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From Homeless to Healthy: How to Effectively Reach People who Experience Homelessness
(and keep them engaged)
June 10, 2015
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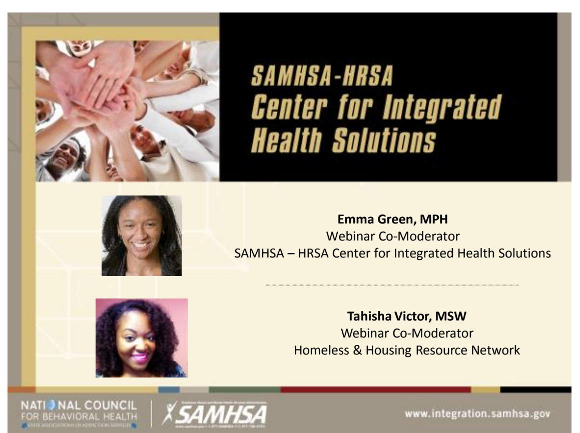
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Emma Green, MPH
Webinar Co-Moderator
SAMHSA – HRSA Center for Integrated Health Solutions
Tahisha Victor, MSW
Webinar Co-Moderator
Homeless & Housing Resource Network
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Before We Begin
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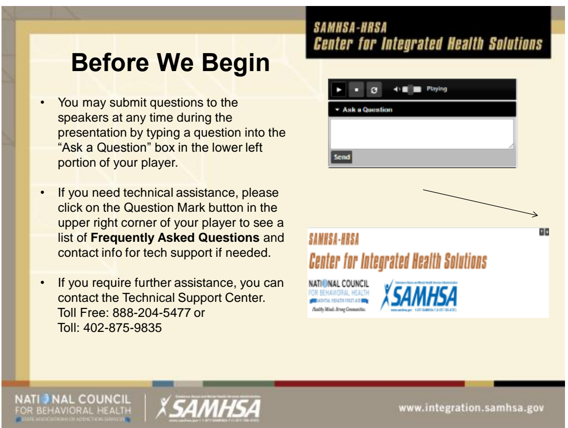

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Today's Purpose

- Recognize the considerations and challenges to providing health care services to people experiencing homelessness.
- Understand how various options for care can be implemented to remove common barriers to care for people who experience homelessness.
- Have strategies for engaging those among the homeless population who have co-occurring substance use and mental health conditions.

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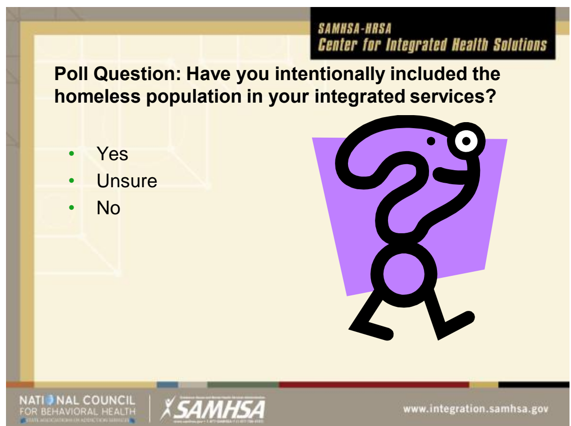

Roles of USICH

- **Coordinates** the Federal response to homelessness
- **Maximizes and leverages** the effectiveness of 19 Federal agency partners
- **Shares** best practices
- **Drives** collaborative solutions

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Opening Doors

No one should experience homelessness and no one should be without a safe, stable place to call home.

Four goals:

1. Prevent and end homelessness among Veterans in 2015
2. Finish the job of ending chronic homelessness in 2017
3. Prevent and end homelessness for families, youth, and children in 2020
4. Set a path to ending all types of homelessness

Opening Doors

Five themes and 10 Objectives

1. Increase leadership, collaboration, and civic engagement
2. Increase access to stable and affordable housing
3. Increase economic security
4. **Improve health and stability**
5. Retool the homeless crisis response system

Federal Strategic Plan to Prevent and End Homelessness

"Popeye"

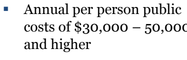
- 53-year old man, 15 years of homelessness
- Often "panhandles" on California freeway near Pasadena
- Suffers from hypertension, asthma, depression, and severe alcoholism
- Identified in 2012 as frequent user of hospitals through CSH demonstration project
- Engaged by hospital social worker, referred to housing organization
- Offered permanent supportive housing by case manager and refused

Homelessness and Health Needs

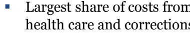
- On any given night, there are nearly 580,000 people are experiencing homelessness
  - 37.4% are people in families; 62.6% are individuals
  - Over the course of the year, 1.42 million people use homeless shelters
- On any given night, over 84,000 individuals are experiencing chronic homelessness (people with disabilities who are long-term homeless):
  - 82% have a mental or physical health disability
  - More than 80% have a substance abuse disorder
  - High rates of chronic physical health problems such as tuberculosis, HIV/AIDS, diabetes, hypertension, renal disease, and liver disease
  - Mortality rates 3-4 times higher than general population

High Public Service Use and Costs

- High utilization of public services, particularly among those with mental illnesses and/or substance use disorders



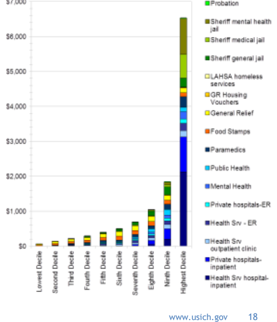
- Annual per person public costs of $30,000 – 50,000 and higher



- Largest share of costs from health care and corrections
- Frequent ED use and inpatient hospitalizations

"Super-Utilizers"

- Los Angeles analysis by Economic Roundtable (2010) found subset of people experiencing chronic homelessness that consumes $6,500 per month in county health and correctional services



"[T]he strong association between psychosocial needs and ED use suggests that interventions aimed at reducing ED use will not be successful unless they address these needs in addition to medical problems...[O]ur findings support recent research suggesting that improved health outcomes may be realized through **increasing expenditures for social services such as housing subsidies and income supplements**."

