Housing WA. ANNUAL CONFERENCE

2026

From Silos to Systems

How Medicaid Health Plans and Housing Partners Built a Shared Path to Housing Stability

This is Sarah.

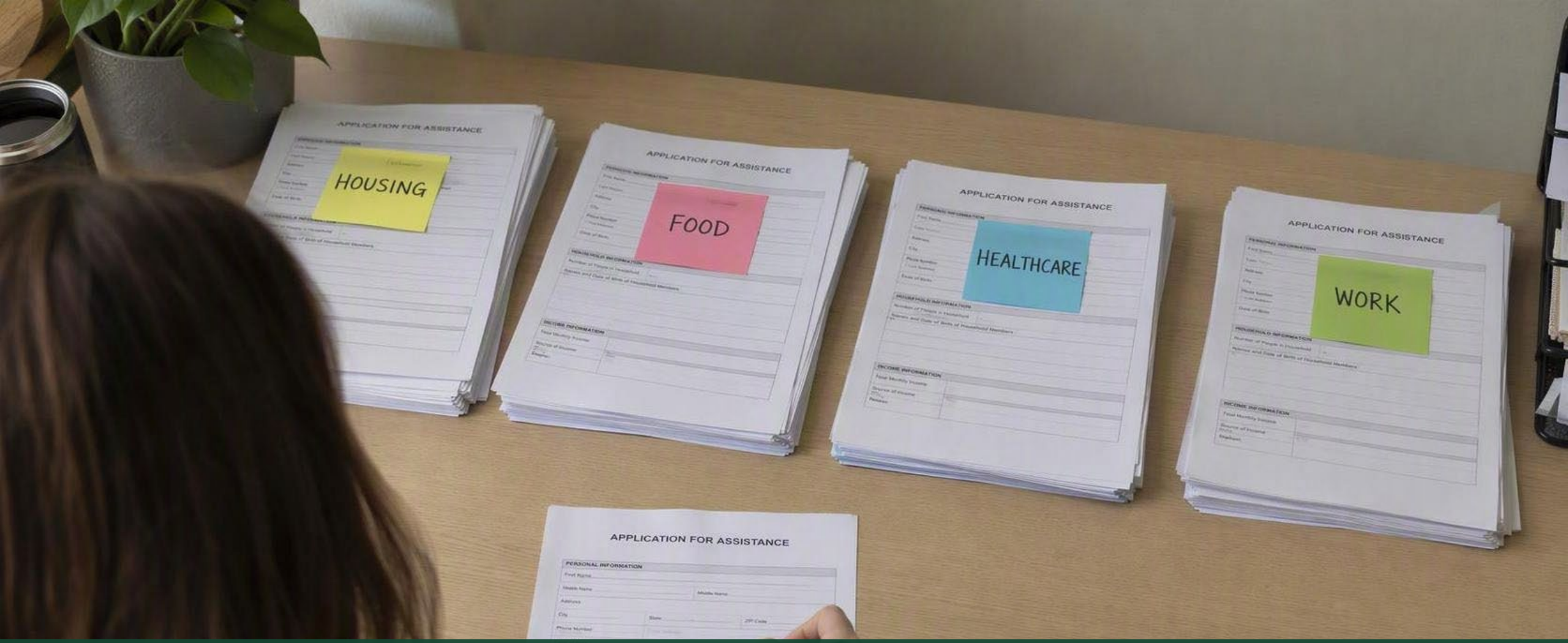




THE ASSUMPTION



The Reality – What It Can Feel Like



Everyone is working hard.
Systems sometimes make it hard to work together.



So we started talking to each other.



Who Sits at the Table

Let's meet some of the players...

Three systems. Different areas of focus. The same people.

Health Plans

Apple Health benefits and care coordination — physical, behavioral, and social needs.

Commerce Housing Division

Statewide housing and homelessness policy, funding, and support for CE systems.

Coordinated Entry

Entry point for local homeless response system. Assess housing needs and connects to available resources and programs.

