Public Health
Seattle & King County

2013 Health Care for the Homeless Network

Annual Report

June 2014

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HCHN MISSION STATEMENT:
Provide health care and ensure access to adapted health care for homeless people.
- adopted in 2013

Acknowledgements

We gratefully acknowledge the following for their support in 2013:

HCHN Contract Partners
Country Doctor Community Health Centers • Evergreen Treatment Services • HealthPoint • Neighborcare Health • Harborview Medical Center • Seattle Indian Health Board • University of Washington Adolescent Medicine • Valley Cities Counseling & Consultation • YWCA Seattle | King | Snohomish

Public Health - Seattle & King County
Downtown Public Health Dental Clinic • Emergency Preparedness • King County Medical Examiner's Office • Public Health Centers and the Community Health Services Division • Robert Clewis Center • HIV/AIDS Program • South King County Mobile Medical Program • Tuberculosis Control Program • Public Health Reserve Corps

Edward Thomas House Medical Respite Partners
Harborview Medical Center • University of Washington Medical Center • Valley Medical Center Virginia Mason Medical Center • United Way of King County • King County Department of Community & Human Services-Mental Illness and Drug Dependency Action Plan • Community Health Plan of Washington • Seattle Housing Authority • Swedish Medical Center • Evergreen Hospital

HCHN Funders
City of Seattle Human Services Department • King County Veterans and Human Services Levy • King County Mental Illness and Drug Dependency Sales Tax • Seattle Foundation • United Way of King County • U. S. Dept. of Health & Human Services, Health Resources and Services Administration, Bureau of Primary Health Care • U. S. Dept. of Housing & Urban Development • Washington State Department of Health

In-Kind Support
HCHN Planning Council members • Homeless service agencies throughout King County • National Health Care for the Homeless Council • Seattle-King County Coalition on Homelessness

Health Care for the Homeless Network (HCHN) Program overview

HCHN provides quality, comprehensive health care for people experiencing homelessness in King County and provides leadership to help change the conditions that deprive our neighbors of home and health. HCHN relies on a service delivery model that combines clinic-based services provided through Public Health – Seattle & King County Public Health Centers, Neighborcare's Ballard Homeless Clinic, and Harborview Medical Center's Third Avenue Clinic with outreach and mobile services that serve homeless patients 'where they're at' in homeless shelters, day centers, in supportive housing and on the streets throughout King County. Single adults, families, and unaccompanied youth receive services through HCHN and in 2013 HCHN served 19,415 patients in 101,236 visits.

The HCHN administrative team is part of Public Health - Seattle & King County's Community Health Services division and HCHN's providers work for both Public Health and community partners to provide services to homeless and recently homeless individuals and families.

2013 Highlights

HCHN took significant strides forward in 2013, with major initiatives and innovations that have made a difference for our clients and advanced the effectiveness of our work.

Medicaid Expansion

Hundreds of homeless people living in poverty in King County are newly able to access health care because of the expansion of Medicaid health insurance through the Affordable Care Act (ACA). Public Health and community providers were trained to be in-person assisters to people applying for Medicaid, starting October 1, 2013. Public Health received a HRSA grant to focus specifically on homeless applicants in order to assist in enrollment and be prepared when specific issues (e.g., problems related to lack of stable address or contact information) could create delays in the enrollment process. Dedicated staff overcame these challenges as they arose, and despite the early bumps in the electronic enrollment system, King County resident enrollments reached 165,000 in 2014, with stories and data to demonstrate the success of efforts on both a local and national level.

Prior to the implementation of the ACA, between 40 to 50 percent of HCHN's Medical Respite program patients were uninsured. In the first quarter of 2014 that number dropped to 20 percent. The Mobile Medical Van found in 2013 that 70 percent of clients seen on the van were uninsured, while in the first quarter of 2014, that number dropped to 20 percent. These dramatic changes demonstrate the very intentional and coordinated team approaches to identifying uninsured clients and potential clients and helping them apply for coverage.

Expanded Medicaid coverage and access to health care has and will continue to have a positive impact on the lives of homeless people. Patients have reported that for the first time, they feel entitled to receive the health care they desperately need. They report finally being able to address

their pain and fill prescriptions on a regular basis, rather than rationing medicines for chronic illnesses such as diabetes and heart disease. A client reported to staff that after his Medicaid benefits became effective he immediately sought out and was provided hernia surgery that brought an end to pain he had lived with for 20 years. New access to coverage and willingness to use the newly acquired benefits has been heartening to HCHN providers who previously could not persuade their clients to seek the health care they needed because the health care system saw these services to uninsured individuals as "charity care" and many homeless individuals felt stigmatized by accepting such care.

Program Innovations and Initiatives

HCHN contracts with nine community agencies to provide services according to performance measures that are delineated in contracts, but each agency additionally brings their own expertise and experience with specific homeless sub-populations to be most effective, responsive and compassionate in serving their clients.