- K. Doran, M. Raven, R. Rosenheck

"The recognition of the complex care needs and fragile social circumstances of [ED super-utilizers] has stimulated fresh thinking about aggressive outreach, intense coordination of services by integrated care teams, and **the need for nonmedical resources such as supportive housing**, all of which could likely help curb the cost of health care."

– M. Raven and D. Gould

"Housing is the best pill."

– J. Brenner

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Permanent Supportive Housing

Supportive housing is a combination of **permanent, affordable housing** and **supportive services** that helps **people with special needs** achieve housing stability and improved health outcomes

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Supportive Housing's Impact on Health and Costs

Impacts on Health

- Denver study found 50% of recipients experienced improved health status, 43% had improved mental health outcomes, and 15% reduced substance use
- Seattle study found 30% reduction in alcohol use among chronic alcohol users
- San Francisco and Chicago studies found significantly higher survival rates, lower viral load, higher T-cell counts for recipients living with HIV/AIDS vs. control group

Impact on Health Costs

- 24% to 34% fewer emergency room visits
- 27% to 29% fewer inpatient admissions and hospital days
- 87% fewer days in detox and fewer psychiatric inpatient admissions
- Upwards of 40% decrease in Medicaid costs

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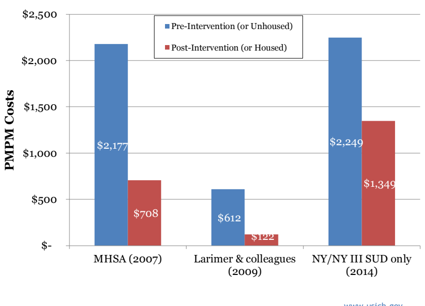
Supportive Housing Impact on Health Care Costs



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The Challenge: Linking the Problem to the Solution

Client-Level
- Frequent mobility makes engagement difficult
- Institutionalization, trauma, negative psychiatric symptoms often mistaken for service resistance/avoidance
- Lack of essential documents (identification, birth certificate)
- Significant barriers to housing (criminal and credit histories)
- Hopelessness, despair

Systems-Level
- Homeless outreach typically neglects health care settings
- Health care system lacks awareness of homeless services and housing
- Housing often allocated on first-come, first-served basis; lack of proactive targeting

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Health Care System as Intercept Point for Ending Homelessness

- Routine screening for homeless status/risk in health care settings

- Data "hot spotting" and triage tools
- Health care, homeless services, and housing collaboration

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Routine screening for homelessness

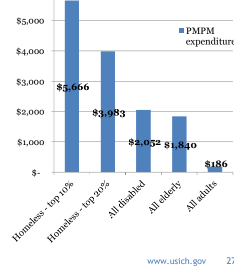
- Hospitals, health and behavioral health care settings can implement routine screening patients for homelessness status and risk
- *Example:* VA Homelessness Screening Clinical Reminder

Data "hot spotting"

- Nearly all communities maintain administrative data on people experiencing homelessness through Homelessness Management Information Systems (HMIS)
- Match hospital or Medicaid data with HMIS to identify subset of individuals known to homeless services with high utilization of services

Example: Connecticut Medicaid-HMIS Data Match

- HMIS data set consisting of 8,132 clients sent to Medicaid Department
- 4,193 single adult Medicaid beneficiaries identified as homeless in Medicaid in 2012
- Among matched, top 10% (n=419) used $28.5 mil in Medicaid service costs in 2011 ($5,666 PMPM)



Triage Tools

CHOOSE ONE AGE GROUP PER CASE:	Case 1	Case 2	Case 3	Case 4	Case 5	Case 6
Age 18-29	y			y		
Age 30-45		y			y	
Age 46+			y			y
CURRENT HEALTH STATUS:						
Disability		y				
Mental illness (case records)			y			
Hypertension			y			
Drug induced mental illness						y
Psychoses						
Alcohol induced mental illness						
Personality disorder						
Urinary disease						
Respiratory disease			y			
Asthma						
Mental disorder (diagnosis)		y				
Disease of nervous system						
Disease of circulatory system						
Disease of digestive system						y
Disease of musculo-skeletal system						
IN PAST 3 YEARS:						
Jail or probation record		y		y	y	
Jail mental health inmate	y					
IN PAST 2 YEARS:						
Hospital outpatient (#admissions)						
Emergency Room (#admissions)			3			3
Hospital inpatient (#admissions)		2			1	1
Hospital inpatient (#days)		8			6	7
Jail, mental health facility (#days)	60				20	
Jail, medical facility (#days)			30			
Jail, not med or mental facility (#days)				400	15	
Estimated probability for 10th Decile	0.82	0.70	0.86	0.35	0.55	0.43

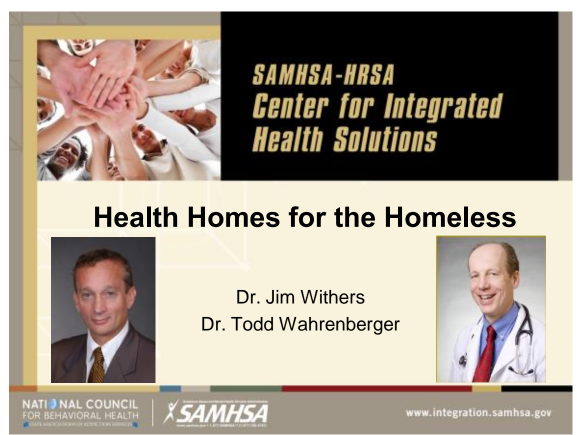
- Los Angeles Economic Roundtable developed a 27-Variable tool that can estimates probability that a individual experiencing homelessness is in top 10% of costs through hospital use
- Tool is administered by hospital social workers and staff on individuals visiting ED and inpatient settings

Health care, homeless services, housing collaborations

- Cross-system training
- Hospital discharge planning and "in-reach" by homeless services organizations
- Medical respite programs
- Targeted supportive housing units for people leaving health care settings

