CSH SUPPORTIVE HOUSING = HEALTH CARE

HEALTH & HOUSING PARTNERSHIPS FOR OLDER ADULTS:
AGING IN PLACE IN SUPPORTIVE HOUSING

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Terminology

Homeless Older Adults: Adults 50+ have been identified as the benchmark for "older" homeless and are much more vulnerable as they are not old enough to qualify for Medicare or social security, and therefore more likely to fall through the cracks of government safety nets. Many do not live long enough to become part of the 65+ group referred to as "elderly"[1] and poor nutrition and harsh living conditions exacerbate both acute or chronic conditions as well as cognitive functioning which causes someone's "functional age" to be older than their "chronological age"

Supportive Housing: Affordable permanent housing with supportive services to help people live with stability, autonomy, and dignity.[4]

Resources

CSH Health Aging Toolkit: http://www.csh.org/wp-content/uploads/2016/09/Healthy-Aging-Toolkit.pdf

New York City's Supportive Housing Aging Learning Collaborative: Core Competencies Checklist & Resource Guide: http://www.csh.org/wp-content/uploads/2016/07/NYC-ALC-Core-Competencies-1.pdf

Overview

Nationwide, the rate of homeless individuals over the age of 50 is growing. Not only are those on the streets getting older, but their health is deteriorating at rates much faster than the general population. Pressing chronic health and geriatric conditions exacerbate the housing crisis for thousands of unsheltered individuals over 50.[1] Supportive housing, a proven intervention for meeting the unique and complex needs of formerly homeless individuals, is also experiencing a "graying" consumer population that calls for changes to the way that quality supportive housing is provided. Nearly 40% of supportive housing consumers are over the age of 50.[1] This group represents consumers who are aging in place and new residents of supportive housing over the age of 50. Research suggests that homeless adults suffer higher rates of premature mortality and age-related medical conditions compared to the general population. The proportion of homeless adults in their 50s with chronic illnesses is similar to those 15 - 20 years older who are domiciled.[2] Supportive housing providers are recognizing the need for unique service enhancements to better serve formerly homeless individuals in supportive housing and partnering with health centers to provide comprehensive and age-appropriate care for their consumers. Health centers are also witnessing a surge in their older consumer population. Between 2013 and 2015, there was an increase in the number of consumers ages 50-64 and 65+ across all health centers at a higher rate than the overall health center population. In this time frame, there was an 18% increase in individuals age 65+ compared to an 11% increase in the total number of health center consumers. Health Care for the Homeless funded health centers saw a 30% increase in consumers 65 and older.[3] The increase in services provided to an aging population is consistent with national trends in the U.S. homeless population and warrants further exploration into how health and housing partnerships can work to address the unique needs of an aging consumer population.

NYU-Lutheran Family Health Centers Woodstock Hotel Clinic

Located in the heart of NYC's Times Square, Project FIND's Woodstock Hotel has 280 consumers over the age of 55 with the average age of 70. Founded in 1967, Project FIND's mission is to provide formerly homeless and low-income seniors with the services and support they need to enrich their lives and live independently. In 1981, an on-site clinic was opened on the 10th floor of the Woodstock Hotel (a supportive housing location) available to all Woodstock residents as well as street homeless elderly who use the Woodstock Senior Center on the second floor of the Hotel.

Seattle-King County's Housing Health Outreach Team (HHOT)

The HHOT is a partnership between Seattle-King County Public Health's Health Care for the Homeless Network (HCHN) and five community partners to provide on-site medical and mental health care to formerly homeless consumers in supportive housing. HHOT's goal is to optimize health and improve quality of life for these vulnerable people by providing consumer-centered care through an interdisciplinary team approach that integrates on-site case management and medical care with off-site primary care, behavioral health treatment services and health education.

[1] Part 2 of the 2015 Annual Homeless Assessment Report. https://www.hudexchange.info/onecpd/assets/File/2015-AHAR-Part-2.pdf

[2] Brown RT, Kiely DK, Bharel M, et al. Geriatric syndromes in older homeless adults. J Gen Intern Med. 2012 Jan; 27(1):16–22. Epub 2011 Aug 31 Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3250555/

[3] Uniform Data System. Analysis of de-identified data sets from 2013-2015. https://bphc.hrsa.gov/datareporting/reporting/index.html

[4] http://www.csh.org/supportive-housing-facts/introduction-to-supportive-housing/

Population

Recent research suggests that supportive housing may serve as an effective intervention to prevent premature placement into costly institutions like nursing homes – particularly for those with behavioral health challenges.[5] Those aging in supportive housing want to remain in their homes for as long as possible, however later life needs can be substantial and are exacerbated by years of trauma from living on the street/in shelter and existing mental health and/or substance use disorders. As such, existing programs may require enhanced and flexible service modalities to support the progressing and unique challenges their consumers now face as they age.

