Health Care for the Homeless Network

Community Health Services Division

Annual Report 2014

Public Health
Seattle & King County

Public Health
Seattle & King County

Contents

Acknowledgments

We gratefully acknowledge the following for their support in 2014:

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

HCHN Administrative Staff
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Public Health - Seattle & King County
Downtown Public Health Dental Clinic • King County Medical Examiner's Office • Robert Clewis Center • HIV/AIDS Program • South King County Mobile Medical Program • Tuberculosis Control Program • Public Health Reserve Corps • Access and Outreach • Kids Plus

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 • Seattle Housing Authority • Swedish Medical Center • Evergreen Hospital • United Health Plan of Washington

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

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

City of Seattle

United Way
United Way of King County

U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration

Overview

Health Care for the Homeless Network (HCHN) provides quality, comprehensive health care for people experiencing homelessness in King County. In 2014, HCHN providers delivered care to 18,804 individuals: single adults, individual members of homeless families, and unaccompanied youth and young adults. These individuals received a total of 104,645 visits at clinic and community-based service sites, including outdoor sleeping locations.

HCHN services are tailored to address the numerous obstacles to maintaining good health and addressing chronic physical and behavioral health conditions faced by people experiencing homelessness. We employ a variety of evidence-based and patient-centered strategies to improve outcomes, not only related to health but also to housing and other social services. Broadly, these strategies include:

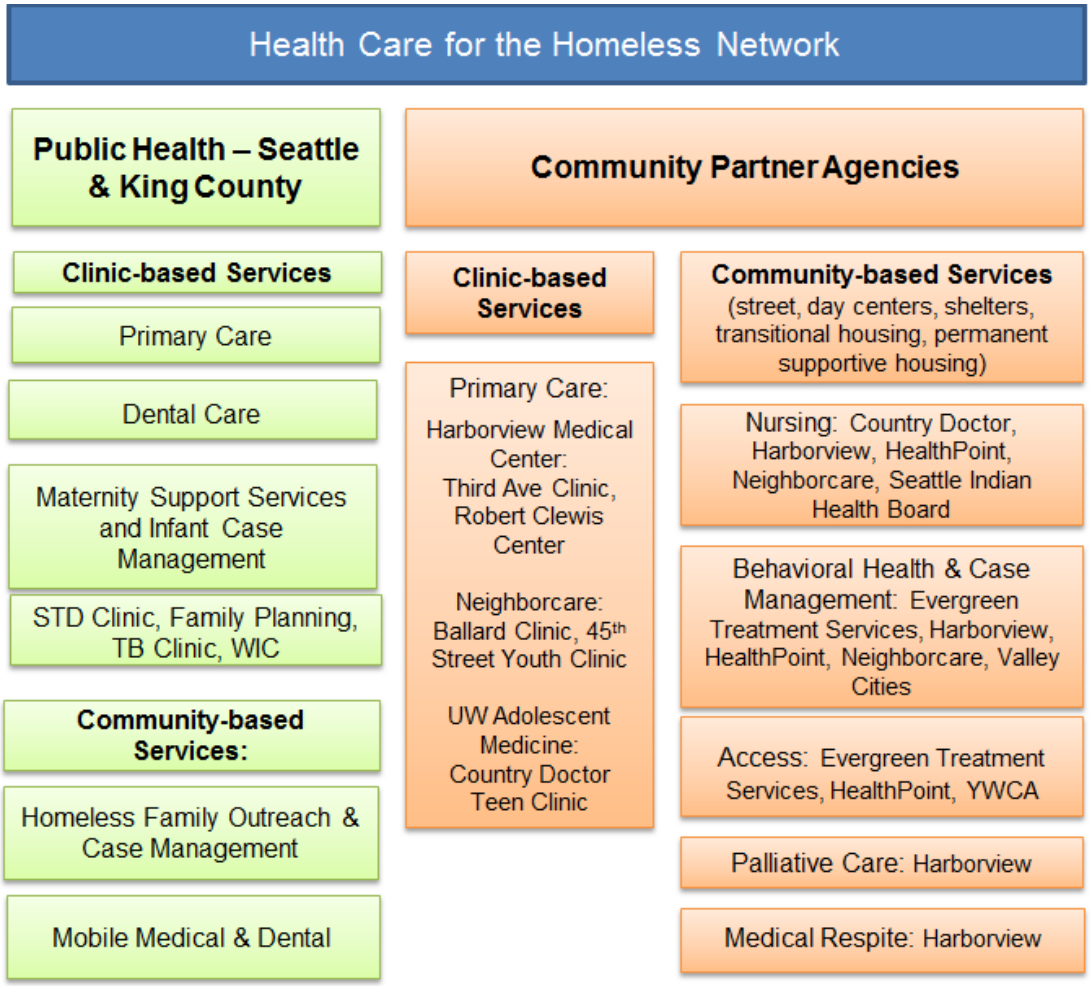
- Integration of physical health, behavioral health, housing, and social services
- Specialized and far-reaching outreach, engagement, and relationship building
- Intensive and flexible case management and care/service coordination
- Mobile clinical services, including physician, dentist, nurse, behavioral health provider, and social worker
- Technical assistance and education for shelter, housing, and encampment operators related to tuberculosis and other disease prevention

The HCHN administrative team is part of Public Health - Seattle & King County's Community Health Services division. HCHN providers are either directly employed by Public Health or contracted through our community partner agencies including Country Doctor Community Clinic, Evergreen Treatment Services, Harborview Medical Center, HealthPoint, Neighborcare Health, Seattle Indian Health Board, University of Washington Adolescent Medicine, Valley Cities Counseling & Consultation, and the YWCA of Seattle | King | Snohomish.

