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Original Research

Providing Health Care to People Experiencing Homelessness: Strategies and Challenges for Cross-Sector Initiatives

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Policy Points:

- Initiatives that effectively bridge health care and housing sectors in serving people experiencing homelessness (PEH) shared four dimensions: success in matching client preferences with readily achievable options, maintaining intensive interaction, initiating outreach where clients are, and co-locating health and housing services.
- Analyses of accounts of those with firsthand experience implementing cross-sector programs yielded valuable guidance on strategies for incorporating these dimensions.
- Changes in policies associated with the new federal administration may pose new challenges but are unlikely to alter the relevance of accumulated experience in making use of available resources to effectively engage PEH in health care and housing services.

Context: Cross-sector collaborations among health care and housing services organizations promise more efficient use of resources and delivery of more coherent and effective services to people experiencing homelessness (PEH). This study analyzes challenges and strategies reported by those currently implementing cross-sector programs.

Methods: Data were collected through in-depth interviews with staff of health care and housing services at eight programs systematically selected to typify the scope and nature of cross-sector collaborations in New Jersey. Respondents included administrators ($n = 14$) and frontline providers ($n = 10$). Questions focused on motivations to collaborate, approaches to sustaining partnerships and managing operations, mechanisms for financing services across sectors, and strategies for effectively engaging PEH in health care services. Interviews were audio-recorded and inductively analyzed using standard qualitative techniques.

Findings: Collaborations were motivated by the impact of housing on health, the ineffectiveness and costs of attempting to address unmet health care needs in the absence of providing shelter, and the promise of harnessing resources from both sectors. Accounts of successful approaches for engaging PEH in health care services had four fundamentals in common: establishing rapport through matching client preferences with readily achievable options,

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maintaining intensive interaction, initiating outreach where clients are, and co-locating health and housing services. Favored policies for promoting effective implementation included financing case management services through contract or capitation arrangements, resolving ambiguities in licensing regulations and reimbursement practices that impede co-location of services, securing direct financing for delivery of nursing services at shelters, and providing greater support for frontline providers.

Conclusions: The programs' accumulated experiences in successfully implementing cross-sector programs yielded valuable insights for other organizations seeking to mount similar initiatives and for creating a more hospitable policy environment for programs to succeed. Policies of the new federal administration may raise new challenges but are unlikely to diminish the importance of lessons for achieving effective cross-sector collaboration.

Keywords: intersectoral collaboration, social determinants of health, housing instability, delivery of health care, health disparities, case management, poverty, qualitative research.

The linkage of housing instability with poor health and the toll on people experiencing homelessness (PEH) has prompted collaborative efforts among health care and housing services organizations to better serve the needs of this population. The association between homelessness and health is well established. For example, the National Academies of Science, Engineering, and Medicine reported that PEH are at greater risk for infectious diseases, serious traumatic injuries, drug overdoses, violence, and death.[1] Cross-sector interventions bridging these domains offer the potential for more efficient use of resources and expertise among providers and a promise of more coherent and effective services to their clients.

This study analyzes strategies and challenges encountered by health and housing organizations that are actively collaborating in programs to deliver health care services to PEH. The study addresses three research questions: What motivated health care organizations to participate in these cross-sector collaborations with housing agencies? What strategies were effective in engaging PEH in health care services? What obstacles did program developers encounter in implementing these strategies? With the intent of generating insights of optimal value to other organizations, in-depth interviews were conducted between October 2023 and July 2024 with administrators and frontline providers from each program, focusing on issues they are currently confronting in planning and implementing these programs.

Prior relevant research consists largely of assessments of the relationship between homelessness and health needs,[2–4] studies of the health care experiences of PEH and the implications for improving services,[5–10] and commentaries on the potential contribution of cross-sector efforts to improving health outcomes.[11–15] Empirical research has not focused on the challenges and opportunities confronting housing and health care organizations as they actively collaborate on providing health care to PEH. The research reported here is designed to address this gap, learning from those

who have firsthand experience implementing such initiatives. The aim is to identify effective strategies for dealing with issues that are distinctive to cross-sector efforts arising from differences in culture, missions, financing arrangements, and other factors that typically distinguish health care and housing organizations.

All programs identified for study can be characterized as serving health-related social needs—that is, needs arising from the interaction between health and housing—as distinct from initiatives aimed at addressing upstream social determinants of health (e.g., root causes such as inequalities in income, wealth, and education). Although the latter focus on broader social forces is critical to long-term and lasting change,[16] addressing these forces was not within the capacity of the programs available for study. Although interviews were completed prior to the chaotic policy shifts of the new Trump administration, the cross-sector dynamics described here are likely to remain important as the housing and health care sectors adjust to their changing environments.

Methods

A qualitative, inductive research strategy serves the goal of the study: to generate a comprehensive, firsthand account of challenges confronted by those currently implementing cross-sector programs and strategies they have pursued to address them. Data were collected through extended, open-ended interviews with provider and administrative staff of programs systematically selected to typify the scope of cross-sector collaborations in New Jersey.