"Popeye"

- Persistent engagement by outreach worker led to "yes"
- Obtained Housing Choice Voucher and found 1BR apartment
- Provided with ongoing case management, assistance with ADLs, money management; quit panhandling
- Enrolled in Medicaid, SSI, and connection to primary care and behavioral health home
- Returned to the hospital once at the end of 2013
- In December 2014, Popeye celebrated his two-year anniversary in his apartment.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Health Homes for the Homeless
Dr. Jim Withers
Dr. Todd Wahrenberger
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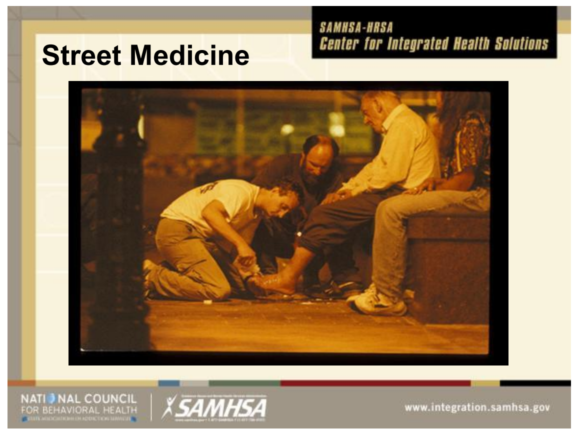
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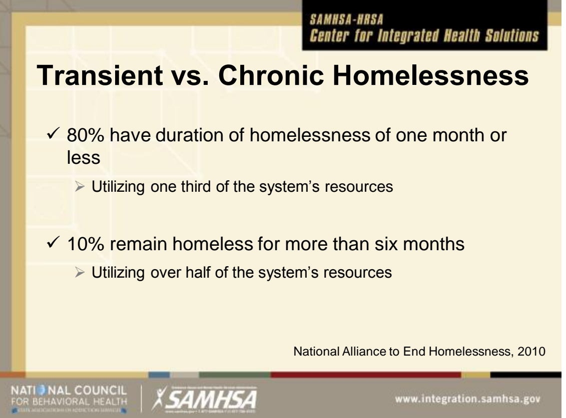
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Transient vs. Chronic Homelessness
80% have duration of homelessness of one month or less
Utilizing one third of the system's resources
10% remain homeless for more than six months
Utilizing over half of the system's resources
National Alliance to End Homelessness, 2010
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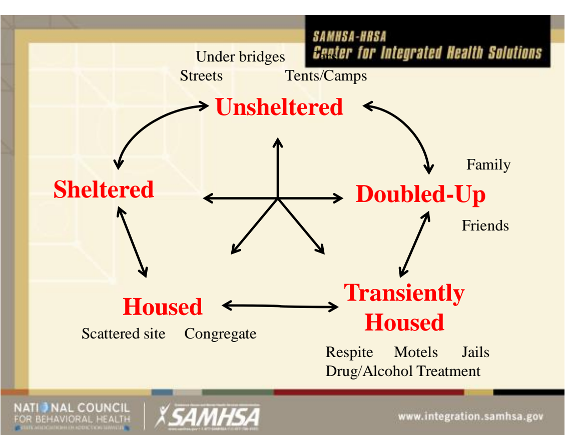
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Under bridges
Streets
Tents/Camps
Unsheltered
Sheltered
Family
Doubled-Up
Friends
Housed
Scattered site
Congregate
Transiently Housed
Respite
Motels
Jails
Drug/Alcohol Treatment
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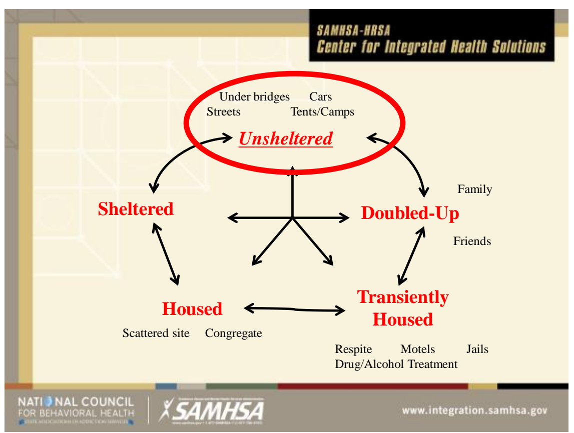
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Under bridges
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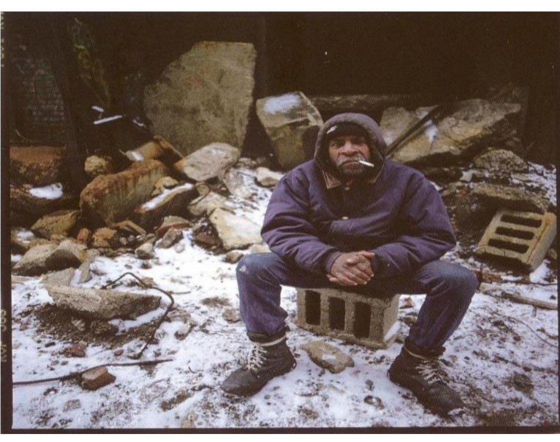

