RECOMMENDATIONS REPORT

Healthcare and Homelessness in the Wenatchee Valley

SPRING 2021

Confluence Health FOUNDATION

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EXECUTIVE SUMMARY

The COVID-19 pandemic abruptly changed nearly every aspect of American life in unexpected ways. As vaccines provide hope for a return to normalcy, there will also be some fallout from the pandemic that will continue for years. The ripple effect on the social and economic fabric of communities around the nation will be more insidious than the virus itself, and those that will feel this most acutely will be the hundreds of thousands of Americans on the edge of homelessness. In January 2021, *The Seattle Times* reported that nationally, homelessness could increase by nearly 50% over the next four years because of consequences related to the COVID-19 pandemic. At first glance, this concerning statistic may not seem relevant to healthcare systems, especially those situated in rural areas, but the following report details the connections between homelessness and organizations like Confluence Health.

Housing and health are inextricably linked. Poor health can precipitate homelessness. Conversely, living without a home exposes people to circumstances that can create or exacerbate health ailments. Regardless of where health and homelessness intersect, people experiencing homelessness have unique interactions with healthcare, characterized by overutilization of acute care services, high healthcare costs, and poorer outcomes. Even in smaller urban settings, homeless presents complex challenges for healthcare administrators.

At Confluence Health, data shows that patients experiencing homelessness have longer hospital stays and a higher-than-average proportion of emergency department and inpatient visits, leading to over $6.8 million in charges a year. These utilization patterns, combined with insufficient insurance reimbursement, contribute to a total loss of about $1.2 million or about $3,500 per patient experiencing homelessness each year. A greater concern is the reasons behind these high costs. For example, according to primary diagnosis data, a substantial number of patients access the emergency department and hospital because of mental health or substance use disorder-related crises. These environments are not equipped to treat and manage the underlying medical and behavioral needs of patients. In these cases, high-cost healthcare settings are used as a safety net rather than a gateway to healing, further perpetuating the cycle of overutilization.

In October 2020, the Confluence Health Foundation hosted members of local healthcare leadership and community partners for a virtual event, *Healthcare and Homelessness Symposium: Understanding the Intersection of Housing and Health in the Wenatchee Valley*. The three-part series was aimed at exploring the causes and effects of healthcare overutilization among people experiencing homelessness and the implications for local communities. Throughout the series, the facilitator shared overviews of innovative, relevant strategies for healthcare-based interventions to improve health outcomes and reduce healthcare costs among patients experiencing homelessness. These strategies represented a spectrum of scalable interventions that have been implemented successfully by other health systems in the Pacific Northwest. At the core of these examples were factors like improved access to housing or low-barrier shelter options, improved access to medical care, and greater coordination and collaboration between healthcare and social service providers.

The purpose of the symposium was to educate a wide range of stakeholders about feasible solutions and to help build consensus about a path forward. Following the symposium, a feedback survey was distributed to symposium participants. The survey was designed to identify the highest-value solutions that were realistic for the local region. Alternatively, stakeholders could provide their feedback in a conversational format. Based on discussions during the symposium sessions and feedback from 12 participants, the recommended next steps include:

1. **Improve access to healthcare services** by co-locating medical services at shelters, supportive housing sites, and other strategic locations

2. **Offset costs of community-owned solutions** by strategically investing in projects that promote development of supportive, affordable housing for people experiencing homelessness

3. **Enhance screening and referral processes internally** to coordinate with external partners more effectively

4. **Provide greater representation in existing community initiatives** and improve feedback loop with decision makers

5. **Contract with housing agencies and skilled nursing facilities** to create space for patients in need of temporary medical respite housing

Throughout the nation, healthcare systems have demonstrated that even small investments in programs that serve patients experiencing homelessness can lead to significant returns on investment. The recommendations provided in this report represent feasible solutions that align with the needs of the community and available resources, but this is not an exhaustive list of possibilities. Confluence Health's leadership is uniquely poised to develop and implement a right-sized approach to effect meaningful change for this unique patient population. Not is there potential to positively impact the lives of patients experiencing homelessness, but there are also opportunities to build a stronger healthcare system and healthier North Central Washington.

INTRODUCTION

The relationship between healthcare and homelessness is influenced by several social, economic, and individual factors that both precipitate and perpetuate poor health outcomes and high healthcare costs. The complexity of this relationship has recently come into focus as healthcare systems throughout the nation shift from a fee-for-service model towards value-based care. This ideal is reshaping the reimbursement process, quality metrics, and the focus of healthcare leaders, who now must seemingly account for the non-clinical factors that influence the health outcomes of their highest-risk patients. This is because clinical care only drives about 20% of modifiable contributors to health. The remaining 80% is attributable to social determinates of health, which include social, physical, and environmental factors, as well as individual knowledge, beliefs, and behaviors. In other words, housing status, food security, employment, educational attainment, and childhood experiences have a greater impact on health outcomes than encounters with clinical care providers.

For a growing number of health systems across the nation, achieving the goal of high-value healthcare means looking beyond the walls of hospitals and clinics and toward the variables that shape health within the community. Partnerships between healthcare systems and community-based groups are targeting social determinants of health to address the prevailing non-medical needs of high-risk patients. These types of interventions have improved health outcomes and reduced healthcare overutilization.

"For a growing number of health systems across the nation, achieving the goal of high-value healthcare means looking beyond the walls of hospitals and clinics and toward the variables that shape health within the community."

For example, in the case of homelessness, co-development of permanent and temporary supportive housing opportunities has provided dramatic examples of health improvement through non-medical interventions. In addition to individual benefits, healthcare systems and partners that implement housing for health (HFH) models have documented an impressive return on investment—in some cases, up to 480%.

The media has widely documented successful healthcare-initiated HFH strategies in major U.S. cities like New York, Chicago, and Portland, Oregon. Beyond the buzz, several smaller health systems, including some in the Pacific Northwest, have been able to move the needle, too. Small and rural healthcare systems have fewer resources than those in metropolitan areas, but because HFH

approaches are scalable and diverse, communities have the flexibility to implement appropriately-sized solutions. Successful healthcare systems have relied on collaboration with community partners, ingenuity, and braided funding streams to reduce the financial and operational impact on any one institution.

