Implementing a Complex Care Shelter: Opportunities and Lessons Learned

April 17, 2023, 2:00 – 3:00 p.m. EST

Yolanda Stevens, National Alliance to End Homelessness

David Rittenberg, Catholic Social Services

Dakota Orm, Anchorage Coalition to End Homelessness

National Alliance to End Homelessness

Catholic Social Services

ANCHORAGE COALITION TO END HOMELESSNESS

Housekeeping

- All attendees are in listen-only mode.
- Please introduce yourself and where you are from in the chat.
- For technical issues, please use the chat.
- Please use the Q&A box for all questions. We'll answer questions at the end.
- Slides will be posted on our website.

Our Presenters

Yolanda Stevens, NAEH, Program and Policy Analyst, Older Adults

David Rittenberg, Senior Director of Adult Homeless Services, Catholic Social Services

Dakota Orm, Healthcare Integration Director, Anchorage Coalition to End Homelessness

Agenda

The Connection between Healthcare and Homelessness

Overview of the Pilot

Highlights of the Landscape

Impact of COVID-19

Getting Community Buy-In

Review of Complex Care

Implementing a Complex Care Emergency Shelter

Outcomes

Q & A

What is Healthcare and Homelessness?

Homelessness is a public health crisis, and people experiencing homelessness often have serious and complex health challenges

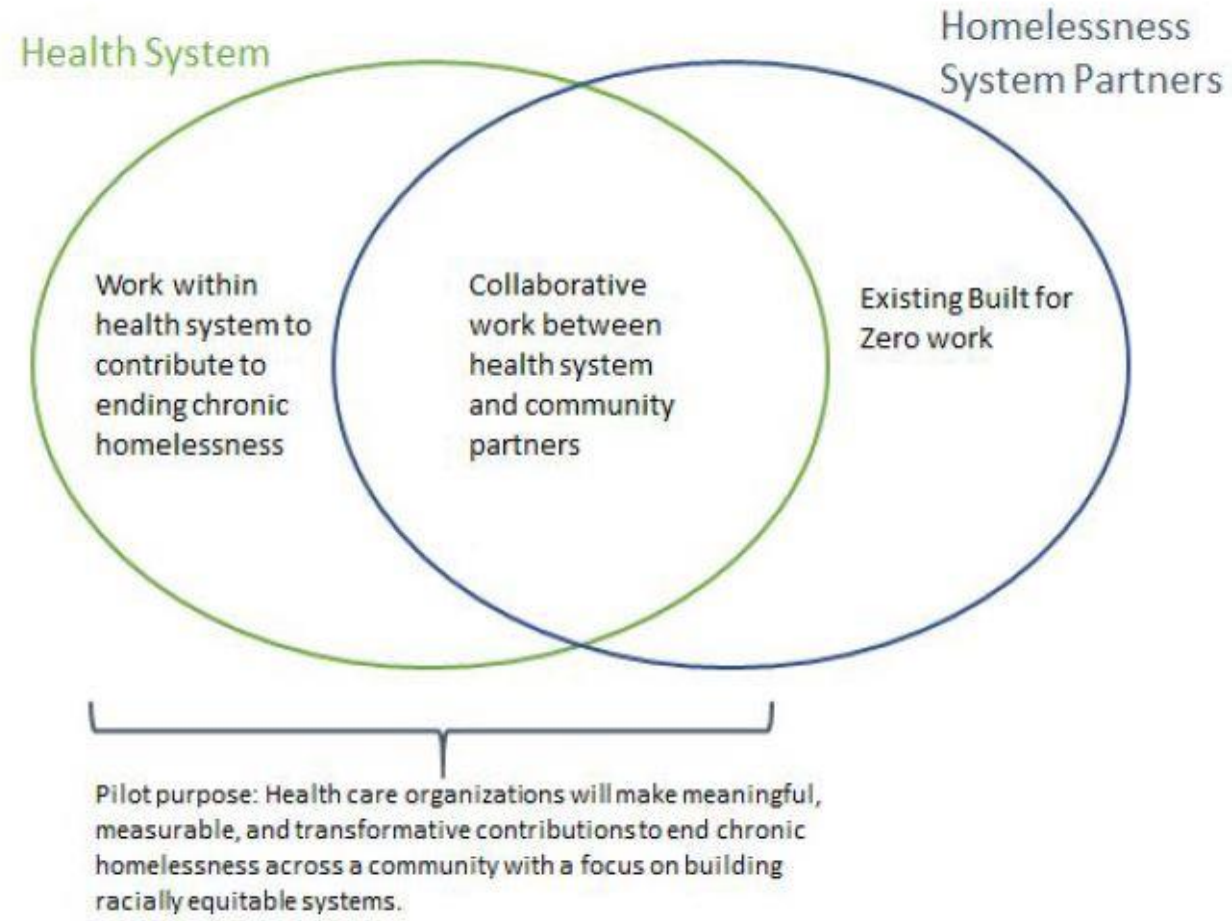
Ensuring access to quality health care must be part of our community's response to homelessness, and is an essential component of our community's five-year plan to address homelessness

Housing is health care

Pilot Initiative

Community Solutions & the Institute for Healthcare Improvement answer the question:

What are the most meaningful, measurable, and transformative contributions healthcare can make toward ending chronic homelessness in a community?



