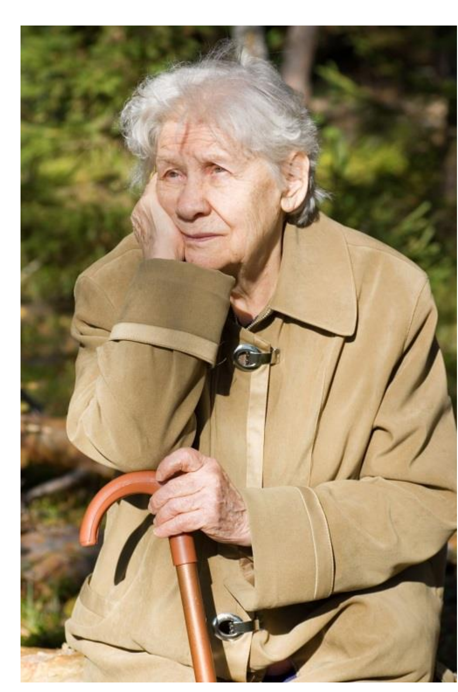
Special & Vulnerable Populations Series

Rural Homelessness



October 27, 2015

OPCA
Oregon Primary Care Association

The Oregon Primary Care Association

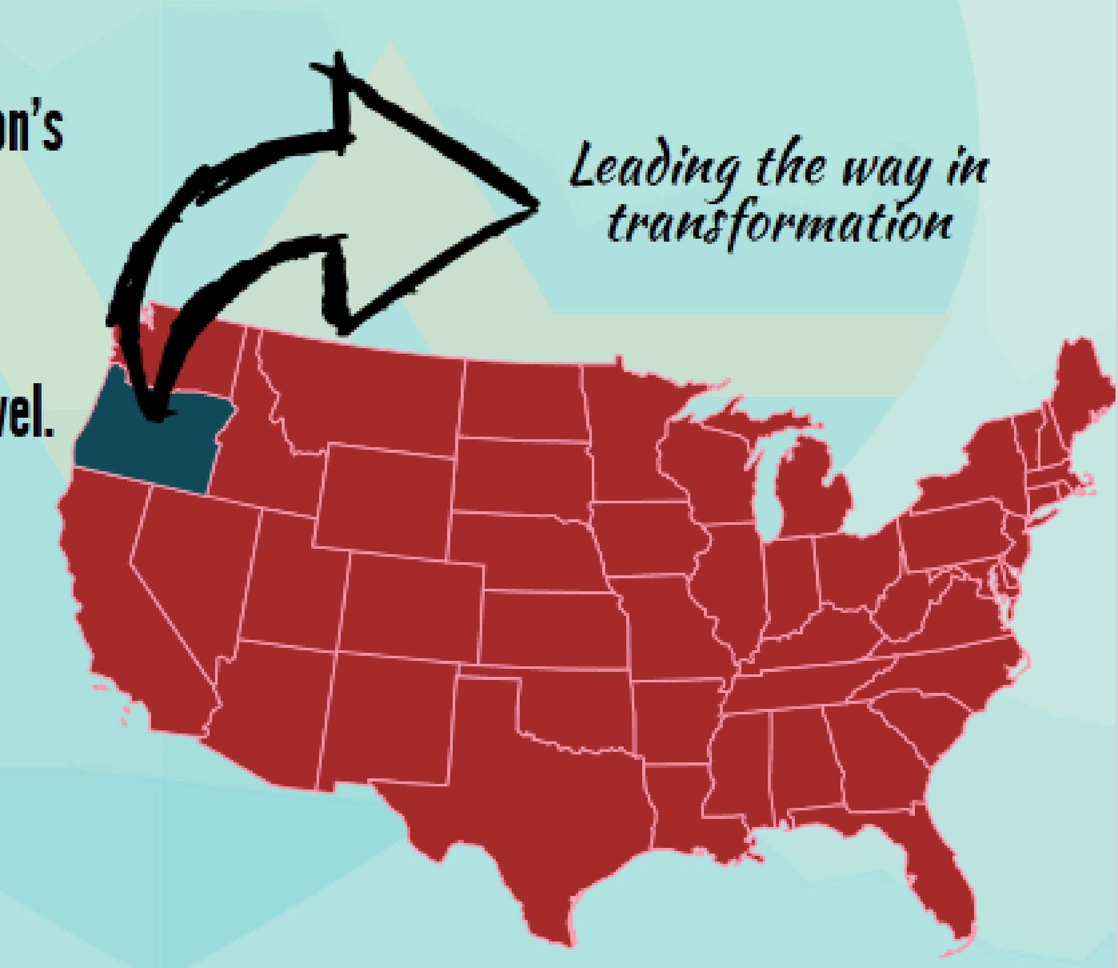
What we do