All HCHN providers work with clients to establish meaningful self-management goals to change behaviors in ways that can improve or stabilize chronic health conditions. **Carolyn Downs shelter nursing team** has been using the Coaching Model in monthly groups to help clients to set and achieve self-management goals. Their most recent innovation is to ask clients "what is getting in the way of your success in this program now?" The providers share examples of things that get in the way of anyone attaining their goals: mental health, chemical dependency, dental issues, fear, anxiety, sadness, relationships issues, debt, not knowing where to start, etc. Providers then help clients set up goals that are specific, measurable, achievable, relevant, and time-bound. Once clients have set goals, providers let them know about the team resources and community resources that can be used to support their efforts. The Country Doctor family team uses an anonymous evaluation at the end of each group session to obtain patient feedback and 98 percent report finding the group helpful.

The REACH case management program creates a therapeutic environment for clients in the Markham Building (where the REACH home offices are located) through a regular calendar of events available to their clients. For example, they hold a weekly Breakfast Club for REACH clients who want to come to the Markham office and eat a morning meal along with REACH staff and other clients. In this setting, clients are able to feel safe and comfortable and have a reprieve from the street and its associated stress, and staff is able to make services readily available in a comfortable and casual environment. This kind of approach can also be referred to as a trauma informed environment and it facilitates and promotes a client's willingness and interest in engaging in services.

Following the publication of a study in 2012 that found that homeless people have notably higher rates of hepatitis C virus (HCV) the **Housing Health Outreach Team** (HHOT) has partnered closely with the Hepatitis Education Project (HEP) to obtain vaccines for Hepatitis A/B as well as antibody testing for Hepatitis C. HHOT nurses scheduled events where people living in permanent supportive housing could be tested and obtain needed vaccines. Nurses in this program administered 73 hepatitis A/B vaccines in 2013.

During 2013, the **Medical Respite program** met with the Washington State Health Care Authority and all five of the Managed Care Organizations (MCO) who insure people through the Medicaid Program. Through these visits the MCO's observed firsthand how the respite program plays an effective and essential role in the continuum of care for homeless people and how it contributes to reducing costs and utilization of health system resources such as emergency departments and in-patient facilities. These discussions will continue with the goal of identifying a Medicaid category of reimbursement that would contribute to the financial stability of the program.

In June of 2013, Neighborcare's **Ballard Homeless Clinic** opened its doors at Nyer Urness House, a newly constructed supportive housing program, owned and operated by Compass Housing Alliance. The clinic operated for over a year out of temporary quarters at St Luke's Episcopal Church, which is across the street from the permanent location. The clinic provided 1,551 visits to 369 homeless clients.

An **HCHN public health nurse**, along with **Public Health's Environmental Health Services**, worked with residents at the Nickelsville homeless encampment to support clean-up of conditions that provide harborage for rats and other pests and create an effective rat control program. This effort included the active and creative assistance of Public Health Reserve Corps and UW nursing students.
Along with EHS, the nurse followed the three camps that were created after the original camp was closed and continued to provide technical assistance and health education.

For nearly four years, the **Downtown Mental Health Team** has conducted groups based on the Trauma, Recovery, and Empowerment Model (TREM) principles for people struggling with issues related to the trauma they have survived. Examples of trauma include violence (as a victim or observer), war, torture, homelessness, imprisonment, racism, and poverty. As providers have gained more experience in facilitating TREM groups, they've recognized the need to adapt the group format to be responsive to the cultural needs and norms of those participating in newly formed groups in 2013.

Health Care for the Homeless Network Data Summary

Health Care for the Homeless Network maintains a database of encounter-level data for every patient visit that is provided by a network provider. On a monthly basis, contracted partner agencies submit data collected during patient visits, either by electronic data transfer or by submitting paper forms that are manually entered into the HCHN database. At the close of each calendar year a dataset containing Public Health homeless client data is created and merged with HCHN contracted service provider data to complete the Uniform Data System (UDS) report, a requirement of HRSA 330(h) funding. The following charts are created from the dataset used to produce the 2013 UDS report.

