Care Transitions from the Streets to Housing

Pia Valvassori PhD, ARNP
Health Care Center for the Homeless, Orlando FL

Catherine Crosland, MD
Unity Health Care, Washington DC

Permanent Supportive Housing

- Combination of affordable housing with supportive services for most complex chronically homeless
- Components: Affordable, permanent, independent, low barrier, tenant-driven
- Partnership with housing and health care critical to retention

Rationale

- Minimize high utilizers of public system expense: hospitalizations, incarcerations, emergency shelters
- Enhance housing stability and quality of life
- Avoid crisis service use
- Increase access to primary and behavioral health services

Time line in Orlando

- 2013 Orlando voted worst area for homelessness in midsize metro area
- 2013-2014 inordinate number die while waiting for housing, increased media attention to crisis
- Central Florida commission on homeless formed bring business and community leaders together
- Study conducted with local partners demonstrating that the cost of one chronic homelessness individual exceeded $31,000 annually
- Stake holders pledging funds including city of Orlando, large hospital system, and other large businesses including Disney and Universal

PSH Team

- Multidisciplinary team:
- Case management ratio 1:17-1:20
- Peer support specialists
- Housing Locator
- SOAR specialist
- Outreach
- Primary Care
- Behavioral Health

Approach

- Outreach workers encounter and engage chronically homeless
- VI-SPDAT conducted to access vulnerability
- If scoring above threshold placed on coordinated entry prioritization list with local COC
- HMIS data, health center data, police arrests and incarcerations all considered
- Client works with housing locator and assigned case manager to identify housing
- Client paired with peer support specialist and SOAR specialist
- Client scheduled for evaluation with PCP and BH if necessary

Challenges

- Ongoing training for staff
- Cultivation of ongoing funding streams/current funding streams fragmented
- Sharing of information, HMIS, EHR, Hospital systems
- Enhanced funding streams for supportive services through Medicaid
- Reimbursement for BH services
- Lack of inventory-few landlords willing to share quality units
- Lack of funds to hire grants manager to continue to cultivate new stakeholders and manage varying sources of funds

Challenges

- Facilitation of discharges from acute care to housing or respite/ need for hospital navigator services
- Earlier client engagement with case managers, PCP and BH to enhance outcomes
- Need for care coordination
- Interdisciplinary visits
- Wet ALF/in patient psych beds

Evaluation/metrics

- Preliminary data from one of the hospital systems demonstrating a reduction in ER use and reduced length of hospitalizations resulting in substantial cost savings when assessing data 2 years before housed and 2 years after being housed
- Satisfaction survey: mail in, email and phone
- 150 distributed: 42 responded, all housed for a minimum of 6 months
- Survey addressed challenges and how program could be improved:
  - 90% like their home
  - 66% satisfied with housing options
  - 73% stated case managers encourage them and help them achieve goals

Consumer survey

- Hardest thing about being housed:
  - Being bored 40%,
  - Feeling lonely 33%,
  - Lack of familiarity with activities in community 24%,
  - Cleaning and maintaining a home hard 15%

Implications of Nonexpansion of Medicaid

- Florida Medicaid waiver and pilot will provide BH and housing services
  - Waiver will sustain funds initially provided by local governments
  - Use of Medicaid funds for approximately half of those chronically homeless who are insured
- Many uninsured and disabled upon entering PSH
  - SOAR specialist engaged in cases
  - Reason for denials: lack of evidence/documentation, non-adherent, unable to follow treatment plan, unable to contact

Covered services with waiver include:

- Housing transition services
- Tenancy –sustaining services
- Intensive on site intervention to individuals experiencing BH crisis
- Peer support services

Case 1

- 56M with h/o AS s/p AVR (coordinated completely through street outreach), ETOH with ataxia and unsteady gait, HTN
- Lived on sidewalk in Foggy Bottom neighborhood
- Received Permanent Supportive Housing 3/2018
- Lost communication with him because no longer on the street outreach path where we saw him weekly
- Never came to clinic
- Learned through the grapevine, he was found dead in his apartment four months after getting into housing.

Case 2

- 73M w well controlled DM on glipizide alone (metformin caused GI distress), lived outside in Georgetown area and encountered frequently during street medicine rounds.
- Housed and lost contact.
- 1 year later, presented to clinic with large abscess L groin and ulcer L anterior shin, FS 450 and A1c >12 no longer taking medication or following up with any medical provider.
- With frequent follow-up, oral antibiotics and daily dressing changes in our clinic, his abscess and ulcer healed.
- After restarting glipizide, his A1c returned to 7.5.

Housing Process – Washington DC

- 2013 - Coordinated Assessment and Housing Placement (CAHP) System
  - "No wrong door" approach
  - Previously folks applied to waiting lists across the city
- VISPDAT/Full SPDAT built into HMIS to assess vulnerability
- Prioritize vulnerable folks for Permanent Supportive Housing or Targeted Affordable Housing
- CAHP meetings twice a month to review the HMIS "by name" list of people with highest scores
  - Drop off list if no "hits" in HMIS in past 30 days
- People get Matched to Housing

Housing Process Continued

- Matched to PSH Team
- PSH Team – described above
- Housing case manager assists with documentation to get person leased up
- Case manager visit twice a month to assist with housing related activities such as paying rent, utilities etc, grocery shopping, etc.

Shortcomings

- Medical/mental health providers are not part of the process
  - Most outreach workers in the room are connected to a PSH provider but not a medical or mental health provider
  - Difficult for non-medical folks to make determination of capacity for level of care needed (ie TAH vs PSH)
- Once matched to PSH, the case management does not explicitly include medical or mental health case management

Solutions

- FQHCs partner with CoC to be part of process
- Have medical respresentation during the matching process
  - Case Conferencing with local CoC
- Develop protocols to ensure that when someone gets matched to housing, the person's medical and mental health providers are notified and able to contact that person's case manager
- Medical home visit/assessment within first 30 days of getting housed
  - Possible to be in clinic depending on person's ability/level of need

Goals of Home Visit

- Assess Level of Need
  - ie Home Health Aide → start referral process
- Assess Need for durable medical equipment
  - ie bathrooom grab bars, shower stools, etc
- Medication – optimizing adherence
  - Medication Delivery options
  - Medication Storage
  - Medication Schedule
- Transportation
  - To and from medical/mental health appointments from new location

Challenges

- Notifying medical and mental health providers
  - Who does PSH rep contact and how to make it streamlined and not too time consuming
  - Suggestion: Dedicated email for each FQHC or CSA in DC: housingmatch@unityhealthcare.org
- Paying for medical home visit
  - MD, NP, RN, LPN?
  - Who employs this provider?
    - Each FQHC assigned to the patient?
    - Centralized organization that employs the RNs who assess patients citywide for Home Health Aide eligibility?

Case 1

- 56M with h/o AS s/p AVR (coordinated completely through street outreach), ETOH with ataxia and unsteady gait, HTN
- Gets matched to housing.
- Primary care doctor notified. Referral for home health aide.
- Home visit within 1st 30 days, gets grab bars, shower seat due to ataxia
- Assistance from home health aide with medication as well as cooking, cleaning
- HHA accompanies him to appts with PMD as well as cardiologist

Case 2

- 73M w well controlled DM on glipizide alone (metformin caused GI distress), lived outside in Georgetown area and encountered frequently during street medicine rounds.
- Matched to Housing.
- Primary Care Provider Notified.
- Home Visit completed. Coordination of transportation to and from PMD through medical insurance. Medication home delivery set up.
- Appt made with PMD. Pt keeps appt and maintains regular q3 month care for his well controlled DM.

Discussion