Provide technical assistance to Oregon's federally qualified health centers.

Learn from, educate and influence health policy at state and national level.

Our mission

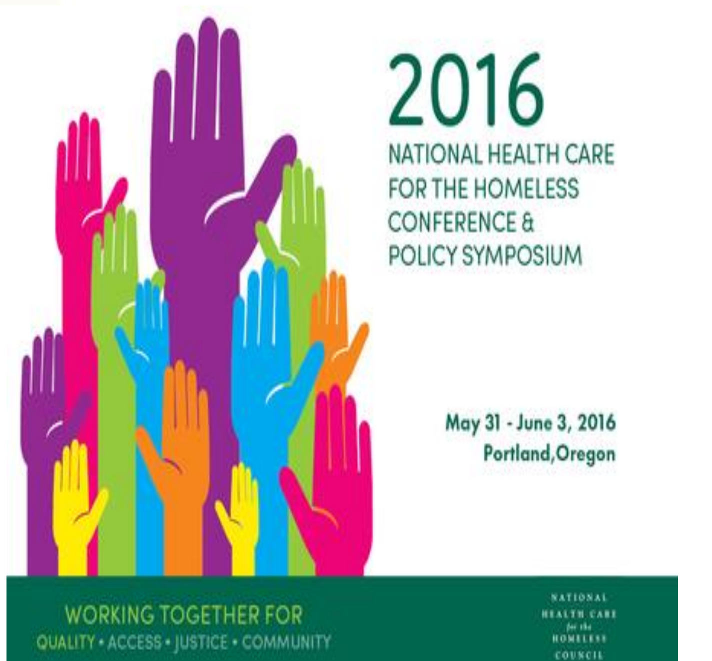
Lead the transformation of primary care to achieve health equity for all.

