From the Streets to Stability: Multidisciplinary Care at Encampments to Reduce Unsheltered Homelessness

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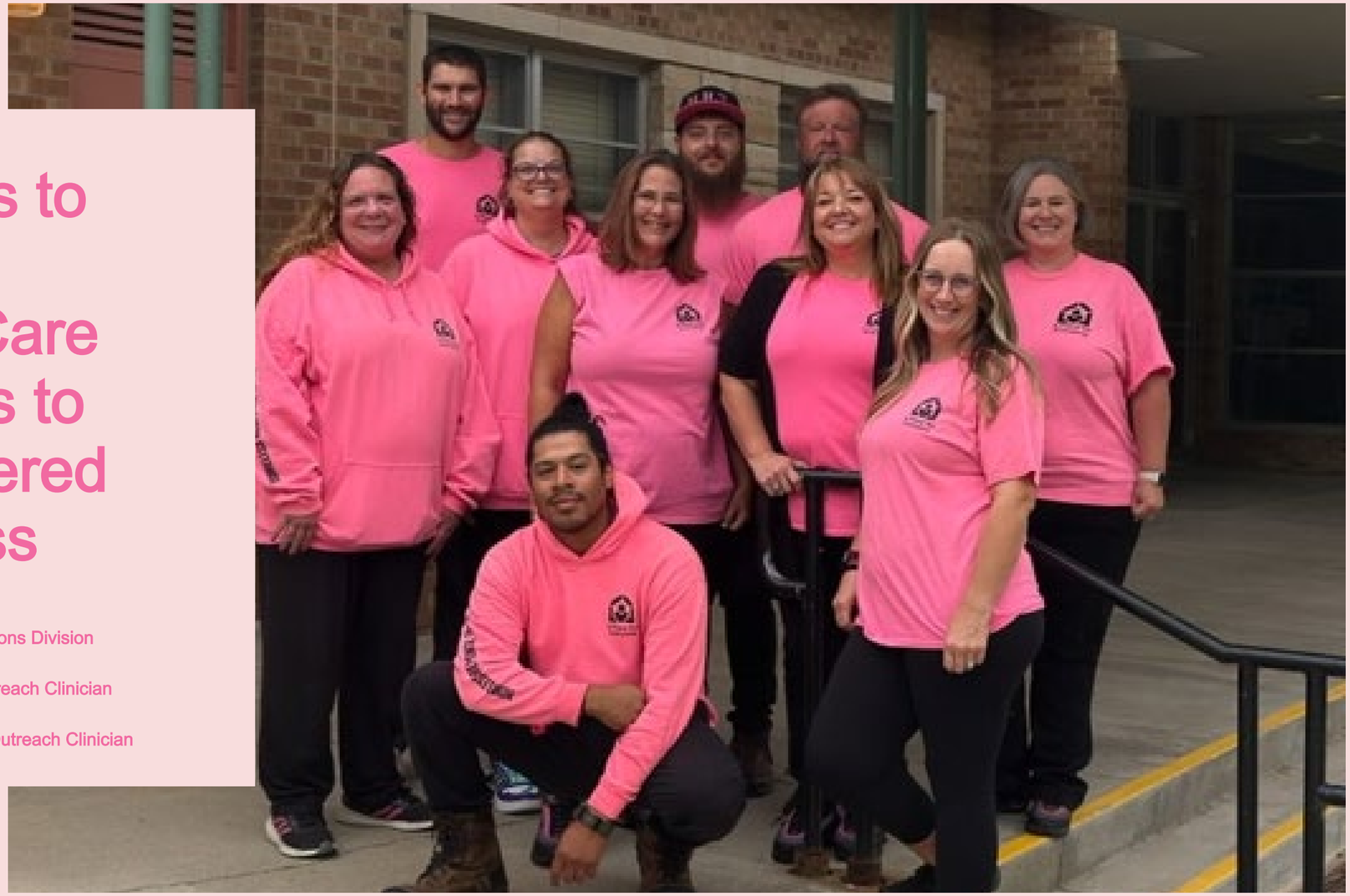


Where It All Began

- Douglas County’s CHIP committed to equity, housing, and health.
- Led to 'A Place for Everyone' plan to end homelessness.
- Our team oversees all outreach and sheltering in Lawrence/Douglas County.
- Started in encampments —now a model of public health care.

