HEALTH CARE FOR THE HOMELESS MODEL OF CARE

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LEARNING OBJECTIVES

• Describe the connection between homelessness and health.
• Identify specific health needs of patients experiencing homelessness.
• Explain key characteristics of the HCH Model of Care and how it is implemented.
OVERVIEW

• Defining:
  → Homelessness & Health

• HCH Model of Care
  → Beyond traditional medical care
  → Incubator for innovation, often driven by patient needs
DEFINING HOMELESSNESS

• An individual who lacks housing, primary residence during night is a supervised public/private facility, or is a resident in transitional housing
• Recognizing the instability of an individual’s living arrangement is critical to the definition

Health and Human Services
• Streets, shelter, mission, single room occupancy, abandoned building, or vehicle
• Doubled up
• Released from prison or hospital

Housing and Urban Development
• Lacking a fixed structure: shelter, street
• Eviction within 14 days
• Moved 2 or more time in 60 days
INDIVIDUAL AND STRUCTURAL FACTORS

**Individual Factors**
- Poverty
- Early childhood adverse experiences
- Mental health and substance use disorders
- Personal history of violence/TBI
- LGBTQ Identity, especially Trans
- Criminal justice system interaction
- Youth: family conflict/victimizations, non-heterosexual sexual identify, having been in childhood welfare system
- Age greater than 50 years old

**Structural Factors**
- Racism
- Absence of affordable housing
- Wage stagnation
- Unemployment for low-wage workers
- Changes in mental health funding

**HOMELESSNESS**
TIPPING THE SCALES TOWARDS HOMELESSNESS

= structural factors
= individual factors
Intersection of Health and Homelessness
549,928 People experiencing homelessness on a single night in 2016.¹

Housing Status
- People in Families, Sheltered: 29%
- People in Families, Unsheltered: 32%
- Individuals, Sheltered: 3%
- Individuals, Unsheltered: 36%

Race
- White: 48%
- African American: 39.5%
- Asian: 3%
- Native American: 1%
- Pacific Islander: 2%
- Multiple Races: 7%

Gender
- Male: 60.2%
- Female: 39.5%
- Transgender: 0.3%

HOMELINESS: HEALTH CENTERS

1,262,961 Patients Experiencing Homelessness served by Health Centers Nationwide in 2016

934,174 Patients served by HCHs in 2016

886,576 Patients Experiencing Homelessness served by HCHs in 2016

2016 Income Level (FPL)

- 100% and Below: 71%
- 101 - 150%: 17%
- 151 - 200%: 3%
- Over 200%: 2%
- Unknown: 7%

2016 Housing Status

- Homeless Shelter: 29%
- Doubling Up: 28%
- Street: 14%
- Transitional: 12%
- Other: 8%
- Unknown: 9%
HOMELESSNESS AND HEALTH

Connection between Homelessness and Health

- Homelessness complicates treatment and recovery
- Health problems cause homelessness
- Homelessness causes health problems

HOUSED VS. NON-HOUSING

- Higher prevalence of physical illness, psychiatric disease, and substance abuse
- Drug overdose is greatest cause of death
  → 8-9 times higher mortality rate compared to general population
- Unsheltered:
  → Unsheltered homeless 2-4 times more likely to die than sheltered homeless
  → 15 times more likely to die than general population
# Two Important Facts

People who are homeless have higher rates of chronic disease and live on average 12 years less than the general US population (66.5 vs. 78.8 years)*

Prevalence of Specific Health Conditions among the Homeless Population in Comparison to the General US Population*

<table>
<thead>
<tr>
<th>Condition</th>
<th>Homeless</th>
<th>General US</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>18%</td>
<td>9.3%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>50%</td>
<td>29%</td>
</tr>
<tr>
<td>Heart attack</td>
<td>35%</td>
<td>17%</td>
</tr>
<tr>
<td>HIV</td>
<td>20%</td>
<td>0.6%</td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>36%</td>
<td>0.7%</td>
</tr>
<tr>
<td>Depression</td>
<td>49%</td>
<td>8%</td>
</tr>
<tr>
<td>Substance use disorders</td>
<td>58%</td>
<td>16%</td>
</tr>
</tbody>
</table>


**Uniform Data System. Data analysis related to 60 health centers receiving 330(h) funding only.
SOCIAL DETERMINANTS OF HEALTH & GENERAL POPULATION

NEIGHBORHOOD AND BUILT ENVIRONMENT
- Lack of Control Over Food Choices
- Access to & Quality of Affordable Housing
- Access to & Quality of Temporary Shelters
- Exposure to Crime & Violence
- Exposure to Environmental Conditions

HEALTH AND HEALTH CARE
- Discontinuous & Fragmented Health Care System
- Access to Social Care
- Access to Public & Private Insurance
- Provider Cultural Humility
- Health Literacy

SOCIAL AND COMMUNITY CONTEXT
- Social Cohesion
- Civic Participation
- Discrimination
- Social Injustice
- Involvement with the Justice System
- Social Inclusion/Exclusion