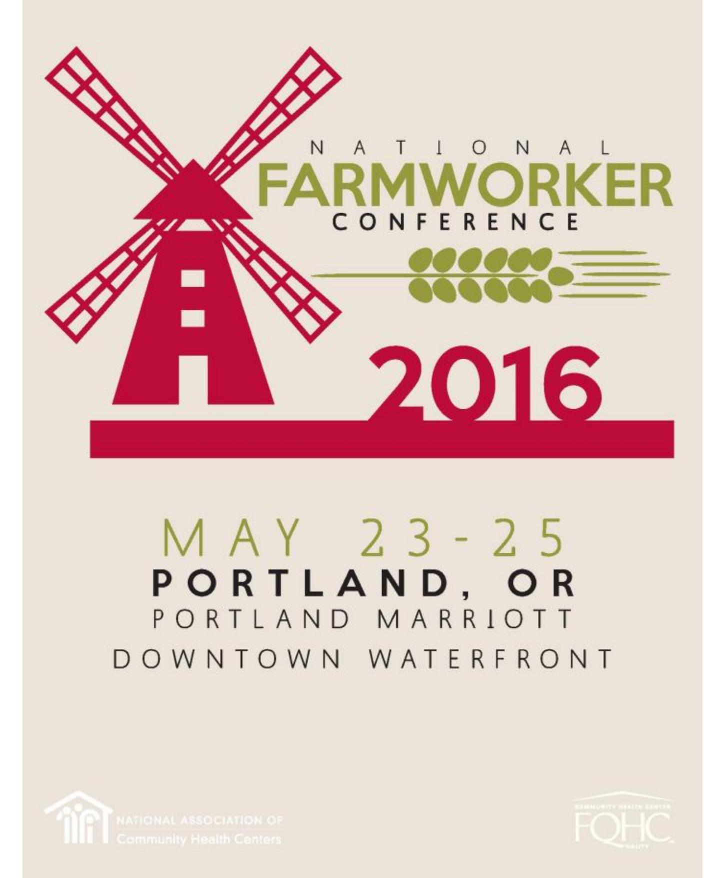


Special & Vulnerable Populations

- OPCA email lists/networks for:
  - Language Access
  - HIV AIDs
  - LGBTQ Health
  - Food Insecurity
- Homeless
- Migrant & Seasonal Farmworkers (December Webinar)

2016 Conferences in Portland





Today's Learning Objectives

- Understand common characteristics & challenges of the Rural Homeless
- Learn how to use clinic & community data to determine what Health Disparities exist for this population
- Consider medical and social interventions you could design or partner to create to meet the needs of this populations
- Learn about the Housing First model

What does Rural & Homeless look like?

According to the National Alliance to End Homelessness, Geography of Homelessness report:

Rural: ~14 homeless people for every 10,000
Urban: ~29 homeless people out of every 10,000.

- More poverty in Rural areas so people are more at risk.
- More homeless families
- More living with other friends or family – harder to get accurate counts

