

Seattle-King County Department of Public Health / Health
Care for the Homeless 2010-2014 Strategic Planning

2008 Local Data Summary

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INTRODUCTION

Health Care for the Homeless Network (HCHN), a program of Public Health - Seattle and King County, contracts with community-based agencies to provide services to more than 8,000 homeless people annually. Services include primary care, nursing services, mental health services, and substance abuse services, as well as referrals and assistance enrolling in Medicaid. HCHN providers are currently located in over 40 sites throughout King County, primarily shelter settings. The Network also encompasses the medical, dental, and case management services provided to homeless people throughout the clinics and programs of Public Health Seattle-King County.

In 2009 HCHN will re-apply for federal funding for 2010-2014 and will review and revise its program focus and priorities for the coming grant period. As part of this process HCHN will make important decisions that will influence how its investments are targeted to best meet the needs of those community members experiencing homelessness, how strategies for service delivery are coordinated, and how to determine the most relevant outcomes to measure improvement of the health of the homeless people served in its programs.

HCHN is governed by an 18-member community-based advisory Planning Council that advises on the program's services and budget, and advocates to improve access to health services. The Health Care for the Homeless Network Planning Council comprises 50 percent persons of color, including four individuals who are formerly homeless.

HCHN values and depends on community input to guide its priorities and therefore, worked closely with its Planning Council providers, staff and consumers to determine the best methods of collecting input from diverse stakeholders to guide this planning process.

In March 2008 the Planning Council identified key actions to ensuring a quality process:

1. Involve individuals impacted by HCHN services, those not accessing services, and front line providers, to help define the issues of greatest concern, as well as coordinated strategies for service delivery.
2. Develop diverse methods of gathering information from homeless consumers to include:
 - Culturally appropriate delivery
 - Delivery for appropriate literacy levels
 - Ways to reduce barriers to participation
 - Use of interpreters as needed
3. Gather information to shape the type of services and sites that will be described in a competitive contract application process in early 2009.

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4. Gather information about the strengths and weaknesses of current HCHN services, opportunities and threats for the future, and focus on fostering positive impacts on individuals as a result of this process.

In addition to identifying the above actions, the Planning Council was also invaluable in targeting population groups, determining data collection methods, and considering locations for greatest access to community members to solicit input for this planning process.

The input collected for this data summary represents a rich response from HCHN provider/consumer surveys, interviews and focus groups. The information that relates to HCHN's scope of work will be reflected in the HCHN planning process as program priorities for 2010-2014 are shaped.

The priority actions identified from an analysis of this data will be integrated with HCHN's involvement with multiple homeless initiatives including policy decisions, ongoing service coordination and funding alignment with the goals identified in the Ten Year Plan to End Homelessness in King County, the King County Veteran's & Human Services Levy Strategic Improvement Plan, the Mental Illness and Drug Dependency Action Plan, and the United Way Blueprint to End Chronic Homelessness.

METHODOLOGY

With support and input from the HCHN Planning Council, HCHN developed an online survey, focus group, and individual interview instruments to solicit community input for HCHN's 2010-2014 planning process. Working with multiple human services agencies serving the homeless, HCHN staff and Planning Council members recruited homeless and formerly homeless volunteers to participate in the focus groups and 1:1 interviews as well as community service agency providers to respond to the online survey.

Consumer members of the HCHN Planning Council, with support from HCHN staff, conducted two consumer focus groups (17 participants) and a series of interviews with 106 homeless and formerly homeless participants. HCHN staff conducted one provider focus group of HCHN providers (13 participants) to obtain information regarding the strengths and weaknesses of current HCHN services. Two additional focus groups (41 participants) were conducted in South King County specifically intended to inform the development of mobile medical van services delivered in that area. All focus groups and interviews lasted from 45 to 90 minutes.

An on-line survey was utilized to gather information from community service providers. The HCHN provider survey was distributed widely among human and homeless service provider email lists, at homeless coalition meetings, at various homeless service agencies, and was available online on the HCHN website. Surveys were distributed beginning in late July 2008 and accepted until August 15, 2008. There were 253 surveys returned.

SUMMARY OF FINDINGS

The data contained in this report was reviewed and analyzed by the HCHN administrative team and Public Health nurses. There were many commonalities found

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among responses when comparing data from the online survey with the consumer interviews and focus groups.