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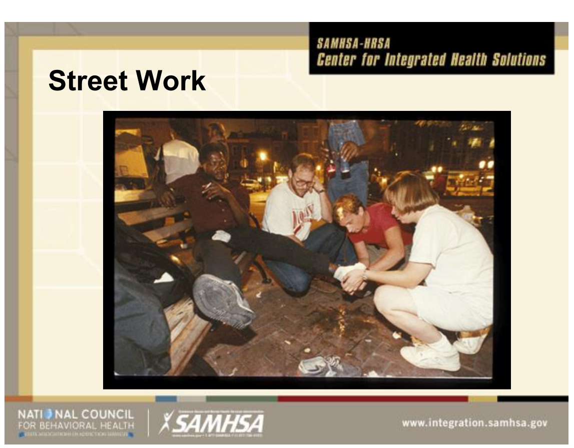
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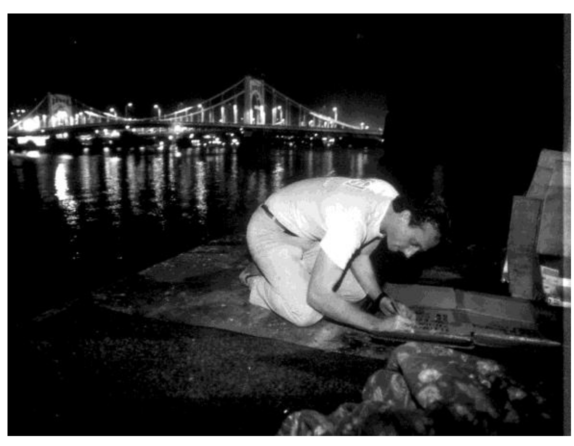

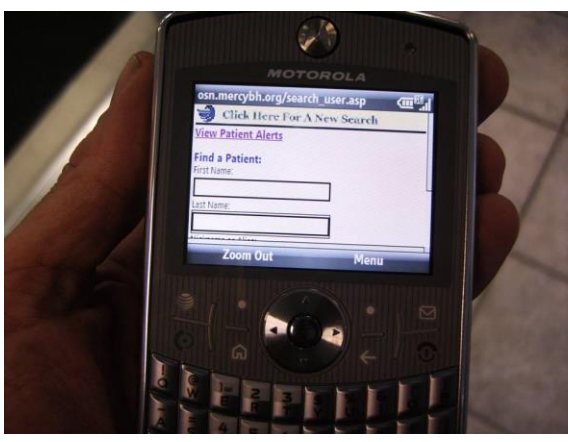
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Click Here For A New Search
View Patient Alerts
Find a Patient:
First Name:
Last Name:
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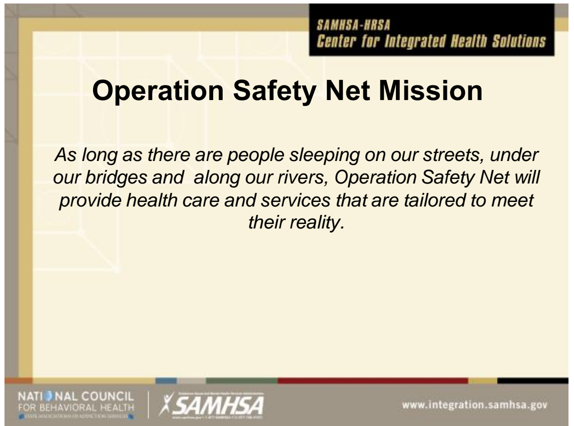
Menu

Mercy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Operation Safety Net Mission
As long as there are people sleeping on our streets, under our bridges and along our rivers, Operation Safety Net will provide health care and services that are tailored to meet their reality.
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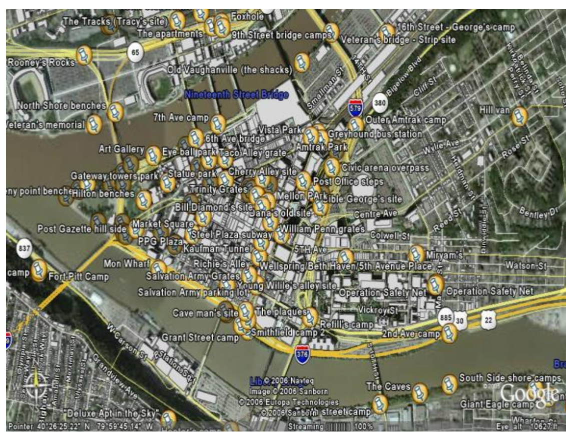
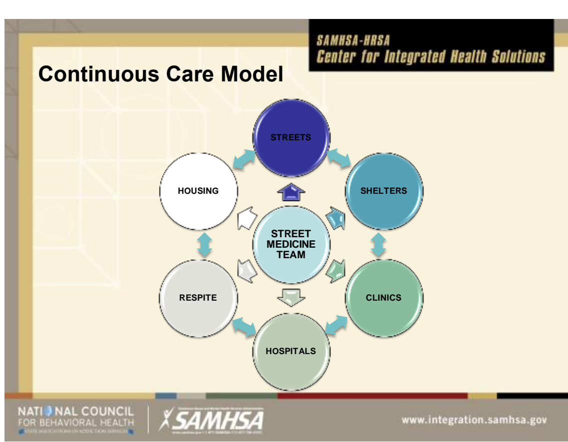

