Health Care for the Homeless Network

Community Health Services Division

2009 Annual Report

Public Health
Seattle & King County

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A. Introduction

The Health Care for the Homeless Network (HCHN) completed its 24th year of health service coordination in 2009 for people living homeless and in supportive housing throughout Seattle and King County. HCHN is pleased to provide this report highlighting our work in 2009.

HCHN Mission:

To provide quality, comprehensive health care for people experiencing homelessness in King County and to provide leadership to help change the conditions which deprive our neighbors of home and health.

HCHN continued to align activities with the *Ten-Year Plan to End Homelessness in King County* and the *United Way Blueprint to End Chronic Homelessness*. These key initiatives influenced the implementation of a more collaborative and systematic approach to addressing homelessness.

Background

HCHN is organized through contracts with community-based agencies, such as community health centers, to provide services to homeless and formerly homeless individuals. HCHN providers are currently located in over 40 sites throughout King County, primarily shelter settings (see Appendix A). These partnerships make up the core of the network. HCHN also encompasses the medical, dental, and case management services provided to homeless people throughout Public Health - Seattle & King County's health centers and programs.

Homeless people are more likely than housed people to use the emergency department as their regular source of care.[1] Due to their lack of insurance coverage and other barriers, homeless people are also far less likely to access regular preventive care and cancer screenings, such as Pap tests and mammograms, than those who have coverage. By providing field-based services, HCHN-funded providers help connect homeless individuals into mainstream services, and often provide those services directly as they work to counter barriers to accessing care.

HCHN supports the right to quality health care for all people, with particular emphasis on access to all aspects of health care for people living in poverty and experiencing isolation and displacement.[2] Staff and programs recognize the importance of providing integrated care through interdisciplinary treatment teams that coordinate primary medical and dental care, access to a health care home, mental health treatment and substance use treatment, affordable housing, food programs, family and community support, and benefits and entitlements.

1 Homelessness and Health: The Effect of the Course of Homelessness on Health Status and Health Care Use, American Journal of Public Health, March 2007, Vol. 97, No. 3.

2 HCHN Philosophy of Care. Available at: http://www.kingcounty.gov/health/hch

Priority Actions

In 2008, HCHN worked with its 18-member community-based advisory Planning Council (see Acknowledgements) and other stakeholders to gather input for a needs assessment from individuals impacted by HCHN services, those not accessing services, and front line providers.

The results of the needs assessment led to the subsequent adoption of the following priority actions for 2009-2014:

1. Ensure the application of evidence based practices that promote human dignity, empower participants, and improve health outcomes.

2. Continue to provide services “where people are” including day centers, shelters, streets, and supportive housing, working to improve access all geographic areas of King County where people are experiencing homelessness.

3. Assure the provision of services that address the increasing acuity and complexity of health care problems.

4. Address the need for increased access to information about health care resources and to health care coverage.

5. Expand our awareness and focus on trauma informed care in recognition and response to the high prevalence of cognitive and emotional impairments in the homeless population.

6. Continue to align investment strategies with those of the *Ten-Year Plan to End Homelessness in King County* including alignment with the goal of the housing first / supportive housing model to increase housing stability for persons with histories of chronic homelessness.

B. 2009 Accomplishments

Enhanced Nursing Services in Supportive Housing

The Housing Health Outreach Team (HHOT) provided 912 nursing visits to 78 clients and linked 46 clients to primary care at Catholic Housing Services' Wintonia building. United Way funded the increased nursing services to support the growing number of Sobering Center frequent users placed in the building. *Neighborcare Health*

Established an Interdisciplinary Street Outreach Team

With funding support from the City of Seattle and United Way, the new REACH outreach team moved 36 clients, found living outdoors, to permanent or transitional housing. Almost 1,200 service encounters were provided to 170 people in 2009. *Neighborcare Health, Evergreen Treatment Services and Pioneer Square Clinic*

Expanded Case Management Services to Chemically Dependent Individuals

The REACH team enrolled 185 chemically dependent, chronically homeless clients into case management, moved 95 clients into permanent housing and 53 into transitional housing, linked 93 people to inpatient CD treatment and helped 138 people access primary care. *Evergreen Treatment Services*

Increased Mental Health Outreach Services

Mental health providers served 435 people in downtown Seattle, south King County and east King County, funded through Mental Illness and Drug Dependency (MIDD) sales tax revenue, with an emphasis on people leaving jails and other institutions. *Valley Cities Counseling and Consultation and Harborview Medical Center/Pioneer Square Clinic*

Coordinated Emergency Response for People Living Homeless

In response to the novel H1N1 influenza and the flood threats posed by Howard Hanson Dam, HCHN developed a homeless response plan in preparation for both emergencies. HCHN convened a stakeholder group of funders, government and health care agencies, and advocates to guide the planning process.

Implemented Two Federal ARRA Grants

Public Health received two federal ARRA (American Recovery and Reinvestment Act) grants to increase primary care and social work, support a site renovation for an expansion of Medical Respite, create new exam rooms in a Public Health Center, purchase medical and dental equipment, and help plan for electronic medical records in Public Health.

In 2009 Health Care for the Homeless Network (HCHN) continued to align activities with the *Ten-Year Plan to End Homelessness in King County* and the *United Way Blueprint to End Chronic Homelessness*.

Linked Homeless People to Systems of Care

HCHN's outreach model locates providers where homeless people spend time and coordinates access to health related services in mainstream systems.

- 2,076 people to primary care services
- 829 people to mental health services
- 490 people to chemical dependency treatment
- 2,020 people to dental services at the Downtown Public Health Dental clinic
- 2,226 households to support for Medicaid and other entitlement applications

Prevented Discharge Back to the Streets

HCHN-contracted programs target high risk, vulnerable people who are often high utilizers of hospitals, jails, and other public institutions.

Harborview's Medical Respite program, operated by the Pioneer Square Clinic at the Salvation Army's William Booth shelter and YWCA's Angeline's Center, served 331 people discharged from hospitals or clinics. They placed 81 clients into transitional or permanent housing at the completion of their respite stay.

The Tuberculosis (TB) program social worker assisted ten homeless TB patients to attain permanent housing after completing TB treatment.

Valley Cities Counseling and Consultation and Pioneer Square Clinic provided mental health services to 400 people targeting people leaving jails, hospitals and other institutions in downtown Seattle and south and east King County.

Provided Services to People Transitioning Out of Homelessness

HCHN supports community efforts to end homelessness through services that help people maintain their housing, using proven models that employ interdisciplinary teams and fostering coordination between partner agencies.

The Housing Health Outreach Team (HHOT) provided medical, mental health, and chemical dependency services to 551 residents in ten supportive housing buildings in downtown Seattle. *Neighborcare Health and Evergreen Treatment Services*

Pathways Home moved 44 families into housing. Providers continued to work with families for six months after they moved into permanent housing. *Neighborcare Health and Valley Cities Counseling and Consultation*

The REACH Case Management team moved 95 clients to permanent housing. Case management continues to help stabilize clients as long as they require support. The Street Outreach team moved 81 people out of encampments and into permanent or transitional housing or shelter. Those who required support to maintain housing were transferred to a REACH case manager.

Conducted Network-Wide Quality Improvement Activities

All HCHN contracts are expected to include homeless populations in their overall quality management activities. In addition, with support from the HCHN Planning Council, the program conducts patient and provider surveys, chart reviews, and monitors extraordinary occurrence forms related to deaths and other incidents.

HCHN family nurses updated their pediatric protocols. The protocols were presented at the National Health Care for the Homeless meeting and are now available on the National Health Care for the Homeless website: www.nhchc.org.

