How Denver Health Partners to Address Homelessness

August 20, 2025 Safety Committee

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My Why

"I just keep falling through the cracks."





Denver Health's Safety Net

In 2024, Denver Health cared for approximately...

16,000

patients experiencing homelessness who had

78,000 visits

"We see a group of people who never

darken the doors of a homeless

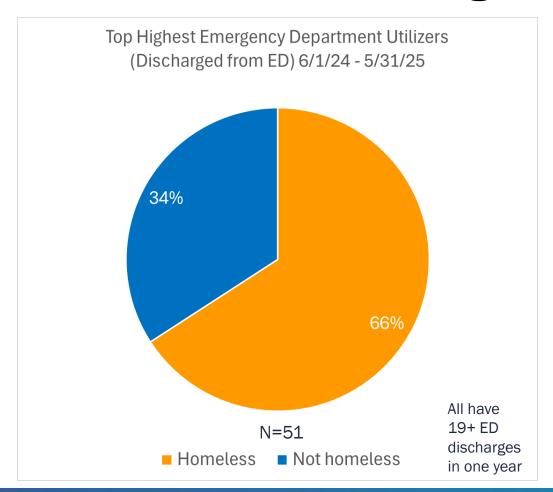
service organization, but they come to

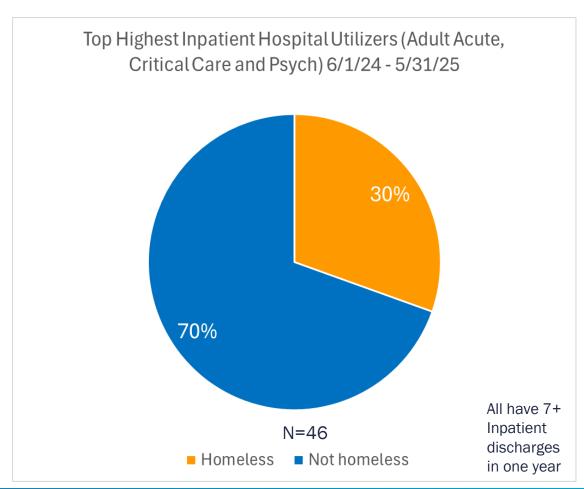
the hospital"

-Denver Health Social Worker



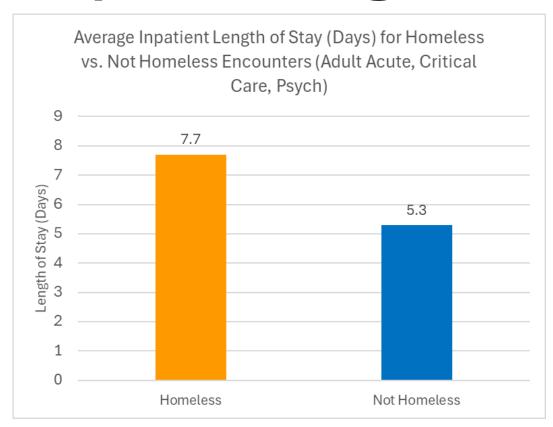
Homelessness Drives High-Cost Health Care Utilization







Impact on Length of Stay and Readmissions



Individuals experiencing homelessness stay on average 2.4 days longer than the general population

30 Day Readmission Rate

Patients Experiencing Homelessness: 17.8%

Housed patients: 11.3%

Readmission data: Jan 2022 - May 2025 Length of stay data: June 2024 - May 2025



Building Connective Tissue for Hospital-Housing Partnerships

























 Joint Strategic Planning and data exchange

2018-2019

2020

- COVID-19 response
- DH Medicaid Housing Pilot
- HCPF Collaboration

2021

- Statewide Supportive Housing **Expansion pilot**
- Research initiatives on housing & health

2022

- SIPPRA Housing to Health
- Data/care integration with CCH
- Safe Outdoor Space at Denver Health
- Hospital Point in Time count