Homeless Numbers from UDS

Trend of Homeless by Type

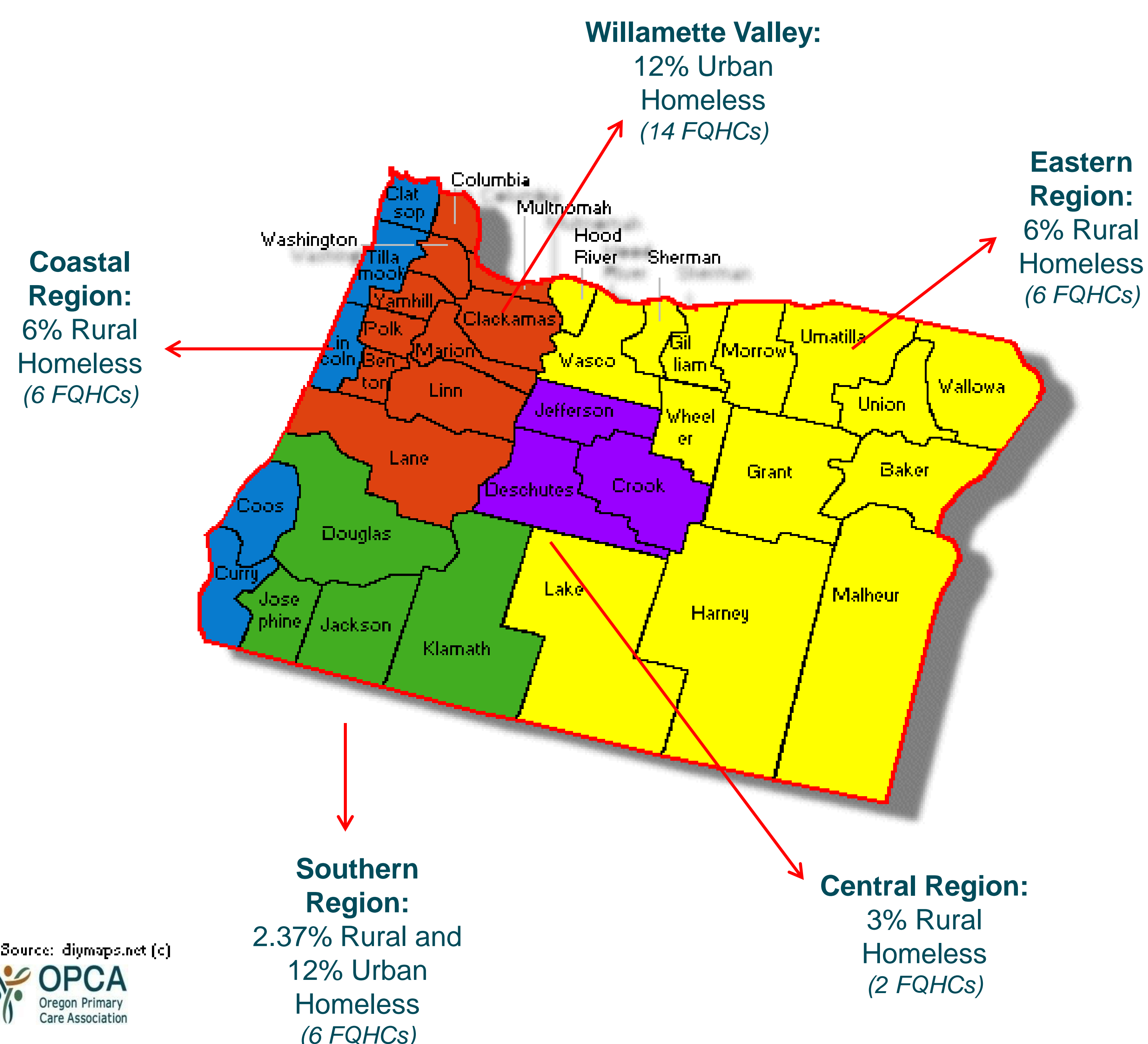
Percentage

18.00%
16.00%
14.00%
12.00%
10.00%
8.00%
6.00%
4.00%
2.00%
0.00%

2010 2011 2012 2013 2014

Year

Total Rural (%)
Total Urban (%)
Oregon (%)



Willamette Valley:
12% Urban Homeless
(14 FQHCs)
Eastern Region:
6% Rural Homeless
(6 FQHCs)
Coastal Region:
6% Rural Homeless
(6 FQHCs)
Southern Region:
2.37% Rural and 12% Urban Homeless
(6 FQHCs)
Central Region:
3% Rural Homeless
(2 FQHCs)
Columbia
Clat sop
Multnomah
Washington
Hood River
Sherman
Tilla mook
Yamhill
Clackamas
Polk
Lin coln
Ben ton
Marion
Wasco
Gil liam
Morrow
Umatilla
Union
Wallowa
Linn
Jefferson
Wheel er
Lane
Grant
Baker
Deschutes
Crook
Coos
Douglas
Curry
Jose phine
Jackson
Klamath
Lake
Harney
Malheur
Source: diymaps.net (c)
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How do we find and compare data on this population?

- What community data does exist in Oregon?

http://www.oregon.gov/ohcs/Pages/research-point-in-time-homeless-count-2011.aspx

- How can you use your own clinic data to understand a population segment?
  - What did Lincoln County learn?
  - Who currently pulls reports on patient outcomes by demographic factors? (age, race, housing status, migrant status . . .)

Medical & Social Interventions

Based upon the data that you can gather, what types of services might you try to implement?

- Questions to ask yourself:
  - How do we currently serve or engage these patients?
  - What natural allies and resources do exist for them already?
  - What do we want to help them with? Social support or specific medical interventions such as lowering their Hemoglobin A1C?

EFFORTS AND INTERVENTIONS IN THE ENGAGEMENT OF HOMELESS POPULATIONS (& PARTNERS)

Presentation for Oregon Primary Care Association, October 27, 2015

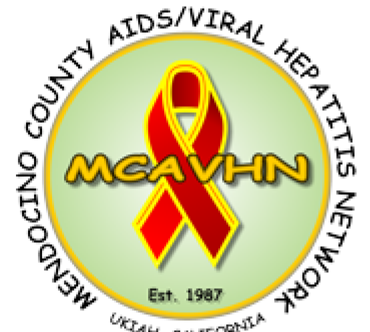
Libby Guthrie, Executive Director MCAVHN