Selection of Programs

A broad approach was employed to identify appropriate programs for study. New Jersey is a suitable setting for conducting this project because it has large numbers of PEH diverse in race, ethnicity, and geography; acute shortages of low-income housing; and state initiatives, including plans for Medicaid coverage of housing support services under the 2023 New Jersey Section 1115 Medicaid demonstration,[17] a state-sponsored housing first initiative,[18] and the New Jersey Housing and Mortgage Finance Agency's Hospital Partnership Subsidy Program.[19]

Two primary criteria governed selection of programs: First, they are designed to deliver health care, housing, and other social services with significant involvement of both health and housing organizations in each program, and, second, they are currently engaged in the implementation or late planning stage of the initiative (e.g., resources have been committed by each partner). Beyond sharing these criteria, studied programs varied in intensity of collaboration, program structure, and scale. A multiphased strategy was used to identify potential programs. We surveyed directors of 13 Continuums of Care in New Jersey (regional bodies responsible for coordinating

Table 1. Types of Programs Studied

Target Population and Program Scope; *Sponsor*	Nature of Collaboration for Each Studied Program
Homeless to PSH in buildings dedicated to the program; *NJ HMFA*[19]	• Intensive collaboration among the health and housing partners (Paterson) • Segmented contributions from each partner (Newark)
Homeless to PSH in the broader housing market (with individual landlords); *NJ DCA Voucher Program for Supportive Housing*[20,21]	• Health care partner plays dominant role (Jersey City) • Housing partner plays dominant role (Middlesex County)
Homeless to qualification and approval for voucher; *PATH*[22]	• Health care partner plays dominant role (Hudson County) • Housing partner plays dominant role (Newark)
Health care onsite at temporary housing; *no formal sponsor*	• Co-location of health and housing services at warming center (Hudson County) • Planned onsite delivery of health care services at homeless shelter (Trenton)

DCA, Department of Community Affairs; HMFA, Housing and Mortgage Finance Agency; NJ, New Jersey; PATH, Projects for Assistance in Transition from Homelessness; PSH, permanent supportive housing.

delivery and funding of housing and services for PEH), asking them to identify relevant collaborations in their regions or elsewhere in the state and provide information about the scope of services offered, the targeted population, and the participating partner organizations. We reached out to health care associations, hospital systems, and state agencies, asking them to nominate initiatives. Similarly, we reviewed websites and reports of national initiatives to identify affiliated New Jersey programs.

Among those cross-sector initiatives that qualified for the study, four program types were distinguished based on the housing status and intended housing end points of the population targeted for health care services: 1) those focused on people who were unstably housed and provided them with permanent supportive housing (PSH) in buildings dedicated to the program, 2) those that provided people who were unstably housed with PSH relying on vouchers to link clients with individual landlords in the broader housing market, 3) those that facilitated approval of a housing voucher for clients who were unhoused, and 4) those that served clients who were temporarily sheltered. Two programs of each type were studied. Table 1 provides details on the scope, sponsorship, and nature of collaboration for each of the studied programs. The range of populations targeted by these programs and the settings in which services are

delivered typify those of cross-sector initiatives in other states,[14,15,23–26] broadening the relevance of the findings.

Data Collection

Twenty-four interviews, averaging 75 minutes in duration, were conducted with staff of the eight programs; 14 interviews were conducted with staff at collaborating health care organizations and ten with staff at housing agencies. Respondents included administrators ($n = 14$) as well as frontline providers ($n = 10$) in order to elicit the perspectives of those most involved with planning and managing the initiative as well as those with direct responsibility for engaging and serving clients. Respondents were asked at length about their views on motivations for health and housing organizations to collaborate, approaches to sustaining partnerships and managing operation of the initiative, mechanisms for financing services across sectors, and challenges to engaging PEH in health care services and strategies to address them. Examples of specific domains and items in the interview questionnaire are presented in Table 2.

Analysis

All interviews were audio-recorded and fully transcribed. Guided by standard techniques for inductive thematic analysis,[27,28] initial (open[29]) coding identified segments of text expressing respondents' views as they relate to issues in planning and implementing the program as well as engaging PEH and providing them with health care services.[30,31] Recurrent themes among these segments were noted and, along with associated passages from the transcripts, were entered into electronic files. Themes were refined (subdivided or combined as new data were entered) and were examined for how they relate to the overall aim of the study—that is, to illuminate challenges confronted and strategies pursued in mounting cross-sector initiatives. Passages and associated codes were shared with a second analyst, and discrepant interpretations were discussed and resolved. Input from the project's advisory committee of stakeholders was elicited on the meaning and salience of the findings. A report of the findings was shared with the study respondents to confirm the accuracy of the presentation of their views.

Findings

Motivations of Health Care Organizations to Participate in Cross-Sector Collaborations With Housing Agencies

An understanding of the organization's motivation to participate may be helpful to other institutions seeking to garner support for similar initiatives. Likewise, the

Table 2. Examples of Domains and Interview Questions

Domain	Stem	Probes
Partnerships	What organizations are collaborating, and what does each contribute?	• What was the process of putting together the program? Did one organization take the lead? What are the specific contributions of each partner? • Are there other partners that would be helpful? • What challenges were encountered in engaging partners? • What are the prime motivations for organizations to participate? What are some obstacles?
Scope of services	What services are offered?	• Where is each service provided and by whom? How is each financed? What challenges were confronted? • How do you view the relationship between housing and health status? What are the implications for your program? • Are there gaps in what you hoped to provide? Plans to expand?
Engagement of clients	How are clients recruited and by whom?	• What are the criteria for selecting clients? • Describe a typical first encounter with a client. • How are clients' needs established? How are priorities set? • How are clients engaged in services? Challenges to their making progress? Strategies for overcoming them? • Tell a story of a client experience with the program that you believe was particularly effective. • Story of a client who might have benefited more.
Program operation	Who is responsible for ongoing administration of the program?	• Is there a separate administrative structure for the program? • Who participates in decisions about program planning? About financing? Staff recruitment and training?

nature of an organization's prior experience in serving health-related social needs calls attention to existing expertise and other valuable resources available to contribute to cross-sector collaborations.

