SHOW Logic Model

Program Goal: Improve health outcomes for unsheltered New Yorkers experiencing homelessness.

INPUTS	ACTIVITIES			OUTCOMES		
What we invest	**What**	**Who**	**Where**	**Short-Term (6 months-1 years)**	**Intermediate-term (1 year – 2 years)**	**Long-Term (2 years +)**
• H+H employees • City Tax Levy funding • Vehicles • Supplies, including medications • Equipment for patients to access telehealth appts • Connections to H+H programs (referral pathways, warm handoffs, etc.) • Expertise in trauma-informed, harm-reduction oriented health care services	<u>What</u> • Basic primary care services (vitals checks; general assessment; wound care; vaccination & medication; screenings) • Material goods distribution • Behavioral health screenings and referrals • Peer counseling • Harm reduction services (Narcan, FTS, bupe/MAT, BH links) • Service Linkages (via CHW and/or PCSN) <u>Where</u> Locations in the 5 boroughs with known presence of unsheltered New Yorkers, [within 2 miles??] from linked facilities <u>Who</u> • Unsheltered NYers experiencing homelessness			• Team build relationships with homelessness support infrastructure throughout NYC • Build trust with unsheltered New Yorkers • Increase awareness among unsheltered NYers on value of primary care / healthcare linkages • Deliver direct clinical and Behavioral Health services to unsheltered NYers • Provide life-saving interventions to address opioid overdose crisis	• Improved connections for New Yorkers to treatment for substance use disorders • Increased ongoing primary care & specialty care engagement for unsheltered NYers across mobile unit & facility campus • Increased ongoing BH engagement for unsheltered NYers • Increased connections to case management services for unsheltered NYers • Improved access and adherence to medications for unsheltered NYers	• Improved retention in care for people currently or formerly experiencing homelessness with a SUD/OUD diagnosis • Improved health for people currently or formerly experiencing homelessness • Reduced street homeless census in NYC [Recognizing this may increase for reasons outside our span of control – but still a goal.] • Reduced ER & inpatient utilization by unsheltered NYers
METRICS						
• # of vehicles active per day • # of employees • $ in budget • Hours in field • Hours of training & professional development • # of types of lab tests offered • # of different medications stocked on bus • # of specialty services offering virtual or in-person services on the unit <u>Metric Tags:</u> Engagement (E) Trust (T) Linkages (L) Health (H)	<u>Process Metrics</u> • Total # of engagements (E) • # of clinical encounters (E) • # of BH encounters (E) • # of hygiene kits distributed (T) • # of Narcan test kits distributed (T) • # of Fentanyl test kits distributed (T) • # of Xylazine test kits distributed (T) • # of linkages to SUD services (L) • # of linkages to Safety Net (L) • # of linkages to H+H specialty care services (L)			<u>Process Metrics</u> • Total # of engagements (E) • # of clinical encounters (E) • # of BH encounters (E) • # of hygiene kits distributed (T) • # of Narcan test kits distributed (T) • # of Fentanyl test kits distributed (T) • # of Xylazine test kits distributed (T) • # of linkages to SUD services (L) • # of linkages to Safety Net (L) • # of linkages to H+H specialty care services (L) <u>Outcome Metrics</u> • # of SHOW patients who complete appointment in Safety Net clinic (T) • #, % of repeat SHOW patients (T) • #, % of SHOW patients with repeat visits in Safety Net (T) <u>Evaluation:</u> • For all engagements, analyze by: ○ Unsheltered / all others (using Z codes) (H) ○ New/repeat (T) ○ Demographics – race, ethnicity, SOGI, age (E) ○ SUD (H)	<u>Process Metrics</u> • Total # of engagements (E) • # of clinical encounters (E) • # of BH encounters (E) • # of hygiene kits distributed (T) • # of Narcan test kits distributed (T) • # of Fentanyl test kits distributed (T) • # of Xylazine test kits distributed (T) • # of linkages to SUD services (L) • # of linkages to Safety Net (L) • # of linkages to H+H specialty care services (L) <u>Outcome Metrics</u> • # of SHOW patients who complete appointment in Safety Net clinic (E) • # of SHOW patients who complete appointment in H+H Specialty clinics (E) • #, % of repeat SHOW patients (E) • #, % of SHOW patients with repeat visits in Safety Net (E) • # of SHOW patients engaged in treatment for OUD or other SUD (E) <u>Evaluation:</u> • SUD outcomes (H) • Medication refill adherence (H) • Vaccinations (H)	<u>Outcome Metrics:</u> • # of SHOW patients placed in housing (E) • # of SHOW patients who are "well engaged" to primary care, utilizing PCSN standard (though including non-PCSN PC): (E) ○ "Well engaged" (>3 visits/6months), ○ "Moderately engaged" (<3 visits/6months) ○ "Not engaged" (no shows) • # of SHOW patients with ongoing connection to BH (E) • A1C trends (H) • BP trends (H) • SISQ / other BH screenings trends (H) <u>Evaluation</u> *H+H System Utilization:* • ER utilization by patients who have seen SHOW in the last 3 months, compared to overall (or regional) ER utilization by unsheltered by reason for ER visit (H) • Inpatient admissions and days for who have seen SHOW in the last 3 months, compared to overall (or regional) ER utilization by unsheltered – by reason for admit (H) *Macro-level:* • Comparison of trends in zip codes with / without SHOW presence: (E,T,L,H) ○ ODs for unsheltered NYers (or overall?) ○ Mortality for unsheltered NYers ○ Homelessness census

NYC Street Medicine: A Human-Centered Approach in Healthcare to Housing, and Housing to Health

Attendee Worksheet

Why did you choose to attend this session?

In your context, what are the top barriers to Street Medicine?

Who are key partners and how can you engage them?

What indicators/measures will you focus on to start? And what are long-term targets?

What is the next step you can take towards either establishing, strengthening, or sustaining Street Medicine at your organization?