

## Health Care for the Homeless Network

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# Integrating Health and Housing Solutions for Older Homeless and Formerly Homeless King County Residents: A Proposed Roadmap for Averting an Approaching Crisis April 29, 2016

## Introduction

In 2015, Public Health-Seattle and King County's Health Care for the Homeless Network (HCHN) began engaging homeless housing agencies regarding health-related problems experienced by the growing number of older residents these agencies serve. The challenges surfaced by these discussions align with those cited in national literature related to common chronic and geriatric conditions affecting an aging homeless population. They also align with calls for assistance that HCHN has received from its physicians, nurses, behavioral health professionals, and outreach workers who are stationed at Permanent Supportive Housing sites. Locally and nationally, housing agencies can find themselves ill-equipped to address widespread issues related to memory loss and other conditions that impact residents' ability to independently perform activities of daily living (ADLs) as well as end-of-life care needs. Statistically, these issues and needs impact the homeless population at a much earlier age than the general population, so homeless housing programs with an increasing proportion of residents over 50 years old have begun grappling with complex and difficult questions about resident health and safety.

The Permanent Supportive Housing (PSH) model offers distinct advantages in terms of meeting the needs of older and other vulnerable people who have experienced homelessness, but many of the challenges older PSH residents experience are testing the adequacy of the supportive services historically provided in these programs. For numerous reasons, homeless housing agencies encounter significant barriers to referring PSH residents with intensive health-related support needs to nursing homes, adult family homes, or other residential alternatives specifically designed to address such needs. At the same time, these homeless housing agencies are generally not staffed to provide anything approaching the intensity of services available in such facilities. In addition, PSH residents often prefer to age in place rather than move, but the local housing and health care providers point to significant difficulties in efficiently and cost-effectively bringing needed care workers or other state-funded resources into homeless housing buildings.

Based on these discussions and following the lead of New York City and other communities, HCHN has begun exploring with community stakeholders service models that better meet the chronic and acute needs of older adults who have experienced homelessness while building on the proven benefits of the Permanent Supportive Housing (PSH) model. The broad outlines of our work to date are provided below.

HCHN now seeks to broaden participation in developing and refining the models that might be tested locally by engaging additional stakeholders as well as potential funders.

## A Pressing Need for Service Model Adjustment

The Corporation for Supportive Housing (CSH) and other national experts have called out the aging of the homeless population as an impending crisis.<sup>1</sup> The homeless population is aging rapidly, mirroring

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<sup>1</sup> *Ending Homelessness among Older Adults and Elders through Permanent Supportive Housing*, a paper published by The Corporation for Supportive Housing and Hearth Inc. Retrieved from <http://www.csh.org/wp->

general population trends. Nationwide, currently half of single homeless adults are aged 50 or older, compared to 11% in 1990.<sup>2</sup> Moreover, according to a recent white paper prepared by the Corporation for Supportive Housing (CSH) and presented to a New York City coalition studying ways to address the aging of the homeless population, “not only are those on the streets getting older, but their health is deteriorating at rates much faster than the general population.”<sup>3</sup> The paper cites research showing that homeless adults over 50 had a higher prevalence of geriatric conditions than that seen in housed adults 20 years older.<sup>4</sup> Another study showed that older homeless adults were 3.6 times as likely to have a chronic medical condition as homeless adults under 50.<sup>5</sup> These studies align with the conclusions drawn from a literature review conducted by the founder and director of Boston Health Care for the Homeless, which found that older adults who experience homelessness have three to four times the mortality rate of the general population due to unmet physical health, mental health, and substance use treatment needs<sup>6</sup>. Such findings clearly indicate that housing and services that specifically address geriatric conditions are needed for older homeless adults living across varied environments.<sup>7</sup>

Overall, PSH has proven extremely effective in helping to stabilize the lives of people with significant vulnerabilities related to their homelessness as well chronic behavioral health and medical conditions, but most PSH program models were not designed with the special needs of seniors in mind. PSH is defined by the Corporation for Supportive Housing (CSH) as a model of affordable housing connected to supportive services typically targeted at individuals or families experiencing or at-risk of homelessness and who are likely unable to retain permanent housing without ongoing supports. According to CSH, supportive housing should not be thought of as a separate and distinct intervention, but rather a combination of:

- affordable housing with deep subsidies and tolerant landlords/property management;
- care management (services engagement, motivational client-centered counseling, goal-setting and services planning, services coordination, and connection to mainstream services); and
- evidence-based service models rooted in cognitive behavioral and family systems approaches.

