Creating integration in complex ecosystems

Partnership pathways for homelessness to health

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Commission on Excellence and Innovation in Health.

AHC26 · Concurrent 5 · 7 October 2026



I acknowledge the Larrakia people, Traditional Owners of the land on which we meet, and pay my respects to Elders past and present.

I bring greetings from Kaurna Country, where this work is based, and based, and acknowledge people with lived experience of homelessness, whose expertise shapes this work.

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TOGETHER, CREATING HEALTH AND PROSPERITY FOR ALL

IN THE NEXT 10 MINUTES

01
The CEIH story and the data

02
What we built together

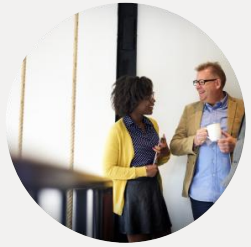
03
Holding course through change

04
What you can take home



Networks

Bringing together clinicians, health services, consumers and carers to forge authentic relationships



Partnerships

Building and strengthening partnerships to help shift the system and transform great ideas



Clinical Informatics

Delivering insights that dramatically dramatically impact how we deliver deliver healthcare



Innovation

Seeking new perspectives and solutions to create meaningful and sustainable impact

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HOW IT STARTED

The emergency department was the signal, not the solution.

ED staff raised concerns through our Urgent and Emergent Care Clinical Network: people sleeping in waiting rooms, and discharges into homelessness.

THE DATA PICTURE · EMERGENCY DEPARTMENT, MAY 2024 – MAY 2025

A small, vulnerable group. A big opportunity.

835
people experiencing homelessness

3,457
ED visits in a year

$3.2M
in ED costs

22
people made 758 visits: 22% of the total

WHAT THE SYSTEM DOESN'T SEE

24%
of visits led to admission

872
stays longer than 12 hours

561
did-not-wait episodes

30%+
discharged back into homelessness

The data didn't give us the solution. It changed the question: what Health was seeing downstream was being created across a much wider system.

Source: CEIH CID data analysis, RAH, May 2024 – May 2025

A YEAR OF LISTENING AND UNDERSTANDING

Engagement was not a phase. It was the intervention.

Who we engaged with

- People with lived experience
- Health, housing and community
- Other government departments
- Interstate colleagues

Discovery workshop, February 2025: new and emerging models, mapping opportunities, lived experience voice central.

Nov 2024 to Apr 2026: from the signal to a workshop, then to working with people one by one through to establishment of Coordinated Health and Homelessness Escalation Response Group . (CHHER.)



ENABLING INFRASTRUCTURE

Data sharing made coordinated care possible

If systems cannot see the same person, they cannot care for the same person.

THE GAP

Only part of the picture

Separate systems meant repeated assessments, incomplete plans, duplication and uncertainty about what could be shared.

THE AGREEMENT

A formal multi-agency DSA

Defined the cohort, purpose, authorised participants, safeguards, consent and conditions for disclosure.

WHAT IT ENABLED

A shared view of the person

One coordinated plan, visible actions, and escalation when ordinary pathways could not resolve the issue.

See relevant, current information. Plan one coordinated response. Act with clear responsibility and follow-through.

No central database. Each agency remained the custodian of its own information and brought what was relevant into the forum.

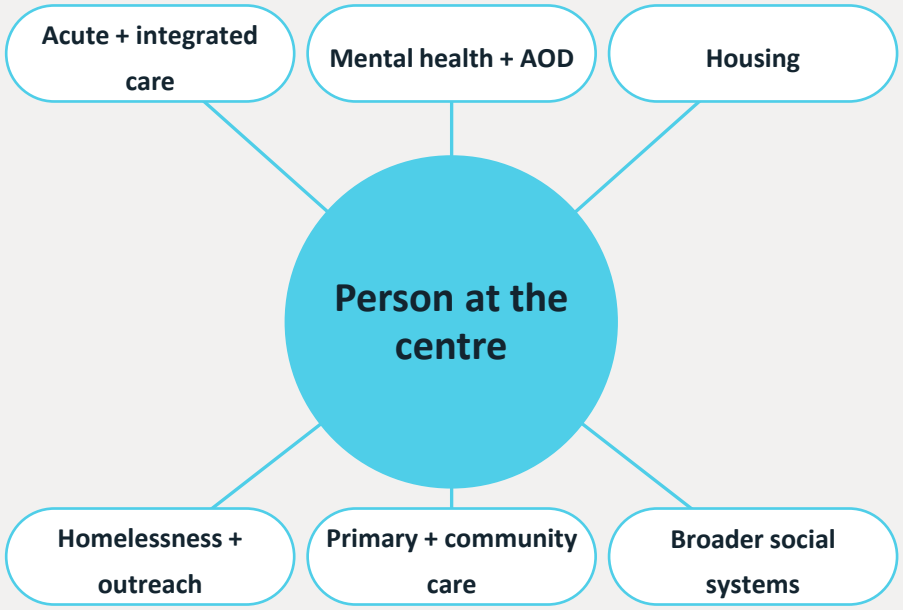
INDIVIDUAL LEVEL · A COORDINATED RESPONSE

Coordinated Health and Homeless Escalation Response: the sectors around the person

WHO

The most complex individuals

Up to ten people who are clinically vulnerable, frequent RAH ED presenters, on the By-Name List and case managed by Toward Home Alliance.