The Tracks (Tracy's site)
The apartments
Foxhole
9th Street bridge camps
16th Street - George's camp
Veteran's bridge - Strip site
Rooney's Rocks
Old Vaughanville (the shacks)
Nineteenth Street Bridge
North Shore benches
Veteran's memorial
7th Ave camp
Vista Park
6th Ave bridge
Greyhound bus station
Outer Amtrak camp
Hill van
Art Gallery
Eye ball park
Taco Alley grate
Amtrak Park
Gateway towers park
Statue park
Cherry Alley site
Civic arena overpass
Hilton benches
Trinity Grates
Post Office steps
Mellon PArk
Bible George's site
Bill Diamond's site
Dana's old site
Centre Ave
Post Gazette hill side
Market Square
William Penn grates
PPG Plaza
Steel Plaza subway
Colwell St
Kaufman Tunnel
5TH Ave
Miryam's
Mon Wharf
Richie's Alley
Wellspring/Beth Haven/5th Avenue Place
Watson St
Fort Pitt Camp
Salvation Army Grates
Salvation Army parking lot
Young Willie's alley site
Operation Safety Net
Operation Safety Net
Cave man's site
The plaques
Vickroy St
Refill's camp
Smithfield camp 2
2nd Ave camp
Grant Street camp
South Side shore camps
The Caves
Giant Eagle camp
"Deluxe Apt in the Sky"
Pointer 40°26'25.22" N 79°59'45.14" W
Streaming 100%
Eye alt 10627 ft
Google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HOUSING
SHELTERS
STREET MEDICINE TEAM
RESPITE
CLINICS
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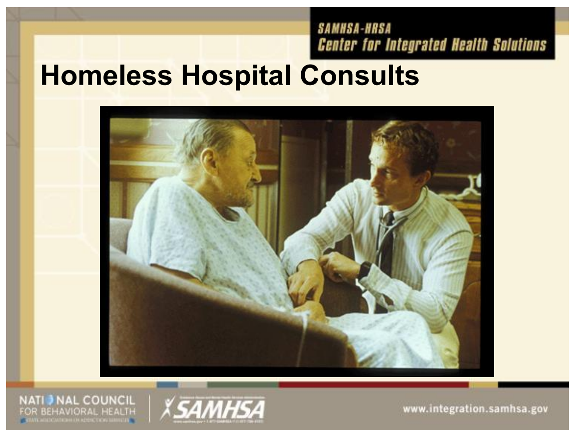
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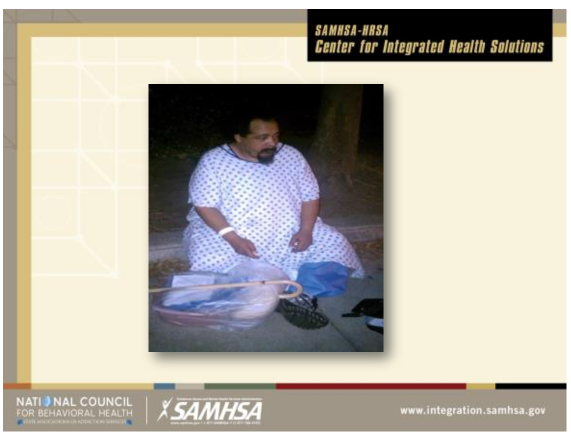
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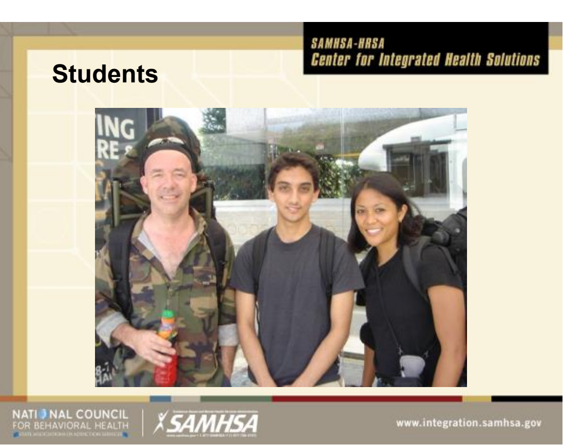
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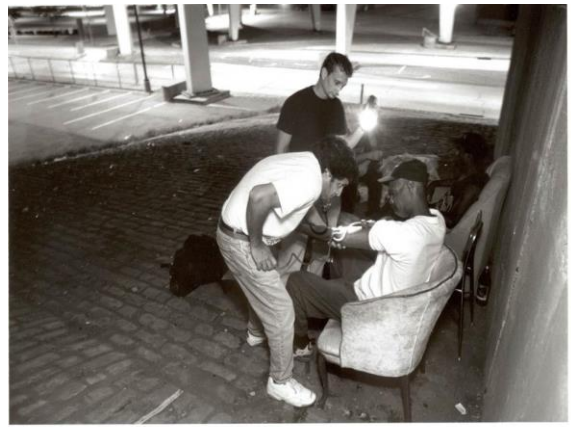

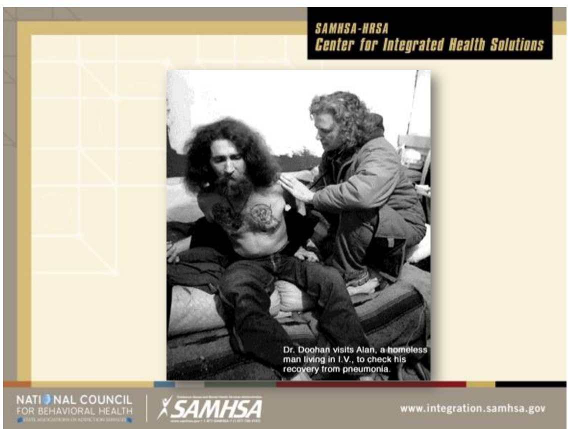
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Dr. Doohan visits Alan, a homeless man living in I.V., to check his recovery from pneumonia.
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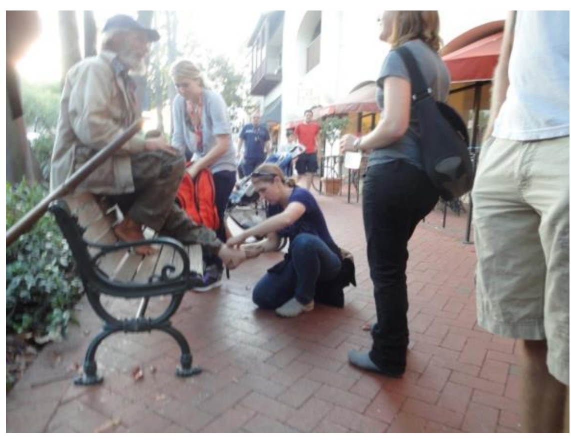