2023

- 655 Broadway **Transitional** Housing
- Stout Street Recuperative Care Center beds leased
- Denver Health Homeless Registry

2024- present

- Expanded partnerships
- Housing Outreach Partnership & Engagement (HOPE)
- Roads to Recovery



Using hospitalization as an opportunity for connection

Right Data



Identify

Right Team



Outreach

Right Partners



Connect

This model has been successful for programs, such as:

• SIPPRA Housing to Health

- Statewide Supportive Housing Expansion pilot
- Housing Outreach
 Partnership & Engagement
 (HOPE)
- Roads to Recovery



Patient Story

Patient "Joel" arrived in the ED due to a complication of unmanaged Type 1 Diabetes and a history of stimulant use disorder. Joel was on a priority list for the Roads to Recovery program and the DHHA HOPE Team was **notified by an alert** in our electronic health records. HOPE outreached the patient, obtained consent, and arranged for a **City case manager to connect with him in the hospital**. Joel enrolled in the program and **entered housing following discharge**. During the initial connection, Joel said to the HOPE team "I'm ready to accept some help and get my life on track."

Note: Patient names have been changed for privacy



Testimonials

"It was really hard when, if we located someone and we couldn't get them in a bridge [housing placement], and sometimes they would go back [to the street] and just be a leaf in the wind... but then we'd get a call from Denver Health."

—Supportive housing staff member, SIPPRA Housing to Health

"It is hard to describe how grateful and ecstatic he was about his housing connection. And that joy was contagious. We regularly took a moment for a brief 'hooray' during rounds in the days leading up to his discharge. We gave him a big high five on day of discharge!"

—Physician, Denver Health



Denver Health Invests in Lifesaving Transitional Housing and Recuperative Care



It is better for us to invest in supportive and recuperative care units than to house people in the hospital





Results from Housing Connections and Investments



700+ patients discharged to CCH Recuperative Care Center since February 2023



34 patients housed at 655 Broadway, 22 of whom were connected to permanent housing



70 patients connected a total of 120 times to SIPPRA H2H housing service providers via a warm handoff



60 patients connected to other housing programs



Housing Outreach, Partnerships and Engagement (HOPE) Program

- Funding: \$999,000 grant from Denver Department of Public Health and Environment, 2 years funding
- Goal: Improve housing-focused screening and care coordination for at-risk patients experiencing homelessness who are utilizing Denver Health's hospital system, including Roads to Recovery

Outputs

- Utilize internal/external data tools to identify patients eligible for housing opportunities & other community supports
- Partnering with housing resolution agencies and the Roads to Recovery program to create workflows and support warm handoffs
- Integrating DHHA within the homeless response system
- Over 200 patients served to date



Housing-focused interdisciplinary team



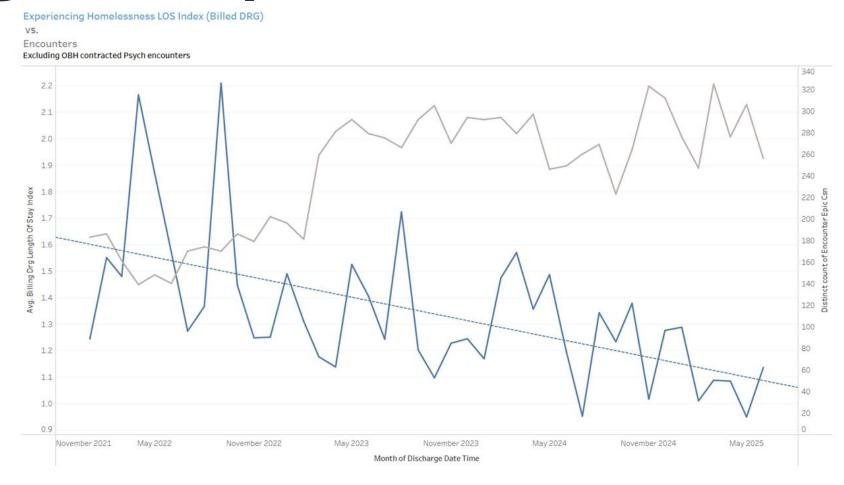
Safer Discharges and Improved Patient Flow

of stay of patients experiencing homelessness, even while the number of encounters have increased.