CEIH FACILITATES

No clinical or operational authority

Brings the right sectors together

Assigns actions and follows up

Escalates barriers the table can't resolve

Not every sector attends for every person. The right sectors come together around the person's needs.

Creation of a Coordinated Plan.

Source: CHHER Terms of Reference (draft, 10 April 2026)

CHHER IN PRACTICE · HOW IT WORKS

How CHHER works for each person

EVERY PERSON HAS

- A lead agency
- A trusted place and person
- A priority to lean into

PRINCIPLES

- Housing First
- Wraparound support, tailored to needs
- Access to primary care

NO ONE-SIZE PATHWAY

Some needed housing first. Housing bans were lifted, because health and mental health were leaning in to support the tenancy, with nursing outreach.

Others needed stabilisation before housing would work.

We're learning each other's roles: how to use the other sectors, and when.

FROM ONE PERSON TO THE SYSTEM

Why we need a whole of government system response

OPERATIONAL LEVEL · PROVING WHY

Coordination works: one person housed, with a connected team around her.

But it relies on goodwill and a six-month pilot.

The barriers it surfaces are systemic: housing options, eligibility, support spread across services.

↑ Evidence up

CHHER escalates systemic barriers to leadership

↓ Permission down

EXECUTIVE LEVEL · CHANGING THE CONDITIONS

Shared accountability across Health, Housing, DHS, Corrections and DCP.

Policy settings that work together, not against each other.

Data sharing and joint commissioning, so success doesn't depend on heroics.

Prove it on the ground. Change it at the top. Without both, every success stays a one-off.

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SYSTEM LEVEL · HOW IT CAME ABOUT AND WHAT IT IS

From CHHER to a statewide brief

HOW IT CAME ABOUT

CHHER escalated barriers that no single table could fix

Stakeholders named the same three transition points, again and again

ED and By-Name List data showed who, where and when

We brought it together in one strategic brief, through a health lens health lens

WHAT IT ASKS FOR

1 · Executive commitment across five portfolios

2 · A current state analysis of three use cases

3 · A joint strategy built on five enablers:

Governance · Data · Integrated service models

Financing and commissioning · Workforce

No new money. Commitment, alignment and focus instead.

Source: Building a Statewide System to End Homelessness, strategic brief

SYSTEM LEVEL · THE THREE USE CASES

Proposed use cases for a whole of government response

Three transition points where the system already holds the person, knows the date and can see the risk.

PREDICTION

Corrections release

We know when a person is leaving. The pathway is predictable, so coordinated planning can start before release.

PREVENTION

Leaving out-of-home care

We know who is transitioning. Coordinated housing, health, income and support can begin before the transition.

AVOIDING CRISIS

Hospital discharge

We know who is presenting or being discharged into homelessness. Coordinated follow-up can be planned before discharge.

Relevant to current system pressures and emerging reform priorities.

Source: Building a Statewide System to End Homelessness, strategic brief

CHANGING ENVIRONMENTS

The context shifted. The anchor held.

Hold tightly

The problem: people are reaching emergency care because pathways failed elsewhere.

The purpose: a coordinated, person-centred response across predictable transition points.

The people: people experiencing, or at risk of, homelessness.

Hold lightly

The governance: who sponsors and oversees the work.

The language: how we frame it for each audience.

The sequence: what happens first, and when.

A new Health Minister and an emerging review of our specialist homelessness service changed the context. Don't wait for certainty: keep the evidence current, maintain relationships and be ready when the window opens.

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LESSONS LEARNT

What was hard, and what we did about it

Not a system

Care in ED depended on who was on duty.

We built an escalation pathway, not heroics.

Data that doesn't talk

Barriers to sharing, and records that say "discharged "discharged home".

We started with imperfect data and used it to start conversations.

No new money

Pilots are time-limited; funding sits in silos.

We used what exists: housing stock, data, people.

Whose problem is it?

Other systems don't see homelessness as theirs.

We framed it as a shared system outcome.

The ground shifted

A new Minister and a homelessness review.

We kept the what and why, and re-briefed fast.

A tired workforce

Frontline workers isolated and burning out.

