COMMUNITY PARTNERSHIPS: TRAINING CASE MANAGERS WORKING WITH INDIVIDUALS EXPERIENCING CHRONIC HOMELESSNESS

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Abstract

Background: Homelessness is a chronic problem across the United States, with approximately 25% of homeless people located in California. In 2012, the United States Interagency Council to end Homelessness developed guidelines to implement Housing First initiatives and training for case managers. Launched in February 2017, Sacramento's Flexible Supportive Rehousing Program, a permanent Housing First initiative, was adapted from Los Angeles County's Housing for Health.

Methods: A comprehensive training academy for case managers working with individuals experiencing chronic homelessness was developed, implemented, and evaluated. Goals were to improve case managers' ability to keep clients in housing, and to improve health outcomes as indicated by the Social Determinants of Health.

Results: Knowledge, skills, and attitudes (KSA) objectives were provided for each training module. Case managers demonstrated knowledge and skills acquisition by presenting case studies following a provided rubric. Attitude changes were assessed using an adaptation of a validated tool. Evaluation of progress toward longer-term goals is ongoing.

Keywords: Social Determinants of Health; interprofessional; homeless; health; education; case managers; knowledge. skills. and attitudes (KSAs); partnership; social work; nursing

Healthy People 2020 notes that since 2017, the number of individuals experiencing homelessness has been steadily increasing; serious health hazards adversely affect

persons who are chronically homeless (Healthy People 2020, n.d.). According to Lewer et al. (2019), the incidence of health problems among low-income, unhoused individuals is significantly higher than for low-income, stably housed individuals, with reports of chronic illness three times more common. In 1987, the United States Interagency Council on Homelessness (USICH) urged the 19 affiliated federal agencies and other health providers to integrate health-care and social services such as case management to improve outcomes in homeless populations (USICH, 2015). In 2010, USICH authored a document (amended in 2015) called "Opening Doors" as a guideline to ending homelessness in the nation. Its recommendations stress Housing First initiatives, an integrated service delivery system specially designed for individuals experiencing homelessness who frequent emergency rooms or who regularly come to the attention of law enforcement agencies.

USICH works to help communities create partnerships, use resources in the most efficient and effective ways, and employ evidence-based best practices to address homelessness (USICH, 2022). Social Determinants of Health (SDH), defined as the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks (Healthy People 2020), indicate society's role in the health and well-being of people. Housing is a well-established aspect of SDH (Henwood et al., 2013). Working in partnership across many disciplines is essential for addressing the problem of homelessness. An effective approach is interprofessional collaboration (IPE), occurring when members of two or more professions work together to achieve common goals; IPE is often used as a means for solving a variety of problems and complex issues (Green & Johnson, 2015).

The Housing First strategy requires preparation of case managers to work with persons who are chronically homeless (USICH, 2015). This article describes the development, implementation, and evaluation of an interprofessional intensive training academy as a quality improvement project for case managers focused on the unique needs of

chronically homeless clients who are being settled into county-sponsored permanent housing.

BACKGROUND

Individuals who experience chronic homelessness are at higher risk for infections, traumatic injuries, drug and alcohol overdoses, violence, exposure to extreme heat or cold, and death (O'Donnell et al., 2016; Saab et al., 2016). Persons who live on the streets or under bridges are more likely to use emergency departments for health care and to be admitted to hospitals for longer stays than persons who have safe housing (Gerber, 2013; Wen-Chieh et al., 2015). Individuals experiencing chronic homelessness have shorter life spans (42 years for men and 52 years for women) compared to the U.S. life expectancy of 78.8 years (National Academies of Sciences, Engineering, and Medicine, 2018).

Sacramento County, California experienced an 80% increase in homelessness in 2016 (CSUS, 2017). The County Board of Supervisors approved four initiatives to address this growing problem and to provide relief to chronically homeless people (Lake & Cavanaugh, 2017). One of the initiatives is the creation of a permanent housing program, the Flexible Supportive Rehousing Program (FSRP), which is designed as a Housing First initiative. The FSRP identified 250 individuals in the county who were experiencing chronic homelessness who made frequent use of emergency rooms and were frequently incarcerated for crimes related to homelessness. These individuals were offered and accepted permanent lifetime housing.