Mendocino County Statistics

- 3510 square miles of rugged terrain
- Very challenging to navigate
- Services sometimes up to 2.5 hours away
- Renegade mentality (Emerald Triangle)
- Injection drug use is higher than most other counties in California
- 80–90% of PWID's have been exposed to Hepatitis C
- 39.7% of county inhabitants living below self-sufficiency standard, compared to California's overall 31%
- 20% of singles live below poverty level
- County jail beds = 301; sometimes as high as 335
- Rate of homelessness 2nd only to Detroit, MI (2007)

Brief History of MCAVHN

- **Volunteer agency** in the mid 80's serving persons living with AIDS (PLWA)
- Early 90's began use of **Title II (now called Part B) Ryan White Care Act funds** for case management/client advocacy, food, transportation, and other supportive services – as well as the **HOPWA** program (Housing Opportunities for Persons with AIDS)
- Prevention/**harm reduction services for HIV, then HCV,** implemented later in the decade



Providing services and comfort to persons and families affected by HIV/AIDS, Hepatitis C, and the co-occurring disorders of mental illness and substance abuse.

Care Services – HIV/AIDS

- **Care coordination** monitoring medical and psychosocial service provision in tandem with the Waiver, CMP (when applicable) and Title III/Part C providers
- **Advocacy** and interface with other medical and psychosocial service providers, as well as the legal system (when applicable)
- **SSDI/SSI** applications and representation

Care Services – Hepatitis C

- **Care coordination** for those with chronic hepatitis C, including extensive education, referral to and monitoring of medical and psychosocial services (similar to HIV program), re-assessments and follow-up – also had a grant to train physicians and mid-levels
- Referrals from **SEP and testing** services
- **Housing** services – case managing (Shelter Plus Care & Section 8/Housing Choice vouchers)

Practical assistance including:

- **Food** vouchers
- **Transportation** services
- **Benefits** counseling and advocacy
- **AOD counseling** & referral
- **Harm reduction** counseling & case mgt.
- **Housing case management** (Shelter Plus Care and Section 8/Housing Choice
- **Client socials; drop-in center**

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Program Additions By Co-morbidity

- **Serving SUD** through both programs and through our harm reduction services
- **High rate** of contact with **criminal justice** system @ local and state levels
- **Relationships built** with medical providers due to HIV and HCV care coordination
- **Relationships with legal** services due to multiple misdemeanor and felony offenses, as well as returning parolees

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Metamorphosis

- Services delivered primarily through **Community Health Outreach Workers** (CHOW's) which helped us to understand the amount of injection drug use (IDU) in our county
- **Implemented syringe exchange** services in light of this issue; knowing that about **40% of HIV infections were from IDU**
- How would we accomplish this **public health intervention?**

Metamorphosis explained

- Because so many of our **HIV clients needed** immediate housing, we **began fast-tracking** (pushing hard for **Housing First**) clients through local HUD office
- Because so many of our **HCV clients** were **fragile, and had mental health challenges,** we were able to start utilizing **Shelter Plus Care** for them as well
- Because we are a **HOPWA provider,** we had housing subsidies and placement experience
- People kept coming **off the streets** and through **our syringe exchange**

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Housing Ready Paradigm

SA Treatment first

Dominates the treatment landscape:

a) Clean time
b) Compliance with rules and restrictions for a specified period of time
c) Circumstances are outlined for the client

Housing First Paradigm

Housing stability first

Alternative approach (now mainstream):

a) Home as constancy
b) Day-to-day routine of human existence
c) Control over ones life and free of surveillance
d) Home is a secure base where identities are constructed

Vulnerability Index

- The **SPDAT is an evidence-informed** approach to **assessing** an individual's or family's acuity. The tool, across multiple components, prioritizes who to serve next and why, while concurrently identifying the areas in the person/family's life where support is most likely necessary in order to avoid housing instability.
- **SPDAT** uses **15 dimensions** to determine an **acuity score** that will help inform professional Housing First practitioners about the following:

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SPDAT (continued)

- People who will benefit most from **Housing First**
- People who are most likely to end their own homelessness with little to no intervention on your part
- Which areas of the person’s life that can be the **initial focus of attention** in the case management relationship to improve housing stability
- How individuals and families are **changing over time** as a result of the case management process

Why This Population?