Over the same period, our readmission rate for patients experiencing homelessness has not increased

Includes: Adult Acute, Critical Care and Psych homeless discharges

Excludes: Contracted long-stay psych patients





Functional Needs for Homeless Hospital Discharges

in 2024

Inpatient Encounters from Patients Experiencing Homelessness

2,218 encounters

(1,539 unique patients)

With Any Impairment

(mobility, cognitive, and/or oxygen dependent)

1,306 encounters (58.9%)

(871 unique patients)

Note: Impairments types not mutually exclusive

Mobility Issues / Challenges Completing Activities of Daily Living

<u>1,234 encounters</u> (94.5%)

(824 unique patients)

Cognitive Impairments

362 encounters (27.7%)

(259 unique patients)

Oxygen Dependent

83 encounters (9.1%)

(46 unique patients)

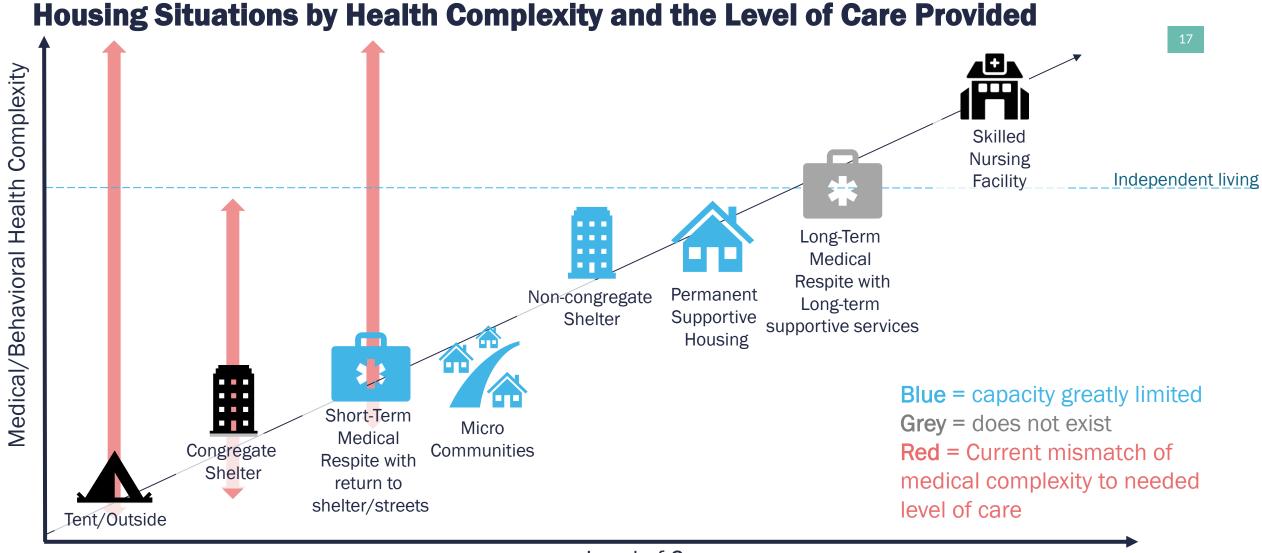
















Takeaways



Denver Health has an important role to play in the homelessness response system, particularly for people with **complex medical and behavioral needs**



Many patients we see are highly vulnerable but **not** engaging with community partners.



Improved methods of data sharing needed to improve timely outreach and enables housing providers participation in care coordination.