Whole Person Care

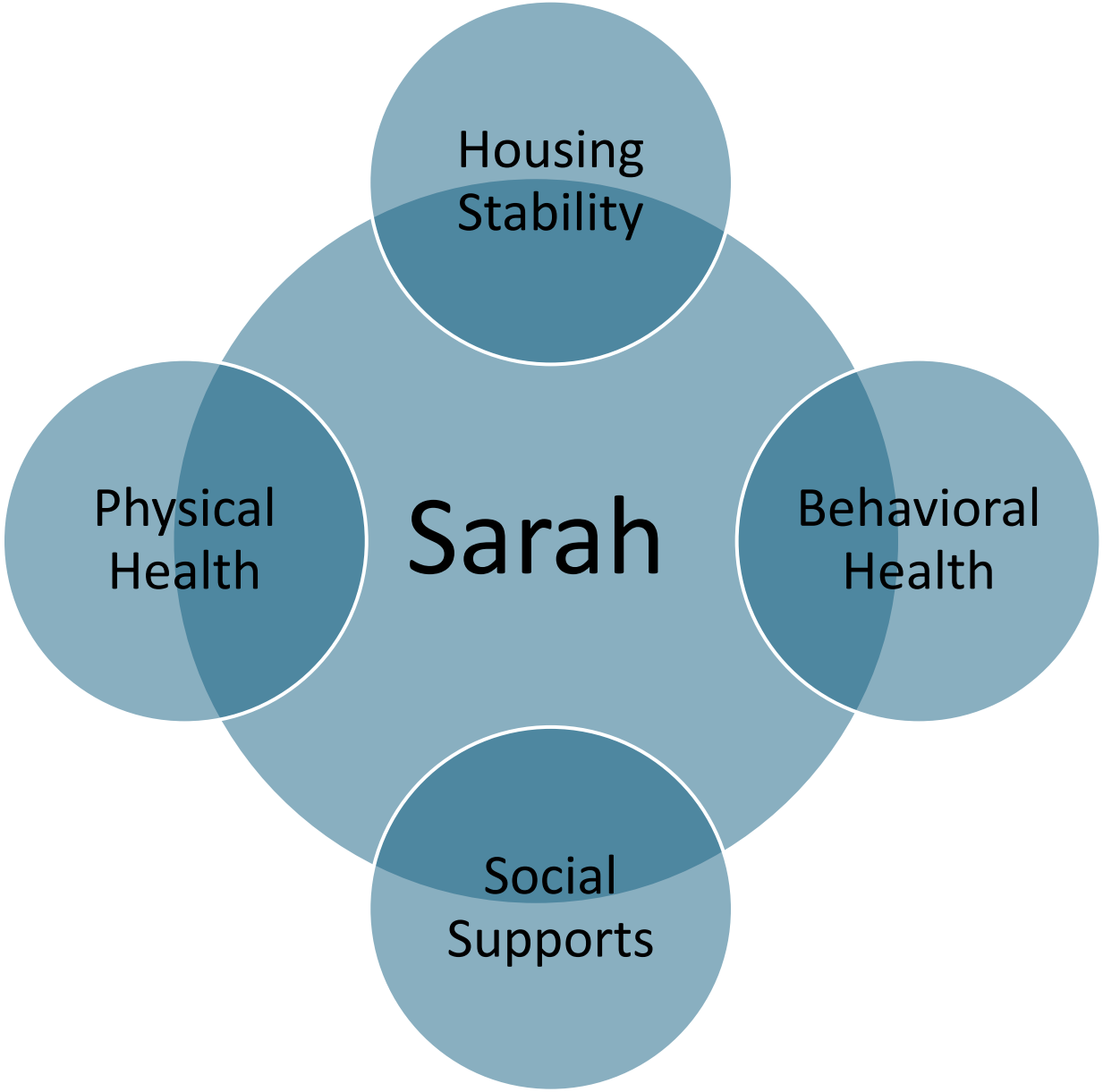
Housing is health care.

Stable housing drives health outcomes.

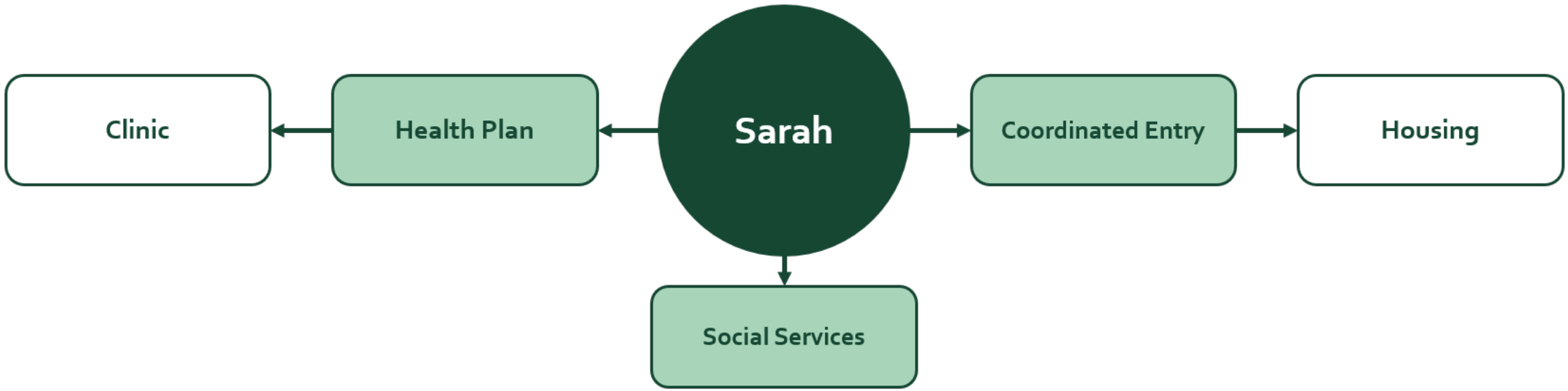
Health, housing, and social needs are connected.

Without a stable home, care is hard to reach.

*Guided by CMS and HCA whole-person care.

