ESSENTIAL HOSPITALS TACKLE HOMELESSNESS AND HOUSING INSTABILITY

DECEMBER 2025

ESSENTIAL HOSPITALS INSTITUTE

HOMELESSNESS AND HOUSING INSTABILITY ARE PUBLIC HEALTH ISSUES

Homelessness and housing have a major impact on community health. They are linked to increased emergency department (ED) visits, hospital readmissions, and overall health care costs. The Department of Health and Human Services recognizes safe housing as a critical social determinant of health that influences health outcomes.[1]

People experiencing chronic homelessness or unstable housing often face worse health outcomes. This is due to limited access to health and social services, greater exposure to toxic environmental elements, poor nutrition, and prolonged stress. Homelessness also makes it harder to manage chronic and acute health conditions, which can shorten life expectancy.[2]

Common conditions among people experiencing homelessness include substance use disorders, schizophrenia, hypertension, cardiovascular disease, and other respiratory and infectious diseases. While homelessness itself is not a direct leading cause of death, the conditions associated with it contribute to higher mortality rates in this population.

People who are chronically unhoused often rely on EDs not only for medical care but also as temporary warm places to sleep. The rate of hospital ED visits by individuals experiencing homelessness increased from an estimated 141 visits per 100 people per year from 2010–2011 to 310 visits from 2020–2021, according to the Centers for Disease Control and Prevention. In contrast, ED visit rates for people with stable housing were considerably lower and did not vary during this time.[3]

Hospitals and health systems can play a critical role in meeting patients' social needs beyond traditional health care. Community-integrated health care initiatives—such as partnering with local motels or shelters to provide temporary post-discharge housing, deploying mobile clinics, and connecting patients to social services—can improve patient outcomes and community well-being.

Investing in stable housing also can reduce hospitalizations and ED visits, saving hospital dollars. However, the return on investment goes beyond cost saving measures by supporting healthier, more resilient communities where individuals and families can thrive. Essential hospitals and health systems across the country are working to target homelessness as a root cause of poor health and improve the overall health and well-being of the communities they serve.

Author:

Amaodo Oguagha, MPH

MEMBER INITIATIVES

Essential hospitals are implementing targeted programs and support services to improve health outcomes for all, including those who are chronically unhoused, experience housing instability, or face environmental barriers to care.

Housing Development and Community Partnerships

STAMFORD HEALTH

Stamford Hospital, ***Stamford, Conn.***
Vita Health and Wellness Partnership

Stamford's lower income and at-risk populations exhibit a disproportionate share of chronic disease and poor health status relative to the greater community. These differences partially reflect their limited access to various forms of health care, largely related to specific social, environmental, and economic conditions.

In 2010, Stamford Hospital partnered with Charter Oak Communities to expand and redevelop a neighborhood on the city's West Side with a high rate of chronic conditions. The goal was to create a healthy neighborhood where residents can thrive. This initiative, known as Vita, translates to "life" in Latin. The Vita Health and Wellness Partnership focuses on targeting the root causes of poor health, strengthening partnerships, collecting data to measure impact, and engaging the broader community to improve health and wellness.

Stamford Hospital and Charter Oak Communities acquired properties to transform the neighborhood, including a new hospital and hundreds of housing units. The Vita Health and Wellness District has become a health-focused neighborhood. Distressed public housing projects have been replaced with lower-density, mixed-income communities with dedicated resident support services, public green spaces, an independent pharmacy, and a revitalized hospital and campus. Designed to promote health, fitness, and belonging, the mixed-income communities are smoke-free and have yards and playgrounds. Each aspect of Vita addresses the social determinants of health, including healthy housing, economic stability, education and attainment, public health and access to medical care, physical activity, and improved social cohesion. Vita provides nutrition counseling for adults and children, cooking classes, and an urban farm to improve access to healthy food. Vita is addressing education and economic development through providing English as a Second Language services and job trainings.

Stamford Hospital supports the Vita initiative by contributing to its operating budget and providing in-kind staff support. Alongside Charter Oak Communities, the hospital provides essential backbone support, including program management, administrative services, communications and public relations, evaluation, fundraising, and strategic leadership.

