HEALTHCARE FOR THE HOMELESS NETWORK

COMMUNITY NEEDS ASSESSMENT 2016-17

Public Health
Seattle & King County

Content

Health Care for the Homeless Network
Community Needs Assessment
2016 • 2017

Introduction

Health Care for the Homeless Network (HCHN) has served individuals and families experiencing homelessness for over two decades as a HRSA 330(h) Health Center grantee. This report serves as documentation of updated need for King County.

The purpose is to continually better address:
1. Current health care needs
2. Factors associated with access and utilization
3. Health disparities and differential needs

Individual perspectives from those experiencing homelessness and service providers are presented first. Data on our full patient population follows and is available through the Uniform Data System (UDS): bphc.hrsa.gov/datareporting

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Approach

Review of Existing Data

HCHN staff reviewed UDS data on our patient population of over 20,000 individuals, performance measurement data from over 200 providers, and reports from our local Homeless Management Information System (HMIS).

Listening Sessions with Currently Homeless Individuals

Primary data was collected at 7 Listening Sessions with 101 individuals in Public Health clinics, shelters, day centers, and a Safer Parking program.

Interviews and Surveys with HCHN Providers

Current insights were gathered from 43 HCHN providers. Methods included an on-line survey and interviews utilizing Rapid-Feedback Evaluation techniques.

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KEY LEARNINGS

INDIVIDUALS CURRENTLY EXPERIENCING HOMELESSNESS

1. Current Health Care Needs

Disease Burden: overall, individuals described the same costly, complex, and preventable conditions as the general population: diabetes, asthma, hypertension, cardiovascular disease, and cancer.

The major differences are frequency of co-occurring conditions and challenges to stop disease progression.

Chronic Disease Management

Chronic Pain

Basic Needs

Dental

Vision

Physical Pain: stems from rough sleeping, early onset of arthritis and aging, disabilities, untreated or undiagnosed conditions, wounds, and lack of medication access.

Emotional Well-being: additional pain and suffering from chronic stress, trauma, and untreated mental health conditions. Alcohol, smoking, and other substance use were intertwined in reports of pain.

Dental Care: reported needs included emergency surgeries and complex oral health needs due to access issues, chronic disease progression, and challenges with basic oral hygiene.
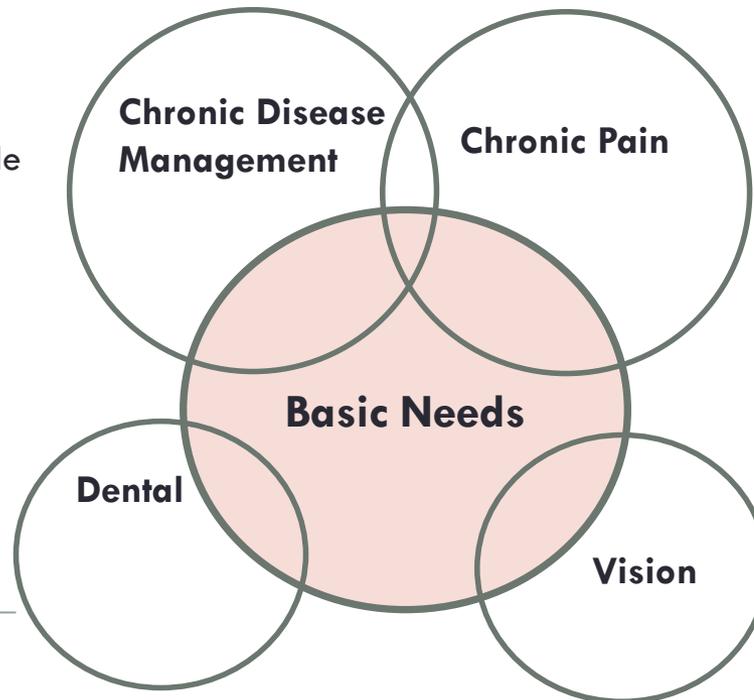
Basic Physiological Needs
- Food, water and refrigeration: limited control over when and what is available
- Showers, laundry, and bathroom access
- Rest and recovery: safe and comfortable places to sleep uninterrupted
- Communicable and transmittable disease concerns (lice, TB, hepatitis A)

Vision Care: reported needs included frequent eye glass replacement, vision loss from diabetes, other disease, and traumatic brain injury.