We asked the system to show up like they do.

STILL TO NAVIGATE	**First meeting of System Response Executive group**
CHALLENGES	**The balance of engagement vs permission**

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WHAT YOU CAN TAKE HOME

Do not start with more. Start with together.

1	**Find your signal**	Ask your ED and clinical networks what they're seeing, then pull one dataset to prove there is a problem to solve
2	**Define the mission on one page**	What exactly are we changing, for whom, by when, how will we know, and what's not included?
3	**Start with ten people**	The most complex, most frequent presenters, with health data and the By-Name List at one table.
4	**Map your transition points**	Where does your system already hold the person and know the date?
5	**Be relevant to what matters now**	Tie the work to the system's current priorities: the review, ramping, mental health, money. Partner, don't compete.
6	**Get your own house in order first**	Align the parts of your own system you'll need before asking others to change.
7	**Resource the glue**	Make the case for dedicated coordination capacity before you start, not halfway through.

Thank you

For more information, visit **www.ceih.sa.gov.au** and subscribe to our newsletter

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APPENDIX

Supporting slides

For the panel and Q&A

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CHHER IN PRACTICE · ONE PERSON'S STORY

A stable place to live. A connected team around her.

BEFORE

Moving in and out of emergency accommodation

Presenting frequently to the RAH Emergency Department

Support spread across housing, primary care, mental health, AOD and more

TOGETHER THROUGH CHHER

One shared plan: what happens, in what order, and who leads

Trauma-informed, with time to build trust

Every service knew the plan, so each contact moved it forward

NOW

Moved into supported accommodation: a steadier base

The team is helping her settle, attend appointments and stay connected with health services

Not a new service, but a different way for existing services to work together around a person. Overall impact, including on ED presentations, will be assessed through evaluation.

Source: CHHER case story, World Homelessness Day 2026

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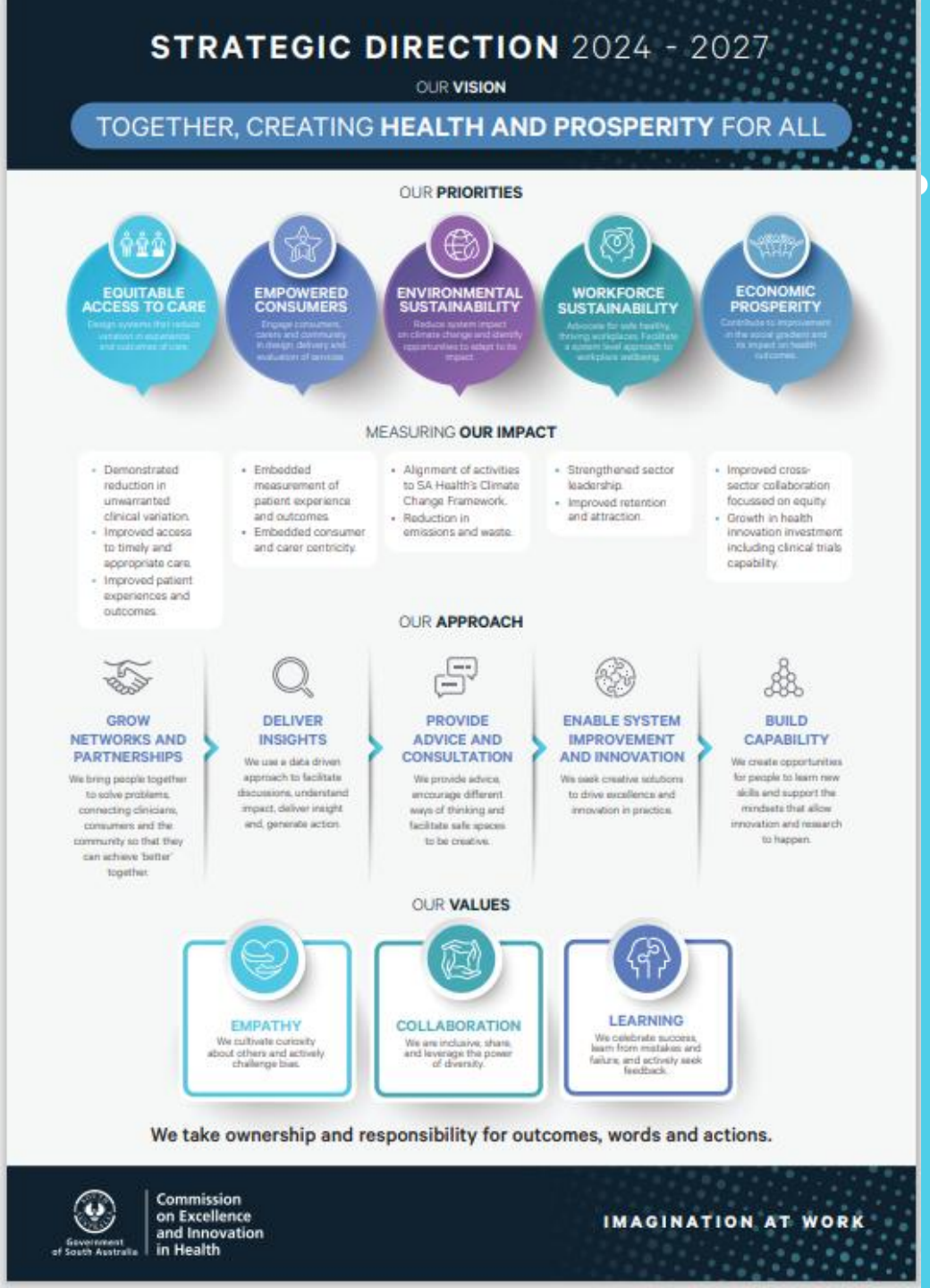
CEIH: Who we are