HCHN's service delivery model combines clinic-based and community-based services. Clinic services are provided at Seattle & King County Public Health Centers, Neighborcare's Ballard and 45th Street Clinics, Teen Clinic at Country Doctor, and Harborview Medical Center's Third Avenue Clinic and Robert Clewis Center. Community-based services meet patients where they spend time: on the streets, in encampments, in homeless shelters, day centers, meal sites, and within transitional housing and supportive housing buildings.

Throughout this report, the two main nodes of the Health Care for the Homeless Network are described as either the "Public Health" or "community partner agencies." The distinction between the two parts of the service model are important because the majority of Public Health homeless services occur in fixed site clinics, whereas community partner agencies serve a much higher percentage of their patients at community-based sites (see 'Service Delivery Model' on page 5). These different service modalities result in differences in the populations served; the tables included in this report illustrate some of the key differences.

Service Delivery Model



Noteworthy Events in 2014

Service Area Competition Renewal

Public Health – Seattle & King County, as a 330(h) grantee under the federal Health Care for the Homeless Program, was awarded a renewal of its Health and Resources Services Administration (HRSA) funding for the three-year project period November 1, 2014 to October 31, 2017, with an annual grant award of $3,095,628. This grant renewal enables HCHN to continue providing comprehensive health care services to people experiencing homelessness throughout King County. Services include primary care, dental, nursing, perinatal services, mental health and substance abuse services, outreach, Medicaid eligibility counselors, case management, and a 34-bed medical respite program. Services are provided at 27 regular sites and more than 60 occasional sites.

HCHN projects that PHSKC providers and contracted community partner agencies together will provide approximately 103,930 visits to 19,800 unduplicated patients annually within the 3-year project period. In addition to these direct patient services, federal grant dollars also support HCHN's technical assistance to agencies serving individuals experiencing homelessness to enhance their ability to ensure a healthy and safe environment for their clients.

Kids Plus Grant from Building Changes

In 2014, HCHN applied for (and was awarded in March of 2015) a two-year grant from Building Changes to extend supportive services to families who need additional case management beyond the time limit related to HUD funding. These funds will allow the Kids Plus Program to provide the needed physical and behavioral health services for the duration of time and with the intensity of services that each individual family needs.

Since 1996, the Kids Plus Program, formerly known as Pathways Home, has been meeting the needs of homeless children and their families whose health issues present a barrier to housing and stability. The program's team of public health nurses and social workers provide outreach to homeless families living on the street and in encampments, cars and emergency shelters. The team then links the families to needed services and resources and provides intensive case management that follows the family from the street and emergency shelters to permanent housing.

Palliative Care Expansion Grant

In September of 2014, the Health Resources and Services Administration (HRSA) awarded an Expanded Services (ESG) grant to PHSKC for HCHN to expand medical capacity to support palliative care services for homeless adults. Homeless people have high mortality rates and tend to die at a significantly younger age than the general population. As their chronic conditions worsen, they often must grapple with acute and debilitating symptoms in isolation from health care providers, family, and social supports. The new grant supports the work of Harborview Medical Center's (HMC) newly formed homeless palliative care team, which works with people who have a life limiting disease and are currently experiencing homelessness or are formerly homeless and now living in transitional or supportive housing. The palliative care team is able to bring end of life care to homeless patients where they are staying and can enhance care coordination services already in place. It consists of a nurse and an Advanced Registered Nurse Practitioner (ARNP), both of whom work with patients to improve quality of life and reduce suffering for those dealing with a serious, life threatening illness.

Noteworthy Events in 2014 (continued)

The team accepts referrals from any healthcare provider or case manager in King County, prioritizing those living on the streets and in the shelters of downtown Seattle. The team is sited in the Third Avenue Clinic in downtown Seattle, but is also using a community outreach model of care for the targeted group of complex clients. Through the first quarter of 2015, the primary diagnosis seen by the team is cancer, and the majority (80%) of clients are male.

Patient Story: *Palliative Care*

Susanna, a 63-year-old female patient of the palliative care team, has a 30 year history of homelessness. While homeless, she typically slept outdoors in downtown Seattle or spent nights in a shelter when feeling ill. She has had multiple hospitalizations for pneumonia and chronic obstructive pulmonary disorder (COPD) exacerbations, smokes crack cocaine intermittently, and has smoked cigarettes since the age of nine. This past winter, Susanna went to the HMC emergency department with a persistent cough and was admitted to HMC and diagnosed with lung cancer. She remained in the hospital for an extensive work up and was referred to the palliative care team to complete an intake assessment while she was still in hospital care. It was very hard for Susanna to accept her cancer diagnosis and she chose to leave the hospital against medical advice (AMA) and return to the streets. The team was able to contact a case manager who has a long-term, good relationship with Susanna who assisted the team to re-connect with her. Having her trusted case manager involved at this difficult time helped to increase rapport with the team.