The FSRP contracts with four local social service agencies to implement Intensive Case Management Services (ICMS) for clients. Each agency is responsible for the employment and oversight of the case management aspects of the program. Eleven case managers provide direct support to 250 previously chronically homeless clients who now have permanent housing through the FSRP. The ICMS team, including agency managers and directors, participate in weekly case conference calls with the FSRP program manager.

Each agency and the program manager contribute to maintaining the philosophy of care delivery, work process, and specialty focus. The case managers are required to understand the depth and breadth of the FSRP's philosophical approach of doing "whatever it takes" to keep clients in housing; cultural aspects of the homeless population being served; role expectations; and necessary preparation for all-inclusive services. A training academy was determined to be the best approach to prepare the ICMS team to work with this often complex and high-need population.

REVIEW OF LITERATURE

A literature search of the Cumulative Index to Nursing and Allied Health Literature (CINAHL) database using the terms "communication," "homeless," and "nursing" yielded 21 articles, 17 of which were in academic journals. Another search with the terms "education," "homeless," and "nursing" yielded 192 articles, with 138 coming from academic sources.

A search of the Cochrane Library using the term "homeless persons" offered 337 results, but only three were specific to Cochrane review. When the term "housing" was added, 391 results were available with five Cochrane reviews, two of which were specific to health and housing. In addition, SAGE Journals was reviewed for both sociology and health. The key terms "homeless and health" and "communication" yielded 5,994 articles. Narrowing further to only Health Sciences journals yielded 103 articles, many about rehousing homeless individuals, with current strategies and barriers to use of services. This information served as a foundation for the development of a training academy for case managers working with both rehoused and chronically homeless individuals.

A search for survey tools that addressed questions about care provider attitudes toward individuals experiencing homelessness identified two. The first was developed for use in England, with terms appropriate to that care system, and minimal details on specific

question validity. The second tool was the Health Professionals Attitudes Toward the Homeless Inventory (HPATHI) (Buck et al., 2005); the article provided details on each question's validity and comparisons to two other tools for validation. Cronbach's alpha was 0.88 and test-retest reliability coefficient was 0.69.

Appraisal of the Evidence

Fifteen relevant articles were assessed for quality of evidence utilizing the Johns Hopkins Evidence-Based Practice (JHEBP) model with Individual Evidence Summary and Synthesis and Recommendation Tools (see Figure 1). These articles provide a baseline investigation into the training needs of case managers working with individuals experiencing chronic homelessness.

Figure 1.

Articles Selected Using Johns Hopkins Evidence-Based Synthesis and Recommendation Tool

Author & Date	Evidence Type	Sample Size and Type	Findings and Recommendations	Level of Evidence
Abramowitz et al., 2010	Qualitative	N=30 (MD residents)	Evidence of improved confidence in clinicians approaching clients with chronic care needs (often the case with homeless people) through Motivational Interviewing	III - Good
Anderson et al., 2007	Expert opinion	N/A	Addresses community-based culturally competent communication (homeless as unique culture) strategies	V - Good
Durant et al., 2015	Position statement	N/A	Provides informal survey of success using Carita's (Caring) Theory in practice	IV - Low
Durning & Artino, 2011	Expert opinion	N/A	Theory addressing impacts of environment on how we think	V – Good
Salem et al., 2017	Mixed methods	N=20 (homeless women)	Identifies need for culturally competent clinicians for homeless population	III –Good
Jirwe et al., 2009	Mixed methods	N=24 (experts: 8 nurses, 8 researchers, 8 lectures)	Identifies core cultural competencies for sensitive communication	III - Good
Kelly, 2005	Expert opinion	N/A	Addresses issues in communication in healthcare relationships	V - Low