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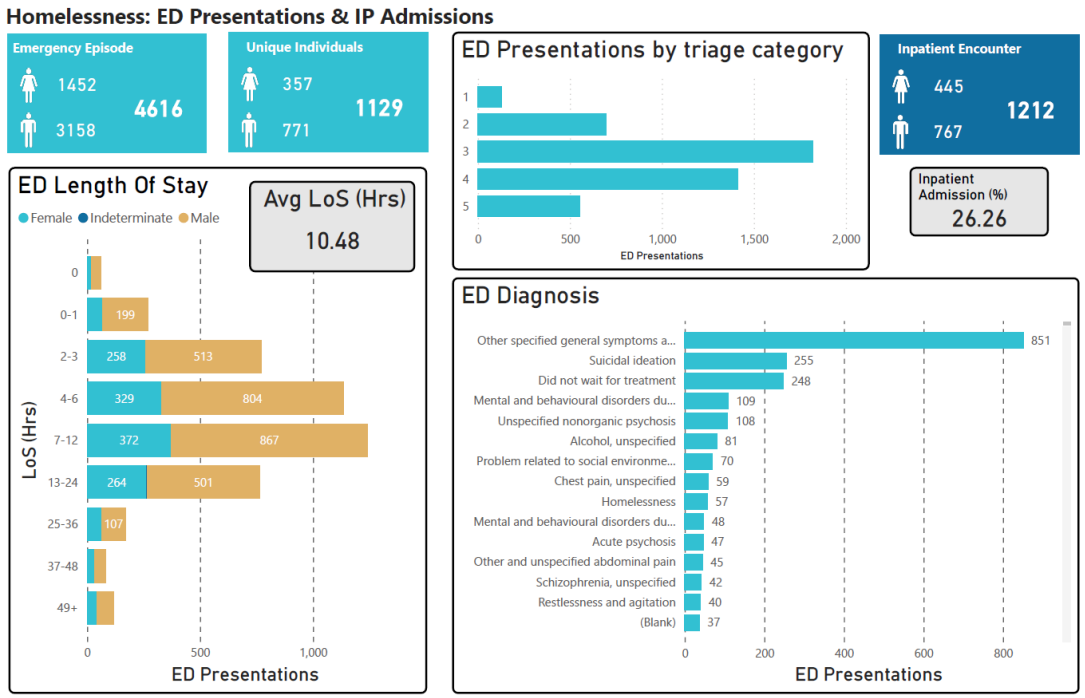
- *connect ideas*
- *connect people*
- *connect the dots*

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WHAT THE DATA SHOWED

Twelve months in our metro EDs



WHAT IT IS

CEIH clinical informatics first-pass data: metro hospitals, Oct 2023 to Oct 2024.

IN PLAIN TERMS

> About **1,100 people** came to ED **4,600 times times**

> They waited **10.5 hours** on average

> Only **1 in 4** were admitted

> A few came back again and again: one person **73 times**

Source: CEIH Clinical Informatics, metro hospitals, Oct 2023 – Oct 2024

THE JOURNEY

From a clinical signal to a system response

2024: November

Signal

ED staff raise concerns through the Urgent and Emergent Care Clinical Network

Oct 23 – Oct 24 data

Data

First-pass ED data to understand the scale and generate discussion

Feb 2025

Convene

Discovery workshop, lived experience voice central

Aug 2025

Act

Brains Trust, RAH ED outreach pilot, coordinated care, data sharing agreements

Apr 2026

CHHER

Escalation response for the most complex individuals

2026

System response

Proposed use cases for a cross-sector executive response - Health Lens

SYSTEM LEVEL · WHAT IS THE SYSTEM RESPONSE?

