

## TRANSCRIPT OF AUDIO FILE:

# FROM HOMELESS TO HEALTHY - HOW TO EFFECTIVELY REACH PEOPLE WHO EXPERIENCE HOMELESSNESS - AND KEEP THEM ENGAGED - 6-10-2015

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### **BEGIN TRANSCRIPT:**

EMMA GREEN: Good afternoon and welcome to today's Webinar, *From Homeless to Healthy: How to Effectively Reach People who Experience Homelessness (and keep them engaged)*. My name is Emma Green, and I am the training and technical assistance coordinator for the SAMHSA-HRSA Center for Integrated Health Solutions or CIHS. As you may know, CIHS promotes the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance use conditions, whether seen in specialty behavioral health or primary care provider settings. [0:50]

In addition to national Webinars designed to help providers integrate care, the center is continually posting practical tools and resources to the CIHS Web site, providing direct phone consultation to providers and stakeholder groups and directly working with SAMHSA primary and behavioral healthcare integration grantees and HRSA product health centers. Joining me is Tahisha Victor who works with SAMHSA's Homeless and Housing Research Network, or HHRN. It is our pleasure to serve as your moderators for today's presentation. Now, Tahisha will go over a few logistical announcements. Tahisha.

TAHISHA VICTOR: Thank you, Emma. All participant lines are muted for the duration of this call. To download the presentation slides, please click the drop-down menu labeled "Event Resources" on the bottom-left of your screen. Slides are available on the CIHS Web site, [www.integration.samhsa.gov](http://www.integration.samhsa.gov) under "About Us/Webinars". [0:01:59] During today's presentation, your slides will be automatically synchronized with the audio, so you will not need to flip any slides to follow along. You will listen to the audio through your computer speakers, so please ensure that they are on and the volume is up.

We welcome questions and we will have a time for a Q&A session after the presentation. You may submit your questions to the speakers at any time during the presentation by typing a

question into the “Ask a question” box in the lower-left portion of your player. The presenters will respond to questions at the end of the presentation.

Today’s Webinar is being recorded, participants will be able to access a recording of this Webinar and will be notified by e-mail when the recording is available. Finally, if you need technical assistance, please click on the “?” button in the upper right corner of your player to see a list of frequently asked questions and contact information for the tech support if needed.

[0:03:04] I’d like to turn the presentation over to Maia Banks-Scheetz and Ruth Hurtado-Day, two government project officers at SAMHSA. Maia will welcome you to today’s Webinar.

MAIA BANKS-SCHEETZ: Thank you so much, Emma Tahisha. Welcome to everyone joining us today. Again, my name is Maia Banks-Scheetz, Project Officer with SAMHSA Center for Mental Health Services, Homeless Programs Branch. And on behalf of SAMHSA, I’d like to thank you all for participating in this Webinar. So today we are really excited to be joined by several fantastic presenters who’ll provide information on how to effectively engage individuals who experience homelessness in primary and behavioral healthcare-integrated service settings. [0:03:53]

So we have with us today Richard Cho, Senior Policy Director for the U.S. Interagency Council on Homelessness, Dr. James Withers, Medical Director with Operation Safety Net - Pittsburgh Mercy Health System, Dr. Wahrenberger, Medical Director for Primary Care - Pittsburgh Mercy Health System, and also Sandy Stephenson, Director, Integrated Healthcare with Southeast, Inc.

So we are going to talk a little bit about the topics to be covered. So we’ve outlined our learning objectives for today’s Webinar here. I would hope that today’s Webinar will allow you all to gain a better understanding of challenges to providing healthcare services to people experiencing homelessness and the various options for care, including strategies for engaging those among the homeless population who have co-occurring substance use and mental health disorders. So let’s get started. I’d like to now turn the presentation over to Emma to introduce our first presenter. Emma. [0:05:01]

EMMA GREEN: Thank you, Maia. Before I introduce our first speaker, I would like to launch our poll question. We are interested in whether you had intentionally included the homeless population in your integrated care services. In other words, is the homeless population a specific subset that your integrated program aims to reach? So we’ll just give everyone a few more moments to respond, and I’ll go ahead and share the results with everybody.

(pause)

EMMA GREEN: I’ll just wait a few more seconds.

(pause)

EMMA GREEN: It looks like about 85% of you have indicated yes, 6.4% of you are unsure and 8.5% of you have not specifically targeted a homeless population. [0:05:59] Thank you for that, and without further ado, I’d like to go ahead and introduce our first presenter.

Richard Cho is the Senior Policy Director for the U.S. Interagency Council on Homelessness where he coordinates their federal policy efforts and the implementation of Opening Doors, the nation's first comprehensive strategy to prevent and end homelessness.

Richard joined USICH in February 2013. Prior to that, he spent 12 years working at the Corporation for Supportive Housing, most recently as the Director of Innovations where he advanced supportive housing innovations for vulnerable populations, including homeless populations with complex health needs who are high utilizers of crisis health services and/or correctional settings, families with recurrent child welfare involvement and more. So now I'd like to go ahead and turn it over to Dr. Cho.

RICHARD CHO: Great. Thank you so much Emma, and I want to thank SAMHSA and HRSA for putting on this Webinar and allowing me to speak. [0:07:00] Why don't I give us a quick overview of who we are and then talk a little about what we see nationally as the challenges facing people experiencing homelessness in terms of their involvement in health services, the healthcare challenges they face, and then talk a little about some of the innovative practices that we're seeing for how to link healthcare with homeless services and housing to better address the needs of this population.

So we are an independent agency. Our role is to coordinate the federal response to end homelessness, and that is the work consisting of 19 federal agencies with whom we work to coordinate their efforts, ensure best practices as well as provide support to the community. Our work is guided by the federal strategic plan to prevent and end homelessness, otherwise known as Opening Doors, which laid out a vision that no one should experience homelessness, and no one should be without a safe and stable place to call home. [0:07:55] That plan, which was adopted in 2010, set forth four goals to end homelessness – to prevent and end homelessness among veterans, to finish the job of ending chronic homelessness, to prevent and end homelessness for families, youth and children, and then to set a path to end all types of homelessness. And we're working every day across our agencies and with our community partners to try to achieve those goals.

The plan itself lays out a pretty comprehensive blueprint consisting of 58 strategies organized around 5 themes and 10 objectives that really lays out, I think, the best of what we know from around the country that works to end homelessness. And those five themes are presented here on this slide, and I just want to point out that one of the most important of the five themes is really about improving access to healthcare and providing integrated primary and behavioral healthcare that's coordinated with housing to assist people experiencing homelessness. [0:08:52]

Let me take this all down to the person level and talk about an individual whose name is Timothy, but he goes by the name Popeye, and this is an individual who was assisted in California. And Popeye is a 53-year-old man who experienced 15 years of homelessness. Prior to a couple years ago, he was often found panhandling on the side of the California Freeway near Pasadena. And Popeye has a number of different conditions, in addition to experiencing long-term homelessness. He suffers from hypertension, asthma, depression and also severe alcoholism.

In 2012, through a pilot project, which I will talk about a little bit later, he was actually identified as someone who was a known frequent user of hospital services in Southern California. And as part of their project, he was identified as being a candidate for this project. [0:09:52] He happened to enter a hospital after getting into a car accident as he was riding a bicycle, and upon entering the hospital, was engaged by a hospital social worker who did confirm that he was a frequent user of hospitals and who then referred him to a homeless services organization known as “Housing Works”.