Report Overview

Confluence Health has an opportunity to strengthen community efforts aimed at improving the health outcomes of patients experiencing homelessness. The following report contains information for Confluence Health's leadership. It describes the rationale for supporting internal and external investments in resources that target the unique needs of this underserved population. Included are the results of two datasets describing healthcare utilization and health outcomes of local patients experiencing homelessness. In addition, the report summarizes the impact of homelessness on the organization's resources and the threat these impacts pose to Confluence's mission and values. The report also chronicles feedback from community partners, which provides further context about specific needs within the community and highlights recommendations that would maximize the impact of future investments. The goal of this report is to create a platform for decision-making and collaboration that will lead to health improvement for people experiencing homelessness, as well as a stronger community for all.

BACKGROUND

The Intersection Between: Homelessness & Health

People experiencing homelessness face limited access to basic household resources that play a profound role in health, such as running water, shelter from the natural elements, or a place to store and prepare healthy foods. Not surprisingly, the prevalence of unmanaged chronic disease is higher in people experiencing homelessness. According to the National Health Care for the Homeless Council, the rates of diabetes and hypertension are nearly twice that of the general population. In addition, psychological effects of homelessness can amplify pre-existing behavioral health conditions. A lack of sleep and prolonged stress contribute to depression, which occurs in nearly 49% of people experiencing homelessness. When it comes to managing chronic diseases of any kind, homelessness makes it nearly impossible to adhere to therapeutic regimens. Not only does this intensify the effects of unmanaged chronic conditions, but it also makes this population more vulnerable to infectious diseases and medical complications, leading to poorer health outcomes. Furthermore, people experiencing homelessness face higher rates of injury. People without shelter are nearly twice as likely to be victims of violent crimes; women are disproportionately affected by physical, emotional, and sexual violence while living on the streets or in shelters. Trauma of any kind can lead to chronic pain and a reliance on substances, factors that further perpetuate alienation from the broader society.

While experiencing homelessness can cause poor health, the reverse is also true: Poor health can cause homelessness. An unexpected medical event can lead to unemployment and lost earnings, loss of health insurance, and ultimately foreclosure or eviction. In fact, nearly two-thirds of all bankruptcies in the United States are related to medical bills. Even with health insurance, individuals and families can still find themselves tangled in a complex system where high premiums and deductibles often exceed their ability to pay. Similarly, some chronic diseases can predispose people to homelessness. Untreated mental illness, substance use disorders, chronic pain—these conditions all reduce an individual's ability to function effectively in day-to-day life and limit their resources for problem-solving when an unexpected situation arises. Once an individual enters homelessness, the ability to self-resolve or manage medical conditions becomes even more difficult. The myth that many people "choose" homelessness as a lifestyle preference does not account for the myriad factors that precede homelessness, nor does it acknowledge the significant barriers to exiting homelessness.

The Intersection Between: Healthcare & Homelessness

Living without a home is a health disparity that leads to significant consequences. Despite having a disproportionately high burden of disease, people experiencing homeless have lower rates of primary care and behavioral health engagement. Combined with a lack of ongoing disease management and non-compliance with medication and post-discharge protocols, these factors will eventually manifest into complex medical needs. To be clear, low engagement in protective health behaviors and poor

health outcomes are not unusual. However, data suggests that the way people experiencing homelessness use healthcare services is unique. The healthcare experience of those facing homelessness is characterized by overutilization of acute hospital services.

For example, individuals struggling with homelessness have emergency department admission rates that are three to four times higher than the average person. Once hospitalized, this patient population also has a longer average length of stay. A patient could be well enough to be discharged but not well enough to be discharged back to the streets. In communities where there are no intermediate respite facilities, homeless patients must stay in the hospital longer. While the benefit to the patient is that they have more time to recuperate under medical supervision, the healthcare costs for prolonged hospitalization can be exorbitant. Because many homeless patients are underinsured or uninsured, these costs often represent financial losses for healthcare systems. Arguably, these losses are then passed onto patients and health insurance companies. For some smaller, independent healthcare systems, losses of any kind challenge their ability to maintain even the slimmest profit margins.

The Intersection Between: Homelessness & Confluence Health

The 2020 Chelan-Douglas Point-in-Time Count conducted by the City of Wenatchee provides information about the number of people experiencing homelessness in the region:

- 350 people identified as homeless, a decrease of about 15% from the 2019 Point-in-Time Count; about one-quarter are unsheltered and live on the streets.
- 43 people identified as chronically homeless, which is about 19% more than the 2019 Point-in-Time Count. An individual is considered chronically homeless if they have been homeless for a period of at least a year and they have a disability.
- Locally, the most frequent self-reported reasons for homelessness include disability, behavioral health conditions, and chronic health conditions, echoing the strong relationship between health and homelessness described above.

Since 2017, the Confluence Health Foundation has been leading a project that explores the intersection between healthcare and homelessness in our local community. The project stemmed from difficulties associated with discharging homeless patients and what some described as a revolving door, where sick and injured patients with no safe place to recover and those with medically complex cases would frequently be readmitted to the hospital for care. Despite the best efforts of providers and case managers, the traditional model of healthcare was not meeting the needs of this population. The focus of this work was to develop an understanding of how the Confluence Health Foundation, Confluence Health, and community partners could better serve the unmet healthcare needs of patients experiencing homelessness. The goal was to improve healthcare outcomes while reducing impacts on the resources and finances of Confluence Health. An important first step was to gather information that would help define the scope of needs and to establish a baseline of healthcare utilization among patients experiencing homelessness in the region. Results from the analysis of two datasets are described below.

ORGANIZATIONAL DATA

Sample 1: Summary of Results

The first data set describes a convenience sample of 25 patients over a one-year period, beginning in March 2018. This sample was selected using information available in the Emergency Department Information Exchange (EDIE), a real-time tracking tool that allows healthcare systems to identify high utilizers and enhance care coordination between hospitals. The emergency department case manager at Central Washington Hospital used EDIE and available housing status information to capture a list of patients that fit the study criteria: those who are known to be experiencing homelessness and have been admitted to Central Washington Hospital's emergency department at least once during the study period. After the initial inclusion list was made, medical records for all healthcare visits across the system during the study period were collected and analyzed. As a result of the sampling methodology and a lack of data on housing status for most patients, the data is not inclusive of all individuals that meet the eligibility criteria, nor does the data reflect healthcare interactions outside of Confluence Health. However, the results provide an interesting snapshot of 25 patients who have a history of high utilization and are known to be experiencing homelessness.