A Public Health Crisis

Preventable deaths, disease, and violence in encampments.

Sex trafficking, physical & sexual assault, and overdose deaths.

Rat infestations, untreated wounds, addiction, mental illness.

This was a public health emergency —not just a housing issue.

Our Health - Focused Breakthrough

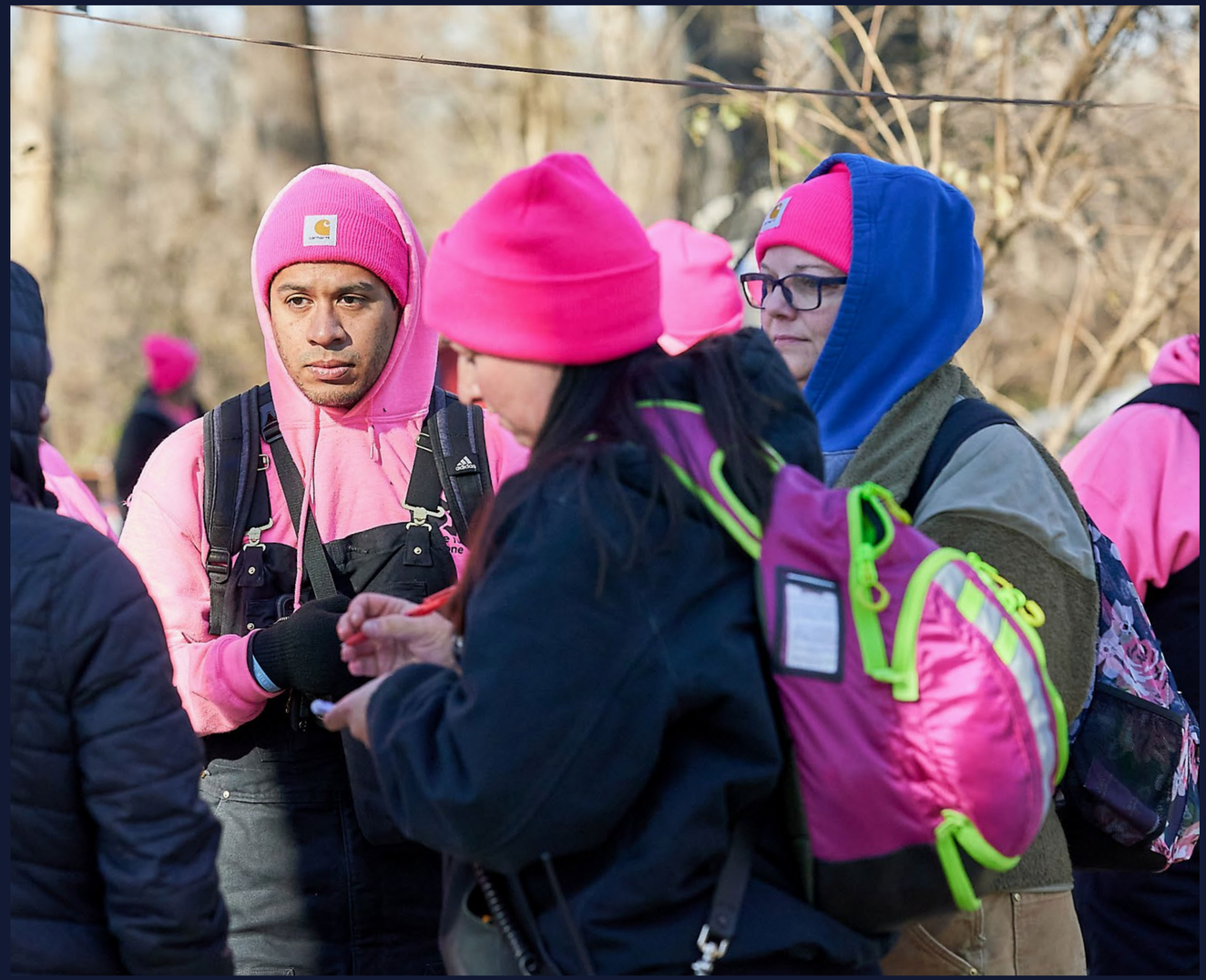
Built a multidisciplinary field team:

•Street medicine (LDCPH), SUD care (Mirror Inc.)