University of Vermont Health — The University of Vermont Medical Center (UVMMC), *Burlington, Vt.*

Harbor Place

UVMMC partnered with the Champlain Housing Trust (CHT) in 2015 to create a shelter option for patients at Harbor Place, a motel that provides temporary housing and wraparound case management services for adults.

Harbor Place focuses on three goals:

1. Reducing the cost of emergency housing
2. Improving outcomes for people in crisis
3. Helping residents secure permanent housing

Harbor Place offers low-barrier access to individuals, including those with substance use disorders (SUD). Recognizing that individuals without stable housing often face significant health challenges, UVMMC's Case Management and Social Work Department actively supports the program by contracting with CHT for seven beds. This allows patients to be safely discharged from the hospital directly into temporary emergency housing. This heavily used program had 24 unique placements in the first six months of the 2025 calendar year.

UVMMC's housing initiatives include medical respite apartments.

Bonvouloir Apartments (formerly Bel Aire Apartments)

In 2016, UVMMC provided financial support to CHT for the purchase and renovation of the Bel Aire hotel to create supportive medical respite. From 2017–2023, UVMMC funded its local federally qualified health center partner to operate a seven-bed medical respite program. Originally named Bel Aire Apartments, this program provided short-term housing to medically vulnerable and chronically unhoused individuals.

The initiative was designed to integrate housing and health care access by funding support for residents and case management. However, it ended in 2023 due to rising needs of the unhoused population that eclipsed the program's design.

In 2025, UVMMC and UVM Home Health and Hospice (HHH) redesigned the medical respite program to provide coordinated and integrated care, leveraging case management to organize patient health care needs with plans to expand support across additional housing settings. HHH launched the redesigned model in July 2025 with one apartment unit, with aims to expand to others in the area once the new model has been tested. HHH and UVMMC are exploring funding and service support for additional beds through partnerships with local nonprofit homeless shelter providers.

Medical Respite and Recovery Care

Denver Health, *Denver*

Building Partnerships and Supporting Housing Connections for Denver's Most Vulnerable

Denver Health serves a large population of Medicaid recipients with unmet health-related social needs, including a large and growing population of people experiencing homelessness. In 2024, Denver Health saw approximately 16,000 patients experiencing homelessness who had 78,000 visits across the integrated health system.[4]

The hospital system developed a population-based registry within its electronic health record, Epic, to more comprehensively identify and enable outreach for patients experiencing homelessness.[5] A 2021 analysis found that only 53% of patients on the registry were using homeless and housing services tracked within the region's Homeless Management Information System.

Members of Denver Health's Housing Outreach, Partnerships and Engagement (HOPE) Team provide housing-focused outreach and assistance for at-risk patients.

Since then, Denver Health has worked to expand strategic partnerships with the city of Denver and community-based organizations to address the housing needs of some of their most vulnerable patients who frequently utilize Denver Health's hospital and emergency department. The hospital has made ongoing investments in strategies that provide alternatives to discharging at-risk patients back to the streets. For example, since 2023, the hospital has discharged over 700 hospitalized patients to medical respite beds at the John Parvensky Stout Street Recuperative Care Center, which Denver Health supports through a partnership with the Colorado Coalition for the Homeless.[6]

In 2023, Denver Health also partnered with the Denver Housing Authority to open the 655 Broadway Transitional Housing Program. This initiative provides 14 apartments with wraparound services for unhoused, low-income older patients or people with disabilities who are exiting the hospital.[7] According to internal data, most of the 39 patients who have been housed in the program have exited into permanent housing. The hospital now has embedded Care Management staff who support both programs, ensuring safe, effective, and efficient transitions of care from hospital to housing.

Building on lessons learned through partnering on Denver's Social Impact Partnerships to Pay for Results Act Housing to Health Program, Denver Health's Housing Outreach, Partnerships and Engagement (HOPE) Team provides housing-focused outreach and assistance for at-risk patients experiencing homelessness during hospitalizations and emergency department visits.