Problem defined:

- **Complex co-occurring** conditions or disorders (e.g. those with at least a dual-diagnosis) and **other co-morbidities**
- Over-utilization of inefficient crisis-oriented, **high-cost** service provision – excessive emergency room **admissions**, psychiatric hospitalizations; incarcerations
- **Financial, medical, behavioral health, legal, psychosocial, housing, resource and transportation challenges**

Why? – (continued)

- High majority of our participants are **homeless** individuals **struggling** with basic **survival** issues
- Help to resolve basic human requirements for **food, shelter, income;** basic **stabilization** by providing assistance to meet these basic needs
- Make **positive connections** – assess **capabilities**; providing substantial assistance in the beginning of the partnership

Common Risks for Recidivism

Risk Factors

- *Antisocial Attitudes*
- *Antisocial Peers*
- *Antisocial Personality*
- *History of Antisocial Behavior*
- *Family dynamics*
- *Education/Employment challenges*

CUSOC/ROSOC

Community partners were chosen from a wide range of service providers to address the issues of **emergency room over-utilization and recidivism** – initiated by concerns for cost cutting measures by our largest local hospital

1. Community hospital
2. Local FQHC
3. AOD treatment center
4. County Sheriff's Department (jail medical services)
5. HIV/HCV case management and harm reduction agency

Comprehensive Assessment Tool (CAT) #1

Pre-screening questions to determine if the household will be best served through coordinated assessment or should be referred to other resources.

For this particular tool, consumers who don't believe they will become homeless within the next 72 hours will be referred to prevention services. Communities can adjust this timeframe as needed or, if prevention services are well integrated with their coordinated assessment process, remove this question.

CAT #2

Questions that cover many of the HUD-required universal data elements and program data elements, which communities should also adjust according to their preferences. However, it’s important that communities share this information with the program receiving the consumer referral so that the program doesn’t ask the consumer the same questions again.

Ideally, this sharing should happen through HMIS.

CAT #3

Prevention and diversion questions to determine if the household can be successfully diverted from entering the homeless assistance system. Integrating diversion questions with the assessment tool ensures that shelter beds are being prioritized for people who have no other housing options, an important systems change that communities should be adopting.

Assessors will likely need to go a bit off script here to determine the best means for diverting each household. Communities should provide training that includes conflict mediation to the assessment staff that provides diversion assistance.

CAT #4

The Housing Prioritization Tool, which identifies housing barriers and prioritizes the people who are usually deemed the hardest to serve for system services.

It helps determine what interventions would best serve each household and how high a priority they are for various services.

The focus within the tool on identifying housing barriers encourages a Housing First and rapid re-housing centered approach to providing homeless assistance.

CAT #5

Population-specific questions that identify consumers who need specialized services (other than veterans and domestic violence survivors, who are covered earlier on in the process).

This section helps identify clients who would benefit most from services provided by just a handful of specialized programs.

CAT #6

A referral discussion section that incorporates consumer choice into the process. Communities will prioritize some consumers for multiple interventions as a result of the Housing Prioritization Tool.

This part of the tool gives consumers an opportunity to decide what intervention they'd most like to participate in.

CAT #7

A modified version of 100K Homes' Vulnerability Index (VI) and VI Scoring for those consumers who are prioritized for permanent supportive housing.

This tool will help determine how high a priority a consumer should be for receiving this service. Communities can substitute in other Permanent Supportive Housing prioritization tools besides the Vulnerability Index.

Questions?

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Resources

- Health Outreach Partners

- Health Care for the Homeless Council

- Local Health Departments & Homeless Shelters
- Other?

Thank you for listening

- We appreciate the time you have taken out of your day to think about this population and the care that they need.
- This webinar has been recorded and will be posted to the OPCA website.
- Any last questions?