Housing is Healthcare: Leveraging Cross-Sector Partnerships to Address the Opioid and Housing Crises

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Housing as a Human Right: Driving Progress in Times of Uncertainty
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Monarch Housing Associates Housing Is a Human Right Conference 2025

Colleen Snow-Quinn

Alcohol & Drug Director/ Mental Health Administrator

Camden County Office of Mental Health & Addiction Services

Department of Health and Human Services

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Camden County's Commitment to Homeless Response

Background: Why Change Needed

- **2018**: System not working
- Created **Homeless Service Coordinator**
- Consolidated HUD, state, and county resources
- **New Focus:** coordinated, outcome-driven system

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A Countywide Plan

2024: Framework to end chronic homelessness

Guided by evidence and cross-sector collaboration

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END CHRONIC HOMELESSNESS CAMDEN COUNTY

Partnerships at the Core

Collaboration across:

- Community Development
- Public Health
- Addiction & Mental Health Services
- Board of Social Services
- Police + Right Path Initiative
- Prosecutor's Office
- Senior Services
- One Stop

Shared accountability

Optimizing Capacity

Funding: From Sources to Services

Homeless Trust Fund

- CPRS Homeless Outreach
- HTF Sober Living
- Youth/ Re-Entry Housing
- Outreach/ Resource Fairs
- Low Barrier County ID Program
- Diversion Program with BSS

Tax Levy

- Building 60-unit Supportive Housing
- Building Multi-Agency Center (MAC)
- Suburban Code Blue

CV/ARP

- Regan Center
  - 15 ES Beds /
    8 medical respite beds
- Work Now Initiative

Challenges Ahead

- State budget cuts across partners
- Shelter & treatment bed shortages
- Criminalization pressures
- County responsibility for 3 facilities

Innovation required to overcome challenges

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Behavioral Health & Homelessness

HUD 2023 (National):

- 28% SMI
- 23% chronic SUD

NJ Courts 2024:

- 26% of homeless adults reported a MH issue
- 19% SUD
- 12% co-occurring MH + SUD are at much higher risk of homelessness. (SAMHSA 2022)

- In NJ, homelessness rose 24% from 2023–2024 → **12,680 people**, including **1,737 unsheltered** [NJ PIT Count, 2024 – Monarch Housing].

Behavioral health challenges drive housing instability

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Camden County: Making it Better Together

Thinking Outside of the Box

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PREVENTION

Prevention & Education

Investing upstream to reduce future homelessness

- Narcotics Overdose Prevention Education (NOPE) Presentations
- Strengthening Families Program
- Senior Education & Outreach
- Naloxbox Initiative *(671 Locations YTD)*
- Fentanyl is Fatal Campaign

Preventing today's crisis is tomorrow's housing stability

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Early Intervention

- Mental Health Navigator in coordination with Project S.A.V.E.
- Behavioral School Clearance Program
- Community & Homeless Outreach + Subcontractor Outreach + County ID Program
- Healing Together Community Support Group

HEALING TOGETHER
A Community Support Group
Because No One Heals Alone

Meeting residents where they are, before crisis escalates.

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Treatment Access

- Mobile Buprenorphine Program
- Post-Crisis Case Management & Follow-up
- Certified Peer Recovery Specialist + County Shelters
- Treatment slots for uninsured
- Subcontracted Treatment providers certified in presumptive eligibility
- Vocational supports in treatment recovery

Treatment is accessible where residents live and recover

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Recovery Supports & Stability

- Real Sports & Activities
- Extended Sober Living stays
- Peer Led Recovery Center extended hours

Recovery supports transform stability into long-term housing

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Recovery Supports & Stability
Beyond Opioid Funds

- **Temporary Shelter Support** – housing for residents discharged from hospital after overdose with nowhere to go
- **Emergency Shelter Placements** – with professional case managers for severe MH needs in treatment.
- **Wraparound Broker Services** – funding rent/ utilities to prevent eviction for individuals with SMI
- **Payee & Financial Planning**– case-managed support for recovery + housing stability