Gerber, 2013	Expert opinion	N/A	Address several homeless needs in regards to interaction with healthcare providers	V - Good
Linden et al., 2010	Prospective study with observational method	N=22 (10 male, 12 female)	Evaluates strategies for stress and burnout reduction in employees	III – Good
Nyamathi et al., 2012	Mixed method	N=156 (homeless youth)	Evidence supporting positive environment, flexible providers and multiple services in one location improve compliance	II - Good
Porr et al., 2012	Qualitative based on Grounded Theory	N=21 (low income single mothers)	Evidence supporting need for positive communication strategies	III - Good
Rief et al., 2012	Qualitative	N=50 (weight loss program participants)	Provides data for practical self-wisdom as an important consideration in approaching care recommendations	III - Good
Rust et al., 2006	Expert opinion	N/A	Provides specific communication tools for working with various cultures	V - Good
Sanders Thompson et al., 2008	Qualitative focus groups	N=49 (African American's 32 men, 17 women)	Identifies types of communication to be culturally specific for healthcare understanding and compliance	IV – Good
Trupp et al., 2011	Randomized Control Trial	N=70 (outpatient sleep study participants)	Indicates message framing impacts compliance with healthcare treatments	III - Low

Themes from Literature Search

Four major themes emerged from the evaluation of literature and use of the JHEBP:

1) Homeless individuals are part of a unique cultural group;

2) Homeless individuals' participation in health-care activities is greater when positive interpersonal interactions occur with service providers;

3) Motivation to interact with service providers may be based on the way homeless individuals perceive themselves; and

4) Service provider attitudes tend toward a negative view of those experiencing homelessness, further affecting homeless individuals' willingness to seek care.

The Culture of Homelessness. Cultural sensitivity is reflected in an accepting, open approach in communication. Anderson et al. (2007) posited that assets and strengths

within a cultural community affect the ability to participate in care. Law and John (2012) remarked that homeless individuals have developed common behaviors out of need. Attempts to re-pattern unhealthy behaviors must be approached with great care to avoid further withdrawal from society and rejection of care (Gerber, 2013; Keenan et al., 2021).

These observations suggest that case managers and other health providers need flexibility to adapt to varying cultures and to demonstrate cultural competency (Jirwe et al., 2009). Caseworkers and caregivers may not possess the skills and attitudes necessary to properly operationalize cultural competence, with significant gaps in capacity and utilization among health-care workers (Horevitz et al., 2013; Bonzanto et al., 2019). Further evidence indicates that cultural congruence is necessary for communication training to be effective (Sanders Thompson et al., 2007).

Interpersonal Interactions with Service Providers. According to Nyamathi et al. (2012), homeless adolescents are more willing to participate in health activities and achieve better health outcomes when nurses present a calm, empathetic, and objective, rather than an authoritarian, approach. Additional evidence on the need to provide supportive and positive therapeutic relationships has been outlined by Porr et al. (2012), who found that low-income mothers who feel stigmatized may be influenced to participate in health activities by public health nurses who establish trusting relationships with them. Gerber (2013) acknowledged the need for care providers to treat indigent people with patience and respect by asking simple, open-ended questions, listening to the responses without judgment, allowing enough time to have a full dialogue while being mindful of personal space, and maintaining a comfortable level of eye contact. A noted barrier to care is lack of trust in care providers among individuals who have suffered past abuse or discrimination (Gerber, 2013; Salem & Ma-Pham, 2015).

Motivation to Utilize Services Based on Self-Perceptions. Although individuals might be interested in the idea of caring for themselves, they may lack the knowledge and/or ability to do so. Trupp et al. (2011) reported that individuals' state of mind and behavioral health influence health-seeking actions; motivation can be influenced by how information is framed. Motivational Interviewing is a technique used by health-care providers to accurately assess client interest in improving self-care (Abramowitz et al., 2010).

Walter et al. (2015) provided another observation on perspective: the definition of "homeless" from a policy perspective does not always coincide with an individual's view of themselves. The way someone is viewed either from within or by another person may affect motivation to utilize services. The "homeless" label also relates to the theme of service provider attitudes about people in indigent situations. In consideration of this, the use of person-first language instead of identity related to circumstances may promote partnership and optimism in clients experiencing homelessness (Carroll, 2019). Rief et al. (2013) presented evidence of experiential learning, which they termed phronesis, as a communication approach for improving chronic, lifestyle-related illness. Porr et al. (2012) suggested that regular and sustained respectful contact with service providers supported desired behavior changes.