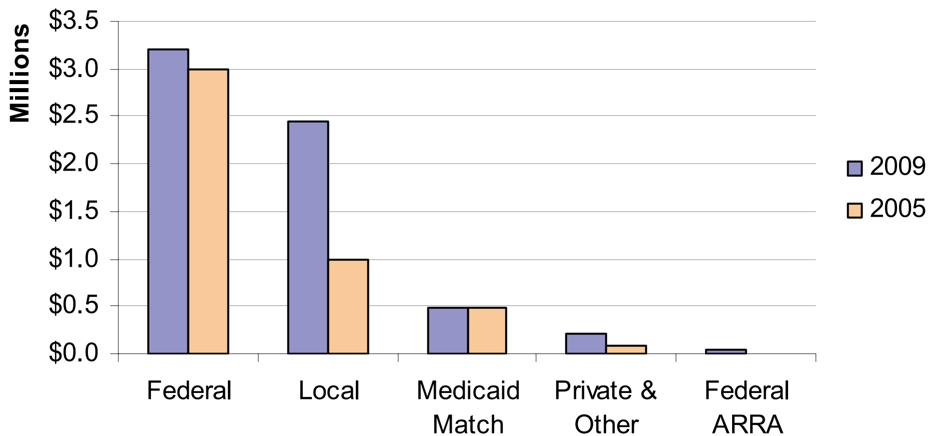
Program Planning

Informed by the 2008 Needs Assessment, HCHN conducted a competitive request for proposal / application process for the 2010-2014 grant period for contracted services. A process for decision making regarding HCHN service sites was completed at the end of 2009. Criteria were established to assess recommended changes or expansions to services as new funding sources become available.

C. Program Resources (Federal, Local, Private)

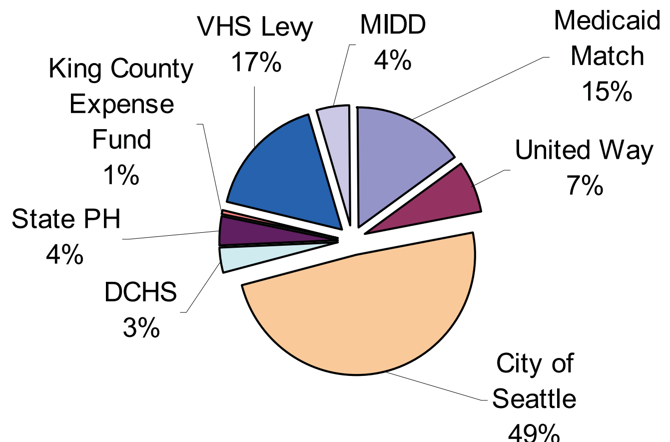
The total HCHN program budget for 2009 was $6,407,256. Federal sources comprised just over half the budget, and included the Health Care for the Homeless 330h grant from the Department of Health and Human Services (HHS), McKinney funds from Department of Housing and Urban Development (HUD), and short-term American Recovery and Reinvestment Act (ARRA) grant funds. HHS funds are spread across multiple contracts, whereas HUD funds are designated for the Pathways Home case management program for families and the Medical Respite program for adults. HHS funds are allocated according to the annual application and plan submitted to HHS-Bureau of Primary Health Care. The majority of funds were contracted to primary care clinics, mental health, and substance abuse agencies.

Chart 1
Revenue Source Comparison 2005 and 2009



Local funding to HCHN increased significantly beginning in 2007, whereas federal funds have remained fairly level. In 2009, local funds comprised 38% of the budget ($2,452,676), up from 22% in 2005 ($986,625). Local funders include the City of Seattle (HCHN's 2nd largest funder), United Way of King County, King County Veterans and Human Services (VHS) Levy, and Mental Illness Drug Dependency (MIDD) sales tax revenue. The increase in local funds has improved the ability to leverage additional Medicaid Administrative Match for eligible services.

Chart 2
HCHN Local Revenue Sources



D. 2009 Data Summary

This section highlights services provided by HCHN-contracted providers in 2009.[3] Services were provided by approximately 118 full time equivalent staff. Approximately half of the providers were medical staff, including nurses and nurse practitioners, physicians and physician assistants. The remaining providers were mental health counselors, substance abuse counselors, case managers, outreach and engagement workers, and Medicaid enrollment specialists.

Number of Clients Served and Visits Provided by HCHN

As illustrated in Chart 3, HCHN contractors provided 52,143 visits with clients in 2009, a 22% increase since 2005. Similarly, HCHN contractors served 8,830 individuals in 2009, an 8% increase since 2005.

These increases likely represent expanded HCHN services due to new local funds.

Chart 3
Total HCHN Visits 2005-09

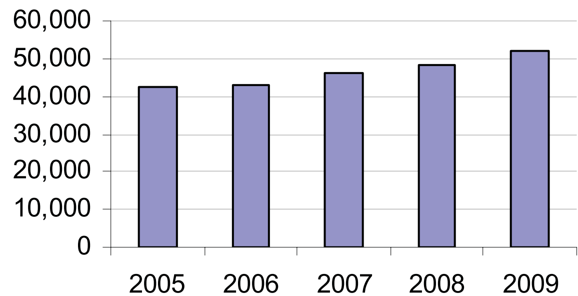
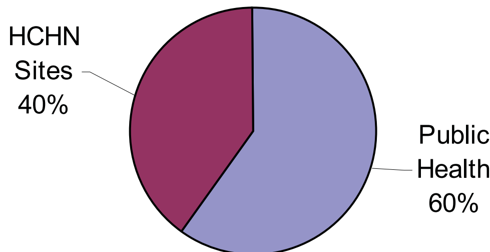


Chart 4
Clients Seen at HCHN and Public Health Sites 2009



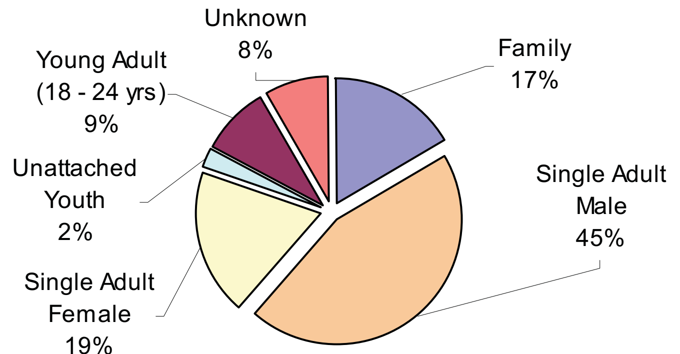
Public Health - Seattle & King County's Health Centers provided 50,646 visits to 13,076 homeless individuals in 2009, representing 60% of clients served.

Household Status of HCHN Clients

Single adult males make up the largest portion (64%) of individuals served by household type, similar to data collected by Safe Harbors Homeless Management Information System in 2008.

In total, 528 families were served representing 1,462 adults and children.

Chart 5
Household Status of HCHN Clients



3 Each time an HCHN-contracted provider sees a client a completed form is submitted to HCHN. A special client code is used across the network to unduplicate client data.

Age and Gender of HCHN Clients

As shown in Chart 6, over the past 5 years, HCHN saw a 23% increase in the number of clients age 40 and over, whereas those 39 and under have remained fairly stable.

The aging trend in the homeless population has been identified in other cities across the country.[4] Although the barriers for elderly persons who are homeless are similar to those of younger homeless persons, they may be more difficult to overcome when compounded by additional challenges associated with aging, such as chronic medical conditions, frailty, poor mobility, and loss of hearing or eyesight.