Tie into what matters right now

One joined-up response across Health, Housing, DHS, Corrections and DCP, built on what government and partners already care about.

The review

Feed into the homelessness review rather than sit beside it.

Ramping

Fewer avoidable ED presentations presentations eases pressure on on ambulances and EDs.

Mental health

A top ED and inpatient diagnosis for this cohort.

Money

No new money: commitment, alignment and focus on existing investment.

Partner, not compete.

Bring this work to existing priorities, rather than adding another program to the queue.

SYSTEM LEVEL · THE CONTEXT

Homelessness is a system failure

THE CHALLENGE

Fragmented pathways: people fall through gaps at every service transition

Siloed systems: conflicting policy settings create contradictory actions

No shared data visibility: predictable homelessness goes undetected

Workforce fragility: isolated workers carry unsustainable loads

WHERE WE ARE TODAY

Predictable homelessness goes unaddressed

Agencies can't see the full picture

Health and housing investments allocated in isolation

Fragmented services, duplication, poor productivity

Frontline workers isolated and burning out

What is predictable is preventable. How might we build a systems response?

Source: Building a Statewide System to End Homelessness, strategic brief

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PRINCIPLES WE FOLLOWED

What the principles looked like in practice

Agree the problem first	Data, frontline experience and lived experience gave partners something common to organise around.
Diagnose, don't guess	The ED was the symptom. The causes sat upstream, at three predictable transition points.
Partner, don't compete	Plug into existing reform, governance and relationships rather than creating another initiative.
Start small enough to learn	CHHER tested coordination with a small, defined cohort first.
Hold the mission, flex the how	Ministers, reviews, governance and language can change. Your anchor shouldn't.

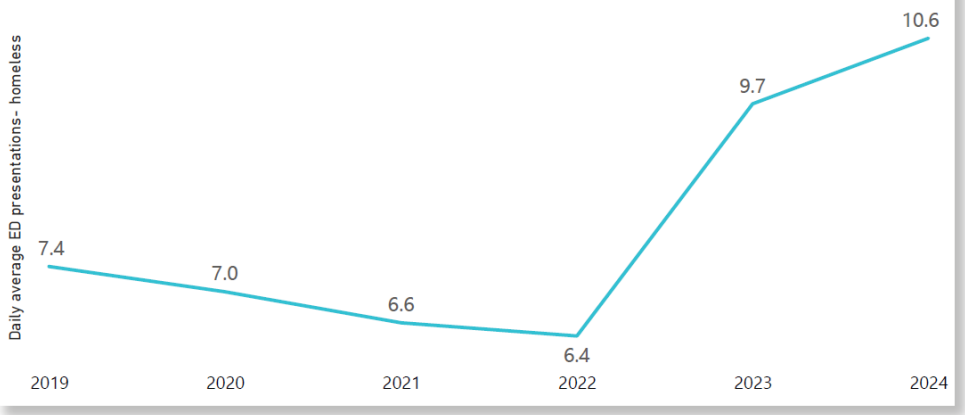
APPENDIX · DATA

ED presentations by people experiencing homelessness, 2024

In 2024 for homelessness related ED presentations:

Total ED Presentations	Unique Individuals	Median ED presentations past 6 months	Arrivals by ambulance
3877	1135	5	42%

The daily average ED presentations has been increasing per year



25% of patients didn't wait or left before treatment was complete

ED Outcome	% of ED presentations
Admitted to ward/EECU /H@H/other hospital	33%
Did not wait & Left before treatment complete	25%
Discharged	42%
Total	**100%**

WHAT IT IS

CEIH clinical informatics first-pass data pull: metropolitan hospitals, 2024 calendar year.