Service Provider Attitudes. As previously indicated, environment and attitude may create unseen barriers to a person's desire to participate in self-care activities (Durning & Artino, 2011). The effects of service provider attitudes and communication skills on patients and families were presented in three articles. Kelly (2005) argued that regardless of whether a provider's display of conflict is with a patient or with a co-worker, negative patient outcomes are more likely to occur. Additionally, the patient-caregiver relationship should be established out of trust, suspending any personal judgments while providing care. Durning and Artino (2011) discussed Situative Theory, which states that learning and knowledge are situated in personal experiences; the

context of environment and circumstances strongly impacts the person's attitude, affecting their ability to learn new information. This theory can be applied to both the service provider and the individual experiencing homelessness.

Evidence on improving provider attitudes, and thus patient satisfaction, through various techniques was provided by Durant et al. (2015). Many homeless individuals avoid health care and other services because they feel discriminated against, judged, unwelcomed, and unsafe (Kotzur et al., 2017; Walter et al., 2015; O'Donnell et al., 2016). Therefore, case managers' communication styles when working with individuals experiencing chronic homelessness require training in specific knowledge and skills to meet their clients' unique needs.

HOUSING FIRST IN SACRAMENTO COUNTY

In 2018, California contained 25% of the nation's homeless population, with more than 44,400 individuals residing in Los Angeles County (United States Department of Housing and Urban Development [HUD], 2018). In 2012, Los Angeles County implemented a Housing First initiative, Housing for Health (HFH), for individuals experiencing chronic homelessness, with intensive case management services. Four years later, 97% of all participants remained housed, with a 20% decrease in county expenses related to caring for this population (Rand, 2017). Based on the success of HFH in Los Angeles, Sacramento County chose the model to develop the Flexible Supportive Rehousing Program (FSRP). Included within both programs is required training for intensive case managers that is focused on the unique needs of individuals experiencing chronic homelessness. These trainings are knowledge- and skills-based for community partners and stakeholders to participate in, focused on the goal of maintaining permanent housing for clients.

The objectives of this development project were:
1) collect baseline data about FSRP case managers' knowledge, skills, and attitudes

(KSAs) about homelessness;

2) in partnership with community experts, develop a curriculum to fill gaps in knowledge; and

3) deliver content in a structured, recurring class.

Desired outcomes were:

1) Case managers will demonstrate increased knowledge regarding multiple aspects of homelessness and caring for vulnerable populations;

2) Case managers will apply the skills acquired from participating in the training academy; and

3) Case managers will demonstrate supportive attitudes to successfully engage with clients.

Aims

The aims of the project were to develop, implement, and evaluate a case manager training academy to improve knowledge of homelessness, services, resources, and related issues. The project's goal was to assist case managers in the development of knowledge and skills to use in engaging clients before and after achieving housing. Graduates of the academy were evaluated to determine changes in their attitudes about homelessness. The ultimate aim was to improve the health of clients experiencing homelessness, and the communities where they reside, through working with community partners and stakeholders. A timeline for training and evaluation based on perceived feasibility and effectiveness is shown in Figure 2.

Figure 2.

Project Timeline

	Spring 2017	Fall 2017	Spring 2018	Fall 2018	Spring 2019	Summer 2019	Summer 2021
Literature Review	X		X		X		X
Identify Community Partners		X	X				
Community Stakeholder Meetings		X	X	X			
Curriculum Development			X	X			

Identify Experts				X	X	X	
Community Collaboration/ Implementation					X	X	
Evaluation of KSAs					X	X	
Health Status	X						X

Ethical Considerations

This study was a quality improvement project; institutional review board approval was not required.

METHODS

Based on the literature review, input from community stakeholders, feedback from partnering agencies, and advice of content experts, a training academy was designed for ICMS staff working with rehoused individuals and those still experiencing chronic homelessness. Included in the curricular design were tools for personal insight, strategies for interaction with clients, and community resources.

Developing the Training Intervention

Awareness of the need for training was identified during the evidence-gathering stage, seeking input from community members and stakeholders. Open meetings were advertised and held to assess case managers' existing training, the knowledge of interested of community members, partner interest in participation as content experts, and general interest in attending the training. The initial meeting was conducted with the FSRP contracted agencies; subsequent meetings were open to all community members. Groups represented included the Continuum of Care agency, Sacramento Steps Forward, the Sacramento County Board of Supervisors, private rehabilitation clinics, a community law clinic, ombudsman, and individuals who had previously experienced homelessness. An outline of the training curriculum was reviewed for relevance for persons who had been chronically homeless in Sacramento County.