Chart 6
Increase in Older Clients, HCHN 2005-09

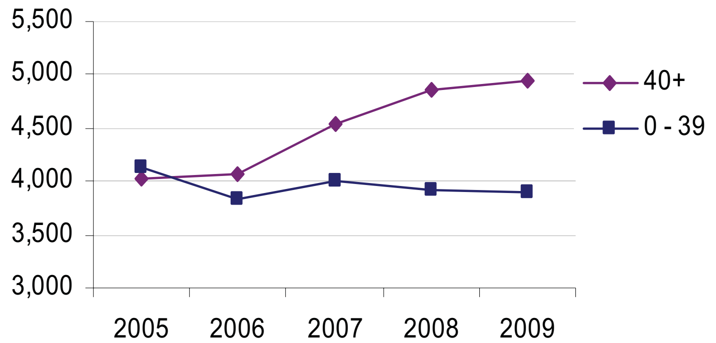
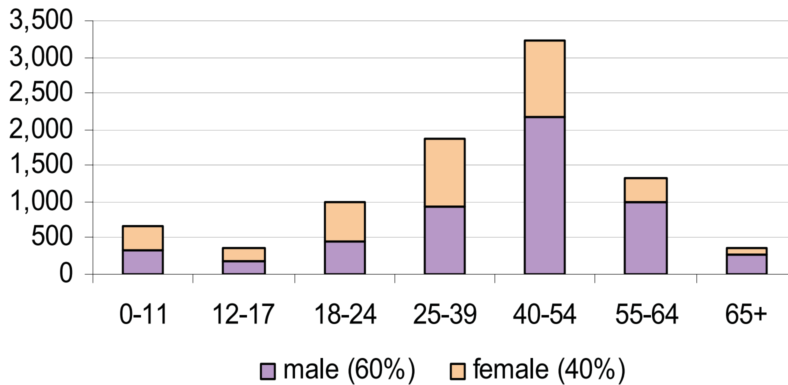


Chart 7
Age and Gender, HCHN 2009



Men served by HCHN in 2009 were older on average (46 years old) compared to women (40 years old).

Two hundred and ten HCHN clients were unattached youth, meaning they were less than 18 years old and not living with their parents. Nine percent (790 clients) were young adults between 18 and 24 years old, living on their own.

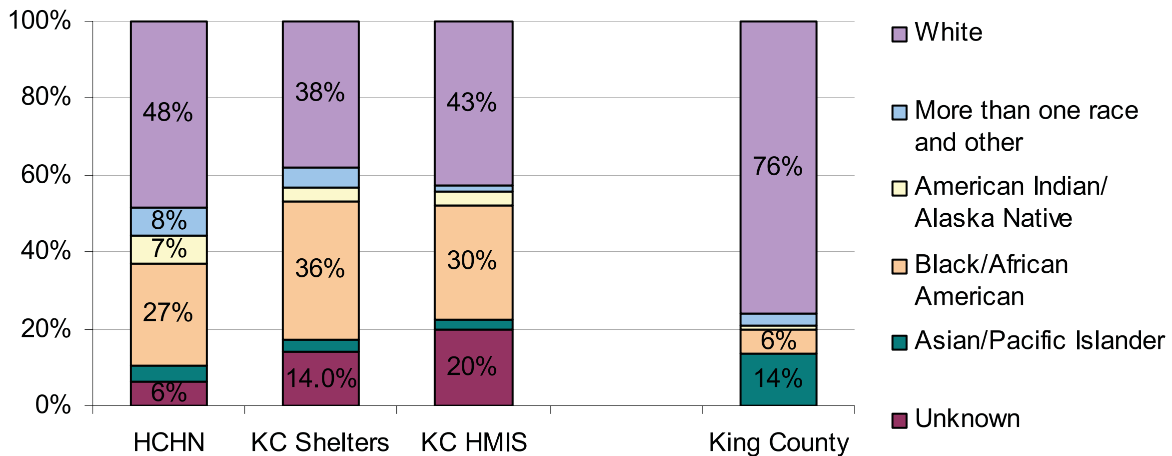
4 Hahn JA, Kushel MB, Bangsberg DR, Riley E, Moss AR. (2006). Brief report: The aging of the homeless population: Fourteen-year trends in San Francisco, Journal of General Internal Medicine, 21, 775–778 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1924700/. Accessed 6/9/10

Race and Ethnicity of HCHN Clients

People of color represented a disproportionate percentage of HCHN clients in 2009 compared to the population of King County (46% vs. 24%). As shown in Chart 8, the race distribution of HCHN clients was similar to race distribution from other data sources in King County that collected demographic information on homeless individuals such as the One Night Count (ONC) of People Who are Homeless in King County and the local Safe Harbors Homeless Management Information System (HMIS).

Although 6% of individuals served by HCHN in 2009 were of unknown race, the majority of those individuals were of Hispanic ethnicity with no other information. In total, 14% of HCHN clients were Hispanic.

Chart 8
2009 HCHN Race Compared to
King County Homeless and Total King County Population



Geographic Location of HCHN Services

The vast majority (89%) of all 2009 visits with HCHN clients were at sites within the City of Seattle, which is where most HCHN services are focused. The higher proportion of HCHN services focused in Seattle reflected the higher prevalence of the homeless population within Seattle as well as funding support from the City of Seattle. In addition, some clients may have traveled to Seattle from areas outside of the city to receive services.

Increases in local funding have enhanced services primarily in Seattle, but in other parts of King County as well. In the second half of 2009, the Mental Illness Drug Dependency sales tax funded two new mental health positions to offer mental health services and linkages to individuals in east and south King County who were leaving jails, hospitals, and crisis facilities.

History and Length of Homelessness of HCHN Clients

Homeless background information was available on about half the HCHN clients served. Of those who reported this information, the number of clients who were homeless more than three years increased steadily from 14% to 20% between 2005 and 2009.

The increase in length of homelessness may be related to the effectiveness of HCHN providers in targeting the chronically homeless population and program expansions such as the REACH case management and outreach teams. Of the people who were homeless for more than three years, almost all (93%) were single adults.

Fairly consistent over the past five years, 43% of HCHN unattached youth and adults had been homeless three or more times. Also consistent over time, 11% of HCHN clients in families were homeless three or more times.

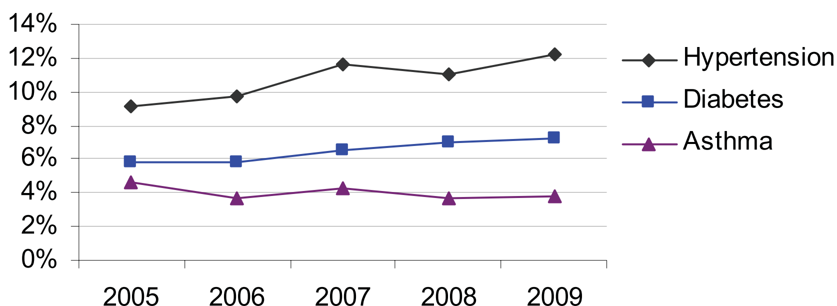
Health Problems of HCHN Clients

Numerous studies have documented that homeless people experience many health problems at rates higher than housed people. Among homeless people nationally, nearly 40% have some type of chronic health condition. Homeless people are more likely to use the emergency department as their regular source of care.[5] Almost one out of nine homeless children experience one or more asthma-related health conditions. In comparison, less than one in 15 middle-class children experience asthma-related health conditions.[6]

Data presented in this report represent clients seen by providers in the Public Health - Seattle & King County HCHN program and appear to confirm that these health conditions are common. As shown in Chart 9, the numbers with hypertension and diabetes have been increasing among the homeless shelter and day program population served by HCHN in recent years.