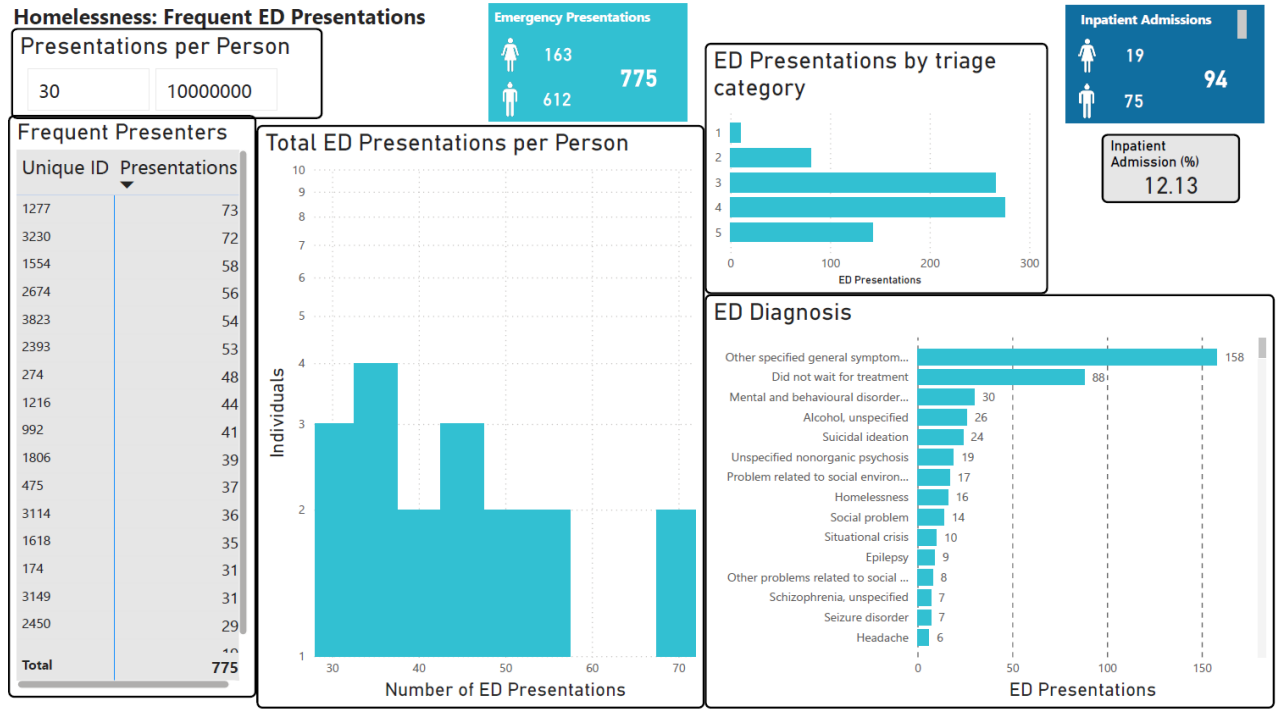
WHAT IT TELLS US

- **3,877** presentations by **1,135** people
- **42%** arrived by ambulance
- Daily average rising since 2022, to **10.6 a day**

Source: CEIH Clinical Informatics, metro LHN ED data, 2024

APPENDIX · DATA

Frequent presenters: a small group, a big signal



WHAT IT IS

People who presented to ED 30 or more times, metropolitan hospitals, October 2023 to October 2024.

IN PLAIN TERMS

- A few people came back again and again: **775 visits** between them
- Only **12%** were admitted
- One person came **73 times**, more than once a week

Source: CEIH Clinical Informatics, metro hospitals, Oct 2023 – Oct 2024

What ED staff said

- High ED re-presentation rates
- ED Impacts:
  - service access - wait times
  - Decreased productivity
  - psychosocial impacts on staff, patients & public
- Complexity of presentations
- Fragmented service response
- Duplication & frustration in finding service pathways

Healthcare needs are not being met

Lack of equity of access to care

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Media Monitoring

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The Advertiser

10/07/2025

'Admitting patients in corridors': RAH nurse lifts lid on overcapacity public hospitals



A nurse told The Advertiser it was an "unethical, immoral, situation. Picture: NewsWire/Kelly Barnes

"We are currently admitting patients into the corridors of wards," the nurse told The Advertiser.

"There is no oxygen suction available in an emergency situation. There is full lighting that cannot be turned off. There is no privacy, no showers, only the public toilets available for these patients to use.

"Meanwhile we have wards full of patients admitted from nursing homes that do not need acute care but are deemed 'too difficult' for the nursing homes to handle."

The nurse also revealed the RAH has become a de facto home for the homeless.

"We literally have people living in this hospital," the nurse said.

"We have homeless patients, many homeless for years, but once admitted cannot be discharged until appropriate accommodation has been found for them which is virtually impossible.

"Therefore they, too, are living here.

ENABLER

Data sharing as essential care infrastructure

> **If systems can't see the same person, they can't care for the same person.**

The gap

Barriers to data sharing. Agencies can't see the full picture, so predictable homelessness goes undetected.