Serve Their Mission and Meet Their Commitments. Motivation to collaborate in housing initiatives among health care providers is often rooted in the history and culture of their institutions. Several felt a moral obligation to address social needs in their communities.

> Health care is not just what happens in the four walls of your environment. — You have to have some type of moral mission to support your community and to support the individuals who probably suffer the most. (hospital executive)

Also prominent was the belief that effectiveness in their mission to improve health outcomes necessitates efforts to reduce the disease burden of social determinants. Substandard housing directly affects health; for example, presence of lead can contribute to nervous system disorders and impair cognitive development, inadequate heating is associated with high blood pressure and respiratory conditions, presence of mold is linked to asthma, and lack of smoke alarms and carbon monoxide detectors can lead to injury and death.[32] Health consequences were prominently cited by program planners.

> Hospitals [need] to — think about housing as a way to address some of the chronic illnesses that they see within their communities around asthma, diabetes, COPD, and things of that nature. (hospital executive).

These effects are generally exacerbated by conditions confronting people who are homeless and living on the street. For many, health care can provide essential services as well as respite.

> Some of their [basic] needs will be addressed by having a place to sleep, a roof over their head and food to eat. [So] they won't be seeking out the emergency rooms for shelter or shower. (director, housing services organization)

Responding to this nexus of needs, several cross-sector programs target for their services PEH who are frequent users of emergency departments (EDs).

Improve Their Financial Viability. Often mentioned as a side benefit, if not the prime motivator, was the belief that addressing housing needs is in the organization's self-interest.

> If you want to continue to grow your emergency volume as a [channel] to inpatient admissions, you want to make sure you have the [capacity] available to attract individuals who are going — to become an admitted patient. — Individuals who are overly utilizing your emergency room consistently, they're taking up space, they're taking up your nursing ratios, they're taking up potential beds [with]

> individuals who are just going to flip and discharge within two hours or three hours anyway. — To revenue enhance your ED and right size your ED, you want to limit the amount of over utilizers. So I think that's one way to get some financial people on board [to support housing services]. There is a financial upside to this. (hospital executive)

A direct focus on providing shelter, in this view, contributes to more appropriate use of health care and may reduce costs associated with overreliance on EDs and avoidable hospitalizations.

Draw on Their Existing Strengths in Building the Collaboration. Health care and housing partners vary in their history of involvement in addressing health needs of PEH, existing expertise relevant to the current cross-sector initiative, and available financial and other essential resources. Differing arrangements among subsets of studied initiatives illustrate a range of potentially viable paths to successful cross-sector efforts.

Providing Health Care at Permanent Supportive Housing Sites. Two of these initiatives (Table 1, first row) house clients in dedicated buildings and provide supportive services, including health care. They vary substantially in the resources each partner brings to the initiative and the intensity of collaboration in planning and delivering services.

In one instance, the hospital rented space in the housing complex and located an outpatient care unit there that also includes space for other services, which are provided by the housing partner. The contributions of the housing and health care partners are segmented by sector, and planning for their associated services is proceeding in parallel with little collaboration. The hospital identifies potential tenants from one of three ongoing community-based programs, which they operate, serving people recovering from trauma, victims of interpersonal violence, and patients who are frequent users of ED services, respectively. Once identified, case managers guide the candidates through the lengthy process of qualifying for housing and preparing them to become tenants. The case manager's engagement ends with the signing of the lease; from that point, the hospital's role is confined to operating the health care delivery component of the on-site services center. The building developer provides housing support as well as other services addressing health-related social needs.

At another of the permanent supportive housing sites, the principal health care and housing organizations intensively collaborated on key segments of the planning and implementation phases of the project. Their collaboration is characterized by explicit recognition of the strengths of each partner:

> [The health care partner] came up with the social determinants of health metrics and then we implemented it [in planning services]. So that's another thing: understand who's got what expertise like, we didn't question him on that and they're not questioning us on the niceties of drafting leases and property management

> questions, and they'll say very readily that they wanted to work with us because we know housing and they don't. (director, housing services organization)

The on-site services are integrated, and their content is determined jointly by the cross-sector partners, informed by a tenant-centered process.

Collaborating on Outreach to Homeless People. Several health care organizations have a history of relying on dedicated case management services to address community needs. Building on this capacity, some have taken the lead in implementing programs placing health care clients who are homeless in temporary housing and qualifying them for vouchers for more permanent sites.

> I think [collaboration is] simpler or an easier task for us is because we have robust case management services at [our] medical center. — When I say robust, I mean the programs that I run are mental health case management programs. — So we already have the foundation. (program director, hospital)

In other cases, housing organizations take the lead, adding health care to their existing casework activities assisting PEH in qualifying for vouchers and preparing them to move into permanent supportive housing. In one such program, the housing organization partners with nearby hospitals that provide lists of patients who are frequent users of their EDs; those patients are cross-referenced with a registry of PEH, and they become the target population for the cross-sector initiative.