Chart 1: HCHN 2013 Expenditures

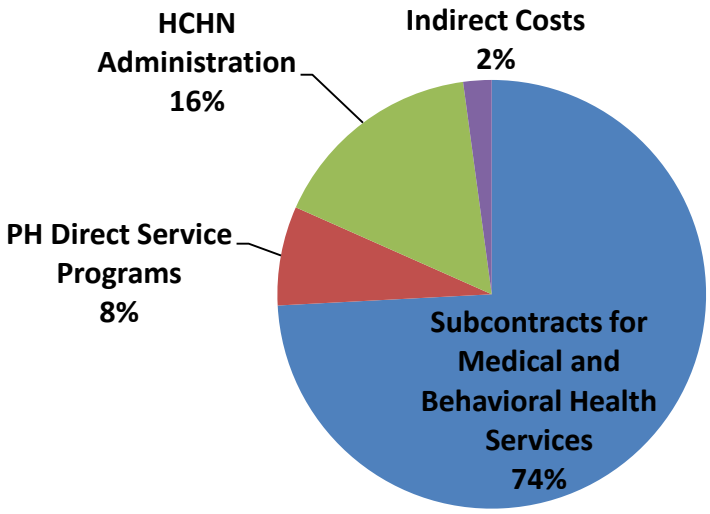
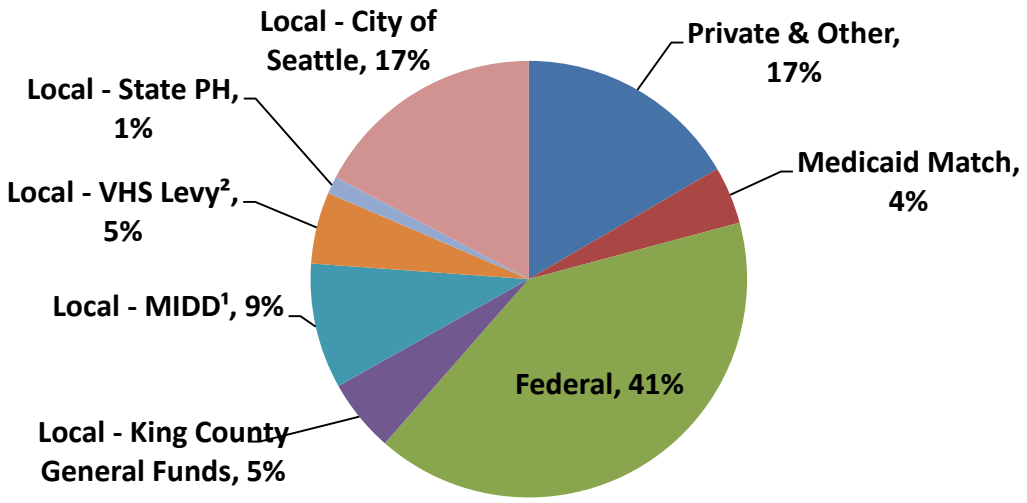


Chart 2: HCHN 2013 Revenue



[1] Mental Illness and Drug Dependency

[2] Veterans and Human Services

The graph below positively identifies those patients who were only seen in Public Health Centers, those who were only seen by contracted service providers, and those patients who were seen by providers in both Public Health Centers and contracted service agencies. Chart 3 is a summary of Health Care for the Homeless Network's 2013 patients and visits, divided by these three categories.

Relative to the total number of patients seen in the Health Care for the Homeless Network, only 1,679 (8.6 percent of all patients) are seen by both Public Health Centers and contracted services agency providers.

Chart 3: HCHN patients and visits

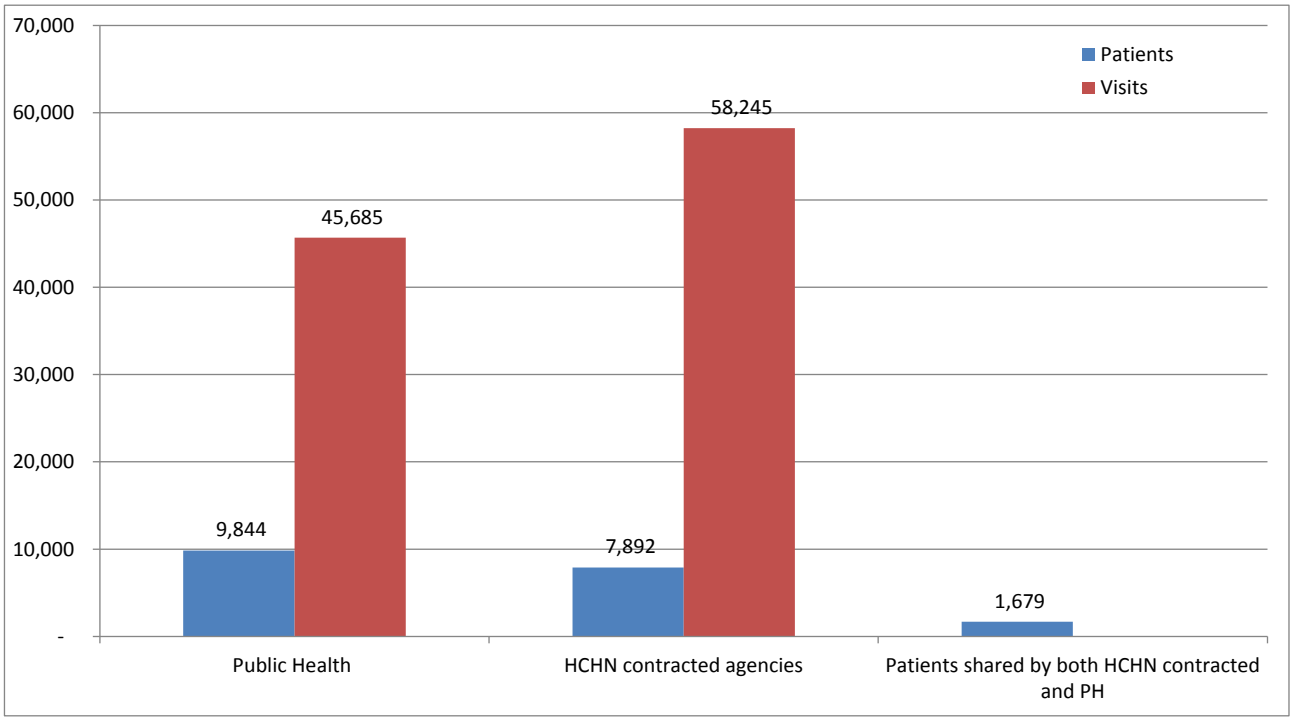


Chart 4 reflects pre-Affordable Care Act levels of medical coverage in the homeless population seen by HCHN providers. In 2013, 47 percent of HCHN patients were covered by Medicaid, 43 percent were uninsured, 7.5 percent were covered by Medicare and the remaining patients were covered by a mix of private and other public insurance.