When comparing data obtained from all participants, it was clear that the most frequently identified priorities were as follows:

- Increase the overall capacity of the health care system to support more clients, especially those with complex health issues.
- Health care services that ensure the promotion of human dignity and the empowerment of its participants
- Multi-disciplinary health services reaching people “where they are”
- Increased awareness of and screening for cognitive impairments
- Accessibility to and quality of information about health care services for people experiencing homelessness
- The provision of services that address the increasing complexity of health problems for homeless people

INDIVIDUALS EXPERIENCING HOMELESSNESS SUMMARY

The following section details data obtained from consumers experiencing homelessness gathered from focus groups and individual interviews. A total of 164 people who were experiencing homelessness or who had previously experienced homelessness participated in this project.

Interviews

One-on-one interviews with 106 homeless individuals were completed, with eight of those interviews conducted in Spanish. Interviews were conducted at Seattle and South King County locations including meal programs, hygiene service sites, churches, and at various service agencies. Sixty two percent of the individuals interviewed did not have access to medical coverage.

Table 1 Individual Interviews Demographics

	Total	Percentage of Total	One Night Count of Homeless People ¹
Gender			
Male	79	75%	74%
Female	26	25%	26%
Transgender	1		
Race			
Black	25	24%	35%
White (not Hispanic)	43	41%	38%
Native American/Alaska Native ²	20	19%	3%
Asian	4	4%	4%
Hispanic	9	8%	10%
Multi-racial	3	3%	6%
Other	2	2%	5%

¹ One Night Count : Shelter Survey http://www.cehkc.org/DOC_reports/2007OneNightCount

² Note: Higher Native American/Alaska Native totals reflect a series of interviews (14 people) conducted on-site at Chief Seattle Club

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One of the key topics noted in the interviews was a perceived lack of sensitivity of service providers towards people experiencing homelessness. Individuals reported discrimination, disrespect, and lack of emotional supports when receiving services. They requested an increase of “clinics with compassion” to enhance consumer trust.

They recommended that services to assist the homeless with basic needs like food and housing should be provided in coordination with health care to improve clients’ likelihood of experiencing improved health. In addition, they suggested that the system acknowledge the lack of family and emotional support for many homeless accessing services and its impact on individuals’ ability to engage in health care services.

Individuals interviewed reported a lack of information about health resources available to them and how to access them. They reported that information needs to be provided in a variety of formats, such as for people with literacy issues and in Spanish and other languages. They recommended that the system of distributing health information to the homeless be expanded to address diverse communication needs and simplified for individuals with barriers to understanding complex information. They reported that it would be beneficial to advertise services in places where the homeless stay so the “word on the street” is correct.

They also suggested that mental health issues create barriers to obtaining information and following directions. It is important to keep this in mind when developing resource information to ensure that clear direction to appropriate services are available despite these barriers.

A majority of individuals interviewed requested an increase in health outreach workers on the streets with good information about clinics and services. Specifically they said, “Make yourselves known to people on the street.” Also, a recurring message emerged about the lack of transportation to get to and from appointments.

Individuals commonly spoke of the frustrations of navigating the complex benefits system and the difficulty of qualifying for and/or maintaining benefits. Also mentioned was the general lack of resources available to pay for those who do not qualify for benefits.

Overwhelmingly, individuals experiencing homelessness spoke about the need to broaden eligibility for Medicaid and other benefits. Ideas such as “guaranteed” SSI for the disabled and more resources for those exiting foster care were mentioned. People also talked about the need for increased free medications to maintain good health.

Specific suggestions offered to increase the capacity of the system, included reduced wait time to get into primary care and more drop-in medical clinics that have appointments available in one to two days or same day (not six weeks or more). Individuals also reported that there is a need for more supports for people during and after health, mental health and substance abuse treatment.

Support for people during and after treatment was also mentioned frequently. Specific ideas include reduced wait time to get into primary care, more drop-in medical clinics that have appointments available in 1-2 days or same day (not 6 weeks or more).

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Focus Groups

Two focus groups of 17 people experiencing homelessness or who were formerly homeless were also completed. One focus group (7 participants) was conducted at The Westlake, a supportive housing program in Seattle for formerly homeless men aged 55 and older. The second focus group (10 participants) was conducted at the Family and Adult Service Center (FASC) in Seattle. Focus group participants were asked to provide their input to the following questions:

- What is good health?
- How has the health care system responded to your needs/concerns?
- What are your recommendations for improvements to the health care system?

In both groups, participants focused on high energy and the ability to function well as the gauges for being healthy. They noted that the capacity to access spiritual and emotional motivators is important to good health, as well as the capacity to manage depression, stress, and mental health issues. Residents in supportive housing emphasized the need for recreational activities at supportive housing facilities as a means to achieving improved health and maintaining energy.