Still resistant to accepting her diagnosis, still sleeping outside, Susanna continued to meet regularly with the palliative care team. One month after leaving AMA from HMC, she was admitted to Swedish Medical Center. The team was quickly notified of her admission and continued to meet with her daily throughout the duration of her stay. Susanna began to acknowledge her cancer diagnosis, but refused follow up with an oncologist or discharge to a community setting. She returned to the streets for four days, after which time she returned to the Swedish Emergency Room (ER) due to increased levels of pain. The team met with Susanna to discuss her goals, her disease process, and her preferences on how to move forward with her care. Susanna was able to acknowledge her need for a higher level of care and was successfully referred to an assisted living facility. With the assistance of the team, the transition to the facility went well. Susanna continues to regularly meet with the team and maintains an ongoing relationship with her long-term case manager.

Health Care for the Homeless Network Financial Summary

Health Care for the Homeless Network is supported by a combination of federal and local funding sources. Charts 1 and 2 summarize HCHN expenses and revenue.

Chart 1: HCHN 2014 Expenditures, $9.9 million[1]

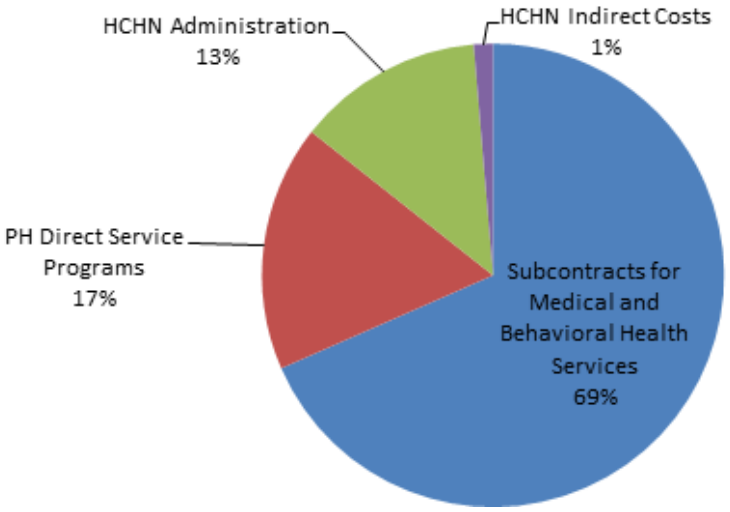
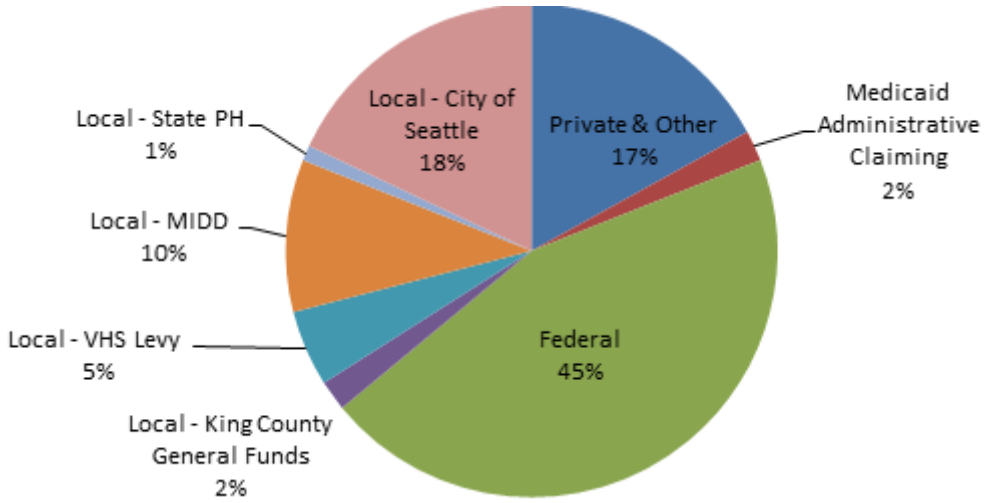


