Health Care for the Homeless Network

Annual Report • 2016

Public Health
Seattle & King County

Health Care for the Homeless Network (HCHN)

Mission Statement and Report Overview

HCHN provides high-quality, low-barrier health care services to individuals and families experiencing homelessness. We lead efforts to change the conditions that deprive our neighbors of home and health.

In 2016, HCHN providers engaged 20,443 individuals and completed over 107,000 patient visits - our highest reported numbers in over five years. The increase confirms a continued need for services and to accelerate change.

This report includes consumer and provider input, highlights progress on current priorities, and offers examples of our best practices.

Thank you for your interest in learning more about Health Care for the Homeless Network.

CONTENTS

Advisory Board	3
Network Partners	5
Needs Assessment	6
Programs	7
Data Summary	15
Financials	16
Acknowledgments	17

HCHN Planning Council and Governing Board

The HCHN Planning Council plays an essential consumer and community advisory role in planning and evaluating HCHN programs and services.

It provides guidance and policy direction to HCHN administrative staff, Public Health - Seattle & King Co. management, and the King Co. Board of Health. The Council also plays a key role in annual community needs assessment and strategic planning.

Members include consumers, health care professionals, homeless service agency providers, and funders. Over half have helped guide HCHN planning for over ten years.

HCHN PLANNING COUNCIL

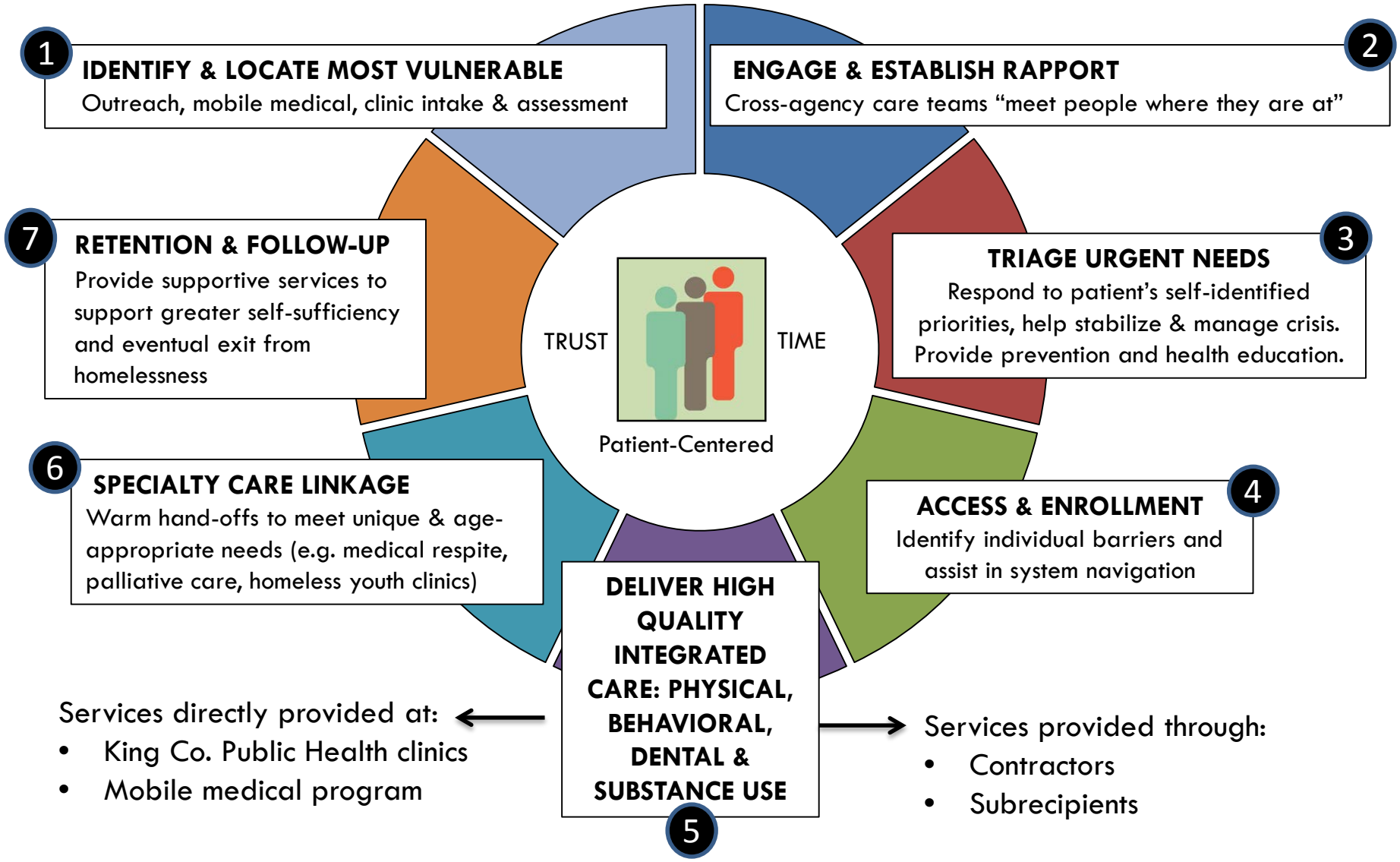
Maureen Brown, MD, Co-Chair, Swedish Family Practice
Gregory Francis, Co-Chair, Consumer Representative
Carole Antoncich, Plymouth Housing Group
Margo Burnison, KC Dept. of Community &Human Services
Rebekah Demirel, Community Advocate
Sinan Demirel, Consultant
Tricia Madden, Harborview Medical Center
Francesca Martin, Compass Housing Alliance
Maria Metzler, Downtown Emergency Service Center
Mark Putnam/Kira Zylstra, All Home - King County
Eva Ruiz, Consumer Representative
Jeff Sakuma, City of Seattle, Human Services Dept.
Charlotte Sanders, UW School of Social Work
Sheila Sebron, Veterans Advocate
Kate Speltz, KC Dept. of Community & Human Services
Susan Vaughn, YouthCare