In addition to improving patients' health through connection to housing and community support, these partnerships have translated into measurable care improvements. For example, in 2021 the hospital saw a reduced length of stay for hospitalized patients experiencing homelessness even while the number of encounters had increased due to the ongoing housing affordability crisis in the region. Over the same period, readmission rates for patients experiencing homelessness have not increased—indicating the positive impact these initiatives have had on patient health, health care utilization, and housing outcomes.

UI Health | UIC

UI Health, *Chicago*
Better Health Through Housing

Located two miles from downtown Chicago in the Illinois Medical District, the University of Illinois Hospital & Clinics (UI Health) main campus is near one of the city's highest concentrations of unhoused residents. Unhoused individuals often cycle among six surrounding EDs for temporary shelter.

To meet this challenge, UI Health and the Center for Housing and Health (CHH) launched the Better Health Through Housing initiative (BHH) in 2015. BHH since has evolved into a contributor of the Flexible Housing Pool of Chicago (FHP). Spearheaded by CHH, the FHP is a collective housing impact program funded by city, state, philanthropic, and managed care organizations; the U.S. Department of Housing and Urban Development; and hospital systems like UI Health. The FHP collaborates with county housing agencies to provide apartments citywide that serve as bridges to permanent housing. In 2024, the FHP provided housing and supportive services to over 1,500 individuals in nearly 840 households.[8]

UI Health refers patients and families to the FHP if they are unhoused and have complex medical needs, are victims of domestic violence, or experience social and environmental stressors that impact their ability to recover safely. Through the health system's partnership with the FHP, UI Health can fund housing for up to 18 individuals for 36-month time periods.

The UI Health team includes a social worker who identifies patients within the hospital system to be referred into the program. The University of Illinois Hospital & Clinics commits $350,000 to this Housing First program and is one of the only Chicago-area hospital implementing this type of health care–and-housing model.

Through participation in the BHH program, UI Health resident physicians were inspired to create the nonprofit Chicago Street Medicine initiative, which provides medical care to patients living in encampments. The Chicago Street Medicine initiative has evolved into five chapters across five schools within the city.

JPS Health Network
Fort Worth, Texas

JPS Health Network, *Fort Worth, Texas*
Casa de Esperanza

In Tarrant County, Texas, home to JPS Health Network, over 5,000 people are experiencing homelessness. People experiencing homelessness are more likely to have mental health disorders and complications from chronic medical conditions such as hypertension, diabetes, and asthma. Casa de Esperanza, a permanent supportive housing program, was developed to address homelessness by providing a home surrounded by supportive resources. Grants made available during the COVID-19 pandemic funded the remodeling of a vacant model, which created over 100 units for individuals experiencing chronic homelessness who have a medical condition that puts them at risk for poor health outcomes following COVID infections. JPS Health Network provides case management services, mental health support, and community health workers (CHWs) at Casa.

On-site CHWs are an integral part of Casa. They help residents navigate the health care system by coordinating with pharmacies to manage medication refills and often deliver prescriptions directly to residents' doors. CHWs also schedule specialty care and same-day appointments, particularly for individuals with urgent health needs. Beyond clinical coordination, they lead group exercise walks twice a week to promote healthy lifestyle choices and foster a sense of community among residents. Support staff assist with transportation barriers and provide a safe space for the residents to explore a healthier lifestyle. Their day might also include advocating for residents' health concerns, organizing flu clinics, and identifying other resident needs. Additionally, CHWs participate in monthly case conferences with partner agencies, ensuring residents' voices are heard and their needs are met through a community approach.

As of December 2024, Casa de Esperanza has offered permanent housing to 119 individuals who were once experiencing homelessness and has reduced ED visits by 50%.[9] The program also equips individuals housed through Casa de Esperanza with education and information to help shape them into productive members of society. This JPS Health Network initiative has received awards for its outstanding efforts in connecting unhoused patients to important health care services.