EDUCATION
- High School Graduation
- Enrollment in Higher Education
- Language and Literacy
- Early Childhood Education and Development

ECONOMIC STABILITY
- Extreme Poverty
- Employment
- Access to Income Support
- Food Security
- Housing Stability

Source: Adopted from HealthyPeople 2020, Social Determinants of Health
*Image developed on Piktochart.com
SOCIAL DETERMINANTS OF HEALTH FOR PEOPLE WHO ARE HOMELESS

- Limited availability of affordable housing
- Unsafe living conditions (exposure to violence and poor environmental conditions) prior to and during bouts of homelessness
- Personal, provider, and systematic barriers to health care
- Social isolation with limited to no social support and social inclusion in the community
- Influence of social networks that engage in risky behaviors and a disconnect from positive home-based networks
- Increased likelihood of involvement with the justice system.
Patient Centered Care
Patient-Centered Care

- Center of treatment process
- Focused on needs, values, wishes of patient when developing the treatment plan
PATIENT-CENTERED CARE IN THE HEALTH CENTER

SYSTEMS
• Organizational philosophy
• Literacy
• Service Agreements

GROUPS
• Transgender affirming
• Culturally-specific

INDIVIDUALS
• Agenda setting
• Provider approach
Models of Care
WHOM WE SERVE

- Increased mortality, comorbidity and chronic conditions rates
- More complex health issues
- Greater trauma
- Exacerbated conditions
- Difficulty in linkage to health outcomes (Z-code)
- 1.2 Million served by FQHC; 70% by HCH grantees

<table>
<thead>
<tr>
<th>Patient Characteristics</th>
<th>All Grantees</th>
<th>HCH Grantees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Patients</td>
<td>24,295,946</td>
<td>890,283</td>
</tr>
<tr>
<td>Total Homeless</td>
<td>1,191,772 (4.9%)</td>
<td>840,130 (94.4%)</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children (&lt;18 years old)</td>
<td>31.2%</td>
<td>12.3%</td>
</tr>
<tr>
<td>Adult (18-64)</td>
<td>60.9%</td>
<td>82.9%</td>
</tr>
<tr>
<td>Older Adults (65 and over)</td>
<td>7.9%</td>
<td>4.8%</td>
</tr>
<tr>
<td>Income Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients at or below 200% of poverty</td>
<td>92.2%</td>
<td>97.7%</td>
</tr>
<tr>
<td>Patients at or below 100% of poverty</td>
<td>70.9%</td>
<td>87.8%</td>
</tr>
<tr>
<td>Insurance Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uninsured</td>
<td>24.4%</td>
<td>37.6%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>48.9%</td>
<td>49.1%</td>
</tr>
</tbody>
</table>

Housing Type

<table>
<thead>
<tr>
<th>Housing Type</th>
<th>All Grantees</th>
<th>HCH Grantees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shelter</td>
<td>258,100 (30.7%)</td>
<td></td>
</tr>
<tr>
<td>Doubling Up</td>
<td>242,562 (28.9%)</td>
<td></td>
</tr>
<tr>
<td>Transitional</td>
<td>101,639 (12.1%)</td>
<td></td>
</tr>
<tr>
<td>Street</td>
<td>72,744 (8.7%)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>100,700 (12%)</td>
<td></td>
</tr>
<tr>
<td>Unknown</td>
<td>64,385 (7.7%)</td>
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HCH MODEL

• Integrated multidisciplinary approach to care coordination
  → Improve health outcomes of individuals with multiple co-morbidities
  → Meet complex needs

• Alignment with Patient Centered Medical Home (PCMH):
  → Patient empowerment
  → Care coordination
  → Delivery of integrated/team based care
Integrated Care

- Primary care and behavioral health
- Coordinated Care/Connection to Services
- Meaningful approaches to care
- Co-located services
- Holistic Care

- Mental Health & Addiction Treatment
- Community Health Workers
- Street Medicine
- Mobile Clinics
- Reducing Stigma
- Harm Reduction
- Trauma-Informed Care
- Medical Respite
- Case Management
- Housing/Shelter Referrals

- Consumer Advisory Boards
- Harm Reduction
- Reducing Stigma
- Community Health Workers
- Co-located services
- Holistic Care
- Mental Health & Addiction Treatment
TRAUMA-INFORMED CARE

Living in poverty and experiencing homelessness, greater risk of experiencing chronic trauma and exposure to violence

• Purpose of TI care & org
  → Mitigate trauma symptoms
  → Prevent further trauma/re-traumatization
  → Treat residual effects of trauma

• TI Organizations (TIO) implement the principles throughout the program
  → Organizational change occurs at the mission, goals, physical environment, policies, procedures, and culture

For more information about our TI projects visit https://www.nhchc.org/tio/ or send questions to tio@nhchc.org.