KING COUNTY BOARD OF HEALTH* HCHN STANDING COMMITTEE

Sally Bagshaw, Seattle City Council Member
Bill Daniell, Health Professional
Jeanne Kohl-Welles, King County Council Member
Largo Wales, Auburn City Council Member

*** Provides governance for our 330h grant from the federal Health Resources and Services Administration**

How We Connect to Patients Most in Need



Services directly provided at:

- King Co. Public Health clinics
- Mobile medical program

Services provided through:

- Contractors
- Subrecipients

2016 Network Partners – Integrated Care Teams Working at over 60 Sites

1. Country Doctor Community Health Services

Nurses from Country Doctor's Carolyn Downs Family Medical Center served over 250 individuals and families in shelters and transitional housing sites.

2. Evergreen Treatment Services

Chemical dependency professionals, REACH program outreach workers, case managers, & benefit enrollment specialists engaged over 2,000 unsheltered adults on the streets, in clinics, and on both mobile medical vans.

3. Harborview Medical Center (HMC)

HMC clinicians provided integrated physical and behavioral health care to over 3,400 patients across multiple clinic and community-based sites. Specialty services include palliative care and medical respite.

4. HealthPoint

A multidisciplinary team of nurses, social workers, and benefit enrollment specialists connected with over 1,000 patients throughout King County. Sites included shelters, permanent supportive housing, and on our South King County mobile van.

5. Neighborcare Health

Neighborcare Health engaged over 2,200 adults and youth at clinics and permanent supportive housing sites through the Housing Health Outreach Team.

6. Seattle Indian Health Board

A Seattle Indian Health Board nurse provided care and linked nearly 200 patients at the Chief Seattle Club to a wide variety of essential health resources.

7. University of WA Adolescent Medicine

Licensed professionals provided medical and behavioral health services to over 100 youth and young adults at the Country Doctor homeless youth clinic.

8. Valley Cities Counseling & Consultation

VCCC provided behavioral health and outreach services to nearly 275 patients in their Families in Shelter and Bridges programs across King County.

9. YWCA – Seattle/King/Snohomish

The YWCA Health Care Access Team linked over 600 women and families to health insurance, medical, dental, and eye care.

Learning from Individuals with Lived Experience: 2016-2017 Needs Assessment

The HCHN Planning Council prioritized increasing consumer input into needs assessment and planning activities. As one strategy to accomplish this, HCHN and All Home/DCHS staff partnered together to conduct listening sessions with 100 individuals currently experiencing homelessness.