Skin issues were the top health concerns of HCHN clients 12 to 54 years old in 2009. Typical skin conditions in in homeless adults include diabetic and vascular ulcers, abscesses, wounds, infections (including infections resulting from itching related to bedbug bites), lice, and scabies.

Chart 9
Selected Chronic Health Conditions, HCHN 2005-09



Skin conditions were the second most common

5 Homelessness and Health: The Effect of the Course of Homelessness on Health Status and Health Care Use, American Journal of Public Health, March 2007, Vol. 97, No. 3.

6 National Center on Family Homelessness http://www.homelesschildrenamerica.org/report_child-wellbeing_health.php

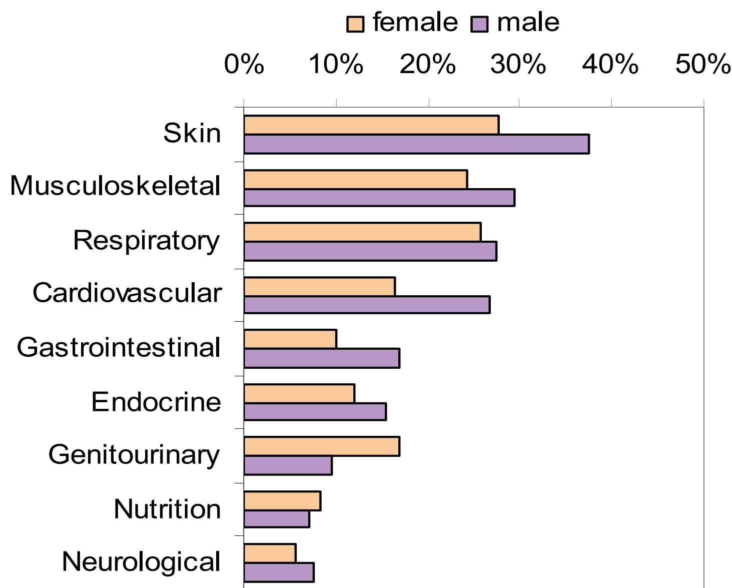
concern for clients under 12 years old. Typical skin conditions in this age group include diaper rash, impetigo, lice, contact dermatitis, and eczema.

The top health concern of those 55 and over was cardiovascular disease. Cardiovascular diseases include hypertension, high cholesterol, congestive heart failure, and stroke. As shown in Chart 9, since 2005, the percentage of HCHN clients with hypertension increased from 9% to 12%. The slight increase could be related to the aging population. In addition, HCHN providers increased blood pressure screening efforts beginning in 2007, which may have resulted in greater identification of hypertension.

Musculoskeletal concerns were ranked second for adults. Typical musculoskeletal conditions in this age group include back pain, joint pain including arthritis, fractures, sprains, and strains.

The third most common health concern of adults was respiratory conditions. Typical respiratory conditions in this age group include colds, influenza, shortness of breath, asthma, chronic obstructive pulmonary disease, pneumonia, and tuberculosis. The top health concerns among children under 12 was respiratory conditions. Typical respiratory conditions in this age group would include colds, influenza, asthma, pneumonia, and sore throats.

Chart 10
Health Problem Prevalence Among HCHN Adults, 2009



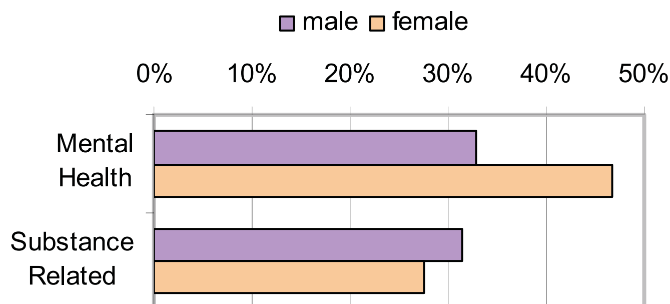
Mental Health and Substance Abuse

The number of homeless people with mental health problems in King County is significant, with about half of all existing HCHN patients having some type of mental health and/or substance abuse disorder. In the 2008 HCHN online needs assessment survey, homeless service providers ranked mental health and substance abuse services the top two areas of unmet need, followed by primary medical care and dental care.

Of all age groups, mental health concerns were most common among women 25-54 years old. Half of the women in this age group had a mental health issue addressed in a visit during 2009. This decreased to 45% for women age 55 and over.

Compared to all health issues, mental health was the top concern of 12-24 year olds. Thirty-two percent of all 18-24 year olds had mental health issues addressed during a visit in 2009. The proportion of young people with mental health concerns jumped from 8% in under 12 year olds, to 21% in youth 12-17 years old.

Chart 11
Mental Health and Substance Abuse Prevalence Among HCHN Adults, 2009



Substance abuse concerns were addressed among 30% of HCHN adults in 2009. Substance related issues were the most prevalent among men age 55 and over. Thirty-five percent of men in this age group had a substance-related issue addressed in a visit.

> Providers reported that clients who need the services of both MH and CD systems are frequently "bounced between them" and may not, in the end, be served by either system.

In the 2008 provider survey conducted by HCHN in its strategic planning process, respondents identified the need for more integrated care between service systems for people dually diagnosed with both mental health and substance abuse problems. Providers concurred that clients who need the services of both systems are frequently "bounced between them" and may not, in the end, be served by either system. They suggested continued training for health care providers regarding appropriate interventions for participants with substance abuse issues and mental health issues including more access to mental health supports.

Providers reported that comprehensive case management is a necessity for any client that has chronic mental health, substance abuse, or language difficulties and that without it, many individuals will continue to fall through the cracks.

Spotlight on Veterans

Due to increased community and funder interest in homeless veterans, a few data snapshots are presented here about veterans served by HCHN.

Military veteran status was not available for all HCHN clients. Providers report that clients are sometimes reluctant to give this information during their initial visits.

Of adults 18 years or older, 839 clients identified themselves as having served in the U.S. military. Based on HCHN encounter information, it is estimated that 20% of adults served in 2009 were military veterans. The number of veterans served by HCHN providers has increased each year for the past 5 years.

2009 HCHN programs report the following veterans participation:

- REACH street outreach 25%
- REACH case management 21%
- Third Avenue Clinic 20%
- Medical Respite 19%
- HHOT 19%

Veterans served by HCHN were notably older (average age of 53 years) compared to all HCHN adult clients (43 years old). According to census data, veterans who are homeless are younger than the general veteran population of King County.[7] Iraq War era and younger veterans are over represented among homeless veterans.[8]

7 American Community Survey 2006 and 2007

8 Veterans and Human Services Levy Outcome Evaluation of Strategy One, Attachment A, King County Department ofof Community and Human Services

Public Health - Seattle & King County
Clinical Measures for Homeless Patients

In 2008, the Bureau of Primary Health Care developed required clinical performance measures for all federally qualified health centers. Public Health - Seattle & King County clinics are established as a federal health center as a part of the scope of services for our homeless grant under section 330(h) of the Public Health Services Act.

Below are two of the HRSA required measures for the 2010-2014 project-period. (The remaining target goals and outcomes for 2009 are included in Appendix C of this report).