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content/uploads/2012/01/Report\_EndingHomelessnessAmongOlderAdultsandSeniorsThroughSupportiveHousing\_112.pdf

<sup>2</sup> Rebecca T. Brown, Kaveh Hemati, Elise D. Riley, Christopher T. Lee, Claudia Ponath, Lina Tieu, David Guzman, and Margot B. Kushel.

Geriatric Conditions in a Population-Based Sample of Older Homeless Adults. *The Gerontologist*, February 2016 DOI Retrieved from

<http://gerontologist.oxfordjournals.org/content/early/2016/02/17/geront.gnwo11.full>

<sup>3</sup> *A Lifetime of Independence: Recommendations to the New York City Supportive Housing Task Force*. Prepared by the Corporation for Supportive Housing. Retrieved from

[https://gallery.mailchimp.com/d477f3e2e075003c9d2f335a3/files/A\\_Lifetime\\_of\\_Independence.pdf](https://gallery.mailchimp.com/d477f3e2e075003c9d2f335a3/files/A_Lifetime_of_Independence.pdf)

<sup>4</sup> Rebecca T. Brown, Kaveh Hemati, Elise D. Riley, Christopher T. Lee, Claudia Ponath, Lina Tieu, David Guzman, and Margot B. Kushel.

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<sup>5</sup> Garibaldi, B., Conde-Martel, A. & O’Toole, T. P. (2005). Self-reported co-morbidities, perceived needs, and sources for usual

care for older and younger homeless adults. *Journal of General Internal Medicine*, 20(729), as cited by Shelter Partnership

<sup>6</sup> O’Connell, J. (2005). Premature mortality in homeless populations: a review of the literature. Retrieved from <http://www.nhchc.org/PrematureMortalityFinal.pdf>

<sup>7</sup> *A Lifetime of Independence: Recommendations to the New York City Supportive Housing Task Force*. Prepared by the Corporation for Supportive Housing. Retrieved from

[https://gallery.mailchimp.com/d477f3e2e075003c9d2f335a3/files/A\\_Lifetime\\_of\\_Independence.pdf](https://gallery.mailchimp.com/d477f3e2e075003c9d2f335a3/files/A_Lifetime_of_Independence.pdf)

On one hand, numerous studies, including some conducted in Seattle, indicate that this combination can appreciably improve a person's health after they have experienced the trauma of homelessness.<sup>8</sup> On the other, late life needs are significant, as nearly half of all adults in the U.S. over age 65 have difficulty, or receive help, with daily activities.<sup>9</sup> To respond to the intensity of support required by many older residents with advanced needs as well as the overall aging of the PSH resident population, PSH providers and their partners need specialized interventions that go well beyond the supports that most residents are typically provided.<sup>10</sup>

*Ending Homelessness among Older Adults and Elders through Permanent Supportive Housing*, published by CSH and Hearth, Inc., a Boston-based non-profit organization dedicated to the elimination of homelessness among the elderly, provides an excellent overview of these needed specialized interventions. The paper suggests that:

*A wide range of age appropriate services, often onsite, are needed by homeless older adults and elders in supportive housing. These services include: specialized outreach services, assistance with activities of daily living, 24-hour crisis assistance, physical health care, mental health care, substance use treatment, transportation services, payee services, care coordination with community providers, nutrition and meal services, and community building activities aimed at reducing isolation. This requires individualized health treatment plans that take into account the interplay of the chronic, often co-occurring, health conditions along with the normal physical and psychological changes that come with age. Making use of multidisciplinary service teams that can provide "one stop" access, and facilitate coordination, has been found to be a successful approach. Providers have also found that offering services on-site is ideal for older tenants who might have difficulty traveling to off-site services.<sup>11</sup>*

### **Challenges for Local PSH Operators**

HCHN conducted key informant interviews with the two local PSH operators represented on its community advisory board, the Health Care for the Homeless Planning Council. Both Plymouth Housing Group and Compass Housing Alliance have experienced a significant increase in the number of PSH residents and candidates with intensive service needs related to dementia, other cognitive impairments, behavioral health issues and various late-stage chronic diseases. HCHN data shows that its contracted health care provider partners have seen a dramatic increase in older patients, so this observation is not surprising. Staff at both agencies interviewed indicated that they frequently feel ill-equipped to meet these clients' needs but see few options because of the dearth of assisted living and nursing home operators who are willing and able to work effectively with people who have been chronically homeless.