Key Lessons – where our current efforts need to be accelerated:

1. Our coordinated focus on both housing and health care needs remains critical. It takes too long to get housing. It takes very little time for our most medically vulnerable clients to lose it.

2. Racial and ethnic disparities in homelessness and health are well documented and felt deeply by our patients. Targeted investments and strategies are needed.

3. Individuals living homeless still experience fragmented care between physical and behavioral health. Receiving integrated services in one place, near where they stay, remains a key need.

4. Communicable disease and outbreak management are key concerns. Individuals living homeless are particularly vulnerable to resource gaps in basic public health services.

5. HCHN strategies to address substance use should align with broader community responses to the opioid epidemic. This includes greater awareness of levels of chronic pain among homeless individuals.

6. Listening session attendees spoke of being treated poorly while navigating health and housing systems. More staff training is needed on stigma, care standards, and burn-out prevention.

7. Strategies to better meet the needs of homeless youth, older adults, and families of different sizes and structures need to be refined and coordinated with other initiatives working with these groups.

8. Meaningful consumer engagement in planning and evaluation must remain a continued priority. Efforts should coordinate with employment training and professional development opportunities.

The full HCHN Community Needs Assessment report is available on our website.

Meeting People 'Where They Are At' - in Practice with the YWCA

Letitia Magee, Support Services Specialist (l)
Renée Wallace, Health Care Access Advocate

Having someone walk beside you who understands where you have been, and where you need to be, can make all the difference.

Letitia's smile is now one of the first things that women and families starting their journey to health and safety see at the YWCA. Letitia knows that journey well. Now in a position to give back, Letitia credits Renée with providing just the right amount of support at the right times.

"*When we first met years ago, she talked to me about my kids and just regular life. One of the things I really needed to do was go to the dentist but I was afraid. I avoided it for over 15 years. She offered to go to Downtown Dental with me. No one had ever offered that before. I didn't have any family or support here other than my children. She sat with me, held my hand... I don't find too many people like Renée.*"

Renée has been known for her real time advocacy and relationship building skills since she started at the YWCA in 2013. Early on, she recognized how many clients avoided care because of trauma. Accompaniment and follow-through are essential aspects of her work.

Renée and Letitia, along with their co-worker, Gabby Picazo, are the YWCA Health Care Access team. Together, these tireless advocates connected over 600 women and families experiencing homelessness to health insurance and multiple services including medical, dental, and vision care.

Treating Every Dental Patient Like a VIP – New Provider Spotlight

Dr. Dawud Raamah, Dentist, Downtown Dental Clinic

"If I can give patients painless dentistry, or less trauma then what they have experienced in the past, than I am headed in the right direction."

Hear more about Dr. Raamah's story and trauma informed dental care: http://us.thinkt3.com/podcast

- Release date late Nov. 2017

Many patients experiencing homelessness, like Letitia from the YWCA, need extensive dental care but face barriers. Public Health's VIP Dental program is changing that. Dr. Dawud Raamah is one of the new HCHN dentists creating smiles.

Dr. Raamah has a love for dentistry and for people. He joined the team in July 2016. Events in his own life help him empathize with those experiencing homelessness.

"I practice the way I do because I really want people to know and own their power. I can give them love in all situations. I don't care if they are having their best day or worst day ever. I want to give them my best. That's the thing that's going to change their life."

Dr. Raamah builds trust, recognizes trauma, and promotes healing.

"I spend time talking. It's not even about dentistry. I love to talk about their lives and know how they are feeling... I am also hypersensitive of where they are at. They may need for me to be quiet and have almost a meditative moment."

The VIP Program is part of HCHN's 2015-2016 strategic priority to expand dental care capacity and is funded in part by HRSA. In 2016, Dr. Raamah and colleagues served nearly 3,700 patients through over 9,800 visits.

Strengthening and Supporting a Skilled Workforce

Ken Kraybill, MSW, leading a four-month long motivational interviewing training series for HCHN providers.

Communicable Disease Prevention Sessions

HCHN led over 30 trainings in shelters and supportive housing sites and consulted on many encampment outreach strategies.

Clinical Practice Webinars

HCHN launched a monthly webinar series with 85 providers participating to date. Topics included dementia and Tuberculosis.

Assurance that all patients receive high quality care across our network is a key priority.