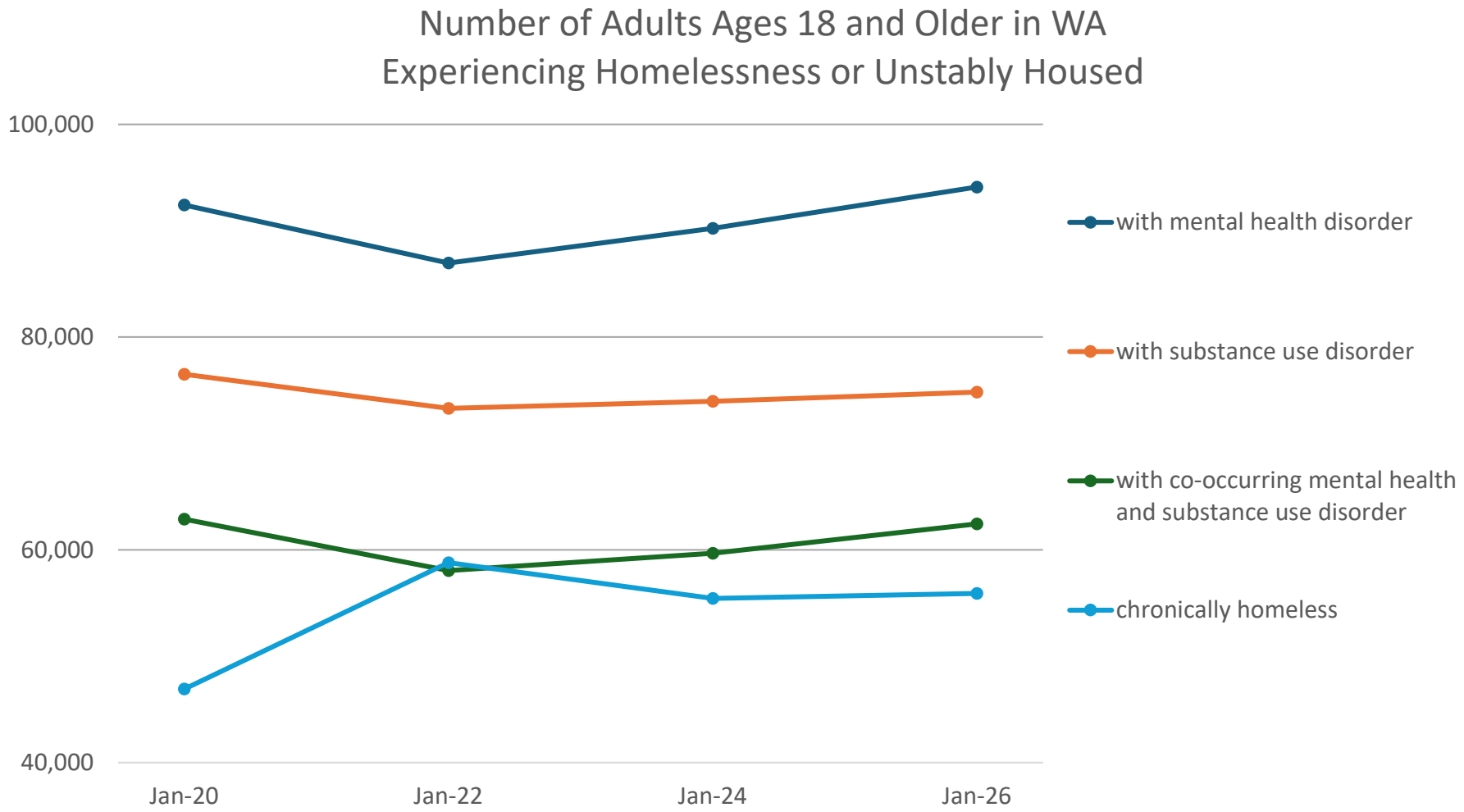


From System Navigation to Collective Responsibility



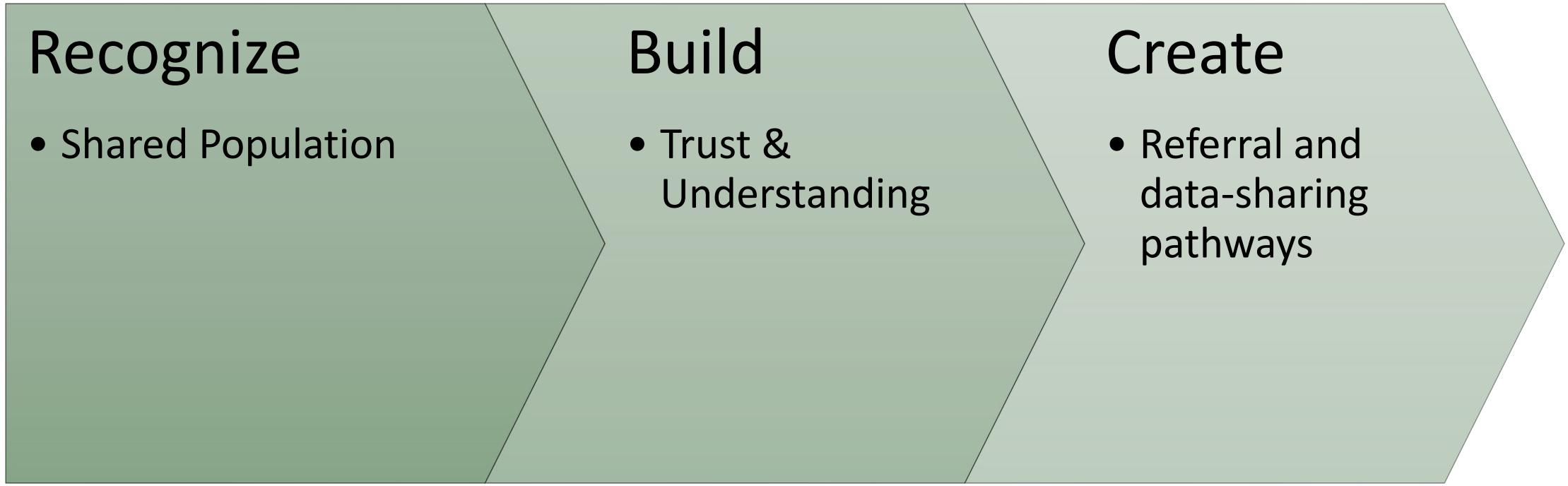
"The challenge is not that people experiencing homelessness fail to navigate systems. The challenge is that our systems often require them to do the coordination work themselves"

The Challenge



Source: Snapshot of Homelessness in Washington State for January 2020, 2022, 2024, and 2026. Washington State Department of Commerce, retrieved from: Reports and Publications – Washington State Department of Commerce