When housing is at risk, flexible supports keep people safe and stable

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Shared Accountability, Stronger Communities

Count departments working as one

Partnerships fuel innovation

Shared accountability drives results

Ending chronic homelessness together

Collaboration drives innovation, stability, and hope

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Camden County OMHA – *at a glance!*

- Treatment Access – County Funding all levels of care
- OMHA Technical Assistance
- 57 OMHA monitored programming SUD & MH
- **OMHA Camden City Outreach Expansion + Mobile Unit**
  - Substance Use, Mental Health, Wound Care, DOH Nurses, CPRS, Treatment connection & Transportation, MAT, SAP.

- Naloxone Box Initiative
- Free Narcan Training
- Overdose Response Kits – 1,750+ YTD
- Mobile Buprenorphine Program
- Sober Living Program
- Camden City Recovery Center Hour Expansion:
- Certified Peers in County Shelters (5)
- Post-Crisis Follow-up Case Mgmt.
- Licensed Clinical School Behavioral Clearances
- NOPE: Narcotics Overdose Prevention & Education
- Prevention & Education in County Schools; Botvins
- Disaster Response Crisis Counselors (DRCC)
- Boarding Home Socialization & Activities

- **Camden County 24/7 SUD Warmline: (877) 266-8222**
- Professional Training & Development
- Project SAVE + Mental Health Navigator Municipal Court Substance Use Diversion
- Healing After Loss of an Overdose (HALO)
- Healing Together Community Support Group
- Family Support Groups for SUD
- Wraparound Broker Services
- Payee Financial & Planning
- Housing for SMI – Emergency Placement
- Case Management – Emergency Placement
- Community Awareness Event
- Fentanyl is Fatal
- Break the Stigma
- REAL Sports & Activities
- Mobile Buprenorphine Program
- Strengthening Families
- Substance Use in the Elderly
- Temporary Shelter Placement
- Patient & Family Education

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Any Questions?

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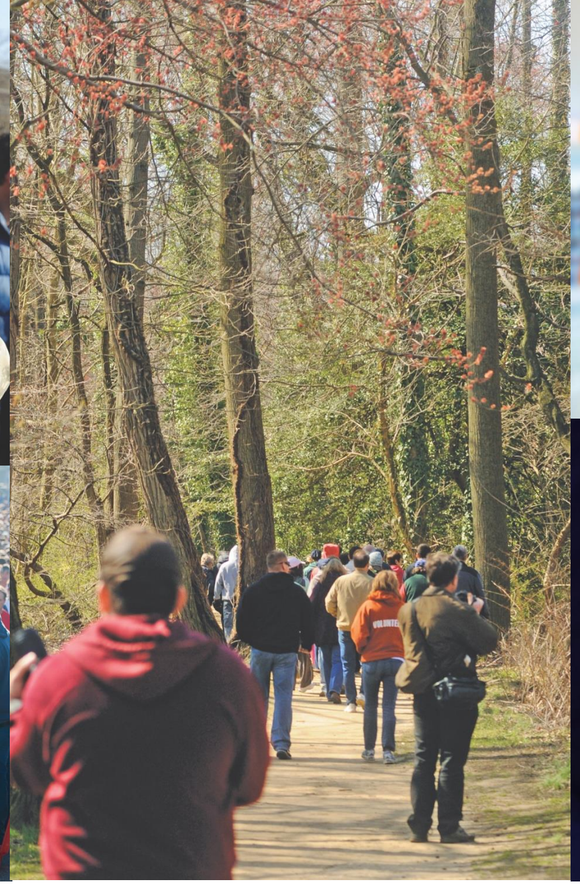


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Social Healthcare Integration (SHI) Services Initiative

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Lorenzo Allen

COMING HOME Ending Homelessness in Middlesex County

SAINT PETER'S HEALTHCARE SYSTEM

RWJBarnabas HEALTH | Robert Wood Johnson University Hospital

Bridge between Healthcare and Social Services Systems

SHI Program

Private Partnership between Coming Home, RWJUH and SPUH to address the SDOH of the Hospitals' High Utilizers of the ED.