Focus area	Project Period Goal 2010-2014	2008	2009
Diabetes: Diabetes in homeless primary care patients	Increase the % of adult patients with type 1 or 2 diabetes who are being test and whose most recent HbA1c is ≤ 9%. Baseline:72% **Goal: 80%**	**72%** Total number of patients: **72** Total number of patients in random sample: **72** Number of clients with HgA1c under 9%: **52**	**59%** Total number of patients: **78** Total number of patients in random sample: **78** Number of clients with HgA1c under 9%: **45**
Cardiovascular: Hypertension in homeless primary care patients	Increase the % of adult homeless patients with diagnosed hypertension whose most recent blood pressure was less than 140/90 (adequate control): Baseline:47% **Goal: 55%**	**47%** Total number of patients: **116** Total number of patients in random sample reviewed: **116** Number of clients with controlled blood pressure: **33**	**60%** Total number of patients: **171** Total number of patients in random sample reviewed: **70** Number of clients with controlled blood pressure: **42**

Testing for hemoglobin A1c (HbA1c) is one of the best ways to assess whether one's blood glucose is under control and to assess the risks of having health problems due to diabetes. For the diabetes measure noted in the table above, the drop in number of controlled blood glucose from 2008 will be analyzed in 2010. There may have been fewer tests done; many diabetic patients living homeless also have mental health issues which can become competing visit priorities. Although taking insulin can be effective for blood glucose control, it requires refrigeration and can be challenging to use when living homeless.

The increased level of control for the cardiovascular measure is likely due to a concerted effort in 2009 at Public Health - Seattle & King County clinics to properly assign patients the diagnosis of hypertension and to assure they were correctly entered into our disease registry. Strategies were implemented to help persons living homeless to be more successful with medication compliance.

In general, patients who are not engaged in a regular source of care often have poorer health outcomes and measures of health. As patients rotate through our expanded outreach and case management services, the overall goal is to identify a medical home and seek care more often, which should result in improved outcomes.

E. Death Data

HCHN annually reviews death information on all individuals who died in King County and who were determined to be likely homeless according to the King County Medical Examiners Office (KCME).[9] This information provides a glimpse into the harms and risks of living homeless.

In 2009, 73 individuals who died in King County were presumed to be homeless at the time of their death. This is the lowest number of deaths reported by the KCME since this data was first collected in 2004. Over the period 2004-09, 526 individuals in total were presumed homeless, with a high of 110 deaths in 2006. Similar to prior years, the average age of death in 2009 was 48 years old.

In 2009, 73 individuals who died in King County were presumed to be homeless at the time of their death. This is the lowest number of deaths reported by the KCME since this data was first collected in 2004.

Homelessness May Increase Suicide, Homicide, and Fatal Accident Risk

HCHN reviewed all deaths for which the KCME assumed jurisdiction in order to determine if living homeless may make a person more likely to die by suicide, homicide, or accident. The information below compares homeless deaths to other deaths in King County from 2004 through 2008. (Data is not yet available for non-homeless deaths in 2009.)

Homeless individuals experienced a disproportionate number of deaths from accidents, suicides, and homicides. Between 2004 and 2008,[11] 5% of deaths due to these causes were among people living homeless. For a rough comparison, only 1% of the King County population is estimated to be homeless during the year. The most significant difference was in homicides: 8% of homicides (30 deaths out of 365) were to individuals who were living homeless at the time of their death.

Another notable difference was in deaths where serious doubt existed as to whether the injury occurred with intent or as a result of an accident.[12] In these cases, the KCME designates the manner of death as undetermined. Eleven percent of such deaths were homeless individuals, which may indicate that the circumstances related to living and dying homeless make it more difficult to determine the manner of death.

9 Only deaths that fall within KCME jurisdiction are included: 1) the cause was unnatural (accidents, homicides, and suicides); 2) the person died suddenly when in apparent good health and without an attending physician in the 36 hours preceding death; 3) the circumstance was suspicious, unknown, or obscure; or 4) no next of kin or other legally responsible representative could be identified for disposition of the body.

10 Centers for Disease Control and Prevention. Heron M, Hoyert DL, Murphy SH, Xu J, Kochanek KD, Tejada-Vera B. Deaths: Final data for 2006. National Vital Statistics Reports, 57(14). Released April 17, 2009. Available at: http://www.cdc.gov/nchs/data/nvsr/nvsr57/nvsr57_14.pdf.

11 This is excluding deaths were the incident leading to the deaths were outside of King County or unknown.

12 This may be due to lack of witnesses or prolonged time between death and discovery. King County Medical Examiner's Office 2007 Annual Report. Available at: http://www.kingcounty.gov/healthservices/health/examiner.aspx.

Profile of Deaths Between 2004 and 2009

The leading single cause of homeless deaths between 2004 and 2009 was acute intoxication (29% of deaths). In 2009, the number of deaths due to acute intoxication decreased (16 deaths compared to the high of 30 in 2005).

Suicide comprised 8% of deaths in 2009, the highest year for suicides (11 deaths compared to the low of 3 in 2007). Homeless individuals experienced the lowest number of homicides in recent years, which comprised 6% of deaths (2 compared to 11 in 2006).

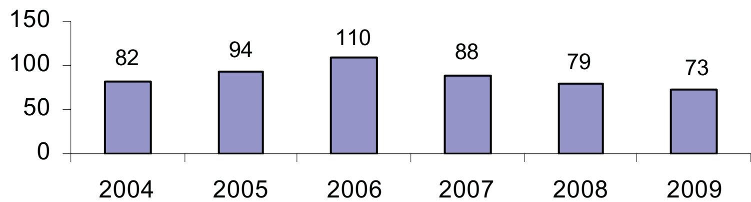
Natural causes combined to total 40% of all deaths across all years. Non-intoxication related accidents totaled 15% of all deaths.[13] These other causes specifically included:

- Killed by cars or train (22 deaths)
- Environmental exposure (9)
- Fires in temporary shelters (9)
- Blunt force under unknown circumstances (8)
- Drowning (7)
- Carbon monoxide-related such as heaters and generators (6)
- Tuberculosis (2)
- Crushed in compacting garbage can (1)

Of the 526 homeless deaths between 2004 and 2009, the majority (85%) were men. The average age of death was 48 years and did not vary significantly between men and women. Ages ranged from infancy to 93 years old, with the majority in the 40 to 59 year old age group.

The majority of the incidents that led to the deaths between 2004 and 2009 occurred in Seattle (73%). Homeless deaths occurred in other regions as well: 81 deaths (15%) in south King County, 22 deaths (4%) in east King County, 8 deaths (2%) in north King County. Incident locations outside King County included 15 deaths (3%). In addition, the incidents in 17 deaths (3%) occurred in unknown locations.[14]

Chart 12
Number of Homeless Deaths,
King County Medical Examiners Office 2004-09



13 Two percent of deaths were due to an unknown cause.

14 Three incidents occurred out-of-state; however, the deaths occurred at local hospitals and were under the jurisdiction of the KCMEO.

F. Program Updates and Expansions

HCHN Contracted Services

This section highlights outcomes of selected HCHN programs. The activities described here are newer and focus on particular sub-populations or emphasize the more recent incorporation of an outcome focus on housing linkages and stabilization.

Chief Seattle Club

Seattle Indian Health Board (SIHB) provides nursing services at Chief Seattle Club, a site in Pioneer Square serving predominately urban Indians. Services were expanded in 2009 to assist clients with chronic and acute illnesses. Also new in 2009, the nurse can access the SIHB electronic medical record system for improved care coordination, the Emergency Services Patrol van (ESP) is available to take clients to appointments, and a refrigerator was added which makes TB skin testing and vaccine provision, such as H1N1 and seasonal flu, possible. The nurse also coordinates the care of chemically dependent clients with a REACH case manager, newly sited at Chief Seattle Club.