What we're doing

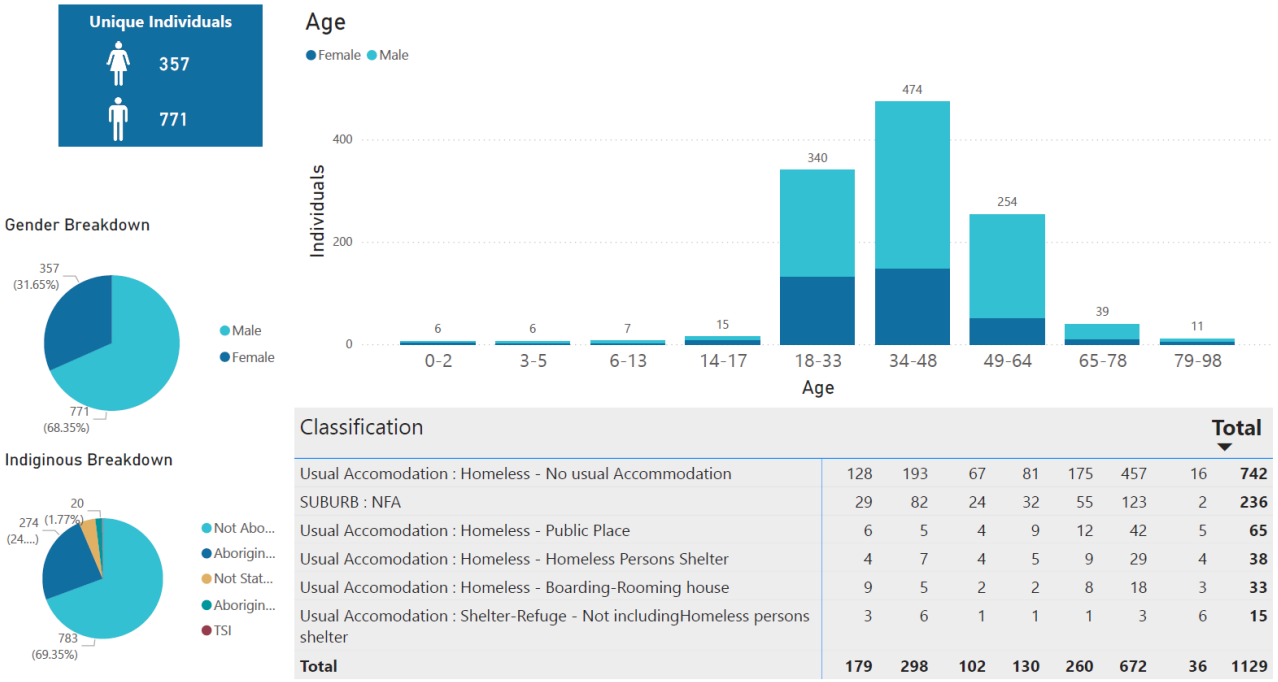
A multi-agency data sharing agreement for agreement for real-time insight across health, housing and social services. [confirm [confirm status]

Why it matters

Less duplication, joint planning, and responses informed by the people we're trying to support.

APPENDIX · DATA

Who presented: the cohort



Classification								Total
Usual Accomodation : Homeless - No usual Accommodation	128	193	67	81	175	457	16	**742**
SUBURB : NFA	29	82	24	32	55	123	2	**236**
Usual Accomodation : Homeless - Public Place	6	5	4	9	12	42	5	**65**
Usual Accomodation : Homeless - Homeless Persons Shelter	4	7	4	5	9	29	4	**38**
Usual Accomodation : Homeless - Boarding-Rooming house	9	5	2	2	8	18	3	**33**
Usual Accomodation : Shelter-Refuge - Not includingHomeless persons shelter	3	6	1	1	1	3	6	**15**
Total	**179**	**298**	**102**	**130**	**260**	**672**	**36**	**1129**

WHAT IT IS

Profile of the 1,129 people identified as experiencing homelessness, metro hospitals, Oct 2023 – Oct 2024.

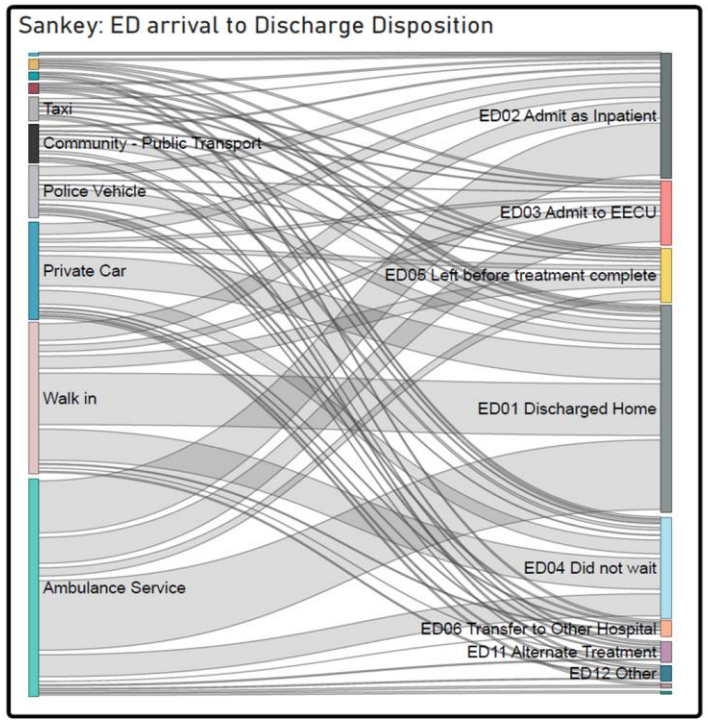
WHAT IT TELLS US

- **68%** male, mostly aged 18 to 64
- **274 people (24%)** identified as Aboriginal or or Torres Strait Islander
- The RAH saw the most people: **672**