Data was collected through group discussion and via optional surveys at Listening Sessions.

"With diabetes, you try to figure out how to test your blood sugar daily and store everything."

"I never get enough sleep. Been woken up 6 to 7 times in a night. I'm always dealing with issues. Constant pain from sleeping all curled up."

"We all have high blood pressure and are (waiting) heart attacks walking around."

"My day is organized around basic stuff — what and when I can eat, where the closest bathroom is where people won't turn me away or watch me suspiciously."

"I use (drugs) for a lot of reasons. To feel normal. To stay alert."

"I've had my dentures thrown away, my inhaler. It happens a lot in shelters and during sweeps. My buddy had his glasses tossed."

"Living in these conditions, everyone got the flu and passed it around. You're not able to wash your hands if the church isn't open. It is hard to use a port-a-potty when you're feeling so sick and have nowhere to go but a cold car."

"I get tripped up at every step with my meds, getting them, taking them like I'm supposed to."

"There is something wrong with my stent (heart disease) but I'm not going back in for help. There is nowhere safe or clean to come back to. Disease and stuff spreads like wildfire in shelters."

"There's a lot I can't chew so I go hungry a lot - even more so - and my gums hurt all the time. People judge you by your teeth and smile."

"It's scary being out here and not being able to really see your surroundings."

2. Factors Associated with Access and Utilization

Series of individual and systemic factors that can make accessing care "feel like an obstacle course."

Individual Level
- Demographics: race, age, income source, & gender
- Physical & behavioral health conditions
- Length & frequency of homelessness
- Differing beliefs & perceptions about priority needs

Accessibility of Locations
- Physical distance, transportation, & wait times
- Accommodations: language & disabilities
- Ease of navigation: clear & consistent processes
- Ability to bring family, belongings, &/or pets

Quality of Care
- Feeling of being welcomed, engaged, & heard
- Self-identified priority needs are taken care of
- Conditions are correctly diagnosed and treated
- Follow-up instructions are tailored to homeless status

Phases of Delay

Delay 1
Deciding to seek care and engage with system

Delay 2
Identifying and reaching facility

Delay 3
Receiving adequate & appropriate treatment

Falling and Staying Outside the Health Care System

Waiting to be seen

Staying for full appointment time

Transitioning between providers

Returning for care and daily adherence

Feeling defeated from being labeled "non-compliant"

Conceptual framework for this visual adapted from:
Thaddeus S., Maine D. (1994). Too far to walk: maternal mortality in context. Soc Sci Med, 38 (8): 1091-1110.

*"A lot of mornings I'm just too sick to even go a few blocks.
My meds haven't kicked in and I'm still wiped out."*

*"You all need to keep the resource lists simple and up to date.
It's easy to give up after all the run around and dead ends."*

*"I didn't know 'til I talked to a buddy where I live that
I could get stuff covered if I came here during specific times."*

*"You move around a lot being homeless, lose paperwork and things, and you have to get care at
a new clinic. They may not cover or offer the same things. You end up with a gap in care."*

*"I didn't want to tell them I was homeless.
They won't approve stuff (surgeries) if you do."*

*"One experience of being turned away was enough.
You can tell when people are judging you,
just want you to go away."*

3. Disparities and Differential Needs

Race and Place were major themes. Both connected to gender, age, and family composition.

Race

Quality of Care: accounts of feeling unwelcomed, not cared for appropriately, language access issues, and ultimately carrying a higher burden of disease.

Similar Experiences in Housing, Employment & Criminal Justice Systems: interconnected experiences of poor treatment and being targeted due to both poverty and race. The combined impact makes it harder to exit homelessness and maintain stability.