•Peer support, behavioral health, housing and benefits

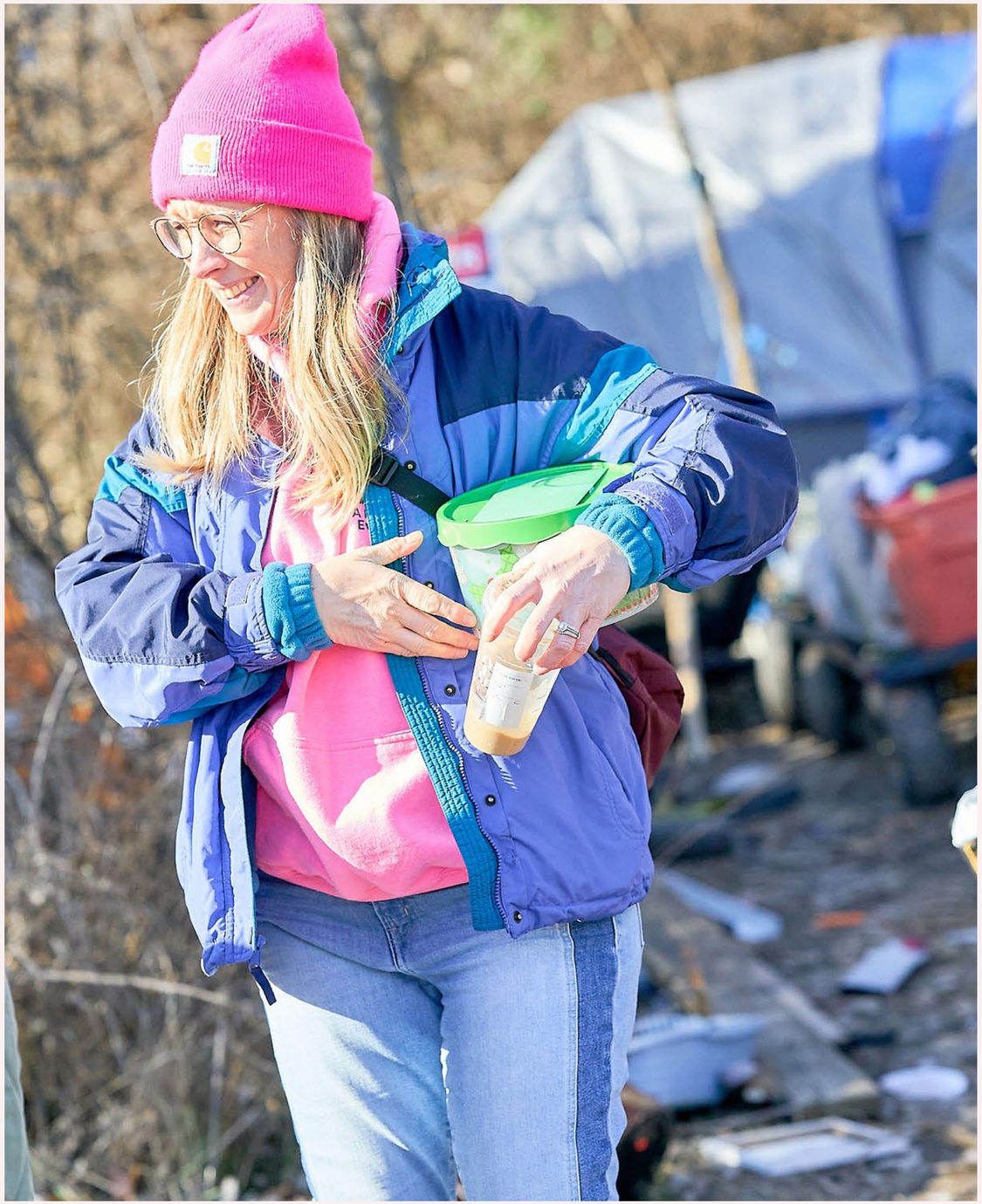
•Launched medical respite for post - acute stabilization.

•Model built on harm reduction, equity, and lived experience.