Chart 2: HCHN 2014 Revenues, $9.9 million

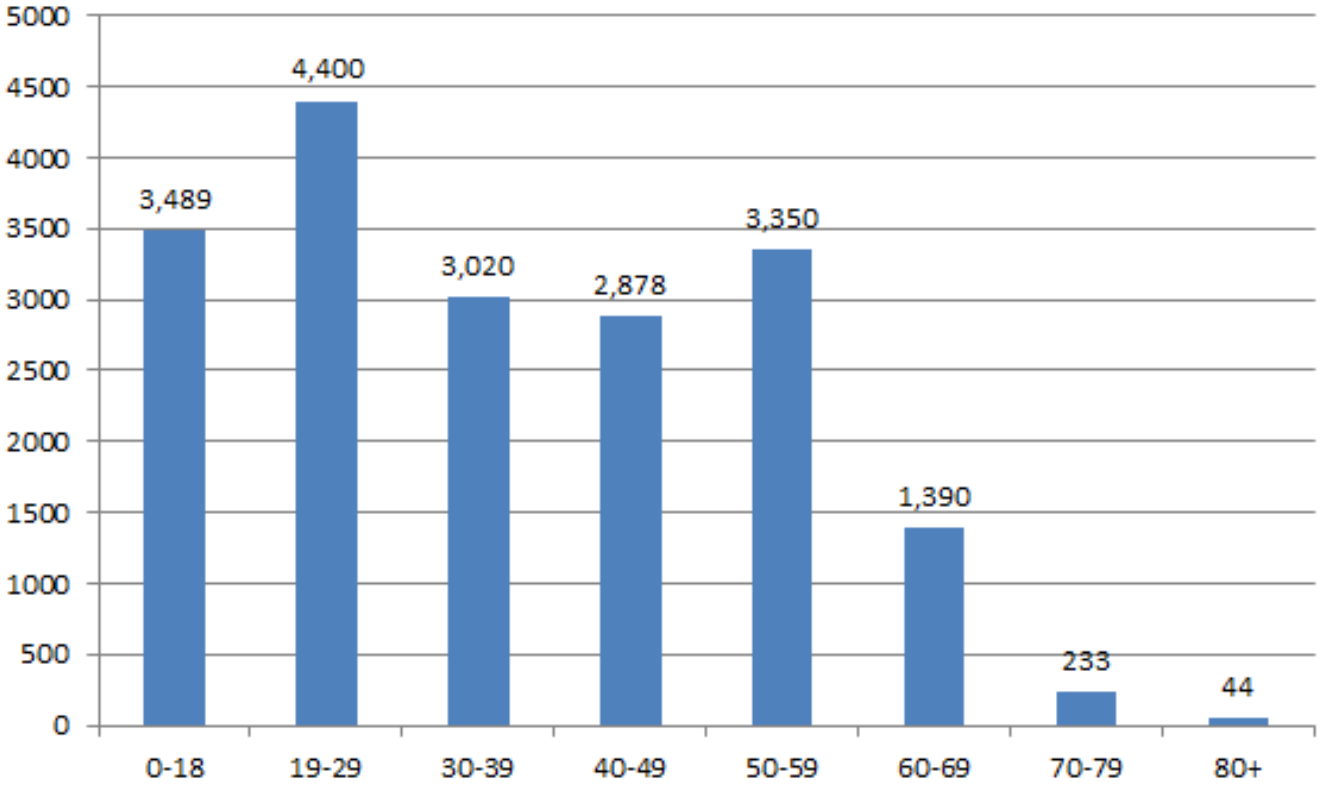


[1] Includes HCHN administration, subcontracts, and the following direct service programs operated by Public Health: Dental, Kids Plus, Mobile Medical.

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, community partner agencies submit data collected during patient visits. At the close of each calendar year, a dataset containing Public Health homeless patient data is created and merged with community partner agency patient data to produce the Uniform Data System (UDS) report, a requirement of HRSA 330(h) funding. The data in the following charts are created from the dataset used to produce the 2014 UDS report, which documented HCHN's 104,645 UDS-eligible visits to 18,804 unduplicated homeless patients.

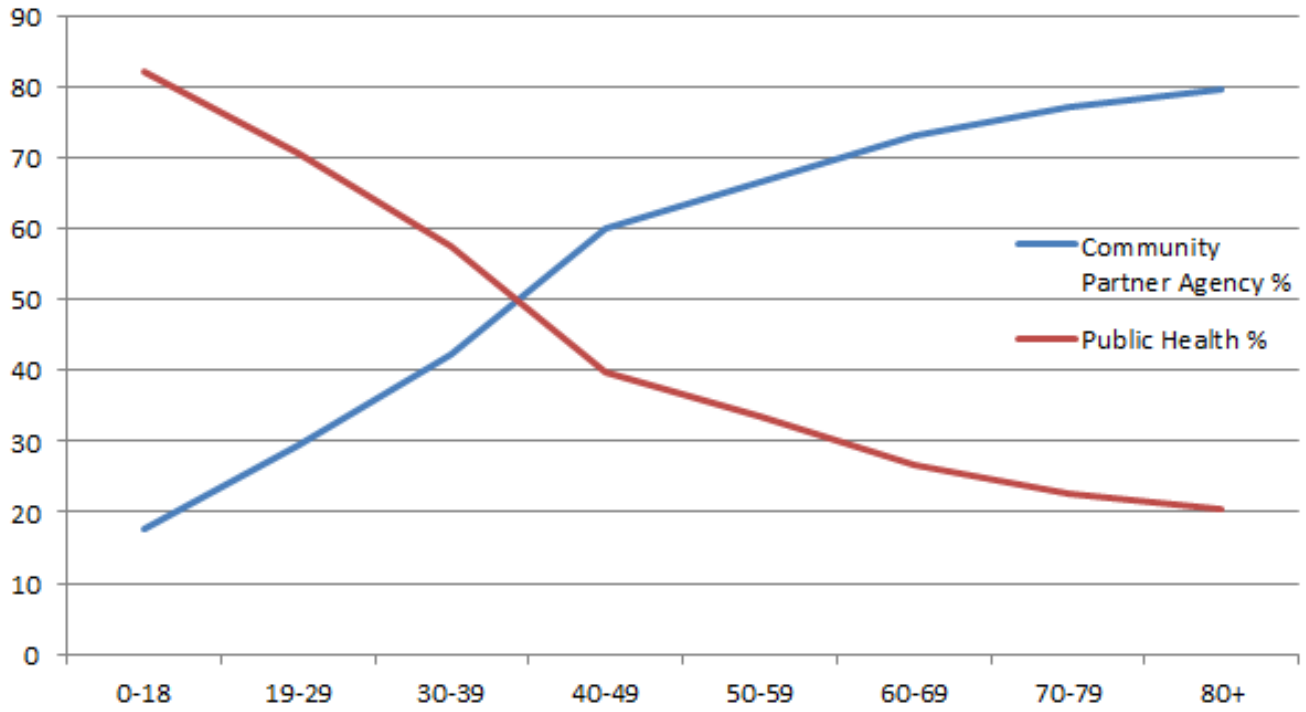
Chart 3: HCHN patient population by age group



Health Care for the Homeless Network Data Summary (continued)

HCHN's patient population reflects the fact that homelessness may be experienced throughout the lifespan: 58 percent of patients seen within HCHN are under 40 years of age, 42 percent are 40 years and older. Chart 3 shows the distribution of HCHN patients by age group, and Chart 4 shows the percentage of HCHN patients by age group and provider affiliation.