Housing Health Outreach Team

The Housing Health Outreach Team (HHOT), formed in 2007, is an interdisciplinary team of medical, mental health, and chemical dependency providers sited in permanent supportive housing buildings. Services are provided by Neighborcare Health and Evergreen Treatment Services.

The team served 587 formerly homeless residents living in ten buildings in downtown Seattle in 2009. Of all clients, 206 (35%) were linked to primary health care services and 385 clients (66%) linked with mental health, chemical dependency, or dental services.

The HHOT team also conducted several clinics for flu shots, as well as foot care clinics in several of the downtown buildings. These activities have proven to be effective ways to connect individuals with providers from multiple disciplines on the team. Clients newly engaged through these clinics not only connected with HHOT nursing or medical services, but met with HHOT mental health and chemical dependency providers as well.

Client Story

Matthew* was actively drinking when he connected with the HHOT team in the supportive housing building where he lives. During discussions with the HHOT nurse and physician, he disclosed that mental stability helped him with sobriety and improvements in his health in the past. The HHOT physician prescribed antipsychotic medication for his bipolar disorder and very disordered sleep pattern.

Matthew stabilized enough on medication to seek out comprehensive mental health care and connect with his primary care provider. Once sober and mentally stable, he reached out to others in the building. He encouraged others to seek help for substance abuse, and brought neighbors to the food bank. He attends Alcoholics Anonymous meetings regularly and was over 100 days sober at the end of 2009. The interdisciplinary approach of the HHOT team, helped him address both his mental health and substance abuse issues, a challenge of many more mainstream providers.

* Name changed

Medical Respite

HCHN contracts with Harborview's Pioneer Square Clinic to operate the Respite program for up to 22 acutely ill homeless individuals at any time. For 15 years, the clinic has provided this care to those who do not require hospitalization but who are too ill to stay in a shelter or on the street. Services are currently provided in downtown Seattle to men at the Salvation Army's William Booth shelter, and to women at the YWCA's Angeline's shelter. The program provides recuperative care, linkage to primary care, mental health and chemical dependency case management, and discharge planning.

The Respite program served 331 homeless individuals in 2009.[15] Sixty-six percent of the clients were chronically homeless and almost 80% had mental health and/or substance abuse problems. The average length of stay in a respite bed was 18 days, a short period of time to accomplish goals set out by the program.

The respite program placed 42 people in permanent housing and 40 people in transitional housing in 2009, which was the highest number of housing placements in the history of the program.

15 As reported for the HUD grant year February 1, 2009 - January 31, 2010.

Mental Illness and Drug Dependency (MIDD) Funded Behavioral Health Services

HCHN received new funding from the King County Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) Mental Illness and Drug Dependency Action Plan. These funds provide mental health outreach services in east and south King County and downtown Seattle. Through HCHN's contractors, Valley Cities Counseling & Consultation and Pioneer Square Clinic, services are designed to stabilize people with mental illness and chemical dependency, diverting them from jails and emergency rooms by linking them to ongoing services.

For Seattle, the expanded mental health capacity was situated in two homeless service sites downtown, YWCA's Angeline's shelter and the Compass Center's Adult Service Center, although referrals are accepted from a broad range of homeless service providers. They provide services to clients referred by the King County Jail release planners, REACH Case management, and the shelter sites where they are located.

Similarly, services outside of Seattle prioritize clients of shelters and day programs that lack behavioral health services and have significant numbers of clients with unaddressed mental health or substance abuse conditions who are involved with hospitals, jails, and/or other crisis facilities.

Pathways Home

The Pathways Home Program (PWH), also known as Medical Case Management for Children, was developed in 1997 to promote housing stability for homeless families experiencing multiple serious barriers. In 2009, Valley Cities Counseling & Consultation and Neighborcare Health provided mental health, chemical dependency, nursing care, social work, and housing assistance to families throughout King County.

Until the family is permanently housed (and for six months afterwards), the multi-disciplinary team provides continuity in case management and therapeutic services regardless of where the family is residing or how many times they move.

During the past year, 99 families were served, with 47 new families entering during the year. Forty-eight families moved one level up the continuum of housing (56%). Thirty-five of those families moved into permanent housing (41%) and nine moved into transitional housing. All

families entering the program during the year (100%) were evaluated for health care coverage and linkage to a primary care provider. Seventy-eight families (79%) met at least one goal of their service plan.

REACH Outreach Team and Case Management Program

In 2009 REACH case management services were significantly expanded. Additional funding from the Veterans and Human Services Levy, the City of Seattle Human Services Division, and United Way of King County supported increased case management and contributed to the creation of a new street outreach team.

Client Story

Alem*, an Ethiopian man and frequent user of the Sobering Center, was referred six months ago. English was his second language and proved to be an ongoing hindrance to accessing services and support to address his addiction. Alem had lost his housing, job, and family ties due to his drinking, leaving him emotionally overwhelmed. Over time he accepted the support of his case manager in addressing his alcoholism. Language and cultural barriers created enormous challenges for him. In order to access a treatment program, an interpreter was requested three different times. Few interpreters speak Amharic. The agency was not able to schedule an interpreter so REACH provided one. After completing detox and entering treatment, the cultural insensitivity of the treatment facilities became painfully apparent. The need for cultural competency in relationship to addiction is imperative to success. To Alem's credit, he was consistent and dedicated to his recovery and has been patient and determined in spite of these obstacles. Alem is now in long-term treatment and looking forward to housing placement when he leaves. According to his case manager, “Fortunately for him, my program encouraged me to make every effort to overcome the difficult challenges thrown his way. Alem stays connected to me and tells me the importance of my advocacy to his success.”

*Name changed

Outreach Team: In 2009 the Outreach team made contact with over 450 people living outdoors and referred 172 people to services. Of those engaged, 91 people entered a shelter or housing and 110 people engaged with a REACH nurse. Experienced outreach workers were surprised by the high numbers of people with serious, untreated health conditions. They found people to be very receptive to services, resulting in high levels of engagement and success in linking them to health care, treatment, as well as housing.

Case Management Team: New funds resulted in expanding the scope of REACH services to a caseload of 320 people, 185 of them new in 2009. Services were made available to the entire Seattle downtown core following years of service almost exclusively at Dutch Shisler Service (DSSC). That notwithstanding, 145 users of DSSC were served by REACH in 2009. Their focus

expanded to included homeless people using illegal drugs resulting in program collaborations at sites including the Chief Seattle Club, the Needle Exchange, the Medical Respite program, the High Utilizer Group, and Angeline's Center. In 2009, 209 case management clients were linked to chemical dependency services, 156 clients moved to an improved housing situation with 95 moving to permanent housing, and 138 people engaged in ongoing primary care services.

Second Avenue Clinic

The Second Avenue Clinic has provided health services side by side with Public Health's Needle Exchange for 10 years, through a contract with Pioneer Square Clinic. In mid-2009, these co-located services, now renamed the Robert Clewis Center, moved to Public Health's Downtown Health Center in Belltown.

The clinic focus is prevention of skin wounds that require hospitalization. Two providers, a Physician's Assistant and a Nurse Practitioner, alternate on-site each afternoon, providing wound care treatment for abscesses, cellulitis, ulcers, and infections. Care for other health issues is available and clients can see the same providers at Pioneer Square Clinic. The vast majority of clients were seen for wound care. Other common conditions included upper respiratory infections, musculoskeletal disorders, and peripheral vascular disease.