Our Goals for Health Equity

Reduce preventable ER and EMS utilization		Provide discharge options and follow-up (medical respite).
Use Aftercare program to support long-term health	Rebuilding client trust in medical systems	Improved and expedited access to physical and behavioral health care



Our Methods in Motion

- Field care: All medical and psychiatric acute care.
- On- site SUD screening and fast - tracked treatment placements.
- Benefits/housing linkage and medical respite referrals.
- GIS- guided daily outreach to encampments.

Results That Matter

Provided 239 medical and psychiatric services to 84 clients.

Lawrence · Douglas County
PUBLIC HEALTH
Advancing Health for All

63% ↓ unsheltered homelessness in one year.

2024 - 2025 was the first winter in two decades that we did not have a weather - related death.

Results That Matter

30% of unhoused neighbors engaged in SUD care when offered at their encampment

MIRROR

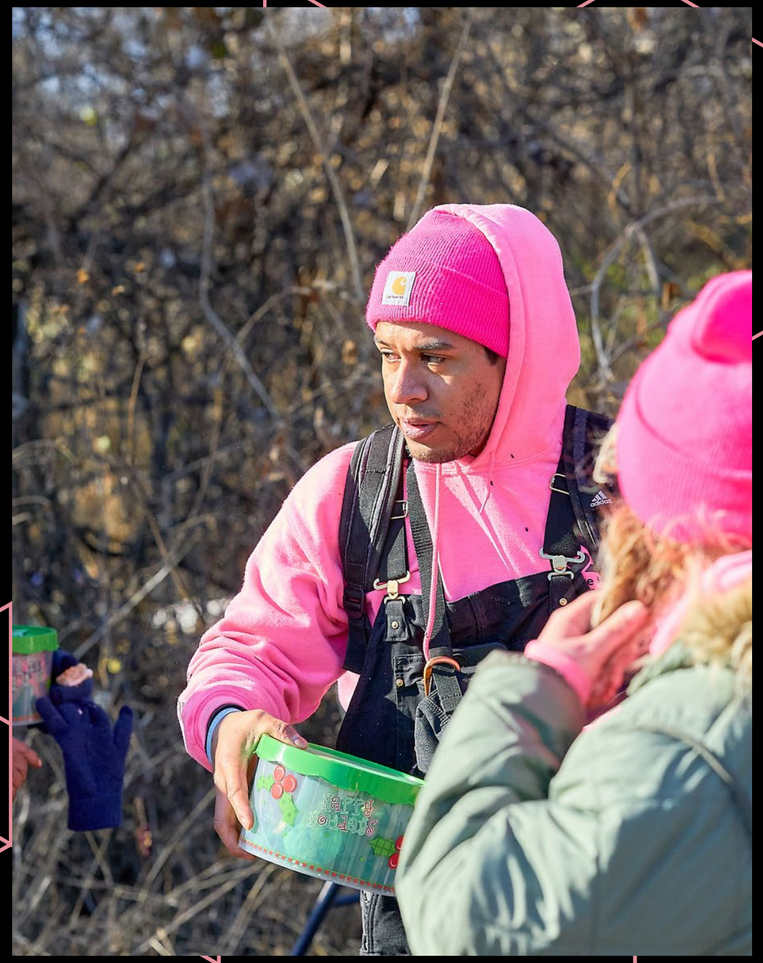
- 50 unhoused neighbors completed assessments for Substance Use Disorder
- 50% of assessed clients completed treatment
- 25% are permanently housed

Lived Experience = Health Access

Peers are essential to de - escalation and reengagement.

Peer specialists build trust, reduce disengagement.

Lived experience = public health access strategy.