The 25 patients included in this sample visited Confluence Health hospitals and clinics a total of 543 times during the one-year study period. **Figure 1** describes the frequency and visit type for each of the 25 patients in the sample. Nearly two-thirds, or 358 visits, were for clinical outpatient services, which

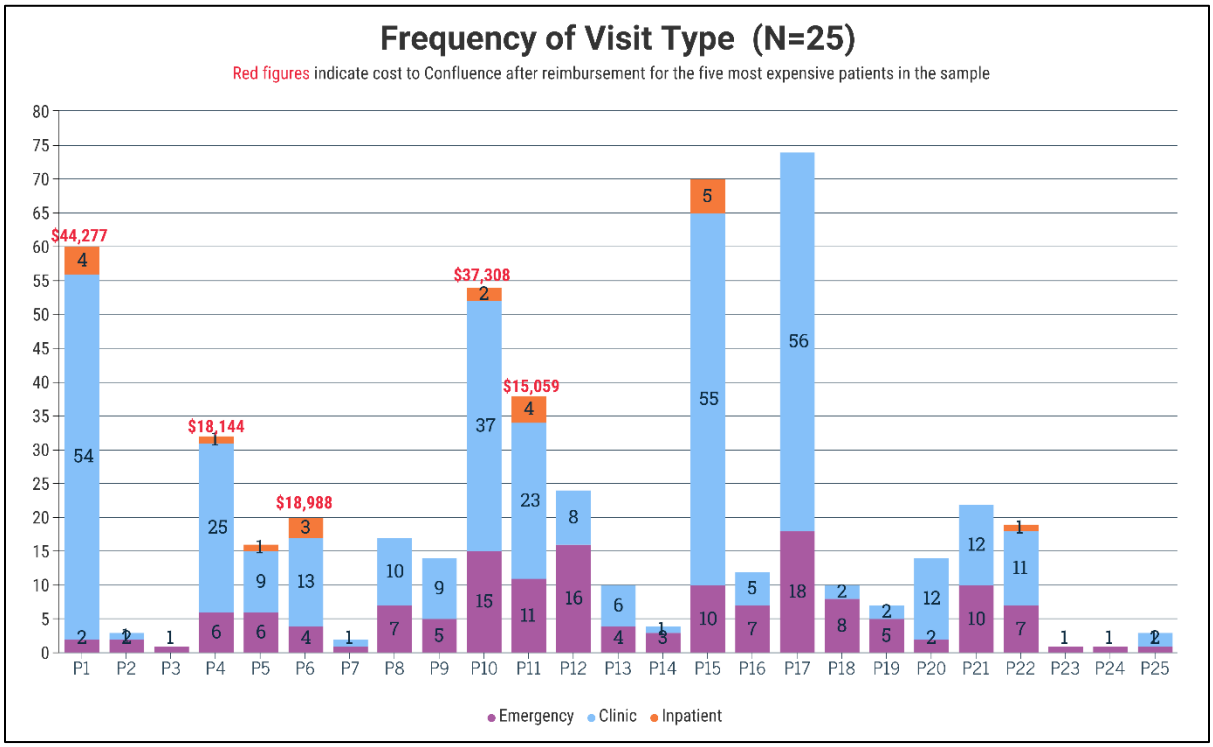

Figure 1: Frequency of Visit Type, Sample 1

included primary care and behavioral health. About 57% of outpatient visits are attributable to just four patients, with three individuals accessing services at outpatient clinics more than 50 times in a year. The second largest visit category was emergency department visits, with 153 visits during the study period. Nearly half of the sample group visited the emergency department more than five times. Most frequently, the primary diagnosis at emergency department encounters were related to drugs and alcohol (26%), followed by illness (22%), mental health (18%), and injury (16%).

Inpatient admissions occurred with less frequency. Eight patients were admitted to the hospital a total of 21 times; however, those visits combined represented 125 inpatient days. Additional services, including ancillary and observation, represented only 2% of the total visits. Illness was the most common reason for inpatient admissions (47%).

Figure 1 on the previous page also identifies the five highest-cost patients in the sample, which was calculated using a formula that estimated the difference between the charges that must be recuperated to cover the cost of services provided and the reimbursement received. For these calculations, the break-even point would be 40% of total patient charges. Therefore, if the break-even cost of care was $1,000 and reimbursement received was $800, the remaining loss incurred by Confluence Health would be $200.

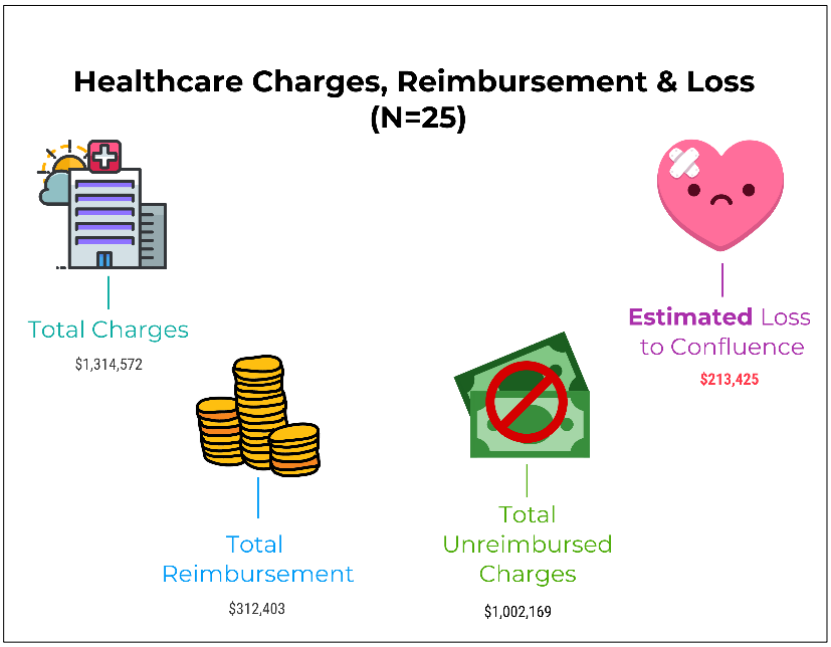

Figure 2: Estimated Loss to Confluence, Sample 1

Figure 2 on this page summarizes the $213,425 overall loss to Confluence Health associated with the 25 patients in the sample based on this same formula.

Sample 2: Summary of Results

The second data set provided a more robust look at healthcare utilization among patients experiencing homelessness. Healthcare encounters were included in the sample if a diagnosis code corresponding with homelessness was captured in medical records during the two-year study period: May 1, 2017-April 30, 2019. A diagnosis of homelessness would occur if a patient self-reported their housing status during the visit. Because this is not a routine question, a patient would have had to disclose their housing status to their provider and that provider would have had to make a note in the medical record. Therefore, it is unlikely that this sample is inclusive of all patients experiencing homelessness and encounters attributable to this group during the study period. This sample includes 342 patients who received a diagnosis of homelessness at least once during a visit to a Confluence Health facility during the study period. Combined, there were a total of 802 healthcare visits included in the analysis.