Building Partnerships Across Systems



Centering Lived Experience in System Design

"People shouldn’t have to choose between their health and housing"

"Designed around the realities people experience. Not the systems they navigate"



Year 1: We stopped guessing and started mapping.

Building the Foundation

Before we built anything, we spent two years learning.

Before we began

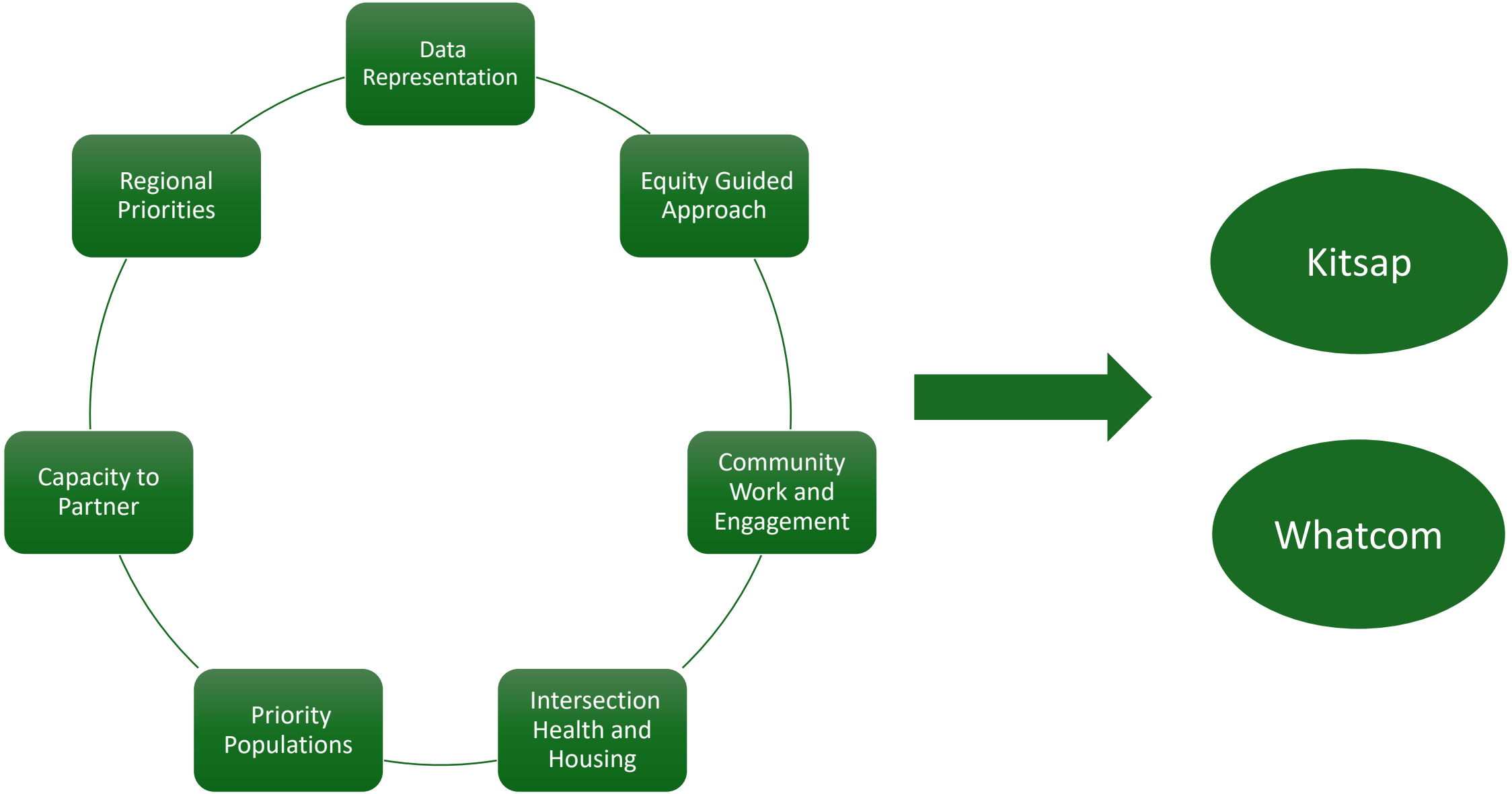
- Literature review
- Current state analysis
- Facilitated conversations across sectors

