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Bridging Housing Instability and Healthcare Fragmentation Through Management-Driven Coordination Models

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Abstract

Homelessness is a chronic factor in healthcare fragmentation, restricting access to healthcare and exacerbating the situation among vulnerable groups. The existing literature usually addresses social determinants or coordination of care in isolation, without merging management-oriented models matched with housing-environment-health and health-governance systems. This paper fills this gap by carrying out a conceptual-comparative synthesis of current peer-reviewed studies on management-based coordination models. The paper provides strategies that enhance service linkage and alleviate inefficiencies by using systems thinking, data-driven decision-making, and cross-sector leadership. The study can add to a coherent model that explains how integrated care could be maintained by organizational leadership and multi-level governance. The results suggest that the policy design and institutional cooperation should be organized and effective to attain equitable, accountable, and robust healthcare systems to support housing-unstable populations.

Keywords: Housing Instability; Healthcare Fragmentation; Management-Led Coordination; Systems Thinking; Health Equity

1. Introduction

Housing instability is a significant challenge to equitable health outcomes because it prevents balanced access to care and aggravates chronic health conditions, as well as leads to a high level of emergency department use in vulnerable populations. Recent trends in the United States and within the healthcare sector have created the need for cross-sector interventions to support the connection between medical care and housing stability and community support services (6). Nevertheless, even with such efforts, responses to healthcare tend to be disjointed because of the lack of coordination among the providers, social service agencies, and policy structures. To overcome this challenge, there is a need to use leadership that is founded in management science, which entails the application of project management principles, systems thinking, and data-driven coordination to harmonize care delivery at the institutional, clinical, and community levels. This would not only close the gap between the housing and healthcare systems but also make them sustainable, accountable, and impactful. Thus, it is necessary to incorporate management-driven models at institutional, community, and policy tiers to enhance coordination of care delivery and promote health equity among underserved populations.

2. Material and Methods

To explore management-initiated measures to enhance care coordination between populations with housing instability, the study employed a conceptual-comparative literature synthesis. The review involved peer-reviewed articles on housing insecurity or healthcare fragmentation or integrated care models. The level of methodological rigor supported

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the inclusion of five studies, direct attention to U.S.-based management-led care coordination, and applicability to the issue of housing instability in healthcare systems. Peer-reviewed articles exploring the use of integrated care models, management or leadership frameworks, and quantifiable coordination outcomes were the inclusion criteria. The research was filtered out in case it was non-peer-reviewed, non-U.S.-based, and had no management or systems-thinking aspect. The scoping review method was chosen because it enables mapping of the arising evidence under different managerial models and identifying conceptual tendencies instead of testing the empirical hypothesis, which perfectly fits the exploratory objective of the present study.

Synthesis was carried out in accordance with the PRISMA-ScR guidelines, which ensure the systematic and transparent reporting of review procedures, and the scoping framework, which systematizes the emerging evidence and allows defining conceptual trends. The studies were thematically grouped into three categories, namely: operational management models, integration frameworks, and leadership-driven innovations in healthcare coordination. This secondary synthesis has the drawback of being non-empirical and focusing on U.S.-based settings, although it has rich interpretative implications on system-level management practices. Altogether, this method presents a sound conceptual framework for understanding managerial strategies of combating healthcare fragmentation.

3. Theoretical Framework

Three complementary frameworks have been utilized in order to explain how the interventions that are based on management improve the care coordination among populations that deal with housing instability and healthcare fragmentation. These models collectively provide a systematic way of analyzing how the system design, data integration, and leadership can collaborate to solve healthcare fragmentation in marginalized groups.

The baseline of such analysis is the Socioecological Integration Model that outlines a three-level framework that balances policy frameworks, community partnerships, and institutional practices. It emphasizes that the coordination among hospitals, community bodies, and policy players, at their multi-levels, is required to achieve sustainable health outcomes. The major limitation of the model is its conceptual broadness, which offers minimal operational advice on how to convert the interdependence of systems into measurable results. This framework is directly connected to the study conclusion that the coordination of organizational and community-based efforts is necessary through structured leadership involvement (5). Therefore, this model forms a systemic ground on how various levels of care delivery can be coordinated under a common management leadership.