Source: CEIH Clinical Informatics, metro hospitals, Oct 2023 – Oct 2024

APPENDIX · DATA

From arrival to discharge



WHAT IT IS

How people arrived at ED (left) and how they left (right), metro hospitals, Oct 2023 – Oct 2024.

WHAT IT TELLS US

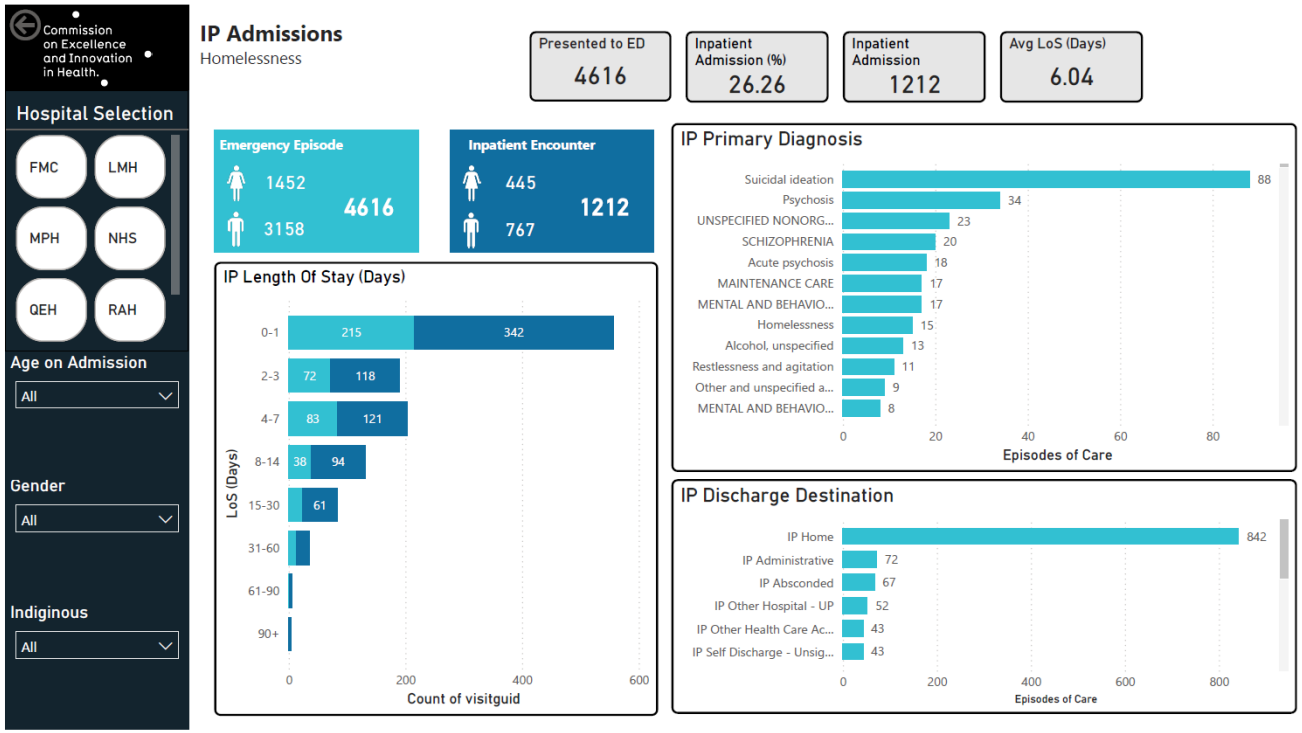
> By ambulance: **702** discharged home, **340** did not wait, **530** admitted

> Walk-ins: **526** discharged home, **324** did not wait not wait

Source: CEIH Clinical Informatics, metro hospitals, Oct 2023 – Oct 2024

APPENDIX · DATA

Inpatient admissions



WHAT IT IS

The presentations that ended in an inpatient admission, metro hospitals, Oct 2023 – Oct 2024.

WHAT IT TELLS US

- **1,212** admissions; average stay **6 days**
- Top inpatient diagnoses: suicidal ideation and and mental health
- Most discharged "home"

Source: CEIH Clinical Informatics, metro hospitals, Oct 2023 – Oct 2024