Overall, as evidenced among initiatives studied here, organizations with varied assets and commitments were successful in launching cross-sector programs. These efforts suggest that even partners making limited contributions can play meaningful roles in effective programs addressing health care needs of homeless populations.

Effective Strategies for Engaging PEH in Health Care Services

Previous accounts by homeless clients of their experiences seeking health care services as well as current interviews with staff of cross-sector programs aiming to serve them reveal pervasive obstacles to success inherent in being unstably housed. Without housing, people find themselves devoting substantial energy to basic, everyday subsistence. In doing so, they may be forced to make untenable choices among priorities, often defying the logic of service professionals who may view health care as an essential stepping stone to a productive life. Acting on those priorities, in turn, necessitates valuing some needs over others, pursuing some and foregoing others. Foreshadowing current experiences, PEH frequently report that service providers in the past have been slow to implement plans and that expectations have often been unmet.[33] Additionally, people often experience trauma in shelters and settings delivering other basic services. Exacerbating these challenges, persistence of outreach and continuity of services are difficult to maintain in the absence of a stable address

and consistent sources of communication—updates in opportunities, progress with applications, and changes in conditions are often unknowable in these circumstances, and meeting deadlines becomes elusive.

Acknowledging these barriers and the challenges of surmounting them, respondents were consistent in identifying key dimensions of strategies for effective engagement. Accounts of what it takes, voiced by program administrators as well as frontline providers, had in common four fundamentals: establishing rapport, maintaining intensive and persistent interaction, initiating outreach where clients are, and building on existing relationships to generate trust. Although these factors have relevance to effective service delivery in general, they have distinctive application and consequences in cross-sector initiatives providing health care to PEH.

Establishing Rapport. Health care services may not be an immediate priority among unstably housed clients when they make initial contact with cross-sector programs, even among those who have unmet medical needs that significantly undermine their quality of life. Citing Abraham Maslow's framework positing a hierarchy of needs,[34] case managers from several programs observed that housing generally supersedes health care in their clients' priorities.

> As a social worker [who's] worked in different areas within the hospital system, especially when it comes to mental health, there's not much you can do if someone doesn't have a place to live as they're struggling with their own depression or anxiety or serious mental illness. (program director, hospital)

Housing was cited as providing "peace of mind" and "a stable and organizing force" in respondents' views on why receipt of supportive housing services may have a positive effect on subsequent use of essential health care. Frontline providers typically anticipate this prospect and focus on developing an agenda that is responsive to clients' immediate priorities. A history of misalignment of the goals of clients with available resources is frequently cited as undermining current outreach efforts:

> [My client's] initial reservation (to working with me) was basically the same as everyone else: a system that has continuously failed them, a system that promised them but would never deliver. So every time I engage my patients, I make sure that the goals that we work at are attainable. (case manager, hospital)

Asked how the agenda-setting process works in practice, a director of case management services explained:

> It's all about shared decision-making and coming to an agreement with one another. "I think you need to work on this." "No, but I want to work on that." — So they might not want to work on, say, going to a podiatrist. But they can't walk. But their immediate goal is [getting] a job. We have to break it down for them: — "you know what, before you can get a job and be active on your feet, we need to go to a podiatrist." (program director, hospital)

Similarly, progress in implementing plans requires attention to basic logistical barriers to sustaining relationships commonly associated with homelessness. Depending on circumstances and available resources, clients may be given cellphones, access to the internet at libraries or other public venues, or direct assistance by case managers or other program personnel in making appointments and completing applications.

Taken together, accounts of establishing effective rapport reflect a complex strategy, summarized by one hospital director as "lovingly stalking people":

> It's all about how you engage the person. — It's your tone, it's your body language. You don't want to appear threatening, you don't want to appear that you are connected to law enforcement. It's just all in your approach. (program director, hospital)

Progress may not be linear and relies on a process of reconciling client preferences with availability of viable options, providing guidance while supporting autonomy, and promoting hope while acknowledging the significance of past disappointments.

Maintaining Intensive Engagement. Service plans are often front-loaded with incremental tasks, which are essential to making progress and valuable to building client confidence in pursuing longer-term goals. The importance of early successes is reflected in the intensity of engagement devoted by case managers to assure their achievement.

> If need be, the case manager is there to drive you to your first appointment. — I'm going to pick you up, we're going to go together. (case manager, hospital)

This emphasis on building momentum is echoed by outreach workers across sectors, who acknowledge the overwhelming challenges that PEH often contend with and the strength required to take meaningful action.

> I feel like the more people feel supported, the more they're willing to say go out on a limb. — Just because I introduced a person to a doctor or a doctor's office doesn't mean that they'll stay with that provider. But the chances [increase with] me walking the step with them. — I think it draws the person into going to their providers versus going straight to the hospital beyond emergency needs. (outreach worker, housing services organization)

Lack of early progress or setbacks in meeting goals pose challenges. Necessary adjustments may include reordering the steps to achieving the client's agenda or recalibrating the balance of client initiation and case worker collaboration in accomplishing specific tasks.