Focus group participants reported that they were satisfied with nursing services obtained in supportive housing as well as the hours of nursing provided. Others noted that health service providers treat people better if they have access to insurance as opposed to those with no insurance or those with Medicaid.

Recommendations for improvements to the health care system included greater access to mental health services for those with minimal or no insurance or health benefits, healthy, low cost or free food sources, free medications, and increased access to dental services.

South King County Focus Groups

Three sites were chosen for a series of focus groups to explore the health needs of homeless individuals in South King County to inform the development of mobile medical van services in South King County. (Though that data is available from HCHN in its entirety, only a portion of the information obtained from these focus groups is discussed here). A total of 41 homeless individuals were surveyed in Auburn, Kent and Federal Way at the following service locations:

- Federal Way Bible Fellowship Free Lunch Program
- Kent Catholic Community Center Shelter
- Auburn Grace Community Church Lunch Program

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The demographic make-up of the groups is demonstrated in the table below:

Table 2 South King County Focus Groups Demographics

	Total	Percentage of Total	One Night Count of Homeless People ³
Gender			
Male	33	80%	74%
Female	8	20%	26%
Race			
Black	5	12%	35%
White (not Hispanic)	20	49%	38%
Native American/Alaska Native ⁴	4	10%	3%
Asian	4	10%	4%
Hispanic	0	NA	10%
Multi-racial	8	19%	6%
Other	0	NA	5%

The key themes noted by participants in the focus group discussions were the lack of access to a primary health care provider or medical care, no insurance and chronic health conditions.

- 100% of participants agreed that a mobile medical van in South King County would be well utilized.
- 75.6% of the participants reported that they did not have a regular doctor or clinic to go to if sick or in need of a check-up.
- 58.8% of the participants reported that they were experiencing chronic health conditions. The most common conditions reported were asthma, arthritis, chronic obstructive pulmonary disease (COPD), depression, diabetes, and hypertension.
- 51.2% of the participants reported that they have been in need of medical care in the last year but have been unable to get it.

SERVICE PROVIDERS DATA SUMMARY

Online Survey

A total of 253 service providers responded to the on-line survey about the health needs of people experiencing homelessness. The primary target populations for each of the service agency staff surveyed were as listed below:

³ One Night Count : Shelter Survey http://www.cehkc.org/DOC_reports/2007OneNightCount

⁴ Note: Higher Native American totals reflect a series of interviews (14 people) conducted on-site at Chief Seattle Club

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- Families
- Unattached Youth (under 18 years)
- Young Adults (18 to 24 years)
- Adults

The service providers surveyed were representatives from the following types of service agencies:

- Shelter (45.2%)
- Food Programs (36.2%)
- Housing (35.7%)
- Hygiene Centers (17.6)
- Mental Health or Chemical Dependency Support (38.2%)

The role of the survey respondents at each of their agencies varied widely but those most frequently identified were as follows:

- Case Manager
- Nurse
- Nurse Case Manager
- Primary Care Provider
- Administration
- Mental Health Counselor
- Chemical Dependency Counselor

The three primary questions asked in the survey are noted below and the responses are illustrated in Tables 3, 4, and 5. Each of the questions included answer options and were not open ended:

1. What makes it most difficult for homeless individuals to get the health services they need?
2. In the next five years, what are the highest priority areas that would result in the most improvements in health for people who are homeless?
3. Specifically, what do people need more access to? Greater access to...

Table 3 Homeless Service Providers – Barriers to Services

What makes it most difficult for homeless individuals to get the health services they need? (Highest ranked highlighted and shaded)										
Provider Type:	Adult (n=93)	Rank	Family (n=75)	Rank	Youth and Young Adult (n=26)	Rank	Services to All (n=11)	Rank	Non-provider (n=19)	Rank
They need help getting there	64.5%	4	86.7%	1	69.2%	4	63.6%	3	68.4%	2
They have trouble remembering appointments	68.8%	3	70.7%	2	69.2%	4	63.6%	3	57.9%	5
They don't have enough health coverage	62.4%	5	57.3%	5	76.9%	2	63.6%	3	63.2%	4