Overall, the documented racial and ethnic health disparities in the general population continue to be magnified for homeless individuals and families.

Place

Regional: physical distance between comparatively fewer homeless-specific service providers is a challenge outside greater Seattle.

Physical Mobility & Cognitive Impairments: many subpopulations describe differential needs including those with disabilities, families with small children, pregnant women, and a growing aging population.

Actual Sleeping Place: reported needs varied significantly based on whether individuals were unsheltered and how frequently they had to move.

"They treat me like that because I'm homeless, I'm Black, I'm young, and transgender."

"My teeth are like this cause of meth use. That's the first thing people see and judge. Can't get a job or housing with my mouth & (criminal) charges."

" All of my travel money goes to getting back and forth to Seattle for appointments. The Eastside is where I'm from and most comfortable. They don't make it easy to stay."

"I have seven kids I'm trying to keep together. That's a full time job on its own. Being homeless is like a second job with all the running around we have to do."

"I don't remember everything now. I missed too many appointments and think I gotta wait another three months to make another one."

"We've had someone die in our parking lot, an old woman with edema. Young people sleep on someone's couch but you find elderly people here."

" Everyone wants us to move away from the streets and parks. Out of sight. Out of mind."

KEY LEARNINGS

HEALTH CARE PROVIDERS

Provider Perspectives: Current Health Care Needs

Overall, providers described the same types of needs as Listening Session respondents. Descriptions of emerging issues related to complexity and the sheer volume of demand:

- Severity of medical needs that accumulate the longer individuals and families remain homeless in King County

- Sheer level of co-occurring behavioral health needs, especially opioid dependence and untreated mental health conditions

- Drug resistance for multiple conditions and challenges in prescribing treatments without full health history

- Growing elderly homeless population who present with early onset of geriatric conditions and cognitive impairments

- Assuring access to prenatal care, reproductive health, family planning, and early intervention services

Resource Needs to Improve Access and Outcomes

Staffing, Supports & Services:

- Medical staff described the need for more case managers, community health workers, social workers, behavioral health clinicians, and chemical dependency professionals.

- In turn, those types of providers described the need for more medical and dental services within, and outside of, brick and mortar clinics.

- All providers described the need for more recognition of daily challenges from funders.

Partnerships, Policy & Systems Change that Lead to:

- Fewer patients being lost to follow-up because of fragmented information systems.

- Strategic use of bed space and facilities in all physical and behavioral health settings.

- Expanded low barrier substance use services, including Medication-Assisted Treatment.

- Efficiencies in regulatory and reporting requirements for payment and documentation.

- Reductions of the number of homeless individuals cycling through criminal justice systems.

- Further integration of public health, health care, and housing services that lead to safe, stable, and secure housing options with clear referral processes based on medical need.

Staffing, Supports and Services

"It has been hard to find counselors for our team. We would also benefit from a social worker."

"We need more mobile social workers who are willing to meet clients where they are at and help them navigate the healthcare system."

"Dental care... so many heath issues I see are increased due to very poor dental care."

Partnerships, Policy and Systems Change

"Clear communication and coordination between agencies, with the County, and especially within the County. The lack of it makes challenging work even harder."

"There is a lack of adequate facilities and need to be using resources much more strategically based on acuity. This includes more options for respite."

"We need more medication monitoring for adults aging in place in permanent supportive housing buildings. We need skilled nursing and adult family homes for folks drinking alcohol and smoking or actively using drugs."

"Housing, inside relationships with other service providers, shelter space, resources to address criminal background/sex offender status, transportation access to medical services, more mobile version of mobile medical- home visiting providers rather than just RN's."

RECOMMENDATIONS

FOR CONTINUAL IMPROVEMENT

In order to better meet current health care needs, we must:

1. Build our clinical quality and education capacity to help patients and providers manage disease, pain, and medication. This includes increasing clinical outcome data across all sites.
2. Help lead efforts to assure patients can meet basic physiological needs. This includes restroom access and facilities to rest and recover from illness based on acuity of need.
3. Increase the number of patients who have access to low barrier behavioral health services. This includes alignment with the King Co. Heroin and Prescription Opiate Addiction Task Force.