Consultation with community experts was ongoing. Once the curriculum areas were

determined, community experts were evaluated for their interest in co-developing learning modules. Presenters were selected based on professional experience, community reputation, lived experiences, and ability to relate the topic to homelessness. Changes to module content and delivery were made based on presenters' requests. Other community experts consulted on content. Module topics were chosen for relevance to homelessness and to Sacramento County's specific needs. See Figure 3.

Figure 3.

Training Modules

	Module	Module Description	Presenters
1	Scope and Perspective	Provides candidates with foundational understanding of the history and current trajectory of homelessness across the nation, state, and county.	Cindy Cavanaugh, Emily Halcon, Chris Martin, Tim Brown, Deborah Finn-Romero
2	Roles and Responsibilities – Life Domains	The roles and responsibilities of ICMS will be defined in relation to boundaries, integrated service model, and coordination of care.	Meghan Marshall
3	Trauma-Informed Approach	Candidates will receive an overview of trauma across the lifespan and skills necessary to integrate the impact of these traumas into interactions and services provided to clients.	Jodi Nerell
4	Human-Centered Care	These two days will explore cultural humility, cultural consciousness, the importance of language and framing, and how these concepts impact our service quality and client outcomes.	Deborah Finn-Romero, Alex Filippelli, Shannon Stevens, Theodore Gehrig, Aaron Cadore
5	Motivational Interviewing	This practical training will provide the candidates with the skills to support clients in resolving indecisive feelings and insecurities to find the internal motivation they need to change their behavior.	Elizabeth Contreras
6	Crisis Identification and De-Escalation	These two days will emphasize the use of critical thinking and continued assessment to identifying warning signs of impending crisis and provide valuable tools to de-escalate situations.	Meghan Marshall
7	Health and Wellness – Physical, Mental, and Alcohol and Illicit Drug Use	Health care and treatment specialists will provide an overview of physical and mental health conditions (including substance use) common in homeless populations and practical ways candidates can support their clients in these areas.	Deborah Finn-Romero, Meghan Marshall, Elizabeth Contreras

8	Restoration - Into Community	Using the Social Determinants of Health framework, candidates will learn how services may change once clients are in permanent housing and how addressing these needs is critical to housing retention and long-term health and wellness.	Deborah Finn-Romero Special Guests
9	Case Manager, Secondary Trauma, and Self-Care	This session will provide candidates with practical skills to limit secondary trauma and prevent burnout by caring for themselves.	Deborah Finn-Romero, Dan Glaze
10	Culminating Experience	Candidates will present a case study identifying how they've incorporated objectives learned in this training in their work within FSRP.	Case Managers

After the major themes were identified, objectives were created for each module.

Measurement Tools

Knowledge and skills acquired during the training were evaluated using a descriptive rubric. See Figure 4.

Figure 4.

Knowledge and Skills Evaluation Rubric

ICMS Rubric S2019	Below Standard	Beginner	Intermediate	Competent	Proficient
Name:	Current Implementation may cause risk for harm for self or client. Unprofessional, unacceptable, no reflection of training standards	Adequate training but inexper-ienced. Requires additional coaching and support	Proper performance with relevant experience/applicat ion. May still need coaching, reminders and support in complex situations	Consistent professional performance. Rarely require guidance	Advanced understanding, serving as role model. Self-monitors and corrects mistakes without prompting
Roles and Responsi-bility: Life Domains					
Trauma-Informed Approach					
Human-Centered Care					
Motivational Interviewing					
Crisis Intervention					
Health and Wellness					
Restoration					
Comments: (SBAR format, general presentation, application examples, self-identification of skills and need development, etc.) **Self-Care Action Plan: (**Personal goals and behavior changes. accountability partner)					

Changes in Attitude were evaluated using an adaptation of the Healthcare Providers Attitude Towards Homeless Inventory (HPATHI) (Buck, et al., 2005). This tool was developed and validated to assess physician and medical student attitudes, levels of interest, and comfort in caring for homeless individuals. Modifications to the HPATHI were made by the author to assess attitudes of case managers with a social work background; modifications included changing terms from health-care provider to case manager, and selecting 25 questions relevant to case management procedures from the

original 35. Both positive and negative terms were used, and reverse coding was applied to the 14 negative questions. See Figure 5.

