

TO: Eleta Wright, Chair, King County Health Care for the Homeless Network Governing Council
FROM: John Gilvar, HCHN Program Manager, Public Health – Seattle & King County
DATE: February 22, 2019
RE: **Response to Governing Council Request for Analysis re: Health Care Needs at New Shelters**

Background. At its January 14, 2019 meeting the Health Care for the Homeless Governing Council (GC) unanimously passed a resolution asking “the HCHN Admin Team to analyze the current need for healthcare services in the new shelters coming online, including information on projected costs.” The Admin Team is aware of multiple new shelters that recently opened or are scheduled open in the next 1-2 months. These shelters include those that are key components of King County Executive Dow Constantine’s emergency housing strategy initiative¹ and shelters funded under separate programs, such as the Bridge Shelter operated by Catholic Community Services in Belltown and serving individuals who are high priority in the coordinated entry process. Altogether, these new shelters will offer several hundred new beds, but only a fraction of the proposed new shelter beds are currently online.

Because the largest of the new shelters at Harborview Hall (on the Harborview Medical Center campus) has only been open for a short time and others have not yet opened, the Admin Team has just begun our planning for formal needs assessment work specific to new sites. Nevertheless, we are able to offer a general assessment of anticipated need based on previous research, observations of the Mobile Medical Program Seattle team from its first clinic at the new Bridge Shelter and its ongoing clinics at the Navigation Center, and a significant number of anecdotal reports from other HCHN front line providers serving residents of existing shelters. As a preliminary response to the 1/14/19 GC resolution we are therefore providing below some contextual information as well as a discussion of two possible complementary strategies to better meet the increasing need for medical and behavioral health services in shelters as well as other hotspots of need among the unsheltered population.

Problem Statement: A Growing Crisis. To address the growing numbers of people living homeless in King County, local government has responded by expanding the shelter system and revamping the coordinated entry process to house more people faster. While the unmet medical, mental health, and substance use needs of people living outside often go undetected, those needs come into sharp focus when they enter a shelter, sanctioned encampment, or housing facility. And as more and more people with acute and complex needs enter these spaces, a bright light is shined on a problem the Governing Council has discussed on several occasions: the healthcare system as a whole – which is largely defined by its rigid reliance on appointments in order to receive medical care - is ill-structured to meet the complex medical and social service needs of a population that struggles to make and keep appointments. The ultimate result of this dynamic has been that local shelter and housing staff, emergency medical responders, and emergency rooms are all telling us that they have now reached a crisis point.

A number of factors drive our current homeless health care crisis, most notably:

- From 2007 to 2017, the number of county residents living homeless increased by 47%.

¹ <https://www.kingcounty.gov/elected/executive/constantine/news/release/2019/January/16-shelter-update.aspx>

- Unsanitary living conditions, unsafe living environments and economic hardship predispose persons living homeless to chronic illness, substance use disorder, and infectious disease while diminishing their ability to manage these conditions. The result is a life expectancy that is dramatically lower than the general population (average of 47 years compared to 77).
- People living homeless face numerous barriers to accessing office-based, appointment-based services. Examples include transportation challenges, past trauma/lack of trust, mental health issues, prioritization of survival-oriented activities, and the stress and organizational challenges that accompany homelessness.
- The opioid crisis has resulted in increased injection drug use among the homeless population. Thirty percent of homeless deaths investigated by the medical examiner were attributed to opioid overdose in 2017, and based on 2017 data from our syringe exchange, 43% of persons who inject drugs are living homeless and an additional 26% are unstably housed, a 19% increase since 2015.²
- The homeless population is rapidly aging. Nationally, over 50% of the homeless population are above 50, compared to 11% in the early 1990s (no comparable local data). Yet skilled nursing facilities and adult family homes are not willing to accept individuals with behavioral challenges or active substance use disorder, leaving them either on the street or with limited assistance provided by non-medical personnel.
- King County has 34 medical respite beds which are reserved for only the very highest acuity patients. Our hospitals have no choice but to discharge homeless patients into shelters and housing facilities that are not equipped to manage their care.
- There is grossly insufficient capacity and geographic coverage at existing clinics dedicated to low-barrier access for the homeless population. *Pioneer Square Clinic has a line around the corner every morning and routinely turns away more than 70 people per day seeking walk-in care.* Other parts of the city offer persons living homeless virtually no access to walk-in medical services.