The largest proportion of visits were outpatient (42%), followed by emergency department (28%). Primary diagnosis data from emergency department visits showed the most common reasons for admission were illness (30%), mental health (27%), drug and alcohol (16%), and injury (10%). The 215 inpatient admissions made up 27% of all encounters within this sample and 48% of the individuals in the sample had at least one inpatient admission. When combined, these visits represented an average of about 1,135 inpatient days per year, with the median length of stay being about five days.

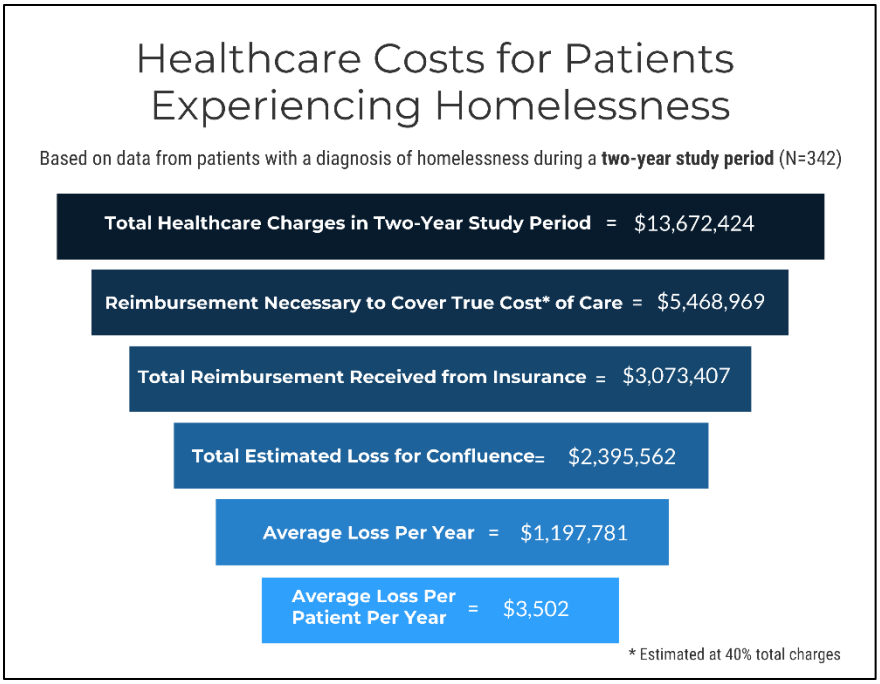

Figure 3: Healthcare Costs and Estimated Loss to Confluence Health, Sample 2

Figure 3 on this page represents the healthcare costs associated with this sample population. If the true cost of the services provided are approximately 40% of the charges, based on the total reimbursement received, Confluence Health incurred a loss of about $1.2 million per year, or $2.4 million over the study period.

Discussion: Organizational Data

The two data sets described above provide an initial glimpse into the relationship between healthcare and homelessness at Confluence Health. The sampling methodologies are based on convenience and lack a comparison group, which limits the ability to confidently draw conclusions. Despite these limitations, both datasets provide interesting insight into how those experiencing homelessness utilize healthcare services.

The first sample (N=25) illustrates that most of the healthcare costs are driven by the highest utilizers within the sample. In this case, five patients are responsible for over 50% of the cost incurred by Confluence. Perhaps more interesting is the connection between the frequency of outpatient encounters and utilization of acute care services. Typically, engagement in outpatient services, which includes primary care and behavioral health, has a protective effect: healthcare providers drive patients to outpatient services to reduce the need for higher cost interventions. However, those in the sample with highest rates of outpatient visits also have relatively high inpatient admission rates, high emergency department admission rates, or both. Although the direction of influence is not clear from the information provided, future analysis should identify whether the absence of housing reduces the benefits associated with primary care engagement.

Those included in the second sample (N=342) have a higher proportion of emergency department and inpatient admissions relative to outpatient visits. The data shows that almost half of those included in the sample (n=165) had at least one inpatient stay during the two-year study period, and about 44% (n= 149) of the sample had at least one emergency department visit. This seems to illustrate that acute healthcare services are used nearly as frequently as services found in the outpatient setting. While the reason for this is not clear, there are likely consequences affecting the health outcomes of patients and the overall healthcare costs attributable to care. Conversely, reducing the proportion of emergency department and inpatient visits would likely reflect an improvement in health outcomes and a reduction of costs.

These data sets demonstrate concerning patterns of healthcare utilization among people experiencing homelessness. Patients are seeking high-cost, higher acuity services related to illness, mental health concerns, and substance use disorders, and as a result of insufficient reimbursement from payors, these patterns lead to losses incurred by Confluence Health. Although the conclusions that can be drawn from these data are limited, they do provide some insight into the scope the problem. For example, it appears that the right investments in a few high-risk patients could make a dramatic impact on health outcomes and healthcare costs.

Data also highlights the role of substance use and mental health disorders in healthcare overutilization, which account for about 44% of the primary diagnoses for emergency department visits in the first sample and 43% in the second sample. Prioritization of community partnerships that strengthen the response and resources associated with these needs could yield more promising outcomes than the current "treat and street" model that perpetuates the cycle of healthcare overutilization.

Finally, the data provided does not account for the human experiences of patients. Those accessing the healthcare services provided by Confluence are routinely seeking help from an organization that is not properly equipped with the tools needed to address the most salient factors affecting the health of their patients, like housing or addiction treatment. Based on these findings, the primary question became: how can Confluence Health better serve the needs of patients experiencing homelessness?