Figure 5.

Modified Attitudinal Survey

	1 Completely Disagree	2 Somewhat Disagree	3 Neutral	4 Somewhat Agree	5 Completely Agree
1. Homeless people are victims of circumstance.					
2. Most homeless people are mentally ill.					
3. Homeless people have the right to basic care.					
4. Homelessness is a major problem in our society.					
5. Homeless people choose to be homeless.					
6. Homeless people are lazy.					
7. Public dollars should be directed toward the poor and homeless.					
8. Caring for the homeless is pointless since they do not follow-up with self-care.					
9. Homeless people come from all walks of life.					
10. Most homeless people tend to be drug addicts or alcoholics.					
11. Homeless people are dangerous, aggressive, and physically threatening.					
12. All people have a right to basic care.					
13. Most poor people have adequate access to care needs through the public system.					
14. I am comfortable being a case manager for a homeless person with a major mental illness.					
15. I feel comfortable providing care to different minority and cultural groups.					

16. I feel overwhelmed by the complexity of the problems that homeless people have.					
17. I understand that my patients' priorities may be more important than following my recommendations.					
18. I enjoy addressing psychosocial issues with clients.					
19. I resent the amount of time it takes to see 20. homeless clients.					
21. I enjoy learning about the lives of my clients.					
22. I believe social justice is an important part of care for the homeless.					
23. I feel overwhelmed by the number of problems that homeless people have.					
24. My knowledge regarding the problem of homelessness is adequate.					
25. I can provide care and support for the homeless effectively.					
26. I think mentally ill homeless people refuse to get treatment.					

Administering the Training

Based on Los Angeles County's HFH experience, it was determined that ICMS staff needed time to practice the use of new concepts before receiving additional content. The FSRP training academy met in person every other week for nine eight-hour sessions hosted by the Sacramento County Department of Human Assistance. Sessions were a combination of lecture, team-based learning, and debriefings. The final session was devoted to case manager presentations of client case studies based on their new knowledge and skills.

RESULTS

Measures of Effectiveness of Training

Each module provided learning objectives broken down into knowledge, skills, and attitudes (KSAs). Additionally, based on knowledge and skills objectives, case managers were instructed to incorporate specific elements into client case study presentations. Short-term evaluation of training effectiveness included pre- and post-intervention evaluation of (KSAs) of ICMS on several topics.

Long-term evaluation was planned using data from the documentation and reporting system Sacramento Homeless Information Network Ecosystem (SHINE). Outcome measures included number of contacts with clients before agreement to accept housing; length of time in housing; frequency and context of ICMS visits; health status at the time of housing; number and frequency of homelessness-related incarcerations; emergent or planned use of health-care services; and management of chronic conditions. Long-term evaluation has been delayed due to the Covid-19 pandemic.

Measurement of Knowledge and Skills

Knowledge and skills developed during the training were evaluated by several methods. The initial assessment was based on each case manager presenting a client case study demonstrating understanding and application of all training modules. Partner supervisors, the FSRP program manager, and the developer of the curriculum evaluated the presentations utilizing a descriptive rubric (Figure 4). Scores ranged from intermediate (3.35) to high competence (4.64), on all modules.

Comments from supervisors included, "I've seen lots of improvement since the beginning of the training" and "This is a highlight of my tenure." Feedback from participants included, "Not new content, but deeper than covered before," "The group discussions were very helpful," and "Great presenters." Several participants indicated that selected content was new to them. All participants had learned some of the content previously, although this varied for each participant. Some participants reported previous exposure to the content but not to the depth or practical application that this training provided.

Measurement of Attitudes

The modified HPATHI (Buck et al., 2005) was completed anonymously before the training and again at the end. The pre-training mean score (n=13,11 ICMS staff and two Property Tenant Relations agents) was 96.75. Post-training mean score (n=10 – three

ICMS changed jobs mid-training) was 101.13, a 4% increase, with the statistical results of the paired sample t = 2.66, df = 7, P = 0.033, SD = 4.66.