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MUSHROOM, Morgantown, WV and CHASM Charleston WV
Street Medicine Detroit, Wayne State University
University of Rochester Street Medicine, Rochester, NY
UCSB, (undergraduate) Santa Barbara, CA
Tampa Bay Street Medicine, University of South Florida, FL
Loma Linda University Street Medicine, Loma Linda University, CA
HealthSTAT, Emory University, Atlanta GA
Street Medicine Network, University of Ibadan, Nigeria
Street Health, Kathmandu Nepal
Prague Street Medicine, Charles Univ.
Homeless Camp Outreach, Des Moines University IA
Project Hope, NOVA Southeastern COM, Ft Lauderdale FL
i-STOP, University of Minnesota School of Medicine, MN
Vanderbilt Street Psychiatry, Univ of Vanderbilt SOM Nashville, TN
Good Neighbors Homeless Outreach, NW University SOM Chicago, IL
UCSB School of Medicine, San Diego, CA
Healthcare for the Homeless Houston, Baylor University SOM, Houston, TX
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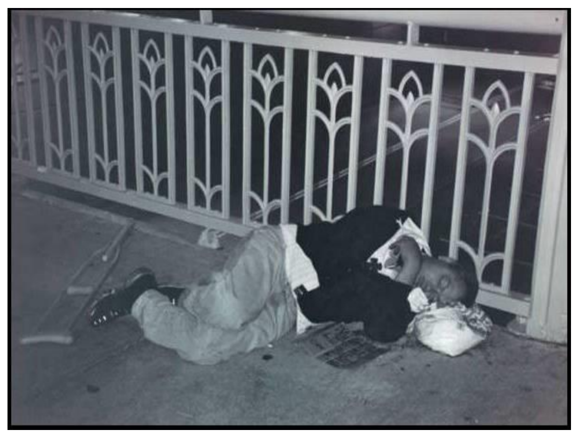

IN MEMORY OF THOSE
WHO LIVED AND DIED ON OUR STREETS
WE BELIEVE YOU ARE NO LONGER
COLD, HUNGRY, LONELY OR FRIGHTENED
MAY YOU WATCH OVER US
FROM A WARM, CARING HOME ABOVE
OPERATION SAFETY NET
STAFF AND VOLUNTEERS
WE REMEMBER
MARY GOLDSTON
1996
WE REMEMBER
MARSHALL HAMM
1996
WE REMEMBER
RICHARD JONES
1996
WE REMEMBER
LEW BRITT
2000
WE REMEMBER
TRACY POTTS
2000
WE REMEMBER
BILL SWOGER
2000

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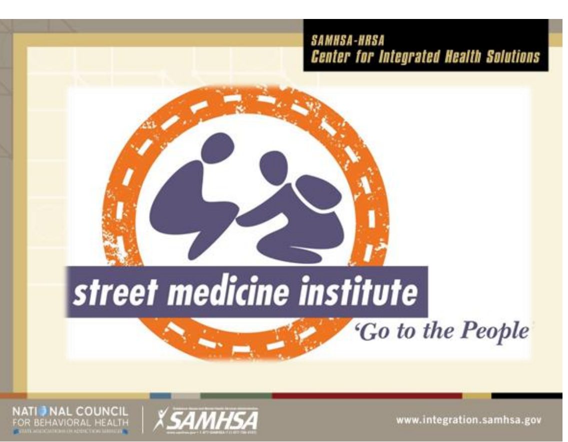
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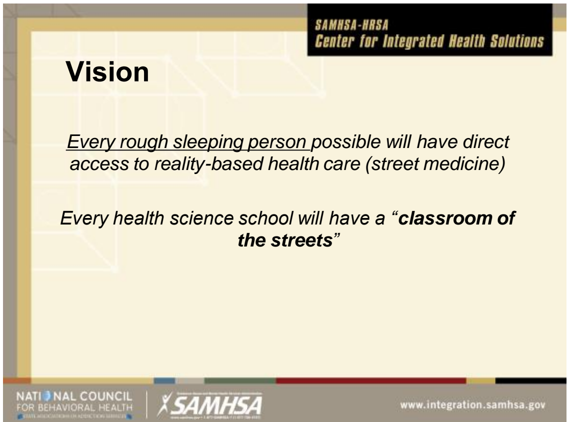

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Mission

- Consult with communities seeking to establish street medicine
- Define and improve street medicine best practices
- Create educational opportunities within the street medicine model
- Nurture the movement

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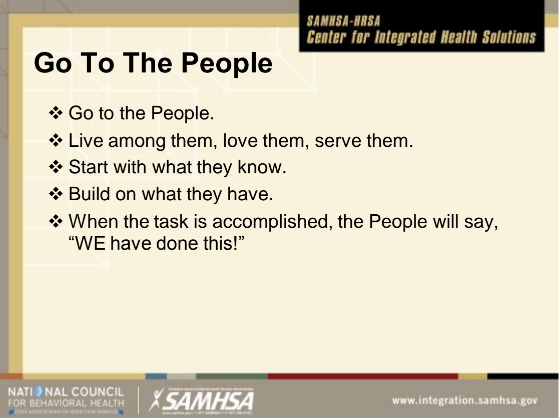