To establish equity in healthcare systems, the DeVoe and Cottrell + NAM 5A Integrated Model creates a system of data that integrates advocacy processes, Electronic Health Records (EHR) interoperability, and tracking Social Determinants of Health (SDOH). Consistent with the finding that hospitals with EHR-based integration show a higher level of compliance with the coordination protocols, there is a relationship between social data and clinical practice. Its primary disadvantage is that it is dependent on high-tech digital infrastructure, which may be restrictive to its use in rural or resource-limited settings (6). By and large, this model explains how data integration through the use of technology transforms equity principles into practical management tools.

The Systems Management Perspective emphasizes the executive role of healthcare leaders as intersectoral coordinators between the social service, behavioral health, and housing systems. It confirms the finding that manager-based integration enhances collaboration and responsibility in the social service and healthcare sectors. The disparity in leadership capacity and governmental frameworks across organizations is likely to restrict its effectiveness, though (1). The model shows that the key to successful care coordination is high-level administrative leadership and cross-sector responsibility in the end. A comparative summary of such interaction can be seen in Table 1 below.

Table 1 Comparative Summary of Theoretical Frameworks for Management-Led Care Coordination. Source: (Author, 2026)

Framework	Core Focus	Limitation	Link to Findings	Practical Implication
Socioecological Integration Model (Liu et al., 2025, pp. 2-3)	Emphasizes multi-level coordination among institutions, communities, and policymakers to achieve sustainable health outcomes.	Conceptually broad; provides limited operational guidance for converting system interdependence into measurable outcomes.	Demonstrates that structured leadership across institutional and community levels is essential for effective coordination.	Encourages integrated management leadership that aligns hospital, community, and policy initiatives to reduce healthcare fragmentation.
DeVoe & Cottrell + NAM 5A Integrated Model (Rangachari & Thapa, 2025, pp. 4-5)	Promotes data-driven equity through integration of SDOH tracking, EHR systems, and advocacy within health institutions.	Dependent on advanced data infrastructure; may not be feasible for resource-limited or rural systems.	Shows that hospitals using EHR-based integration achieve greater adherence to coordination protocols and equity goals.	Supports the use of information systems to bridge social and clinical data, advancing measurable and accountable coordination.
Systems Management Perspective (Grove et al., 2025, p. 2)	Highlights leadership as a coordination mechanism across healthcare, behavioral health, and housing sectors.	Effectiveness constrained by inconsistent governance structures and leadership capacity across organizations.	Confirms that management-led coordination enhances accountability and cross-sector collaboration.	Strengthens intersectoral governance and leadership accountability to sustain equitable and efficient care delivery.

The three frameworks are dynamically interdependent: it is the socioecological model that provides the structure, the integrated model that offers the data mechanism, and the systems perspective that provides the leadership role that maintains coordination. Their complementarity creates a whole systems management-based framework of housing-healthcare integration. Figure 1 demonstrates this interaction, which supports the progress of theoretical integration towards sustainable, equitable, and coordinated care delivery.