PARTICAPATORY DATA

Symposium Overview

In October 2020, the Confluence Health Foundation brought together healthcare leadership and community partners for the *Healthcare and Homelessness Symposium: Understanding the Intersection of Housing and Health in the Wenatchee Valley*, a three-session series aimed at exploring the causes and effects of healthcare overutilization among people experiencing homelessness and the implications for our local communities. The goal of the symposium was to start a meaningful conversation between healthcare leadership and the community to understand the most appropriate role for Confluence Health to play in improving the health of patients experiencing homelessness. The meeting was facilitated by the Technical Assistance Collaborative (TAC), a national nonprofit consulting firm dedicated to assisting human services, healthcare, homelessness, and affordable housing systems to implement policies and practices that empower people to live healthy, independent lives. TAC was selected to facilitate the symposium based on the organization's expertise in healthcare-initiated housing opportunities and Housing First projects. Originally, an in-person meeting was scheduled in March 2020, but because of the COVID-19 pandemic, the event was rescheduled over a period of three weeks in October 2020. Ultimately, it took place virtually. There were 43 attendees representing 23 organizations, listed in **Figure 4**

Figure 4: Healthcare & Homelessness Symposium Attendees

Action Health Partners (1)
Amerigroup (1)
Cascade Medical Clinic (2)
Catholic Charities (1)
Chelan County Sheriff's Department (1)
City of East Wenatchee (2)
City of Waterville (1)
City of Wenatchee (4)
City of Wenatchee Police Department (1)
Columbia Valley Community Health (1)
Confluence Health Behavioral Health (4)
Confluence Health Case Management (3)
Confluence Health Emergency Department (1)
Confluence Health Executive Leadership (3)
Confluence Health Finance (1)
Confluence Health Volunteer Services (1)
Coordinated Care (1)
Douglas County Solid Waste (1)
Grant County Integrated Services (1)
Hope Care Clinic (2)
Link Transit (1)
Molina Healthcare (1)
North Central Accountable Communities of Health (3)
Physician & Healthcare Consulting, LLC (1)
Wenatchee Housing Authority (1)
Wenatchee Public Schools (1)
Wenatchee World (1)
Women's Resource Center (1)

Symposium Sessions

Session 1: Homelessness, Healthcare, and Our Community
During this session, participants reviewed the causes and effects of healthcare overutilization among people experiencing homelessness and the implications for patients, healthcare systems, and local communities.

Session 2: What Solutions Already Exist?
This session explored the different ways other healthcare systems have worked with their communities to improve healthcare outcomes for people experiencing homelessness.

Session 3: Community Input and Panel Discussion
Panelists from healthcare, community-based organizations, law enforcement, and government discussed the topics presented in previous sessions and the ways that these ideas are relevant in North Central Washington. During the discussion, panelists shared their thoughts on the opportunities in our community to build stronger partnerships between healthcare providers and community organizations.

Community Feedback & Summary of Survey Results

A link to an electronic survey was emailed to participants following the symposium. The brief survey was designed to collect feedback and gain insight into future planning efforts. As an alternative to the electronic survey, participants could schedule a 20-minute feedback session to provide their insight. Twelve participants responded to the electronic survey, and two participants provided verbal responses during a feedback session, for a cumulative response rate of 33%. A summary of all feedback is below.

Symposium Evaluation

Overall, participants had a favorable opinion of the symposium. Respondents indicated that information about healthcare costs and the impact of homelessness from a variety of perspectives was valuable. Some felt the shared information highlighted the complexity of the problem and noted that the solutions would require strong collaboration and coordination between agencies, while avoiding duplication of services and competition for funding.

General Priorities

Nine survey participants ranked *general* solutions in order of priority. The results are listed in Table 1 at right. During a feedback session, one respondent shared a story about a client who was experiencing a rapid deterioration in their health. The care coordinator helped the client contact Confluence Health to schedule an appointment with a provider, but the first available appointment was two

TABLE 1: SOLUTION CATEGORY	SCORE
CONTRACTING SERVICES WITH HOUSING PARTNERS	3.56
DIRECTING FUNDS TOWARDS EXISTING HOUSING PROGRAMS AND SUPPORTIVE SERVICES	3.33
IN-KIND CONTRIBUTIONS	3.33
PROVIDING FINANCIAL SUPPORT OR RESOURCES TO NEW AFFORDABLE HOUSING PROJECTS	3.0
"OTHER" CATEGORIZED AS CO-LOCATION OF SERVICES (3) AND OUTREACH TO VISIBLY HOMELESS POPULATIONS (1)	3.0

months away. To paraphrase the respondent's key point, social service providers often jump to meet the needs of their client—especially ones identified by healthcare providers; however, when social service providers reach out to healthcare, the perception is that the response is not met with the same attention. Healthcare tends to be a difficult system to navigate, especially for many people experiencing homelessness, who may already feel disenfranchised. Because of this, they often rely on the support and advocacy of social service providers to help manage their unique and complex medical needs. Improving the ability of social service providers to reach medical providers on behalf of their clients–and to work collaboratively towards better health for the client–is a priority.

Specific Solutions

When asked for more specific actions Confluence Health should take to improve access to safe and affordable housing for patients experiencing homelessness, electronic responses varied widely. The most common themes emphasized the need to work collaboratively with local housing partners. For example, respondents cited the need to provide either financial support or in-kind services to low-barrier and/or initiatives for transitional housing. This could mean co-locating services at housing and shelter sites or contracting with housing agencies to provide medical respite space. Though the respondents were overwhelmingly in support of Confluence's involvement, one respondent cautioned that tackling affordable housing or providing financial support to a low-barrier shelter would be outside of the organization's mission and would create a financial burden for the health system.

Another person had a different perspective, stating that the most imminent need within the community is a universal community information exchange system for vulnerable populations. In their opinion, this type of resource would address a wider range of social determinants of health that create and perpetuate the behaviors and circumstances associated with poorer health, including homelessness. By improving coordination and reducing duplication of services upstream, this respondent believes the same desired outcomes would be achieved downstream.

Other suggestions included: development of a stronger referral system from Confluence's emergency department and case management teams to the coordinated entry system; expanding medical services to include addiction rehabilitation; and providing rent subsidies for low-income families.

Confluence's Role in Housing and Homelessness

Respondents were asked to describe the role that best suited Confluence Health. Nearly all respondents stated that the medical, behavioral health, and case management services provided by Confluence Health would complement existing and future efforts within the community. Another resounding theme was the unique relationship that healthcare providers have with members of this population because they are often attending to these patients in moments of vulnerability, when patients may be contemplating behavior change or experiencing a call to action due to a medical event. In this way, the perception from the respondents is that interactions at Confluence Health could serve as a critical touchpoint for linking patients to supportive community-based services.

A final theme was that Confluence Health has a robust infrastructure with unparalleled administrative and development resources. In-house services, including a finance department and charitable foundation, expertise with land acquisition and large-scale project management, and access to technology together create opportunities to more efficiently move the needle. Some feedback

highlighted the perception that Confluence feels like it is looked at as a "cash cow." Respondents emphasized that they didn't want Confluence to "build things" and "take over." Finally, some concerns were expressed about Confluence's history of low or inconsistent engagement in community-based initiatives, which has led to frustration and distrust among community-based service providers.