Housing Support Services

University Health Truman Medical Center, *Kansas City, Mo.*
500 in 5 Campaign

In 2017, University Health Truman Medical Center's Behavioral Health (UHBH) partnered with a supportive housing developer and a local university to provide stable housing for behavioral health clients with multiple health care needs who frequently visited the ED. The hospital renegotiated a state contract with unused funds, and its partners conducted a brief market analysis to identify the number of housing units necessary for a significant impact. This led to the development of a five-year campaign to develop 500 housing options in the metro area while measuring the impact on health care and treatment outcomes. The campaign stopped in 2020 due to the COVID-19 pandemic; however, the program connected patients to over 300 housing options in the short span of 2.5 years—on target to exceed its initial goal.

University Health Truman Medical Center provides housing support services and programing at Cadence House and 2911 Holmes.

Although UHBH did not contribute direct funding, the hospital leveraged Medicaid to support most tenants. The hospital used funding from the U.S. Department of Housing and Urban Development, Missouri Department of Mental Health, and private foundations for rental assistance and support services that Medicaid did not reimburse. In its first year, the initiative began targeting chronically homeless individuals who frequented the ED and transition-aged youth at risk of homelessness. The first-year report demonstrated a 68% reduction in ED visits for 22 clients within six months of being housed.

UHBH partnered with a local housing developer, the Vecino Group, and the Corporation for Supportive Housing for annual data tracking and outside evaluation. The hospital also worked with multiple community landlords, resulting in a wide variety of housing options that met the need of their intended population demographics. For transition-aged youth experiencing mental illness, UHBH partnered with a local private university to convert vacant dorm space into four supportive housing units and used funding from private foundations to enroll the youth in college. For chronically homeless individuals, staff secured a master lease with HUD and state funding. UHBH provided 40 hours of on-site staffing per week and ensured no units were vacant for longer than 30 days.

Post-pandemic, UHBH is reassessing this campaign to align with evolving cultural shifts, demographics, and needs within the inner city. The initiative is actively exploring a new multi-year strategy, including the development of a homeless prevention fund, and new partnerships with community organizations to expand housing efforts within and outside the health system, prioritizing housing and employment as both an intervention and an outcome.

UHBH remains committed to creating safe, affordable housing solutions for patients, which also will support a reduction in unnecessary ED visits and crisis care spending. For example, UHBH is also home to a regional center of excellence (The Center for Trauma Informed Innovation). This center served as the lead consultant to the Preservation on Affordable Housing—the nation's largest affordable housing management provider—during the development of a trauma-informed housing toolkit for property managers that provide housing to people with disabilities and limited incomes.

Temple University Health System, *Philadelphia*

HomeBASE: Housing-Integrated Recovery for Vulnerable Populations

Temple University Health System's HomeBASE program is a multidisciplinary housing and recovery initiative designed to stabilize individuals with substance use disorders who face chronic homelessness and extreme social vulnerability. Launched in 2025, HomeBASE operates across multiple care levels—hospital, outpatient, and community—and integrates housing advocacy, peer recovery, and trauma-informed care into a unified service model.

The program assigns participants to dedicated teams, each staffed with housing advocates, certified recovery specialists, and community health workers. Weekly case reviews, daily huddles, and structured referral processes ensure coordinated care and accountability. A comprehensive operations manual and eligibility protocols guide staff actions. HomeBASE partners with community organizations to connect patients to short-, medium-, and long-term housing.

In its first year HomeBASE has:

- Enrolled 73 individuals, who all received temporary housing and wraparound support
- Graduated 8 participants from street homelessness to full independence
- Developed case review documentation and dashboards to support data-driven storytelling and monthly reporting
- Delivered trauma-informed care and harm reduction training to all staff

HomeBASE is embedded in Temple's broader addiction medicine service line and aligns with the system's Community Health Needs Assessment goals. It exemplifies how housing-first principles, peer engagement, and operational rigor can transform recovery pathways for high-risk populations.

Mobile Health

Alameda Health System (AHS), *Oakland, Calif.*
Mobile Health Clinic

Alameda Health System (AHS) is a leading safety net, integrated health care provider and medical training institution recognized for world-class patient and family-centered care. AHS provides comprehensive medical treatment, health promotion, and disease prevention throughout an integrated network of hospitals, clinics, and health services. AHS has the only adult level I trauma center and psychiatric emergency department in Alameda County.