Further evaluation of the results included matching eight of the pre- and post-tests and running paired t-tests of all questions. This analysis indicated significant changes in questions six, Homeless people are lazy. (t=3.862, df=7, p=0.006) and 11, Homeless people are dangerous, aggressive, and physically threatening. (t=2.366, df=7, p=0.05). These results demonstrate specific improvements in attitudes about laziness and aggressive behavior of individuals who have experienced chronic homelessness.

ANALYSIS AND INTERPRETATION

The knowledge and skills assessment provided evidence of successful completion and understanding of all modules. Pre- and post-training scores enabled the measurement of attitude change among case managers who completed all the modules. These changes were around perceptions of laziness and motivation, and beliefs about aggressive and threatening behaviors by individuals experiencing homelessness. Changes in attitude may have many causes besides the training content and structure. Factors such as personal experiences cannot be excluded as other causes of change in attitude.

SUMMARY

Improving the health outcomes of individuals experiencing homelessness is a complex process requiring participation by many members of the community. Determining baseline KSAs of case managers, utilizing community partner experts in developing curriculum, and delivering content over time to case managers working with individuals who have experienced chronic homelessness appear to be effective methods for supporting permanent housing. By working in a partnership manner with the clients, community agencies, and governmental bodies rather than in a domination manner

(Interdisciplinary Journal of Partnership Studies, n.d.), clients and case managers have an opportunity to develop realistic plans for personal as well as community success in sustaining housing and improving health.

Through a training program designed to increase case managers' knowledge, skills, and attitudes about the complex issues related to homelessness, the basic living needs of this vulnerable population are being addressed. Cooperation from multiple agencies in Sacramento County allow for many perspectives and resources to combine for the best possible outcomes for housing and health within this community. Addressing housing needs as a key element of SDH has implications for improving the well-being of people in Sacramento County.

The use of KSAs to assess the understanding and capacity of case managers working with homeless individuals appears to be effective. This method of evaluation must take into consideration the type of content being taught, the frequency of training sessions including time to practice new skills prior to the introduction of additional content, and the expected outcomes of trainings for clients experiencing homelessness.

Frequency of clients' use of emergency services and frequency of incarcerations will be evaluated over an extended period. The Los Angeles County HFH program captured data for four years before generating a formal evaluation (Rand, 2017). It is expected that FSRP will need a similar amount of time for proper outcomes assessment. Training for new ICMS staff, and updates to the curriculum based on case manager knowledge, skills, and attitudes, will need to be planned, implemented, and evaluated. Societal impacts such as the Covid-19 pandemic and other major changes will also need to be included in the program and training academy.

Sacramento County has determined that all employees of homeless services should attend this training. They have launched the Sacramento County Homeless Initiatives Training Academy, and consider the ICMS training described in this article as a pilot for

all future trainings within the county. Future training will also be offered to providers including public health nurses, law enforcement officers, and program managers who work with persons who are chronically homeless. Ongoing community partnerships will need to be maintained, and new ones established, to support the ongoing health of the population.

Limitations

This study was limited by lack of data about years of experience as a case manager, time spent working in homeless services, personal lived experience, and previous training. Agencies contracted to the FSRP are autonomous in the selection of their employees and placement into ICMS status. The FSRP may determine minimum qualifications of placement, but not necessarily specific experience.

Linking training of ICMS staff to health outcomes of homeless clients is challenging due to many non-measured factors. Severe mental illness or other disabling conditions may impact results related to housing stability and health outcomes. Further evaluation of

client use of emergency rooms, incarceration rates, and sustained housing will need to be conducted for a full assessment of the program.

Emily Halcon, Homeless Services Coordinator, City of Sacramento; Christopher Martin, Housing California, Homeless Legislative Advocate; Jodi Nerell, Director of Behavioral Health Integration, Sacramento Covered; Marlene von Friedrichs-Fitzwater, Founder, Healthcare Communication Research Institute; Susan Peters, District 3 Sacramento County Board Supervisor; and Jonathan Porteus, CEO WellSpace Health.

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