Chart 4: HCHN patient medical coverage, 2013 (N = 19,415)

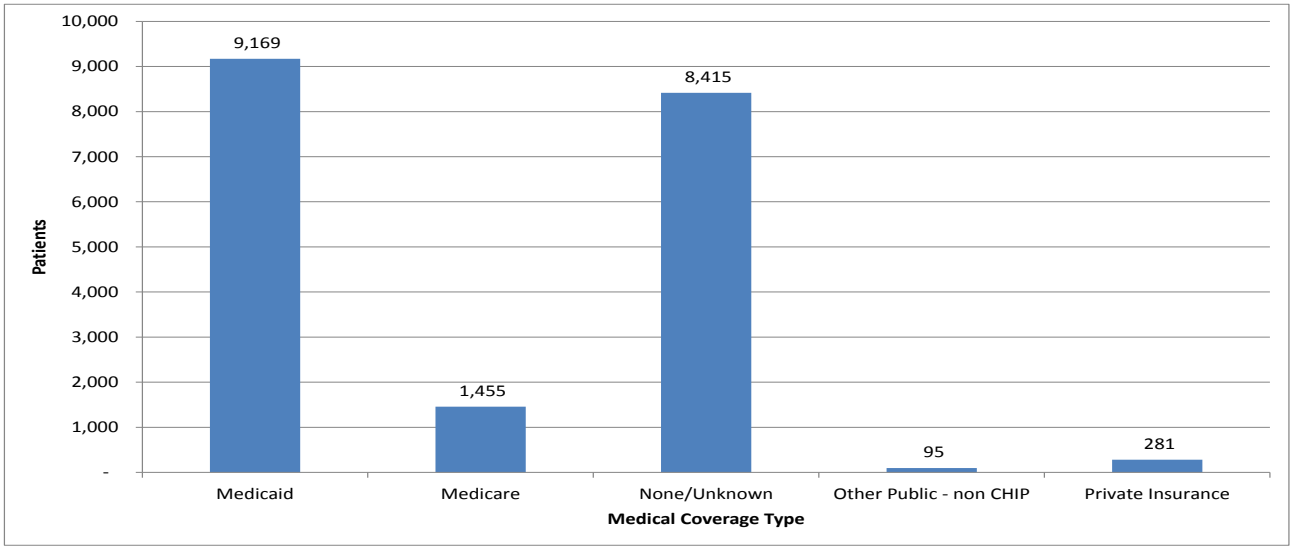
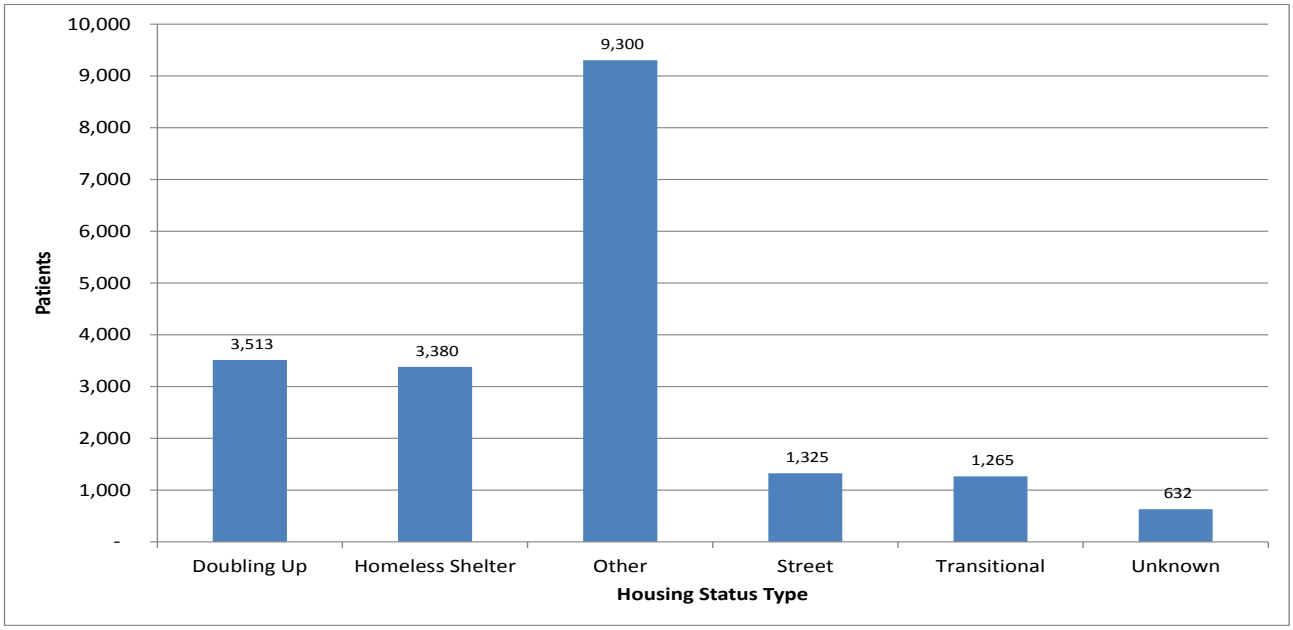