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Provider Type:	Adult (n=93)	Rank	Family (n=75)	Rank	Youth and Young Adult (n=26)	Rank	Services to All (n=11)	Rank	Non-provider	Rank
Mental health-related barriers	77.4%	1	65.3%	3	80.8%	1	72.7%	1	73.7%	1
Substance use-related barriers	74.2%	2	49.3%	6	73.1%	3	72.7%	1	68.4%	2
They don't have child care	17.2%	11	62.7%	4	26.9%	10	36.4%	8	57.9%	5
They have other things to do	25.8%	10	34.7%	9	50.0%	6	27.3%	10	5.3%	13
They don't know where to go	46.2%	7	41.3%	8	34.6%	9	45.5%	6	57.9%	5
It takes too long to get an appointment	54.8%	6	44.0%	7	42.3%	7	36.4%	8	31.6%	11
Clinic hours or locations are not convenient	33.3%	8	32.0%	10	38.5%	8	45.5%	6	52.6%	8
The staff at the clinic don't understand their language	16.1%	12	22.7%	12	3.8%	13	27.3%	10	42.1%	9
The staff at the clinic don't respect them	26.9%	9	17.3%	13	19.2%	11	18.2%	13	42.1%	9

Table 4 Homeless Service Providers – Priorities

In the next five years, what are the highest priority areas that would result in the most improvements in health for people who are homeless?							
Answer Options	Very high	Somewhat high	Moderate	Low	Not a priority	No opinion	Response Count
Help getting and keeping health care coverage	72.4% (155)	17.3% (37)	7.9% (17)	1.9% (4)	0.0% (0)	0.5% (1)	214
More health services in shelters, day centers, housing sites, etc.	59.8% (125)	23.9% (50)	9.1% (19)	3.8% (8)	1.0% (2)	2.4% (5)	209
Street outreach with nurses	41.8% (87)	26.4% (55)	18.3% (38)	6.3% (13)	1.0% (2)	2.4% (5)	200
Help using health services, such as escorts to appointments	28.5% (59)	35.7% (74)	25.1% (52)	8.7% (18)	1.4% (3)	0.5% (1)	207
Assistance working with immigrants and refugees, such as interpretation	30.6% (63)	27.2% (56)	33.0% (68)	4.4% (9)	1.5% (3)	3.4% (7)	206

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Answer Options	Very high	Somewhat high	Moderate	Low	Not a priority	No opinion	Response Count
Weekend and evening hours at local clinics	28.6% (59)	27.7% (57)	27.2% (56)	10.7% (22)	3.4% (7)	2.4% (5)	206
Health training for service providers	26.3% (54)	27.3% (56)	27.8% (57)	11.2% (23)	3.4% (7)	3.9% (8)	205

Table 5 Homeless Service Providers – Access

Specifically, what do people need more access to? Greater access to...							
Answer Options	Very high	Somewhat high	Moderate	Low	Not a priority	No opinion	Response Count
....mental health services	81.5% (172)	15.6% (33)	2.8% (6)	0.0% (0)	0.0% (0)	0.0% (0)	211
...substance abuse services	75.0% (156)	19.7% (41)	4.3% (9)	0.0% (0)	0.5% (1)	0.5% (1)	208
...primary care	65.4% (136)	27.4% (57)	6.7% (14)	0.5% (1)	0.0% (0)	0.0% (0)	208
...dental care	71.7% (152)	18.4% (39)	9.4% (20)	0.5% (1)	0.0% (0)	0.0% (0)	212
...case management	54.0% (108)	31.0% (62)	12.0% (24)	1.5% (3)	0.5% (1)	1.0% (2)	200
...vision care	46.6% (95)	33.3% (68)	15.2% (31)	3.9% (8)	0.0% (0)	1.0% (2)	204
...specialty care	39.1% (79)	34.2% (69)	22.8% (46)	2.5% (5)	0.0% (0)	1.5% (3)	202
...alternative care (such as naturopathic)	13.0% (25)	21.9% (42)	32.3% (62)	25.5% (49)	4.2% (8)	3.1% (6)	192

Respondent Suggestions

139 respondents provided comments within the survey offering the following input and suggestions:

The respondents recommended increased provider education to improve staff understanding of the diverse and sometimes challenging needs of the homeless population. They reported that if turn-over in direct care staff was minimized, relationships with homeless clients could be improved and vulnerable individuals would experience fewer barriers to accessing compassionate care. Also, 23.9% of the online survey respondents (providers) reported discrimination against homeless clients at clinics, creating barriers to good health care.

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Respondents requested simplified intakes, access to care, and referrals. They recommended that there be a reduction in the “systemic hoops to jump through” to get medical care so people can be treated sooner. In addition, they recommended that providers develop some way of tracking patients through the health care system so that initial care is not duplicated.

Respondents mentioned that there is a need for more integrated care between social service networks (e.g., CD & MH programs) so that clients are not bounced back and forth. 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.

They reported that case management is a must for any client that has chronic mental health, substance abuse or language difficulties. The system should reflect a systemic and collective response to the individual’s problems with case management. Many individuals fall through the cracks.