Address factors associated with access and utilization

4. HCHN consumers and former consumers must be more involved in planning and evaluation. Efforts should coordinate with training and professional development opportunities.
5. Support our providers through capacity building training and workforce development strategies. This includes partnering with providers to reduce reporting burden where possible.
6. Sustain existing partnerships and cultivate new ones in South, East, and North King County. This includes a focus on outreach to individuals with mobility and language access barriers.

Reduce disparities and differential needs

7. Implement strategies to measure our progress towards reducing documented racial and ethnic health disparities. This includes establishing network-wide learning objectives.
8. Enhance our partnerships with housing providers. This includes supporting Coordinated Entry for All efforts to better integrate health services into their Continuum of Care.
9. Help lead efforts to care for both an aging homeless population and assure access to prenatal care, family planning, and early intervention services.

Limitations

Overall Study Design: Listening Sessions and provider interviews were not designed to produce generalizable findings for three reasons:

- Size of HCHN patient population is over 20,000. A valid sample size could not be achieved.

- Significant data exists from both patients and providers. Thematic findings of need are consistent across local and national reports. More granular data is needed.

- Multiple government agencies were conducting similar assessments at the same time and could share learnings.

Choice of Methods

- Listening Sessions were selected over focus groups for flexibility in allowing participants to shape conversations.

- Rapid-Feedback Evaluation was selected to balance producing reliable data with a short time frame.

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Appendices

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LISTENING SESSIONS

METHODS AND DATA

GOAL: **Deepen our understanding of how currently homeless individuals experience King County's public health, health care, and housing systems.**

ELIGIBILITY CRITERIA: Currently homeless individuals in King County. Definition included those who were homeless in the past 12 months.
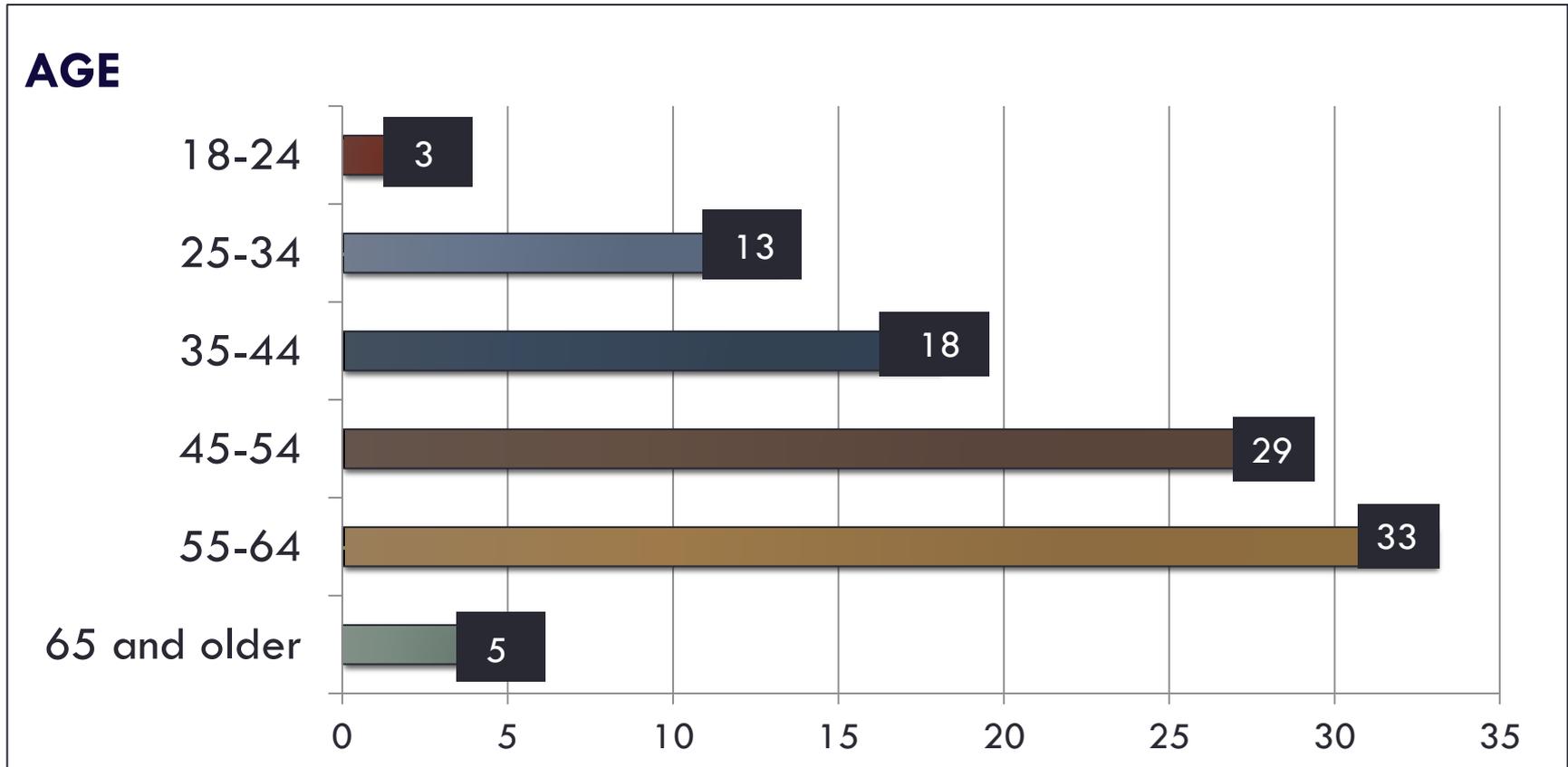
METHODS: Staff and advisors from King Co. Public Health and Dept. of Community & Human Services facilitated seven 45-60 minute listening sessions. Notes were captured on flip chart paper and by scribes. A voluntary self-administered survey captured demographics and individual experiences.