Chart 5 reflects the housing status reported on the first encounter of the year for each HCHN patient. HCHN collects living situation history by asking patients at every encounter where they slept the previous night. Over the course of a year a single individual may report sleeping outdoors, doubled up with a friend or family member, or in a shelter. Some may obtain housing for a period of time, and some individuals will cycle back into homelessness even within a single year.

HCHN utilizes the guidance outlined by the Bureau of Primary Health Care for the Uniform Data System (UDS), a federally mandated data collection format that all health centers receiving Health Resources Services Administration (HRSA) money must conform to. According to the UDS guidance, the "Other" category for the 'Homeless Status' field may be used to report previously homeless patients who were housed when first seen but who were still eligible for the program (Health Care for the Homeless rules permit a patient to continue to be seen for 12 months after their last visit as a homeless person, regardless of their current housing status). Additionally, patients whose housing is paid day-to-day (such as single room occupancy hotels or motels) are also reported in the "Other" category.

Chart 5: HCHN patient homeless status, 2013 (N = 19,415)



Charts 6 and 7 reflect the racial and age composition of HCHN's patients, respectively. Forty-two percent of patients are White, 24 percent Black/African American, 14 percent refused to report their race, 7.3 percent report more than one race, 4.6 percent American Indian/ Alaska Native, 4.5 percent Asian, and less than one percent of patients are Native Hawaiian and Other Pacific Islander. Fifteen percent of HCHN's patients are of Hispanic descent.

Chart 6: HCHN patients by race (N = 19,415)

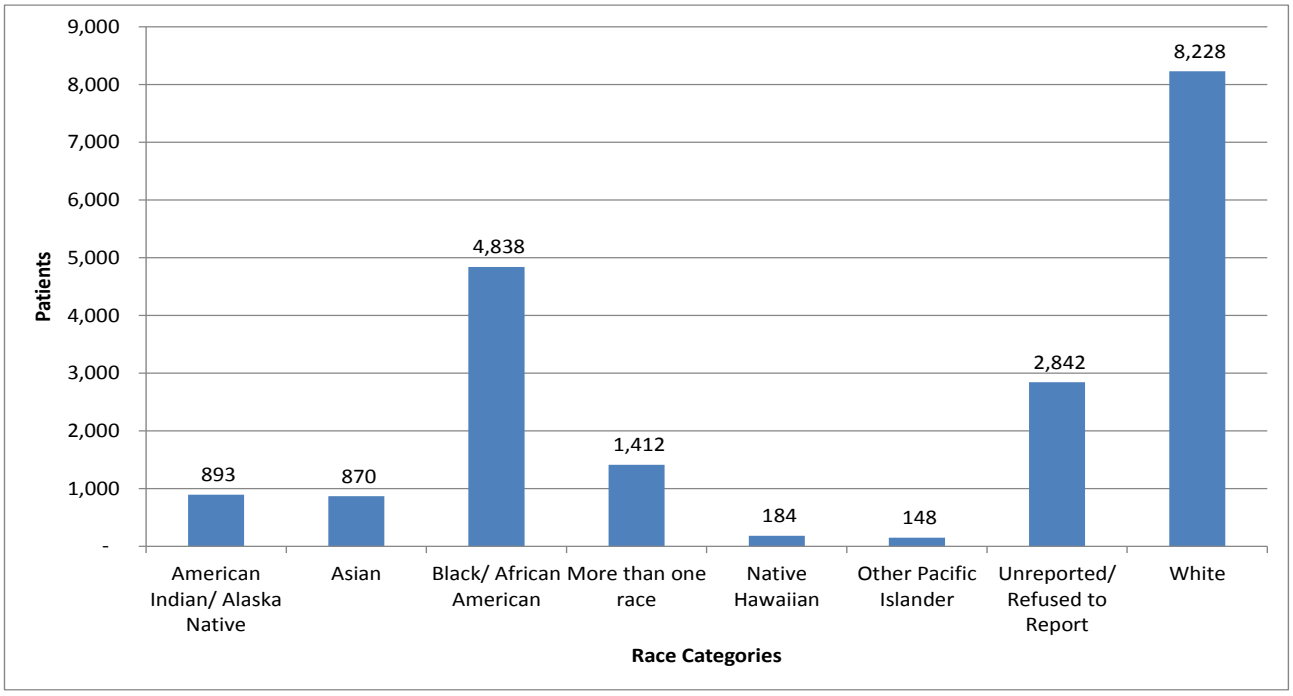


Chart 7: HCHN patients by age (N = 19,415)