Data. 2018 was the deadliest on record for homeless people in King County, with 191 deaths of homeless individuals recorded by the medical examiner’s office. 2018 also saw the identification of an ongoing HIV outbreak in north Seattle among homeless individuals who inject drugs; this outbreak contributed to a 1-year 300% increase in the number of HIV diagnoses among heterosexual persons who inject drugs, a development that threatens to undermine two decades of progress in King County’s fight against HIV/AIDS. This outbreak mirrors other outbreaks of HIV, hepatitis A, typhus, and other communicable diseases among homeless populations in other cities across the nation. The following data provide an additional window into the extent of unmet health care need among our homeless population:

- Among the 93 locations in Seattle with the highest volume of documented first responder (911) calls in 2018, 40% of those locations were either shelters or supportive housing facilities, and these sites accounted for 45% of total calls and 50% of low acuity 911 calls received (n=4,973).
- Among chronically homeless single adults with co-occurring substance use and mental health disorders who used a shelter or transitional housing in 2016 (n=4,247), 57% were not enrolled in publicly-funded mental health or substance use treatment at the time of their shelter or transitional housing usage.

² The Mobile Medical Program’s Seattle team reports that at its first clinic at the recently opened Bridge Shelter in Belltown, it saw a very high volume of need, particularly among injection drug users who had moved into the shelter due to the impending closure of the Licton Springs low-barrier sanctioned encampment and their eligibility for a Bridge shelter bed, based on a high score on the vulnerability assessment tool (VI-SPDAT) use by the Coordinated Entry system.

- Similarly, among the 2,666 homeless families awaiting housing via coordinated entry in Q4 2017, 77% of heads of households self-reported that they had a mental health and/or substance use issue, but when cross-walked with Medicaid data, only 10% of these individuals had received services in the prior 4 months.
- About 50% of the inmate population in King County jails is homeless and about 10% suffers from severe mental illness, making our correctional facilities both the largest homeless shelters and the largest institutions for the mentally ill in the county. As documented by the Familiar Faces Initiative, only a small fraction of people experiencing homelessness are successfully linked to health care and other services upon release.

Current Public Health Strategies and Limitations. As you know, HCHN currently provides numerous outreach-based services including nursing care and mental health outreach in shelters, on the street, and in permanent supportive housing; shelter-based palliative care; and two mobile medical vans that visit encampments, day centers, and meal programs. Public Health’s HIV/STD Program provides needle exchange and HIV/Hepatitis testing services in various street-based mobile and fixed locations. These specialty providers use a trauma-informed, relational approach that builds trust over time to engage a population that is often resistant to office-based care.

Medicaid reimbursement restrictions severely limit the extent to which outreach-based programs can be covered with state and federal funds, however. Public Health must therefore spread FTE thinly to provide service to as many sites as possible. For example, the current mobile medical vans, while effective in expanding low barrier access to care for the unsheltered population, cover a very wide geographic area. Currently operating at its full capacity, the program rotates among a long list of sites to provide a mobile clinic once or twice per month at each. Likewise, the 20 FTE of HCHN-funded medical and behavioral health staff who provide shelter-based services do not have nearly the capacity to serve the over 30,000 unduplicated individuals per year who use King County’s 6,470 emergency, transitional and Safe Haven beds. And most clinics offer very limited walk-in clinical services, which are more costly to provide.

A Two-Pronged Approach to Creating a Low Barrier Continuum of Care for the Most At-Risk. A nimbler strategy is needed to quickly respond to acute levels of need at new hot spots and engage small pockets of sheltered and unsheltered individuals who are most at risk. One such strategy would employ mobile multi-disciplinary teams that include medical and behavioral health providers offering acute treatment services as well as specialists who can provide HIV and other communicable disease testing and prevention services including needle exchange and HIV/STI screening and treatment. Given the constant movement of the homeless population from neighborhood to neighborhood and in and out of shelter, often resulting from enforced encampment clean-ups, the teams would need to be structured to maximize flexibility. Current mobile vans are full-sized RVs which require special parking and cannot easily be deployed to multiple locations per day.