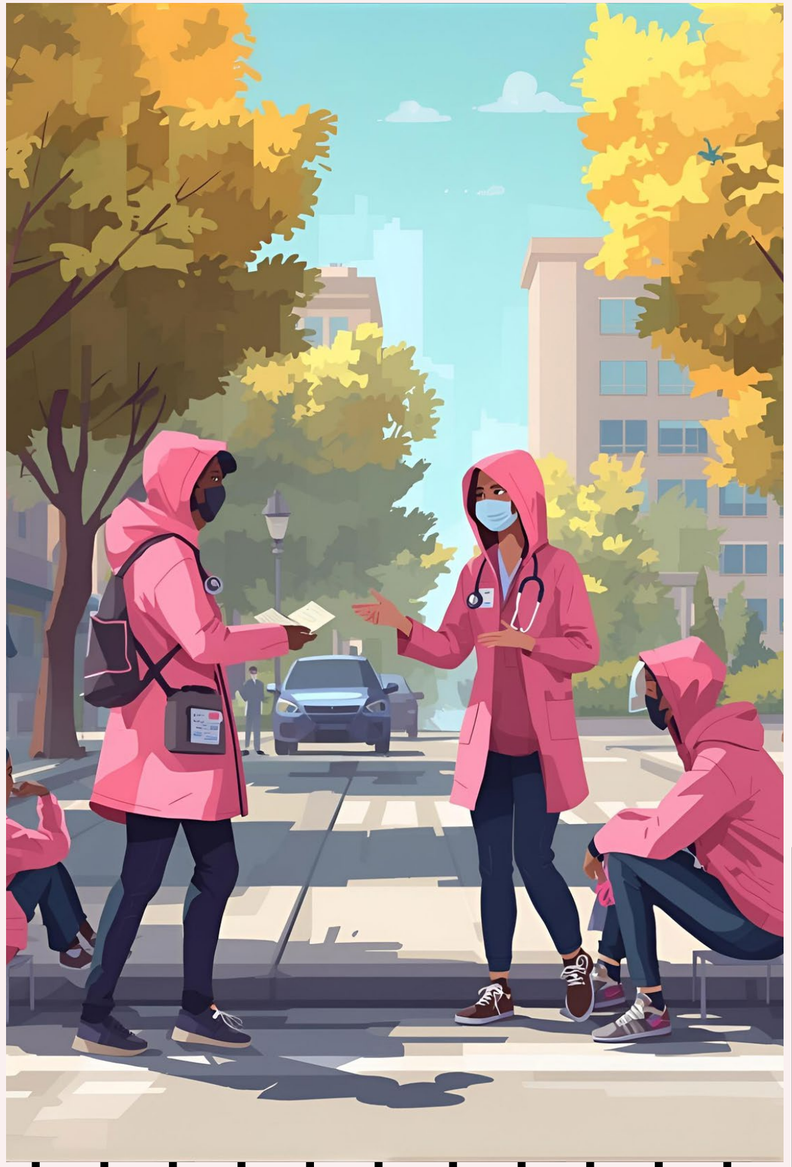


A Model of Collaboration

Partners:

- LDCPH
- Mirror
- RADAC
- Heartland Health
- Lawrence Memorial Hospital
- Mobile Integrated Health
- Jax Project
- Homeless Resource Center
- Lawrence Community Shelter
- Kansas Statewide Homeless Coalition
- Douglas County

Joint case conferencing, shared outreach plans, unified strategy



Innovation + Accountability

GIS locator integrated into HMIS for real - time tracking.

Biweekly cross - sector case conferencing.

HUD and public health - aligned workflows.

Leveraged grants + local investment for sustainability.

