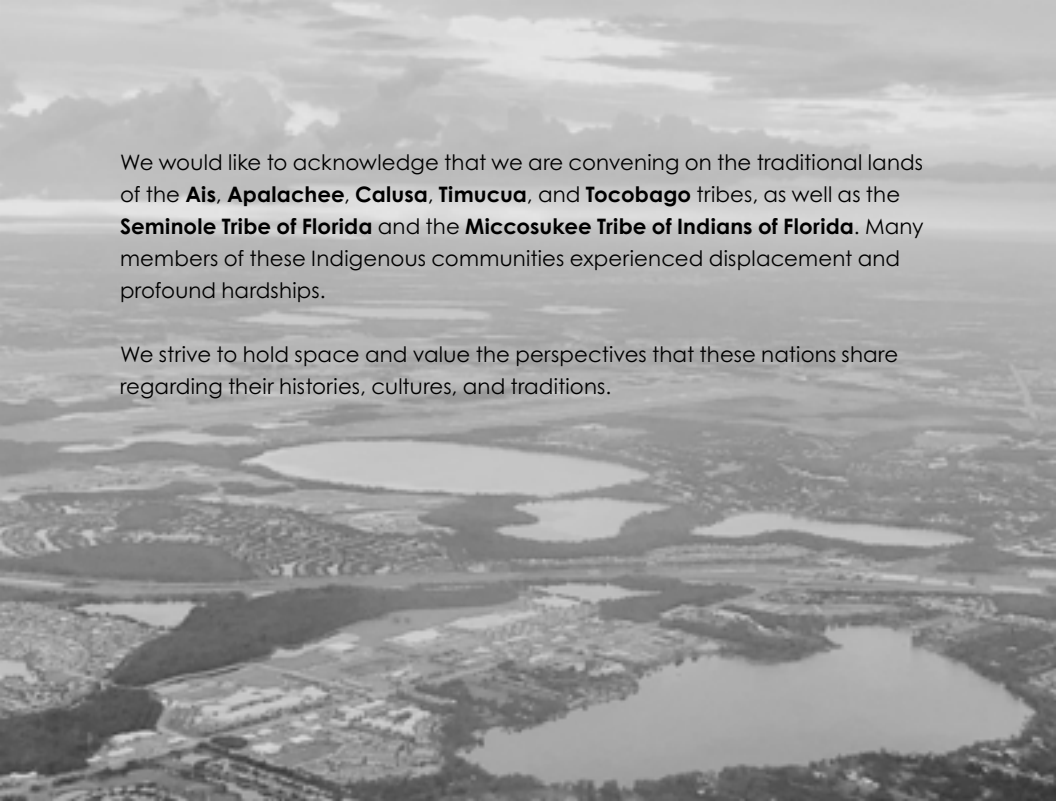
LOEWS SAPPHIRE FALLS RESORT AT UNIVERSAL ORLANDO

CommonSpirit

The future is ours for the healing.

The CommonSpirit Health® philosophy of care is rooted in over a hundred years of healing ministry and service. We believe every person deserves to be cared for with dignity, respect, acceptance, and love. In this spirit, we are proud to support the essential work of the National Health Care for the Homeless Council.

Hello humankindness®



We would like to acknowledge that we are convening on the traditional lands of the **Ais**, **Apalachee**, **Calusa**, **Timucua**, and **Tocobago** tribes, as well as the **Seminole Tribe of Florida** and the **Miccosukee Tribe of Indians of Florida**. Many members of these Indigenous communities experienced displacement and profound hardships.

We strive to hold space and value the perspectives that these nations share regarding their histories, cultures, and traditions.

WELCOME TO ORLANDO

The program in your hands provides a great overview of what's happening during HCH2026, but **the conference mobile app has full session details and the most up-to-date schedule**, including schedule and programming adjustments made after this program was printed.

SCAN TO GET THE APP

CONFERENCE WIFI

Network	Password
Loews_Conf	HCH26

CONFERENCE HOTEL

LOEWS SAPPHIRE FALLS RESORT AT UNIVERSAL ORLANDO

6601 Adventure Way
Orlando, FL 32819

PHOTOGRAPHY AND VIDEO

By attending HCH2026 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 NHCHC, whether now known or hereafter devised, in perpetuity. If you do not agree to the foregoing, please register your objection at the conference check-in desk so we can try to accommodate your wishes.

WELCOME FROM THE CEO OF NHCHC

Reflect, Connect, and Recharge — We're Glad You're Here!

BOBBY WATTS, MPH, MS

CEO, National Health Care for the Homeless Council

On behalf of the National Health Care for the Homeless Council, it is my privilege to welcome you to the 2026 National Health Care for the Homeless Conference & Policy Symposium in beautiful Orlando, Fla. We are so glad you're here.

Each year, this gathering is a powerful reminder of what it means to be part of a community committed not just to care, but to one another. In clinics, outreach teams, medical respite programs, shelters, and community spaces, you show up every day with determination, creativity, and compassion. This conference is a chance to connect, reconnect, to learn from one another, and to strengthen the relationships that sustain us in our common purpose.

The theme Rising Together: Community, Courage, and Care speaks to the spirit we see across this community. It shows in the way you share ideas and lift up promising practices (and just as importantly, share what didn't work to shorten the learning curve for others), in the way you courageously speak out for and with your patients and advocate for systems that truly meet their needs, and in the steady, person-centered care you provide every single day.

As you participate in the conference, I hope you find space to reflect, to be inspired, and to connect with colleagues who understand both the challenges and the importance of this work. Whether you're here to deepen your practice, build new partnerships, or simply recharge, your presence with us matters and strengthens our community.

Thank you for all that you do, and for being part of this gathering. It is an honor to be in community with you.

In Solidarity,

Bobby Watts, MPH, MS

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

Join the Conversation on Social or In the App

Use the hashtag **#HCH2026** on social media to share your conference highlights!

Download the conference app to connect with other attendees, share photos, and plan your conference experience.

Conference Schedule

JUNE 8-11, 2026

MONDAY

7 a.m.-4 p.m.	Check-In Open (Grand Foyer — PreFunction North)
7-8:30 a.m.	Breakfast (Grand Caribbean 6-7)
8:30 a.m.-4:30 p.m.	Pre-Conference Institutes
11:30 a.m.-12:30 p.m.	Lunch (Grand Caribbean 6-7)

TUESDAY

7 a.m.-1:30 p.m.	Check-In Open (Grand Foyer — PreFunction North)
7-8:30 a.m.	Breakfast (Grand Caribbean 6-7)
8 a.m.-12:30 p.m.	Exhibitors (Grand Foyer — PreFunction North)
8:30 a.m.-12:30 p.m.	Learning Labs
12:30-2:15 p.m.	Building What Lasts: Partnership, Policy, and the Future of Medical Respite (Grand Caribbean 6-7)

WEDNESDAY

7 a.m.-4 p.m.	Check-In Open (Grand Foyer — PreFunction North)
7-8:30 a.m.	Breakfast (Grand Caribbean 6-7)
8 a.m.-5 p.m.	Exhibitors (Grand Foyer — PreFunction North)
8:15-9:15 a.m.	Morning Plenary (Grand Caribbean 6-7)
10 a.m.-5:30 p.m.	Breakout Sessions
12:45-2:15 p.m.	Lunch (Grand Caribbean 6-7)
12:45-2:15 p.m.	Network Membership Lunch (Kingston Hall)
5:45-7:30 p.m.	Welcome Reception/Rally/Poster Presentation (Cayman Court and Kingston Foyer)

THURSDAY

7 a.m.-4 p.m.	Check-In Open (Grand Foyer — PreFunction North)
7-8:30 a.m.	Breakfast (Grand Caribbean 6-7)
8 a.m.-4 p.m.	Exhibitors (Grand Foyer — PreFunction North)
8:15-9:15 a.m.	Morning Plenary (Grand Caribbean 6-7)
10 a.m.-5:30 p.m.	Breakout Sessions
12:45-2:15 p.m.	Awards Luncheon (Grand Caribbean 6-7)

Don't Be Shy — Take Some Credit!

We're thrilled to offer continuing education credits for HCH2026. Scan the code or check out the conference app to learn more.

WEDNESDAY

Network Membership Lunch

12:45-2:15 P.M.

Kingston Hall

Are you a member of the Respite Care Providers' Network (RCPN), the HCH Clinicians' Network (CN), or the National Consumer Advisory Board (NCAB), or are you interested in becoming one? Join us for a special membership and networking lunch just for you! Connect with network members from across the country, build new relationships, and strengthen existing ones. Share ideas, learn from one another's experiences, and hear what other programs are working on in dedicated spaces set aside for each network. You'll also have time to meet members from other networks and connect with Council staff.

PLAN YOUR CONFERENCE EXPERIENCE

WEDNESDAY

Welcome Reception, Poster Presentations, and Housing Rally

5:30-7:30 p.m.

Mix, mingle, and hear from this year's slate of poster presenters during the Welcome Reception. Exhibitors and sponsors will be on hand to share resources and information. Small bites and a cash bar will be available.

From 6-7 p.m., bring your energy over to the Housing Justice Rally, led by the National Consumer Advisory Board and the Central Florida Councils: The Youth Action Society & Lived Experience Council. We'll gather in community, lift up our collective voice, and build momentum for change.

Cayman Court & Kingston Hall Foyer

MONDAY-THURSDAY

Photography Exhibit Explores the Challenges of Kicking Tobacco While Unhoused

Stop by the "Through Our Lens" exhibit just outside the conference check-in desk and experience a powerful collection of images and words created by people with lived experience of homelessness. During the winter of 2025, five lived-experience leaders took part in a creative photo storytelling project in Nashville, Tenn. Over four sessions, they explored the real challenges of trying to reduce or quit tobacco use while experiencing homelessness.

PHOTO BY KENNETHA PATTERSON

Grand Foyer

Each week, participants Kennetha Patterson, Traveion Jackson, April Burns-Norris, Nefertiri Rollins, and Robert Knight reflected on a different part of their journey. They took photos in their communities and wrote short stories to explain what those moments meant to them. Together, the photos and stories offer honest, personal insight into their struggles, strengths, and hopes.

The exhibit was first shown at the Pruitt Branch of the Nashville Public Library — a place chosen by participants as an important community space. You'll find the exhibit just outside registration. Take a few minutes to look, read, and reflect. Be sure to share your thoughts in the response book and help spark conversation about how our community can better support people who want to reduce or quit tobacco use.

Need to recharge? Visit the **Relaxation & Lived Experience Lounge** in Gardenia in the Royal Pacific Foyer! Open Tuesday through Thursday from 7:30 a.m.-4:30 p.m.

TUESDAY AND WEDNESDAY

Visit an Orlando-Area HCH Program

Want to see how local programs provide care in their communities? Sign up to visit one of two Orlando-area programs!

Site visit signup opens at 7:30 a.m. on the day of each tour. Signup will close each day when all spots are full. You must be present to sign up, and you can only sign up for that day's visits.

Signups and Departures in Royal Pacific Foyer

Please Note: While each site is fully accessible, the vehicle used to transport the group from site to site requires a person to be able to climb approximately three steps.

PATHWAYS TO CARE

A Florida licensed assisted living facility that specializes in medical respite care in Casselberry, Fla.

HEALTH CARE CENTER FOR THE HOMELESS ORLANDO

An FQHC offering primary care, behavioral health services, oral health care and outreach services. We'll visit their location at Christian Service Center of Central Florida.

	PATHWAYS TO CARE	HCCH ORLANDO
TUESDAY P.M.	**JUNE 9** **Depart hotel:** 2 p.m. **Return:** 5 p.m.	**JUNE 9** **Depart hotel:** 2 p.m. **Return:** 4 p.m.
WEDNESDAY A.M.	**JUNE 10** **Depart hotel:** 10 a.m. **Return:** 1 p.m.	**JUNE 10** **Depart hotel:** 10 a.m. **Return:** 12 p.m.

Return times are approximate due to traffic and travel distance.

WEDNESDAY 9:30 a.m.-2:30 p.m.

Pinellas County Mobile Unit Available for Tours

Pinellas County Health Care for the Homeless Program invites conference attendees to tour their mobile medical unit and learn from staff about their program.

Outside — Bus Loop

MONDAY-THURSDAY

Ready to Get Certified?

Last year, NHCHC launched our voluntary certification process for recuperative and medical respite care programs across the U.S. Dozens of programs across 22 states have achieved certification, representing nearly 1,000 beds that provide safe, high-quality healing environments for people experiencing homelessness.

This certification builds on the groundbreaking work of the Council's 6-year-old National Institute for Medical Respite Care, and indicates a commitment to high-quality care, continuous improvement, and the advancement of medical respite care nationally. Learn more at our certification table in the Exhibitor Hall!

Grand Foyer

EXHIBITORS

Visit these great exhibitors in the Grand Foyer Monday-Thursday to learn more about their services!

Americares

A.T. Still University

Bloomberg American Health Initiative (Johns Hopkins Bloomberg School of Public Health)

Capital Link

CommonWealth Purchasing Group

Dignity Bus

Empowerment Plan

NHCHC & Our Membership Networks

Pulse For Good

SAMHSA Homeless and Housing Resource Center

U.S. Department of Veterans Affairs Office of Suicide Prevention

Marisol Bello

Executive Director, Housing Narrative Lab

WEDNESDAY
MORNING PLENARY

Marisol Bello (she/her) has spent a career championing the stories and voices of people with lived experience, so they lead in creating the solutions that help every family thrive. First as a career journalist telling the stories of families working to make ends meet, and then in the nonprofit world, where she led narrative strategies to change hearts and minds about those living on the brink and move people to action.

A first-generation American from a Caribbean family full of colorful storytellers, Bello is originally from NYC. Home is chicken and rice, family game nights, and gathering around the dining room table until the wee hours talking about books, movies, and everything we love.

Anna Eskamani

District 42 Representative, Florida Legislature

THURSDAY
MORNING PLENARY

Anna Eskamani is a bold fighter for Florida families and everyday people. Born and raised in Orlando, she's the daughter of working-class immigrants who came to the United States in search of the American Dream. Eskamani went to public schools in Orange County and then to the University of Central Florida where she earned dual degrees as an undergrad and graduate student. She now has a PhD in Public Administration, works in the nonprofit sector, and serves as the Founder and Executive Director of People Power for Florida, a voter registration and engagement organization. She is proud to be a State House Representative in the Florida Legislature serving District 42 in the Central Florida area. A bridge builder, Anna ran for office for the first time in 2018, flipping her legislative seat and making history as the first Iranian-American elected to any public office in Florida. Before running for office, she served as the Senior Director of Public Affairs and Communication at Planned Parenthood of Southwest and Central Florida.

A problem solver with a track record of kind sacrifice, endless hard work, and iron-clad values, Eskamani is known across the state and nation as a leader who is unbothered, unbossed, and committed to the people of Florida.

California Health Care Foundation

Advancing Health Care Solutions for Californians Experiencing Homelessness

At the California Health Care Foundation, we know the health care system cannot by itself solve homelessness. Yet there is a key role for the health system to play. Health care providers can effectively treat the physical and behavioral health needs of people experiencing homelessness so they can achieve stability and live independently.

Visit our resource center.

Watch how California is harnessing the power of medical respite care in this 90-second video.

Each year, the Council asks our members to nominate outstanding peers and colleagues in the Health Care for the Homeless field for our annual awards and conference scholarship. ***Please help us congratulate this year's honorees during Thursday's Awards Luncheon at 12:45 p.m.***

PHILIP W. BRICKNER NATIONAL LEADERSHIP AWARD

Jenny Metzler

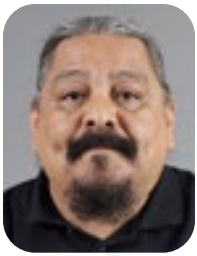
Albuquerque Health Care for the Homeless

Jennifer L. Metzler is Chief Executive Officer of Albuquerque Health Care for the Homeless, Inc. (AHCH), a Federally Qualified Health Center that has served exclusively the population experiencing homelessness in the Albuquerque, N.M., area since 1985. AHCH's integrated, comprehensive range of health services and philosophy of care organize around the circumstances of homelessness and an emphasis on ending it. A hallmark of the AHCH model is field-based service delivery by all programs and disciplines, in shelters, meal sites, the library, and through roving street outreaches to settings where people without homes congregate and reside.

Metzler has over 40 years' experience working in community-based organizations dedicated to health, ending homelessness and poverty, immigrants' rights, media justice, and addressing violence against women. In Latin America and New Mexico, she has developed and implemented a range of outreach and services programs and led collaborative initiatives of diverse community groups. In late 2010, she concluded 15 years at AHCH where, as Development and then Executive Director, she created strategic and unique annual participatory planning processes, and successfully generated millions of dollars in a sustainable business model that drew a diverse public/private mix of operating revenues each year.

