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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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Today's Presenters

Richard Cho, MCP
Senior Policy Director
U.S. Interagency Council on Homelessness

James Withers, MD
Medical Director
Operation Safety Net, Pittsburgh Mercy Health System

J. Todd Wahrenberger, MD, MPH
Medical Director for Primary Care
Pittsburgh Mercy Health System

Sandy Stephenson, MSW, MA
Director – Integrated Healthcare
Southeast, Inc.

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.
Poll Question: Have you intentionally included the homeless population in your integrated services?

- Yes
- Unsure
- No

Richard Cho, M.C.P.
Senior Policy Director
U.S. Interagency Council on Homelessness

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
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

“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 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

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.

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 13% reduced substance use.
- Seattle study found 50% 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.
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

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
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

Los Angeles Economic Roundtable developed a 27-Variable tool that can estimate the probability that an individual experiencing homelessness is in the top 10% of costs through hospital use.

The 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.
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
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.

Continuous Care Model

[Diagram showing a network of services including streets, shelters, hospitals, and housing.]
Street Medicine Education

- University of New Mexico, Albuquerque, NM
- 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 Boston, 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

Housing
Vision

Every rough sleeping person possible will have direct access to reality-based health care (street medicine)

Every health science school will have a “classroom of the streets”

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

Go To The People

- Go to the People.
- Live among them, love them, serve them.
- Start with what they know.
- Build on what they have.
- When the task is accomplished, the People will say, “WE have done this!”
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

Coordinated Care Model

It takes a team!
Thank you!
Southeast PBHCI – Serving People Who are Homeless and Living with SPMI/Addiction and Co-Occurring Health Disorders

Sandra Stephenson, LISW-S, LPCC-S
Director, Integrated Healthcare Services
Southeast, Inc. Healthcare Services

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

Significant shift occurred over PBHCI grant period toward enrolling homeless adults with SPMI

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The Majority (85%) of PBHCI Enrollees were Members of Four “Clusters”

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

Rubin & Panzano, Psychiatric Services, 2002

A Disproportionate Percentage of Homeless PBHCI Enrollees were in Cluster 2A

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
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

**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

**Contact Information**

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Q & A
You may submit questions to the speakers by typing a question into the “Ask a Question” box in the lower left portion of your player.

Additional Questions?
Contact the SAMHSA-HRSA Center for Integrated Health Solutions
integration@thenationalcouncil.org

For More Information & Resources
Visit www.integration.samhsa.gov or e-mail integration@thenationalcouncil.org

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