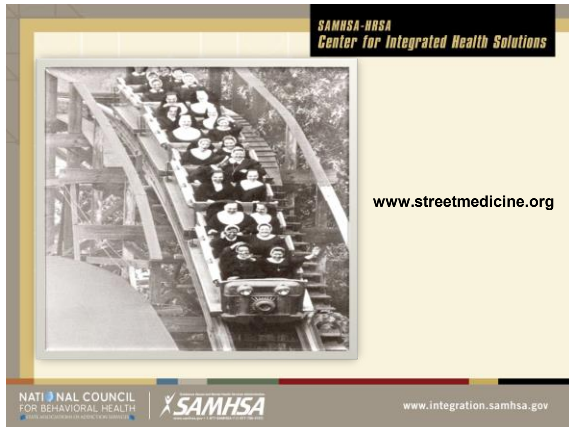
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www.streetmedicine.org
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Pittsburgh Mercy Family Health Center
A 2010 survey of over 25,000 patients showed that only 50% of Pittsburgh Mercy Health System service consumers were receiving any routine primary care
PMFHC opened its doors in May 2012, providing a fully integrated Primary and Behavioral Health Practice
Engaging a highly complex population with complex needs takes a TEAM!
ACT Model in Primary Care:
Multi-disciplinary Care Team approach, pulling in resources from all programs
Highly engaging team meets the patient where they are in their lives
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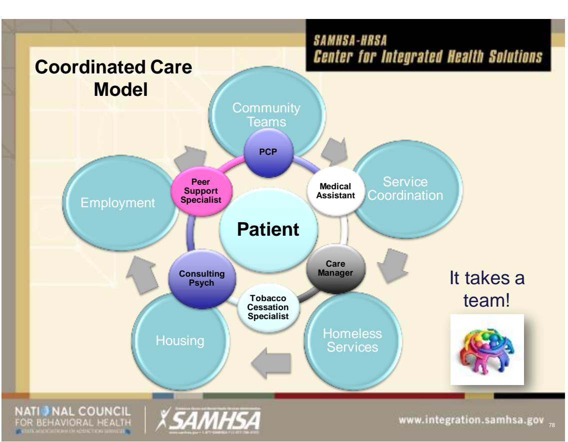
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Coordinated Care Model
Community Teams
PCP
Service Coordination
Medical Assistant
Employment
Peer Support Specialist
Patient
Care Manager
Consulting Psych
Tobacco Cessation Specialist
Housing
Homeless Services
It takes a team!
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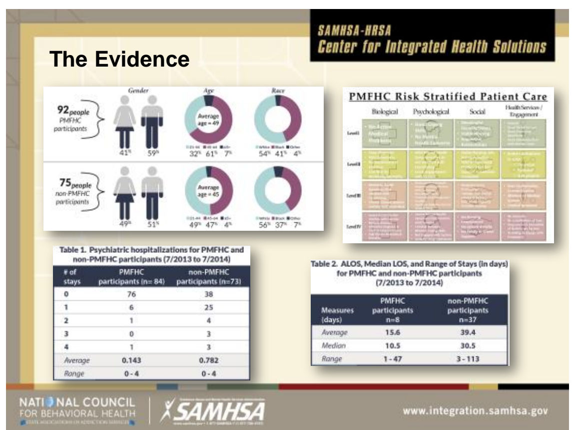
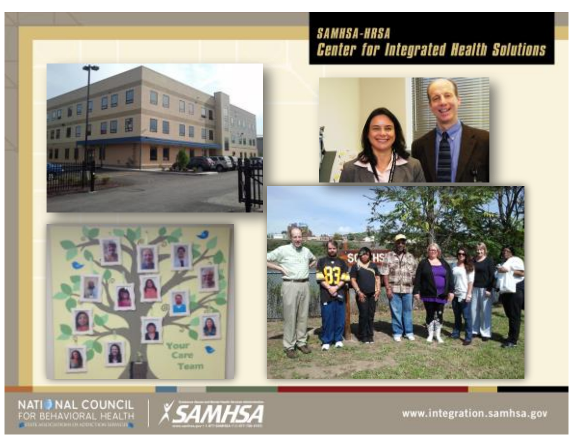


Table 1. Psychiatric hospitalizations for PMFHC and non-PMFHC participants (7/2013 to 7/2014)

# of stays	PMFHC participants (n= 84)	non-PMFHC participants (n=73)
0	76	38
1	6	25
2	1	4
3	0	3
4	1	3
Average	0.143	0.782
Range	0 - 4	0 - 4

Table 2. ALOS, Median LOS, and Range of Stays (in days) for PMFHC and non-PMFHC participants (7/2013 to 7/2014)

Measures (days)	PMFHC participants n=8	non-PMFHC participants n=37
Average	15.6	39.4
Median	10.5	30.5
Range	1 - 47	3 - 113



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PBHCI Context: Southeast Homeless Services History

1984 – Initiation of MH/Addiction Services to Homeless Populations
1986 to Current – Federal McKinney Award (Today's PATH Program)
1990 to Current – Addition of Numerous Homeless Programs
2006 – Acquisition of 140-Bed Men's Homeless Shelter
2009 – 2013 – SE PBHCI Project in Columbus OH – Solo Model
2010 – Integrated Healthcare with Hospital System Outreach to the Homeless
2011 – Ongoing – HRSA Grant for FQHC Healthcare for the Homeless at IHC Site(s)
2014 – New Build-out of IHC in Proximity to Largest Community Soup Kitchen
2014 – Placement of Primary Care within new Homeless Shelter

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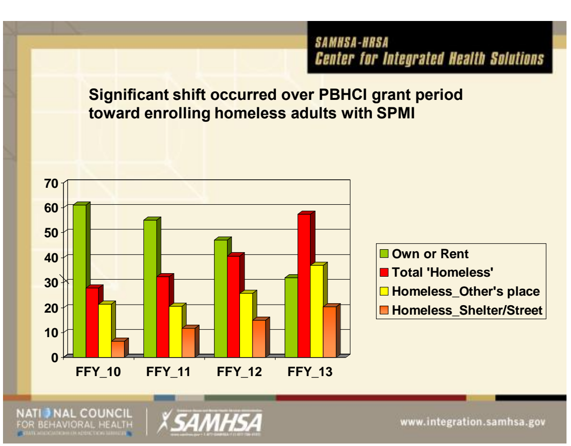