So the case manager reaches out the Popeye and engages him and said that he has access to permanent supportive housing as a result of this pilot project, and of course, Popeye refuses to enter housing. I’ll come back to what happens to Popeye a little bit later. But I want to say that across the country, there are many individuals who have very similar stories to Timothy, otherwise known as Popeye, and we know that on any given night, there are at least 580,000 people who are experiencing homelessness, about a little more than a third of which are people in families, and a little less than two-thirds are individuals without families. [0:10:49] And that again only represents a snapshot of homelessness on a particular night, and we know that over the course of the year, at least 1.4 million people actually used homeless shelters, and that doesn’t include all the people who are living on the streets, as well as individuals and families and youth who are in substandard housing or doubled-up.

And of that large number of people who are experiencing homelessness over the course of a year, about 84,000 individuals, on any given night, are experiencing what is known as chronic homelessness, which essentially means that these are people with disabilities and chronic healthcare challenges who are also experiencing long-term homeless. So an individual like Popeye would be an individual who’s experiencing chronic homelessness. And we know that within this subset, we have a high concentration of really severe and chronic health challenges. Eighty-two percent have a mental or physical health disability, really high rates of substance abuse disorders among the population, as well as chronic medical challenges – TB and HIV infectious diseases – as well as other chronic conditions like diabetes, hypertension, renal disease, and liver disease. [0:11:56]

And we also know that this population tends to have a higher risk of premature mortality, and some studies have shown that they have mortality rates that are three or four times higher than the general population. We also know that with having poor access to healthcare and that confluence of complex health needs, this is a population that tends to be involved in using some of the more expensive types of public services, particularly Healthcare Services. And numerous studies have really documented the fact that individuals experiencing homelessness, particularly those with chronic health challenges, tend to cycle in and out of a number of different settings where the annual per-person public cost could be as high as 30,000 to 50,000 per person per year, and some studies have identified people who are “frequent users” who cost much more than that in terms of their use of crisis services.

The larger share of those costs we know come from both healthcare and secondly from corrections – jails and prisons. [0:13:00] And we also know that a lot of the pattern of the healthcare utilization tends to be focused on frequent emergency-department visits as well as

inpatient hospitalizations. Again, there have been a number of studies now that have begun to identify that even among people experiencing chronic homelessness, there is a range of costs and that within that group, you can identify a subset of “super-utilizers” who really represent the highest of both need as well as cost. For example, a study in 2010 by a Los Angeles-based think tank, the Economic Roundtable, identified a subset of people experiencing chronic homelessness that consumes about \$6,500 per month in county health and correctional services. So over \$70,000 per year. [0:13:44]

So I think the fact that we’ve identified that folks are not only experiencing homelessness but also are consumers of healthcare services and not of the kind of healthcare services that are necessarily benefiting them but actually driving up costs. We’ve see a real surge on the part of the healthcare sector – and in particular, emergency department physicians and other healthcare providers – who have begun to recognize that the kind of tools and interventions they have to provide emergency medicine aren’t necessarily adequate in addressing the needs of individuals.

And here are just a couple of quotes from people who are working in the emergency medicine field, as well as the healthcare field, who’ve identified that essentially the kind of tools that they have aren’t adequate and that what are really needed for addressing the health needs of this population are things like social services, as well as housing and the need for non-medical resources, such as supportive housing, or as Jeffrey Brenner of the Camden Coalition of Healthcare Providers has said, I think succinctly, “Housing is the best pill”.

We know that often for this population, the best solution is an intervention known as “Permanent Supportive Housing” that combines access to permanent affordable housing with an array of case management and supportive services that assess people to not only achieve housing stability but also access the needed healthcare and behavioral health services that help them achieve stability and well-being. [0:15:10] Supportive Housing is a way that uses housing as a platform for helping people achieve health and wellness and to access the array of services, treatment and recovery services that they need. And there again, there’ve been a number of studies that have shown supportive housing’s really impressive impact on not only health outcomes but also costs.

Studies have shown improvements in health status, both mental health and substance use, reductions in alcohol use and substance use, and even for people living with HIV and AIDS, they’ve found that placement into supportive housing is associated with higher survival rates, lower viral loads, and higher T-cell counts so that people actually can live longer after living in supportive housing. [0:15:52] And not only that, with the shift in health service utilization from emergency department visits and inpatient hospitalizations to primary and preventive care, we know that people experiencing homelessness, once placed in this supportive housing, also tend to use fewer emergency room visits and become hospitalized less and also visit detox and psychiatric centers at a lower rate, all of that translating to lower healthcare costs.

And with the expansion of Medicaid programs at the state level, we know that a greater share of healthcare costs are being covered by Medicaid, and therefore, by placing people in supportive housing, we know that we can also potentially help curb spending in Medicaid costs.

This is just a chart that shows, I think, some of the studies that I've mentioned. The one on the far left is from Massachusetts that have shown a pretty dramatic reduction in per member per month costs going from about \$2,000 per person per month to about \$700. [0:16:54] The one in the middle is from Seattle, the one on the right is from New York, and I think if you look across the country, there have been a number of studies that have shown this similar pattern that moving people from homelessness to housing and giving them access to healthcare services has really dramatic reductions in healthcare costs.

So I think that brings us to what I think the primary challenge is, is that unlike many other challenging and vexing social problems, this is not a case where we don't know what the answers are. In fact, we do know what the solutions are, and really, what the challenge is, is how do we bring the problem to the solution? In other words, how do we find the people who need this intervention the most and help them connect to the intervention which is permanent supportive housing with access to integrated healthcare services? We know there're a number of challenges to doing so. Some are at the client level, and I'm sure my colleague on this Webinar will speak to this to some degree that this is a population that is frequently mobile. Not only are they often living on the street and moving from location to location but also involved in various institutions – hospital, jails, psychiatric centers, detox programs – and because they cycle in and out of those institutions, it makes it really difficult to engage them. [0:18:04]

Secondly, we know that their pattern of institutionalization, their history of being in and out of these settings and not necessarily having the best experiences and having experiences of trauma, often result in their having behaviors that are mistaken for service-resistance or avoidance. And in addition, some people have what are known as “negative psychiatric symptoms”, which means that they're withdrawn, that they don't necessarily engage. And that either can be mistaken for not having high needs or where they are often written off as being antisocial. These are also individuals who lack essential documents, they don't often have government-issued identification, and they don't have access to birth certificates, which can be challenging to obtain housing, as well as other benefits.

In addition, they often have criminal histories, as well as poor credit histories which serve as significant barriers to housing. [0:19:00] And certainly, last but not least, there's a sense of hopelessness and despair, and I think the reason why individuals like Popeye often refuse offers of housing assistance is not because they want to be remain homeless but also often because they've given up on the future. At a systems level, we know some of the challenges are just that we have the homeless services and housing that often work in silos with the healthcare system where homeless outreach typically doesn't often work in healthcare settings and also where the healthcare system and hospitals lack awareness of how to access both homeless services, as well as housing. And then, when you have a housing or even permanent supportive housing, there's still the dynamic where a lot of housing is allocated on a first-come, first-served basis, and again, with a population like this, their challenges are that they're not necessarily the ones to be the most forthright in seeking help, and there's often a lack of proactive targeting. [0:20:00]

So what we're seeing around the country is that that all is beginning to change, and that there're beginning to be really innovative collaborations between homeless services and the healthcare

system and where, increasingly, we're seeing the healthcare system serving as an intercept point for addressing and ending homelessness.