Third Avenue Center

The Third Avenue Center (TAC), a health care clinic operated by Harborview Medical Center's Pioneer Square Clinic, opened in 2004 to provide walk-in specialty health services five days a week. TAC offers management of acute and chronic illness, well adult exams, women's health care, family planning, diagnostic testing, podiatry, and mental health services including psychiatric services. The clinic primarily serves homeless adults and individuals without health insurance. People with Medicare and Medicaid are eligible for services and sliding scale fees are available.

Client Story

Sally* is diabetic and struggles with mental illness and substance abuse. Sally came to the Third Avenue Center (TAC) homeless and without a primary care provider. She was managing her diabetes through visits to the emergency room (ER). She was reluctant to talk with anyone in the clinic, and often walked in and then back out the door. When she finally met with a provider, she was so fearful she left crying.

Over time, clinic staff developed a rapport with Sally and she attended appointments regularly. Her almost daily ER visits decreased as she started taking daily medications managed by the TAC nurse. Eventually she met with the psychiatrist and was prescribed medications for post-traumatic stress disorder and depression. Sally continues to visit the clinic daily for medication and support. She is now permanently housed and connected with the mental health case manager in the building where she resides.

* Name changed

- In 2009, the Third Avenue Center (TAC) served 1,121 patients and provided an average of 3.1 visits per patient. Fifty percent of TAC clients were women, which exceeds the proportion of women in the King County homeless population overall (25%), and reflects success in reaching out to women.

- Fifty three percent of patients were people of color, similar to the overall racial make-up of the local homeless population.

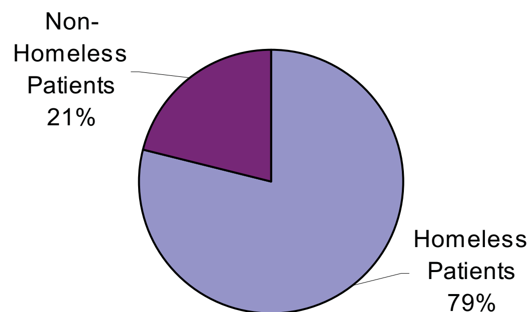
HCHN Services Provided Within Public Health for Homeless People

Oral Health

Since 2005, Public Health's Downtown Dental Clinic has prioritized services for homeless adults. This work is supported by a federal oral health expansion grant from the Bureau of Primary Health Care. In addition to self-referred patients, the clinic maintains partnerships with agencies providing supportive services to currently and formerly homeless individuals. Case managers at partner agencies refer and support clients in keeping their appointments and completing their dental treatment plans.

In 2009, 79% of the patients (comprising 76% of the total visits) at the Downtown Public Health Dental Clinic were individuals who were homeless. As a result of the grant implementation, the number of homeless users at Downtown Public Health has more than tripled since 2005. Of homeless patients receiving periodic or comprehensive exams between July 1, 2008 and December 31, 2008, 28% completed treatment within 12 months.

Chart 13: 2009 Downtown Public Health Dental Patients (n=2,020)

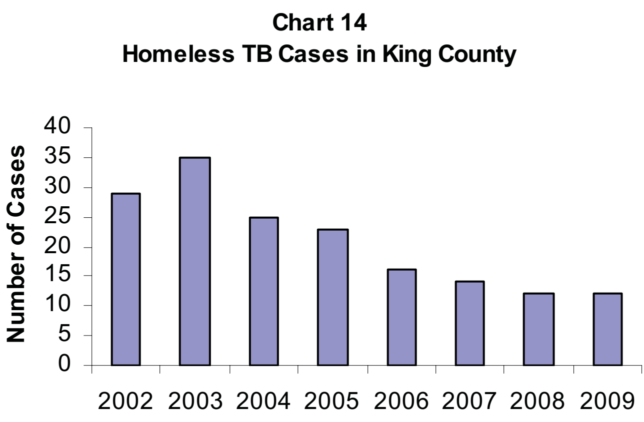


Health and Safety Project: Communicable Disease and Health Education

A Public Health nurse on the HCHN team is dedicated to assisting homeless service agencies to reduce risks associated with communicable disease. In 2009, she conducted 25 health and safety workshops for 483 staff and volunteers. She also assured that 80% of City of Seattle - funded shelters met best practice standards for communicable disease risk reduction. Through the cooperation of community agencies, health care partners, and the Public Reserve Corp, HCHN delivered over 2,400 doses of H1N1 and seasonal flu vaccine to people living homeless throughout King County.

Enhanced Tuberculosis (TB) Services

TB cases among the homeless have been declining since the TB outbreak in the homeless community in Seattle in 2002-2003. See chart 14.



For the past five years, the HCHN TB prevention nurse has provided technical assistance to homeless service agencies. In that time, agencies have instituted TB prevention policies that include annual risk assessments, staff TB screening, increased awareness among staff through annual staff TB trainings and new staff orientation, bed maps, education of clients, and improved attention to ventilation. In 2009, 250 staff in these agencies received TB training. In addition, HCHN has supported a social worker in the TB Control Program to provide case management to people with TB who are homeless, helping them get into permanent housing by the time they complete TB treatment. Ten of those clients retained stable housing six months after completing treatment.

Client Story

Alfonso,* a homeless man from Mexico, was hospitalized with infectious pulmonary TB. He also had uncontrolled diabetes and spoke little English. Although he had been clean and sober for five years, Alfonso had a long history of alcoholism and criminal activity.

About ten years ago, someone stole all his important personal documents: his ID, legal permanent resident card, and passport. He never tried to replace the lost documents. All housing and social services require picture ID and proof of immigration status. The TB program social worker helped him apply for a legal permanent resident card using HCHN housing stabilization funds to cover the cost. After several months he finally obtained a legal residence card, social security card, and WA State ID.

Alfonso remained under the care of the TB clinic for nine months. During that time, he attempted to find daily work at the Millionaire Club. Since he had all proper identification, he was finally connected with a job working on an Alaskan fishing boat and was able to start work there within a few months of completing his TB treatment.

With the help of the TB program social worker and nurse case manager, Alfonso completed his TB treatment, attended to all of his other health needs, established the groundwork for housing stability, and became employed.

*Name changed

The TB and Homelessness Coalition, a partnership between HCHN, the TB Control Program, homeless services agencies, and funders, held three meetings in 2009 in their work to prevent the spread of TB in the homeless community.

Emergency Preparedness for Homeless People

In order to address the potential H1N1 influenza epidemic and possible flooding in south King County, HCHN and King County Emergency Preparedness convened a stakeholder group of agencies serving homeless people, funders, local and county governments, health care agencies, and advocates.

The group prepared a community-wide plan for coping with an epidemic, such as H1N1. The plan is multifaceted and includes a surveillance system for influenza-like illness (ILI) at homeless sites, a plan to isolate and care for people with ILI, the stockpiling of supplies, a detailed communication plan, and an antiviral distribution system. A cornerstone of the preparedness plan is the prevention of influenza through health education, emphasizing protective behaviors, and vaccination.

The stakeholder group also examined the potential impact of flooding from the Howard Hanson Dam. Although the dam did not flood in 2009, the groundwork was laid for assisting homeless individuals when a flood is imminent, and for developing an adequate response plan during and after the flood. This information was made available to local and regional jurisdictions to guide planning.

