King County

Department of
Community and Human Services

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IMPLEMENTATION PLAN
2012 – 2017 Veterans and Human Services Levy:
Activity 2.4 A: Support Services for Housing: Housing Health Outreach Team

1. Goal

The primary goal of this activity is to reduce unnecessary criminal justice and medical system involvement.

2. Strategy

The Levy's investment in Strategy 2 focuses on ending long-term homelessness through a variety of interventions including identification, outreach, prevention, housing, supportive services and education.

3. Activity 2.4 A: Support Services for Housing: Housing Health Outreach Team (HHOT)

Strategy 2.4(a) is designed to support formerly homeless individuals in permanent housing through the Housing Health Outreach Team (HHOT) sited at supportive housing sites in Seattle and South King County.

4. Service Needs, Populations to be Served, and Promotion of Equity and Social Justice

a) Service Needs

Levy funding provides the HHOT program with the operating and staffing resources needed to effectively contribute to the long term stabilization and success of formerly homeless clients at the 13 HHOT housing sites. Services are coordinated by the Health Care for the Homeless Network (HCHN), and provided by Evergreen Treatment Services, Neighborcare Health, and HealthPoint. The majority of tenants in the HHOT buildings live with co-occurring disorders that contribute to behavior or actions which can jeopardize their housing. Key services such as patient referrals, substance abuse treatment coordination, counseling, wound treatment, medical care referrals, and crisis intervention are an integral component to the work needed to keep clients stably housed. This is the work that the HHOT team does, and these critical services are supported directly through VHSL funding and support.

The objective of this investment is to assure that appropriate health care linkages and supports are included in permanent supportive housing projects, so that the tenants can establish a

regular health care regimen, rather than relying on costly emergency care. Health care and wellness services are cited by the Corporation for Supportive Housing as among those that are needed in supportive housing for homeless people.

b) Populations to be Served

The homeless population in King County resides mainly in two geographic areas: the Seattle downtown core and its adjacent urban neighborhoods, and South King County, an area which includes sixteen cities spread amongst large unincorporated areas. Downtown Seattle and nearby neighborhoods have the county's highest density of homeless individuals, with large numbers of chemically dependent and severely mentally ill people living in shelters, on the streets, in greenbelts and in cars.

The target population is a highly vulnerable group of chronically homeless individuals living in supportive permanent housing. Residents in permanent supportive housing experience a wide range of health concerns, exacerbated by poverty and long histories of lack of access to adequate health care. They suffer from substance abuse disorders and/or diagnosed mental health conditions, in addition to chronic health conditions and a history of high utilization of crisis health services. Veterans are overrepresented among those served by HHOT providers; the percentage of veterans served by the program is high when compared to their number in the general population. Co-occurring substance abuse and mental health issues, including Post Traumatic Stress Disorder (PTSD), are common.

For a person experiencing chronic homelessness, self-management of a chronic health condition can be perceived as a low priority and may be postponed, even within supportive environments. Clients who are dually diagnosed with both mental health and chemical dependency issues face particularly significant challenges, and years of homelessness can intensify existing mental health and substance abuse conditions, making it increasingly difficult to stabilize and maintain housing.

c) Promotion of Equity and Social Justice

The Equity and Social Justice Ordinance requires King County to consider the impacts of its policies and activities on its efforts to achieve fairness and opportunity for all people, particularly for people of color, low-income communities and people with limited English proficiency.

i) Will your activity have an impact on equity?

The HHOT program's primary focus is on coordinated efforts to achieve fairness and opportunity for people of color, low-income communities and people with limited English proficiency. The nursing and mental health team work closely with hospitals and homeless outreach teams to help clients access their benefits and establish primary care with services. Oftentimes, clients have gone for years with no medical care. Nurses and mental health professionals who have received in-service are able to help bridge the gap to establish a medical home for clients. Nurses often accompany patients to initial appointments providing a 'warm hand off' to the service team and developing a plan for communication and care coordination between the provider, patient and HHOT nurse. Awareness and sensitivity to the client's history, pride and barriers to care allow HHOT to develop a sustainable working relationship with the patient and support them in negotiating the health system and establishing primary care.

ii) What population groups are likely to be affected by the proposal? How will communities of color, low-income communities or limited English proficiency communities be impacted?