> If we come up with goals first, let's say I need a job, I need an apartment and I need money. And then we try to establish ideas and ways to establish those goals, but I see some barriers or some resistance. Then I go and reorganize the goals like, well, maybe you're not ready for work yet, maybe we can do some emotional support to

> get your mind a little bit more mentally stable so you can feel more confident with looking for work. (outreach worker, hospital)

In sum, intensity of engagement, variously expressed by frontline workers as "being there" for the client and "walking with them," is essential to success in reversing a downward trajectory in getting basic needs met and customizing a plan of action that accounts for the unique challenges as well as distinctive strengths of those they seek to help.

Initiating Outreach. Case managers tend to be proactive rather than relying on potential clients to initiate contact in the office. The process varies by the housing status of the targeted population as well as availability of program resources.

> How can you expect someone that is looking for their next meal or has so many other things on their mind — to come across the county to get to this one building? So we go to them. We will meet with them in the shelter, on the corner, in a park, on the bench, under the bridge. We meet with them there because that's where we're going to get the most success. (program director, hospital)

Options for maintaining contact are identified early in the relationship with the intent of minimizing loss-to-follow-up.

> We [seek them] where they told us – During the intake, you ask them, okay, if you're not in the shelters, you're outside. Where do you usually go? (outreach worker, hospital)

Any client interaction that does not include updating contact information is viewed as a lost opportunity for maintaining the relationship.

Generalizing Trust. Although intensive case management was the dominant factor in respondents' accounts of effective engagement of PEH in services, several also called attention to the potential importance of the setting in which services are offered. Co-location of services has long been regarded as a boon to access for all populations. For PEH, co-location is viewed as serving a distinctive function—generating trust in newly offered health services. An administrator of a federally qualified health center (FQHC) described this dynamic:

> Where do people feel safe? And then how do you either make them feel safe at a different location or bring the services to where they feel safe? And I will say after 20 plus years of working in this kind of work, it's a lot easier to bring services to where people feel safe than to train everybody at a different location, how to make people from another location feel safe. (administrator, health center)

Program administrators at temporary housing sites echoed this view. Shelters are associated with traumatic experiences and often are the options of last resort for PEH; yet, according to staff, for some, they may offer a rare source of relative stability in

otherwise chaotic days. A shelter administrator illuminated the setting's potential role in conferring trust on other service providers:

> [PEH] have struggled forever to go and get services from [the health center] even though it's across the street from the shelter. But when we brought those services into the shelter and you had the provider there, they actually had a waiting list to see the provider. — I think some of it is they feel safe in that space. They trust us that we're providing them the right level of care and the right level of treatment and things of that nature. For anybody else it's easier to do anything if you're doing it in your home environment. I think for them they're getting healthcare in their home environment albeit a shelter. (director, housing services organization)

Another administrator at a shelter observed that, by stationing a nurse in a room with an open door down the hall from the dormitory, seeking basic health services becomes routinized for many residents. A decisive element is that residents do not have to enter a separate institution with its own staff and procedures:

> I think the accessibility, making it as — low-barrier as it can be — that's going to always be our biggest thing. — You can't be like, oh, it's here but you have to have an ID and then you have to have this and you have to be on time and you have to like only come between one and two on Monday. (administrator, housing services organization)

A health center administrator contrasted this low-barrier approach with the typical initial encounter at an FQHC:

> So they [PEH] come into our health center and they experience our staff asking for proof of income, or Medicaid eligibility, or immigrant status, and they're just as likely to walk out and what they often hear is no, [they] can't help me. (administrator, health center)

Co-location of health care services at permanent supportive housing promises additional benefits, including a wider spectrum of offerings and greater accessibility.

> It's going to be a lot richer for the service recipients than if it were just unidimensional. If it were just the hospital, for example, there would be medical services and maybe some mental health services and maybe some nutrition services. But because we're (housing agency) involved, there's going to be programming related to financial literacy, which we do – and youth development activities. (director, housing services organization)

For providers, co-location fosters ongoing communication and real-time exchange of expertise.

> We are a healthcare facility and every single person who works here is trained in [the] approach of, let me tell you what we need and give you a bunch of things to do, and then tell you it's your fault if you didn't do that. It's a constant reeducation and cultural change and we're working on ourselves as well. I think one of the reasons we appreciate partnering with the [housing organization] is that they're

> probably our best partner from the harm reduction perspective. — Co-locating solves a lot [of shortcomings]. —It gets people to talk to each other, it gets people to understand each other. (administrator, health center)

Increased intensity of interaction promises to improve effectiveness of services offered in cross-sector sites as compared with those offered in traditionally siloed settings.

Facilitators and Constraints to Implementing Effective Strategies

Case Management. Case management was the prime mechanism for incorporating three of the four essential elements of effective engagement of PEH in health care services—establishing rapport, maintaining intensive involvement, and initiating outreach. Partnering organizations from both sectors have substantial capacity for case management. In some instances, it is provided mainly by the health care partner, in others by the housing organization, and sometimes by both. Perceptions of the value of these services is widely shared.