Year One

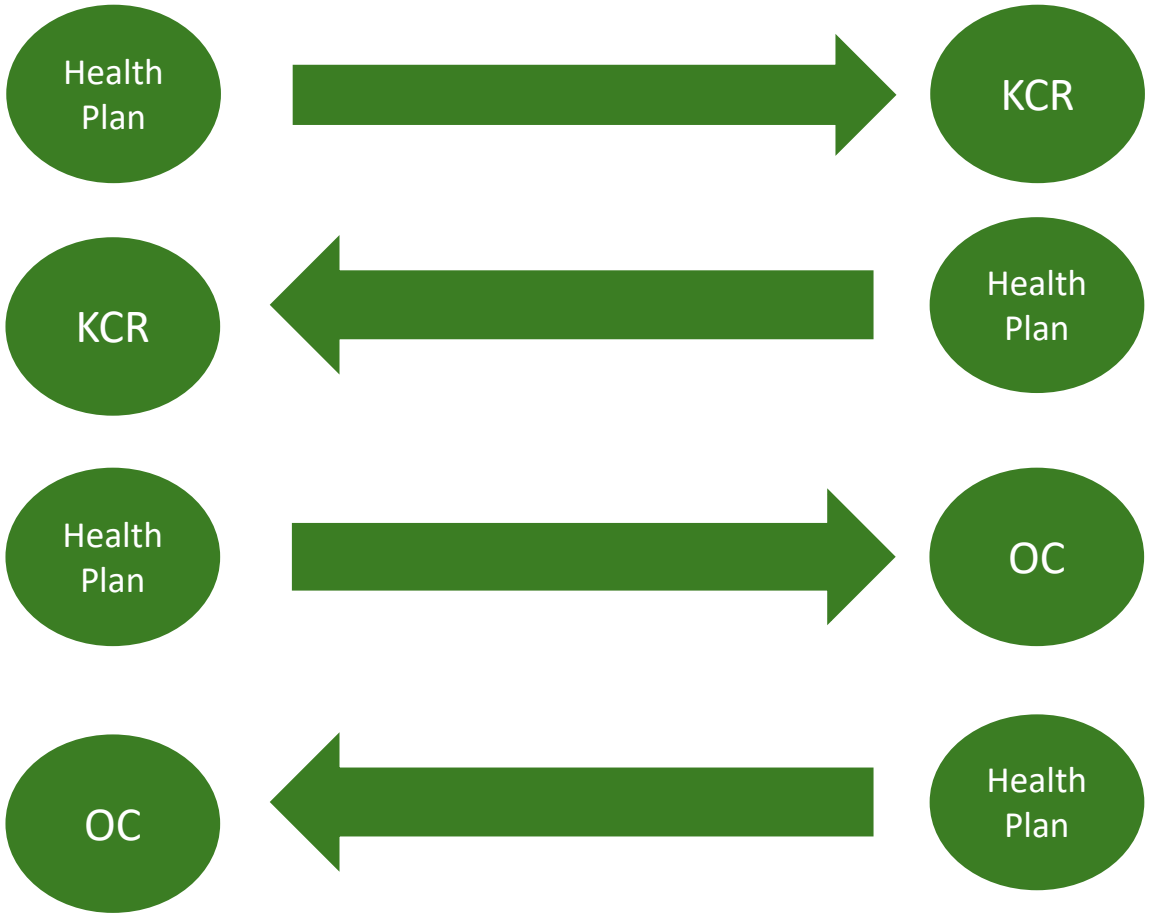
- Multi-plan collaboration
- Direct work with Coordinated Entry sites
- Standing Friday meetings

Lay the groundwork.