- CMS: Accountable Health Community Application
- Scaled back from 11 Social Service Navigators to 2
- Hospital Funding Support
- DCA: Support dedicated rental assistance vouchers
- Coming Home: Dedicated Housing Case Management for High Utilizers (Social Service Navigator SSN: 20 clients each)
- Implementation Team: first monthly, then bi-monthly, iterative

Essential Terms

- **SDOH or Health Related Social Need (HRSN) CHM addresses**
  - Housing instability
  - Food insecurity
  - Failure to access mainstream entitlements and services
  - and/or breakdown of family and social network
- **High ED Utilizer (HU)**
  - a person who is a Middlesex County resident and has visited the hospital emergency department 20 or more time in a 24-month period and who is included on each hospital's list. (STATIC V. DYNAMIC)
- **SSN outreaches**
  - Engages
  - Ascertains SDoH & develops personal service plan to resolve SDoH
  - Provides supportive services and linkages to community resources, including housing .
  - If unsuccessful for 3-6 mos., case closed. If successful, keep open for awhile for maintenance.

Disabilities Among SHI Participants (Out of 30)

	Jan-Feb			Mar-Apr			May-Jun			Jul-Aug			Sep-Oct		
Key Challenges:	RWJ	**SPUH**	**Total**	**RWJ**	**SPUH**	**Total**	**RWJ**	**SPUH**	**Total**	**RWJ**	**SPUH**	**Total**	**RWJ**	**SPUH**	**Total**
Substance Abuse	9	**6**	**15**	**7**	**8**	**15**	**6**	**6**	**12**						
Severe Mental Illness	17	**10**	**27**	**15**	**12**	**27**	**16**	**10**	**26**						
Co-occurring Disorders	11	**5**	**16**	**12**	**3**	**15**	**11**	**4**	**15**						
Physical Disability	12	**2**	**14**	**10**	**7**	**17**	**12**	**2**	**14**						

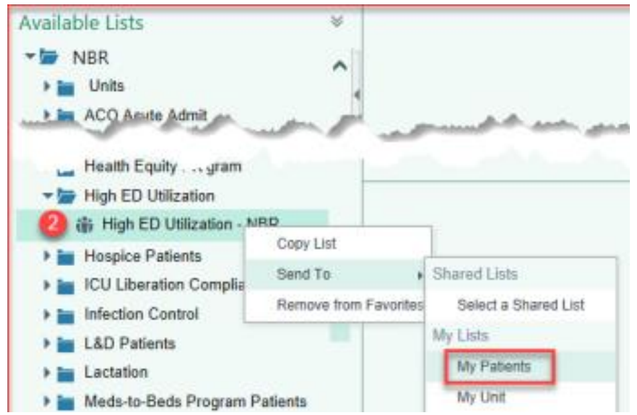
Outcomes

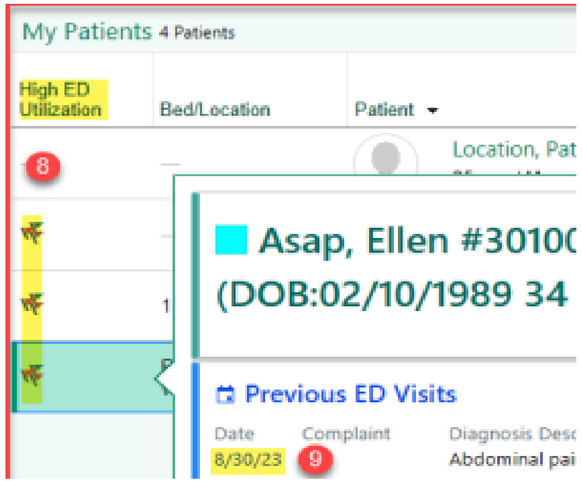
- **For RWJUH:**
  - For the clients that are housed, there was an average decrease of 37% in ER visits compared to the **6 months prior** to enrollment in the program.
  - For all clients who are enrolled in SHI there is an average decrease of 24% in the ER visits, excluding the extreme outliers.
- **For SPUH:**
  - For the SHI clients that are housed there is an average decrease of 93.5% in ED Visits compared to the visits pre-enrollment, **dating back to 2021**
  - For all clients who are enrolled in SHI, excluding outliers, there is 87% decrease in ED visits once the Participant was enrolled