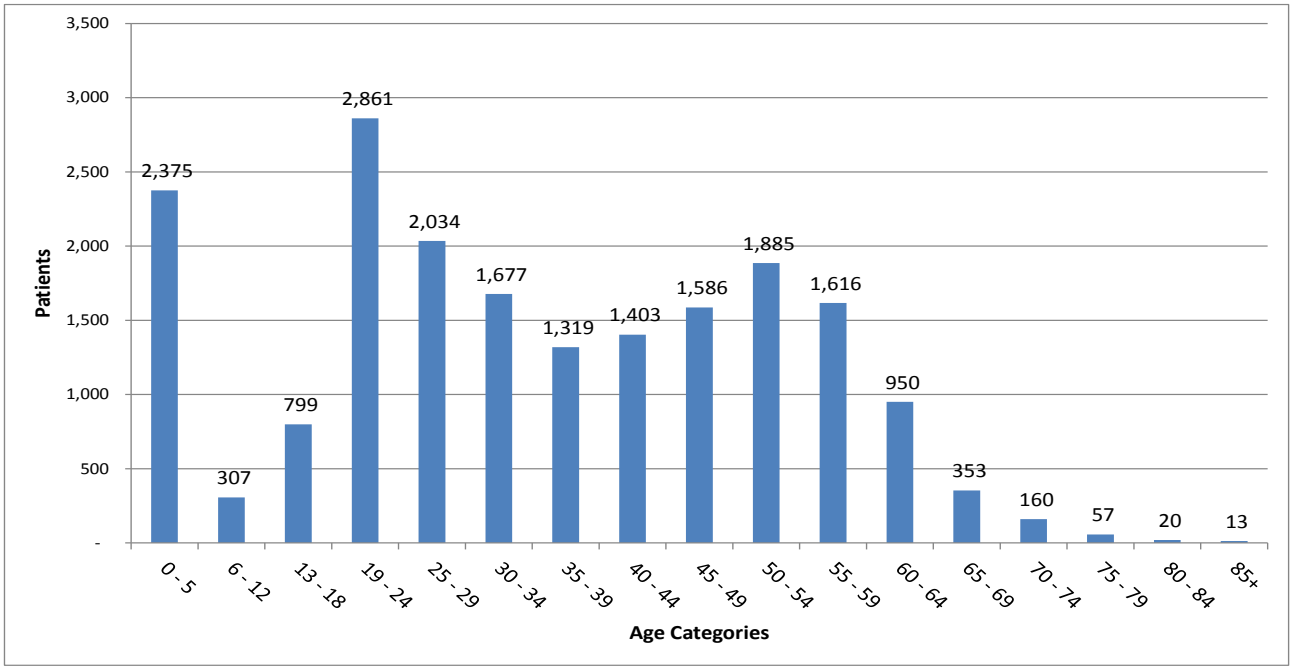
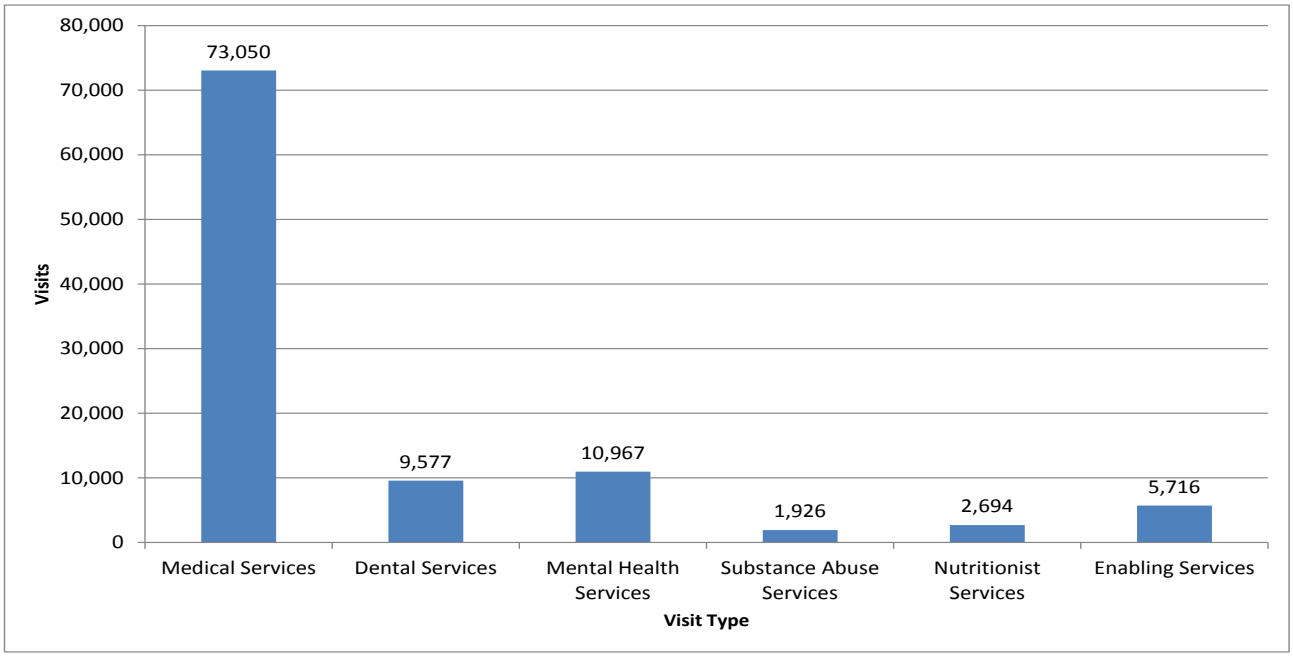