To be effective a new approach such as this one will also require improved linkages to enhanced, low-barrier brick and mortar clinics that have adequate walk-in capacity and case management services. After outreach-based care providers work to build relationships and engage their clients into care, they face the fresh challenge of transferring their patients to a brick and mortar clinic to establish a health care home or for specialty care. But even the most skilled case managers fail in this task more often than not because most clinics only offer 15-20 minute appointment slots which must be booked well in advance. For individuals who are struggling to survive each day, for individuals with mental illness, for individuals with substance use disorders, set

appointment times are just one more barrier to receiving the care they need. This population needs on-demand care to successfully engage with the health care system.

There are several examples of clinics that excel in serving this population by offering low barrier, harm reduction-oriented walk-in services: Public Health's Buprenorphine Pathways clinic downtown provides low barrier suboxone treatment to homeless needle exchange patients. The Max Clinic – a collaboration between Harborview and Public Health - provides care to approximately 150 primarily homeless persons living with HIV who have failed to engage in care elsewhere, with 65% achieving viral suppression. The Navos Clinic, Ballard Clinic, Boren Clinic, and five homeless youth clinics provide low barrier primary care to 1,600 homeless people each year. But these model clinics unfortunately come nowhere close to providing the geographical spread or service capacity that is needed.

The following is a preliminary outline of a two-pronged strategy that the HCHN Admin Team believes should be explored.

Strategy #1: Increase the capacity of outreach-based health care services to reach priority populations and provide an appropriate level of coverage at the most impacted locations, including shelters coming online in upcoming months, as indicated by needs assessments

- Pilot a new mobile street medicine team that includes health care, immunizations, substance use treatment, and harm reduction services using two small vans that can be parked in virtually any location and deployed wherever they are needed most. This nimble team could follow hotspots as they shift in response to encampment closures and shelter openings.
- Expand on-site health care provider capacity to serve shelters and PSH sites with the highest volume of low acuity 911 calls

Strategy #2: Create a network of low barrier access points at existing clinics in strategic locations to facilitate health care system access for the most vulnerable in our community

- Explore how to provide supplemental resources to FQHCs, community mental health centers, and other partners to expand low barrier, on demand care that is tailored to the homeless population's unique needs, in alignment the Familiar Faces future state vision of the drop-in Campus of Health. These access points would also be a resource for emergency responders to divert patients away from unnecessary emergency room utilization.
- Prioritize go-first pilots in geographic areas with the most critical needs, such as Pioneer Square and North Seattle.
- Leverage local and federal funding for expanding treatment for opioid use disorder, including MIDD and SAMHSA funding.

Current Geographic Priority Areas. There are a number of current hot spots in the homeless health care crisis that have already been identified by the shelter providers, public health disease surveillance, and Seattle Fire Department, including the following:

- North Seattle Aurora corridor- ongoing HIV outbreak among homeless individuals who use IV drugs
- Bridge Shelter, Belltown- operated by Catholic Community Services, this shelter houses individuals who are high priority in the coordinated entry process and by definition have significant health and mental health needs

- Lazarus Center Day Center, south Seattle- serves and elderly and infirm population including many individuals recently discharged from the hospital
- Union Gospel Mission Shelter, Pioneer Square- very high volume of 911 calls
- Navigation Center, International District- shelter for individuals moved out of unsanctioned camps by the navigation team. Very high medical and mental health need reported by shelter operators
- Winter Emergency Shelters, multiple locations- during the recent weather event, the emergency shelters experienced high volumes of health and mental health need among shelter users

Cost Considerations. The Admin Team has developed a cost estimate for piloting a mobile street medicine team as described above. We estimate that the first-year operating cost would be approximately \$625,000 and the one-time capital cost to purchase a small, customized van and medical equipment for this team would be approximately \$185,000. To date we have not identified a funding source that could cover the total first-year cost of about \$810,000.

It is more difficult to provide an estimate of the cost of pursuing the various components of Strategy #2, above. As a reference point, however, the annual operating cost for the 5-day per week low-barrier HCHN's Boren Clinic at the Sobering Center, which includes medical, behavioral health, and case management services, is between \$650,000 and \$700,000. Obviously adding one additional clinic of this scale will not achieve the larger goals of this strategy, so the cost of expanding access to on-demand services across the county will likely be several times this figure. We are currently exploring potential sites for a new 40-hour per week clinic that we would propose to HRSA for New Access Point grant funding, as discussed with the Executive Committee. Both the Ballard Clinic and the Boren Clinic were created using HRSA New Access Point grant funding. Another successful New Access Point grant would provide a down payment of sorts toward the comprehensive goals outlined in Strategy #2.