Other educational support on trauma can be found on our clinical resources page, here: https://www.nhchc.org/resources/clinical/diseases-and-conditions/trauma/
MEDICAL RESPITE CARE

Acute/post-acute care for individuals too sick/frail to recover on the street but not sick enough to stay in the hospital

• NHCHC is the leading organization for this program
  → In 2016, 80 known programs across 29 states, 1,574 beds
  → Developed a set of 7 Standards to serve as a framework
• **Shortens** hospital lengths of stay, **reduces** readmissions, and **improves** outcomes

Resources: Medical Respite Standards, Respite Care Providers Network, Other Medical Respite Support, National Health Care for the Homeless Council. (June 2017.) Medical Respite Care: Financing Approaches. (Author: Barbara DiPietro, Senior Director of Policy.)
STREET MEDICINE

Street medicine teams can be the connection between the disjointed care of people experiencing homelessness

• Taking Health care to where people are
  → Under bridges, narrow alleys
• Telemedicine helps teams be more interdisciplinary
• Types of settings:
  → Fixed site
  → Mobile
• End goal to engage patients at clinic site
  → Reasons why won’t come into clinic: stigma, paranoia, not wanting to leave belongings
HARM REDUCTION

• Pragmatic approach to reducing harmful consequences of addictive or high risk behaviors

• No requirement of abstinence, low-thresholds and flexibility in sessions

• Work with the individual to minimize harmful effects of given behavior

• Examples: needle exchanges
CASE MANAGEMENT

• Intensive Case management Framework:
  → Average case load 15, high intensity contact with client

• Basic Elements:
  → Manage intake, assess patient needs, service planning, linkage to services, continued monitoring, client advocacy

• Implementation:
  → Support psychosocial services, crisis intervention, discharge planning, emotional support
CONSUMER ADVISORY BOARDS

- “Nothing about us without us”
- Local and national level
- Important part of keeping us honest, checking in as organizations grow and change
- Give consumers a clear pathway to expressing opinions
- Leadership opportunities for consumers
EQUITY OF TAILORED SERVICES

- Services not always captured by traditional health care surveillance
- HCH grantees wrote in tailored services provided on daily basis to meet patients where they are

**Professional Services**
- Acupuncturists
- Contract for Provider Services (M.D.)
- Crisis Intervention Audiologist
- Dietitian/Nutritionists
- Dietary Supplements
- Naturopaths
- Occupational therapist
- Dues & Licensing
- Physical Therapist
- Adult Residential Treatment
- Podiatry
- Speech Pathologist

**Enabling Services**
- Art Studio Staff
- Child Care Provider
- Client Advocates
- Community Health Worker Contracts for Services
- Employment/Recruitment Specialist
- Eyeglasses
- Homeless MIS data system: data collection and entry
- Housing Specialist
- Medical Home for Homeless Children
- Monetary Assistance
- Navigator
- Research Associate
- Respite Care
- Shelter & Lodging Support Service
- Stipends

**Related Services**
- Clothing
- Food/Meals
- Haircuts
- Housing
- Respite
- Money Management Specialist
- Open Door-Supervisor Peer Support Specialists
- Personal Hygiene Items
- Policy Team
- Shelter Utilities
- Assistance WIC
INTEGRATED CARE AT CCC

• Primary Care and Behavioral Health
  • Mental health
  • Counseling and medications

• Plus
  • Substance Use services
  • Wellness classes
  • Acupuncture

• Access to
  • More comprehensive MH services
  • More comprehensive substance use services
  • Housing
  • Employment services
JAMES

56 year old new patient with significant problems with communication and cognition.

Mental health
Current substance use
Sequelae from substance use
TBI
Medications
PTSD
Developmental delay

Primary Care Provider who cares
Psychiatric Provider
Alcohol and Drug Counselor
Social Worker, Occupational Therapist
Pharmacy
Counseling, Wellness Classes
33 year old on his way to fishing boats in Alaska, money ran out in Portland and got the flu on the bus. Came to the homeless day center for a shower, found our clinic there

Kindness and connection

Free meds
Socks!
Navigation to primary care and other services
22 year old transgender woman, Dusty lives under the highway overpass. She has some sort of breathing problem but she won’t talk about it when the street outreach workers come to see her each week. She will take some toiletries and food, so the outreach team is hopeful that she’ll talk to the health care provider one of these days.

**Consistent, non-threatening kindness**

Gentle reconnection
Very low barrier health care services
Navigation to higher levels of care
SHARON

35 year old opioid user, homeless, being discharged from hospital after 3 days for abscesses and cellulitis

Provider who is non-judgmental

Recuperative Care Program
Primary Care
Mental Health Treatment with trauma-specific therapies
Medication Assisted Treatment with groups
Referral to syringe exchange
Detox
Recovery Housing: abstinence based or not
SPECIAL SAUCE

Sophisticated, integrated, complex services not nearly as important as:

- Desire for true, heartfelt connection
- Respect for all as fellow human beings
- Interest in working with people on their priorities, at their pace
- Understanding that housing is essential to health

This is patient-centered, trauma-informed care.

This is Health Care for the Homeless.
Questions?

Contact us:
Eowyn Rieke, MPH, MD,
Alaina Boyer PhD
Technical Assistance, ta@nhchc.org or click here