FORMAT: Sessions were grounded in the World Café Model. Facilitators provided three open-ended questions around health, housing, and resource needs. Conversations were participant directed. (www.worldcafe.com)

ANALYSIS: HCHN's Data and Evaluation Manager identified themes with Grounded Theory methods. Surveys were entered and analyzed with Excel.

CONFIDENTIALITY & CONSENT: No protected health information was collected. Participants gave verbal consent. All participation was voluntary.

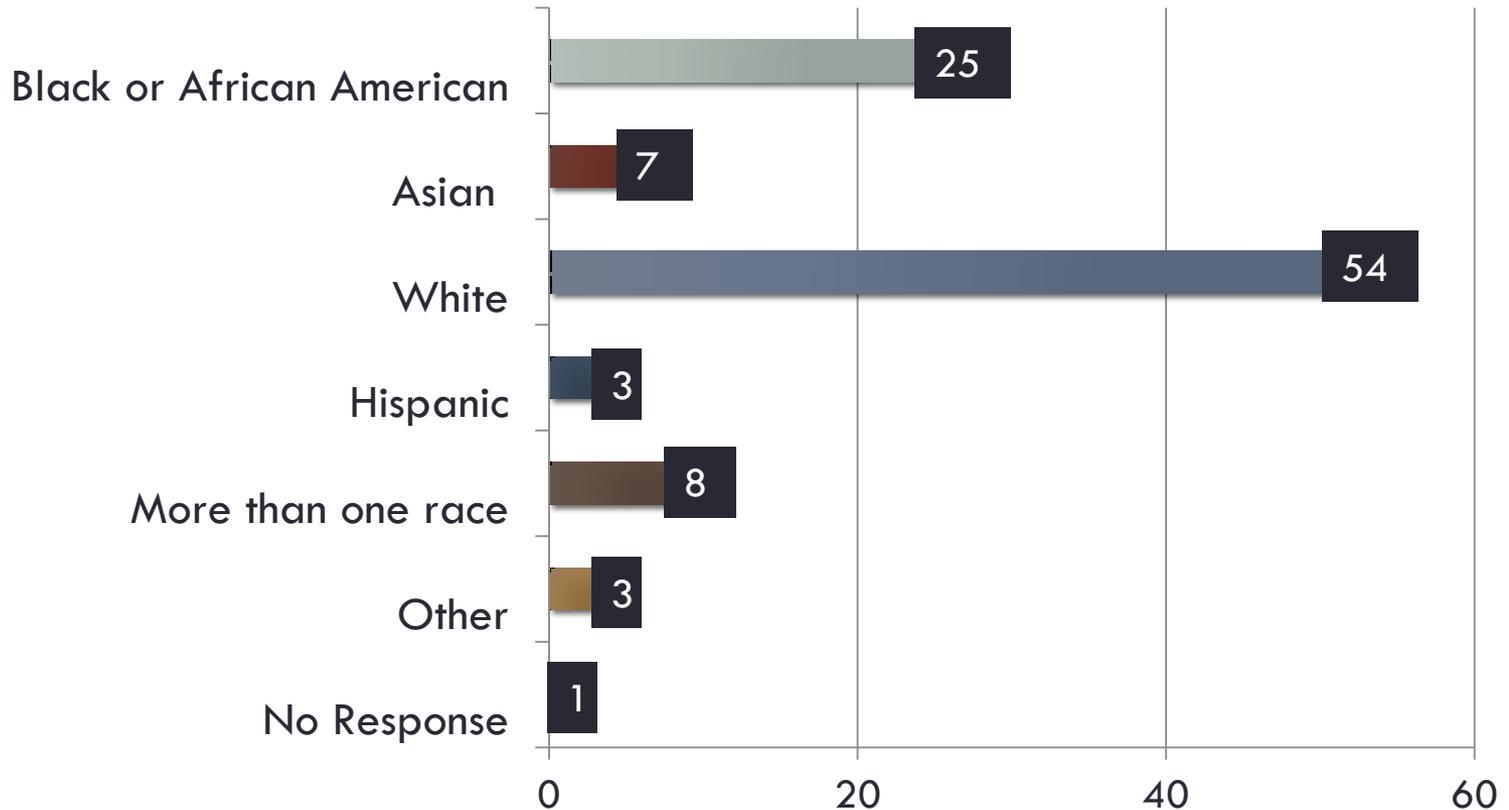**INCENTIVES:** $15.00 ORCA bus cards and meals provided.

LISTENING SESSION LOCATIONS

1. **Safe Parking Program, Kirkland***
   Lake WA United Methodist Church

2. **The Sophia Way, Bellevue***
   Women's Emergency Shelter

3. **Downtown Dental Clinic, Seattle**
   Public Health – Seattle & King County

4. **St. Martin De Porres, Seattle**
   Men's Emergency Shelter over 50

5. **YWCA, Renton***
   Regional Access Point and Day Center

6. **Catholic Community Services, Fed. Way***
   Regional Access Point and Day Center

7. **Meridian Center, North Seattle***
   Public Health – Seattle & King County

* = co-facilitated with King Co. DCHS

Site selection was based on data gaps and coordinated to avoid duplicative efforts.

TOTAL PARTICIPANTS | 101

AGE

Horizontal bar chart showing participants by age:
- 18-24: 3
- 25-34: 13
- 35-44: 18
- 45-54: 29
- 55-64: 33
- 65 and older: 5

DATA NOTES: No one under 18 directly participated in the Listening Sessions.

System-wide concerns on age include:

- Challenges and need to obtain better data on the experiences of children, youth, & young adults.
- Growing aging population over 50.

RACE AND ETHNICITY

Bar chart:
- Black or African American: 25
- Asian: 7
- White: 54
- Hispanic: 3
- More than one race: 8
- Other: 3
- No Response: 1

(x-axis: 0, 20, 40, 60)

DATA NOTES: More than one race included individuals who identify as Native American or Alaska Native.