Appendix A. HCHN Major Service Sites in 2009

Single Adults

- Angeline's (YWCA)
- Chief Seattle Club
- Compass Center & Compass Cascade
- Downtown Emergency Service Center
- Downtown YWCA
- Dutch Shisler Sobering Support Center
- Katherine's House
- Robert Clewis Center (formerly Second Avenue Clinic at Needle Exchange)
- St. Martin de Porres Shelter (Catholic Housing Services – CHS)
- Third Avenue Center (at YWCA Opportunity Place)
- William Booth Center (Salvation Army)

Housing Health Outreach Team (HHOT) Sites

- Frye Apartments(CHS)
- The Gatewood (Plymouth Housing Group PHG)
- Kerner-Scott House (DESC)
- The Lewiston (PHG)
- The Morrison (DESC)
- Plymouth on Stewart (PHG)
- Scargo Apartments(PHG)
- Simons Senior Apartments (PHG)
- The Westlake (CHS)
- The Wintonia (CHS)

Youth and Young Adults

- 45th Street Clinic (Neighborcare Health)
- Country Doctor Youth Clinic (through UW Adolescent Medicine Clinic)
- YouthCare Orion Center

Families

- Avondale Park
- Broadview Shelter
- Catherine Booth House (Salvation Army)
- Domestic Abuse Women's Network
- Eastside Domestic Violence Program
- Family & Adult Service Center
- First Place School
- Hopelink sites
- Morningsong Family Support Center
- New Beginnings
- Providence Hospitality House
- Sacred Heart
- South King County Multi-Service Center sites
- Union Gospel Mission Family Shelter
- YWCA East Fir Street Shelter
- YWCA family sites countywide

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

Appendix B. Other Established HCHN Services

Programs for Families

- **Valley Cities Counseling & Consultation** manages the Families in Shelters programs providing mental health and chemical dependency services to families who are enduring homelessness in Seattle and in south King County.

- **Carolyn Downs Family Medical Center – Homeless Team** provides on-site nursing services to women and families who reside at shelters/transitional housing sites in central Seattle.

- **Odessa Brown Children's Clinic** provides on-site primary health care to children who attend First Place School and Wellspring Family Services Early Learning Center (formerly Morningsong Day Care) in Seattle

- **HealthPoint** provides on-site nursing services to women and families who reside in shelters and transitional housing sites in north, east and south King County.

- **Neighborcare Health/45th Street Clinic** provides on-site nursing and mental health services to women and families who reside in shelters and transitional housing sites in north Seattle.

- **YWCA Health Care Access** advocates help people apply for benefits and link them to medical care, including eye exams, glasses, prenatal care and dental.

Programs for Youth and Young Adults

- **45th Street Clinic Homeless Youth Clinic** is a medical clinic of Neighborcare Health for homeless youth and young adults aged 12-23 in the Wallingford neighborhood of Seattle.

- **Country Doctor Free Teen Clinic** is a medical clinic for homeless youth and young adults aged 12-23 in the Capitol Hill neighborhood of Seattle.

Programs for Single Adults

- **Pioneer Square Clinic (Harborview Medical Center)** provides mental health and nursing services to homeless adults in shelters and transitional housing sites in downtown Seattle

- **HealthPoint** provides nursing services for formerly homeless adults living in South County Housing First units managed by Sound Mental Health (SMH) and King County Housing Authority. Residents are referred to housing from the SMH Projects for Assistance in Transition from Homelessness (PATH) program. Medical case management services are also provided to clients of the Public Health - Seattle & King County South King County Mobile Medical Van.

Appendix C. PHSKC Clinical Measures for Homeless Patients

Focus area	Project Period Goal	2008	2009
Diabetes: Diabetes in homeless primary care patients	Increase the % of adult patients with type 1 or 2 diabetes who are being test and whose most recent HbA1c is ≤ 9%. Baseline:72% **Goal: 80%**	**72%** Total number of patients: **72** Total number of patients in random sample: **72** Number of clients with HgA1c under 9%: **52**	**59%** Total number of patients: **78** Total number of patients in random sample: **78** Number of clients with HgA1c under 9%: **45**
Cardiovascular: Hypertension in homeless primary care patients	Increase the % of adult homeless patients with diagnosed hypertension whose most recent blood pressure was less than 140/90 (adequate control): Baseline:47% **Goal: 55%**	**47%** Total number of patients: **116** Total number of patients in random sample reviewed: **70** Number of clients with controlled blood pressure: **33**	**60%** Total number of patients: **171** Total number of patients in random sample reviewed: **70** Number of clients with controlled blood pressure: **42**
Cancer: Pap testing for homeless women	Increase the % of homeless women ages 21-64 (24-64 in 2009) who have a pap test during the same year or the two previous years. Baseline:70% **Goal: 75%**	**70%** Total number of patients: **1672** Total number of patients in random sample reviewed: **70** Number of clients tested: **49**	**63%** Total number of patients: **1043** Total number of patients in random sample reviewed: **70** Number of clients tested: **44**
Prenatal and Perinatal Health: Birth weight for infants of homeless primary care patients	Among homeless patients, increase the % of birth weights of more than 2500 grams to prenatal patients. Baseline:90% **Goal: 92%**	**90%** Total number of patients: **11** Total number of patients in random sample reviewed: **11** Number of clients with infants with birth weights more than 2500 grams: **10**	**42%** Total number of patients: **7** Total number of patients in random sample reviewed: **7** Number of clients with infants with birth weights more than 2500 grams: **3**
Prenatal and Perinatal Health: Early prenatal care for homeless pregnant primary care patients	Increase the % of women who receive prenatal care and initiate care with our organization who start care in the first trimester. Baseline: 53% **Goal: 75%**	**53%** Total number of patients: **15** Total number of patients in random sample reviewed: **15** Number of clients with receiving first trimester prenatal care: **8**	**47%** Total number of patients: **17** Total number of patients in random sample reviewed: **17** Number of clients with receiving first trimester prenatal care: **8**
Child Health: Childhood immunizations for homeless children in primary care	% of 2 year old homeless children who are up to date on immunizations. Baseline: 78% **Goal: 80%**	**78%** Total number of patients: **91** Total number of patients in random sample reviewed: **91** Number of children up to date on immunizations: **71**	**77%** Total number of patients: **94** Total number of patients in random sample reviewed: **94** Number of children up to date on immunizations: **73**
Behavioral Health:	% of homeless chronic inebriates served by REACH case management team who engage in substance abuse treatment. **Goal: 55%**	**50%** N=132	**71%** N=145
Oral Health:	% of homeless dental patients at Downtown Public Health with a comprehensive oral exam who have completed their treatment plans within a 12 month period. **Goal: 35%**	**28%** N=100 (chart review sample)	**32%** N=1249

Acknowledgements

Contract Partners

- Country Doctor Community Health Centers
- HealthPoint (formerly Community Health Centers of King County)
- Evergreen Treatment Services
- Odessa Brown Children's Clinic
- Pioneer Square Clinic – Harborview Medical Center
- Neighborcare Health (formerly Puget Sound Neighborhood Health Centers)
- Seattle Indian Health Board
- University of Washington Adolescent Medicine
- Valley Cities Counseling & Consultation
- Salvation Army William Booth Center
- YWCA of Seattle-King-Snohomish County

Funders

- City of Seattle Human Services Department
- King County Department of Community & Human Services
- 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, HRSA, Bureau of Primary Health Care
- U.S. Dept of Housing & Urban Development
- Phoebe W. Haas Charitable Trust
- Small Changes (calendars for clients)

Public Health - Seattle & King County

- Downtown Public Health Dental Clinic
- Tuberculosis Control Program
- Robert Clewis Center/Public Health HIV/AIDS Program
- King County Medical Examiner
- Assessment, Policy Development and Evaluation Unit
- Emergency Preparedness
- Public Health Centers, Community Health Services

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- Evergreen Treatment Services REACH program
- Public Health - Seattle & King County