HCHN implemented multiple initiatives to increase the capacity of our provider community in 2016.

Best Practices in Homeless Health Care

Nearly 200 providers from 16 programs attended our Motivational Interviewing training series with follow-up learning circles and booster sessions.

Secondary Trauma and Resiliency Workshops

HCHN designed a new evidence-based training to help providers recognize and prevent burn-out. Over 70 individuals participated.

Aging in Place

HCHN convened a series of community stakeholder meetings and developed a widely distributed policy paper in response to our Planning Council's priority to enhance healthcare support for homeless housing agencies that help residents age in place. Meetings were attended by representatives of over 20 state and local agencies. A workgroup is now charged with a care coordination improvement pilot.

Mobile Medical Program: Doubling our Capacity Across the County

The Seattle mobile medical van partners with Compass Housing Alliance outreach workers to serve individuals living in their vehicles at the Spokane Street RV Safe Lot.

Our new City of Seattle mobile medical van is on track to nearly double the number of patients served.

Building partnerships with other homeless service providers in the city was a key strategy to the program's early success.

New referral pathways with primary and behavioral health care systems were developed with Neighborcare Health, Harborview and Seattle Indian Health Board.

Outreach efforts were closely aligned with the People's Harm Reduction Alliance, the Hepatitis Education Project, and the Downtown Emergency Service Center.

<u>New Mobile Medical Locations in the City of Seattle</u>

- Community Lunch on Capitol Hill
- Interbay - Tent City 5
- Licton Springs Camp
- Peter's Place
- University District
- Outdoor Sack Lunch Meal
- Othello Village
- Spokane Street RV Safe Lot
- St. Vincent de Paul Food Bank

Mobile Medical served over 1,200 patients and recorded over 3,800 visits for medical, behavioral health, and dental services in Seattle & South King County in 2016.

Helping Patients Recognize Their Own Strengths to Rebuild

The Seattle mobile medical team first met K.J. and her partner while providing outreach at a small encampment in the downtown corridor.

K.J. resisted coming onto the medical van for care but was willing to talk to the team's physician at her campsite and to accept prenatal vitamins.

Over time, the team earned K.J.'s trust. She agreed to see the mobile medical physician so she could hear her baby's heartbeat using the van's doppler monitor.

After a successful first visit, K.J. agreed to follow up with the same physician at the Downtown Public Health Center.

K.J. maintained regular obstetric care with the Downtown team and gave birth to a healthy baby boy. Before discharge from the hospital, the medical van team introduced K.J. and her family to a nurse with the Kids Plus program.

With the help of Kids Plus, the family found shelter and have since transitioned into their own apartment in Federal Way.

J.R. had been sleeping in the woods of Burien for several years. A man in his late 60s, he has chronic mental illness and multiple medical conditions including COPD, uncontrolled hypertension, diabetes, and has suffered heart failure.

He had been to the Highline Hospital ER over a dozen times in one year. J.R. initially came onto the South King County medical van during the hot meal program at Transform Burien. The van physician helped him monitor his medications.

Over time, he began working with the van's social worker. She connected him to our Navos Public Health Center for primary and behavioral health care, and a supportive housing case manager.

J.R. was deemed eligible for their permanent supportive housing program. Since moving into housing nearly one year ago, J.R. has not returned to the ER. He continues to access care at Navos and occasionally on the medical van when it is at the meal program.

Learning with the University of WA – Innovative Community Partnerships

Lois Thetford, PA-C & **Charlotte Sanders,** MSW, onsite at Tent City 3.

HCHN Planning Council Member Charlotte Sanders, and HCHN pioneer Lois Thetford, are building new academic and community partnerships at the University of Washington.

Fueled by student leadership, they teamed up in 2016 to create an innovative opportunity for students and homeless residents of Tent City 3 to learn about, and from, each other.

MEDEX 580: Homelessness in Seattle is their inter-professional course that trains future health care providers to improve health through building trusted relationships today. Multiple HCHN providers and consumers have been guest speakers.