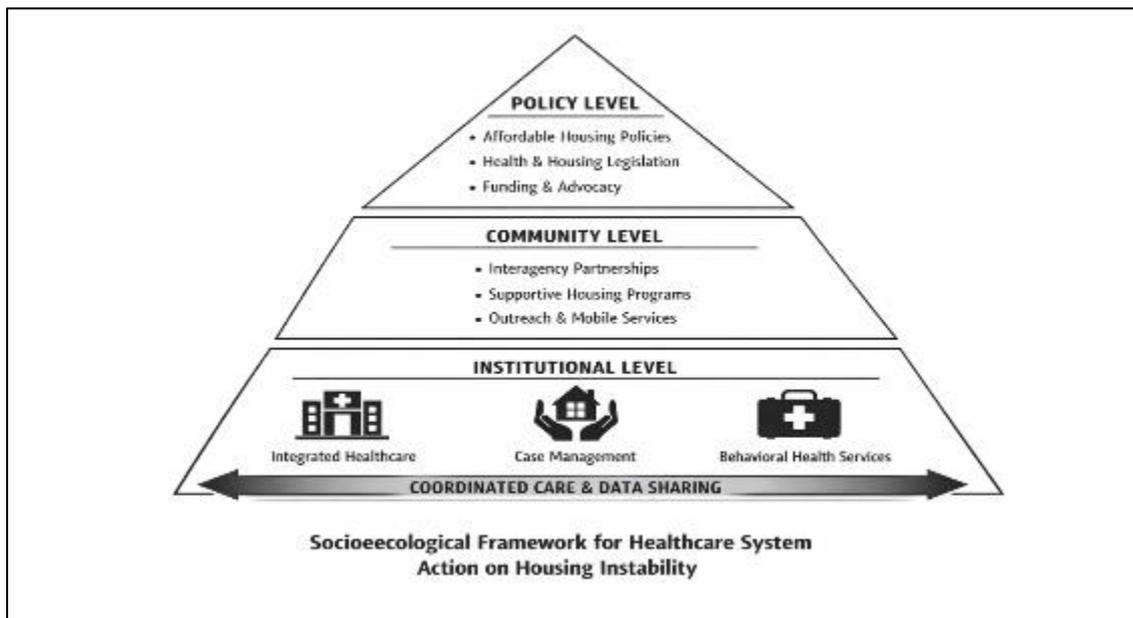


Figure 1 Socioecological Framework for Healthcare System Action on Housing Instability. Source: (Author, 2026)

4. Results and Discussion: Care Coordination Models

The findings prove that management-based integration has always focused on the coordination of social systems, medical systems, and behavioral health systems through organized leadership to minimize fragmentation and enhance patient outcomes. The national tendencies support the urgency of the work: in the United States between 2010-2021, the number of emergency department (ED) visits by individuals experiencing homelessness increased more than twice, to an average of 141 to 310 visits per 100 persons per year, and the percentage of visits by housed persons did not change significantly (8). Such unequal ED dependency is indicative of longstanding obstacles to primary, preventive services of housing-unstable people and the importance of coordination frameworks that help overcome service silos.

4.1. Integrated Care and Service Delivery

The integrated care models have shown quantifiable positive changes in patient outcomes where medical, behavioral, and social care are integrated and managed through one management structure. Grove et al. (2) tested the Mobile, Medical, and Mental Health Care (M3) Team, a multidisciplinary model of outreach to unhoused adults; they reported that ED visits were reduced by 2.3 visits per participant per year, with statistically significant positive changes in behavioral health symptoms and addiction severity scores. The findings, as summarized in Table 2, suggest that standard data sets and effective oversight between providers, case managers, and behavioral health specialists are more effective in coordinating and sustaining care.

Table 2 Comparative Outcomes of the M3 Integrated Care Model. Source: (Author, 2026)

Outcome Measure	Baseline (Pre-Enrollment)	Post-Enrollment (12 Months)	Mean Difference	Significance (p)	Interpretation
Emergency Department (ED) Visits per Participant per Year	3.89 ± 7.28	1.56 ± 3.52	-2.33	< 0.05	Significant reduction in acute care utilization after M3 Team enrollment.
Probability of ED Visit (12-Month Estimate)	—	—	-0.093	0.078	Decline in ED visit probability, though not statistically significant.
BASIS-24 Total Symptom Score	15.8 ± 0.37	12.5 ± 0.28	-3.3	< 0.05	Improvement in behavioral health symptom severity.
Addiction Severity Index (ASI) Composite Score	15.8 ± 0.28	12.3 ± 0.25	-3.5	< 0.05	Reduction in substance use severity, indicating enhanced recovery stability.

Although the M3 model reduces acute care utilization, the implementation trade-offs of M3 are lower compared to lower-resource case management models due to the high resource demand (mobile teams and data platform). Koeman and Mehdipanah (4) found that supportive housing with case management lowered healthcare spending and enhanced the stability of the participants. Nevertheless, such programs are often weak in integrating their data and are not as effective in providing real-time clinical tracking. When comparing the two directly, the increased coordination yield of the M3 model should be offset by its increased labor requirements and operations costs.

4.2. Health System Integration and Leadership

In the areas of data analytics and system alignment, leadership must be strong, and coordination efforts are more likely to be successful. Rangachari and Thapa (6) found that hospitals that have fully integrated EHR data showed twice as much compliance with evidence-based coordination rules compared to those without this data. This means that electronic data connectivity is a measure of care alignment performance and also a driver towards coordination. To further incorporate integration into upstream policy and housing support, as well as clinical services, Liu et al. (5) emphasize the role of institutional leaders in managing cross-sector partnerships to include the anchor institutions,

medical-legal collaborations, and medical respite programs. Although hospitals with massive data loads might attain high clinical coordination fidelity, those with a wider cross-sector involvement might be better equipped to act upon social determinants, yet might fail at this due to inconsistent exchanges of data between partners. A trade-off of depth of data use and breadth of partnership engagement exists in this instance.