Referrals

- **Static (Report Based) List**

- **Dynamic (Referral Based) Referrals**
  - Multidisciplinary Team
    - Via EPIC alerts
    - Team Member Identification
      - SDOH Screening





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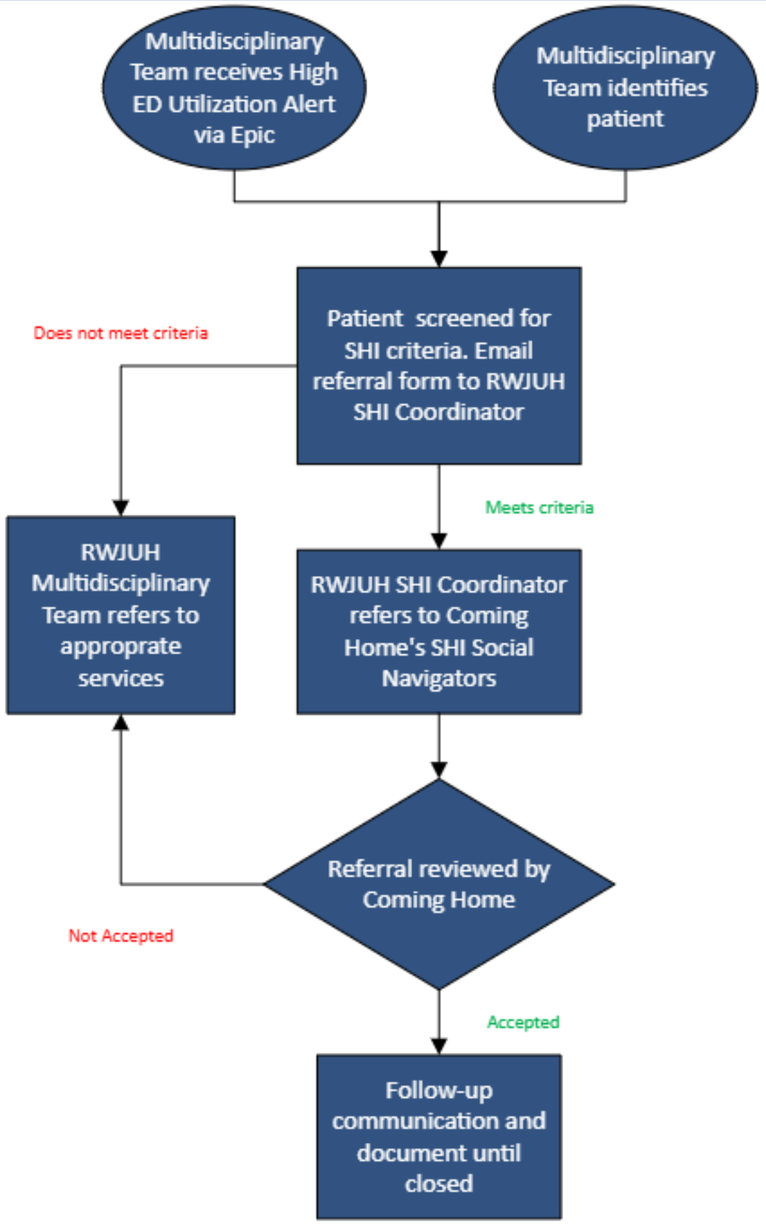
Hospital SHI Workflow



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Participant’s Story

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Thank you

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RWJBarnabas HEALTH | Robert Wood Johnson University Hospital

Thank you to our Speakers!

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