Metzler served as President and Strategic Planning Chair of the National Health Care for the Homeless Council board, was an APD Forward Coalition Steering Committee founder and member working on law enforcement reform, and she has served on advisory groups for both Generation Justice and the Building Movement Project in New Mexico.

ELLEN DAILEY CONSUMER ADVOCATE AWARD



Joseph Becerra

USC Street Medicine, Los Angeles

Joseph Becerra is the original Community Health Worker (CHW)— he helped start USC Street Medicine and now is the Supervising CHW. Becerra is also a Certified Addiction Treatment Counselor, Domestic Violence Counselor, and certified Gang Interventionist who has worked with the underserved, incarcerated youth/adults, at-risk youth/CSEC youth. Becerra was also homeless for more than 13 years. Becerra worked closely with the Department of Mental Health in the juvenile justice system with incarcerated youth and at USC for several years on studies focusing on intravenous drug users.

In 2022, Becerra was named to the Steering Committee of the Health Care for the Homeless Clinicians' Network, a membership network of the National Health Care for the Homeless Council. Becerra also serves as a representative for USC Street Medicine on the workforce development/education team, including taking part in trainings and consulting for outside programs on harm reduction and safety for the future of street medicine program development.

WILLIE J. MACKEY NATIONAL MEDICAL RESPITE AWARD

Mary De Guzman, RN

Good Samaritan Shelter, Santa Barbara County, Calif.

Mary De Guzman, RN, oversees recuperative care at four locations with Good Samaritan Shelter in Santa Barbara County, Calif. Through her work, she has cultivated a deep understanding of the barriers faced by the homeless population, striving to bridge the gap between healthcare services and those who need them most.

Her passion lies in honoring the lives of the underprivileged and ensuring they receive the care they deserve. Known for second chances, De Guzman leads her team and hopes to inspire others in the community with her motto, "If not us, then who?"

KAREN ROTONDO AWARD FOR OUTSTANDING SERVICE

Dr. Sabina Wong

The Boulevard of Chicago

Sabina Wong, MD, is the Clinic Coordinator for the PCC Clinic at The Boulevard of Chicago. In her role coordinating the PCC Clinic, Dr. Wong ensures that clients receive high-quality, patient-centered medical care in a setting designed to support healing and stability. A colleague notes, "She approaches everyone with dignity, empathy, and clinical excellence, recognizing the complex health challenges that often accompany homelessness. Her work reflects the hands-on commitment and deep respect for clients." Dr. Wong also plays a key organizing and coordination role within the Chicago Homelessness and Health Response Group for Equity (CHHRGE) Advocacy Communications Committee.

Learn about the namesake for each award at nhchc.org/council-awards

JOHN N. LOZIER SCHOLARSHIP FOR NEW MEMBERS

Shasha Jones

Janian Medical Care

Originally from Jamaica, Ms. Shasha Jones began her journey in homeless healthcare as a security guard and security supervisor in homeless shelters in New York City. Ms. Jones worked in facilities with co-located medical services provided by Janian Medical Care. Through her collaboration with on-site healthcare teams, Shasha was inspired to pursue Medical Assistant training and began working with Janian Medical Care as a Medical Assistant. Ms. Jones now works directly with patients in shelter and permanent supportive housing programs, serving individuals currently and formerly experiencing homelessness. At this time, Ms. Jones is also completing her educational requirements to become an RN, while maintaining full-time employment at Janian.

Happy, healthy neighbors. That's our mission.

Kaiser Permanente is a proud supporter of the 2026 National Health Care for the Homeless Conference & Policy Symposium.

At Kaiser Permanente, we continuously strive to improve the conditions for health and equity in our communities. Our doors, hearts and minds are always open to help you thrive.

KAISER PERMANENTE®

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

JOIN THE COUNCIL!

NHCHC membership provides unique opportunities to network, collaborate, and advocate alongside an expansive group of leaders and professionals working at the intersection of health care and homelessness.

Scan this code or visit nhchc.org/membership to learn more

WHY JOIN NHCHC AS A MEMBER?

- Get training and technical assistance
- Enjoy discounted conference pricing
- Post to our job board
- Lend your expertise to a committee or board
- Nominate and be nominated for Council awards

Street Medicine Blueprints

Brett Feldman *(University of Southern California, Director, USC Street Medicine);* ***Corinne Feldman****;* ***Kaitlin Schwan; Katia Cnop*** *(USC Street Medicine, Associate Medical Director);* ***Katie League****;* ***Liz Frye****;* ***Richard Bryce****;* ***Joseph Becerra*** *(University of California, Supervising Community Heath Worker)*

GRAND CARIBBEAN 1-2

Providing comprehensive primary care for unsheltered homeless people in their lived environment requires a robust continuum of services that cater to the reality of the streets. Street medicine provides health care directly to patients where they are living- under bridges, at encampments or in the woods. Join street medicine experts from across the country in this session to learn the foundational philosophy of street medicine practice and discuss the policy and operational steps to develop a blueprint for bringing street medicine to life in your communities.

Addressing Behavioral Health Needs in Medical Respite Care

Carol Benner *(Boston Health Care for the Homeless Program);* ***Christa Signor*** *(National Health Care for the Homeless Council, Senior Medical Respite Manager);* ***Christy Sheehan*** *(Boston Healthcare for the Homeless Program, Director of Nursing);* ***Leilani Flynn*** *(Haven Recovery Homes, Recuperative Care Nurse Liaison);* ***Tarryn Bieloh****;* ***Caitlin Synovec*** *(National Healthcare for the Homeless Council, Assistant Director of Medical Respite);* ***Rima Benson*** *(Shasta Community Health Center, Mental Health Therapist);* ***Vinny Greico*** *(Haywood street congregation, Lead peer support specialist)*

GRAND CARIBBEAN 11-12

Medical respite care programs often provide support for people with co-occurring behavioral health needs in addition to the medical conditions that prompted their referral. These clients can especially benefit from the client-centered care and stability that medical respite care programs provide. This PCI will provide an opportunity for providers to to develop a more in-depth understanding of how behavioral health conditions can present, and will engage with presenters and interactive activities to develop skills and practical strategies for programs to better and more effectively support their clients and program.

Motivational Interviewing

Lily Catalano *(National Health Care for the Homeless Council, Senior Clinical Manager);*
Rafael Martinez *(Circle the City, Director of Behavioral Health)*

GRAND CARIBBEAN 3-5

How can we better help the people we serve make changes in their lives? Through empathy, partnership, and honoring each person's choices, we can strengthen their motivation and commitment to action. Motivational Interviewing (MI) is a proven way to guide people to make the changes important to them. Through discussions and small group exercises, we will explore how MI can shape your conversations, build trust, and empower those you serve. Whether you're new to MI or refining your skills, this workshop will provide you with useful ideas and tools to support your efforts to serve your community.

Leveraging Health Center Data: Digging Into Administrative Tools for Health Center Sustainability

Lauryn Berner-Davis *(National Health Care for the Homeless Council, Director of Community Engagement and Impact)*

GRAND CARIBBEAN 8-10

Health center data analysis is a helpful tool to assess and evaluate the services they provide and for the patients they care for and to support financial sustainability. This pre-conference institute will provide guidance and examples of how health centers can use their operations data for financial sustainability planning and to address health care efficiency to support patients. Join us to see how you can use your own administrative data to support efficiency and sustainability.

IMPORTANT FUNDING NOTE

The National Health Care for the Homeless Conference & Policy Symposium is presented by the National Health Care for the Homeless Council. Select conference sessions are supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $1,788,315. **Those sessions titles are marked within this program.** Remaining conference sessions are funded in full by non-governmental sources. The views expressed during the conference do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.

Meeting People Where They Are: Lived Experience-Informed Medical Outreach Increases Access

Joseph Cowboy Benson *(National Consumer Advisory Board, NHCHC Board of Directors, President);* ***Kendall Clark*** *(National Consumer Advisory Board, Member-at-Large);* ***Rodney Dawkins*** *(National Consumer Advisory Board, Co-Chair);* ***Valerie B. Dowell*** *(National Consumer Advisory Board, Steering Committee Mentor);* ***Charlotte A. Garner*** *(National Consumer Advisory Board, Member-at-Large);* ***Amy Grassette*** *(National Consumer Advisory Board, Peer Advocate);* ***Mrya Nagy*** *(National Consumer Advisory Board, Regional Representative);* ***Deirdre Young*** *(National Consumer Advisory Board, Chair);* ***Mamie Gathard*** *(National Consumer Advisory Board, Regional Representative)*

GRAND CARIBBEAN 1-2

This Learning Lab explores how people with lived experience of homelessness can help improve access to health care through medical outreach, in particular mobile health care and street medicine. The session will be led by presenters with lived experience, who will share real stories, lessons learned, and practical strategies.

Participants will learn about the different roles people with lived experience have on care teams, and how these roles help reduce barriers like mistrust, stigma, and challenges navigating the health care system. The workshop will also show how lived experience can improve engagement in care—helping people start services, stay connected, and follow through with treatment. Through group discussion and examples, participants will see how lived experience leadership builds trust and strengthens relationships, making it easier for unstably housed and unsheltered individuals to access care.

By the end of the workshop, participants will be able to:

• Describe the roles people with lived experience can play on street medicine and mobile health care teams.
• Explain how these roles reduce barriers and improve engagement in care. Identify examples of how lived experience-informed outreach approaches increase access to care."

Starting a Medical Respite Program

Alysia Paaluhi *(Virginia Garcia Memorial Health Center, LATS Nurse Practitioner);* ***Amanda Bradke*** *(Rush University Medical Center, Internal Medicine Physician, FranRu Respite Medical Director);* ***Kyle Brand Padilla*** *(Rush University Medical Center, Licensed Clinical Social Worker);* ***Martin Mendoza****;* ***Roxanna Pascual*** *(VGMHC, Medical Operations Department Administrator)*

GRAND CARIBBEAN 11-12

Starting a Medical Respite Care Program Learning Lab is an opportunity for attendees to take a deep dive into the process of planning and developing a medical respite program. Facilitated by NHCHC staff and provider experts, this session will provide an overview of the foundations and models of medical respite care, program design guidance, and strategies for developing critical partnerships. Attendees will have an opportunity to learn from the experiences of providers in the field and apply this expertise into their own community's context.

Evaluation of Homeless Health Care Programs

Craig Mendoza *(National Health Care for the Homeless Council, Evidence and Evaluation Coordinator);* ***Joseph Kenkel*** *(National Health Care for the Homeless Council, Sr. Research and Data Manager);* ***Natalie Rejto****;* ***Ben King*** *(University of Houston College of Medicine, Clinical Assistant Professor);* ***Joshua Barocas*** *(University of Colorado, Associate Professor);* ***Vickie Ramirez*** *(University of Washington, One Health Clinic, Sr Research Coordinator/ Program Manager);* ***Jess Sherman****;* ***Ashley Meehan*** *(Johns Hopkins University)*

GRAND CARIBBEAN 3-5

The key to ensuring that the work we do is effective is to have an evaluation plan in place. Creating a strong evaluation plan starts early — as communities identify goals for their process and system, they are laying the foundation for how to determine their process's efficacy toward that goal. This interactive learning collaborative will provide an opportunity for health centers and medical respite programs to learn best practices in program evaluation and apply it directly to their work.

Participants will be able to describe the basic terminology, major concepts, and logic of public health program evaluation. Participants will identify at least one of each: evaluation goal, objective, question, and measurement tool. Participants will be able to apply evaluation frameworks to their program utilizing tools and activities during the learning lab.

Care for Older Adults

Alaina Boyer *(National Health Care for the Homeless Council, Senior Director of Programs);* ***Alric Nembhard*** *(NYU Grossman School of Medicine, OATH Study Collaborator with Lived Experience);* ***Giselle Routhier*** *(NYU Grossman School of Medicine, Research Assistant Professor);* ***Leanna Travis****;* ***Pia Valvassori*** *(Health Care Center for the Homeless, clinician);* ***Devora Keller*** *(National Health Care for the Homeless Council, Director of Clinical and Quality Improvement)*

GRAND CARIBBEAN 8-10

The older adult population experiencing homelessness, comprised of individuals who are aging while chronically homeless and those who are experiencing first time homelessness at an older age, is the fastest growing PEH group. At the same time, existing HCH service models were not designed to support the complex needs of this population. This LL will explore the unique needs of this population, share novel approaches to supporting older adults being tried by communities, and spotlight areas for additional growth in the practice and policy spheres. This LL will integrate the perspectives of individuals with lived expertise, direct service providers, policy leaders, and researchers. Participants are encouraged to join ready to share challenges and solutions they are seeing in their own community.

Characterizing the Overlap of Homelessness, Mental Health, and Substance Use: Surveillance Insights from Michigan's Opioid Response Strategy

Lynn Hendges *(Michigan Department of Health and Human Services- Housing and Homeless Services Division, Manager);* ***Megan Zabinski*** *(Michigan Department of Health and Human Services — Opioids and Emerging Drugs Unit, Senior Epidemiologist);* ***Sarah Konefal*** *(Michigan Department of Health and Human Services- Opioids and Emerging Drugs Unit, Epidemiologist Specialist)*

GRAND CARIBBEAN 1-2

Housing instability and homelessness are important risk factors associated with substance use disorder and drug overdose. The intersection of homelessness, substance use, and mental health creates complex challenges to treatment and recovery for substance use disorders. This study uses a range of state-level administrative data to highlight the prevalence of homelessness among populations with substance use disorders (SUD) and those who have experienced drug-related overdoses. This includes data from MiCelerity, a repository for non-fatal healthcare and fatal overdose events, that are linked to the Homeless Management Information System (HMIS), which tracks housing and service provision for individuals experiencing homelessness. Descriptive statistics summarize the demographic and clinical characteristics of affected populations, focusing on racial and ethnic disparities. Drug overdose deaths are a leading cause of mortality among people experiencing homelessness in Michigan, and Black non-Hispanic (NH) populations are disproportionately affected. In Michigan, at least one in five drug overdose deaths are individuals who have experienced homelessness at least once in their lifetime and this figure rises to more than one in four among Black NH demographic groups. In 2022, an estimated 0.3% of Michiganders experienced homelessness, but among SUD treatment episodes in 2023, 16.3% were among people experiencing homelessness. Moreover, the prevalence of homelessness in SUD treatment was 29.2% among individuals with a co-occurring mental health diagnosis. The prevalence of homelessness in SUD treatment among Black NH individuals with a co-occurring mental health diagnosis was 44.4% compared to 21.8% among White NH individuals with a co-occurring mental health diagnosis. These results highlight the overlap between homelessness, SUD, and mental health disorders and a disproportionate burden of homelessness borne by Black NH populations.

A Collaborative Approach to Integrating HIV and Hepatitis C Care on Street Medicine

David Holland *(Mercy Care, Chief Medical Officer);* ***Joy Fernandez de Narayan*** *(Mercer University, Clinical Assistant Professor)*

GRAND CARIBBEAN 11-12

Street Medicine is the provision of healthcare services to those experiencing unsheltered homelessness directly in their own environment. Mercy Care's Street Medicine Team (SMT) is a multidisciplinary team providing direct medical and psychiatric care as well as substance use and case management services to those experiencing unsheltered homelessness in Atlanta, GA. This presentation will introduce the SMT's hospital follow up care model, including their multi-prong approach to identifying and reaching clients in need of services. This includes a combination of traditional street outreach including persons with lived experience, on-site and outreach collaboration with community partners, hospital referrals, and open-access clinic hours staffed by SMT providers. This presentation will focus heavily on the hospital referral system. The presentation will also detail how this SMT grew and leveraged their network to respond to the unmet need for HIV and hepatitis C treatment amongst those experiencing unsheltered homelessness. The medical providers underwent training and infectious disease supervision to expand their scope of practice to include HIV and hepatitis C treatment. The SMT utilized their nurses to offer screenings to clients who needed TB clearance for housing and also leveraged partnerships with organizations providing rapid testing and hospitals caring for those who would ultimately end up back on the streets. Finally, this presentation will explore the special challenges facing those experiencing unsheltered homelessness and how the SMT has found success in viral suppression in HIV and cure of hepatitis C in this population. Supports such as regular nurse check-ins, assistance with medication storage and dispensing, peer guidance and support, and field lab draws and medical visits played a pivotal role in the success of this project. Transportation by familiar team members to see familiar providers in the clinic setting further elevate the effectiveness of this approach and ensures that clients are receiving the best care possible.

What's New in Homeless Health Care? A No-Jargon Summary of the Latest Research

Stefan Kertesz; Travis Baggett; Kate Diaz Vickery *(Hennepin County Health Care for the Homeless, Medical Director/Researcher)*

GRAND CARIBBEAN 3-5

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, 2025. 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.