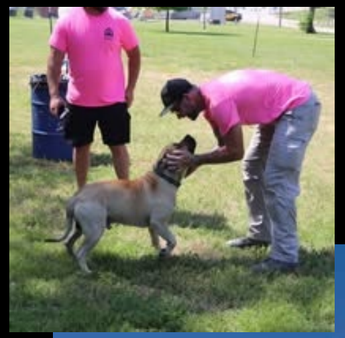
What You Can Try First

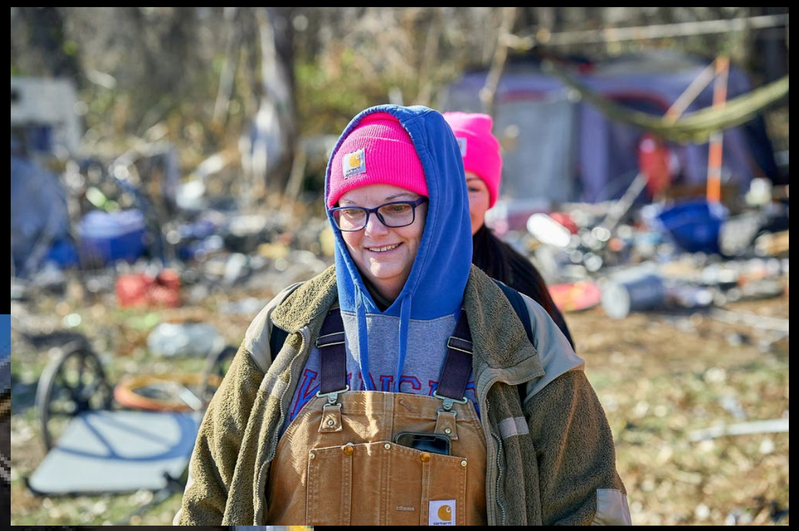
- Use EMS/ED data to locate top need areas.
- Deploy peer + nurse outreach weekly.
- Track with shared metrics, don’t wait for perfection.
- Engage community allies early.

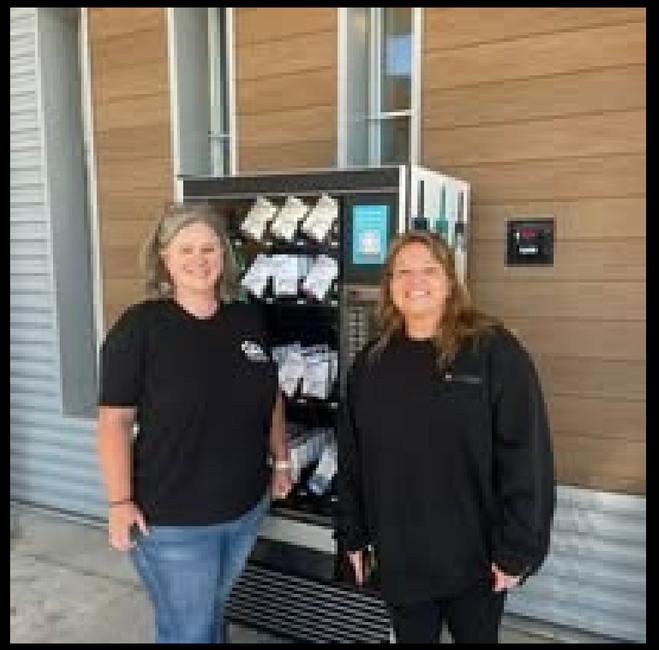
Final Reflection

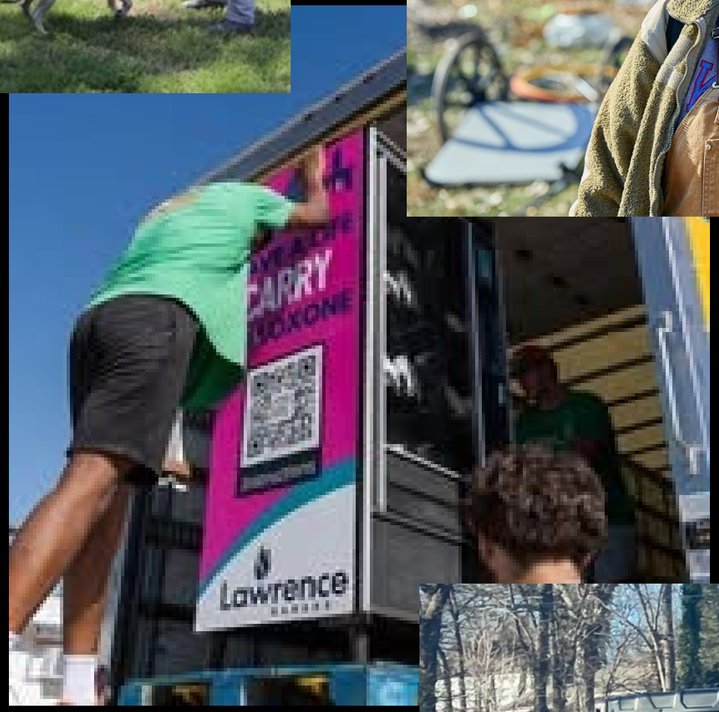
This isn’t just outreach. It’s public health. And it’s working.

Meeting people where they are is how we move forward.









Questions?