Engagement in Future Work

All respondents would like to be included in future discussions. In addition, they provided a description of resources or expertise they could bring to the table. Community partners stressed the importance of their services as a vital part of any solution, echoing the idea that this is a complex problem requiring collaboration. Notably, some responses from Confluence staff expressed the limitations of the organization to provide support to issues surrounding homelessness. One respondent cited the limited capacity of case management staff to provide services outside of the hospital setting, but offered other solutions, including training and greater coordination with external groups. Another respondent believed it was not the role or responsibility of Confluence Health to contribute capital or operating support to affordable housing and low-barrier shelters but believed there was an opportunity to play a supportive role in improving the health and wellbeing of patients experiencing homelessness.

Discussion: Community Feedback

The symposium drew community leaders from a diverse set of stakeholder agencies, indicating a high level of interest in this work. This fact was reinforced by the feedback collected in the follow-up surveys and interviews. Participants were largely enthusiastic and supportive of Confluence Health's engagement in issues surrounding homelessness and affordable housing and are keen on learning more about how Confluence Health might support future efforts on this topic. However, feedback also suggests the need to strike a fine balance in the roles and responsibilities of Confluence Health within this work.

Community partners are not looking to Confluence Health to take on a leadership role or to duplicate existing services within the community; rather, they are hopeful for a partnership where Confluence provides targeted medical and behavioral health services to people experiencing homelessness. Partners expressed the need to co-locate or provide mobile healthcare that complements existing medical services provided by the Hope Care Clinic, Chelan-Douglas Health District, and other community-based services. Partners also leave room for financial relationships, citing opportunities to provide contractual resources, such as medical respite space or case management. Other needs included investments in future housing or shelter projects and help with start-up and administrative costs associated with a community information exchange system.

Survey respondents from Confluence Health largely favor the co-location of medical, behavioral health, and case management services within community-based settings, though as one person pointed out, staff capacity is often limited to providing services within the hospital or clinical settings. Another high-priority item is access to medical respite that serves as transitional housing for high-need and at-risk patients. One respondent reported that Confluence's case management department spends around $100,000 per year to assist unstably housed individuals with post-acute housing. Perhaps a stronger partnership with housing organizations or investments in new housing and shelter initiatives that

prioritize vulnerable at-risk patients would impact the ongoing costs associated with this patient population. More research would need to be done.

Those that engaged in the follow-up activities were largely supportive of some level of commitment to housing and greater collaboration between healthcare and community partners. However, there were concerns raised about the degree to which Confluence Health will be engaged in activities related to affordable housing and homelessness, which are important to address. One voice was persistent in their concern about financial investments in affordable housing and low-barrier shelter projects, based on their belief that community and social services are not within the scope of Confluence Health's mission. Another concern raised was regarding the system's finances, which are strained by the ongoing COVID-19 pandemic, the rising cost of providing healthcare to rural communities, and a high proportion of Medicaid and Medicare patients. In this way, the respondent challenged Confluence Health to weigh the possible benefit to this relatively small population against possible financial overreach of an under-resourced healthcare system that could have implications on the wider patient population. (Resources to mitigate these concerns will be discussed in the Recommendations section below.)

Other feedback expressed concern over a widely-held myth that providing additional resources for people experiencing homelessness will lead to an increase in those who would access the services from other communities. This idea is simply not supported by local data. In fact, data from the City of Wenatchee indicates that 77% of people experiencing homelessness who are receiving services and support locally are residents of Wenatchee or East Wenatchee. Another 15% are from smaller communities in the region, including Leavenworth, Chelan, Entiat, and Cashmere. An additional 5% did not provide specific information. These results are also supported by Confluence's own data that demonstrates that most of the high-cost, high-utilization patients who are experiencing homelessness have a long history of receiving healthcare in this region. Homelessness is an endemic problem to communities throughout the United States, including those found in North Central Washington. The experience of homelessness is caused and perpetuated by social and economic factors, most notably, a lack of affordable housing, as well as unemployment, generational poverty, health-related conditions, addictive behaviors, and much more. Homelessness is *not* caused or increased by the supportive services communities provide to their residents.

The symposium brought together a group of local leaders, healthcare providers, and social service providers to discuss the ways that homelessness, healthcare, and the community intersect with one another. The initiative was well received by both healthcare providers and community stakeholders; there continues to be enthusiasm for the work and curiosity about the next steps. Feedback from participants has stressed the importance of greater collaboration between groups to more efficiently utilize services and minimize duplication of efforts, and there appears to be general agreement between community stakeholders and those at Confluence Health in the methods that would provide the greatest immediate benefit. These include **co-located medical services and access to medical respite facilities.** The next step for Confluence Health leadership is to find a right-sized approach that carefully considers the financial risk, but strives to achieve a meaningful return on investment, both in terms of the value of care provided to patients, but also cost savings to the healthcare system.

RECOMMENDATIONS

The following recommendations have been included based on feedback from stakeholders. Each section describes a general idea or opportunity for Confluence Health that has the potential to lead to benefits for patients, the organization, and the broader community. These recommendations provide a platform for decision-making and collaboration but are not inclusive of all avenues of investment. Examples and supporting documentation, like videos, have been hyperlinked in blue for further information.

Recommendation 1: Improve access to healthcare services by co-locating medical services at shelters, supportive housing sites, and other strategic locations

People experiencing homelessness face greater barriers to accessing healthcare as a result of their economic circumstances, medical conditions, and limited mobility within the community. Providing healthcare services in strategic locations would reduce the need for transportation, scheduling, and complicated logistics that can prevent people in need from accessing care. On-site healthcare would also reduce the painful stigma the population encounters when visiting traditional healthcare facilities.

Currently, shelters and supportive services are dispersed throughout the region, and centrally locating these services in the community would be difficult. However, the City of Wenatchee is spearheading efforts to create a low-barrier sleep center model like the initiative that launched in Moses Lake in December 2020. A key component of the low-barrier sleep center framework is enhanced access to critical services for people experiencing homelessness. Co-locating medical services at the sleep center, or any future low-barrier shelter site, would significantly reduce obstacles to healthcare access, reform healthcare utilization patterns, reduce high costs, and improve health outcomes. Alternatively, in the absence of a low-barrier shelter, a mobile medical clinic could be stationed at locations including homeless encampments, shelters, and temporary housing facilities run by housing partners. Medical mobile units have been successfully implemented throughout the nation, including in King County, Washington.