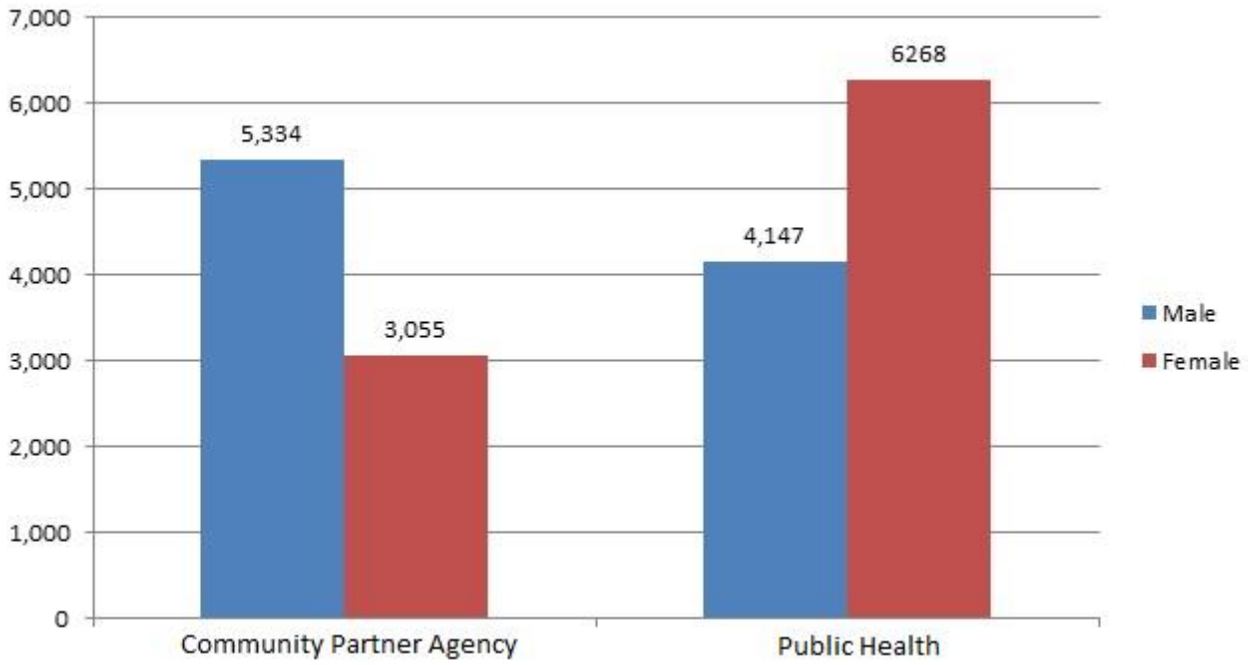
Chart 4: Percentage of HCHN patient population by age group and provider affiliation



The comparison of the age of HCHN patients served by Public Health programs with those served by community partner agency programs depicted in Chart 4 shows two distinct age profiles. Public Health programs - clinics, Parent-Child Health, and Maternity Support Services - deliver services to 71 percent of HCHN patients under 40, with the community partner agency programs providing care to the remaining 29 percent. The primary care, community-based nursing, mental health care, chemical dependency services, outreach, access, and respite care services provided by community partner agencies account for 66 percent of patients who are 40 years of age or older, while Public Health programs account for only 34 percent.

Health Care for the Homeless Network Data Summary (continued)