Chart 8 reflects HCHN visits by type. Medical services include doctors, physician assistants, nurse practitioners, and nurses. Mental health services include psychiatrists, licensed clinical psychologists, licensed clinical social workers, other licensed mental health providers, and other mental health staff. Substance abuse services include chemical dependency specialists. Enabling services include case managers, outreach workers, and eligibility assistance workers.

Chart 8: HCHN visits by type (N = 101,930)



2013 Community Needs Assessment

Providers in the Health Care for the Homeless Network (HCHN) regularly see clients who not only struggle with homelessness, mental illness, and substance abuse—but also untreated diabetes, cardiovascular disease, and other chronic conditions that have major impacts on their quality of life. Motivated by the stories and input from HCHN providers, and the disproportionately high self-reported prevalence of diabetes and cardiovascular disease, the HCHN administrative team decided to gain a better understanding of health care needs of the homeless population, by having a focus on chronic disease in its 2013 Community Needs Assessment (CNA).

The 2013 Community Needs Assessment (CNA) is an integral part of the HCHN strategic planning process and orients the program's goals and vision for the next Health Resources Services Administration (HRSA) 5 year project period. The information contained in the report will be useful to providers, policy-makers, researchers and others interested in the chronic disease risk and prevalence of homeless adults, and specifically users of homeless day services in Seattle and King County. The HCHN administrative team intends to use these data to inform their service delivery model and focus for the next five years of programming.

Key findings of the CNA include:

- Eighteen percent of HCHN community needs assessment respondents have diabetes.
- Sixty percent of HCHN community needs assessment respondents have a diabetes risk that is considered "high risk" by the American Diabetes Association.
- Of the roughly 800 respondents who report they have not been told they have diabetes, 56 percent (449 individuals) have a risk score of four or higher.
- Over 80 percent of respondents have three or more risk factors for heart disease.
- Forty-four percent of respondents have high blood pressure.
- Sixty percent of respondents are overweight.
- Sixty-nine percent of respondents smoke tobacco.
- Thirty-seven percent of respondents are uninsured.

Data Source:

One thousand interviews were conducted using a survey instrument developed by the HCHN CNA design team. The instrument adapted the American Heart Association and the American Diabetes Association risk self-assessment tools for use with this unique population. Respondents were selected for the sample based on convenience sampling and respondents received a five dollar gift card to compensate them for their time in completing the interview. Public Health Reserve Corps volunteers and Public Health administrative staff conducted one-on-one interviews on multiple visit days at 15 homeless day service sites throughout Seattle and King County between May and August, 2013.

Data limitations:

The large sample size provides worthwhile information on a significant number of individuals within this population however it was gathered using convenience rather than random sampling, thus direct estimates from sample to population are not possible.

Conclusion:

The results of the 2013 HCHN Community Needs Assessment indicate a clear demand for intervention and prevention within the adult homeless population using day services within Seattle and King County. Tobacco use, weight, diet and exercise are risk factors that can be addressed by collaborations between Public Health, homeless service providers, and funders whose respective interests could align more to benefit homeless individuals already on the path of unmanaged chronic disease.

As health systems in Washington state begin to shift in 2014 with the implementation of the Affordable Care Act and expansion of Medicaid, Public Health - Seattle & King County's Health Care for the Homeless Network (HCHN) hopes this needs assessment will both inform community stakeholders of the shockingly high risk and prevalence of chronic disease currently afflicting the adult homeless day center population and motivate action toward better integration of health promotion in all facets of homeless service delivery.

Appendix A: 2013 HCHN Planning Council members

Heidi Albritton, Human Services Department, City of Seattle

Carole Antoncich, Social Services Director, Plymouth Housing Group

Maureen Brown, MD, Swedish Family Practice Residency Program, Downtown Public Health Center, Co-chair

Rebekah Demirel, L.Ac.