Let me talk about three of the innovative practices that we're beginning to see. The first is the practice of doing routine screenings for homelessness status and housing and homelessness risk within healthcare settings. The second is something known as "data hotspotting" or the use of triage tools to identify individuals who are frequent users of healthcare services; who are experiencing homelessness. And third are really examples where the healthcare sector, and healthcare providers are collaborating with homeless service organizations and housing to actually better serve the population. [0:20:53]

So around the country, we're beginning to see a lot of healthcare institutions and providers, as well as hospitals, beginning to do routine screening for homelessness and homelessness-risk among patients. And this is where, either through hospital social workers, working in emergency departments or inpatient facilities are beginning to ask a series of very brief questions to at least determine if patients are at risk of homelessness or experiencing homelessness. And I think one good example of that is not necessarily in the mainstream U.S. healthcare system but really through the U.S. Department of Veterans Affairs where over the last few years, they've begun to transform their healthcare system to become much more focused and attuned to the needs of people who are experiencing homelessness who are veterans, and where they begin to implement a homelessness screening clinical reminder within all of their VA hospitals around the country.

And this is too small to read on the screen, but it shows an example of what this one-page checklist of questions look like, which really is a five-part questionnaire to help answer questions about whether or not the patient is experiencing homelessness or is at risk of homelessness. I think that this is a tool that could be easily adapted for mainstream healthcare settings and hospitals. [0:22:08] We're also beginning to see communities experiment with data hotspotting, and this is an example where data is being used to identify individuals who are frequent users of healthcare services, as well as those experiencing homelessness. And we know every community maintains administrative data on people experiencing homelessness through something known as Homelessness Management Information Systems or HMIS.

And we've seen a number of communities now experimenting with matching hospital data or Medicaid claims data with HMIS to begin to identify the subset of individuals who, again, have histories of recent homelessness or are known to the homeless service system who also are high utilizers of emergency departments or hospital services. [0:22:52] And one example of that is in Connecticut, where the State of Connecticut matched their Medicaid claims data against state-wide HMIS data, and that resulted in a match that identified 4,193 single adult Medicaid beneficiaries who were experiencing homelessness. They also were able to sort them into costs quintiles and they essentially identified people who are at the top 10% of costs who use about \$5,600 per member per month in Medicaid costs, so a really high expensive cohort.

And there are now efforts underway in the State of Connecticut to begin to target that subset of individuals and provide them with permanent supportive housing. Other communities are beginning to experiment with the use of triage tools. Again, the same organization that identified the cohort of high utilizers in Los Angeles used that data to develop a triage tool, which is

essentially a tool that took all of the aggregated data that helped identify folks in that top decile of costs within Los Angeles and then determine, what are the kind of characteristics and factors that indicate whether an individual would be most likely? [0:24:11] And so this is the tool that involves 27 different variables and is administered by hospital social workers working all over Los Angeles County to identify individuals who enter their emergency departments or hospitals and who are both experiencing homelessness and then are likely to be in that 10% decile of cost.

And this is actually the tool that was used to identify Popeye when he entered the hospital setting that I mentioned earlier. We are now also seeing a number of healthcare homeless services and housing collaborations where both the healthcare system and homeless services are engaging in cross-system training so they can speak a common language and vocabulary, and we think that's a really critical starting point for helping the healthcare system to understand how do you access homeless services, how are homeless services and access to housing organized in the community? [0:25:01] And similarly, on the homeless services and housing side, how do you begin to speak the language of healthcare and the language of Medicaid so they can begin to understand what are the kind of things that they can ask for?

And we know in states like California, in places like Utah and other states, their efforts to try to begin that cross-system training, so we can begin to build better collaborations. There are also efforts underway to do hospital-discharge planning that is much more attuned to understanding how to access homeless services and housing. And I think, frankly, all of the illness doesn't need to just be on hospitals but also where the homeless service organizations need to also understand that the clients and individuals that they're trying to reach also frequent healthcare settings, as well, and that they need to not only do street outreach but also inreach into healthcare settings and hospitals to help identify and engage the population. [0:25:52]

And that is exactly the kind of partnership that we saw that was successful in engaging Popeye where the hospital social worker reached out to Housing Works, the Los Angeles homeless service organization, who then did inreach into the hospital to engage Popeye. Some communities are also implementing medical respite programs which can serve as a critical bridge for people who are being discharged from hospitals and who either have still some medical vulnerabilities where they can't necessarily enter into their own housing or return to housing or where that medical respite then serves as a kind of waystation before people are then placed into permanent housing with services.

And last but not least, again, like the Los Angeles pilot and the work that's happening in Connecticut where efforts are underway to target supportive housing units specifically to people who are leaving healthcare settings, including those that are targeting people who are frequent users of hospitals. So let me then return to Popeye. After refusing an offer of housing, he was discharged by the hospital and ended up back on the streets. [0:26:55] He was then reengaged and identified back on the freeway near Pasadena where he had frequented by that outreach worker who really, over the course of weeks and months, continued to engage Popeye and offered him housing, and finally he was able to build enough trust to get Popeye to agree to enter housing.

Popeye was actually able to obtain a housing choice voucher and, using that voucher, was able to find a one-bedroom apartment. Housing Works, the organization when engaged him, was able to provide him with ongoing case management, assistance with activities of daily living and money management, and Popeye eventually quit panhandling. He was also enrolled in Medicaid, supplemental security income and was then connected to a primary care and behavioral health home. And since entering housing, he's returned to the hospital only once at the end of 2013 – so only once over the course of two years – as opposed to being in an out on a very infrequent basis. And in December of last year, he actually celebrated his 2-year anniversary in his own apartment after living on the streets for 15 years. [0:27:57]

And so I think Popeye is an example of the kind of results that we can see if we build the kind of healthcare and homeless services and housing collaborations that we're hoping for. So with that, I'm going to conclude my segment and turn this back over to you, Emma. [0:28:08]

EMMA GREEN: Thank you, Richard. Our next presenter is Dr. James Withers, founder and medical director of Operation Safety Net - Pittsburgh Mercy Health System's award-winning innovative medical and social service outreach program to individuals who are homeless. To date, the program has successfully housed more than 1,000 individuals who were once homeless. In 2005, Dr. Withers and Operation Safety Net co-founded the International Street Medicine Symposium which has evolved to include partners in North America, South and Central America, Europe and Asia. In 2008, Dr. Withers created the Street Medicine Institute to focus on helping communities establish street medicine programs, improve existing practice and create a student fellowship in street medicine. [0:28:54]

Joining him will be Dr. Todd Wahrenberger, a family practice physician who currently works at the Pittsburgh Mercy Family Health Center as the Medical Director for Primary Care at the Pittsburgh Mercy Health System. He is currently working on a project to bring a primary care medical home model to persons with severe persistent mental illness. For 16 years prior to this effort, Dr. Wahrenberger was cofounder and medical director of the Northside Christian Health Center, a federally qualified, faith-based Health Center that serves uninsured and underserved persons in the inner city of Pittsburgh. I would now like to turn it over to Dr. Withers and Wahrenberger.