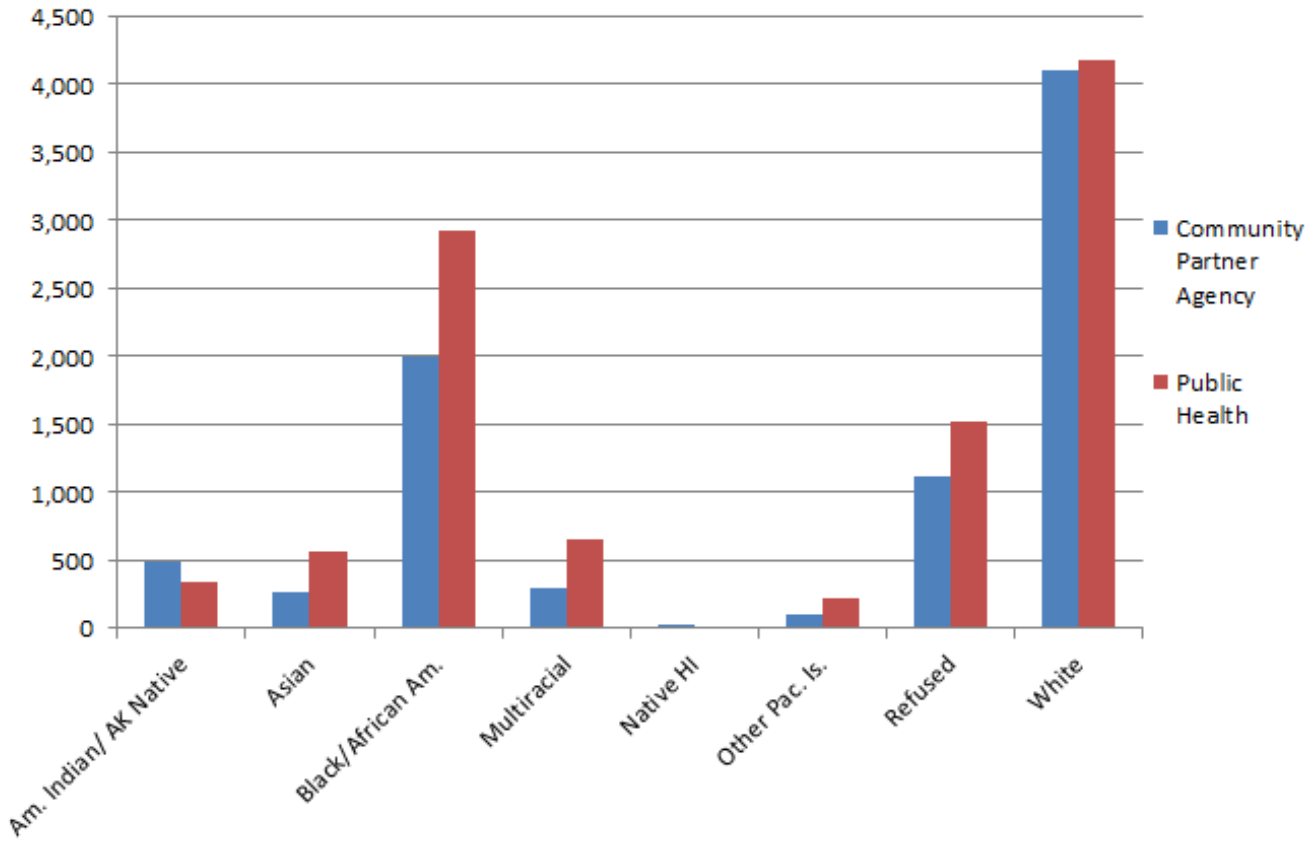
Chart 5: HCHN patient population by gender and provider affiliation



With Public Health services concentrated in the under 40 age group and many of those services being delivered through Maternal Support Services, it is not unexpected that Public Health saw 67 percent of all female patients in 2014. Chart 5 reflects the gender distribution between Community Partner Agency patients and Public Health patients.

Health Care for the Homeless Network Data Summary (continued)

Chart 6: HCHN patient population by race



Nationally, the population experiencing homelessness, as measured by those utilizing homeless services, at any given time has a disproportionately high percentage of people of color when compared to the general population, and that disproportionality is also seen in King County. For example, African Americans comprise 6.6 percent of King County's overall population[2], but represent 27 percent of the individuals staying in homeless shelters in King County. American Indian/Alaska Natives make up 1.1 percent of the King County population overall, but represent 4 percent of individuals staying in homeless shelters[3]. Chart 6 shows the breakdown of HCHN patients by racial group. Not shown on chart but of note: 16 percent of patients are of Hispanic descent, and in the overall King County population, 9.3 percent of all residents are Hispanic

[2]U.S. Census Bureau: State and County QuickFacts. Last Revised: Tuesday, 31-Mar-2015 18:01:23 EDT. Accessed 5/4/15. http://quickfacts.census.gov/qfd/states/53/53033.html

[3]Annual Homeless Assessment Report (10/1/2012 – 9/30/2013). Accessed 5/4/15. http://safeharbors.org/reportsALL.htm

Health Care for the Homeless Network Data Summary (continued)