 System-wide concerns on race and ethnicity include:

- Over-representation of Native American, Hispanic, African American, and some API individuals.
- Challenges and need to obtain better data on the experiences of smaller ethnic communities. Census-level information can mask further disparities within subpopulations.

GENDER
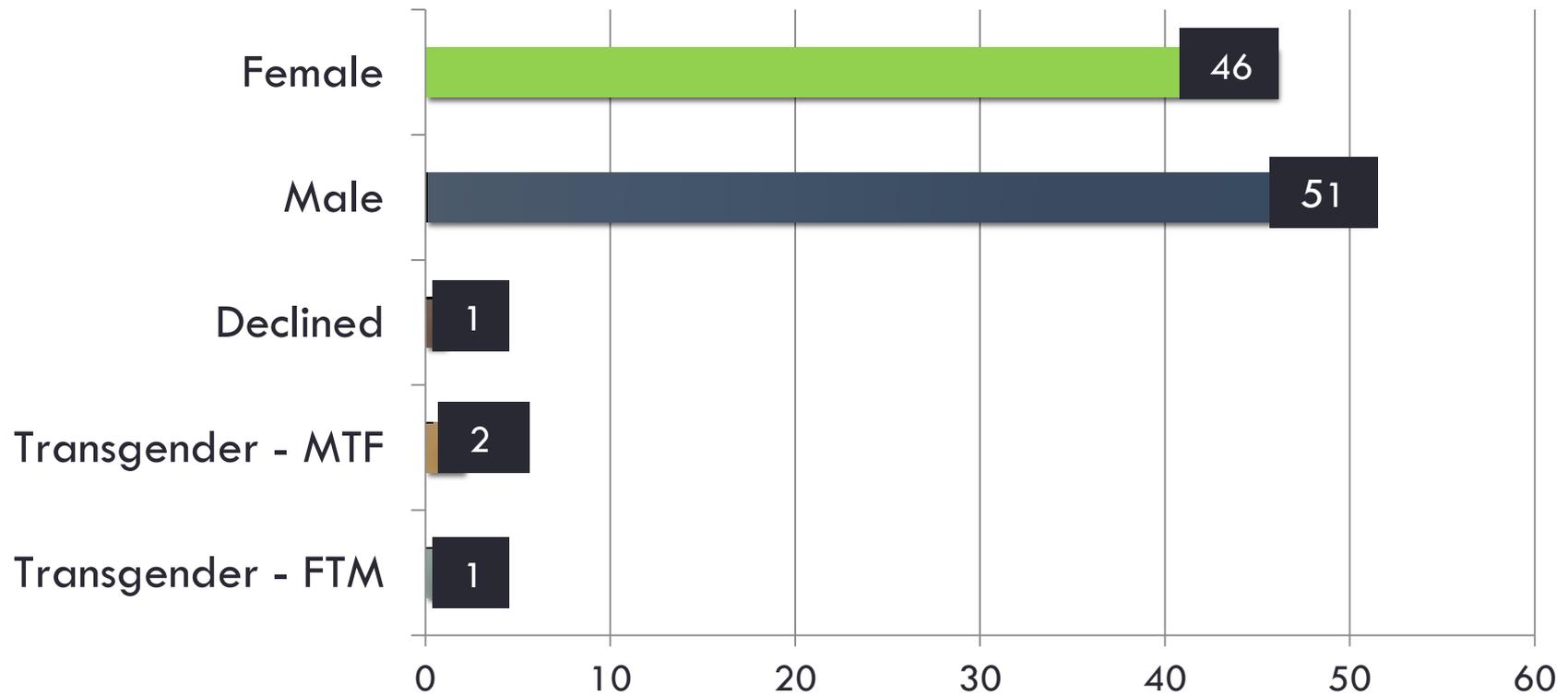
System-wide concerns on gender include:

- Assurance that women and other individuals needing prenatal care, family planning, and reproductive health can access these services in low barrier and culturally sensitive environments.
- Men tend to present for care at more advanced stages of disease and avoid preventive care.
- Agencies provide varying levels of culturally competent care for transgender individuals.