DR. JAMES WITHERS: Thank you very much. Delighted to be part of this effort and I'd like to begin right discussing the concept of street medicine which is central to my experience. It's basically the bringing of the medical care and the services that the homeless population need – specifically, the street homeless population – directly to where they are in their campsites, abandoned buildings and riverbanks, etc. [0:30:06] This is something that I got involved in as a medical educator because I felt that we have a very systems-based thinking process, and the only way to address this was a radical departure from that, going directly to where people were and beginning to build healthcare responses, social responses that were directly grounded in the reality of people who are excluded and disillusioned and disconnected from the healthcare system. It began as an educational concept, but then it evolved here in Pittsburgh into a delivery model, if you will, that's actually accomplished a lot more than I would've thought.

This is our lovely city here in Pittsburgh. You're all welcome to come visit. We are a postindustrial city that's re-inventing itself. We have the claim to the most bridges of any city in the world, and that's where a lot of my work has actually occurred. [0:31:05] As I said, I chose to focus on, specifically, the unsheltered homeless population because I felt that if we could make our responses wrap around a group of people, individuals that were disconnected, that then we would learn viewing our own health system from the outside; where we needed to address reforms in our own programs.

This picture here I always appreciate because of its connection of health with homelessness, and I loved Richard's summary of the statistics and things of homelessness, so I won't go over that too much. But homelessness is often preceded by healthcare issues. I believe there was a study that showed that that was #1 cause of people losing their housing, was diminishment of their health and then all the resources that eventually got exhausted. [0:32:07]

This picture also speaks to me because of the pigeons in the background, and we were talking before the conference a little bit on the stigmata, the stigma of being homeless and how many people when you start working with people on the street will say, "Well, you know, you're just feeding the pigeons. If you provide services, you'll just encourage homelessness". And so one of the things that our students and others really see is that from the outside, there're complexities to each individual case. I say you can't take care of a patient unless you go into their room and see them directly, and that's very much the experience of working with people directly on the streets.

What you find is a very rich and diverse number of people, each of whom have their own life trajectory and reasons for being out there on the street. [0:32:57]. And there are strengths that people have that are therefore identified; there are things about the street life which have become very important to people and are very difficult for folks to undo their current survival strategy and embrace a different pattern that we might want them to have. And so there's only one way to know that is to get to know the individuals directly.

Survival strategies, as I mentioned, are complex and individualized, but when you begin to talk and get to know each individual, then you have a chance of doing what I also call in-reach, which is in-solidarity, looking from the outside into the system and addressing the needs, one-by-one, which each individual has and unraveling them. [0:33:51] A large number of the folks that are in the homeless experience are only there for a short time, so we focus on that group that Richard and others have identified as the higher-utilizing – in other words, the folks that are unsheltered – but being aware that it's a complex matrix, and people will move amongst all these different experiences while they're struggling to achieve housing.

When you get on the streets, you realize that there are communities out there, there are individuals that are surviving that have coping mechanisms and others that are isolated. And so to get into that population, I needed to have a guide who was aware of the homeless situation, and so I tend to, when I counsel other cities' communities, I always counsel that you should have a component which is familiar with the streets, preferably folks who have had a homeless experience and are trusted. [0:35:03] And to that, I attached myself, and I began to make journeys under bridges, and such, back in 1992. It led to, first of all, a profound sense of connection with people, but then immediately, you saw the things that were untreated. The

people who were released from hospitals and jails, people who were discouraged and had given up. And so I just began to practice medicine as an emergency way of keeping people alive.

I think a lot of what we've lost is the trust of people who've been excluded – all kinds of populations – but it's particularly poignant with folks that are sleeping outside. And I think the medical approach is not sufficient to address the needs of people, but I think it's a very powerful part of the message that we send of the value of people. So making house calls to people in the camps has a tremendous and unique impact on the people who are out there. [0:36:04] So much of what we do, of course, as you know, depends on trust and continuity, not doing more than you can actually do, not promising more than you can deliver, and establishing a network of trust with a disillusioned population.

And pretty soon, I began to make appointments for people from under the bridges to go see their physicians. And in the inreach process, there are four stages or phases of that. I like to say you collaborate, you advocate, you innovate when nothing has been done but needs new solutions, and then you integrate. And these things can all be done at the same time, but these are four of the major experiences that you have when you see the outside view from the streets, and you want to bring people into care.

So here I am making an appointment for someone for his medical appointment. We're very mobile, we have medical packs and we have a manual and training for how to do this kind of work. [0:37:07] And then, of course, you have folks that then become interested in their healthcare and they show up, and you have to have user-friendly areas for people to come, too. Drop-in centers, offices – places where the message you send under a bridge is consistent with the message that they're receiving when they walk into your facilities. We've had electronic medical records since 1992. This is an old cellphone version, but it allows us, under bridges, to know what the current medical issues or if someone has a housing appointment.

The street population experience also tends to divide into two large areas – the people that will come to you in a congregate area, a park or a medical van, as we have here, or people that you have to go find, and I call that 'chase management'. And for that, the two people in the front are about to take off with their backpacks and go find some of the people who are more reclusive. [0:37:58] So to cover the zone of the streets, if you will, you need to have these different dimensions. Increasingly, we have been able to bring social workers, mental health experts and others directly into the camps, not to require people all the time to come to an office somewhere but to actually bring the point-of-care right out into the camps where we can be most effective.

This is just a Pittsburgh picture of the level of commitment we have to going wherever people are. So here in Operation Safety Net in Pittsburgh, we're basically dedicated that, as long as our brothers and sisters are out there, we will continue to go out and work with them on their terms; in their reality. This is an old picture just to show some of the areas we identified where people were sleeping, and a street medicine team, such as we have, is able to connect some of those various elements of the homeless experience in a way that was not possible before. [0:38:56]

One of the things that we're able to do is to have any homeless person call at 2:00 in the morning, and we can address their needs by the next day. Any hospital emergency room or other

provider can call us and say, “We have a patient who lives under a bridge. Could you go see them?” And so this 24x7 homecare service, I think, is something that every American or city in the world should actually have. Much like you’d have a fire department, you have a program that never really sleeps; is always aware and never drops the ball on the care of the street client.

We’ve also been able to do housing first. We’ve housed about 1,400 people, starting with our medical relationship but then moving into different levels of housing, either in apartments or safe havens, and soon, hopefully, we’ll have a respite care center, as well. This, of course, is a discharge plan that you don’t want to see, and by going into the hospitals and doing street medicine consults, we’re able to improve the efficiency, decrease the length of stay and prevent hospital readmissions and discharge plans like this. [0:40:02]

Central to what I believe is integrating medical education, so we have a classroom of the streets, and we have students coming from all of the country, all over the world, who will spend time with us, working specifically in a setting of being outdoors. For example, this young woman, on the right, was homeless as a child. She’s a physician and she’s one of many who went on to start their own medical programs, this one in Santa Barbara. And one of our goals is to have street medicine involved in medical education, and these are just some of the medical schools and others that have embraced street medicine as part of their curriculum. It’s a great classroom, and I think, from the streets, we can learn much that we need to do to reform our structures of healthcare.

As I said, we’ve had housing. I always think if you can get a guy like this stably-housed, that’s based on a lot of work and a lot of trust, but it’s well worth it, and it’s really rewarding to see people able to reconnect with family. [0:41:05] It’s an unfortunate truth that a lot of these folks do pass away, and the people that we remember, we were able to create a memorial wall here in Pittsburgh where, the folks that die, we have a memorial service for them every December 21, National Homeless Memorial Day. This just deepens our sense as a community that everyone matters.