Anchorage Healthcare & Homelessness: Then and Now

Pre-Pilot

- Medical Respite pilot made permanent
- Caring Clinic within our most-used emergency shelter
- Trust built with healthcare partners throughout the community

Pilot in Action

- Reduce chronic homelessness while building racially equitable systems
- New partnerships
- Measuring for success
- Transferrable learning
- Dynamic project portfolio

COVID-19 Impact

- Expanded emergency shelter beds
- Worked with landlords and tenants to access funds
- Created financial assistance programs
- Used non-congregate & smaller congregate shelters for medically fragile
- Used COVID-19 testing, vaccination & other protocols to slow the spread
- Brother Francis Shelter served a specific population of people
  - High vaccination rates

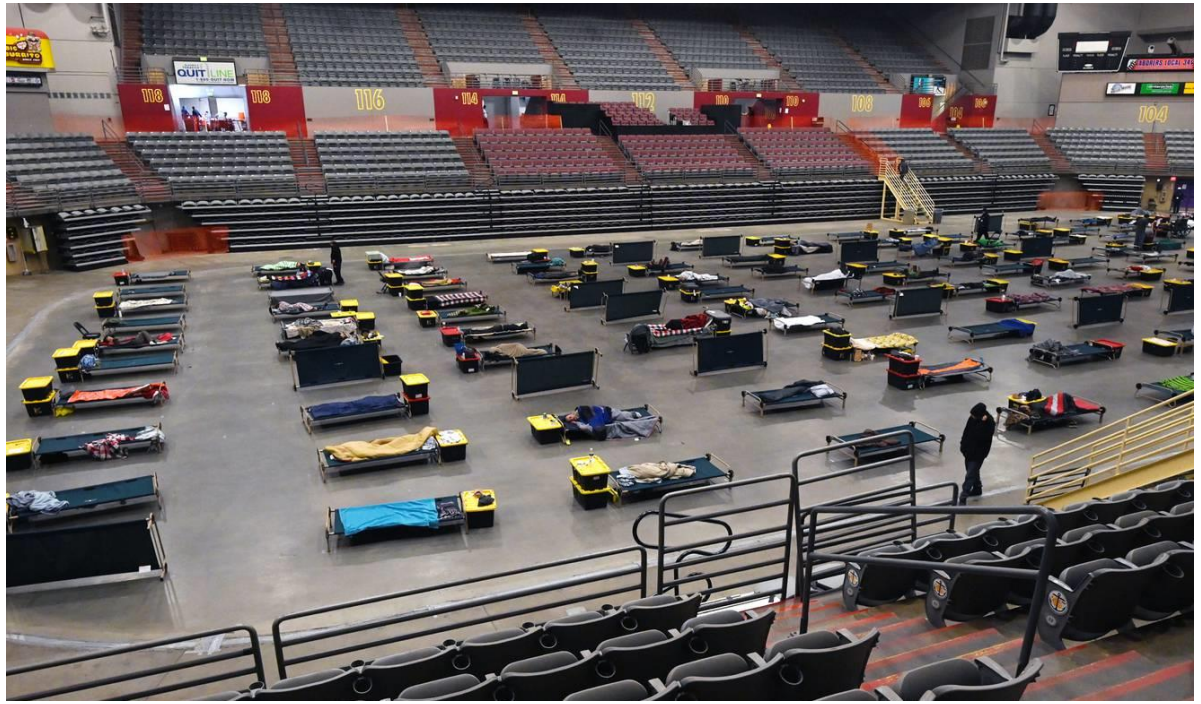


Figure 1: Sullivan Arena Mass Care Shelter. Photo by Bill Roth, Anchorage Daily News

Brother Francis Shelter

- Originally opened in 1983
- Served as primary shelter for Anchorage until pandemic
- 240 Beds, night by night shelter
- Basic needs services, case management
- Healthcare and Homelessness Partnership