To support the health and social needs of patients experiencing homelessness, AHS' Mobile Health Clinic provides essential medical, dental, and outreach services throughout Alameda County in the Bay Area. With more than 800 visits annually, the clinic delivers care directly to the community, reducing barriers and promoting long-term health and wellness. Services include primary and urgent care; specialist referrals; vaccinations (including flu and COVID-19); and dental care, such as screenings, cleanings, fluoride treatments, and education. In addition, the clinic offers community support services, including insurance enrollment, public benefits assistance (Medi-Cal, CalFresh), transportation resources, and health education. Through these comprehensive services, the Mobile Health Clinic connects patients to ongoing care, supports preventive health, and improves access for those most in need.

The mobile health team includes a nurse practitioner, a dentist, a certified medical assistant, a patient services representative, and two mobile health specialists. The mobile health specialists are vital to connecting patients to care and other resources. They help build rapport with patients to support providers in developing personalized care plans, delivering patient education, and building patient confidence. The Mobile Health Clinic plays a key role in supporting patients' overall health and well-being. Patients report interactions with the Mobile Health Clinic team helped them understand their health conditions and receive transportation to appointments, and that service was attentive and respectful.

The Mobile Health Clinic is delivered in collaboration with Alameda County Health Care for the Homeless, a health center program that provides direct care services and coordinates a network of county and community health clinics and organizations to increase access and improve care for people experiencing homelessness.

AHS' Mobile Health Clinic team poses in front of its van.

> ***"People face tremendous challenges getting health care when they need it, and when you're unhoused, the task can be monumental. AHS' mobile clinic ensures that people in Alameda County who are experiencing homelessness—whether living on the streets, shelters, or doubled-up with friends and family—receive quality health care, with dignity and respect."***
>
> **Luella Penserga, MPH,** director of Alameda County Health Care for the Homeless Housing and Homelessness Services at Alameda County Health

NYC Health + Hospitals, *New York*
Street Health Outreach & Wellness

New York City has the largest homeless population of any city in America, with more than 100,000 people experiencing unsheltered homelessness on the streets or living in city shelters. These New Yorkers have poor health outcomes and fragmented connection to care—a matter that NYC Health + Hospitals, the nation's largest municipal health care system, is determined to address. NYC Health + Hospitals launched the Street Health Outreach & Wellness (SHOW) program in April 2021. This initiative brings medical care, behavioral health services, substance use treatment linkages, and housing support to New Yorkers experiencing homelessness.

NYC Health + Hospitals implemented SHOW during the COVID-19 pandemic, initially to provide vaccines to people experiencing homelessness who were not getting vaccinated. The program then evolved into a focus on street-based primary care and social determinants of health support. SHOW connects patients to NYC Health + Hospitals Primary Care Safety Net clinics—specialized primary care sites in four system facilities designed for individuals experiencing homelessness with complex or chronic health conditions. NYC Health + Hospitals understood that for SHOW to be most effective, it needed to be directly connected with the organization's larger ecosystem of services. Therefore, SHOW is linked into the organization's electronic health record to ensure coordination of SHOW and hospital-based services.

The Street Health Outreach & Wellness Van at NYC Health + Hospitals brings medical care, behavioral health services, and housing support to New Yorkers experiencing homelessness.

SHOW also is a street response to the opioid epidemic, incorporating behavioral health and harm reduction services into its model. The program works to link patients to services and programs within NYC Health + Hospitals focused on substance use, as well as to community-based SUD treatment. SHOW is one of NYC Health + Hospitals' many initiatives aimed at supporting individuals who may be homeless, have mental health conditions, or face opioid use disorder.

With six mobile units, SHOW teams operate with physicians from the Safety Net clinics as well as NYC Health + Hospitals social workers, addiction counselors, peers, nursing staff, community health workers, and administrative staff. These teams work together to bring the system's full range of care to meet people where they are and broaden the doorways to more advanced care. SHOW also works closely with the city's designated street outreach teams in each borough to provide wraparound services and connect patients to housing support. A key part of this housing-focused approach is the NYC Health + Hospitals Housing for Health program, which connects patients with permanent housing through housing navigation services, medical respite, support for newly housed patients, and leveraging hospital land for affordable housing.