Ongoing Investment is needed to support sustainability

- Investments
 - Recuperative Care Center bed lease: \$864,000/year
 - 655 Broadway lease: \$150,000/year
 - HOPE team: \$800,000/year

- Uncompensated Care
 - Hospital costs of excess days:\$8,421,400 (5375 excess days in 2024)
 - Without funding to integrate housing and healthcare, this cost increases

Right Data



Right Team



Right Partners



Denver Health is positioned to be a critical partner in the City's housing response and resolution





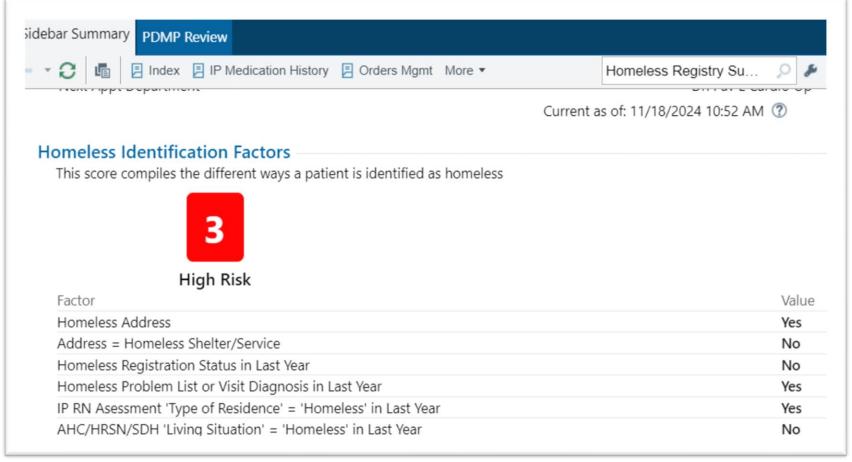
Contact HOPE@dhha.org





Denver Health's Homeless Registry

More comprehensively and inclusively identifies patients and populations experiencing homelessness



Stella SA et al. Improving Identification of Patients Experiencing Homelessness in the Electronic Health Record: A Curated Registry Approach. J Gen Intern Med. 2024 Dec;39(16):3113-3119. doi: 10.1007/s11606-024-08909-1



Roads to Recovery and Denver Health HOPE Referral Workflow

DHHA HOPE Activity

Patient Identification

Alert fires within DHHA EHR notifying HOPE team an individual from the R2R list is in the DH system.

Actions

 HOPE Team reaches out to R2R on their capacity for coordinating an outreach

Patient Outreach

HOPE Team coordinates outreach with pt care team

Actions

- 1) HOPE updates R2R with anticipated outreach time
- 2) HOPE team talks to patient with R2R scripting and ROI
- 3) HOPE team collects ROI and facilitates phone call to R2R contact

If <u>unable to outreach</u> pt OR pt does not sign ROI -Workflow stops

Warm Handoff

HOPE Team helps coordinate participant handoff-off to R2R

Actions

- 1) HOPE discusses outcome with care team including discharge plan, medication, follow-up appts, etc.
- 2) HOPE sends completed ROI via encrypted email to R2R
- 3) HOPE helps facilitate warm-handoff when R2R arrives

Reconnection

HOPE Team will reach out to R2R team if an individual previouslt connected is back in the DHHA system

Actions

- 1) Coordinate needs with R2R team more immediatley with ROI on file
- Facilitate connections as needed

R2R Team Activity

Prep for Intake

R2R team asses capaccity and communicates with DHHA.

Actions

1) R2R identifies who is able to take the lead on new participant outreach, communicates this to DHHA team

If no R2R capacity -Workflow stops



Coordination of Intake

R2R team recieves phone call from participant / HOPE team memeber and establishes first contact with the program

Actions

1) R2R makes a plan with participant and HOPE team to coordinate intake (ideally same day or at time of discharge)

R2R Intake

Meets with participant at DHHA or carriers out other plan for contact

Actions

- 1) R2R completes intake of participant
- 2) Connects with NCS, Motel, Sober Living, etc.
- 3) Continues R2R program activity