Charlotte and Lois reflects on three lessons learned from students & Tent City 3 residents working together:

1. *It is imperative that we provide future health care providers opportunities to engage people who are experiencing homelessness. This connects those in need with resources as well as connects students to social justice issues.*
2. *Healthcare and social service outreach are greatly needed in Tent City communities. There are barriers to accessing care such as transportation, disabilities, work schedules, mistrust of systems, and mobility.*
3. *We need to be part of broad anti-poverty and affordable housing movements. Health care is one piece. Continually finding ways to reach out and make connections between organizations is key.*

Learn more about the work of Charlotte, Lois and others at UW: http://www.washington.edu/community/homelessness
Watch HCHN Planning Council Member Sheila Sebron's guest lecture here: https://youtu.be/ig0AK6D8BQQ

New Publications from HCHN Planning Council Members

Learning about our past for the future from Sinan Demirel

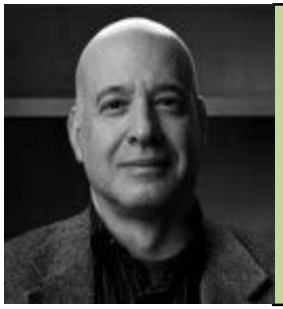
Read more from Sinan:
crosscut.com/author/sinan-demirel

HCHN Planning Council member Sinan Demirel is a long-time community advocate, educator, and leader. In 2016, he published an in-depth three-part series on our local history of homelessness.

Sinan shared reflections with HCHN staff:

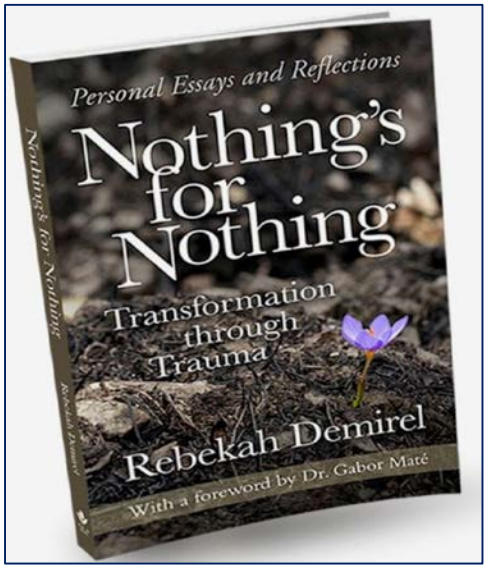
Q. In your 2016 series, you pose the question '*What type of community do we need to be to end homelessness?*' As we plan for the years ahead, what are those key qualities our community must possess and prioritize?

A. "*As so much research has demonstrated, almost every measure of well-being in a society decreases as economic inequality increases. Inequality makes us all unhappy and eats at our social fabric, leaving mistrust and suffering in its wake. How can we begin to reverse the changes of the past forty years? It is easy to feel powerless, but in reality there is so much we can do in our personal lives and as a community.*



"A place to start collectively is in what we prioritize, where we spend our tax dollars, and what we talk about in our public discourse. We demonstrate what is truly important to us in how we spend our time, attention - and money."

New Insights on Resiliency and Community Well-Being, Rebekah Demirel



HCHN Planning Council member Rebekah Demirel's recent writing is an invaluable community resource on the topics of trauma, courage, healing, and resiliency.

Rebekah shared reflections with HCHN staff:

Q. Your writing focuses on healing, resiliency, and conscious living at personal and community levels. As we plan for the years ahead, how should these themes be incorporated into our strategies and partnerships?

Read more from Rebekah:

- ***traumaprograms.com***

A. *"To me our focus is already changing in HCHN to one which is more personal, direct and inclusive. Asking the people we serve how they feel and what they need is the most sensible and respectful way to achieve good results, rather than trying to learn about folks through an arms length approach.*

Doing our own personal work and self care is also very important so we don't get burned out and forget why we started doing the work we do. I call it "Being well enough to do the job" of caring for others. Let's all work together. In a world that is so out of balance, we need to keep coming back to being the change we wish to see in the world."