Implementation of Trauma Informed Assessments for Direct Client Services

Richard Southee *(Central Ariz. Shelter Services, Director of Compliance & Continuous Improvement)*

GRAND CARIBBEAN 8-10

As Trauma-Informed Care becomes more centered and moves from a best practice to an industry standard, providers are increasingly seeking ways to understand, implement, and reevaluate services from a trauma-informed lens. Critical to this process is understanding how trauma manifests in a providers service population. This workshop explores a study conducted at one of the largest congregate shelters in the country, the implementation of a pilot tool for the assessment of trauma. Through the workshop we'll explore the findings of the study, the process underwent to create it, and key takeaways from the project. The workshop will also include an practical application portion, with the audience will work to identify key points of focus if they were to implement a similar assessment within their own service population.

Oh Look, My Career is on Fire: When Burnout Leads to Burning Bridges

April Krall *(Colorado Coalition for the Homeless, Director of Nursing)*

OCEANA GRAND 11

Burnout in healthcare is more than exhaustion—it can erode relationships, cloud judgment, and derail careers. Drawing on over two decades in nursing, from bedside care to leadership in a Healthcare for the Homeless organization, this session uses personal stories of successes, setbacks, and lessons learned to explore the emotional and cognitive toll of the work. Attendees will gain insight into navigating challenges without losing professional footing—or burning bridges. This session will help participants understand their reactions to stress, uncertainty, and overload, and provide practical, in-the-moment tools to stay grounded. We will focus on recognizing subtle signs of strain, maintaining composure, and safeguarding career longevity—not through self-care basics, but through behavioral awareness and intentional workplace presence. Rather than prescribing more sleep or deep breathing, we'll focus on the concept of How You Show Up.

Through humor, candid storytelling, and interactive reflection, we will explore: Passion projects as burnout buffers, strategic use of Paid Time Off, building and leaning on "work besties", the art of "fixing your face" in tense moments, why it feels better to bounce back than spiral out.

Lessons from mistakes and burned bridges Anticipated Outcomes Participants will leave with: greater awareness of their emotional and behavioral patterns, practical strategies for managing high-pressure interactions, approaches to channel passion into sustainable, rewarding work Implications for the Field High turnover in healthcare—especially in Healthcare for the Homeless—threatens continuity of care and staff well-being. By sharing replicable strategies rooted in lived experience, this session aims to equip attendees to return home more resilient, resourceful, and ready to stay in the work for the long haul. Session Summary Burnout can scorch more than your energy—it can make ashes of your reputation, relationships, and career trajectory. In this candid, humorous session, a nurse-turned-leader shares hard-earned lessons from two decades in healthcare, including the mistakes that set bridges ablaze and the strategies that kept others standing. Walk away with practical, in-the-moment tools to "fix your face," protect your career, and thrive in the work you love.

Health Equity: Local Analysis and National Conversation

Ali Davidson *(Colorado Coalition for the Homeless, Specialist Evaluations);*
Beth Gregory *(Colorado Coalition for the Homeless, Director of Evaluation)*

OCEANA GRAND 12

All people have the right to adequate and accessible housing and health care. Since 2020, the Colorado Coalition for the Homeless has completed an internal analysis of key metrics to evaluate the equity of client outcomes and access to services. This presentation aims to share the methods, results, and lessons learned from internal health equity analyses. Using a mixed-methods approach, disparities were identified across federal, state, and internal data sources. Across the disparities that were identified, trends were found to be consistent with both national sources and internal annual reports, sparking conversations surrounding the effectiveness of past and present efforts in reduction of inequities and proposals for future improvement efforts.

Successful Academic Collaborations

Christina Walters *(Community Legal Services, Sr. Managing Attorney);*
Carla Cox *(Christian Service Center, Director of Operations)*

OCEANA GRAND 3

Academic partnerships play a critical role in improving health care delivery for individuals experiencing homelessness by fostering collaboration, innovation, and sustainability. Through partnerships between universities, health care institutions, and community-based organizations, evolving evidence-based practices are integrated into care models, enhancing both quality and access. Academic institutions contribute research expertise, interprofessional training, and workforce development, preparing future health professionals to address the complex medical, behavioral, and social needs of persons experiencing homelessness. By underscoring the importance of social determinants of health, these collaborations also support program evaluation and continuous quality improvement initiatives. These collaborative efforts ensure that interventions are effective and responsive to this populations needs. By combining academic resources with community partners, academic partnerships create scalable, patient-centered solutions that address health disparities, reduce emergency department utilization, and mitigate escalating rates of morbidity and mortality among those experiencing homelessness.

Restoring Function, Rebuilding Lives: Case Studies on Integrating Physical Therapy into Medical Respite

Alexus Carson *(Care Beyond the Boulevard, Physical Therapist)*

OCEANA GRAND 4-5

This session presents a case study on the integration of physical therapy (PT) into a medical respite program for individuals experiencing homelessness with complex medical needs. Through real patient stories, participants will explore how trauma-informed, community-based PT services can improve mobility, functional independence, and facilitate community reintegration following a musculoskeletal impairment. The session will highlight the role of PT in addressing both clinical recovery and social determinants of health, emphasizing cross-sector collaboration, consumer engagement, and strategies for replicating this model in other respite settings.

RISE UP: A State-Level Blueprint to Protect the Rights of Unhoused Communities

Chelsea Rose *(Care For the Homeless, Policy and Advocacy Manager);* ***Nathalie Interiano*** *(Care For the Homeless, VP of Policy and Advocacy);* ***Will Woods*** *(Care For the Homeless, Consumer Advisory Board Member; Board of Directors)*

OCEANA GRAND 8-9

Across the country, stigma against unhoused communities is on the rise, fueling a climate of hostility that results in discriminatory policies, targeted harassment, and even physical violence. Local ordinances increasingly criminalize homelessness, while attacks against individuals based on their housing status are often underreported and rarely prosecuted. This is due in large part to the absence of legal protections. To address this urgent gap, the RISE UP (Rights, Inclusion, Safety, and Equality of Unhoused Persons) campaign was created which is a New York-based initiative led by advocates with lived experience that seeks to dismantle discriminatory practices through state-level legislation, public education, and grassroots organizing. This session will present findings from RISE UP's recent report on discrimination against unhoused individuals and introduce its legislative model that is designed to establish enforceable protections against violence and discrimination based on housing status. Attendees will gain insight into the campaign's development, comparative legal research, and advocacy strategy. The session will also explore how this model aligns with or expands upon similar efforts in other states, offering a framework for replication across diverse political and legal landscapes

Have you seen…? Fostering Innovative and Creative Solutions to Locate Individuals Who Are In Great Need of Healthcare Access.

Bernie Delgado *(Community Health Center Inc, Connecticut, CKP Nurse Manager);* ***Cecilia Hackerson*** *(Community Health Center, Inc. | Center for Key Populations, Family Nurse Practitioner, Mobile Health Unit Provider);* ***Hillary Miller*** *(Community Health Center, Inc, Family Nurse Practitioner - Center for Key Populations Fellow)*

HIBISCUS

This abstract was developed due to the increased difficulty in locating unhoused individuals who are living further and further off the grid, increasing substantially, due to the continued criminalization of homelessness. This abstract emphasizes the importance of adapting and developing creative ways to locate unhoused individuals. Through leveraging connections with local community partners, including public health department staff, harm reduction teams, local shelters, and food service centers, this mobile health team has facilitated unique, creative, and effective ways to both locate and provide healthcare to individuals who are in greatest need of healthcare access. This session aims to discuss effective ways to reach the individuals who are difficult to locate, to continue to provide the high-quality healthcare that the patients and participants deserve.

Informing the Future of Street Medicine: Insights from a Large-Scale Mobile Health Program in Los Angeles

Giovanni Righi *(UCLA, Graduate Student)*

GRAND CARIBBEAN 3-5

Street medicine programs are expanding rapidly nationwide, yet evidence to guide service design and impact remains limited. Drawing on electronic health record data from one of the largest and longest-running street medicine providers in Los Angeles, this session examines who is served, what conditions are addressed, and how care is delivered in the field. We compare clinic- and street-based populations, identify five clusters of common health needs, and apply secure LLM tools to analyze clinical notes and interventions. Findings offer actionable insights for tailoring services, strengthening care delivery, and using data to inform policy and program design.

Consumer Participation Outreach Survey: Weather Emergencies and Homelessness

Valarie B. Dowell, BA, CHW, CDCAII, Warren Magee & Myra Nagy *(National Consumer Advisory Board)*

OCEANA GRAND 10

This year, the National Health Care for the Homeless Council supported the 10th Consumer Participation Outreach (CPO) survey. In this project, people with lived experience of homelessness spoke directly with individuals who are currently homeless to gather their input. The survey focused on the needs of unhoused individuals before, during, and after weather emergencies, and how health centers can better support them. In this workshop, lived experience leaders will present the background of the project, how it was organized, and how the survey was conducted. They will also share the key results. Finally, presenters will lead a discussion to explore the project findings and what they mean for health centers and the broader community in supporting unhoused individuals during weather emergencies.

IMPORTANT FUNDING NOTE

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Linkage to Care — Reflections on 18 Months of Inpatient Consults for People Experiencing Homelessness at MGH

Carolyn Matheson *(BHCHP, Nurse Practitioner);* ***Catherine Whelan****;* ***David Munson*** *(Boston Health Care for the Homeless Program, MD);* ***Naomi Harris*** *(BHCHP)*

GRAND CARIBBEAN 11-12

In this 90 minute presentation, we describe our experience providing inpatient consults for people experiencing homelessness at an academic medical center. Broadly, we plan to break the presentation up into 3 sections. The first section will describe the work that occurs while patients are admitted to the hospital and include a description of the consult work as well as patient and hospital level data (length of stay, self directed discharge). Our next section will focus specifically on aftercare planning and transitions of care. We'll describe how our consult service integrates with BHCHP's medical respite program and our outpatient clinic at MGH. Concurrently, we will present data on post-discharge follow up visits, new patients brought into care and hospital re-visit rates. Lastly, we will describe how our consult service has linked with the Continuum of Care for people experiencing homelessness in Boston. We have leveraged the inpatient admissions of people experiencing chronic homelessness to initiate a referral to a housing pathway through the city of Boston. We will present number of housing referrals submitted, number of housing matches and number of individuals who have been housed through referrals initiated by our service. Our overall goal is to show the importance of integrating hospital work of PEH into the larger system of care for these patients within a specific community.

Optimizing Operations and Funding to Maximize Impact and Sustainability for Medical Respite Programs

Anais Fuentes*;* ***Kathleen Recchia*** *(The Boulevard of Chicago, Chief Program Officer);* ***Nicole Langston*** *(Director of Clinical Services);* ***Richard Ducatenzeiler*** *(The Boulevard of Chicago, Chief Executive Officer)*

OCEANA GRAND 4-5

This session will describe certain concrete steps that The Boulevard of Chicago implemented to create a detailed roadmap to generate sustainable revenue growth, implement quality standards, and adapt to emerging challenges and technology. Generating sustainable revenue growth is critical for medical respite programs to achieve financial stability, enhance flexibility for services, and ensure long-term sustainability by reducing reliance individual funding sources.

COMBINED SESSIONS: PREVENTIVE CARE

GRAND CARIBBEAN 8-10

A Multisectoral Community-Academic Partnership Increasing Access to Cervical Cancer Screening for People Experiencing Homelessness

Janelle Tipton *(Purdue University, Clinical Associate Professor);*
Jodie Hicks *(LTHC Homeless Services, Director of Health and Wellness)*

Self-Administration of Injectable Hormone Contraception

Jenna Evans *(Colorado Coalition for the Homeless, Clinic Nurse Manager)*

From Clinic to Community: Point-of-Care Long-Acting Antiretroviral Therapy for Homeless Patients

Zachariah Badii *(University of Southern California, Fellow Physician)*

Tobacco Treatment for People Experiencing Homelessness

Erin Crosbie *(TCC Family Health, Nurse Practitioner)*

Embedded, On-Site Healthcare at Permanent Supportive Housing

Maureen Regan *(Janian Medical Care, Primary Care Provider);*
Van Yu *(Janian Medical Care, Chief Medical Officer)*

OCEANA GRAND 8-9

On-site healthcare that is embedded in Permanent Supportive Housing, and that is integrated with social services, provides effective care to people with experiences of homelessness and who face many obstacles to effective care or any care at all. We describe a long-standing model of integrated mental healthcare and physical healthcare embedded in congregate, Housing First permanent supportive housing programs. We describe outcomes that indicate this care is effective and comparable to healthcare provided in more traditional, brick-and-mortar settings.

HMIS Data Linkages for Homeless Mortality

Carlie Stratemann *(University of Houston College of Medicine, Research Assistant);* ***Keiki Hinami*** *(Cook County Health, Physician);* ***Laureen Masai*** *(LA County Department of Public Health)*

OCEANA GRAND 12

As more communities undertakes efforts to understand and reduce homeless mortality, there is greater interest in linking data from Homeless Management Information Systems (HMIS) to public health data (e.g., vital records), clinical health data, or medical examiner and coroner data. Such data linkages could be useful for identifying potential homelessness status of decedents, or for estimating service utilization and potential opportunities for mortality prevention. This panel discussion will focus on different purposes for data linkage and explore linkage methods used for homeless mortality determination in communities across the U.S. Specific topics will include data sharing agreements and infrastructure needed to perform linkages, specific linkage or matching techniques, and critical appraisal of the strengths and limitations of HMIS data linkage approaches.

Transforming Care through Cross-Sector Collaboration: Lessons from a Housing and Health Innovation Accelerator in Los Angeles County

Chris Rubeo *(Center for Care Innovations, Director of Research and Organizational Learning);* ***Chrismen Oliver*** *(SSG HOPICS, Associate Director of Interim Housing);* ***Meg Prescott*** *(Healthcare In Action, Registered Nurse);* ***Rosario Trejo*** *(Downtown Women's Center, Deputy Housing Program Officer);* ***Taylor Nichols*** *(Los Angeles Christian Health Centers, Director of Social Services)*

OCEANA GRAND 11

Addressing the health and housing needs of people experiencing homelessness requires service providers to collaborate across disciplines, organizations, and sectors. Yet building and sustaining cross-sector partnerships to integrate medical care and homeless services is complex and often challenging.

In 2022, Cedars-Sinai partnered with the Center for Care Innovations (CCI) to conduct an exploratory study to identify factors that contribute to effective collaboration between health care and homeless services organizations. Building on these findings, CCI and Cedars-Sinai launched an 18-month Innovation Accelerator for Housing and Health in February 2025. The accelerator supports six healthcare and homeless services organizations in Los Angeles County to design, test, and expand integrated models of care that improve access and quality of services for people experiencing homelessness.

This panel will feature leaders from four organizations participating in the Innovation Accelerator. Panelists will share practical strategies for strengthening cross-sector collaboration, highlight the importance of including frontline providers in innovation projects, and discuss how integrated care has impacted their patients and clients. We will highlight strategies that healthcare and homeless services leaders can use to better link medical care and homeless services in their own organizations.

COMBINED SESSIONS: STORYTELLING

HIBISCUS

Elevating Lived Experience to Drive Change

Charlotte A. Garner *(National Healthcare for the Homeless Council, Consumer Advocate);* ***Valarie B Dowell*** *(Cincinnati Health Network "DBA" Neighborhub Health, Community Health Liasion)*

Storytelling 101

Lauryn Berner-Davis *(National Health Care for the Homeless Council, Director of Community Engagement and Impact)*

Storytelling for Advocacy: Elevating Lived Experience to Drive Change

Amy Grassette *(Family Health Center of Worcester, NCAB Steering Committee Mentor);* ***Deidre Young*** *(Health Care for the Homeless Houston, Change Committee Member);* ***Mamie Gathard*** *(Central City Concern, HSAC mentor)*

COMBINED SESSIONS: MEDICAL RESPITE CARE

OCEANA GRAND 10

Leading in Recuperative Care and Adaptability to Current Changes

Carla John *(Gospel Center Rescue Mission, Recuperative Care Assistant Director);* ***Sandra Maple-Deaver*** *(Gospel Center Rescue Mission, Recuperative Care Director)*

Dental Care in Recuperative Care

Allison Kapple; Carol Rykiel (*Colorado Coalition for the Homeless, RDH Manager of Integrated Dental Services)*

COMBINED SESSIONS: OLDER ADULTS

OCEANA GRAND 3

Geriatric Outcomes for Living with Dignity: Early Findings and Lessons Learned

Amelia Landess *(Boston Health Care for the Homeless Program, Geriatric Outcomes for Living with Dignity Team Case Manager);* ***Emily Cohen***

Empowering Our Aging Patients Through Access to Advanced Care Planning

Christine Kilgallen *(SEARCH Homeless Services, Associate Program Manager);*
LaTreshia Chevalier *(Healthcare for the Homeless - Houston, PSH Nurse Manager);*
Victoria McCurry *(Healthcare for the Homeless - Houston, Chief Medical Officer)*

Aging without Shelter: Meeting the Growing Needs of Seniors Experiencing Homelessness

Warren Foster *(Health Care Center for the Homeless, Inc., Orlando, Fla., Director of Outreach and Permanent Supportive Housing)*

Looking for full session details? Download the HCH2026 mobile app

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Housed, Now What? Occupational Therapy Skills Training to Maintain the Transition Out of Homelessness

Jordann Antoan *(Outreach Therapy, Occupational Therapist);* ***Julia Lam*** *(Outreach Therapy, Executive Director, OT);* ***Rachael Rosenstein*** *(Outreach Therapy, Occupational Therapist)*

GRAND CARIBBEAN 1-2

Housing is often deemed the gateway out of homelessness, but the journey to stability does not end with keys to the door. Without targeted life skills (re)training, death or eviction may result. Occupational therapy (OT) provides an integrative approach to physical, cognitive, mental health, and environmental factors with focus on function. Our OT services span outdoors, shelters, and housing to maximize success of housing transition. We will discuss patient stories of common challenges such as hoarding, isolation, and chronic conditions; trauma-informed, harm reductionist strategies for assessment and skill training; prevention of institutionalization; and ways to replicate this innovative model.