Chart 7: HCHN visits by type and provider affiliation

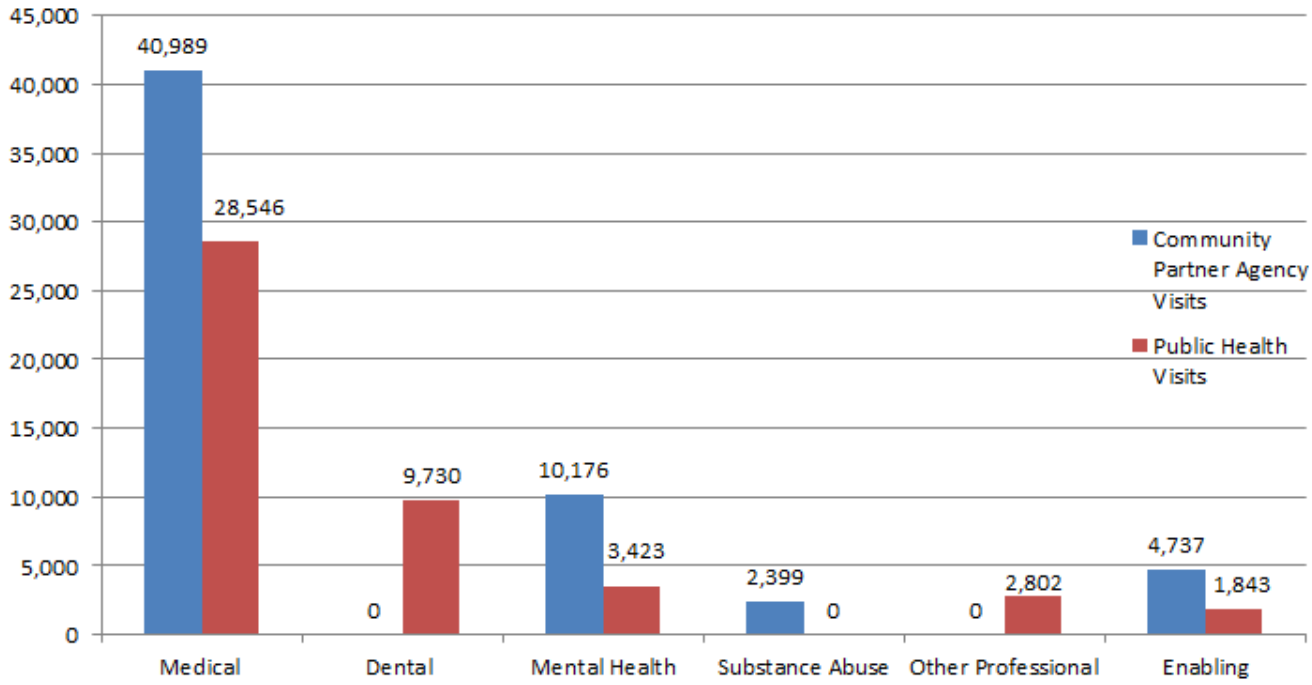


Chart 7 reflects HCHN visits by type. Medical services include the work of doctors, physician assistants, nurse practitioners, and nurses. Mental health services include the work of psychiatrists, licensed clinical psychologists, licensed clinical social workers, other licensed mental health providers and other mental health staff. Substance abuse services include a variety of chemical dependency specialists. Other professional services include the work of occupational and physical therapists, dieticians, nutritionists, podiatrists, naturopaths, chiropractors, acupuncturists, and community health aides and practitioners. Enabling services include case managers, outreach workers and eligibility assistance workers.

Health Care for the Homeless Network Data Summary (continued)

Chart 8: HCHN patient homeless status distribution by provider affiliation

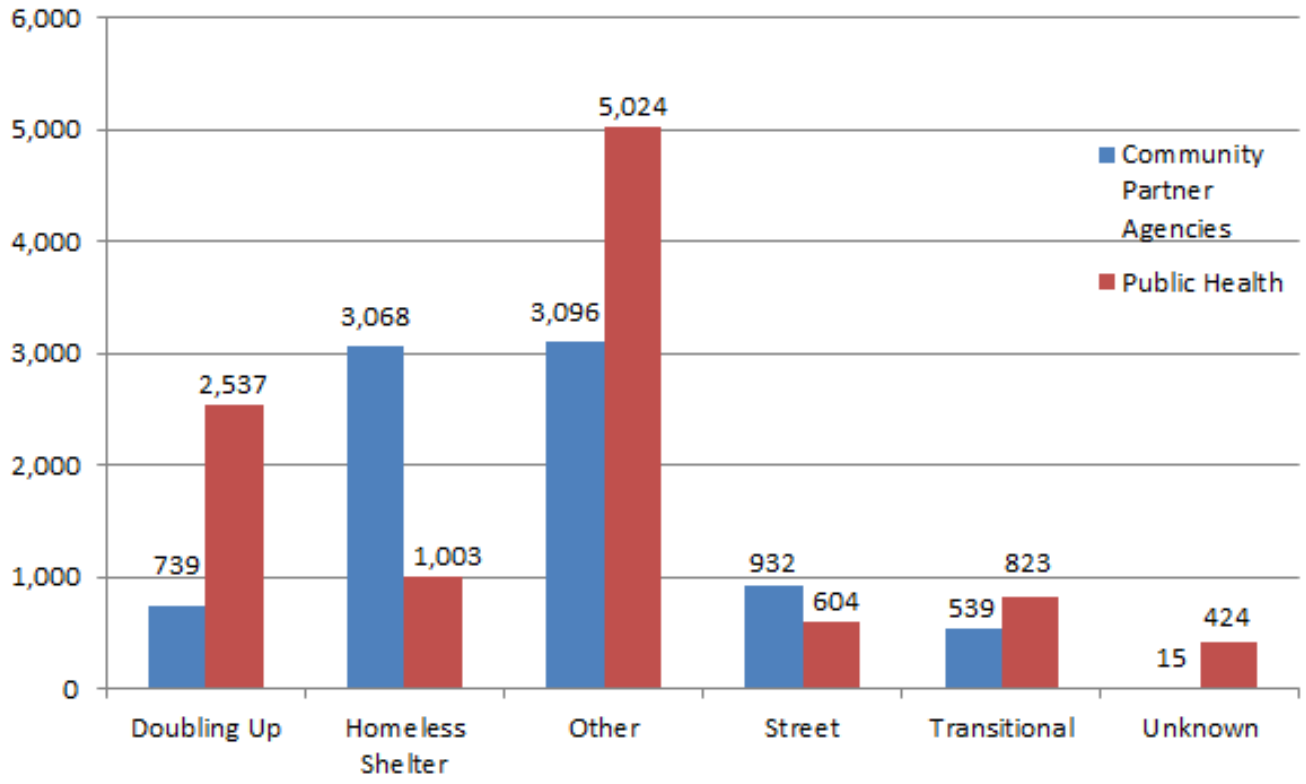


Chart 8 reflects the housing status of each patient as reported on their first visit of the year. HCHN collects living situation history by asking patients at every encounter where they slept the previous night. Over the course of a year, a single individual may report sleeping outdoors, doubled up with 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. The static representation in Chart 8 does not represent the variability in sleeping locations that many homeless patients experience over the course of a year. Please note that the "Other" category is used to report previously homeless patients who were housed in the 12 months prior to being first seen but who were still eligible for services, as well as those whose housing is paid day-to-day (such as single room occupancy hotels or motels paid for via a subsidy).