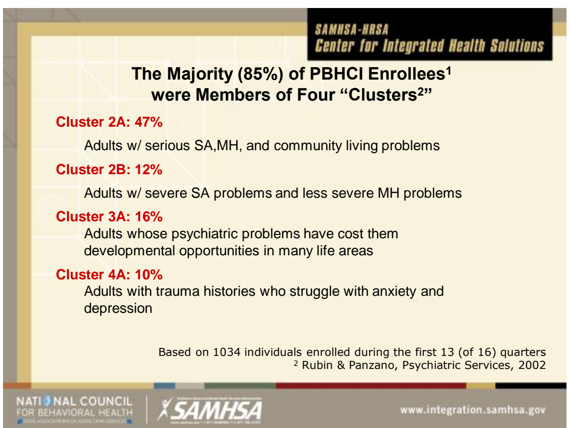
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The Majority (85%) of PBHCI Enrollees1
were Members of Four "Clusters2"
Cluster 2A: 47%
Adults w/ serious SA,MH, and community living problems
Cluster 2B: 12%
Adults w/ severe SA problems and less severe MH problems
Cluster 3A: 16%
Adults whose psychiatric problems have cost them developmental opportunities in many life areas
Cluster 4A: 10%
Adults with trauma histories who struggle with anxiety and depression
Based on 1034 individuals enrolled during the first 13 (of 16) quarters
2 Rubin & Panzano, Psychiatric Services, 2002
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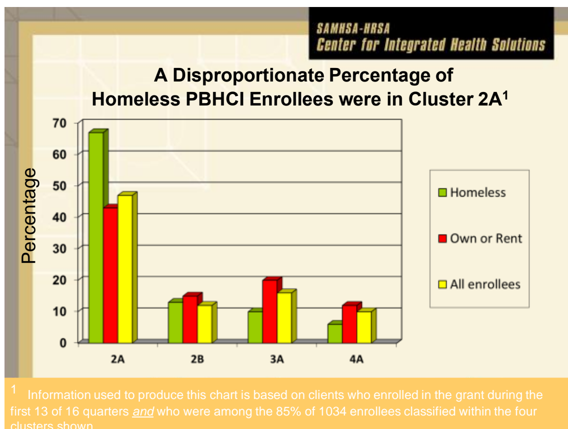
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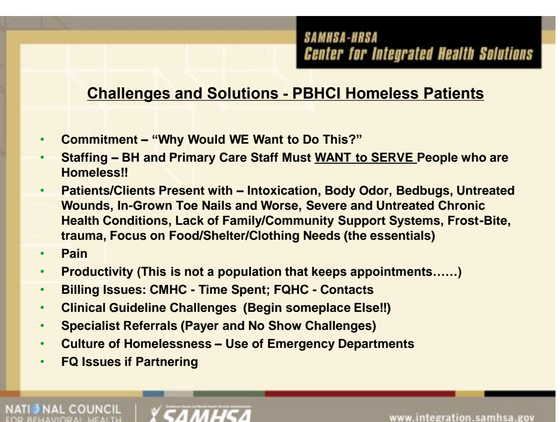
A Disproportionate Percentage of
Homeless PBHCI Enrollees were in Cluster 2A1
Percentage
70
60
50
40
30
20
10
0
2A
2B
3A
4A
Homeless
Own or Rent
All enrollees
1 Information used to produce this chart is based on clients who enrolled in the grant during the first 13 of 16 quarters and who were among the 85% of 1034 enrollees classified within the four clusters shown.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Challenges and Solutions - PBHCI Homeless Patients
Commitment – "Why Would WE Want to Do This?"
Staffing – BH and Primary Care Staff Must WANT to SERVE People who are Homeless!!
Patients/Clients Present with – Intoxication, Body Odor, Bedbugs, Untreated Wounds, In-Grown Toe Nails and Worse, Severe and Untreated Chronic Health Conditions, Lack of Family/Community Support Systems, Frost-Bite, trauma, Focus on Food/Shelter/Clothing Needs (the essentials)
Pain
Productivity (This is not a population that keeps appointments……)
Billing Issues: CMHC - Time Spent; FQHC - Contacts
Clinical Guideline Challenges (Begin someplace Else!!)
Specialist Referrals (Payer and No Show Challenges)
Culture of Homelessness – Use of Emergency Departments
FQ Issues if Partnering
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Challenges and Solutions

Family Practice Retraining

1. Motivational Interviewing and Harm Reduction Skills
2. Rethinking "Where to Start"
3. Trauma Informed Care in the Exam Room
4. Rethinking Clinical Guidelines – Prevention and Chronic Conditions
5. Reason for Visit (Patient Picks One; You Pick One)
6. Tolerance – Changed Expectations
7. PBHCI Blood work (Re-Thinking Response to Critical Values)
8. Screening for Hep B and C; TBI; HIV (Rapid Testing)
9. Impact of Addiction including Heroin Use
10. Working with Pain and "Drug Seeking Behaviors"
11. Tobacco Use and Cessation
12. Becoming the PCMH for People Who are Homeless
13. Using Homeless Patient "Survival Mode" as a Strength

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Challenges and Solutions

- **Develop Homeless IHC Engagement and Service Locations – Accessible, Acceptable, Appropriate (with/without FQHC)**
- **Identify Locations of Homeless Shelters, Camps, Soup Kitchens and "Magnet" Areas of Community (Where do people hang out…..)**
- **Go To These Locations/Locate Within These Locations!!**
- **Encourage ROIs and Alternative Contact Information**
- **All Staff Learn/Use Motivational Interviewing and Harm Reduction Skills**
- **Offer Items That Have Meaning (Clean Dry Socks, Sunscreen, gloves)**
- **Provide Services That Have Meaning (Clip Toenails, Treat Wounds)**
- **Develop Alternative Pain Interventions (Acupuncture, Physical Therapy, CBT, Dental Services)**
- **Ensure Transportation**
- **Try to Hire Peers and Form a Homeless Patient Advisory Committee**
- **Engage SAMHSA re: PBHCI Expectations and Homeless Populations**

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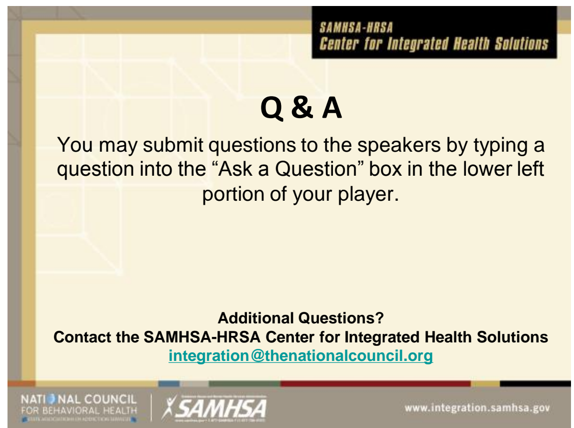
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