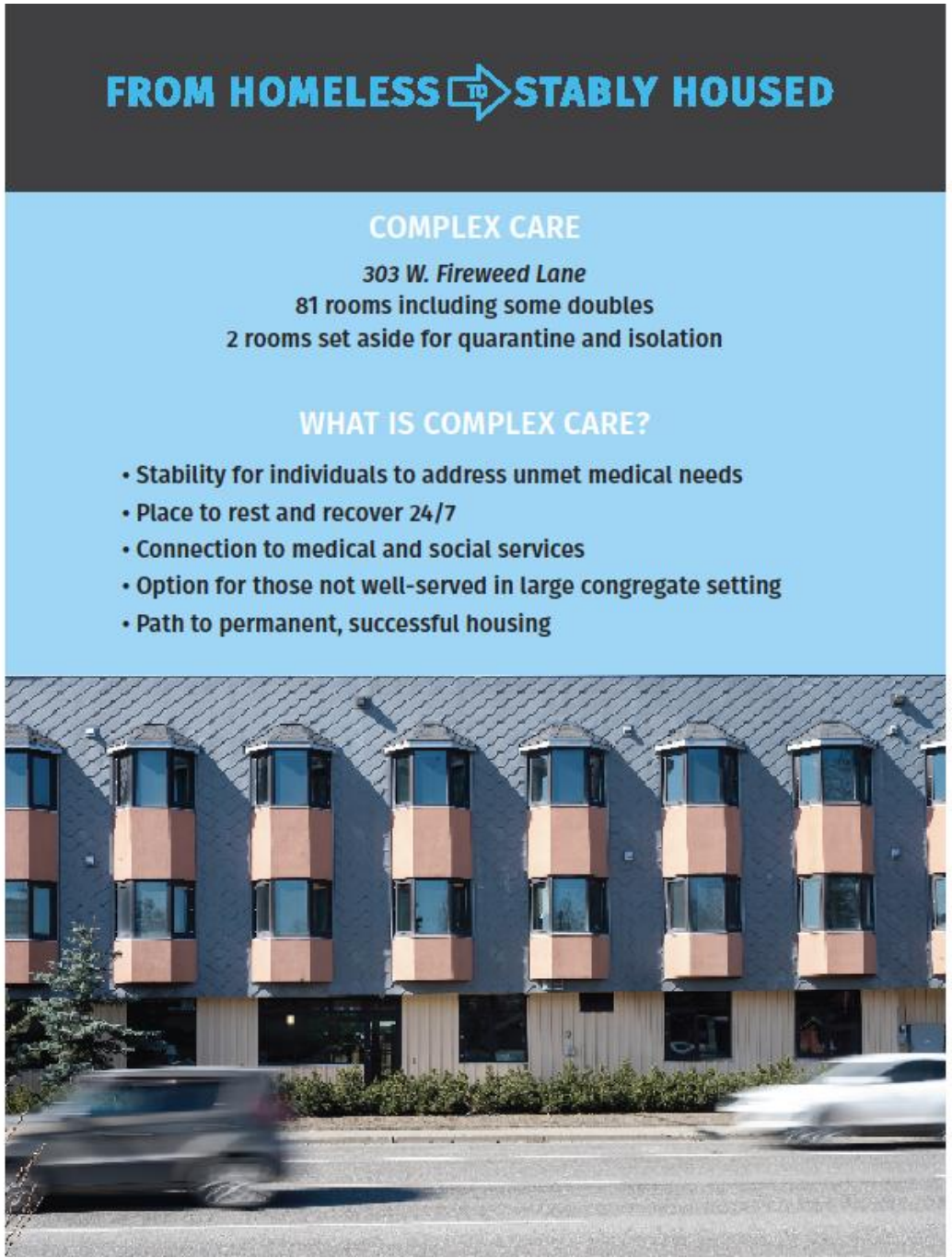
Pandemic Response:

- Reduced capacity
- Special population
- 24-hour services
- Referral-based access

Community Building

Cross-sector Collaboration to End Homelessness in Anchorage

- Recognizing the gaps in services and underserved populations
- Working with all parts of the community to make homelessness rare, brief, and one-time
- Partnerships with local businesses, landlords, government, philanthropy, and service providers
- Special focus on quality data



Complex Care Shelter

- Start of move towards smaller, specialized shelters
- Opened in Summer ‘22 with 83 beds
- Initially filled with BFS pandemic cohort, BFS back to LBS for 120
- Non-Congregate shelter – single and double rooms
- Similar basic needs services
- Emergency Shelter, not ALF

Operations & Case Management

- Referral based access from healthcare and shelter/outreach programs
- Prioritization list based on acuity
- 24-Hour staff
- Showers, laundry, meals, transportation
- Social and emotional well-being activities
- Specialized case management to connect people with stability supports
- Emphasis on connection with primary care, healthcare payer, and support services
- Transportation Services
- Coordinated Entry and appropriate housing

Data

As of April 14, 2023, 10.5 months of Operations

- 201 unduplicated individuals served
- >50% of referrals from shelter partners
- Finding most accepted referrals have 4 or more prioritization points
- 70% of referrals have been accepted/added to prioritization list

- Out of 140 Exits (132 People):
  - 27 moved to temporary or permanent housing situation
  - 17 to non-psychiatric hospital
  - 4 to long term care/nursing facility
  - 1 to detox/treatment
  - Average LOS is 107 days

Q&A

Thank you!

Contact

David Rittenberg drittenberg@cssalaska.org

Dakota Orm dorm@aceh.org

National Alliance to End Homelessness

Follow Us on Social Media

@naehomelessness

facebook.com/naehomelessness

Thank You!