Health Care for the Homeless Network Data Summary (continued)

Chart 9: HCHN patient medical coverage by category, 2013

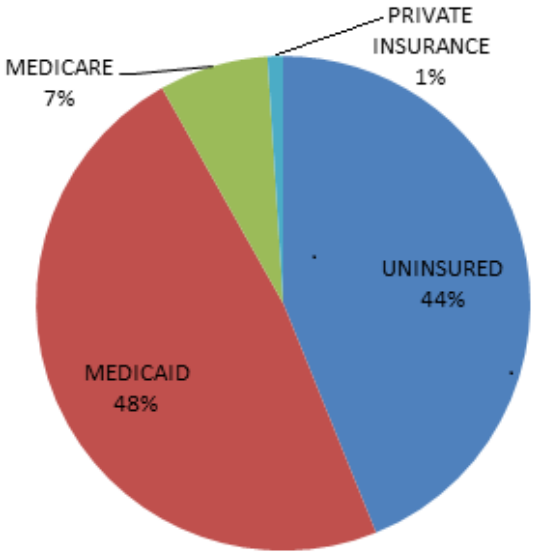
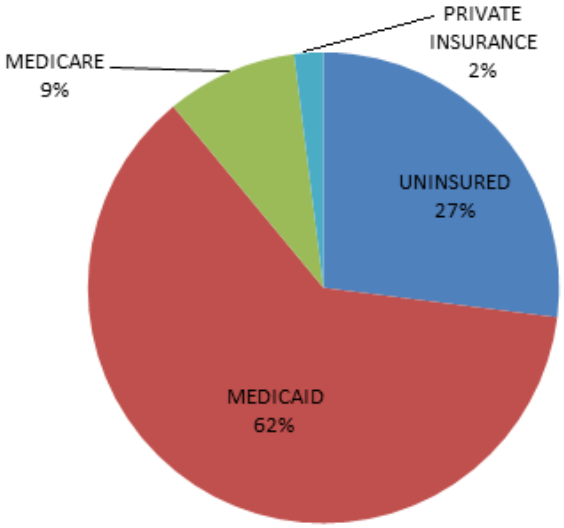


Chart 10: HCHN patient medical coverage by category, 2014



Charts 9 and 10 represent the mix of health care coverage types that HCHN patients reported in 2013 and 2014. King County has been a national leader in Affordable Care Act enrollment activities, enrolling 165,000 people in health insurance in its first six month period. The percentage of uninsured patients seen by HCHN providers dropped dramatically with the Affordable Care Act—from 44 percent uninsured in 2013 to 27 percent uninsured in 2014. Related data show that the number of HCHN patients covered by Medicaid grew from 48 percent of all patients in 2013 to 62 percent of all patients in 2014.

The support of a diverse mix of funding sources remains crucial to the provision of homeless health services, despite the implementation of the Affordable Care Act and rise in the number of homeless patients that are insured. Even when Medicaid billing revenue increases for HCHN providers, it often covers a relatively small portion of the costs of providing the highly specialized and patient-centered care that HCHN funding supports.

Appendix A: Planning Council Members 2014

Heidi Albritton, City of Seattle Human Services Department

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., Community Advocate

Sinan Demirel, Consultant

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

Gregory Francis, Community Advocate, Co-chair

Megan Gibbard, Homeless Youth and Young Adult Initiative Project Manager

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

Kate Speltz, Housing Planner, King County Department of Community and Human Services

Appendix B: 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.

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 Health Care Access: 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 living homeless gather.

Public Health TB Control Program: Engagement and Case Management for homeless adults receiving TB treatment with the goal of finding and maintaining 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: 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, Hammond House, Hygiene Center, Women's and Men's Programs, Peter's Place)
Congregations for the Homeless
Downtown Emergency Service Center — DESC (Shelter & 1811 Eastlake)
Elizabeth Gregory Home
Harborview Medical Center (Third Avenue Center at YWCA Opportunity Place)
Jefferson Terrace/Edward Thomas House
Jubilee Women's Center
Katherine's House
Markham Building
PHSKC (Robert Clewis Center, Downtown Dental, Dutch Shisler Sobering Support Center)
Sound Mental Health (Housing First in South King County)
Sophia's Place Day Center
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

Broadview (Emergency Shelter and Transitional Housing)
Catherine Booth House (Salvation Army)
Carolyn Downs Family Medical Center
Domestic Abuse Women's Network
KentHope
Lifewire
Hopelink sites
Mary's Place
New Beginnings Shelter
Sacred Heart Shelter
Multi-Service Center sites
Union Gospel Mission Hope Place
Women's Wellness Center
YWCA family shelter and housing 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.