Evaluating an Embedded Nurse and Navigator Model to Improve Access to Care for Individuals in Shelters

Nirah Johnson *(NYC Department of Homeless Services, Director of Health and Homeless Services Integration);* ***Scarlett Wang*** *(NYU Wagner, Associate Research Scientist);* ***Fabienne Laraque*** *(NYC Dept Social Services, Chief Medical Officer)*

GRAND CARIBBEAN 11-12

People experiencing homelessness have high rates of serious medical, mental health and substance use-related conditions and often rely on emergency services due to barriers in accessing outpatient care. The Nurse-in-Shelter program embedded nurse and navigator teams in five urban shelters with high 911 call volume and overdose incidents to provide outreach, health promotion, onsite clinical assessment and nurse services, insurance enrollment, and linkage to care via telehealth or referral. Study objectives were to assess whether the program increased access to comprehensive healthcare services and reduced acute care utilization.

Balancing Risk and Values: Charting a Path Forward During Difficult Times

Kevin Lindamood *(Health Care for the Homeless, Baltimore, President & CEO);* ***Barbara DiPietro*** *(National Health Care for the Homeless Council, Senior Director of Policy);* ***Rhonda Hauff*** *(Yakima Neighborhood Health Services, CEO)*

GRAND CARIBBEAN 3-5

The HCH Community has never had the funding or political support it needed to end homelessness. There was never a time when the work was easy or came without struggle. However, the current environment brings new risks to our work and those we serve and makes it much more challenging to adhere to long-standing values in the same ways. HCH Community leaders will talk about how they are balancing their organizations' roles as employers, direct service providers, community leaders, and advocates. Join this moderated panel discussion to hear how some are navigating this new territory and charting a path forward amid significant changes at both the federal and local level.

Poverty Simulation: Closing the Empathy Gap in Health Care

Amy Henneman *(Belmont University, Professor and Co-Director Clinic);* ***Laurie Gavilo-Lane*** *(Belmont University, Assistant Professor);* ***Tracy Frame****; (Belmont University & Flourish Health Clinic, Professor and Co-Director)*

GRAND CARIBBEAN 8-10

Healthcare professionals frequently encounter individuals impacted by poverty, homelessness, and systemic inequities—yet many trainees enter practice without deeply understanding the lived realities of economic hardship. This study evaluates the impact of a Community Action Poverty Simulation (CAPS) on graduate healthcare students' attitudes toward poverty, social accountability, and team-based care for marginalized populations.

The CAPS experience, an immersive 2.5-hour simulation, was conducted with three cohorts of interprofessional graduate students, including those in occupational therapy, physical therapy, mental health counseling, and medicine. Participants completed pre- and post-simulation surveys using the Attitudes Toward Poverty (ATP) short form and the Interprofessional Socialization and Valuing Scale (ISVS).

Findings revealed statistically significant improvements in attitudes across multiple domains, including stigma ($t = -1.99$, $p < 0.02$) and structural perspective ($t = -2.93$, $p < 0.00$). Students became more likely to attribute poverty to systemic forces rather than personal failure and expressed increased support for social programs and structural interventions. Notably, over 30% of our graduate student participants themselves lived at or below the federal poverty level—highlighting that many future providers are intimately familiar with economic hardship.

This session will share research findings, reflections on simulation facilitation, and discuss how immersive learning experiences can strengthen empathy, reinforce social determinants of health frameworks, and prepare future health professionals to better serve people experiencing homelessness and poverty. We also explore how trauma-informed, community-engaged pedagogies can deepen students' commitment to advocacy and health equity.

Evaluation of Mortality and Factors Associated with Preventable Deaths within Permanent Supportive Housing

Kathleen Joseph *(Denver Health, Physician)*

OCEANA GRAND 10

There is a paucity of information on factors contributing to mortality among clients housed through permanent supportive housing (PSH). We describe data on service engagement related to preventable mortality, defined as death related to accident, suicide or homicide among clients in PSH. We will review mortality data from PSH sites coordinated by a single non-profit in Colorado and associations between preventable mortality, substance use treatment and services engagement.

Betting on Impact — AHCH's Journey Towards the Development of a Strategic Operations Framework

Rachel Biggs *(Albuquerque Health Care for the Homeless, Chief Executive Officer)*

OCEANA GRAND 11

Since its beginning in 1985 as one of the 19 initial Health Care for the Homeless Programs funded by the Robert Wood Johnson Foundation and Pew Memorial Trust, Albuquerque Health Care for the Homeless, Inc. (AHCH) has been a leading provider in health and supportive services for PEH in Central New Mexico. Through many decades of service delivery, AHCH has launched innovative programs aimed at improving long-term outcomes of people experiencing homelessness. Each program's launch resulted in lessons learned from successes and failures and has since shaped the organization's structure for growing confidence in achieving impactful outcomes through its new initiatives by using an internally established strategic operations framework. This framework builds potential for success by providing a structured, repeatable, and scalable approach towards problem solving by offering a set or proven principles and practices that streamline efforts, reduce errors, and align community partners towards a common objective. This session will introduce the key components of AHCH's 7-Clover Strategic Operations Framework, review its application with current and past AHCH initiatives, and ensure participants walk away with a tool to support future HCH strategies.

Low-Barrier Innovations and Best Practices

Andrea Barraza *(Symba Center, Director of Wellness Services)*

OCEANA GRAND 12

This session will explore effective, field-tested innovations and best practices that reduce barriers to service access for highly vulnerable populations. Drawing from our direct experiences in program implementation and evidence-based strategies, we will highlight approaches that prioritize dignity, cultural responsiveness, and immediate engagement—particularly within the context of housing navigation, behavioral health, and wraparound support. Participants will gain practical tools and frameworks for designing and delivering low-barrier services that enhance stability and retention, even in complex, resource-limited environments.

Key themes will include trauma-informed access points, peer-led engagement models, and cross-system collaboration. The session will also include discussion on implementation challenges, lessons learned, and outcome data that illustrate the impact of these approaches.

Building a Research Education for Addressing Challenges of Homelessness (REACH) Program

Kate Diaz Vickery *(Hennepin County Health Care for the Homeless, Medical Director/ Researcher);* ***Joshua Barocas*** *(University of Colorado, Associate Professor);* ***Lauryn Berner*** *(National Health Care for the Homeless Council)*

OCEANA GRAND 3

We have designed the Research Education for Addressing Challenges of Homelessness (REACH) Program, with funding from the National Institute on Drug Abuse, to enhance training of clinical researchers from a variety of disciplines to the realities of homelessness. The program overall seeks to foster the next generation of clinician investigators with the interdisciplinary skills and experiences necessary to effectively design and conduct research related to substance use disorder, chronic diseases, and HIV. The program will enroll 4 fellows per year for 24 months from across the U.S. starting in 2027. With support from NHCHC leadership, each fellow will be paired with a Community Advisor to ensure the perspectives of consumers (people with lived experience) and/or frontline clinicians are honored in the design and conduct of pilot projects. Please join us to kick off this program, brainstorm ideas for integration with NHCHC activities, and begin recruitment of Community Advisors. Our workshop will involve a mix of didactic presentation and review of program description and small and large group brainstorming exercises. We will specifically facilitate the discussion to raise up input from consumers and frontline clinical staff with lived experience.

Medical Respite Care Space Planning Guidelines

Alison Leonard *(CannonDesign, Vice President);* ***Debbie Jacobs*** *(CannonDesign, Vice President);* ***Susan Silverman*** *(CannonDesign, Vice President)*

OCEANA GRAND 8-9

To provide evidence-based space planning guidelines for medical respite care (MRC) programs to enable the desired Model of Care of Medical Respite and while meeting the Standards for MRC. Because of the variability in medical respite programs across the country, there have been minimal space guidelines to support organizations that wish to develop or expand their medical respite care facilities. Planning guidelines were developed to establish a national evidence-based guideline to inform the planning and design of medical respite facilities. These guidelines are based on best practices in medical, residential, and long-term care facility design, and were adapted to be applicable to the needs of medical respite programs and in alignment with the NIMRC Framework for Medical Respite Care. These guidelines were developed with an overarching trauma-informed approach and by a team of clinicians and design professionals with experiential and professional knowledge in this area. Adaptations from evidence-based practice were made to fit the varying needs of medical respite programs through focus groups, interviews, and surveys with existing medical respite care programs and providers. Results: Establishment of national evidence-based space guidelines to inform the planning and design of MRC facilities that align with and support the Models of Medical Respite Care and the Standards for Medical Respite Care Programs. Implications • When planning a facility, "form follows function". In other words, the Model of Care, operational workflows and standards of care should inform the design, adjacencies and attributes of the space to create trauma-informed and functional facilities. • Trauma-informed space design is critical to achieve a safe, healing and dignified environment for the residents of the MRC facility. • Member organizations or any organization wishing to design a MRC facility have a consistent set of space planning guidelines as the foundation for their project which would also be adaptable to their specific facility planning opportunity.

Direct-to-LAI: One-Day Injectable Buprenorphine Initiation for Patients in Street/Transitional/Supportive Housing Settings

Christina Stanton *(Janian Medical Care, Nurse Practitioner);* ***Andreas Lazaris*** *(Janian Medical Care, Primary Care Physician / Assistant Medical Director of Primary Care)*

OCEANA GRAND 4-5

The opioid epidemic has impacted communities across New York City (NYC), but none as significantly as the unhoused population. It is estimated that in 2023, approximately 44 in 100,000 deaths in NYC were a result of drug overdose/poisoning. In contrast, approximately 45% of all deaths among people experiencing homelessness in NYC were drug-related. In response, Buprenorphine has been developed as a safe and effective medication for the management of opioid use disorder (OUD): treating symptoms of withdrawal, preventing cravings, and reducing risk of overdose / transmission of communicable disease / soft tissue infection through reduced use. Despite its benefit, there is limited utilization of this lifesaving medication by patients and prescribers, with estimates of only 1 in 5 people with OUD in the US receiving treatment. Traditionally, initiating Buprenorphine treatment has required patients to be experiencing withdrawal symptoms at time of initiation, to ensure successful treatment. However, a primary concern for patients initiating treatment is the risk of "precipitated withdrawal" - severe withdrawal caused by the administration of Buprenorphine itself. With the prevalence of Fentanyl in opioid supplies, established initiation methods have met considerable difficulty in avoiding precipitated withdrawal due to the pharmacokinetics of Fentanyl. For patients experiencing homelessness, the risk of withdrawal is compounded by a lack of privacy, access to a bathroom, and spaces to rest safely and comfortably. As a result, past experiences of precipitated withdrawal and the increasing risk for precipitated withdrawal using conventional Buprenorphine initiation methods has prevented patients from pursuing Buprenorphine for treatment of OUD, leaving them at continued risk for overdose death. This project highlights the work of Janian Medical Care, a place-based homeless healthcare organization based in New York City, providing on-site primary care in street / transitional / permanent supportive housing settings. This project will highlight Janian's development of a one-day, injection-based Buprenorphine initiation method aimed toward minimizing withdrawal symptoms and avoiding precipitated withdrawal for patients experiencing homelessness. This protocol is adapted from emergency-department-based studies, geared toward patients seeking to avoid withdrawal prior to and after medication administration, patients unable to tolerate traditional initiation with oral buprenorphine, or those with preference to minimize a need for daily medication administration. This presentation will provide a walk-through of Janian's novel one-day, injection-based Buprenorphine initiation protocol, and will provide a replicable blueprint for successful Buprenorphine initiation using this method. The presentation will focus on provider perspectives from providers who have successfully initiated treatment using this method, as well as subjective experiences of patients who have successfully initiated and continued treatment using this streamlined protocol. The presentation will also outline its programmatic development: relationship-building with community pharmacies, collaboration with public hospital systems and partnered community organizations, and roll-out in a community-based practice with multiple satellite street / housing-based clinical sites.

Adding a Crisis Intervention Team to Your Services

Stephanie Pardue *(Knox Area Rescue Ministries, Director of Health Services)*

GRAND CARIBBEAN 1-2

A Crisis Intervention Team (CIT) is an essential component of effective support services in an emergency shelter environment, where guests often face acute emotional distress, trauma, or mental health challenges. Our shelter's CIT plays a vital role in de-escalating crises, promoting safety, and connecting individuals with appropriate care. A key resource supporting this effort is our Calm Room— a designated space designed for guests experiencing emotional crises, overstimulation, or the need for immediate de-escalation. This sensory-reduced environment, offering ambient temperature, lighting, and sound, fosters self-regulation and provides a dignified, trauma-informed alternative to punitive or restrictive interventions.

Additionally, our Medication Locker Program offers secure, staff-monitored storage for personal medications. This initiative has significantly improved medication adherence by ensuring consistent access and reducing the risk of loss or theft—common challenges in a communal living setting. As a result, we have observed increased compliance with prescribed treatment plans and reduced emergency medical interventions. The program also mitigates financial strain for our medication budget as well as community partners, helping to lower medication replacement costs and preserve limited personal resources. Through our medication locker program our CIT is able to get to know our guests on a different level, educating and assisting with how to use a pill planner, and the importance of medication compliance.

Together, the CIT, Calm Room, and Medication Locker Program form an integrated support system that enhances individual stability, preserves dignity, and fosters a safer, more therapeutic shelter environment. These services not only reduce the frequency and severity of crises but also strengthen trust between guests and staff, ultimately contributing to better long-term outcomes for individuals experiencing homelessness.

Advocacy Made Simple: Practical Actions for Change

Laura Brennan *(National Health Care for the Homeless Council, Senior Policy Manager)*

GRAND CARIBBEAN 11-12

Advocacy can feel overwhelming and, in today's political climate, you may wonder if it even makes a difference. But the HCH community has a powerful voice that lawmakers at all levels of government need to hear. You don't have to be a policy expert or dedicate hours of your time to make an impact. This workshop will break down what advocacy really means and highlight the unique voice of the HCH community. We'll focus on practical, realistic actions that anyone (clinic, program, administrative staff, etc) can take to integrate advocacy into your work without adding more to your plate. We'll explore how policy decisions affect HCH programs and patients, where small actions can have impact, and how to use real-life stories and data to influence policymakers. Participants will leave with a set of action items and the confidence to use their voice in advocacy.

Beyond the Streets: Confronting Stigma in Healthcare During and After Homelessness

Keara Wrightsman *(Strategies to End Homelessness, CoC Coordinator with Lived Experience)*

GRAND CARIBBEAN 3-5

Stigma in healthcare toward people experiencing homelessness is not limited to the period of housing instability, it can persist long after an individual is housed, affecting health outcomes for years. Drawing from lived expertise and professional experience, this session explores how bias, labeling, and systemic discrimination can lead to delayed diagnoses, inadequate treatment, and avoidable harm. Through personal narrative, real-world examples, and evidence-based strategies, participants will learn how to recognize, challenge, and dismantle stigma in both clinical practice and policy. This session emphasizes actionable changes to ensure equitable, respectful care for all patients, regardless of housing history.

Advancing Coordinated Entry Through Data Science and Lived Experience: A Facilitated Workshop on Novel Approaches to Housing Navigation

Ishita Sharma *(University of Houston);* ***Joyati Modak*** *(University of Houston College of Medicine, Lead Research Tech)*

GRAND CARIBBEAN 8-10

Purpose: Coordinated Entry (CE) systems are the backbone of housing access for individuals and families experiencing homelessness. Yet in practice, CE often falls short of capturing the health burdens and structural barriers that shape housing trajectories and recovery opportunities, particularly for those with substance use disorders (SUDs) and other complex medical and social needs. As advanced data science methods, including deep learning and advanced decision-support tools, become available to optimize CE processes, it is essential to pair these innovations with community and practitioner perspectives to ensure models are meaningful and actionable.