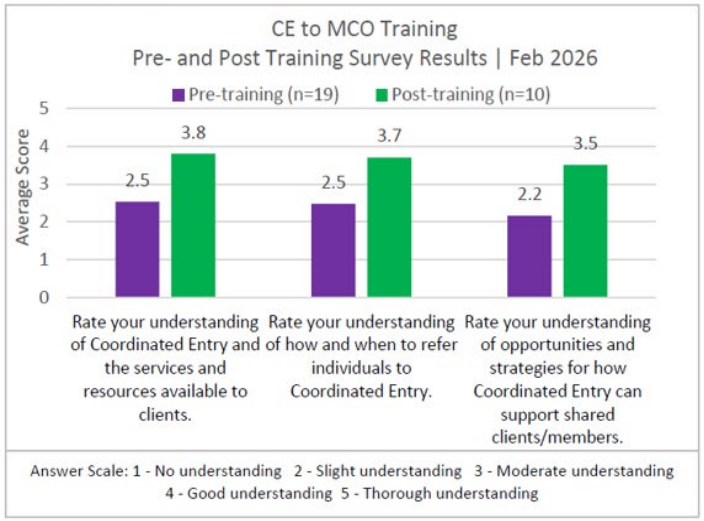
Coordinated Entry Partner Assessment



Bi-directional Trainings

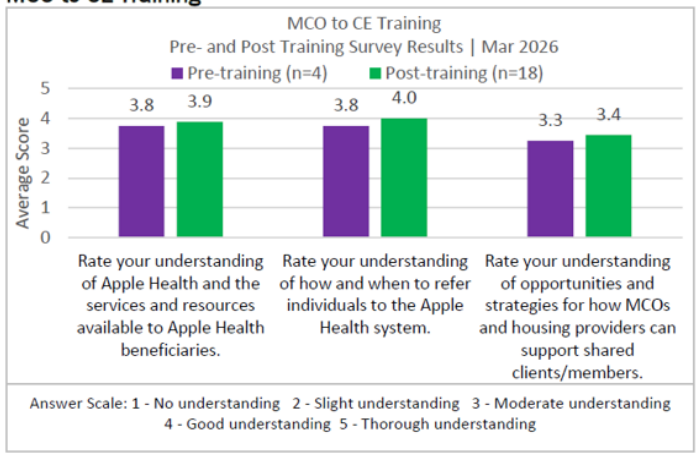


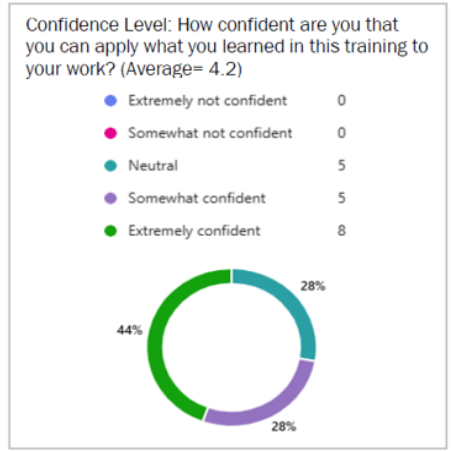
CE to MCO Training





MCO to CE Training





Shared Language, Shared Accountability

DEFINE	CLARIFY	CONNECT
Shared terminology	Shared roles	Clear handoffs
Build common definitions across health & housing	Make responsibilities explicit	Reduce “who owns this?” moments
What do we mean?	*Who does what?*	*What happens next?*

We're building a common language so partners can move from understanding each other → working together.

We Asked Our Partners If This Was Working

Mid-point check-in – facilitated discussion with CE and Health Plan partners

We can see each other's systems now.

Greater visibility into services, resources, and capabilities.

Gaps surface faster.

Collaboration made system gaps and opportunities easier to spot.

Trust made the workflow possible.

A structured space to work together, not just alongside.

"There always has to be a connection before there can be a correction."

— Mid-point Check-in Participant



Year 2: Then the workflow changed.

What Was Actually Standing in Sarah's Way

Six categories of barriers came out of our joint analysis.

1. **Economic & Individual**
   Literacy · Affordability · Accessibility
2. **Cultural & Communication**
   Language · Cultural responsiveness
3. **System Level**
   Housing system · Health system
4. **Perception**
   Stigma · Trust · Prior experience
5. **Physical & Psychological**
   Physical health · Psychological health
6. **Environmental & Location**
   Location · Environment

Systems Level Barriers

ACCESS TO RESOURCES
Housing | Rental Assistance | Essential Supports

HEALTHCARE BARRIERS
Improve access to care and services

CARE COORDINATION
More support for high-needs clients

RESOURCE AWARENESS
Make available resources easier to find and navigate

BRAIDED FUNDING
Align funding across systems to fill gaps

DATA SHARING
Strengthen connections across health, housing & community partners

Capacity Building and Year 2 Interventions



Capacity Building



Stay Housed Rental Assistance Pilot



Bidirectional Referrals

Capacity Building Investments



Capacity Building

- *Made available May 2026*
- Partner directed capacity building
- Flexible funding allowed partners to invest in infrastructure they identified as most needed.
- Examples: technology and system upgrades (documentation, cell phone use for client management, etc....)
- One time funding opportunity.

Kitsap Community Resources



Capacity Building

Year one capacity-building funds, and what they made possible on the front line.