So Operation Safety Net is our Pittsburgh-based program, and briefly, I want to just mention another organization which I helped to create, which is the Street Medicine Institute. We are a separate nonprofit. The purpose of the Street Medicine Institute is to help communities everywhere to create their own street medicine programs. We believe that every rough-sleeping person in the world should have direct access to care, and every health science medical school should have a classroom of the streets. [0:41:57] We consult with communities wherever they are, we help define and improve the practices of street medicine, create educational opportunities and nurture the movement through our Annual International Street Medicine Symposia.

We’ll have our 11th meeting this October in San Jose, and the Web site for the institute, I will give you in a moment. Our tagline is “Go to the people”, and I think the saying of Lao Tzu here pretty much summarizes our philosophy, “Go to them, work with them on their terms, and when we accomplish our tasks, the people themselves will say, “We have done this together”“. We’re ultimately building community from the streets up. So that’s the Street Medicine Institute Web site, and I welcome you all to connect, as well, with that, and I’ll pass it on to my colleague, Dr. Wahrenberger, now.

DR. WAHRENBERGER: Okay. Thanks, Dr. Withers. Again, I'm Todd Wahrenberger. I'm a family practice physician and have spent most of my career working for a federally-qualified healthcare center. [0:43:00] And in that federally-qualified healthcare center, we touch street homelessness, but it was quite frustrating for me to try and take care of the super-utilizer patient population. And so in 2010, I started to have discussions with a large community behavioral health center, Pittsburgh Mercy Health System, here in Allegany County about starting a primary care clinic that would be a medical home for people that were super-utilizers, people that have serious and persistent mental illness, and particularly among them are people that are street homeless.

So one of the ministries of the sisters here at Pittsburgh Mercy is Operation Safety Net, and as Jim has so eloquently displayed, for decades now, they've done such an excellent job engaging on the street, people that are homeless and street homeless, but they really don't have a primary care clinic that engages them very well. [0:43:59] And so that was the idea of the formation of the Pittsburgh Mercy Family Health Center. In 2010, the system surveyed their patient population and found that over half of the patients there weren't receiving any routine primary care, and those were folks with the serious and persistent mental illness. And so in May, three years ago, we opened the doors to a fully-integrated primary and behavioral healthcare practice. We engage with folks with a high degree of medical complexity and mental health complexity, and we follow an ACT Team model.

For folks that don't know what ACT team is, it is a bridge for people coming out of chronic institutionalization for mental health issues, and it's a multi-disciplinary care team approach pulling resources from multiple programs, including programs like Operation Safety Net, and engaging people at a very high level. Our model of care is listed here, I love these kinds of diagrams. [0:44:54] But the patient is in the center here, and we have a primary care physician, we have medical assistants, we have care managers, we have tobacco cessation specialists as part of the team. [0:45:05] As we see smoking cessation; if you can get a person to stop smoking, it makes such a huge impact on the future of their health.

As Jim said, housing is important too, and so linking people up with our care manager is very important. And also having a consulting psychiatrist on our team as a family practice doctor. It's just been a delight to be able to work shoulder-to-shoulder with a psychiatrist to be able to get people on the right medication and on the right treatment program for things like schizophrenia and bipolar and schizoaffective disorder because if we don't treat that, if we don't get them house, if we don't get them in their right mind, it's very, very difficult to get their blood pressure under control and get their diabetes under control and to have their cancer diagnosed.

We also utilize peer support specialists who are patients that are in recovery from their serious and persistent mental illness that have been specially trained to help us to engage with this patient population. [0:46:00] And so then you see on the periphery of the diagram that we have service coordination programs, housing programs, homeless services and employment services. We've done some studies to try and understand the impact of the clinic that we have here and how we engage people. It is a high-touch program. We're probably seeing about 60% of the

input that I would see at a regular FQHC in terms of the number of patients that I would encounter, that I would see per day.

We do risk-stratify our patients. So on the upper right-hand quadrant, each one of our patients is labeled in our system as a problem list on a scale of 1 to 4, 4 being the most medically-complex biologically, psychologically or psychiatrically and from a social system standpoint and a help engagement standpoint down to people that would have no active medical issues, mental health issues or social or engagement issues. And we probably have over 50% of our patients that are at the very highest level and another 40% to 30% being at Level 3. [0:47:08] But tagging them in the system that way gives us a registry that we can pull from and talk about them at a weekly treatment team meeting and run the registry for our entire list of population and engage with the other teams that are here at the Pittsburgh Mercy Health System. And we have seen a reduction in our psychiatric hospitalizations and in length of stay. We're trying to get data on the medical half now from the insurance companies to see the impact of that.

The next slide illustrates some of our team members. The consulting psychiatrist and I are standing in the upper right-hand quadrant. Our building is on the left side, our clinic is on the 1st floor. There're educational suites on the second floor, and the top floor is HUD-funded housing for people that are formally homeless. So people that have been engaged with Operation Safety Net that they've been able to get off the streets are living on the 3rd floor of our building. [0:48:01] And they're just a wonderful group of people to be able to engage with around a number of different medical issues. So thanks for listening and thanks for being a part of this Webinar.

EMMA GREEN: Thank you, Drs. Withers and Wahrenberger. Our final presenter is Sandra Stephenson who currently serves as the director of Integrated and Primary Healthcare for Southeast, Inc. in Columbus Ohio. In this position, she also serves as Project Director for our national SAMHSA demonstration grant, Primary and Behavioral Healthcare Integration. She began her employment with Southeast, Inc. in 1983 as their Clinical Director and Associate Executive Director and became Executive Director in 1987, a position she held until 2007. She also serves as a member for the Mount Carmel Health System Community Benefit Advisory Board and is a board member of the Columbus Coalition for the Homeless. Sandy. [00:49:04]

SANDY STEPHENSON: Thank you. First, I'd like to thank CIHS. It's just incredible the way you pull us all together for these teaching-learning opportunities, and it allows us to get connected with each other across the country in ways we couldn't otherwise, so thank you so much for this.

I first want to talk a little bit about Southeast's history and working with folks who are homeless. We would never have been able to do a PBHCI project working with our homeless population without this history. In 1984, we initiated one of the first community mental health outreach projects in the United States, reaching aggressively into the camps, under the streets, into the dumpsters – wherever homeless people were to really begin to engage with them and work on mental health and addiction issues. [0:50:05] We found along the way, when we added psychiatry to our projects, that in order for the psychiatrist, as a physician, to gain credibility, he

or she first had to attend to primary healthcare issues. Wound care infections, things of that nature.

In 1986, Southeast received a McKinney Grant which evolved into the PATH grants from SAMHSA, and we've held that grant through the years. We consider PATH mental health boots-on-the-ground within our community, targeting camps, streets and shelters. We also have mobile coach services, and today, we've been running two different mobile coaches into the community team-up with other providers who are out there in mobile coaches to do integrated healthcare. [0:50:56] Southeast has operated a 140-bed men's homeless shelter that we acquired in 2006, and we work very closely with the people in that shelter around their mental health and their primary healthcare needs.

In 2009, we were awarded, from SAMHSA-HRSA, a PBHCI grant as part of Cohort 1, and we intentionally included people who were homeless in our PBHCI project knowing that we might be swimming upstream in terms of all of the regulatory requirements that go along with that grant. I'll talk a little bit more about that. In 2010, we joined with Mount Caramel, a large healthcare system, with their community outreach project, doing an integrated healthcare program in which they do primary care on an acute basis, and we team up assisting with people who have behavioral healthcare issues. [0:52:01] In 2011 – and this was a turning point for our organization – Southeast was selected by HRSA to implement an FQHC healthcare for the homeless. That was part of our PBHCI sustainability plan, and it made a huge difference with regard to our primary healthcare capacity to serve people who were homeless.