Methods: This facilitated workshop seeks to engage healthcare providers, case managers, administrators, and consumers in structured dialogue about the opportunities and challenges of reimagining CE. After a brief overview of current research and emerging tools, participants will be invited to share how they interact with their local CE systems: what works, what doesn't, and how health information is, or isn't, integrated into assessment. Guided prompts will encourage participants to consider novel strategies such as health-based survey questions, structured documentation of barriers to care, and the use of predictive models to inform referrals.

Results (anticipated): The session will yield participant-identified priorities for CE redesign, including types of health and social data most relevant to improving housing navigation for healthcare patients. Participants will share concerns about feasibility, fairness, and transparency, creating a foundation for iterative, community-engaged innovation.

Implications: Findings will inform development of AI-powered decision-support tools that integrate community perspectives into CE optimization, with the ultimate goal of improving housing stability and health outcomes. Because the workshop approach is structured and replicable, other communities can adopt the same facilitated discussion model to evaluate and strengthen their CE processes. Consumer involvement will be central, both through direct participation in the workshop and through integration of feedback into future tool development in progress.

Disability Advocacy: Navigating the Benefits Web for the Most Vulnerable, Disabled Patients

Ashley Sturm *(Pinellas County Human Services, Disability Advocacy Section Manager);* ***Danyelle Green*** *(Pinellas County Human Services, Community Connections Program Administrator)*

OCEANA GRAND 10

Through a unique interdepartmental cross collaboration, the Pinellas County Health Care for the Homeless Program and the Disability Advocacy (DA) Program helps clients with a physical and/or mental health disorder apply for supportive benefits through the Supplemental Security Income (SSI) and Social Security Disability Income (SSDI) programs. Navigating the complex and lengthy benefits system is beyond the reach for many unhoused individuals further complicating their health and future. Learn how this medical/advocacy partnership helps client obtain needed current medical treatment for their disabling condition increasing the likelihood of their case being awarded. The team has one of the highest awarded case rates in the County and has brought hundreds of thousands of dollars back to the most vulnerable clients in need.

A Syllabus for Healthcare for People Experiencing Homelessness: Educating the Next Generation of Medical Practitioners

William Ellert *(Circle the City, Chief Medical Officer)*

OCEANA GRAND 11

It is largely becoming recognized that Health Care for People Experiencing Homelessness is a specialty that requires targeted learning goals, a specific syllabus, and workshops, discussion groups and didactic lectures that address the complex needs of people experiencing homelessness. This session reviews a syllabus and educational model that was created for the academic Programs in Phoenix, Arizona. These include rotations in street medicine, medical mobile medicine, ambulatory care, addiction medicine, and respite care. The session will look at curriculum design as well as the practical implications of designing a comprehensive program that meets the needs of the students at various levels of education with varied educational needs as well as incorporating the principles of integrated primary care with behavioral health consultants.

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The Benefits of Incorporating Drug Checking with Outreach

Megan Smith *(Rhode Island College / Brown University, Assistant Professor);*
Merci Ujeneza *(Brown University Health, Senior Clinical Research Assistant)*

OCEANA GRAND 12

This session describes a collaboration between Rhode Island Street Medicine (SM) and the Community Use and Testing Study (CUTS) and the benefits it provides to people we serve, as well as to the programs themselves. The primary benefit to participants is an additional access point for drug checking that does not require visiting a fixed location, facilitating access to information that allows for informed decision-making about use of substances with results annotated to their reported experience with targeted messaging. From the perspective of SM, it provides an additional harm reduction tool and offers an entree into ongoing conversations about peoples' relationships with drugs, if and how they want these to change, and what support we can offer. From the perspective of CUTS, collaboration expands reach to low-access settings, diversifies the sample frame and enables rapid, field-informed messaging and updates on local supply shifts. It also allows for communication of results to be a shared and practical conversation so both the person and the team can act-translating results into care, affirms a "meet people where they are" approach and enhances data quality with richer encounter context, making findings more actionable for people we serve, outreach and clinical teams. Finally, we discuss safety, legal, and ethical considerations, including the potential risks of handling and transporting controlled substances and the ethics of providing drug checking services to people who provide drugs to others.

Development of a Medical Student Health Advocate Experiential Learning Opportunity for Clients Experiencing Unsheltered Homelessness

Beatrice Antonenko *(Kansas City University, Medical Student);* ***Benjamin Grin*** *(Kansas City University, Assistant Professor of Primary Care);* ***Rosheen Kamal*** *(Kansas City University, Medical Student)*

OCEANA GRAND 3

In 2025, Kansas City University's Center for Population Health and Equity launched a new experiential, volunteer learning opportunity for medical students in partnership with Care Beyond the Boulevard, a local organization that provides healthcare to houseless populations. In this program, teams of 4–6 medical students are paired with a "StreetWise Scholar," an individual experiencing homelessness who shares their lived experience and ongoing challenges navigating health care and social needs. Students meet weekly with their Scholar to provide non-clinical support, including support with health care navigation and assistance with applications for housing and public benefits. As students engage longitudinally with their Scholar, they learn and practice trauma-informed advocacy skills critical to working with clients that face many barriers to health. This session will include a brief presentation on program structure and lessons learned in the first year, followed by a panel discussion with medical students who recently completed a year of service in the program. The interactive discussion session will emphasize how sustained community engagement with houseless individuals shapes medical students' perspectives on health equity, barriers to care, and the social drivers of health. Discussion will also explore the value of interprofessional collaboration, the importance of self-care and boundary-setting when working with vulnerable populations, and opportunities to adapt or scale similar initiatives in other settings.

Looking for full session details? Download the HCH2026 mobile app

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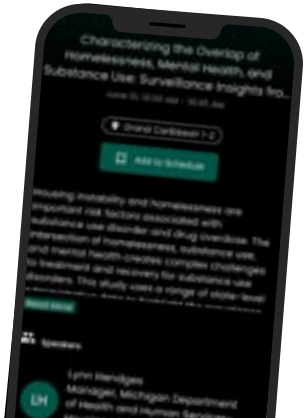

Staff Planning for Medical Respite Models of Care

Laurel D Nelson *(Center for Respite Care, Inc., CEO)*

OCEANA GRAND 4-5

Medical Respite Programs provide short-term, post-acute care for individuals experiencing homelessness who are too ill or frail to recover on the streets or in shelters, yet do not require hospital-level care.

Effective staffing is essential to ensure quality outcomes, continuity of care, and cost efficiency. A multidisciplinary team approach may include medical providers (physicians, nurse practitioners, physician assistants), nursing staff for daily clinical oversight, case managers and social workers to address psychosocial needs, behavioral health specialists to support mental health and substance use recovery, and peer support staff to foster engagement and trust.

Additional roles such as care coordinators, housing specialists, and administrative personnel can be integral for transitions to stable housing, primary care, and community-based services. Optimal staffing, scaled to the Medical Respite Models of Care, balance clinical expertise with trauma-informed, person-centered approaches, emphasizing collaboration with hospitals, shelters, and community partners. Investing in comprehensive staffing supports not only improved health outcomes for medically vulnerable populations but also reductions in avoidable repeat hospitalizations and overall healthcare costs.

The goals of this presentation include:

• Learning to identify skill sets and areas of expertise necessary to provide comprehensive services and care required by each Medical Respite Model of Care.
• Strategies for developing job descriptions, recruiting, hiring, and retaining staff.
• Creating staffing patterns, within budget, which will maximize client/guest support.
• Identifying community partnerships that can supplement and/or fill gaps in service.
This presentation will outline what investing in a comprehensive staffing plan can accomplish to equip Medical Respite programs with the staff necessary improve health outcomes, reduce preventable hospital readmissions, create sustainable pathways toward housing stability and recovery, while staying as cost efficient as possible."

Establishing & Maintaining a CAB (Consumer Advisory Board)

Kendall Clark *(Team Management 2000, Inc., Senior Case Manager)*

OCEANA GRAND 8-9

This presentation will include members of NCAB Steering Committee, who will discuss how to establish and maintain a Consumer Advisory Board (CAB), and the importance it can have on an organization by bringing together the voices of people with lived experience of homelessness. Presenter will present NCAB's Consumer Advisory Board Manual, which is used as a guide to start a CAB.

The presenters hope to show the importance of the CAB to the organization and how members of the CAB can contribute to the work and make changes to policies that effect the lives of all homeless people.

A Million-Dollar Impact on a Small Budget: Building a Freestanding Street Medicine Team with Community and Courage

Dalton Nelsen *(HEAL Omaha, Chief Executive Officer);* ***Melissa Neuenfeldt*** *(HEAL Omaha, Chief Operating Officer)*

GRAND CARIBBEAN 1-2

The healthcare for the homeless community faces a future of potential funding cuts and rising need, sparking widespread anxiety over program closures. This abstract presents an alternative narrative of resilience and resourcefulness, showcasing how HEAL Omaha built a freestanding street medicine team to deliver a significant volume of care with a minimal operating budget. We believe the most important work in street medicine—building trusting relationships—doesn't require a mountain of money, but rather courage and community. Our purpose was to prove that a large-scale street medicine program could be sustained by leveraging untapped community resources and a dedicated volunteer base. Our method involved recruiting and training over 100 passionate volunteers, from clinicians to community advocates. We developed a grassroots network to access in-kind donations and services, effectively transforming community goodwill into clinical capacity. Our approach prioritized patient relationships, dedicating resources to consistent, boots-on-the-ground engagement over administrative overhead. The results of our model demonstrate that we delivered a high volume of compassionate care over the past year. Consumers were deeply involved in our work, with our street medicine team receiving continuous guidance from individuals with past and current lived experience to shape service delivery and outreach strategies. This model is easily replicable for other organizations seeking to maintain or expand services in resource-constrained environments by focusing on human capital and creative community partnerships. This presentation will serve as a roadmap, offering hope and practical strategies to empower others to rise together, even when faced with financial uncertainty.

Decreasing Barriers to Healthcare Access Through a Mutual Aid, Mobile Free Clinic Model

Lucy Smith *(Mutual Aid Wellness Collective, Cofounder)*

GRAND CARIBBEAN 11-12

For many years the homeless population in Asheville, North Carolina has been increasing however there was a dramatic increase in the number of homeless in the area after Hurricane Helene in September of 2024. It is well known that there exist numerous barriers to the ability to access healthcare among the homeless community which are often referred to as "Social Determinants of Health" however there seems to be little reflection in the healthcare system of their own place in creating and reinforcing some of those barriers. Some of the most pervasive barriers to accessing care include; lack of trust in providers, location of clinics and different experiences of time in general among others. Mutual Aid Wellness Collective has attempted to overcome some of these barriers by establishing community relationships with participants through the mutual aid model, bring healthcare to the places where our unhoused community are located with a mobile clinic and offering free care and resources at a centralized location which is frequented and accessible by many in the homeless community. We have attempted to ease the barrier of time restraints, so prominent in traditional healthcare systems and indeed even in other Community health centers in which visits are scheduled at certain times and for specified lengths of time, by attending to and offering free care and resources without appointment or time limitation to all who approach without question.

The HEART Program – Centering Empathy in Public Safety Through Alternative Crisis Response

Abena Bediako *(City of Durham, Clinical Manager);* **Janae Sanders** *(Durham Community Safety Department HEART, Advance EMT);* **Keshawn McCleod** *(Durham Community Safety Department, Program Manager for the Care Navigation Unit with the Durham Community Safety Department – HEART Division);* ***Steven Kersey*** *(Durham Community Safety Department HEART, Peer Support Specialist)*

GRAND CARIBBEAN 3-5

This session will introduce the Holistic Empathetic Assistance Response Teams (HEART), Durham's innovative alternative to law enforcement in responding to behavioral health and quality-of-life crises. HEART integrates licensed clinicians, peer support specialists, EMTs, and survivor advocates into nine specialized units that provide trauma-informed, compassionate, and coordinated care across the crisis continuum. Participants will explore how HEART diverts behavioral health calls from 911, provides on-site de-escalation and medical support, connects individuals to long-term services, and addresses complex needs related to trauma, homelessness, and re-entry from incarceration. Presenters will highlight the role of peers and individuals with lived experience, whose voices and expertise shape HEART's design, delivery, and outcomes. The session will emphasize how HEART advances health equity and social justice by reducing criminalization of mental illness, promoting housing stability, and creating inclusive pathways to recovery. Drawing from early outcomes, participants will learn about HEART's use of evidence-based practices (e.g., Trauma-Informed Care, Harm Reduction, Motivational Interviewing) and hear real-world examples of how lives have been stabilized through coordinated interventions. Attendees will leave with practical strategies to adapt or replicate HEART's modular framework in their own communities, whether through call diversion, mobile response, care navigation, or re-entry supports. Policy implications will also be discussed, focusing on how municipalities and health systems can realign public safety investments toward care and away from punishment. By the end of the session, participants will understand how HEART's model transforms crisis response into an opportunity for healing, empowerment, and long-term community resilience. Learning Objectives By the end of this session, participants will be able to: Describe how Peer Support Specialists, Clinicians, and EMTs collaborate across HEART's nine specialized units to provide holistic, trauma-informed responses to behavioral health and quality-of-life crises. Identify at least three evidence-based or promising practices (e.g., Trauma-Informed Care, Harm Reduction, Motivational Interviewing) used by HEART teams to stabilize individuals in crisis and connect them to ongoing supports. Examine the unique contributions of Peer Support Specialists in building trust, reducing stigma, and ensuring consumer voice is central to care navigation and service delivery. Analyze how Clinicians and EMTs work together within HEART to balance behavioral health expertise with medical stabilization, particularly in high-risk or involuntary commitment situations. Apply lessons from HEART's collaborative model to design or strengthen multidisciplinary crisis response systems in other communities, including health centers, supportive housing programs, and homeless service providers.

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Learning from Lived Experience and Extreme Heat

Carla Cox *(Christian Service Center, Director of Operations)*

GRAND CARIBBEAN 8-10

As extreme heat events grow in frequency and severity, frontline outreach workers and medical professionals are increasingly called to respond to its acute and long-term impacts on unsheltered populations. This session centers on the lived experiences of individuals experiencing homelessness during periods of extreme heat in Central Florida—a region where exposure can rapidly escalate into medical emergencies such as heat exhaustion, dehydration, and cardiovascular stress. Using qualitative, person-centered methods, researchers conducted in-depth, semi-structured interviews with individuals navigating life without shelter, capturing firsthand accounts of how heat affects their physical health, decision-making, and access to care. These interviews were supplemented by participatory mapping activities to identify hyperlocal thermal danger zones and service gaps, and by collaborative workshops where participants helped design components of heat emergency response plans. By directly involving those with lived experience, the study surfaces critical insights into barriers to hydration, shade, cooling centers, and medical care. Findings offer practical guidance for improving street outreach, triage protocols, and public health planning during extreme heat. For medical and outreach personnel, this research provides an urgent call to integrate climate-responsive strategies into everyday practice, ensuring that those most vulnerable are seen, heard, and better protected.

Cross-Sector Work in Action: A Community of Practice for Problem-Solving Simple, Low Cost, and Safe Data Sharing Between Health and Homeless Systems

Julie Silas *(Homebase, Senior Directing Attorney);* ***Lindsey Barranco*** *(Homebase, Directing Analyst);* ***Riley Meve*** *(Homebase, Policy Analyst)*

OCEANA GRAND 10

People with complex needs who touch both health & homeless systems of care do not always get necessary coverage, services, or care because there is no simple way to coordinate across systems. Data sharing is vital to greater coordination to identify shared clients, enable comprehensive care, and connect people to all the services they need. Yet, health and homeless systems lack a trusted and low-cost way to share data in a streamlined manner. Homebase, Connecting for Better Health (C4BH), and Georgetown University have developed a cross-sector partnership to provide technical assistance to Continuums of Care (CoCs), managed care plans (MCPs), and their partners to help problem-solve through a Community of Practice (CoP). The CoP is actively in the process of problem-solving the following ongoing issues that stand in the way of realizing the full potential of Medicaid coverage for housing-related services:

- Inability for a Continuum of Care (CoC) to identify if a person experiencing homelessness is a Medicaid member, their Medicaid number, and the specific MCP they are enrolled in;
- Inability to identify if an MCP member is touching the homeless system of care and if so, if there is a case manager assigned to that member, and how to connect with the case manager for further assistance.
- Inability to document through a non-manual process which clients have been referred to Medicaid housing-related services and which clients have been enrolled in and are receiving Medicaid housing-related services; and
- Inability for CoCs and MCPs to share information about their mutual clients' housing status so that when someone is successfully housed, both parties can track housing status.

C4BH, Georgetown, and Homebase are working together to provide technical assistance that models the kind of cross-sector partnerships needed between MCPs, CoCs, and their partners. The approach starts with flexible, open-source software that enables encrypted client matching and limits data sharing to individuals served in common. We solicit input from MCPs, CoC providers, and HMIS vendors on the problems we will solve together in the CoP, use an application process to assess readiness and fit, and lead human-centered design workshops to identify common challenges. Each participating site receives follow-up support with tailored policy and technical guidance to help implement practical, low-cost, and secure solutions.