2016 Patient Demographics & Impact

Total Served: 20,443

Visits: 107,029

African American/Black	26%
American Indian/Alaska Native	7%
Asian	7%
More than one race	6%
Native Hawaiian	1%
Other Pacific Islander	3%
Unreported	7%
White	43%
Hispanic	13%

Female	48%
Male	51%
Transgender	1%

Under age 1	9%
1-3	3%
4-11	2%
12-17	2%
18-24	13%
25-35	20%
36-54	32%
55-64	14%
65-79	4%
80 and over	1%

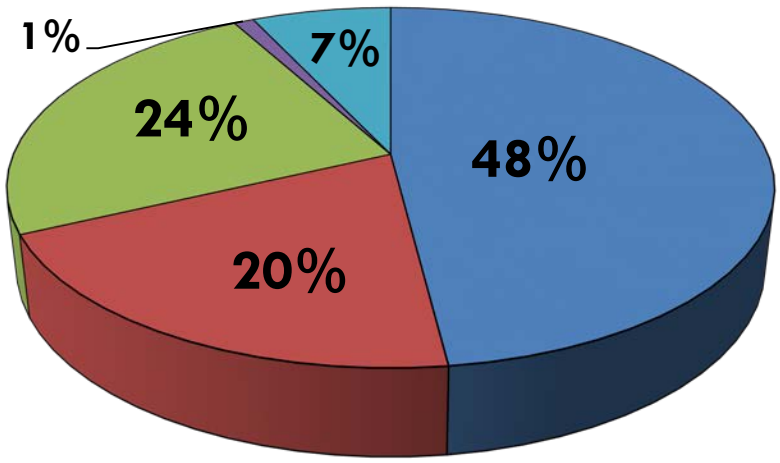
Uninsured	7%

Veterans	4%

Rounded percentages = unduplicated patient characteristics

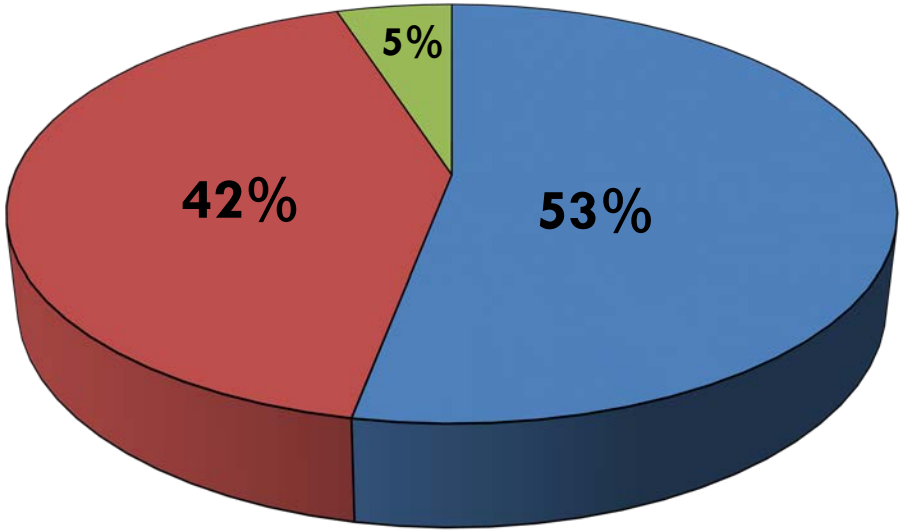
Visits = medical, mental health, dental, substance abuse, and enabling/support services

2016 Revenue & Expenses



REVENUE: $24,446,668

- Medicaid & Other Insurance (48%)
- Federal: HUD & HRSA (20%)
- Local: City & County (24%)
- State: Dept. of Health (1%)
- Private & Other (7%)



EXPENSES: $24,446,668

- Patient Services: Public Health (53%)
- Patient Services: Subcontracts (42%)
- HCHN Administration (5%)

Revenue is on accrual basis. Expenses based on UDS data and accrual basis.

Acknowledgments

Funders

Anonymous donors • Building Changes • City of Seattle Human Services Department • King County Veterans and Human Services Levy • King County Mental Illness and Drug Dependency Sales Tax • United Way of King County • U.S. Department of Health & Human Services, **Health Resources and Services Administration, Bureau of Primary Health Care** • U.S. Department of Housing & Urban Development • Washington State Department of Health • Wyncote Foundation Northwest

Edward Thomas House Medical Respite Partners

Harborview Medical Center • University of Washington Medical Center • Valley Medical Center • Virginia Mason Medical Center • King County Department of Community and Human Services - Mental Illness and Drug Dependency Action Plan • Seattle Housing Authority • Swedish Medical Center • Northwest Hospital • United Health Plan of WA.

The Health Care for the Homeless Network,
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Public Health
Seattle & King County

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