There is a variety of private grant funding available for programs aimed at delivering medical services to people experiencing homelessness and other vulnerable populations. An essential first step would be for Confluence Health to work with key partners to develop an appropriately-sized model that fits the needs of the community and to identify what resources partners can contribute.

Recommendation 2: Offset costs of community-owned solutions by strategically investing in projects that promote development of supportive, affordable housing for people experiencing homelessness

There is widespread agreement that affordable housing is a regional crisis. In 2019, Confluence Health's Community Health Needs Assessment (CHNA) ranked access to affordable housing as one of the top six health-related needs in the community. In addition, groups like Our Valley, Our Future have developed workgroups to help reduce the significant dearth of suitable housing for middle- to low-income families. Despite local efforts, development of affordable housing is often stymied by the market forces that drive up the cost of land and development. Any newly-developed affordable housing for people experiencing homelessness in the community has been largely subsidized by government grants and philanthropy. This trend is likely to continue as both the value of property and construction costs continue to increase and the inventory of affordable housing dwindles.

Healthcare systems can help support affordable housing projects with resources that reduce overall costs of development. Community benefit funds–funding federal tax laws that require hospitals to reinvest in the community–can be used to support local efforts. While this funding cannot be used to provide a direct benefit to the hospital (e.g., staff housing), it can be leveraged to increase access to housing within the community and improve the health and wellbeing of at-risk populations. In 2018, Catholic Health Association of the United States published Housing and Community Benefit: What Really Counts?. This document provides guidance on the types of investments a healthcare system can make under the purview of community benefit. Examples could include provision of community-based clinical services for vulnerable populations or short-term rental assistance to low-income and homeless patients. Federal grant funding is tightly controlled and unavailable for innovative work that might fit the needs of the community better than the federally-prescribed approach. Therefore, financial investments from private partners and philanthropic sources will be an essential part of reducing homelessness and improving the overall health of this population in a way that makes the most sense for the local community.

Land makes up a significant portion of the cost of developing affordable housing. Because of this, hospital-owned land can be a critical contribution to the expansion of affordable and supportive housing opportunities, especially in tight markets. Real estate investments can take many forms depending on the assets available and needs of the community. Locally, a complex, but mutually beneficial land swap between Chelan Valley Housing Trust and local non-profits resulted in the housing trust receiving a larger piece of property that enabled them to increase the number of affordable housing units built for the community. In Wenatchee, the groups Our Valley, Our Future and Serve Wenatchee, as well as other community partners, are assessing the feasibility of a Wenatchee Valley housing trust. Donated land could provide a huge launchpad for an initiative like this.

Other healthcare systems have leased land and buildings to partner agencies for development of affordable housing. For example, the State of New York collaborated with public and private hospitals to develop affordable and supportive housing on four hospital-owned sites in Brooklyn. By working together to develop a request for proposals, the State and its partners incentivized developers and

property managers by including an opportunity to request state grants, tax credits, and loan funds for the development projects.

Smaller-scale property investments have also been successful to help improve access to housing. Nationwide Children's Hospital in Columbus, Ohio used an initial $6.6 million investment to purchase vacant and blighted homes in the community. The properties were renovated and sold at a profit, and the funding generated was used to build new affordable housing units. Serve Wenatchee has considered a similar program. The Confluence Health Foundation also has experience with renovating and selling donated real estate to maximize the charitable impact of the gift. There could be an opportunity to partner with other economic and housing organizations as well.

There are community-based affordable housing efforts that could use Confluence Health's support. The availability of alternative funding sources or tax breaks would be dependent on the details of the work. However, development of affordable housing continues to be a high priority for local elected officials and their constituents. No doubt, there would be wide support for any activities that would increase the stock of safe, affordable housing in the Wenatchee Valley.

Recommendation 3: Enhance screening and referral processes internally to coordinate with external partners more effectively

One theme among survey respondents is the desire for Confluence Health to play a supportive role in the efforts to improve health outcomes for people experiencing homelessness. Community leaders see Confluence Health as a critical touchpoint for this population and a key partner in connecting patients with community services. Providers could maximize the number of referrals to coordinated entry and community care coordinators if they are able to identify a patient's non-medical needs during the healthcare encounter. For example, adding a screener question to general intake forms or screening those with certain risk factors could identify needs that can be addressed by community social service partners. Although there are case managers and social workers embedded in the hospitals and clinics that already link patients to resources within the community, they may not become engaged as a resource if patients do not disclose their needs to a care provider. Improved screening would catalyze important information sharing between patients and providers.

Screening tools would need to be combined with referrals that connect patients with the community-based resources they need. Currently, Washington 211 provides the most comprehensive community resource database. Local service providers are hoping to take a resource like Washington 211 a step further by developing a cohesive Community Information Exchange (CIE). A CIE would not only serve as a directory of local resources, but it would provide cross-sector care coordination by linking individuals with relevant services in the community and then tracking connections and progress, much like an electronic medical record but for community-based services rather than clinical care. Throughout the country, CIEs are enabling healthcare providers and community partners, including social service, criminal justice, and health providers, to build a more complete picture of health needs and to drive more efficient use of resources. CIEs capture referrals and utilization of community services, eligibility,

unmet needs, and ongoing concerns. The idea is to ensure all community supports are working together to manage the needs of their clients rather than duplicating efforts; monitoring progress on action plans and referrals rather than prescribing conflicting approaches; and leveraging proven programs and services.

Locally, there continues to be interest in and work toward the development of a CIE. Action Health Partners and others are assessing feasibility of implementation and considering products and models that have worked for other communities. A local CIE would likely require capital investments from partners or grants to acquire the software product, as well as ongoing funds for administration of the program. The return on investment would come in the form of improved community health outcomes, especially for vulnerable populations that have difficulty accessing resources. Other communities, like San Diego, California, have demonstrated that the implementation of a CIE led to improvements in healthcare utilization among high-cost and high-need patients and a decrease in the number of people experiencing homelessness in the community. In addition to serving the needs of patients who are experiencing homelessness, a large-scale implementation of a CIE would provide benefits to underserved communities throughout the region and shows promise of being a powerful tool in improving access to critical resources for those in need.