And in 2014, we were able to place primary healthcare in an integrated model within our communities. A homeless shelter, a new homeless shelter that serves up to 400 people. So that's just an amazing operation to be in that shelter where people are coming in on an acute basis with everything going on in their lives being extremely complex and being able to meet both primary and behavioral healthcare needs. [0:52:53]

This is a depiction of what happened to Southeast with our PBHCI project, and I find this of interest. If you look at the first year of our project in '10, while we intentionally were targeting homeless people, we had a more typical population. The red bar on this graph are people who were living, literally, in homeless situations. So you note in 2010 – and that was the first full year of our grant – about 28% of our population was literally homeless, and these are not the people homeless for 3 or 10 days. These folks were chronically homeless due to co-morbid health situations and other factors in their lives. We received our FQHC, as I mentioned, in 2011, and in our PBHCI project, you can look at that red bar to see what happened to our project. [0:53:56]

In 2013, the last year of our grant, we were pushing 60%, with regard to people in our PBHCI project being homeless. And for those of you doing PBHCI, you'll probably appreciate that our ability to stay as squarely on track with the data collection required for SAMHSA was much more challenging.

Southeast has engaged in an evidence-based practice. For many years, it was developed in Ohio in its client clustering. I believe you must understand your PBHCI or your integrated healthcare populations, and this is one way that we were able to better understand who we were serving.

This information helps guide and direct our staff as they provide interventions for the population. [0:54:54] So in this depiction, along the way, this shows all of our PBHCI clients, whether homeless or not, and the clusters they were in. Cluster 2A and 2B are truly the most complex, with 3A, of the clusters. With Cluster 2A and 2B being people with serious mental illness and chronic addiction, there's a slight difference in the clusters. But you get the picture of very seriously ill with mental illness and having chronic addiction, as well. Cluster 3A are people that are very seriously ill with mental illness but generally don't have an addiction.

So we knew that we would see a lot of our homeless people in these clusters and we did. This is a depiction of where they fell within the clusters. You'll note that in Cluster 2A, almost 70% of our homeless people were in that cluster, and again, that's most seriously mentally ill with most serious addiction issues; 2B is some additional homeless folks, and you see them then on these other two clusters. [0:56:05] So we knew we were up against an extreme challenge with regard to the complexities of healthcare issues our clients would have within PBHCI and also the other issues of getting them connected with services they needed.

I want to talk a little bit about operating a PBHCI program and the challenges and solutions, starting with the challenges. If you are doing PBHCI now and you look at the homeless population, you may ask yourself, "Why would we want to do this?" If you do it, both your primary care staff and your behavioral healthcare staff must absolutely want to serve the population who are homeless. You may actively decide to not serve or not focus on serving people who are homeless in your PBHCI program, or you may begin to serve the population and then dis-enroll them due to the many challenges you are experiencing, including SAMHSA's required data collection. [0:57:15]

When we had this population begin to dominate our SAMHSA-HRSA PBHCI program, we did end up dis-enrolling a significant number, in my opinion, from the project because we couldn't collect the data, but – and this is the important point – we did not dis-enroll them from integrated healthcare. So if we couldn't keep them in PBHCI, we continued to serve them with the services they'd been accustomed to receiving from us. The population is not the population served by most FQHCs or primary care practices, and I want to take a quick look with you at the reality of who walks in your door to be seen in primary care. [0:58:01] The patients present with intoxication, body odor, bedbugs, untreated wounds, ingrown toenails and worse, severe and untreated chronic health conditions, lack of family-community support systems. And in northern states in the winter, frostbite, trauma, focus on food shelter and clothing needs rather than other healthcare needs, and they present with issues of pain.

I want to take a look at the issue of pain. Many people who work in FQHCs or who work in primary care would view many of these clients as drug-seeking, and it's very important to understand that some do. But for many, if not most of these clients, their emotional and their physical pain is very real. [0:59:04] They need to be respected for what they are experiencing and treated appropriately. Other challenges in working with the population include productivity. FQHCs are accustomed to seeing 23 to 27 people per practitioner per day, and this population is not a population that keeps your traditional appointments, so many FQHCs do not want to be healthcare for the homeless or do not apply for these grants because it is not a productive

population to work with when you're forced to look at productivity, which drives your revenue, and then there are the billing issues.

In the CMHC world, we bill by time spent. So if you have a complex situation and you spend an hour with the person, you can bill the full hour, but within the FQHC environment, the billing is based on contacts. [01:00:05] So if that person takes an hour of time with the primary healthcare practitioner, that's one contact, and otherwise, in that hour, they might have seen four or five people. There are going to be clinical guideline challenges, and I will talk a little bit more about this but practitioners have to begin someplace else, in general, rather than to follow what a clinical guideline might suggest.

There are also issues around specialist referrals. When we refer this population to specialists, which we do on a regular basis, there are payer issues, but more important, there are issues of no-shows. And when you're referring outside of your own organization and the people you refer no-show, you often lose that relationship with that referral source, so that has to be very carefully monitored and taken care of. [01:00:57] And then, as noted, there's a culture of homelessness. A lot of folks we serve have been using the emergency departments as their medical homes, and it takes significant effort to turn around that pattern of behavior. I want to quickly mention the FQHC issue. As I noted earlier, Southeast became a federally-qualified health center, and that's made a big difference in our ability to serve this population because we, as one corporation, have both the behavioral healthcare and the primary healthcare. If we partnered with an FQHC, rather than being a solo integrated practice, we would have to convince the FQHC that they really wanted to serve this population.

So I want to move on to solutions. I consider this retooling. Family practice physicians and docs that have come out of internal medicine residencies are not really trained to serve this population. [01:02:04] We can't minimize this focused area, this solution, if we really want to serve the population and impact the health and recovery of people who are homeless. Motivational interviewing and harm-reduction skills are generally not taught in medical curriculum, but it has to be taught to staff working with the population. Our primary care staff have all gone through about 20 hours of motivational interviewing and harm reduction and also have learned stage-based interventions.

We have asked our primary care staff to rethink where to start. In a general practice, people have a presenting problem, and you do some labs, and that's where you start. I suggest where to start in most cases with folks who are homeless is how to work so that they are no longer homeless; how to work with others so that they are housed. [01:03:02] We must focus on trauma-informed care in the exam room, and I want to stress this. Beware of the family practice physicians and nurse practitioners who don't understand why patients may want to select a woman for their GYN exams, and we've had some physicians here who have not been comfortable with or suggesting that all clients have a right to select the practitioner they want to see based on what's going to happen to them that day.

So we ask our practitioners, with regard to trauma-informed care, to do just four things. One is have a good history; to really look at that history. And there's an advantage if you have an integrated healthcare record as we do, because you can see the behavioral healthcare history in

that record. [01:03:58] Then we ask them to watch the nonverbals. You cannot walk into the exam room and work as you usually do. Many homeless people have experienced trauma, and it will be expressed through nonverbal reactions. And the two most important things are whatever you do, slow down. Work more slowly; talk more slowly. The fourth thing is ask permission. “May I?”, “Is it all right?”, “Would it be okay with you if I?” for that next step you’re going to take in that exam.