Sinan Demirel, Consultant

Edward Dwyer-O'Connor, Sr. Clinic Practice Manager, Harborview Medical Center

Charissa Fotinos, MD, Medical Director, Public Health – Seattle & King County

Gregory Francis, Community Advocate, Co-chair

MJ Kiser, Program Director, Compass Center

Hedda McLendon, Director of Programs, YouthCare

Katy Miller, Supportive Housing Planner, King County Housing and Community Development

Sola Plumacher, City of Seattle Human Services Department

Neil Powers, Manager, Campaign to End Homelessness at United Way of King County

Eva Ruiz, Community Advocate

Sheila Sebron, Veteran Advocate

Revel Smith, Community Advocate

Appendix B: HCHN Program Summaries

Services for single adults

Evergreen Treatment Services/Housing Health Outreach Team: Chemical dependency services for formerly homeless adults living in supportive housing in Seattle.

Evergreen Treatment Services/REACH Program: Outreach and Engagement to people living unsheltered in Seattle. Case management to chronically homeless and chemically addicted adults.

HealthPoint: Nursing services for formerly homeless adults living in units supported by Sound Mental Health in south King County. Social work and benefits assistance on the South King County mobile medical van.

Neighborcare Health/REACH program: Nursing and nurse outreach services to chronically homeless and chemically addicted adults.

Neighborcare Health/Housing Health Outreach Team: Medical and mental health services for formerly homeless adults living in supportive housing.

Neighborcare Health/Ballard Homeless Clinic: Medical, case management, mental health, chemical dependency and referral services for adults.

Harborview Medical Center: Mental health and nursing services to adults in shelters, day centers, and transitional housing in Seattle.

Pioneer Square Clinic (Harborview Medical Center) / Medical Respite Program: Medical, case management, mental health and chemical dependency services for adults in King County.

Seattle Indian Health Board: Nursing services at Chief Seattle Club.

Valley Cities Counseling and Consultation: Mental health and referral services to individuals living homeless in north, east, and south King County.

YWCA: Outreach and enrollment assistance for Medicaid coverage at homeless sites throughout Seattle.

Dental Clinic at the Downtown Public Health Center: Oral health services for homeless adults and formerly homeless adults living in Permanent Supportive Housing

Robert Clewis Center at the Downtown Public Health Center: Health care provided by Harborview to adults who use the needle exchange services, with a focus on abscess care.

South King County Mobile Medical Van: provides primary and episodic health care and linkages to primary care, mental health, chemical dependency services and enrollment for entitlements at meal sites and other sites where people who are homeless gather.

Public Health TB Control Program: Engagement and Case Management for homeless adults receiving TB treatment with the goal of finding and maintaining permanent housing.

Services for families

Carolyn Downs Family Medical Center – Homeless Team: Nursing services to women and families in shelters and transitional housing sites in central Seattle.

HealthPoint: Nursing and benefits assistance to women and families in shelters and transitional housing sites in North, East and South King County.

Neighborcare Health/45th Street Clinic: Nursing and mental health services to women and families in shelters and transitional housing sites in North and Central Seattle.

Valley Cities Counseling & Consultation: Mental health and chemical dependency services to families in shelters and transitional housing sites in Seattle & King County.

Public Health – Kids Plus – Medical Case Management for children and their families; to meet their medical, social and developmental, and behavioral needs until the household becomes stabilized in permanent housing.

YWCA Health Care Access: Benefits assistance and linkage to medical care for women and families.

Services for youth and young adults

Neighborcare Health/45th Street Clinic Homeless Youth Clinic: Medical clinic services to youth and young adults age 12-23 years.

University of Washington Adolescent Medicine Section/Country Doctor Teen Clinic: Medical clinic services to youth and young adults age 12-23 years.

Appendix C: HCHN Major Service Sites

Single Adults
Ballard Homeless Clinic (Nyer Urness)
Catholic Housing Services – CHS (St. Martin de Porres Shelter)
Chief Seattle Club
Compass Housing Alliance (Adult Service Center, Hygiene Center, Women's and Men's Programs)
Downtown Emergency Service Center (Shelter & 1811 Eastlake)
Harborview Medical Center (Third Avenue Center at YWCA Opportunity Place)
Jefferson Terrace/Edward Thomas House
Katherine's House
Markham Building
PHSKC (Robert Clewis Center, Downtown Dental)
Sound Mental Health (Housing First in South King County)
YWCA (Angeline's Day Center)

Housing Health Outreach Team (HHOT)
Canaday House (DESC)
The Gatewood (Plymouth Housing Group-PHG)
Humphrey House (PHG)
Kerner-Scott House (DESC)
The Lewiston (PHG)
The Morrison (DESC)
Noel House (CHS)
Plymouth on Stewart (PHG)
Rose of Lima (CHS)
Scargo Apartments (PHG)
Simons Apartments (PHG)
The Westlake (CHS)
The Wintonia (CHS)

Families
Avondale Park
Broadview Shelter
Catherine Booth House (Salvation Army)
Domestic Abuse Women's Network
Eastside Domestic Violence Program

Hopelink sites
New Beginnings
Sacred Heart Shelter
South King County Multi-Service Center sites
Union Gospel Mission Hope Place
YWCA The Willows
YWCA family sites countywide

Youth and young adults
45th Street Youth Clinic (Neighborcare Health)
Country Doctor Teen Clinic (through UW Adolescent Medicine Clinic)

Certain visits also take place in the client's home (once housed), streets, encampments, and other sites.