4.3. Community Outreach and Mobile Care

Street medicine and community outreach increase coordination in places that cannot be accessed by the traditional clinic-based models. Kaufman et al. (3) state that street medicine and mobile clinics decrease duplication in service provision and promote access to preventive care outside hospital settings through the development of trust-based networks among homeless people. This approach is consistent with the concept of wraparound services, which consider patient needs on a holistic level in the community. The scalability and data continuity of these models of outreach are, however, limited. Community outreach can lead to positive trust and access with little longitudinal surveillance, where, without rigid linkages to the centralized EHR systems, the continuity of data and its accessibility becomes a conflict.

4.4. Strategic Synthesis

Some of the central themes are present in each model: to decrease ED reliance and increase the health outcomes of those who are housing-unstable populations, data-driven management, cross-sector collaborations, and organizational accountability are needed. National statistics indicate that nearly 1.4 million ED visits are the result of homelessness every year (almost 1 million by men and 460,000 by women), highlighting the volume of acute care that coordinated models aim to reduce (7). Analyses of cost utilization support the role of coordination. The California Whole Person Care (WPC) pilot reported a decrease in ED visits by 130 per 1,000 beneficiaries- and 196 per 1,000 among homeless participants- and a reduction in Medi-Cal expenditures by \$383 per enrollee each year as a result of a decrease in hospitalizations and outpatient care (1). These results show that the housing and health systems management-led integration is a measurably cost-saving and more successful strategy. As illustrated in Figure 2, cohesive care ecosystems that can support the multi-layered needs of populations with housing and health vulnerabilities are built through an integrated management-led coordination structure, organized leadership, strong use of data, and sector alignment.

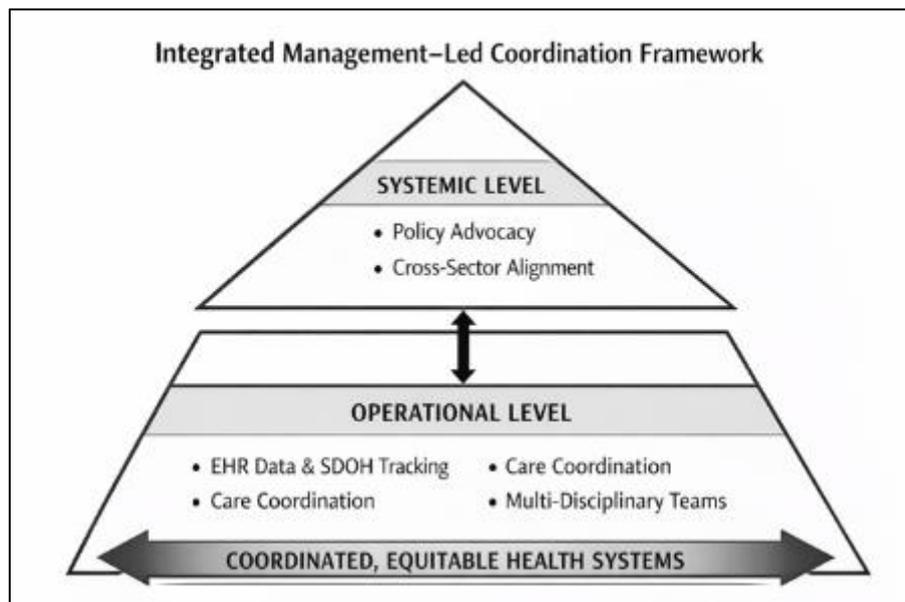


Figure 2 Integrated Management-Led Coordination Framework. Source: (Author, 2026)

5. Toward Sustainable and Inclusive Care Coordination

The change to structured, management-based governance of the entire healthcare ecosystem requires a conscious shift towards sustainable and inclusive care coordination of marginalized people. Every hospital, community housing, and behavioral health network should have formalized partnerships with one another to scale successful integrated models to ensure continuity of services and shared accountability (4). To enhance equity in population health, to enhance these partnerships, further investment into multi-sector governance and robust data infrastructure enabling the real-time

exchange of information within housing, social service, and health systems is necessary. Additionally, sustainability requires federal intervention and alignment of policies; national programs, such as the Centers for Medicare and Medicaid Services (CMS) health equity programs, formalize those structures within different jurisdictions (5). Combined together, these strategies reveal that long-term success in coordination is based on leadership commitment, combined policy formulation, and equitable distribution of resources at all levels of care.