Project FIND Woodstock Hotel

Ages 55+
Formerly Homeless and Extremely Low Income

Seattle Housing Health Outreach Team

No specific age requirements, though a majority are over 55
Formerly Homeless and Extremely Low Income

While older homeless adults have lower rates of mental illness and substance use disorders compared to younger homeless people, their rates are much higher than general population:[6]

- ***Mental Illness:*** Nearly 75% report 1+ psychiatric conditions. Major depression: 34-60%, Anxiety disorder: 19%, Post-traumatic stress disorder: 12%
- ***Substance Use Disorder****:* Reported rates vary. Current alcohol use problems: 20-40%, Current drug use problems: 15-25%, Lifetime rates much higher: >80%, Current tobacco use: ~65%

Service Approach: The Woodstock Hotel

NYU-Lutheran Family Health Centers Woodstock Hotel Clinic

This program employs a housing stability model where case management and service providers serve as partners in a consumer's ability to stay housed. Consumers are informed about their options, and obtain access to services critical to maintaining independence

Referrals from Department of Homeless Services

Supportive Housing

Services provided by a sis-person care team with a substance use specialist and primary care providers

Care coordination with monthly case conferences

Referrals

A majority of its consumers are directly referred from the NYC Department of Homeless Services (DHS) shelter system and nearly 70% of its consumers have incomes that fall below the federal poverty level (less than $12,060 for an individual in 2017).

Staffing

With funding from the DHS, the Woodstock Hotel has a 6-person social services team, which includes a substance abuse specialist. Psychiatric services are provided by the Center for Urban Community Services on a contract basis and in-house medical care is provided by the NYU-Lutheran Family Health Centers network. This primary care team includes a part-time physician, part-time medical assistant, part-time administrative assistant and part-time social worker who provides supportive therapy.

Services

Services include primary care, episodic care, physical exams, TB screening, STI/HIV testing, health education, vaccinations (including Influenza), psychiatric assessments, substance abuse screening and education, entitlements assistance and gynecological care. Referrals are also made to primary care, dental services, HIV care, psychiatric treatment, consumer navigators and other specialty services.

Care Coordination

The Woodstock social service team and the health network team have monthly case conferences on all the consumers receiving care at the health center. Approximately 35% of the Woodstock's 280 consumers receive regular care at the medical center and more than 50% receive some services from the onsite medical center at least once a year. With the appropriate releases in place, the teams track and monitor their consumer's chronic conditions and engagement in care. Woodstock staff have Health Insurance Portability and Accountability Act (HIPAA) release forms signed at intake. Once trust is established, staff are able to obtain information on wills, health care proxies, and Advanced Directives. In 2016 the health center fully merged with New York University (NYU) Hospital providing greater access to a consumer's electronic health records and continuity of care. The onsite physician also makes home visits as needed for consumers who are unable to access the 10th floor clinic due to mobility challenges.

[5] Bamberger, J. D., & Dobbins, S. K. (2015). A research note: Long-term cost effectiveness of placing homeless seniors in permanent supportive housing. Cityscape, 17(2), 269-277. Retrieved from https://www.huduser.gov/portal/periodicals/cityscpe/vol17num2/article11.html

[6] Brown RT, Goodman L, Guzman D, Tieu L, Ponath C, Kushel MB (2016) Pathways to Homelessness among Older Homeless Adults: Results from the HOPE HOME Study. PLoS ONE 11(5): e0155065. https://doi.org/10.1371/journal.pone.0155065

Service Approach: Housing Health Outreach Team

Seattle-King County's Housing Health Outreach Team (HHOT)

The HHOT provides formerly chronically homeless supportive housing residents access to both on-and off-site comprehensive and age-appropriate services provided through an interdisciplinary team of providers.

VI-SPDAT and/or VAT scores are included with the housing application

Supportive Housing

HHOT connects consumers to primary care and social services

Care coordination is essential to address co-occurring conditions

Referrals

Supportive housing candidates are identified through a vulnerability assessment tool (VI-SPDAT/VAT). Those with the highest scores are targeted for available supportive housing slots and are provided assistance with the housing application. Once a lease is signed, the HHOT clinical team connects with the consumer to engage them in services and begin the care coordination with other key partners.