HHOT works in 13 housing first supportive housing sites which have various funding contracts to target specific social groups. All of the housing first programs prioritize chronically homeless adults who are high utilizers of community resources such as Jail Health, Medical Respite, hospital emergency rooms, and sobering center. Two of the sites provide elderly care and housing for seniors, two sites exclusively serve women, three sites focus on chronically mentally ill clients, and one site receives all new residents from the sobering center. All 13 sites provide care to low-income people with diverse cultural backgrounds. People of color, women, limited English speakers, Native Americans and people with a history in the criminal justice system are over-represented in the housing first supportive housing sites as well as in the homeless population in King County.

iii) What actions will be taken to enhance likely positive impacts on these communities and mitigate possible negative impacts?

HHOT's client centered model focuses on patient participation in creating plans of care, with clients setting self-management goals, action steps and assessing progress. Staff focus on providing culturally competent care and coordinating with services that are culturally appropriate. The clinical team is diverse with a variety of life experiences and backgrounds. They participate in regular group clinical consultations, which allow the diverse staff backgrounds and training to be reflected in treatment planning. Staff have had the opportunity to use interpreters and seek consultation on special populations to ensure care is provided in the patient's first language and is culturally appropriate. Staff have had trainings to support awareness and competency in providing care to a diverse group of patients. Recent trainings have included trauma informed care, elderly care and services, veterans' services and street drug usage.

5. Activity Description

HHOT is comprised of two distinct teams that operate separately in South King County and Seattle. HHOT provides nursing, mental health and chemical dependency services in permanent supportive housing buildings throughout Seattle and South King County.

In Seattle, an interdisciplinary team provides services in 13 selected permanent supportive housing sites for formerly homeless adults. Medical services are provided by 6.3 FTE nurses, 1.0 FTE mental health practitioner and 0.2 FTE physician. The two chemical dependency providers on the team are employed by Evergreen Treatment Services. The chemical dependency and mental health specialists help clients connect with resources, and advocate for them once care is established. They spend a considerable amount of time helping clients get to a point where they are eligible for financial and medical resources which help lessen their risk for eviction. HHOT chemical dependency staff emphasize harm reduction and motivational interviewing. The team coordinates closely with housing support staff to connect formerly homeless residents with primary care, mental health, and chemical dependency services in the community.

In South King County, a cross-agency team includes a 1.0 FTE nurse employed by HealthPoint who works closely with staff of South Mental Health (SMH) to connect residents of SMH's South County Housing First Project to primary care. Every new resident undergoes a thorough health

screening and assistance connecting with the appropriate health care provider in the community. The nurse assists with medication, coordination with outside care, and provides extensive chronic disease management support, which can be particularly challenging for patients with acute mental health issues. Residents are similarly formerly homeless and are challenged by mental health and addiction histories.

6. Funds Available

The 2012 Service Improvement Plan identified the following allocations for this activity.

	2012	2013	2014	2015	2016	2017
Veterans Levy	**$ 75,000**	**$ 75,000**	**$ 75,000**	**$ 75,000**	**$ 75,000**	**$ 75,000**
Human Services Levy	**$165,000**	**$165,000**	**$165,000**	**$165,000**	**$165,000**	**$165,000**
Total	**$240,000**	**$240,000**	**$240,000**	**$240,000**	**$240,000**	**$240,000**

7. Evidence-based or Promising Practices

In implementing on-site health services, Health Care for the Homeless Network uses best practices in care delivery techniques. For example, all members of the HHOT receive training in motivational interviewing, a proven method for enhancing motivation to change. Staff also work with clients with chronic health conditions to set self-management goals. Self-management support is one of the six areas in the Chronic Care Model advanced by the Institute for Health Care Improvement and the national Health Disparities Collaboratives designed to encourage high-quality chronic disease management (Glasgow RE, Davis CL, Funnell MM, Beck A. Implementing practical interventions to support chronic illness self-management. *Joint Commission Journal on Quality and Patient Safety*. 2003 Nov; 29(11):563-574).