This session will share information about how we recruited CoP participants, what we are learning about opportunities and challenges from doing this work, and some early findings from the CoP process.

Preparing for Immigration Enforcement in Clinical and Outreach Settings

Lawanda Williams *(HCH Baltimore, Chief Behavioral Health Officer);* ***Tolu Thomas (****Health Care for the Homeless, Chief Administrative and Quality Officer)*

OCEANA GRAND 11

No description available.

Restoring Health, Housing, and Dignity: A Rural Response to Homelessness in Appalachia

Debra Murphy *(The Center for Restorative Justice at WV Wesleyan College, Co-Director);* ***Makayla Garcia*** *(Resilience Collaborative, United Way of Harrison and Doddridge Counties, Case Manager);* ***Marissa Rhine*** *(The Resilience Collaborative, Founding Director);* ***Tom Rhine*** *(Resilience Collaborative, United Way of Harrison and Doddridge Counties, Director of Medical Respite Care)*

OCEANA GRAND 12

The Circle is a Community Center in Clarksburg, WV, that is the result of a years-long collaboration between three organizations: Resilience Collaborative, First United Methodist Church, and the Center for Restorative Justice. These three organizations came together with a goal of providing holistic services for people experiencing outdoor homelessness. Through providing a weekly meal to the community, we began to realize that not only people living on the street needed a meal. Beyond services, our three organizations share a concern for the safety of people living on the street in our community. The combination of hostility toward homelessness and lack of shelter for individuals experiencing homelessness in our community posed a challenge for us that we wanted to answer with a space free of stigma and hostility. First United Methodist Church has been a place where unhoused people feel safe gathering, so First United Methodist Church became the place where we established The Circle.

The Circle, named for a practice central to restorative justice frameworks, is a site for eating a lunch-time meal in community, seeking connection to services such as housing, basic health care needs, section 8 vouchers, SNAP benefits, showers, and medical respite care, as well as building relationships through the implementation of conversations held through the circle process. While the organizations strive to meet the basic needs of unhoused and housing- and food-insecure residents of our Harrison County, our focus in this presentation is the work we have done toward fostering an environment for community-building, and the direct impact that work has had on Resilience Collaborative's housing and medical respite care programs. Through involving individuals with lived experience to staff the kitchen and community center spaces, through introducing college students and other community members into the space, through regular circle conversations, and through mutual support among clients and staff, we have found that the most vital and life-giving work is the community we have built among a diverse set of stakeholders in our community.

Partnership in Action: Growing Medical Respite Capacity through State and Community Collaboration

Eugenia Olison *(IDPH, Senior Policy Advisor);* ***Molly Pilgreen*** *(Phoenix Community Development Services, Vice President/Chief Operating Officer)*

OCEANA GRAND 4-5

In Illinois, individuals experiencing homelessness die, on average, 18 years earlier than the general population. Expanding access to medical respite care is a critical part of the state's strategy to reduce this stark disparity. In response to the urgent needs of the unsheltered population, the City of Peoria partnered with Phoenix Community Development Services (Phoenix CDS) to launch The Bridge, a medical respite program designed to provide short-term, recovery-focused care for people experiencing homelessness.

This session will explore how Phoenix CDS repurposed an existing facility to create The Bridge, leveraging capacity-building support from the State of Illinois and the City of Peoria. Presenters will share key insights into the program's development, how funding from IDHS has evolved through multiple phases, and how the initiative has grown more sustainable over time. Learn how state and local collaboration is driving innovative, community-based solutions to reduce homelessness and improve health outcomes across Illinois.

Medicaid Cuts and State Choices: Protecting Access to Care Through Advocacy

Laura Brennan *(National Health Care for the Homeless Council, Senior Policy Manager)*

OCEANA GRAND 8-9

Congress passed Medicaid cuts into law through the One Big Beautiful Bill Act (HR 1), but many key implementation decisions now rest with state governments. This panel discussion will feature the policy leads for several HCH programs who will unpack how state decisions directly impact the HCH community and what you can do to mitigate harm. Panelists will share how they are advocating with state-level decisions makers, policy recommendations, and approaches for building support at the state level. Panelists will offer concrete implementation recommendations that you can bring back to your state governments and will include time for audience Q&A.

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THURSDAY
JUNE 11, 2026

Main Conference Day 2

10-10:45 A.M.

Funding the Frontlines: Sustaining Mobile Health for Homeless Communities

Gab Sauder *(CapitalLink, Project Consultant);* ***Jermaine Pope*** *(National Association of Community Health Centers, Manager);* ***Rebecca Stauffer*** *(CohnReznick, Senior Manager)*

GRAND CARIBBEAN 1-2

As mobile health programs continue to expand their reach and impact, securing sustainable funding remains a critical challenge—especially for initiatives serving vulnerable populations such as individuals experiencing homelessness. This session equips attendees with actionable strategies to strengthen the financial foundation of their mobile health efforts. Led by experts from CohnReznick, Capital Link, and the National Association for Community Health Centers, the presentation explores the current funding landscape, including federal, state, and private opportunities, and highlights innovative revenue models and partnership frameworks. Special attention will be given to funding approaches that support mobile units targeting homeless communities. Participants will learn how to align strategic business planning with funding goals, diversify income streams, and leverage data-driven approaches to demonstrate value. Whether you're launching a new mobile unit or scaling an existing program, this session offers practical insights to help you build a resilient and financially sound mobile health operation.

Sustaining the Mission: Revenue Cycle Tools to Keep Care Accessible

Tolu Thomas *(Health Care for the Homeless, Chief Administrative and Quality Officer)*

GRAND CARIBBEAN 3-5

For Federally Qualified Health Centers (FQHCs), the revenue cycle isn't just about dollars and cents, it's about keeping the doors open and making sure people experiencing homelessness can continue to get the care they need. A strong revenue cycle can feel like the invisible backbone of our work: when it's healthy, it allows us to expand services, ease staff stress, and focus more fully on patients. When it struggles, everyone feels the strain.

In this session, we'll take a closer look at how FQHCs can strengthen their revenue cycle while staying true to their mission. We'll share real-world examples of what works: like tightening up front-end processes, building stronger relationships with payers, and finding ways to bring clinical, operational, and financial teams into the same conversation. We'll also talk about what it looks like to put people at the center of revenue cycle work, from simplifying billing language to weaving trauma-informed practices into financial interactions.

By the end, participants will walk away with practical tools and fresh ideas for making revenue cycle management more sustainable and more humane. Together, we can reimagine financial systems not as barriers, but as pathways that support community, courage, and care.

Interdisciplinary Podiatric Hygiene Groups as a Bridge to Primary Care Engagement for Patients Experiencing Homelessness in Transitional Housing

Kate Mannion *(Janian Medical Care, Nurse Practitioner);* ***Shasha Jones*** *(Janian Medical Care, Medical Assistant)*

GRAND CARIBBEAN 11-12

Given unique risk factors including variable access to clean and supportive footwear, consistent exposure to adverse weather conditions, and unstable housing conditions necessitating frequent walking, people experiencing homelessness (PEH) are at high-risk for developing foot problems when compared with their housed counterparts. Podiatric disease in PEH routinely leads to surgery, amputation, increased hospitalization, and long-term disability, the challenges of which are augmented by higher rates of persistent mental illness and substance use in PEH. Despite the high prevalence of foot-related morbidity, documented feelings of stigma and discrimination by healthcare providers against PEH prevents patients from receiving necessary foot care, and ultimately reduces the possibility for long-term engagement in preventative primary care. This presentation profiles the work of Janian Medical Care, a place-based homeless healthcare organization providing primary care in street, transitional housing, and permanent supportive housing settings across New York City. The workshop explores the process of organizing interdisciplinary hygiene / podiatric care groups for residents of transitional housing settings where Janian provides on-site primary care, as a bridge toward connecting patients to long-term primary care. This workshop includes first-hand experiences of patients who have participated in hygiene/podiatric care groups with Janian and have enrolled formally in primary care services on-site. In 2024, Janian Medical Care began to offer hygiene and podiatric care groups for clients experiencing homelessness, who were staying at drop-in centers and safe havens in New York City. These groups were developed and led largely by Janian medical assistant staff, and supported by the on-site primary care Nurse Practitioners at participating sites. Groups were developed as a method of engaging clients in capacity-building around high-yield health education topics, with a goal of serving as a bridge to primary care engagement. Through these groups, clients were able to meet Janian medical staff, understand the primary care offerings on-site, and were able to engage with peers and develop their own knowledge set around issues of personal hygiene and podiatric care. This presentation will be led by the Janian medical assistant who developed these groups, and co-led by the primary care providers who supported their facilitation. The presentation will provide an overview of topics covered in the groups, educational tools utilized, and will incorporate photographic and editorial evidence of staff and client experiences. The presentation will incorporate data on pre-group and post-group engagement in primary care services. The presentation will ultimately showcase the development of MA and NP-led interdisciplinary groups in shelter and drop-in center settings, and will allow attendees / service providers to develop a blueprint for organizing similar groups as tools for engaging patients experiencing homelessness in primary care.

Street-Based Care Coordination for Unsheltered Individuals: Lessons from Miami Street Medicine

Annika Priyanka Dhawan *(Miami Street Medicine, Director of Care Coordination);*
Christina Garibaldi-Morales *(Miami Street Medicine, Director of Research & QI)*

GRAND CARIBBEAN 8-10

Unsheltered individuals face significant barriers navigating health and social service systems, contributing to poor outcomes and preventable hospitalizations. Challenges include Florida's Medicaid non-expansion, fragmented services, racial housing discrimination, and medical mistrust. Miami Street Medicine (MSM), a free non-profit clinic, delivers care directly on the streets of Miami. Its care coordination (CC) program uses a brokerage model to bridge systemic gaps for people experiencing unsheltered homelessness (PEUH). CC emphasizes patient-driven SMART goals and limited, goal-oriented navigation.. Care Coordinators join weekly street rounds to identify patients, conduct risk stratification, and initiate individualized service plans. Core functions include medical and community referrals, appointment scheduling, prescription access, ID/documentation support, and delivery of essential supplies. Methods: We conducted an IRB-exempt, retrospective, anonymized REDCap EMR analysis of 270 CC intakes, representing 259 unique patients (11 re-entered CC services). Data included intake, care trajectory, and outcomes. We examined key performance indicators such as goal accomplishment, duration of CC engagement, and outcomes at discharge. Results: MSM's CC approach improved continuity of care, facilitated referrals to medical and social services, and fostered trust between patients and providers. Preliminary metrics suggest patients were almost equally as likely to be lost to follow-up as to complete specific care goals by discharge.Findings also reveal opportunities to strengthen metric tracking to streamline data review, improve efficiency for CC and street care teams, and enhance data quality in mobile settings. Conclusions: A street-based CC model rooted in empathy and consistency can effectively address the complex needs of PEUH. By lowering barriers to care, MSM advances health equity for Miami's unsheltered community. Results underscore the importance of policy recognition and financial support for street-based CC, including sustainable reimbursement models for mobile, low-barrier health delivery.

Building Better Panels: Using Iterative Design to Implement a Risk-Enhanced Empanelment Tool in an FQHC Setting

Melissa Iwanowski *(Colorado Coalition for the Homeless, Quality Improvement - Informatics Specialist);* ***Sean Kiley*** *(Colorado Coalition for the Homeless, Director of Integrated Health Operations)*

OCEANA GRAND 11

Risk-enhanced empanelment supports care coordination, population health management, balanced panel sizes, and the evolution of care delivery models within clinical practice. While several proprietary risk models exist, they can be cost-prohibitive, complex, and inadequately meet the unique needs of Community Health Centers (CHCs) and Federally Qualified Health Centers (FQHCs)—especially those serving people experiencing homelessness. This session shares one FQHC's experience developing a custom risk stratification tool grounded in simplicity, accessibility, and transparency. Participants will explore a practical, replicable framework for implementing risk-enhanced empanelment in resource-constrained settings, with a focus on equity and population-specific relevance.

Sobering Care: The Missing Link

Jesse Sieger-Walls *(Wellbeing in Action, Owner and Managing Principal);* ***Sylvia Barnard*** *(Good Samaritan Shelter, CEO)*

OCEANA GRAND 3

Most behavioral health urgent cares still turn away people who arrive intoxicated—sending them to ERs or jails and breaking the handoff to shelters and housing. This session makes the case for sobering care as the missing link in the crisis continuum and shows, step by step, how to add it inside behavioral health urgent care without creating a new silo.

Attendees will learn a replicable model they can implement in 90 days: inclusion/exclusion criteria and safety protocols for acute intoxication; right-sized staffing (techs/peers with on-call or tele-RN oversight); transport and documentation workflows with EMS/law enforcement; and warm handoffs to shelters and supportive housing that prevent evictions and speed stabilization. We'll cover financing logic (CalAIM and local funding can sustain the urgent-care + sobering bundle), an outcomes dashboard (ER/jail diversion, length of stay, transfers, housing retention), and urban vs. rural design options.

The 60-minute design balances inspiration and action: a brief story to humanize the use case, a concise "what it is/what it isn't" framework, a concrete case example, and a table-top mini-lab where participants map their local crisis-to-housing pathway and identify three immediate changes they can make on Monday.

Integrating Peer Support as Case Management in a Homeless Medical Respite Program

Virginia Masoner *(Care Beyond the Boulevard, Peer Support Specialist)*

OCEANA GRAND 4-5

This session outlines a model for incorporating peer support specialists into case management roles within a homeless medical respite program. By leveraging the lived experience of peers who have navigated homelessness, mental health challenges, and recovery, this model aims to improve engagement, continuity of care, and long-term outcomes for medically vulnerable individuals experiencing homelessness. It also discusses the importance of peer education and support to encourage their participation, growth and independence in the role.

Medical Respite Care provides a safe, supportive environment for individuals experiencing homelessness to recover from illness or injury. However, medical recovery is only one piece of the continuum; sustainable recovery requires addressing complex psychosocial barriers, including mental health needs, substance use, systemic mistrust, and chronic instability. Case management is a vital piece of the recovery and working with clients to achieve the goal and post stay location most desirable to them.

Building Towards Long-Term Financial Sustainability: Alternative Payment Models for Medical Respite

Alana Podolsky *(QV Health Solutions, Associate Director);* ***Alex Mitra*** *(UCSF Health Stanyan and Hyde Hospital, Director of Community Health, Government Relations and Volunteer Services);* ***David Knego*** *(Curry Senior Center, Executive Director)*

OCEANA GRAND 8-9

Though medical respite (MR) – also known as recuperative care in some markets – is widely accepted as a valued model of care for individuals experiencing homelessness, providers across the country report that current reimbursement levels do not cover full operating costs. This is especially the case for more robust MR models offering wrap-around services and clinical care, and/or engaging clients for longer periods to facilitate broader recovery and connection to appropriate housing.

This session will explore the opportunity for alternative payment models (APMs) to enhance financial sustainability of MR programs. APMs, sometimes referred to as performance-based contracting, tie a portion of revenue to outcomes achievement and offer high-impact MR providers the opportunity to draw down additional revenue beyond typical contracted rates.

Based on NHCHC's recently published white paper, Alternative Payment Models: Supporting Long-Term Sustainability of Recuperative Care Programs written by QV Health Solutions, this session will outline the process for developing and implementing an APM, discuss different types of APMs, and note the role of data to ensure APM success. The session will include the following speakers and perspectives:

- QV Health Solutions will share research and experience developing APMs for MR programs in diverse markets
- Curry Senior Center will share insights from developing an APM for its forthcoming recuperative care program in San Francisco, and explain the impetus for an APM even given MR as a covered benefit under CalAIM
- UCSF will share its rationale for supporting Curry's program and APM model development

Through this session, attendees will gain insights into innovative financing models for medical respite and practical considerations for the conditions necessary for their success.

ICYMI: Catching Up on the National Policy Landscape

Rachel Biggs *(Albuquerque Health Care for the Homeless, Chief Executive Officer);* ***Barbara DiPietro*** *(National Health Care for the Homeless Council, Senior Director of Policy)*

GRAND CARIBBEAN 1-2

In the last 18 months, federal lawmakers made a tremendous number of policy decisions that directly impact the HCH Community—and are leading to even more changes at the state level. The pace and intensity have been unprecedented and it's easy to lose track of all that has happened and what we can do in response. In this session, we will catch you up on topics such as Medicaid, immigration, housing, public health, criminalization…and more. Come to this workshop to get an overview of the key policy changes that have already happened, what comes next, and how you can get involved for change.