Since the program launched in April 2021, SHOW teams have completed more than 273,000 street engagements, including 33,200 visits with a primary care provider, 1,200 connections to substance use services, and 450 connections to homeless shelters from the streets. SHOW units now provide essential primary care services, including point-of-care lab, blood draw, and point-of-care ultrasound services, as well as behavioral health services and links to treatment. The SHOW program aims to sustain its progress in understanding and meeting the health and housing needs of New Yorkers experiencing homelessness, as well as improving clinical and social outcomes.

Harborview Medical Center, *Seattle*
Homelessness Palliative Care Team

In 2015, Harborview Medical Center launched the Homeless Palliative Care Team, the nation's first mobile outreach program supporting people experiencing homelessness who also live with serious, life-threatening conditions such as cancer, heart failure, and end-stage diseases. Operating through Harborview Medical Center's Pioneer Square Clinic Downtown programs, the team serves people without housing or who live in supportive housing.

The team partners with health and social service providers across King County to help patients navigate complex care systems from diagnosis through end of life. The team travels to meet people wherever they live, sleep, or receive care, including encampments, shelters, and permanent supportive housing buildings. They see patients with their case managers, primary care providers, and other medical specialists and often visit patients when admitted to Seattle-area hospitals.

The program's primary interests are to:

1. Support the physical, psychological, social, existential, and systemic suffering that impacts patients
2. Create trusted relationships that help facilitate care, build meaningful connection, and offer a source of trusted advocacy in navigating the experience of serious illness
3. Provide goal-aligned care that is trauma-informed with a harm-reduction lens for people with lived experience who often lack access to normative palliative care services and who also often experience bias in their care
4. Reduce the barriers to equitable, appropriate, and acceptable care and to support clinicians, teams, and institutions to adapt their care and systems of care to better serve patients

The interprofessional team, comprising a social worker, nurse, and nurse practitioner, specializes in relieving the symptoms and stress of serious illness to improve quality of life. They assist patients and care teams with symptom management, health decision-making, advance care planning, coordination of hospice services, family support, and legacy planning. The team also provides complex care management and health system navigation while attending to immediate health and resource needs including wound care, medication management, and shelter access. Together, the team serves more than 100 patients each year with over 700 annual visits.

To improve access to primary palliative care for unhoused community members, the team also provides consultation, training, and education services to health and social services organizations in King County and across the country.

COMMUNITY-INTEGRATED HEALTH CARE STARTS WITH HOUSING

With a mission to care for all, essential hospitals have consistently served patients with high medical and social needs. These patients frequently encounter challenges accessing and affording care and struggle to manage a host of societal barriers to health, of which housing insecurity is one of the most significant. All these factors combined impact patients' ability to live optimally healthy lives. Essential hospitals have found themselves at the forefront of this issue, recognizing the correlation between socioeconomic factors and health.

To meet the needs of their communities, our members are collaborating with local organizations, housing development partners, social services, government, and other stakeholders to address the underlying socioeconomic factors that influence negative health outcomes. This strategy reflects what America's Essential Hospitals has defined as community-integrated health care, in which health care providers work with other sectors, such as government, private entities,* social services, and community development, in both complementary and collaborative ways to improve health.[10]

Our members are investing in housing, not just health care, to improve well-being, in recognition of how closely health and housing are interwoven. They are building partnerships to integrate medical care and social support services for patients wherever they are in the community.

By treating housing as a root social need, these initiatives are achieving decreased hospital length of stays, reduced emergency housing costs, and stable readmission rates, while improving patient health outcomes. As programs evolve to meet the growing and changing needs of homeless populations, America's Essential Hospitals is committed to helping support member hospital efforts.