Recommendation 4: Provide greater representation in existing community initiatives and improved feedback loop with decision-makers

There is growing recognition that the factors influencing the wellbeing of patients and health of communities largely occur outside of the clinical setting. As the importance of social determinants of health gain traction in the public eye, healthcare systems and hospital foundations are launching efforts to address health-related needs within the community and making strategic investments in community-based services that affect health, like affordable housing, nutrition, health equity initiatives, and so on. Inevitably, as the traditional framework of healthcare becomes wider, healthcare systems must determine what work aligns with their mission and corporate goals, while balancing public perceptions and financial capacity. Supporting the health of communities upstream from the hospitals and clinics is best for patients, communities, and healthcare systems.

Confluence Health's stated mission is "…dedicated to improving…patients' health by providing safe, high-quality care in a compassionate and cost-effective manner." As Confluence Health strives to meet the needs of the community in an increasingly-challenging economic environment, there is an even greater incentive to support local work that will ultimately manifest in improved community and individual health outcomes. In the Wenatchee Valley, there are ongoing initiatives that address affordable housing, transportation, economic development, recreational access, education, health, and more. In addition, there are networking groups that seek to build community and share information among stakeholders. Confluence has much to gain from supporting initiatives led by other organizations; likewise, community efforts could benefit from partnering with Confluence Health, which is uniquely poised with significant social and political capital, as well as resources and expertise

that can complement or reinforce community efforts. Despite the opportunities and benefits, community feedback has noted a lack of consistent and meaningful participation in these types of initiatives and a perception that Confluence is not invested in external initiatives or unwilling to partner.

Confluence Health has an opportunity to become a stronger community partner. One possible method is a "represent and report" model of community engagement. For example, Confluence Health employees are selected to serve as representatives on a full spectrum of community committees, boards, and workgroups that match individual expertise and interests. Representatives fulfill their duties as stakeholders and regularly report on initiative progress to members of leadership and other representatives. This method of information sharing provides leaders with a broader view of the local environment and a greater understanding of opportunities and challenges facing the community. This model helps ensure representatives follow through on commitments to community partners (e.g., accountability), are present for important discussions to advocate for patients, and communicate important information to leaders. Greater collaboration can only improve the efficiency and equity of health resources within North Central Washington.

Recommendation 5: Contract with housing agencies and skilled nursing facilities to create space for patients in need of temporary medical respite housing

One consistent challenge facing Confluence Health has been the lack of resources available to support the safe transitions of care for patients experiencing homelessness. Unlike people with stable housing, patients experiencing homelessness often don't have a place to recuperate when they are sick or injured. In some cases, patients remain in the hospital until they are in better condition; however, this method is expensive for insurance companies and Confluence Health, and it takes up valuable bed space that could be used for other patients who need it. Alternatively, if a patient experiencing homelessness is discharged too soon, it can be dangerous, and the likelihood that they are readmitted to the hospital in distress increases.

Other communities have respite programs that serve people experiencing homelessness. In Yakima, for example, Yakima Neighborhood Health runs a medical respite program that reduces healthcare disparities by providing a safe, healthy environment for individuals to recover from their illness or injury. Unfortunately, these types of services are not currently available in our community. Development of a local medical respite program for patients experiencing homelessness is seen by Confluence Health employees and community partners as an effective and valuable solution. However, this is a long-term goal, rather than a solution that would meet immediate needs.

In the meantime, contracting with housing partners, hotels, or skilled nursing facilities for medical respite space for people experiencing homelessness would provide eligible patients at Confluence Health with a safe place to recover as an alternative to being released back to the streets or remaining in the hospital longer than necessary. This type of investment would reduce disparities that lead to healthcare overutilization and poorer health outcomes among this population. It would also reduce the

likelihood of readmissions and promote efficient use of valuable bed space during the COVID-19 pandemic.

This type of model has been used successfully in our region.

Case study: A patient in her late thirties was admitted to Central Washington Hospital because of shortness of breath and pain. Previously, this patient had been diagnosed with congestive heart failure, and her condition was rapidly declining due to endocarditis, a stroke, pneumonia, and a urinary tract infection. Despite improving during her 43-day hospital stay, her doctors felt the condition was terminal and estimated she had six months to live.

In addition to her significant medical needs, this patient was experiencing homelessness with no family or friends who could care for her. Central Washington Hospital administrators reviewed her options and decided the best approach was to work with a local housing agency to find her a safe, comfortable place that would serve as a temporary medical respite so that she could begin hospice, stabilize, and receive supervised visits from her children. Confluence Health found an available handicapped-accessible room at a local transitional housing site and worked with other community-based organizations to maximize the resources she could access to improve her quality of life. Community partners worked diligently to find her a more permanent housing solution that was appropriate for her condition.

The investment in temporary medical respite for this patient enabled her to improve her overall health and quality of life despite the overwhelming circumstances. In addition, this solution was cost effective. Confluence Health could develop this model into something more formal to reduce the logistical barriers to implementation. Contracts with housing partners, hotels, or skilled nursing facilities could provide rooms or services for people as needed. The Confluence Health Foundation was recently awarded a small grant to help pay for respite and recovery services for people experiencing homelessness, and the likelihood is high for additional funding partnerships to help pay for these types of services. While this should not be viewed as a long-term solution, it could provide compelling evidence that small investments made in housing do positively impact health of high-need, high-cost patients.

CONCLUSION

Healthcare systems can no longer ignore the profound role social determinants of health play in shaping the health of patients and communities. Progressive healthcare systems are seeking partnerships with community groups to create and enhance resources that promote better health outcomes upstream of medical encounters. Undoubtably, the goal of any investment is to utilize the fewest resources but yield the highest impact, which is why many healthcare systems are implementing programs that target housing for homeless patients. Partnerships that focus on Housing for Health initiatives have demonstrated impressive returns on investment for all parties involved, including better health outcomes for patients, lower healthcare utilization rates, and healthier communities. Even smaller communities like the Wenatchee Valley can reap the benefits of a "housing first" approach or other solutions that focus on addressing the unmet needs of this high-priority population.

The contents of this report are meant to provide important insight into interactions between patients experiencing homelessness and Confluence Health to help leaders make meaningful, data-supported decisions. What is clear from the data is that for some patients experiencing homelessness, medical services are used as a stopgap in the absence of solutions that will truly meet their needs. Using healthcare as a substitute for social and economic resources is both ineffective and expensive, and further separates patients from the health improvement opportunities and wellbeing all people deserve. While some may view it as unreasonable for healthcare systems to bear the responsibility of non-medical needs of patients, it is becoming clearer that the status quo is the true enemy of the nation's healthcare system, especially for underserved populations. Those at the top of the healthcare hierarchy are the ones that have the power to change the model, and when they do, we all benefit.