6. Conclusion

Healthcare fragmentation within marginalized populations can be reduced by having sustainable management coordination of institutional care, community outreach, and policy advocacy. These ideas facilitate behavioral wellness, justice, and the use of the ER. Answering the question of how to make policies more effective, it is necessary to provide more federal incentives to share data across sectors, connect housing and healthcare financial resources, and make coordinated care systems more performance-based. The future study needs to focus on the long-term effectiveness, costs, and feasibility of implementation with the mixed-method longitudinal design. Institutional and policy coordination through management will stimulate fair, effective, and sustainable care delivery in different healthcare and housing systems.

Compliance with ethical standards

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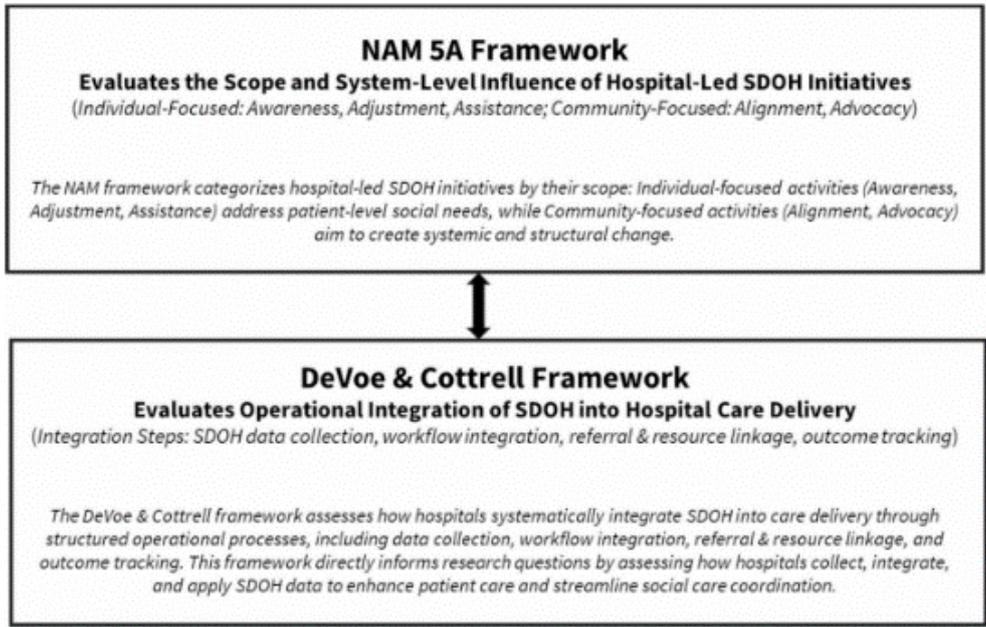
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Appendices

Appendix A: Combining the DeVoe & Cottrell and NAM 5A frameworks to assess hospital-led SDOH programs. Source: (Rangachari & Thapa, 2025)



Appendix B: Comparative Analysis of Emergency Department Utilization Pre- and Post-M3 Team Enrollment. Source (Groove et al., 2025)

Table 3 Unadjusted emergency department utilization six- and 12-months pre- and post-M3 team enrollment

Variable	6 months [†] N (%)	12 months [‡] N (%)
Pre-M3 Team enrollment		
Had ED visit	34 (71)	32 (74)
Number of ED visits (Mean ± SD)	3.15 ± 5.11	4.86 ± 7.28
Post-M3 Team enrollment		
Had ED visit	25 (52)	28* (65)
Number of ED visits (Mean ± SD)	1.46 ± 2.32*	2.65 ± 3.52*

ED emergency department
*p<0.05 in Chi-squared test comparing proportions or paired t-test comparing means pre- and post-enrollment
[†]N=48
[‡]N=43

Table 4 Adjusted changes in participant emergency department utilization pre- and post-M3 team enrollment

Outcome	Estimate [†] (SE)
6 months, pre-post change [‡]	
Probability of ED visit	-0.187* (0.086)
Number of ED visits	-1.713* (0.520)
12 months, pre-post change [§]	
Probability of ED visit	-0.093 (0.078)
Number of ED visits	-2.332* (1.051)

ED emergency department
*p<0.05, SE=standard error
[†]Estimated average marginal effect retrieved from multilevel mixed-effects generalized linear model with logit link and binomial family for binary outcomes and log link and negative binomial family for count outcomes
[‡]N=48, NT=96
[§]N=43, NT=86