> I believe there's inherent power of having a guide to navigate you. — You reduce the outreaches to other environments —because they have their safety net. They know they have someone that's going to be there to catch them. And so instead of having to go to the ED all the time, instead of having to inappropriately utilize other services, they know they can make one call [to get help in meeting their need]. (hospital executive)

Capacity for case management in New Jersey has been enhanced by recent initiatives to train community health workers—for example, establishment of the New Jersey Department of Health's Colette Lamothe-Galette Community Health Worker Institute[35] founded in 2020 through a partnership between employers and community colleges. Support for expansion of services delivered by community health workers is included in the current New Jersey Section 1115 Medicaid demonstration program.

Barriers to realizing the potential of case management, cited by those implementing the programs studied here, centered on current and anticipated Medicaid reimbursement arrangements, insufficient funding for providing services to homeless immigrants, restrictions posed by other funding sources, and inadequate support for frontline workers.

Medicaid Reimbursement. A prominently voiced concern was that reliance on per-service Medicaid reimbursement would not support the intensity and rhythm of effective case management. An administrator at a housing service organization doubted the viability of existing reimbursement schemes for supporting such services:

> I think that the manner that the services are provided by someone who has to bill Medicaid is going to be very different than the manner [we provide] services

> because you have to provide a billable service versus a service that's funded by a grant that allows you [more flexibility in accomplishing goals with a particular client]. (director, housing services organization)

Issues cited as problematic in formulating workable reimbursement methods included: What should be the appropriate reimbursement rate for services of a caseworker who spends several hours accompanying a homeless client to an initial health care visit, helping to overcome fears of walking in the door and assisting in communicating needs to the medical staff once there? Will reimbursement cover the service of an outreach worker who seeks to engage a street-homeless client only to discover that the encampment has been dismantled the night before? No-shows in this context are very costly in time and effort, and failure to compensate will be a strong disincentive for meeting clients where they are.

A second concern about potential Medicaid support was that the trend toward value-based reimbursement may preclude support for several of the strategies deemed effective in serving PEH.

> Unsheltered individuals — many of them would love housing but — are never going to follow through on the [healthcare] requirements of housing. — And so you have to create health care delivery that is deeply harm reduction in nature. And one of the challenges about the direction that CMS is moving — is toward value-based payment, it's moving toward paying for outcomes. And so when you're talking about trying to care for a population that does not want those outcomes, it really — puts you in a quandary. — The places that serve individuals who don't want to be housed will get less funding under that kind of model. So it's worrisome. (administrator, health center)

If measures of value are confined to achievement of health care outcomes, reimbursement may not support services for clients for whom housing is the first priority in their hierarchy of needs—that is, an agenda that includes health care but is initially focused on shelter. An associated concern is whether health care outcomes will include achievement of proximal ends, as are often incorporated in harm reduction approaches.

Support for Uninsured. Health centers that serve large numbers of patients who are uninsured and do not qualify for Medicaid (e.g., undocumented immigrants) face severe resource constraints. Funds available through the state's charity care payment program cover some of the costs, but there are significant shortfalls:

> What the state pays for charity care is about half of the rate we receive from Medicaid. — All the things for homeless individuals, the care co-ordinations, the navigators, the connecting pieces, all the things that truly help them be better, help them meet their goals rather than just getting lost in the system, none of those services are reimbursable by the state Uncompensated Care Act. (health center administrator)

There is little support for those services that are essential to effectively meeting the needs of people who are homeless.

Constraints Imposed by Other Funding Sources. Several of the studied programs receive funding from the New Jersey Department of Health's Community Support Services (CSS) program[36] that serves homeless clients with serious mental illness, as administered by the Division of Mental Health and Addiction Services. Directors of these programs noted a tension between adherence to the psychiatric rehabilitation model,[37] which is required by CSS, and their overall strategy for engaging PEH. In particular, they found it difficult to reconcile enactment of client-centered care with the intake process required by CSS, which one respondent characterized as a "rigid assessment of qualifications for services that may not be of interest to clients":

> A lot of folks have either grown out of — those intense needs or they don't want to meet with us for the long CRNA (Comprehensive Rehabilitation Needs Assessment) process, and then they become CSS ineligible. (director, housing services organization)

Another housing program administrator echoed this view, contrasting the flexibility afforded by contract funding with the CSS reimbursement approach:

> [CSS] really drives the manner in which services are provided. — Rooted in the psychiatric rehab model, it's much more directive, which I feel doesn't always work as well with — the population that we're serving. (director, housing services organization)

Similarly constraining, the mandated standardized assessments are required to be administered by Master's-prepared individuals who are licensed to complete this process. This emphasis on credentials and certification may undermine efforts to recruit outreach workers with lived experience, which is embraced by administrators of several of the cross-sector initiatives.

In response, some programs have foregone reimbursement, choosing to finance the necessary intensity of services by hiring and paying case managers directly from their operating budgets.

> We felt this is a necessary service to provide to a very marginalized population. So we have decided that there's no contract, there's no reimbursement. We have decided that we're going to foot the bill because that's the right thing to do. (program director, hospital)

Such allocations reflect a balancing of commitment to mission with availability of resources.

Support for Frontline Providers. Paralleling their high valuation of the role of outreach and case workers, respondents called attention to the potential emotional toll and burnout that may arise from the daily challenges and intensity of the work.

> It's not an easy challenge to try to help people who in most cases don't trust you, or — feel the system has failed them or who have addiction or psychological issues that aren't being addressed. So you have this multitude of things that you have to deal with to try to help the patient. (hospital executive)

Prominent among the accounts of outreach workers in dealing with clients' inertia or halting progress were reminders to avoid internalizing setbacks and respond with renewed determination.