Models of Partnership: Using Community Collaboration through Skilled Nursing Facilities to Increase Access to Medical Respite Care

Anira Khlok *(CommonSpirit, System Manager);* ***Keith Helmka*** *(CommonSpirit Health, Manager, Complex Placement Team);* ***Tara Lucas*** *(Avalon Health Care, Director of Case Management and Business Development)*

GRAND CARIBBEAN 11-12

Many people experiencing homelessness who are hospitalized have challenges accessing skilled nursing care services. However, formalized partnerships between hospitals, medical respite programs, and skilled nursing facilities can address some of these barriers and facilitate a smooth transition between services. This community collaboration results in increasing access to appropriate services, while facilitating a safe discharge plan. This session will showcase two communities who have effectively established these partnerships, and share recommendations for attendees to apply within their own communities.

Let us know what you think about this year's conference!

Healing Together: The Human-Animal Bond as a One Health Strategy in Healthcare for Homeless Populations

Amanda Richer *(Public Health - Seattle/King County/HCHN, Displacement Consultant);* ***Elizabeth Hiser*** *(Breaking Ground, Assistant Director, Models of Care);* ***Ellen Santos*** *(Pima County Health Department, Program Manager);* ***Jill Maddox*** *(Janian Medical Care/ Breaking Ground, Medical Director)*

GRAND CARIBBEAN 3-5

Many people experience homelessness alongside a service animal, emotional support animal, or pet. This panel explores the transformative power of the human-animal bond in the lives of individuals experiencing homelessness, highlighting its role not only as a source of emotional resilience but also as a strategic pathway to healthcare and housing engagement. By applying a One Health lens—which recognizes the interconnectedness of human, animal, and environmental health—panelists reframe pets not as barriers to services, but as bridges that foster trust, stability, and holistic care. This integrated system of care honors the full spectrum of relationships and needs within communities. Panelists will present three innovative models from distinct geographic and demographic contexts, each demonstrating how One Health principles can be operationalized in service delivery: Site 1: Breaking Ground One Health Clinic, NYC, NY - Breaking Ground uniquely hosts internal One Health clinics in partnership with Street Dog Coalition and Janian Medical Care, offering free veterinary care alongside on-site medical and mental health services for clients across our housing continuum—meeting people and their pets where they live and receive care. Site 2: Healthy Companions, Tucson, AZ - Healthy Companions provides integrated care and need-based resources supporting human-animal family units through a mobile, non-traditional One Health approach for those in Pima County unable to access traditional sources of care Site 3: One Health Clinic, Seattle, WA - Two Seattle-based clinics provide fully integrated medical and veterinary care at each clinic, where human and animal healthcare providers work in tandem to develop joint care plans. Through data-driven insights and lived experience narratives, this panel will challenge conventional, single-service delivery models and advocate for pet-inclusive, One Health–aligned approaches that honor the dignity and interconnectedness of people and their animal companions. Attendees will leave with actionable strategies to embed One Health practices into holistic care frameworks for vulnerable populations.

Rising Together Through Dignity: End-of-Life Care for the Unsheltered in Medical Respite

Jillian Olmsted *(The INN Between, Executive Director)*

GRAND CARIBBEAN 8-10

For individuals experiencing homelessness, access to end-of-life care is often limited, fragmented, or entirely absent. Many die alone in hospitals, on the streets, or in shelters unequipped to meet their physical and emotional needs. Medical respite programs are uniquely positioned to bridge this gap by offering not only a safe place to heal, but also a compassionate setting to die with dignity. This session explores how medical respite can expand its mission beyond recovery and stabilization to embrace end-of-life care for the unsheltered. Drawing from the model developed at The INN Between in Salt Lake City, participants will learn how hospice partnerships, trauma-informed approaches, and community support systems can be integrated into respite programming. Through case examples and real-world lessons, we will highlight how programs can honor resident choice, provide culturally responsive and person-centered care, and foster connection in life's final chapter. Attendees will leave with practical strategies to replicate aspects of this care model in their own communities, regardless of program size or resources. Policy implications—including Medicaid reimbursement, state-level support, and the role of housing instability in accessing hospice—will also be discussed. By centering dignity, courage, and community, medical respite programs can ensure that no one dies alone, overlooked, or without care.

Community and Care: The Value of Persons with Lived Expertise

Kacia Wilkinson *(BHCHP, Consumer Advisory Board);* ***Rodney Dawkins*** *(Heartland Alliance Health, Lived Experience Leader)*

OCEANA GRAND 10

This session will emphasize the importance of preserving dignity for people with the lived experience of homelessness through the leadership of peers. Peer leaders are able to build trust and connections that positively impact those they work with, and strengthen community among people served at Health Care for the Homeless programs. In challenging times, community and care from peers is all the more essential. Though there is plenty of evidence to support the value of peer support in housing and health care settings, there is a need for more training and community conversations designed and led by speakers with lived experience. This session, led by consumer advocates with many years of experience in peer support roles in housing programs and health centers, will provide the audience with lessons-learned and guided conversation that will deepen understanding of how peer roles are essential to building equitable health care communities for people who are served at Health Care for the Homeless clinics. This session will highlight three key areas in which peer support, engagement, and connection to services are essential to centering the consumer: 1) leveraging Consumer Advisory Boards as a way to support the evolution of people with lived experience as leaders, 2) providing peer support and/or connections to services, and 3) promising strategies for supporting people who have moved into housing. Using their unique perspectives, the presenters will provide an overview of peer support and Community Health Workers, highlighting the roles and strengths of this position, as a means to connect with services, center choice, and provide necessary social integration. Additionally, the role of Consumer Advisory Boards will be discussed, including strategies to integrate this group into the decision-making structure.

The Intersection of Housing, Homelessness, and Oral Health: Addressing Systemic Barriers and Innovative Solutions

McAllister Castelaz *(Wisconsin Department of Health Services, Dental Policy Consultant);* ***Nadia Fazel*** *(University of New Mexico, Associate Professor of Dental Services and Public Health)*

OCEANA GRAND 11

Oral healthcare is often one of the highest needs of the unhoused population. Yet access to adequate oral healthcare remains low and systemic barriers further reduce the ability for patients to receive the dental treatment they need. This can lead to high utilization of hospital emergency rooms and piecemeal care that further complicates chronic health conditions, and undermines overall well-being, employment, and housing stability. In this 90-minute presentation, two public health dentists will discuss existing key barriers to oral health access for individuals experiencing homelessness and how healthcare organizations can overcome those barriers. They will also discuss highly innovative, replicable approaches and solutions to providing oral healthcare in unconventional settings, including going beyond the four walls of a dental clinic to reach patients where they are. This section will also include anecdotal data on what consumers say regarding their oral health and what they need most from their dental teams. Finally, they will discuss how best to engage in policy and advocacy around access to oral healthcare and what you and your organizations can do to promote real change.

A Practice Framework for Serving Folks with Complex Trauma

Margaret Wessner *(Contra Costa Health, Mental Health Clinical Specialist)*

OCEANA GRAND 12

What is Complex Posttraumatic Stress (C-PTSD) and what distinguishes it from PTSD? How can I best show up for patients, clients, community members, and loved ones with complex trauma histories? In this session, we will answer these questions, drawing on peer-reviewed research, consumer perspectives, and professional practice guidelines. We will also explore the trans-diagnostic nature of complex trauma, as it so frequently shows up in our HCH consumer population in the form of multiple chronic health, mental health, relational, and addiction issues. This presentation will be clinical and compassionate, instructive and experiential, and will honor the whole person care model of health services.

NEED TO RECHARGE?

Visit the Relaxation & Lived Experience Lounge in Gardenia in the Royal Pacific Foyer!
Open Tuesday through Thursday from 7:30 a.m.-4:30 p.m.

"When You Get a Certain Age, They Count You Out": Exploring Pathways to Housing for Older Adults Experiencing Homelessness in NYC

Ashley Truong *(NYU Grossman School of Medicine, Postdoctoral Fellow)*

OCEANA GRAND 3

A growing number of older adults are facing housing precarity and homelessness in the United States. In 2024, an estimated 28% of people experiencing homelessness were 55 years of age or older. A growing body of research is concerned with the unique health and housing needs of older adults experiencing homelessness. Few studies to date have explored pathways from shelter to housing and the associated health and social needs of this population. This panel will present results from a community-engaged qualitative study that explores experiences exiting shelter for permanent housing among older adults in New York City. We conducted 38 in-depth one-on-one interviews with older adults currently and formerly experiencing homelessness and four focus groups with homeless services, healthcare, and housing providers (n=16). Data were analyzed using hybrid inductive/deductive thematic analysis. Final results are still in progress and will be refined in collaboration with community partners. Results will include elaboration on 1) barriers and facilitators to the housing search process unique to older adults, 2) suggestions for improving access to housing for older adults, and 3) the health and social needs and assets of older homeless adults. Additionally, this panel will reflect on the study's community engagement process, highlighting 1) efforts to elevate community voices across all stages of the research process, 2) lessons learned for effective and sustained engagement, and 3) strategies to build capacity for community-engaged research at the intersection of health and housing for older adults. Panelists will include up to three community collaborators (exact participants pending community partner input and approval) and two academic researchers. Through highlighting academic-community partnerships, this panel will advance evidence on the unique experiences of older homeless adults and identify opportunities to develop targeted interventions to reduce and end homelessness among this population.

MCO 101- How Managed Care and Housing Providers Can Partner to Support Our Shared Community

Rachel Briegel *(Community Health Plan of WA, Health and Housing Program Manager II)*

OCEANA GRAND 4-5

Healthcare systems are clearly noting a connection between positive health outcomes and housing, but how do housing providers engage and build partnerships with Managed Care plans to achieve whole person care? Who do you reach out to and how to you pitch your program as a potential partner? What are the outcomes that MCOs are interested in? And besides funding, what else can MCOs offer in partnership?

Community Health Plan of Washington (CHPW) is a local not-for-profit health plan based in Washington state. In 2020 we collaborated with our network of health centers to develop a social drivers of health strategy to reduce upstream causes of health inequities and remove unjust barriers to health and well-being through local and state-wide cross-sector partnerships, notably with housing providers.

Throughout the past few years, CHPW has worked with various housing providers to develop partnerships and contractual relationships in order to best meet the needs of our community. Some of these providers had never worked with managed care before. Through this presentation, we hope to share our perspective and learnings on how MCOs and housing providers can work together, and to support in translating MCO language for a housing provider audience.

This presentation is for any housing providers interested in learning about how to connect with Managed Care providers in their state will address questions like:

- Who at MCOs are best to connect with to move partnerships forward?
- What metrics and data are MCOs most interested in? (And what data collaborations are possible?)
- What are payment/contracting/funding options? (1115 waivers and beyond)
- What other partnership opportunities can MCOs provide? (Ex: Enrollment, care management…)

This presentation will include examples of MCO and housing provider partnership and collaboration efforts, including with Medical Respite Providers in Washington State.

There are also potential opportunities to connect with national efforts through the Association of Community Affiliated Health Plans (ACAP) which represents not for profit health plans across the country.

From Referrals to Partnerships: Building Scalable Approaches to Immigration Legal Support in HCH Settings

Aly Madan *(Greater Boston Legal Services, Immigration Attorney);* ***Maggie Sullivan*** *(FXB Center for Health & Human Rights, Harvard University, Director of the FXB Center Program on Immigrant Families and Unhoused Communities);* ***Manuela Arroyave Monsalve*** *(Community Health Center, Immigrant Health Care Coordinator);* ***Mara Quinn*** *(Community Health Center, Youth and Young Adult Care Coordinator);* ***Salamata Barry*** *(Greater Boston Legal Services, Interpreter and Community Liaison)*

OCEANA GRAND 8-9

Community health centers nationwide are increasingly caring for immigrant patients with complex legal needs. While HCH programs may hesitate to engage in immigration legal support due to limited resources or the complexity of the field, legal interventions can improve health access and program sustainability, such as when immigration status upgrades allow for expanded insurance eligibility. This panel, led by case managers (CM), an immigration attorney, and a community-based cultural liaison/interpreter, will discuss a "spectrum" of approaches for supporting immigrant patients with legal needs. Drawing from the experience of one HCH Program, presenters will walk through each "level" of the spectrum: (1) resource list dissemination; (2) CM-assisted navigation to legal counsel; (3) in-depth legal accompaniment by "champion" CMs trained in immigration law; (4) staff-facing case conferencing with immigration attorneys; and (5) formal immigrant-focused medical legal partnerships (I-MLPs) with legal aid organizations. Presenters will describe the scalable roles of CMs in (2) and (3), including the basic immigration law training that CMs can pursue to provide more extensive legal support. Presenters will also describe the HCH Program's experience in establishing (4) and (5). Audience members will hear directly from the HCH Program's partnering immigration attorney, who will offer insights about developing scalable medical-legal partnerships with immigration legal aid organizations. The panel will also include a community-based cultural liaison/interpreter, who will describe her work supporting both the HCH Program and the legal aid organization in providing person-centered linguistically- and culturally-resonant support for patients. This panel will emphasize practical steps for creating scalable models that fit diverse organizational capacities. Audience members will be invited to share challenges and successes from their own communities. Participants will leave with concrete approaches for adapting these strategies into their settings, as well as an understanding of how legal support can strengthen patient health outcomes and program sustainability.

Assessing the Unmet Healthcare Needs of Newly Arrived Refugees and Immigrants

Aimee Lee *(Public Health - Seattle & King County, Social Worker);* ***Jessica Knaster Wasse*** *(Healthcare for the Homeless Network, Public Health - Seattle & King County, Resource & Partnership Development Manager);* ***Semone Andu*** *(Healthcare for the Homeless Network, Public Health - Seattle & King County, Regional Health Administrator)*

GRAND CARIBBEAN 11-12

This workshop will share King County's experience conducting a survey to assess the unmet health care needs of newly arrived refugees and immigrants, a large majority of whom are experiencing homelessness and/or housing insecurity. The survey was distributed to local organizations whose work interfaces with this population; respondents included organization employees in various roles including direct service staff, administrators, program managers, and clinicians. The session will present methods for survey dissemination and suggestions for replication in other jurisdictions, as well as survey results and implications for program and service development.

Reimagining Intake: How Client Voices Improved Access and Care

Riley Wilgenbusch *(Colorado Coalition for the Homeless, Evaluation Specialist);*
Wren Duggan *(Colorado Coalition for the Homeless, Clinical Program Manager)*

GRAND CARIBBEAN 3-5

Clients are the experts in their healthcare needs, and service providers have a duty to hear and respond to them. But with care systems often fragmented, how can we ensure that clients have the services they need accessible to them? The Colorado Coalition for the Homeless set out to answer that question through a project that addressed challenges to case management intakes. In an exciting workshop drawing from the project's successes, attendees will learn how to collect and apply client feedback to drive decisions and creatively leverage their own resources to create integrated care systems that are responsive to client needs and benefit staff and organizations in the process.

Launching a Medical Respite Program Through Collective Impact: Pilot Findings from a Waitlist Control Trial

Halli Schulz *(Rapid City Fire Department, CHW Supervisor);* ***Natalie Lecy*** *(University of South Dakota, Assistant Professor);* ***Stephen Tamang*** *(Monument Health, Director of Addiction Medicine and Community Health Services)*

GRAND CARIBBEAN 8-10

This session will explore the development and pilot evaluation of a medical respite program in South Dakota, built on a collective impact framework with a local hospital serving as the backbone agency. Presenters will describe the program's formation, community collaboration, and innovative care delivery models—particularly the integration of community healthcare workers who support care coordination and patient advocacy. This session will explore the utility of having a hospital serve as the backbone agency, and the integral role of an interdisciplinary team, including hospital providers, community health workers, emergency housing partners, the fire department, and a local university. Pilot data from a waitlist control trial will be shared, comparing outcomes such as hospital readmissions between patients who received medical respite care and those who met eligibility criteria but did not receive services. We will conclude the session with a discussion of lessons learned, strategies for replication, and policy implications for expanding medical respite programs in underserved communities.

Street-Smart Wound Care: Evidence-Informed, Low-Barrier Practices for Unsheltered Settings

Brenda Madril *(Circle The City, Medical Coordinator);* ***Perla Puebla*** *(Circle The City, Associate Medical Director of Street Medicine Central)*

GRAND CARIBBEAN 1-2

This 45-minute skills workshop equips clinicians, nurses, MAs/CHWs, and street-medicine teams to deliver high-quality wound care in low-resource conditions. Using TIMERS as a simple scaffold, we'll walk through rapid assessment, pH-balanced cleansing, when and why to debride (and when not to), and a simplified dressing approach organized by exudate level and wound etiology. We'll practice concise documentation that supports handoffs, review the Levine culture technique, and define clear referral criteria. The session weaves in harm-reduction and pragmatic strategies for environmental realities (heat/cold, mobility, limited hygiene) and for maintaining continuity with transient patients. Attendees leave with confident, repeatable methods they can start using immediately across HCH clinics, shelters, mobile vans, and respite.