I want to talk a little bit about other retooling, and that’s asking our family practice doctors to rethink clinical guidelines, and I’ll just give two quick examples. One in prevention is the colonoscopy. We’ve had family practice physicians coming in here referring homeless folks for colonoscopies extensively, and that’s a good practice. However, if somebody is living in a homeless situation, where are they going to cleanse? [01:05:01] If they are living in a camp, it’s not going to happen. If they’re living in a homeless shelter, they’re generally asked to leave at 7 or 8 o’clock in the morning, and if they’re living in a single-room occupancy, they’re sharing a bathroom. So this is not a reasonable expectation. And even stool samples, even the fecal occult cards, are difficult. We have moved to the FIT in our practice, which is, I think, a newer product on the market, and that has served us somewhat better with our homeless population in meeting this HRSA requirement.

With regard to chronic condition and rethinking clinical guidelines, let’s look at diabetes. It is a tendency of our family practice docs, and absolutely a correct one, to talk with our patients with diabetes about nutrition and about physical activity, as they would with other populations. [01:05:57] But if you tell a person who’s homeless to really eat more fruit and vegetables, you have to think about the shelf life of those products and where they are going to get them and the fact they’re eating in soup kitchens where that type of food may not be available. And if you ask them to exercise more, the homeless person is just going to look at you because they’re walking all over the city right now. So there has to be a rethinking of a lot of these clinical guidelines upfront when working with this population.

And then addiction, addiction, addiction, addiction. It can overwhelm the best practitioner. There’s a lot of heroin use and a lot of injection-site infections from that. And we ask our family practice physicians to really think about their training in these areas; to rethink some of their biases about the population of people who are addicted, if they’re going to be successful with the population.

We’re doing a lot of work with pain-management in our organization. We have acupuncture available. [01:06:57] We have physical therapy now available and cognitive behavioral therapy available focusing on pain. So we’re able to kind of wrap around our clients, and we work with our family practice physicians and other primary care staff to understand that whole range of services that are available.

And then, we ask our staff to use the homeless patient survival mode, their survival capacity, as a strength. That need to survive may not work well in terms of traditional practice expectations, but it is a strength. And to be able to harness that and use that in practice is an extremely important skill.

More challenges and solutions. It's important when you work with this population – and this has been stated – to develop homeless integrated healthcare engagement in service locations. They have to be accessible. In other words, they have to be easy to get to on bus lines or close to shelters. [01:08:01] Our sites have to be acceptable. A homeless person walks in, and they must have the feeling, “This is for me, I feel comfortable here”. And then the services offered have to be appropriate. We have to be providing what homeless people really find beneficial and not necessarily what we think we should be doing.

Practitioners and staff must develop relationships with the entire homeless-serving community. You must know the homeless magnet locations in areas of your community and be comfortable going there. When we have new staff come in, we take them to those areas first with other people. We make introductions so there's a great deal of comfort. And if you're working with the population, it really is helpful to get releases of information for just about any place a homeless person might show up and get alternative contact information because if you need to get your SAMHSA data, you need to be able to find the person you're serving. [01:09:07] You need to know where they are, and you need to be able to have outreach to find them. And you also need to be able to get a hold of them when labs come back and so forth, and you have to share the results, or you need to do something pretty quickly. So this is a challenge on a good day, and we found that the more we get these releases of information, the more successful we are in actually getting ahold of people.

And then, I can't emphasize enough that we must offer items that have meaning to our population and these aren't incentives. These are things that create a sense that this site understands me. So we offer items such as dry socks, sunscreens and caps and gloves in the winter. And then we must make sure the services we provide have meaning. [01:09:55] And that can include clipping toenails, washing feet and treating wounds.

We find with our homeless population, they often don't want to take off their shoes and socks for their foot checks and so forth because they're embarrassed. So we work hard to decrease that embarrassment. We offer things that enhance their willingness to do that.

We have to ensure transportation. If we want to get them to a primary care site or we need to get them to a specialist, we need to make sure that we have the transportation available to get them there. It's important to hire peers, and it's important to form a homeless patient advisory committee. That continues to sanction the work that we do, and that allows us to be more successful with the population we serve.

And I do want to mention, in my opinion, the importance of engaging SAMHSA regarding PBHCI expectations with the homeless populations. I think a lot more people would be interested in serving this population, but it's extremely difficult with regard to the data expectations and those timelines on the data. [01:11:02] And I think it would be fascinating if SAMHSA would look at a consideration for perhaps the next PBHCI cohort to target those CMHCs that have PATH programs and to determine if there could be some way to build slightly different expectations around those data programs to determine, with the data collection that we have, what kind of difference we could make together in working with people who are homeless and have such high needs.

This is my contact information. If you have questions based on anything I've said or if you would like to come to our site and see what we're doing, please feel free to get ahold of me, and thank you.

EMMA GREEN: Thank you very much, Sandy. Now we have time for questions. To submit a question, type your question into the "Ask a Question" box in the lower left portion of your player. We will do our best to answer all your questions in the remaining time. [01:12:04] We do have some questions in here, and I'm just going to start reading them off, and I would ask that the presenters please answer them, if possible.

I believe this question is directed to Richard Cho but feel free for all of you to answer, "How many domestic violence victims are homeless each night?"

RICHARD CHO: That's a great question. I don't know if I have that number offhand. And that is a number that can be found in a number of different data sources. One of the challenges there, of course, is the kind of federal data we have doesn't necessarily provide a great picture. But we do know that one of the causes of homelessness often is that people are fleeing situations of domestic violence or, frankly, even of other kinds of victimization and human trafficking. And that is a significant concern, both among people experiencing homelessness who are people in families, as well as among youth and young adults who are experiencing homelessness. [01:13:10] So I don't have that offhand, but that is something we can definitely provide as a follow-up.

TAHISHA VICTOR: Thank you. The next question is, "Is supportive housing only available to populations classified as chronically homeless?"

RICHARD CHO: So this is Richard, again. I can take that one. The answer is actually no. Who is actually eligible for supportive housing often is dependent on who pays for the supportive housing, and there are a number of different ways that that can be financed. One of the most important source is, of course, through HUD's homeless assistance grants, and for the supportive housing that exists around the country, that is financed using HUD's homeless assistance grants, otherwise known as Continuum of Care funds, which is one of the programs there. [01:14:03] The eligibility for those units does require people to be defined as homeless, according to HUD's definition, as well as to have a disability.

Now because not every person experiencing homelessness does need supportive housing – there are people who are experiencing homelessness that can receive other forms of housing assistance but don't need that kind of dedicated, intensive supportive services – HUD has been encouraging communities to ensure that people who are experiencing chronic homelessness, and also those who have more severe service needs, are being prioritized for placement into supportive housing. But that said, HUD's eligibility for the supportive housing that they fund is only limited to people who meet the overall homeless definition, meaning that they are experiencing homelessness. [01:14:59] They're living in a shelter, on the streets or in places not meant for human habitation or are experiencing homelessness because they're fleeing from domestic violence or victimization – that's the HUD definition – and that they have a disability.

There's also supportive housing that's financed by state or local sources, and in those cases, it doesn't necessarily have to be people experiencing homelessness or even chronic homelessness.

SANDY STEPHENSON: I believe the HUD definition, too, requires time around that definition of chronic homelessness. Is it six months?

RICHARD CHO: Right. So for purposes of ensuring that supportive housing is giving a preference or priority for people who are experiencing chronic homelessness, in order to qualify as chronically homeless, an individual or a family has to have been homeless continuously for the last year or have had four occasions of homelessness over the past three years. [01:16:00] And HUD is in the process of finalizing their final definition of chronic homelessness, which will be out fairly soon, which provides more specifics around how one is to meet that length of time, as well as how to document that. And again, I think the focus really is on knowing that you don't have to document every single day and minute of their homelessness but just establish that they are someone who has experienced that long-term persistent pattern.