> It's the willpower to want to connect with them. You need to not lose hope. (outreach worker, hospital)

> You need to be able to have empathy with them. But then also be strong and not let what they're telling you in the beginning get to you. Because it's a lot of trauma they're dealing with and it's also – they're going to be defensive at first. So you need to not be scared as well to deal with that. (outreach worker, hospital)

Asked how she has been able to sustain her commitment to the role over 20 years, one outreach worker responded:

> The short answer is I don't know how not to. I'm a people person and I'm a servant. And I just need to help and there's always somebody that needs help. So for me it's like second nature for me. (outreach worker, hospital)

Most programs sought to reduce stress on caseworkers, instituting staff wellness events and sharing strategies for dealing with job-related tensions. Apart from emotional support, one hospital executive asserted the need for greater material rewards for case managers:

> I will tell you — we undervalue the role of case management in our society. And I know because I know how much we pay them, and we should probably pay them a lot more for the work and the knowledge that they do (hospital executive)

Most respondents eschewed exclusive reliance on staff idealism and sought proactive opportunities to prevent burnout.

Constraints on Co-Locating Services. Partnerships with organizations delivering complementary services at the same site is a defining element of many cross-sector collaborations. Complexities in interpreting and applying existing regulations pose barriers to seeking reimbursement to support services in these circumstances.

Ambiguity of Facility Licensure Regulations and Associated Reimbursement Policies. At one program, a health center is seeking to provide services on-site at a shelter. The shelter is licensed to provide mental health and addiction services, whereas the health center is licensed to deliver medical care. According to the center administrator:

> We think that as long as we have a separate license, meaning we're in medical care, they are mental health and addictions and we have separate addresses – [e.g.] so they're suite A, we're suite B — the state will allow us to bill.

However, the health center offers integrated health and behavioral health services, which may pose problems for reimbursement:

> The challenge is we're billing the same codes. [O]ur behavioral health team sends through the same codes with the same diagnoses as the team at the shelter would. And so if the state is seeing duplicate codes on the same day, from the same address, [they may reject our claims]

Absence of clarity on this issue could preclude support for integrated care:

> If we were going to be co-located, we would just be doing primary care and we'd be going back in time and really losing the benefit of all that learned experience and expertise that our teams have.

Lack of Direct Reimbursement for Nursing Services at Shelters. Making basic nursing services available at shelters could fill significant gaps in caring for PEH.

> [Nurse visits] are enormously valuable. Sometimes it's just someone to change your bandages once a day. Sometimes it's someone to make sure you take your medications. Homeless shelters don't have nurses built in for the most part, they don't have family members built in, and if you're uninsured you really can't qualify for those services. So, [a message for] Medicaid, the managed care organizations (MCOs), "Pay for these services, pay for a nurse to be here because it's cheaper than paying for someone to go to the hospital." (administrator, health center)

Medicaid reimbursement for such services, in addition to benefiting the health of clients, may also reduce unnecessary use of more expensive options.

Conclusion

Those implementing cross-sector programs offered compelling reasons for collaboration among health care and housing organizations—citing the impact of housing on health status, the ineffectiveness and costs of attempting to address unmet health care needs among PEH in the absence of providing shelter, and the promise of harnessing resources and expertise from both sectors in coordinated efforts to address distinctive challenges confronting homeless populations. Variations in the intensity and commitment of resources among partners collaborating in cross-sector programs bode well for proliferation of future efforts. Collectively, the studied programs demonstrate a range of potentially viable paths to successful cross-sector efforts. Practices critical to the effectiveness of these programs included delivering persistent and intensive case management services, adopting goals that optimize harm reduction, maintaining low-barrier access, developing service plans that are consistent with client priorities, and co-locating health care and housing services. Poli-

cies essential to facilitating success in incorporating these practices are discussed below.

Providing Resources to Support Intensive Case Management

Adequate financing to support the intensity of services provided by case managers and the scope of their engagement activities (e.g., meeting with clients on the street, accompanying them to health care visits) poses significant challenges. Housing programs have often relied upon grant funding, which permits flexibility essential to adjusting staff workloads to suit the ebb and flow of client needs, but the amounts of such awards, particularly for pilot projects, limit the volume of clients that can be served. Although case management is a familiar role in health care delivery, respondents emphasized the importance of making critical adjustments in usual practice to be successful; the enduring magnitude and scope of unmet needs among homeless clients were often attributed to insufficient persistence of previous attempts to improve the well-being of this population. Health care respondents expressed skepticism that predominant methods of reimbursement, based on units of service, would afford this level of intensity. Similar sentiments were voiced by stakeholders interviewed in a four-state study of implementation of Medicaid demonstration initiatives financing tenancy support services[38]; specifically, they cited concerns about the adequacy of procedures for delineating services considered reimbursable, specifying allowable numbers and frequency of client contacts, and avoiding overlap with services provided by other funders. Similarly, a study of case managers in supportive housing programs documented impediments posed by Medicaid fee-for-service funding to delivering individualized services to their clients.[39] Health care respondents in the current study emphasized the importance of experimenting with contract or capitation arrangements as the preferred mechanism for Medicaid MCOs to pay provider organizations for case management services.