In addition, these PSH operators, as well as health care providers who partner with PSH programs, point to significant challenges in making Washington State's Community Options Program Entry System (COPES) work for older residents with dementia and other cognitive impairments. COPES is a Washington State Medicaid (Apple Health) program designed to enable individuals who require nursing

<sup>8</sup> CSH, *Housing is the Best Medicine*, July 2014. Retrieved from <http://www.csh.org/resources/housing-is-the-best-medicine-supportive-housingand-the-social-determinants-of-health/>

<sup>9</sup> Freedman, Vicki A., and Brenda C. Spillman (2014) Disability and care needs among older Americans. *Milbank Quarterly*. Vol. 92, No.3  
Retrieved from <https://aspe.hhs.gov/sites/default/files/pdf/77136/NHATS-DCN.pdf>

<sup>10</sup> *A Lifetime of Independence: Recommendations to the New York City Supportive Housing Task Force*. Prepared by the Corporation for Supportive Housing. Retrieved from [https://gallery.mailchimp.com/d477f3e2e075003c9d2f335a3/files/A\\_Lifetime\\_of\\_Independence.pdf](https://gallery.mailchimp.com/d477f3e2e075003c9d2f335a3/files/A_Lifetime_of_Independence.pdf)

<sup>11</sup> *Ending Homelessness among Older Adults and Elders through Permanent Supportive Housing*, a paper published by The Corporation for Supportive Housing and Hearth Inc. Retrieved from [http://www.csh.org/wp-content/uploads/2012/01/Report\\_EndingHomelessnessAmongOlderAdultsandSeniorsThroughSupportiveHousing\\_112.pdf](http://www.csh.org/wp-content/uploads/2012/01/Report_EndingHomelessnessAmongOlderAdultsandSeniorsThroughSupportiveHousing_112.pdf)

home level care to receive that care in their home or community living environment. PSH operators report that their case managers encounter difficulties in advocating on behalf of their clients within the COPEs intake process, for example when their client's cognitive impairment complicates the assessment process. In addition, case managers struggle with the COPEs process for scheduling cluster care visits during which one COPEs worker can visit multiple residents during the same day. As a result, a method of providing services that could be a very efficient avenue for meeting the needs of multiple residents with COPEs service needs is underutilized. Given the limited capacity of the PSH case managers, these challenges can create unnecessary barriers to care that increase the risk for poor health outcomes and premature exits from PSH.

### **Prioritized Chronic and Geriatric Conditions Impacting the Aging Homeless Population**

Discussions with HCHN health care provider partners and a review of national literature suggests the prioritization of the following conditions:

#### Dementia and other cognitive impairments

- A review of 12 studies on the prevalence of cognitive impairment among homeless persons suggests that as many as 80% of homeless persons tested displayed marked deficits in cognitive functioning in at least one domain: language, immediate memory, delayed memory, visuospatial/constructional, or attention.<sup>12</sup>
- Older homeless adults are more likely than younger homeless adults to have cognitive impairments.<sup>13</sup> Such impairments may result from dementia. Dementia describes a series of symptoms of decline in memory or other thinking skills that affect someone's everyday life. Symptoms include memory loss, problems with language, faulty reasoning, and impaired judgment.
- Other cognitive impairments may result from depression, long-term effects of alcohol abuse, traumatic brain injuries, or be caused by health conditions such as cardiovascular problems.<sup>14</sup> Regardless of the cause, cognitive impairments can impact a person's ability to follow medical recommendations, successfully seek out healthcare services and navigate the systems that provide public benefits, services and housing opportunities.

#### Mental health and substance use

- Though the physical healthcare needs of this population are considerable, like other people who have been homeless for long periods of time, older homeless persons frequently also have co-occurring mental illnesses and/or substance abuse disorders. While experts estimate that 30% of the general homeless population has a mental health condition<sup>15</sup>, close to 70% of residents at Plymouth Place, a Seattle PSH building operated by Plymouth Housing Group, reported having one or more diagnosed mental health conditions and almost 60% reported chemical dependency problems.

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<sup>12</sup> *TBI among Homeless persons.2008 - Jennifer Highly*

<sup>13</sup> National Health Care for the Homeless Council. (2008). Healing hands newsletter: Aging on the streets. Retrieved from [www.nhchc.org/healinghands.html](http://www.nhchc.org/healinghands.html)

<sup>14</sup> U.S. Department of Health and Human Services, Health Resources and Services Administration. (2003). Homeless and elderly: Understanding the special health care needs of elderly persons who are homeless. Retrieved from <http://bphc.hrsa.gov/policy/pal0303.htm>

<sup>15</sup> McKenzie, J. F., Pinger, R. R., & Kotecki, J. E. (2008). *An Introduction to Community Health (6th ed.)*. Sudbury, MA: Jones and Bartlett Publishers, Inc.