What the capacity funds paid for

- Cell phones for Coordinated Entry staff
- Charging stations for clients waiting in the lobby
- All-in-one client-facing computers for the online application
- Tablets for outreach workers in the field

What it changed

- Staff could complete follow-up calls
- Clients could keep a working phone and stay reachable
- Outreach could help people apply for CE and sign up for health coverage on the spot
- Identifying and staying connected to clients stopped being the bottleneck

“We were able to support people where they are at — navigating not only the CE application, but getting signed up for health care.”

— Kitsap Community Resources

Opportunity Council



Capacity Building

Year one capacity-building funds, and what they made possible on the front line.

What the capacity funds paid for

- Implementation of a case management software system that strengthens our ability to support housing stability by improving how we track and manage client information, communication, and progress.

What it changed

- Maintain real-time documentation of client needs, goals, service plans, and progress.
- Monitor landlord relationships, payment issues, and emerging concerns that could lead to eviction.
- Track referrals to resources for behavioral health or benefits support so households receive timely assistance.
- Record all communication with clients, landlords, and service providers, helping us intervene early when issues arise.

The Red Tape Was the Work



Capacity Building

HIPAA · HMIS Rules · Client Consent · Five Separate Health Plans · State Contract Requirements · DOH Review

What we could share

- Health Plan enrollment
- Consented contact and referral information
- Whether the handoff actually closed

What we could not

- Clinical and diagnosis-level detail
- Anything without documented consent
- HMIS data beyond existing agreements

Stay Housed Project: Rental Assistance Pilot

Stay Housed Pilot

Sept 2026
Pilot launched

10
clients served at each CE site

$30,000
administered per CE site

One-time
time-limited, not a permanent funding stream

GOAL Keep people housed, prevent homelessness, and stop people from falling through existing gaps.

WHO Medicaid-enrolled adults 18–64 with a health-related need who did not qualify for other available funding.

Stay Housed Project: CE Perspective

Stay Housed Pilot

Filling the gap in health-related rental assistance

THE GAP

A health need cuts income, and the door closes. Reduced hours from illness, COVID, flu, pregnancy, or an undocumented mental health condition left people behind on rent and ineligible for every existing program.

THE DESIGN

Low-barrier by design. Self-attestation, minimal administrative requirements, and brief financial assistance instead of long-term case management — built for people who stabilize quickly.

THE RESULT

Fewer denials at the front door. People screening through the prevention line who previously qualified for nothing now receive help, easing the bottleneck across prevention services.

Stay Housed Project: Evaluation

Stay Housed Pilot

AT INTAKE

Household size, age range, type of assistance requested — past-due rent, current rent, utilities, other fees — and baseline ratings of housing stability and stress.

AT 30 AND 90 DAYS

Housing status, qualitative feedback, and repeat ratings of housing stability, stress, and health-related impacts.

HOW IT IS REPORTED

Aggregate only. No identifiable information, and no individual Health Plan or CE data is shared.

Small, targeted investments can help us see where larger system changes are needed.

Stay Housed: Early Implementation Lessons

CE Partners	Health Plans
Low-barrier assistance fills a critical gap. Self-attestation and flexible documentation help reach households underserved by existing programs.	Referral workflows are taking shape. Health plans are receiving intakes and beginning care-management outreach.
Eligibility limitations remain. The $3,000 cap and restrictions on combining funding sources exclude some households.	Cross-system coordination is improving. Partners clarified referral procedures and opportunities to connect rental assistance recipients with additional care.
Implementation is progressing. Both sites reported being on track to fill their pilot slots, despite screening and documentation challenges.	Member engagement remains a learning opportunity. Early outreach highlights the importance of timing, clear communication, and voluntary participation.

Bidirectional Referrals

GOAL
Improve cross-system care coordination so housing and healthcare needs are addressed together.

PHASE 1 · SEPT 2026

CE to Health Plan referrals — live now.