Since 2016, with support from external funders, Essential Hospitals Institute, the association's research, education, dissemination, and leadership development arm, has conducted research, developed written materials, and facilitated interest groups to demonstrate the many ways essential hospitals are addressing the social needs of patients and how they can continue to enhance their efforts. These initiatives include:

- Building community connections to offer supportive and affordable short-, medium-, and long-term housing units
- Offering coordinated medical care in the varied settings unhoused patients are located, like shelters, encampments, and through mobile vans
- Designing structured, data-driven initiatives that treat housing as critical to health outcomes
- Managing the complex social needs of patients disconnected from larger health systems like housing, food, education, and income
- Achieving measurable reductions in ED visits and homelessness, while supporting individual recovery and independence

For more information, read **Outside the Hospital Walls: An Update on Essential Hospitals' Efforts to Improve the Health of Their Communities**, which provides details on how essential hospitals are implementing community-integrated health care programs and policies. You can also visit **Essential Communities**, the Institute website featuring snapshots of hospital programs and resources focused on meeting patients' social needs.

America's Essential Hospitals members can learn more about what other essential hospital programs are doing to improve the medical *and* social needs of patients through a monthly **Community-Integrated Health Care Interest Group**. The group convenes virtually to

Community-integrated health care is a strategy in which health care providers work with other sectors, such as government, private entities,[10] social services, and community development, in both complementary and collaborative ways to improve health.[11] Community-integrated health care can culminate in creating a connected system that meets the physical, mental, and social needs of individuals and improves the structures and conditions that influence those needs.[12]

discuss opportunities to improve the structures and conditions that influence the mental, physical, and social needs of our communities. These meetings are free and open to all employees of association members and allow them to share innovative resources and identify barriers and facilitators to their work.

Notes

1. *Social Determinants of Health*. Office of Disease Prevention and Health Promotion. https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health. Accessed Aug. 21, 2025.

2. *Homelessness Makes You Sick*. Health Care for the Homeless. https://www.hchmd.org/homelessness-makes-you-sick. Accessed Aug. 21, 2025.

3. Schappert S, Santo L. QuickStats: Rate of Emergency Department Visits, by Homeless Status — National Hospital Ambulatory Medical Care Survey, United States, 2010–2021. *MMWR Morbidity and Mortality Weekly Report*. 2023;72:1153. http://dx.doi.org/10.15585/mmwr.mm7242a6. Accessed Aug. 21, 2025.

4. Denver Health. Report to the City 2024. April 25, 2025. https://www.denverhealth.org/-/media/files/about/annual-reports/Report%20to%20the%20City%202024%20Digital%20Final. Accessed Oct. 2, 2025.

5. Stella S, Hanratty R, Davidson A, et al. Improving Identification of Patients Experiencing Homelessness in the Electronic Health Record: A Curated Registry Approach. *Journal of General Internal Medicine.* 2024;39:3113–3119. https://doi.org/10.1007/s11606-024-08909-1. Accessed Oct. 2, 2025.

6. *John Parvensky Stout Street Recuperative Care Center*. Colorado Coalition for the Homeless. https://www.coloradocoalition.org/sites/default/files/2023-01/TwoPager_JPStoutStreetRecuperativeCareCenter%20%281%29.pdf. Accessed Oct. 2, 2025.

7. Jojola J. Residents move into office building converted into affordable housing in Denver. *9News.* Dec. 12, 2023. https://www.9news.com/article/news/local/office-building-converted-into-affordable-housing/73-7ae28e6a-d274-48a5-b4ac-be01ff43be47. Accessed Oct. 2, 2025.

8. Center for Housing and Health. Welcome Home: 2024 Annual Report. https://housingforhealth.org/wp-content/uploads/2025/08/CHH-2024-Annual-Report.pdf. Accessed Oct. 2, 2025.

9. JPS Health Network. Excellence in Healthcare. Dec. 10, 2024. https://www.jpshealthnet.org/news_article/excellence-healthcare. Accessed Oct. 2, 2025.

10 2025 addition to 2019 definition

11. White M, Roseman D, Roberson B, et al. Outside the Hospital Walls: An Update on Essential Hospitals' Efforts to Improve the Health of Their Communities. *America's Essential Hospitals.* December 2019. https://essentialhospitals.org/wp-content/uploads/2020/01/EHI-CIHC-Progress-Report-December-2019.pdf. Accessed Oct. 15, 2025.

12 Ibid.