- PSH operators and their health care provider partners report that mental health and substance use disorders frequently represent the most significant barriers to success in referring PSH residents to assisted living facilities and nursing homes.
- About 40% of Hearth, Inc. residents in Boston, MA reported past alcohol or drug problems along with chronic health conditions that include 69% with heart or circulatory problems, 61% with high blood pressure, 52% with diabetes and 52% living with arthritis.<sup>16</sup> These characteristics are typical of older adults experiencing homelessness.<sup>17</sup>

### **Building on PSH’s Solid Foundation**

Notwithstanding the gaps in typical PSH service arrays that impact the health and safety of residents with the highest degree of debilitation related to chronic and geriatric conditions, the PSH model offers some distinct advantages over other strategies for addressing the formidable challenges of an aging homeless population. In fact the national literature points to promising adaptations of existing PSH programs to specifically address these gaps. Here a few of the examples that HCHN found in its review:

- According to researchers Hahn, et. al, “New programs that integrate health care with more stable housing, such as supportive housing, may be important steps for avoiding end stage disease and institutionalization in older homeless persons with complex medical regimens needing frequent office visits<sup>18</sup>.” A case study by National Church Residences found that the cumulative annual cost savings for one of their buildings, the Commons at Buckingham, was greater than \$800,000 based on 18 residents who had moved into the permanent supportive housing development from skilled nursing care and group homes.
- Brooklyn Community Housing and Services’ (BCHS) aging program brought on a part-time onsite nurse for a walk-in clinic, added case management and medical and senior-specific programming as well as a geriatric case manager with a smaller, targeted caseload to provide additional case management services for residents 55 and over and developed several social and wellness groups for aging residents including movie nights and peer led groups on nutrition. As a result of these program changes, inpatient hospitalizations decreased by 92% and resulted in annual savings of over \$400,000. When the program first started in 2007, there were 415 days of in-patient medical stays. By 2013, there were only 30 days of in-patient medical stays which resulted in greater housing stability.<sup>19</sup>

### **Opportunities in King County**

King County has numerous successful PSH programs operated by a variety of agencies that could form a solid foundation upon which to build in experimenting with these types of adaptations. Many of these programs, including those operated by Plymouth Housing Group and Compass Housing Alliance as well as Downtown Emergency Services Center and Catholic Housing Services, have partnered with HCHN to bring limited levels of nursing, behavioral health, primary care, palliative care, and other services into some of their PSH buildings. HCHN proposes to build on these successful partnerships and experience in exploring adaptations that would go further than these embedded health services have gone to date and provide a robust response to meeting the specific and intensive needs associated with dementia and other illnesses that compromise residents’ ability to perform ADLs.

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<sup>16</sup> Hearth, Inc. (2009). Ending elder homelessness: The importance of service-enriched housing. Retrieved from [http://www.hearth-home.org/media/hearth\\_research09.pdf](http://www.hearth-home.org/media/hearth_research09.pdf)

<sup>17</sup> Brown, R.T., Kiely, D.K., Bharel, M., & Mitchell, S.L. (2011). Geriatric syndromes in older homeless adults. *Journal of General Internal Medicine, Published Online in Advance of Publication*

<sup>18</sup> Hahn, J.A, Kushel, M.B., Bangsberg, D.R, Riley, E., & Moss, A.R. (2006). The aging of the homeless population: Fourteen

year trends in San Francisco. *Journal of General Internal Medicine, 21(7), 775–778.*

<sup>19</sup> *Best Practices for Serving Aging Tenants in Supportive Housing.* July 2014 retrieved from <http://www.csh.org/resources/best-practices-for-serving-aging-tenants-in-supportive-housing/>

HCHN-sponsored discussions have surfaced the following potential adaptations for older PSH residents:

- On site patient assessment, nursing/care coordination services, primary care, mental health and chemical dependency services tailored to the specific needs of people with common geriatric conditions
- Improved access to chore workers and home health aides who assist with ADLs, possibly through negotiations with the Washington Department of Social and Health Services (DSHS) to improve coordination of COPEs services with PSH case management and pilot a streamlined system for clustered COPEs assessments and services
- Individualized treatment plans for older residents with special needs for intensive support, to be developed by health care providers working in coordination with PSH case managers
- Multi-disciplinary teams that include housing case managers, health care providers, chore workers or other staff assigned to help with ADLs that are provided the time required to enhance coordination and communication among the key individuals supporting older residents with intensive support needs
- Expansion of Harborview Medical Center's Homeless Palliative Care Program, created in partnership with HCHN, to serve additional PSH buildings and increase its PSH service level and intensity for residents with end-of-life care needs
- Training for all staff at selected PSH buildings on working with cognitively impaired clients on life skills, end-of-life planning and issues, and creating safe living spaces
- Adaptations of existing training on motivational interviewing and trauma-informed care to better equip health care and housing providers to meet the needs of cognitively impaired clients
- Adoption of PSH program policies and procedures that accommodate stays in hospitals and convalescent care facilities, avoid tenants' loss of housing, and provide clearly established referral routes to smooth the transfer of the tenant to the most appropriate setting
- Training and consultation to PSH program staff provided by Harborview Medical Center's Comprehensive Outpatient Rehabilitation Program (CORP) and/or other geriatric health and housing experts related to strategies for conducting assessments and modifying interactions, environments, and expectations related for residents with cognitive impairment and other geriatric conditions impacting ADLs

Both of the PSH key informant agencies consulted for this paper, Plymouth Housing Group and Compass Housing Alliance, have offered to explore how these adaptations might work in some of their existing PSH buildings, and HCHN is eager to gauge interest among other PSH operators. Both Plymouth and Compass have identified specific buildings at which they are willing to pilot adapted service arrays pending funding. Plymouth has put forward its Pacific Place building, where current staffing is limited to one housing case manager. Pacific Place has a total of 70 residents; 50 residents (71%) are over the age of 50. Compass Housing Alliance has put forward its Nyer Urness House in Ballard. This building has three housing case managers on site. Additionally it has on-site chemical dependency services and a three day /week primary care clinic, which serves the larger homeless community and is available to Nyer Urness residents. The clinic is operated by operated by HCHN-partner Neighborcare Health. Nyer Urness has 29 residents (56%) who were over the age of 50 at entry, and average age at entry is 51.

### **Next Steps**

The April 6, 2016 all-day annual meeting of HCHN's partnering providers included a robust of discussion of strategies for remedying the gaps in health-related services for older residents of homeless housing. Physicians, nurses, behavioral health professionals, outreach workers, and program managers joined HCHN staff and HCHN Planning Council members in brainstorming next steps to rapidly move forward collective planning and avert what is widely perceived locally and nationally as an approaching crisis. This discussion ended with an agreement for HCHN to convene a follow-up meeting to continue

brainstorming on May 18, 2016. HCHN has incorporated input from the April 6 discussion into this paper. We hope the paper provides not only as a starting point for the May 18 discussion but a vehicle for attracting additional stakeholders to join in exploring the path forward.

HCHN recognizes that this path must build on and complement other community initiatives and ongoing planning aimed at helping seniors and others with heightened health and psycho-social vulnerabilities. Further, discussions to-date regarding potential pilot projects have highlighted the need for in-depth consideration of project evaluation among a broader group of stakeholders. Examples of overlapping community work that pilot planning and outcome measurement discussions will need to consider include:

- All Home's Coordinated Entry for All initiative
- Ongoing planning at the City of Seattle's Aging and Disability Services Division
- The King County Accountable Community of Health Interim Leadership Council's initial work on integrating health and housing solutions for Medicaid beneficiaries at high risk for hospitalization and long-term care
- University of Washington School of Nursing research and planning for community engagement around the needs of the aging homeless population.

A critical next step, therefore, entails HCHN dialogue with managers involved in these and other initiatives and programs. In particular, HCHN will facilitate exploring the alignment of pilot project outcome indicators with existing evaluation strategies related to engagement in primary care or behavioral health treatment services, reduction in emergency room or emergency medical service utilization, and reduction in exits from homeless housing back into homelessness. The potential for alignment of pilot project evaluation with evaluation work related to reducing costs for high-risk Medicaid beneficiaries represents one key opportunity to demonstrate the success of PSH service model adjustments in a way that could vastly increase the chances that they could be taken to scale. In preparation for the May 18 follow up meeting, HCHN will work to ensure the inclusion of representatives of All Home, the City of Seattle Human Services Department and its Aging and Disability Services Division, The King County Accountable Community of Health Interim Leadership Council, and the University of Washington School of Nursing as well as PSH and shelter operators that have not yet been part of HCHN's work on this topic.