The program model and approach embodies core guiding principles; namely, housing first, harm reduction, housing as a platform for healthy futures, and the patient-centered health home. Once linked to affordable housing, a connection to health services is established through an integrated model of supportive housing and health services. Staff employ motivational interviewing methods to encourage and promote behavior change and the pursuit of healthier choices; through this harm reduction approach, the barriers to health care access are removed and patients with complex, co-occurring health conditions are able to receive the coordinated care they need.

Utilizing a highly interdisciplinary team that collaboratively implements a comprehensive plan of care and eliminates the need for patients to navigate multiple health services systems on their own, HHOT provides integrated primary and behavioral health care in supportive housing with the goal of assisting clients stabilizing their health and maintaining their housing.

King County has piloted several studies to decrease utilization of crisis healthcare services and resulting public costs with notable positive outcomes. The Begin at Home Project (piloted at Plymouth on Stewart in Seattle) integrated mental health, chemical dependency and primary health care into a single comprehensive team and provided rapid housing to chronically homeless individuals with significant physical or psychiatric disabling conditions. Participants

showed significantly greater reduction in emergency department and sobering center use relative to a comparison group and greater reductions in hospital admissions and jail bookings[1].

The findings of another study of chronically homeless individuals with severe alcohol problems supported strategies to place and retain individuals in housing, including offering on-site medical and mental health services and case management. The study found not only improvements in life circumstances and drinking behaviors of the target population, but significant reduction in use of costly health and criminal justice services. Length of time in housing was significantly related to reductions in use and attendant costs, with those housed for the longest period experiencing the greatest reductions[2].

8. Service Partnerships

HCHN staff and its contract partners participate actively in the planning groups related to the *Ten-Year Plan to End Homelessness in King County* and VHSL.

Services are coordinated by the Health Care for the Homeless Network (HCHN), and provided by Evergreen Treatment Services (chemical dependency services, funded through the City of Seattle and United Way), Neighborcare Health (medical and mental health services), and HealthPoint (medical services). Clients engage one-on-one with the HHOT nurses for assessment, medication compliance, and assistance linking to primary or specialty direct care. In addition, the physician on the HHOT team provides on-site services to resident with acute needs who have been unable to establish primary care services off-site. The HHOT chemical dependency providers engage with chemically dependent clients who are most at risk of losing their housing. HHOT CD providers provide direct counseling to individuals who are unable to link to off-site services, and coordinate and receive referrals from HHOT nurses.

Housing partners include Catholic Housing Services, Downtown Emergency Service Center, and Plymouth Housing Group. Additional funding for the HHOT is provided by City of Seattle and United Way of King County.

9. Performance Measures

The following performance measures were identified by the Levy's Evaluation Team.

Objectives	Service Outputs/ Measures	Most Recent Performance	2013 Target(s)	Data Source

[1] Srebnik, D. (2007). *Begin at Home: A Housing First Pilot Project for Chronically Homeless Adults. One Year Outcomes*. King County Department of Community and Health Services, Mental Health and Chemical Abuse and Dependency Services Division.

[2] Larimer, M.E., Malone, D.K., Garner, M.D., et al. (2009). Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons With Severe Alcohol Problems. *JAMA*, 301(13), 1349-1357.

Treatment/ Intervention	• Clients served (screened)	655	700	Report Card – Services
	• Linked to primary care	295	280	Report Card – Services
	• MH/CD engagement		260	Report Card – Services
	• Self-manage chronic condition		315	Report Card – Services
	• Increase housing stability (retention at 1 year)	93%	93%	Report Card – Outcomes