Service providers recommended developing more multidisciplinary teams where health care providers go out to people who can’t access care. They suggested a one-stop, community based, integrated health system to help people maintain health and general welfare. They also mentioned that advertisements should be posted detailing when and where people can get free or low cost medical attention without barriers.

In addition to helping people get to appointments, providers talked about the need to offer services at convenient times and at locations that are accessible to homeless people. They said that there is a need for more social workers to do outreach and ongoing disease case management. They reported that the system should hire more culturally competent and Spanish speaking workers. Additionally, support for the elderly experiencing higher acuity of health issues is needed.

Providers said that people need help identifying health care options and then making appointments with providers who accept their insurance. Health coverage needs to be available for undocumented people, including refugees and immigrants. Also, there is a need to improve system issues regarding insurance.

Providers would like to see primary/pediatric care expanded to outlying clinics to cut down on transportation problems of going downtown for services. Other ideas included increased satellite clinics, small basic hygiene centers, and medical vans.

Providers also requested improved response to TB outbreaks and more TB/HIV/HepC testing. They suggested "more teeth in the law to force people to take TB meds" and free vaccinations for health care workers.

The providers would like to see an increase in mental health services for children under the age of 10 specifically related to abuse or from children witnessing abuse to a close member of the family. Providers reported a need for more on-site mental health services, simplified access to prescription medication, and manageable intakes for mental health appointments. An increase in co-occurring disorders was mentioned as well as substance abuse issues continuing to be a primary obstacle for many homeless individuals.

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Population Specific

Providers recommended that an emphasis be placed on providing additional services for the following populations:

- Families when one or both adults have mental and/or substance abuse problems.
- Single women without children
- South King County doubled-up families
- Sexually exploited youth and young adults
- Refugees and Immigrants
- Undocumented homeless people

Geographic Specific

Recommendations were received around specific areas in King County that need to have expanded services. The most frequent suggestions included:

- Expanded mental health services available to clients in shelters and supportive housing in South and East King County
- Increased health, outreach and transportation services in East King County, specifically the I-90 corridor from Factoria to North Bend
- Increased access to primary care for uninsured and Medicaid clients in White Center, Kent, Des Moines, Renton
- Increased health care focus on rural homelessness
- Increased transportation options in South King County

HCHN Provider Focus Group

A focus group of 13 Health Care for the Homeless Network (HCHN) providers, including nurses, mental health practitioners, and case managers was conducted. The participants represented family, youth and adult service providers. They were asked questions related to their role as HCHN providers.

Lack of services to address health issues

Numerous comments related to the difficulties of getting both assessments and treatment for clients with cognitive impairments, especially if they do not have a mental illness. Providers reported seeing more complex mental health and chemical dependency issues. They suggested improved access to detoxification services in a timely way for homeless individuals wanting to access treatment since alcohol addiction is often a barrier to improved health outcomes.

They reported that there are not enough treatment options, including primary care, for people with complex health problems. The waiting time for first appointments is too long and in general appointments are not long enough: the primary care model may allow for 4 patients per hour and the client with complex health issues usually requires additional time with the primary care provider. Finally, HCHN providers mentioned that it is difficult

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to find providers who are sensitive to obesity related issues and who can provide the services.

Lack of appropriate housing settings for clients

The impact of adverse health conditions relating to homelessness and poverty was discussed extensively. Serious chronic health problems (heart problems, cancer, renal failure, diabetes for those who can't manage their own care, oxygen dependence) make it difficult to place people in shelter or housing. Some clients need assisted living arrangements, but there are extremely long waiting lists for assisted living and nowhere for people to stay while they are waiting. People needing chemotherapy for cancer or needing dialysis for renal (kidney) failure can't get it without a stable place to live. Oxygen dependence makes it difficult to find appropriate housing, especially for clients who are chemically dependent. Oxygen dependence is also a barrier to accessing medical detox services which is usually necessary for people seeking treatment for alcohol dependency. Neither family nor adult shelters are equipped to take people who require oxygen. There is also a need for some type of a step down respite program for wound care.

Limitations Due to System Requirements and Service Delivery Methods

HCHN providers reported that they could be more mobile and flexible in the provision of services. They mentioned the need for more cross integration and training of mental health and chemical dependency services providers – with a shared philosophy of care. Cognitive impairments impact people's ability to live independently and manage their other health problems. People cannot get occupational therapy to find out if they can live independently. Family shelters are structured to serve families who can succeed more easily. Complex families with multigenerational poverty and mental health and chemical dependency issues need appropriate services rather than letting them fail in the current system.