HOPE Squad: Activating a Consumer Led Syndemic Approach to HIV, HCV, and Overdoses in SF

Yuval Tankel *(SF Community Health Center, Program Manager of Community Outreach and Linkage)*

OCEANA GRAND 10

HOPE Squad is a consumer driven and led HIV and Hep C, and Overdose Prevention Empowerment team. Started in 2021, HOPE Squad conducts daily outreach throughout San Francisco, focused on engaging consumers and people who use drugs to assess their risk for HIV, Hep C, and accidental overdose, and to provide direct linkage to testing, harm reduction supplies, and essential care. Working in close collaboration with programming within SF Community Health Center, HOPE Squad is a first point of contact in the community for anyone interested in changing their lives. The team aims to increase access to testing, treatment, and resources, by utilizing a status neutral, whole person, and most importantly, peer-based approach. Since 2023, this team has completed over 11,000 substance use assessments, interviewing participants on their relationship with drugs, their risks for HIV, Hep C, and overdose, and their interest in treatment resources. The team also provides consumers with health education, offering in the moment one-on-one or group sessions to increase knowledge and awareness. Having provided over 90% with linkage support, HOPE Squad has connected consumers to Narcan, safe use supplies, medically assisted treatment, street medicine programming, primary care, drop-in hospitality services, and intensive case management. HOPE Squad members are also representative of the communities they are outreaching, with many speaking about services that they themselves may have accessed. Additionally, HOPE Squad provides direct linkage to REACT, a 16-week peer-based contingency management program that supports participants with reducing risk for HIV, Hep C, and accidental overdose. Having served 160 participants, REACT provides structured support groups, daily drop-in case management, and referrals to additional substance use treatment. The close collaboration between HOPE Squad and REACT continues to demonstrate the incredible power of peer-based approaches, highlighting the beauty that can occur when consumers are given space at the table.

The State of Homeless Mortality

Ashley Meehan, Rachel Biggs, Barbara DiPietro

OCEANA GRAND 11

Since 2019, the National Health Care for the Homeless Council's Homeless Mortality Working Group (HMWG) has been working to advance policy and advocacy, improve evidence and data, and facilitate cross-jurisdiction support and information sharing. Each year, numerous HCH conference attendees express interest in the HMWG, and more jurisdictions begin homeless mortality assessments. This session will provide an overview of what is currently known about homeless mortality, what the HMWG is and what the group has accomplished, how people can get involved with the HMWG, and tips for navigating the 2026 HCH Conference sessions on mortality for maximal gain. Come to this discussion to learn how you can maximize mortality data to advance public policy solutions to premature mortality—or call attention to the impact new laws are having on unhoused people.

Mindful Movement, Meaningful Connection: Chair Yoga in Supportive Housing Settings

Kelsie Shelby *(Colorado Coalition for the Homeless, MA Supervisor)*

OCEANA GRAND 12

This project explores the impact of mindfulness-based practices—specifically chair yoga—on individuals with lived experience of homelessness and highlights how integrative healthcare approaches can support healing in this population. As a Medical Assistant Supervisor, EMT, and 200-hour certified yoga instructor, I (Kelsie Shelby) facilitated weekly chair yoga sessions for residents at the Colorado Coalition for the Homeless (CCH). These trauma-informed sessions offered accessible movement, breathwork, and guided meditation designed to meet both physical and emotional needs. Methods included direct participant engagement, informal feedback, and interdisciplinary collaboration with medical staff, behavioral health staff, and case management. These partnerships ensured the program aligned with clinical goals and supported continuity of care within a holistic framework. Participants reported significant outcomes: reduced stress, increased morale, and decreased physical pain related to mobility. Sessions also fostered a stronger sense of community—enhancing staff-to-client rapport and deepening peer connections. Many residents also reported improved sleep, emotional regulation, and a renewed sense of personal agency. Consumer involvement was integral throughout. Ongoing feedback informed how sessions were structured—adjusting pacing, language, and approach to ensure inclusivity and cultural sensitivity. The consistent offering of sessions also provided residents with structure and stability during otherwise uncertain times. This mindfulness-based intervention is highly replicable in other shelter or supportive housing environments. With minimal equipment and training, programs can be delivered by certified instructors or trained healthcare professionals. Integration into existing care teams highlights the feasibility and value of incorporating holistic, trauma-informed care within traditional service models. This work supports a growing movement to humanize care for marginalized populations and reaffirms the role of mindfulness in fostering resilience, connection, and healing among individuals with lived experiences.

Primary Care Home Visits for Permanent Supportive Housing Clients, the Denver Pilot

Chiru Gunawardena *(Colorado Coalition for the Homeless, Medical Assistant);* ***Dan Rincon****;* ***Jordyn Nursall*** *(Colorado Coalition for the Homeless, Program Manager Housing Retention);* ***Lorenzo Rodriguez*** *(Colorado Coalition for the Homeless, Physician)*

OCEANA GRAND 4-5

Our purpose is to report on an innovative collaboration between property-based case management and HCH primary care providers- now in its fourth year- that delivers in-home primary care visits to PSH tenants with barriers to traditional outpatient primary care. Our multidisciplinary approach (medical, behavioral, psychiatric, case management) seeks to (1) address primary care and mental health needs, (2) assess and manage substance use, (3) reduce mortality, and (4) reduce evictions. Our health care model addresses care gaps not met through existing care delivery models (brick and mortar clinic, respite care, street outreach and mobile care clinics) at our organization. In tracing the evolution of our program, we hope to offer our peers a template to consider replication at their respective organizations. Implications of our work suggests HCH organizations consider the unique unmet heath care needs among their PSH clients.

Harnessing Artificial Intelligence to Transform Homeless Healthcare, Recuperative Care, and Policy Strategies

Ashish Abraham; Clayton Chau; Dariel Flores

OCEANA GRAND 8-9

This presentation explores the transformative potential of artificial intelligence (AI) in improving healthcare delivery, recuperative care, policy development, and service coordination for populations experiencing homelessness. Through case studies and recent innovations, we will examine AI-driven tools that enhance predictive modeling for health risks, personalize care interventions, and optimize resource allocation across systems. Participants will learn about emerging AI applications that address social determinants of health, facilitate cross-sector collaboration, and empower advocates with data-driven insights. Emphasis will be placed on AI's role in enhancing recuperative care programs—an essential component in transitional and post-hospitalization support—by enabling better case management, resource planning, and health outcomes. The session will also critically evaluate ethical considerations, data privacy, and equitable access in deploying AI solutions within vulnerable communities. By demonstrating scalable models and practical strategies, this presentation aims to inspire integrated, technology-enabled approaches that align with community-defined health outcomes.

Using Story to Create Change

Ashley Jarrett *(Burke County Public Health, Interim Health Director);*
Myra Nagy *(Lived Expert, Artist, Regional Representative 6 & 8)*

GRAND CARIBBEAN 1-2

This session will feature a diverse panel of individuals, including storytellers with lived experience of homelessness and practitioners who have successfully applied storytelling in their professional work in clinical practice, research, and policy. Together, they will explore how stories can shift perspectives, influence decision-makers, and strengthen health care and homeless services. Panelists will reflect on both personal journeys and professional practices, highlighting the power of storytelling as a bridge between lived expertise and systemic change.

Enhancing Healthcare Access for People Experiencing Homelessness: The Austin-Travis County EMS Community Health Program's Approach

Amber Price *(Austin-Travis County EMS, Captain);* ***James Hubley*** *(Dell Medical School / CommUnity Care Clinic, Physician);* ***Randy Chhabra*** *(Austin-Travis County EMS, Commander)*

GRAND CARIBBEAN 11-12

The Austin-Travis County Emergency Medical Services (ATCEMS) Community Health Program (CHP) was designed to address recurring challenges in the 911 system, particularly related to the growing population of people experiencing homelessness (PEH) in Austin. This vulnerable group often delays seeking care until their conditions escalate, contributing to overuse of emergency services. In response, ATCEMS launched two key initiatives: the StreetMed Team and Pop-Up Resource Clinics (PURC). The StreetMed Team, a collaborative effort with local organizations, provides comprehensive medical care in encampments, conducting assessments, refilling prescriptions, and connecting clients with essential resources. This proactive approach aims to reduce unnecessary ER visits by addressing health issues early. The PURC model brings multiple community resources together in one location, reducing barriers to care for PEH and improving service delivery. PURCs offer a range of services, including medical care, mental health assessments, and legal assistance. Special events like the "Pink PURC" cater specifically to female clients, providing a safer, psychologically-informed environment. Through outreach, referrals, and ongoing case management, CHP paramedics support PEH in accessing healthcare and social services, fostering long-term support and improving their overall well-being.

Utilizing Death and Hospital Records to Improve Identification of Decedents with a History of Homelessness

Dana Madigan *(University of Illinois Chicago, Research Assistant Professor);*
Lee Friedman *(University of Illinois Chicago, Research Professor)*

GRAND CARIBBEAN 3-5

Homelessness impacts health through an array of social, economic, behavioral, and nutritional risk factors, including situational circumstances (e.g., lack of housing, transportation, phones, financial resources, physical hazards, environmental conditions), that are associated with an increased risk of injury and earlier onset, exacerbation, and inadequate management of chronic health conditions. As a result of both acute and chronic adverse health outcomes, the average age of death among people experiencing homelessness (PEH) is 15-20 years younger than the general population. Recently, there has been an increase in highly innovative methods aimed at more accurately characterizing mortality among PEH. Researchers have used an array of data sources to improve ascertainment of PEH decedents, including cohort samples, Census and Social Security Administration data, data from clinics serving PEH, local ME data, and local homeless service registries. In the present study, we evaluate a new methodology for identifying decedents with a history of homelessness by linking Illinois hospital data that identified patients experiencing homelessness during a hospital visit (ICD-10-CM code for homelessness Z59.0X) with all state death records for the period 2017-2023. Cases in both datasets were linked on first and last name, date of birth, and gender using deterministic and probabilistic methods. We compare decedents with a history of homelessness but documented housing at the time of death with decedents with documented homelessness at the time of death. The new methodology identified 7,314 decedents with a history of homelessness but documented housing at the time of death. The new strategy increased the number of ascertained PEH decedents by more than threefold relative to methods that only evaluate residential information on death records (n=2,994), and the groups of decedents were similar across demographic characteristics, causes of death, and toxicology findings. This strategy can be replicated in most states to better characterize the true mortality burden.

Heat, Hydration, and Healing: Addressing Extreme Heat in Unsheltered Communities

Brenda Madril *(Circle The City, Medical Coordinator);* **Maritza Arias** *(Circle The City, Behavioral Health Consultant)*

OCEANA GRAND 8-9

Extreme heat is a leading health threat for people experiencing homelessness, increasing the risk of dehydration, heat exhaustion, and heat stroke. This session shares field-tested hydration protocols and trauma-informed strategies developed from two years of frontline outreach in Phoenix, AZ. Attendees will gain practical tools and policy insights to reduce heat-related complications and improve care for unsheltered populations.

Leading Through Uncertainty: Building Resiliency and Preventing Burnout in Homeless Health Care

Matt Bennett *(Optimal HRV, CEO)*

OCEANA GRAND 10

Leaders and managers in health care for the homeless settings face unique pressures: chronic uncertainty, high staff turnover, vicarious trauma, and the daily weight of systemic inequities. These stressors erode organizational health, strain leadership capacity, and fuel burnout. This workshop equips leaders with a neuroscience-informed framework for managing uncertainty, stress, and organizational fatigue. Drawing from trauma-informed leadership, neurobiology, and resilience science, participants will learn practical strategies to support staff well-being, strengthen team resilience, and foster organizational cultures that thrive under pressure. By reframing stress as both a challenge and an opportunity, leaders will leave with actionable tools to sustain themselves, their teams, and the mission of homeless health care

The Development of a New Low-Barrier Navigation Center in Miami, FL

Jenny Gomez *(Better Way of Miami, Program Director)*

OCEANA GRAND 11

This session will address the development and implementation of a new low-barrier navigation center in Miami, FL. The navigation center was developed when Better Way of Miami, which has provided residential and outpatient treatment since 1984 and permanent supportive housing since 1995 for unhoused individuals, decided to convert a one-story warehouse into a low-barrier navigation center to fill a gap in the community. The center is funded by the Miami-Dade County Homeless Trust as part of a larger action plan to address a new state law prohibiting overnight camping and sleeping. The pilot project was envisioned as a type of homeless shelter designed to be more accessible and welcoming to people who might be hesitant to go to traditional shelters, with few barriers to entry, more flexible services, and a low-barrier, high support approach. Built on principles of dignity and accessibility, the navigation center removes common barriers by accommodating households with pets, people with considerable belongings, and non-traditional household units, keeping couples or other extended adult family members together without separation. The center is also designed to serve priority populations which includes: chronic homelessness, substance use, mental health, HIV or chronic medical conditions, people who are pregnant, and people living in encampments. With a capacity of 80 beds, the center operates 24 hours a day, 7 days a week, offering a safe place to sleep, meals, showers, and laundry. Staff are trained in psychologically-informed care and de-escalation strategies, ensuring a supportive environment where residents are respected and empowered. A safety and overdose-prevention philosophy are at the core of the program, emphasizing compassion and practical strategies to reduce the risks associated with substance use. Onsite services and strong community partnerships are crucial to helping residents move toward permanent housing solutions. This innovative approach not only addresses immediate needs but also builds pathways to long-term stability and improved health outcomes for Miami's most vulnerable residents.

Getting Started with Homeless Mortality Reporting

Ashley Meehan; Pia Valvassori; Rachel Biggs

OCEANA GRAND 12

This session is for anyone looking to start homeless mortality reporting in their community, whether you are from an HCH or clinical program, a CoC, a public health agency, an academic institution, or somewhere else! The session will outline why tracking and reporting homeless mortality is critical for program planning and for broader health and housing policy and advocacy, review the range of data sources communities could consider using for mortality reporting, discuss partnerships and institutional infrastructure needed for ongoing reporting, and provide attendees with tools and resources to take back their communities and organizations. Throughout each of these topics, presenters will share examples and lessons learned throughout the last 5+ years of the National Health Care for the Homeless Council's multi-sector Homeless Mortality Working Group. There isn't one single way to determine or report on homeless mortality, because every community context differs. While this is sometimes a challenge when summarizing and synthesizing homeless mortality efforts, it also means that anyone can start from anywhere with whatever they've got. Some communities partner with Medical Examiner/Investigator and Coroner's Offices and others work with public health agencies to access vital records. Some determine homelessness using HMIS while others reference a check box or search for key terms in death certificates. Some produce a report or publication summarizing their findings while others share findings informally and internally. Regardless of the approach, communities across the country have used their homeless mortality reporting to evaluate housing programs, advocate for additional medical respite beds, apply for (and receive!) additional overdose prevention grant funding, and more. Join this session to start or advance your plans for homeless mortality reporting in your community.

Community Care in Motion: Lessons from the Skilled Nursing Pilot Program in Bexar County

Marcie Ramsey *(Close to Home, SOAR Lead and Outreach Coordinator)*

OCEANA GRAND 3

In 2024, Close to Home, the Continuum of Care for San Antonio and Bexar County, launched a Skilled Nursing Pilot Program to address post-hospital care needs for people experiencing homelessness. A need was identified for access to long-term care for clients with high acuity needs who are not able to care for themselves and are not able to access shelter due to their physical barriers. This session will share lessons learned from implementation, including program design, funding strategies, and the role of community partnerships. Participants will gain insights into how the pilot is shaping sustainable approaches to health and housing integration.

Your Support Makes NHCHC's Work Possible

Through our training, research, and advocacy, the National Health Care for the Homeless Council is making a difference! Since 1986, we have brought together thousands of health care professionals, medical respite care providers, people with lived experience of homelessness, and advocates to create an organization like no other in the country.

We can continue to drive positive change for those working in the Health Care for the Homeless field with your support. **Please join those who already contribute to our work by making a charitable donation to NHCHC today!**

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NHCHC'S MISSION

Grounded in human rights and social justice, the mission of the National Health Care for the Homeless Council is to build an equitable, high-quality health care system through training, research, and advocacy in the movement to end homelessness. Learn more at nhchc.org.

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We believe in fostering an environment free from harassment and discrimination, where individuals of all genders, gender identities, sexual orientations, ages, abilities, body types, ethnicities, races, and religious beliefs feel safe and respected. Harassment in any form is strictly prohibited, including inappropriate physical contact, unwelcome sexual advances, and any form of sexual language or imagery. This policy applies to all aspects of the conference, from sessions and workshops to social events, exhibits, sponsorship materials, and social media interactions.

If you are asked to cease any inappropriate behavior, we expect immediate compliance. Violations of this code may result in sanctions, including removal from the event without a refund, at NHCHC's discretion. If you experience or witness harassment or have any concerns, please reach out to a member of the NHCHC staff right away.

PRINCIPLES OF ENGAGEMENT

Our values and priorities are rooted in NHCHC's Mission and Strategic Goals, which guide our work in the national Health Care for the Homeless community. These principles are central to how we collaborate with our consumers, funders, corporate partners and other stakeholders.

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