PHASE 2 · 2027

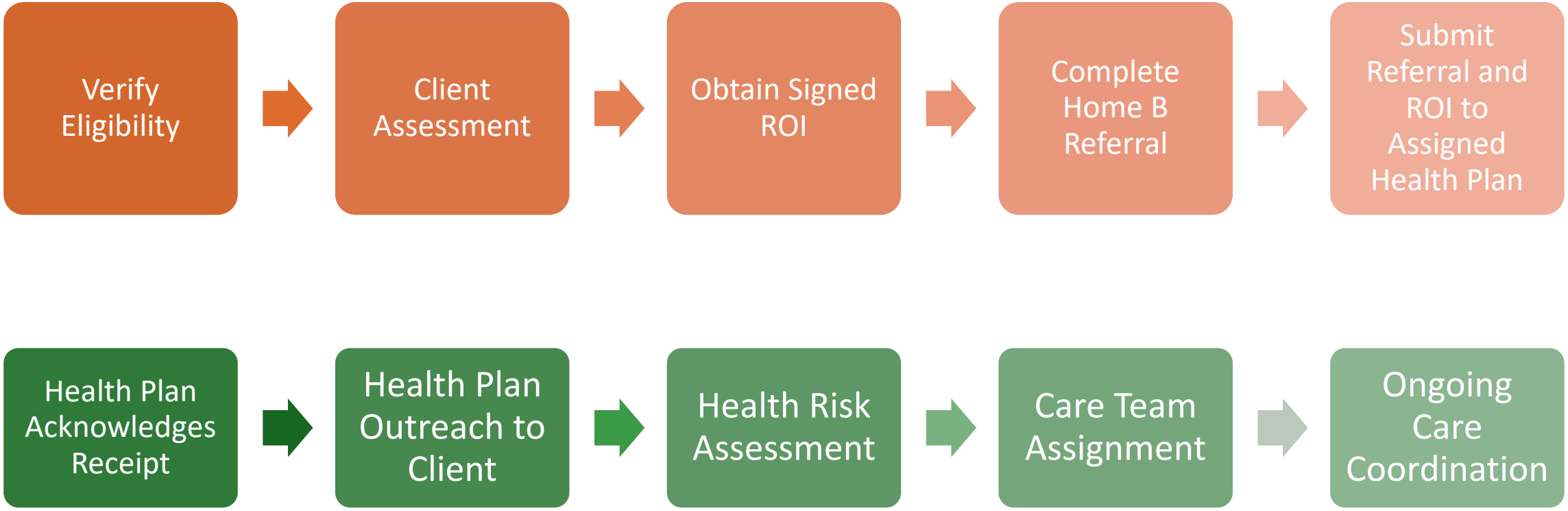
Health Plan to CE referrals.

ELIGIBILITY

Apple Health adults with a healthcare need.

Bidirectional Referrals Workflow

Bidirectional Referrals



Bidirectional Referrals: CE Perspective

Bidirectional Referrals

WHERE THE SILOS BREAK

This is the point where two systems stop running in parallel and begin working together.

WHAT CHANGES FOR STAFF

A health need no longer means handing someone a stack of information and leaving them to sort it out alone.

WHAT CHANGES FOR SARAH

Someone struggling to stay housed can also get help from their Health Plan to manage a health need — one clear path forward once that need is identified.

Bidirectional Referrals: Early Implementation Insights



Bidirectional Referrals

A manageable referral process

CE partners report that referral forms are straightforward, with limited administrative burden after initial training.

New connections across systems

Initial CE-to-Health Plan referrals have begun, with Stay Housed providing another opportunity to identify healthcare support needs.

Real-time process improvement

Regular partner check-ins are identifying opportunities to strengthen referral confirmation, contact information, and tracking workflows.

Meeting members where they are

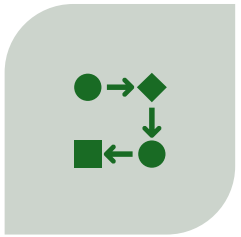
Partners are exploring how the timing of outreach affects willingness to engage in additional healthcare support.

System Gaps We Are Closing



CONNECT ACROSS SECTORS

STRENGTHEN COMMUNICATION BETWEEN HEALTH, HOUSING, AND COMMUNITY PARTNERS



CLOSE THE REFERRAL LOOP

IMPROVE FOLLOW-UP SO REFERRALS DON’T BECOME DEAD ENDS



CONNECT BACK TO CARE

CREATE STRONGER PATHWAYS BACK TO PRIMARY CARE



COORDINATE COMPLEX NEEDS

STRENGTHEN CONNECTIONS TO BEHAVIORAL HEALTH AND CARE COORDINATION



EXPAND COMMUNITY CONNECTIONS

LINK PEOPLE TO BROADER COMMUNITY SUPPORTS AND RESOURCES

The goal isn't more systems. It's stronger connections between the systems we already have.

Lessons Learned: Partnering Across Sectors

1. **Find out who is already serving the same people you are.**
   The person you are trying to help is almost always in someone else's system too.
2. **Go to the experts instead of trying to become one.**
   We were not housing experts so we went and asked the people who were.
3. **Put people in the room who do not usually work together.**
   Including your competitors. The overlap is bigger than the rivalry.
4. **Meet on a standing schedule, not only when something breaks.**
   Regular time together is what turned separate agencies into one working group.
5. **Learn each other's language before you design anything.**
   Different sectors describe the same person in different words. Fix that first.
6. **Close the loop, or it is not a partnership.**
   Know what happened after the handoff, and agree who asks what so people answer once.

The partner you need is probably already working with the same person you are. You just have not met yet.



Sarah's story is not finished.

Sarah Has What She Needs — For Now

The same person. The same needs. A system that finally moves with her.

A door that stays open

Dedicated Coordinated Entry support

A call she didn't have to make

Direct outreach from her health plan

Care that follows her

Care management and local provider connections

A way to get there

Transportation assistance

For now. Keeping it is the part of Sarah’s story we’re still writing.

Where This Goes Next

In 2027 we build on the foundation.

Expand & Automate the handoff

Referrals expand and move between systems automatically.

Connect statewide

Joining the statewide information exchange.

Future project considerations



Now we want to hear from you.

Questions?

If there are any other questions, please send your email to:

jennyna.golveo@doh.wa.gov

Housing WA. ANNUAL CONFERENCE

Thank You

2026

Sources

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