TAHISHA VICTOR: Thank you. The next question – there are a couple of questions like this – and it seems our audience want to know more suggestions and considerations for working with different, I guess, subgroups for the homeless, like the LGBT community, the geriatric community, the undocumented community. [01:16:58] What are your thoughts on that, and this is to all the presenters?

SANDY STEPHENSON: That's an extremely important population to target with integrated healthcare, addressing specifically the homeless. LGBT community of Southeast has been engaged with the community through outreach. There are several homeless shelters, and they're not really shelters. They're places where youth can go; where 60% to 70% of the population sometimes falls into this category. We also just hired a physician who specializes in working with transgender adults. So we build our skill and capacity around our community needs, and we look at gaps in those needs. So we have staff going directly into one of the facilities where we become acquainted with the young people who are LGBT, and we encourage them to come back to us for primary care as we're also dealing with the behavioral healthcare issues. [01:17:59]

TAHISHA VICTOR: Thank you, Sandy. Any other thoughts before I move on to the next question?

RICHARD CHO: So this is Richard. My quick response to that is for people who are LGBT or the aging population, I mean many of the same interventions and solutions that have been proven to assist people experiencing homelessness – permanent supportive housing, the Housing First approach, and access to affordable housing with other services – are also absolutely things that are effective for members of that population. And I think the key is really, how do we tailor those approaches to be individualized? And I think the key with supportive housing, as well as other interventions, is that they need to be always individualized and tailored in terms of the way that they deliver services, and that with respect to LGBT status, there is both understanding how to certainly impose policies that are non-discriminatory but also understanding whether there've been particularly unique needs that come with that. [01:19:18] We know that, for example, youth

who are LGBT have a really high prevalence of experiences with the victimization – trading sex for a safe place to stay and often falling into behaviors that are high risk. And so having services that are attuned to really understanding what some of those challenges are, what the experiences of trauma that may have been experienced as a result of those experiences, is really critical. And again, I think SAMHSA has been a really terrific resource for providing some of the ways to individualize services for the needs of various populations. [01:20:01]

TAHISHA VICTOR: Thank you. The next question is, “How do you leverage public and policy support, such as the city or mayor’s office, for homelessness in the community where the authorities say there is no homeless problem?”

RICHARD CHO: Again, I’ll jump in. I’m curious if others have thoughts, too. I think that’s an interesting dynamic of a lot of communities, particularly in suburban areas where the leadership would rather not confront the fact that they have people experiencing homelessness. And frankly, in many rural communities and suburban communities, there may not be a visible population of people experiencing homelessness because they aren’t necessarily on the streets or as visible as they were in cities. [01:21:01] And I think there’s a temptation to try to essentially defer to the large metro and urban areas to try to take responsibility for homelessness when we know that it’s often not the case that people experiencing homelessness are just concentrated in cities. And in fact, the national data shows that, while I think two-thirds or so of people experiencing homelessness are in city centers, there are quite a number of people who are in suburban and rural areas, as well.

And I think what we’ve seen to be effective in many places is where communities take a regional approach; where you have a city center or an urban area working alongside some of the surrounding towns to really approach homelessness regionally, understanding that you can’t solve homelessness by just kicking people from one location to another. You have to solve homelessness by helping people obtain housing and access to a variety of services. And that’s the kind of approach that we’re starting to see. [01:22:06]

I was recently in Las Vegas where the mayor of Las Vegas joined alongside mayors of four other communities in southern Nevada, who are surrounding Las Vegas, to jointly take a regional approach to ending homelessness. In this case, particularly among veterans. But again, that’s the kind of partnership that we’ve seen happen. Same thing in the city of Seattle and King County and the surrounding communities there. But again, that kind of city and regional approach, we think, has been really effective, and it’s a better approach than just trying to sweep the problem under the rug or kind of push it off to someone else.

TAHISHA VICTOR: Thank you. This is a question really going back to street outreach. “Could any of the presenters comment on assessing and addressing homelessness in rural areas?” [01:23:02] This audience member goes on to say, “It seems that there are unique challenges and somewhat different pictures of that population, so obviously, a lot of the principles would be the same as those for an urban street population of homelessness that have been addressed in the presentation.”

SANDY STEPHENSON: That work has generally happened in urban areas. We are just now becoming more acquainted in part of Ohio – part of the Appalachia and part of Ohio – with homeless problems, and our approach has been to talk to hospital system there, as well as other people associated with the hospital system. We've been talking to some of the criminal justice folks, and we are attempting to figure out a way to do outreach and linkage as we do in urban areas, knowing that there are fewer resources. [01:24:06] We are thoughtful about family relationships in the more rural parts of the state, and in talking to some people, we believe that we may be able to do more work with developing or redeveloping some of the family and community supports that sometimes are lacking in the urban area where there's less knowledge about who lives there, but it is a challenge, and that's more of an invisible issue easier to ignore.

TAHISHA VICTOR: Thank you, Sandy. I think we have time for one more question. "What methods, other than infrequent face-to-face interaction, can be used to stay in contact with and activate people experiencing homelessness without a phone or e-mail?" This is a two-parter. [01:24:55] "Given new pressure to report state and national matrix around medication adherence, tracking, treatment plan, goal tracking, etc., are their thoughts on how to capture this information, given the complex situation given to the homeless population?"

RICHARD CHO: So – this is Richard, again – I think that it's important to think about what engagement looks like for people who are still experiencing homelessness and cycling in and out of various institutions or living on the streets, as opposed to engaging folks who've now been stably-housed and are certainly still in need of ongoing engagement and case management services and being connected to primary and behavioral healthcare. And where life on the streets and in and out of shelters and other institutions is often not a place where people are able to really access the Internet or have regular forms of technology to stay in touch in that way. [01:26:08] And I think there's nothing that really can substitute for kind of face-to-face contact and the trust that that is able to build.

That said, it certain seems potentially feasible to figure out how some kinds of care can be held better coordinated through non-in-person contacts and using either telemedicine or e-mail and other kind of communication. But even there, we've seen that particularly people who have more severe challenges, behavioral health challenges, complex chronic conditions, that really high-touch care management is often what's really needed to help people stay engaged.

This is a population that uses a lot of crisis healthcare services, not for no reason. [01:27:01] They have a number of challenges. And so trying to find ways to essentially avoid having to do in-person contact is maybe not the best approach for this particular population. But I'd love to hear from others who work in providing care more directly on what their thoughts are about that.

TAHISHA VICTOR: Thank you, Richard. It looks like this is going to conclude our question and answer session. I want to thank all of the participants and the speakers. I would like to hand the Webinar over to Ruth Hurtado-Day, one of the government project officers for SAMHSA Center for Substance Abuse Treatment for some final thoughts. Ruth?

RUTH HURTADO-DAY: Thank you so much, Tahisha. [01:27:58] I would like to extend a sincere thank you to all of our speakers today. We greatly appreciate you in joining us and

sharing all of your expertise. We hope that this Webinar provided you a better understanding of your role as a provider and the many resources that are available to you.

We welcome your questions at any time and are here to provide support and guidance to help ensure that your programs are providing effective services to individuals who are experiencing homelessness. Thank you all and have a great rest of your day. [01:28:38]

**END TRANSCRIPT**