Staffing

Services are coordinated by the Health Care for the Homeless Network (HCHN), and are provided by the partner health center, Neighborcare Health. Additional behavioral health services are provided by Evergreen Treatment Services. HHOT began with HCHN grant funding in 2007 in seven supportive housing sites in Seattle and included three nurses, a part-time primary care provider, and two chemical dependency counselors. Services gradually expanded over time, and by 2017 now includes nine nurses, a mental health provider, chemical dependency provider, PCP, ARNP, and services at seventeen supportive housing sites.[7]

Services

The HHOT connects consumers to primary care, brings the physician to the housing site when necessary, coordinates referrals to specialty care, and assists with setting up in-home services such as palliative care. HHOT staff also provide disease management education and assist with setting self-management goals, immunizations, medication support, and monitoring of health status. HHOT teams conduct groups and classes to educate the consumer on fall prevention, infectious disease prevention, advanced planning for end of life, nutrition and exercise. Key services such as consumer referrals, substance abuse treatment coordination, counseling, wound treatment, and crisis intervention are an integral component to the work needed to keep older consumers stably housed.

Care Coordination

The majority of consumers in the HHOT buildings live with co-occurring disorders that contribute to behavior or actions that can jeopardize their housing. The HHOT integrated team knows that housing separated from services will not fully address the conditions for this older population – effective planning and care coordination are key to maintaining housing.

Challenges & Opportunities

Challenges

- Supporting a consumer's desire to remain in their home as they become more medically frail
- Medication assistance (e.g. discrepancies in drug regimens, medication reminders)
- Assisting clients to have a positive view of healthy aging
- Building the trust of formerly homeless consumers who have had negative past experiences with the health care system
- Co-occurring poly-substance use and mental health challenges with other chronic health conditions
- High need for wound care
- Building cross-sector partnerships; incorporating different funding streams and staff i.e. health home care workers,

Opportunities

- Ability to see and directly impact the health issues facing consumers through established trusted relationships
- Ability impact not only medical/ behavioral needs but also social and long-term support need
- Empower consumers, with the assistance of supportive staff, to improve health care management and self-care
- Establishing integrated models of effective care for replication in other supportive housing sites
- Strong care coordination and treatment planning with key partners: home health aides, hospitals, managed long-term care plans, occupational and physical therapists, pharmacies, churches, and consumers

[7] http://www.kingcounty.gov/~/media/operations/DCHS/Levy/2012_Updated_Imp_Plans/2_4_A_HHOT_2012_Implementaiton_Plan_final.ashx?la=en

About CSH

CSH transforms how communities use housing solutions to improve the lives of the most vulnerable people. We offer capital, expertise, information and innovation that allow our partners to use supportive housing to achieve stability, strength and success for the people in most need. CSH blends over 20 years of experience and dedication with a practical and entrepreneurial spirit, making us the source for housing solutions. CSH is an industry leader with national influence and deep connections in a growing number of local communities. Our headquarters is in New York City with staff stationed in more than 20 locations around the country. Visit csh.org to learn how CSH has and can make a difference where you live.

About NHCHC

The National Health Care for the Homeless Council (NHCHC) is a network of doctors, nurses, social workers, consumers, and advocates who share the mission to eliminate homelessness. Since 1986 we have been the leading organization to call for comprehensive health care and secure housing for all. We produce leading research in the field and provide the highest level of training and resources related to care for persons experiencing homelessness. We collaborate with government agencies and private institutions in order to solve complex problems associated with homelessness. Additionally, we provide support to publicly funded health centers and Health Care for the Homeless programs in all 50 states. Visit

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Impact

Seattle's Housing Health Outreach Team (HHOT)[8]

Housing Stability: *One year 92% remained housed* – 2013

37% Reduction in ambulance calls in supportive housing with nurse onsite

Increased Access to Care:

- 6,840 encounter in 2014
- 65 Psychiatric
- 320 Primary Care
- 386 Behavioral Health Counseling
-

Establish Primary Care Provider: *51% established PCP in community*

The Woodstock Hotel[9,10]

83% have an identified primary care provider

62% have a health care proxy identified

Approx. 13% (n=37) were hospitalized at some point in 2016 and about 10% (n=27) visited the ER and were released

Housing Stability: Over a 3-year period (2010-2013) less than 3% of the Woodstock consumers faced eviction. During this period, of all their movements (n=81), a majority (32% or n=26) were due to death or moving elsewhere to be closer to family or friends (30% or n=24).

Getting Started

1 Understand Need
Those who are aging and have experienced homelessness tend to have health and geriatric issues that are typical of individuals who are 15-20 years older

2 Identify Partners
Consider stakeholders such as Home Health Agencies, Hospitals, Homeless Service Providers, Housing Providers, Department of Aging, and Medicaid Department, etc.

3 Define Services and Model
Explore other models that are effective for an aging population and develop service team to meet the needs of this group.

4 Determine Costs and Funding
Start-up and continuing costs; Funding from grants, hospital contracts, managed care, etc.

[8] http://www.kingcounty.gov/depts/health/locations/homeless-health/healthcare-for-the-homeless.aspx
[9] http://www.projectfind.org
[10] Data provided by ProjectFINDs annual report for 2016