Supporting Proximal Outcomes

Prominent in the intervention strategies of housing organizations studied here was an emphasis on harm reduction, acknowledging the priorities and capacities of PEH and sequencing interventions to address realistic and meaningful goals. This emphasis often conflicts with the overriding commitment to optimizing health outcomes central to the mission of health care institutions. This tension complicates the viability of Medicaid financing for cross-sector services; it may surface in future operationalization of value-based reimbursement, particularly if proximate outcomes—that is, improvements that are feasible but not necessarily optimal—are not captured in calculations of value.

Maintaining Low-Barrier Access

Important to homeless services delivery is a low-barrier approach to initial engagement of clients, meeting them where they are (including on the streets and in shelters) and minimizing, when possible, the initial paperwork. Typical of first contact with health centers are requests for proof of income, Medicaid eligibility, or immigrant status that often discourage homeless clients from seeking care even if they qualify. Although the need for some preliminary documentation is inevitable, outreach workers in these cross-sector programs seek ways of establishing rapport and a safe context for making such requests. Wider adoption of this practice may require weighing the net costs—human and financial—of polices requiring restrictive qualification processes and the ultimate consequences for housing and health outcomes. Changes in federal policy in the current administration are likely to exacerbate rather than reduce burdens to access. Project 2025 Medicaid reform proposals, for example, mandate beneficiary work requirements, which would be especially challenging for PEH.[40]

Addressing Client Priorities

As evidenced in the accounts of frontline providers, people without shelter experience myriad unmet needs and may be forced to make untenable choices, prioritizing some over others. Choosing housing first, delaying treatment for stabilizing a serious chronic condition, is inconsistent with the standard practice of health care professionals. Some sources of current financial support relied upon by housing organizations do not accommodate divergent priorities—for example, CSS, which mandates behavioral health services compatible with the psychiatric rehabilitation model. Furthermore, signaling potential shifts in future federal funding, housing first was singled out in Project 2025 for dismantlement: "Federal intervention centered on Housing First has failed to acknowledge that resolving the issue of homelessness is often a matter of resolving mental health and substance abuse challenges.— Instead of the permanent supportive housing proffered by Housing First, a conservative administration should shift to transitional housing with a focus on addressing the underlying issues that cause homelessness in the first place."[41]

Facilitating Co-Location of Services

Incompatible financing arrangements and regulatory requirements were cited as potential impediments to co-location of services—for example, offering health services at housing sites or shelters. Some of the most significant benefits of cross-sector programs stem from co-location—which promises to foster trust among clients, facilitate more effective and real-time communication among staff, and deliver more timely

care. Respondents cited a need for resolving ambiguities in regulations governing licensing of discrete organizations providing complementary services at the same address; similarly, they sought clarity on reimbursement policy for claims submitted for seemingly overlapping but additive services (e.g., integrated primary care and behavioral health services provided by a health center at a shelter that has substance use prevention and addiction rehabilitation programs). To further address gaps in caring for PEH, respondents suggested that Medicaid reimbursement for nursing services at shelters would have distinctive value for well-being and may reduce use of more expensive options.

Funding of Medicaid Waiver Demonstration Programs

Virtually all of the studied initiatives received some support for health care services from the state's Medicaid program, which covered significant proportions of PEH through the program's expansion initiated in 2014. New benefits for tenancy and housing services (but not rental assistance) will augment existing Medicaid services for PEH in the coming year as part of the state's demonstration program. Whether approval of health and housing initiatives under the demonstration waiver authority will continue is uncertain. New Jersey's Medicaid tenancy and housing supports initiative operates under a Section 1115 demonstration waiver, as do programs of varying scope in 23 other states, including deep-red states, such as Arkansas and Florida.[42] It is notable that, among its first actions on waiver applications, the Trump administration approved the expansion of Florida's Housing Assistance Pilot initiative.[43] At the same time, the new administration may rescind Biden administration guidance promoting Medicaid demonstrations that address health-related social needs (including housing-related initiatives) but thus far has not acted to revoke approval of existing Medicaid demonstrations.[44]

Strengths and Weaknesses of the Study

Three issues are discussed here that pose limitations to the findings. First, the research was designed to yield findings having national relevance, yet it was conducted in a single state. To broaden the relevance, we pursued a systematic sampling process yielding program types that encompass the range of cross-sector efforts in New Jersey; reports of efforts in other states confirm that these program types reflect the range of strategies implemented nationally. Second, the analyses reported here do not directly incorporate the perspectives of homeless clients. Underscoring the importance to learning from clients, we conducted a separate study based on analysis of in-depth interviews with PEH; findings are available elsewhere.[45] Third, the interviews conducted for the research reported here were completed before the reelection

of Donald Trump; it is far from clear how the rapidly and chaotically changing policy environment of the new administration will affect prospects for strengthening cross-sector collaboration. Funding of homeless services as well as Medicaid and other programs providing services for PEH is likely to be reduced, perhaps dramatically. The early actions of the current administration suggest that at least some housing-related demonstrations will proceed, allowing for continued testing of innovative cross-sector initiatives addressing the needs of PEH.

Changes in the sources and scale of funding may pose new challenges to implementing initiatives. However, they will not alter the relevance of the accumulated experience of respondents in this study in using available resources to effectively engage PEH in health care services.

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