WHERE DID YOU LIVE IMMEDIATELY PRIOR TO BECOMING HOMELESS?	Total
King County	43
Outside King County but within Washington	12
Outside Washington	11
No Response	35
Total	**101**

65%
King County

The 2016 City of Seattle Homeless Needs Assessment reported similar findings and with a larger sample size.

HOW LONG SINCE YOU LIVED IN PERMANENT STABLE HOUSING?	Total
Less than 6 months	4
6 months to 1 year	10
1 to 2 years	21
2 years or more	42
No Response	24
Total	**101**

Homeless **55%** longer than two years

The importance of creating different strategies to engage individuals based on length of homelessness has been detailed in multiple recent reports from All Home. Please see references on page 41.

HOW MANY TIMES HAVE YOU BEEN HOMELESS?	Total
1	30
2	17
3	6
4	7
5 or more times	13
No response	28
Total	101

59%
Homeless more than 1X
Provider's ability to identify, engage, and accurately assess service needs based on frequency of homelessness is a key factor in effective resource allocation.

WHERE DO YOU USUALLY SLEEP?	Total
Shelter	28
Multiple	11
Car	15
Outside	12
Couch or Friends	4
Housing System	5
Other: 1) "wherever I can"; 2) "where the cops don't bother me" 3) "Aurora"; 4) "The Ranch"	4
Not Counted or collected	22
Total	101

SAMPLE RESPONSES: "WHERE DO YOU USUALLY SLEEP?"

Tent in the woods
Tent in the woods of XX and 320th
Tent or in doorway of businesses
Tent, other peoples' tents, or vehicle

A mat on a mission floor
Cascade Hall
Cascade's Women's Shelter
Church (as a shelter)
City Hall Shelter
Hope Place Shelter
In a shelter
Lower Queen Anne Men's shelter
Overnight women's shelter
St. Martins
William Booth Center

DESC Shelter; Ballard; back of truck; my friend's for 6 months
Encampment or severe weather shelter
Outside and shelter
Shelter when possible, tent in summer
Shelters, Church
Shelters, street
Sometimes car or abandoned building
Totally slept on the pavement; also emergency centers
Wherever I can
Where the cops don't bother me
Where "they" allow us

Responses reflect:

- Homeless status is often a changing and dynamic data point over the course of a night, week, or year.
- Outreach workers and program planners often need more granular information than federal definitions. Producing this "real-time" information can be challenging within current Management Information Systems.

DO YOU HAVE A WORKING CELL PHONE?	Total
Yes	**48**
No	23
No Response	30
Total	**101**
IF YES, DO YOU USE IT TO SEND AND RECEIVE TEXT MESSAGES TO CONFIRM APPOINTMENTS WITH YOUR HEALTH AND SOCIAL SERVICE PROVIDERS?	
Yes, and I use it for health and social service appointments	16
Yes, but I don't use it for appointments	16
Other; 1) "text message only and e-mail"; 2) "depends if I can receive anything"; 3) "**none of my health or social services offer this nor by e-mail.** They just call."	3

Anecdotal remarks made within Listening Sessions suggest that reasons for not having, or using cell phones for appointments, are more tied to economics than unwillingness to use newer technologies.

Multiple programs across the country are pilot-testing new projects to support homeless individuals in keeping appointments, treatment adherence, and overall health promotion. These include a current study at the Boston Health Care for the Homeless Program: https://clinicaltrials.gov/ct2/show/NCT03034993

PROVIDER FEEDBACK

METHODS AND DATA

GOALS

- Learn more about current health care needs from front line providers.
- Identify unmet resource needs to address barriers to care.
- Understand improvements HCHN could make as a funder and community partner.

ELIGIBILITY CRITERIA:

Survey was open to any HCHN funded providers. Interviews were conducted with nurses, physicians, mental health clinicians, and administrators.
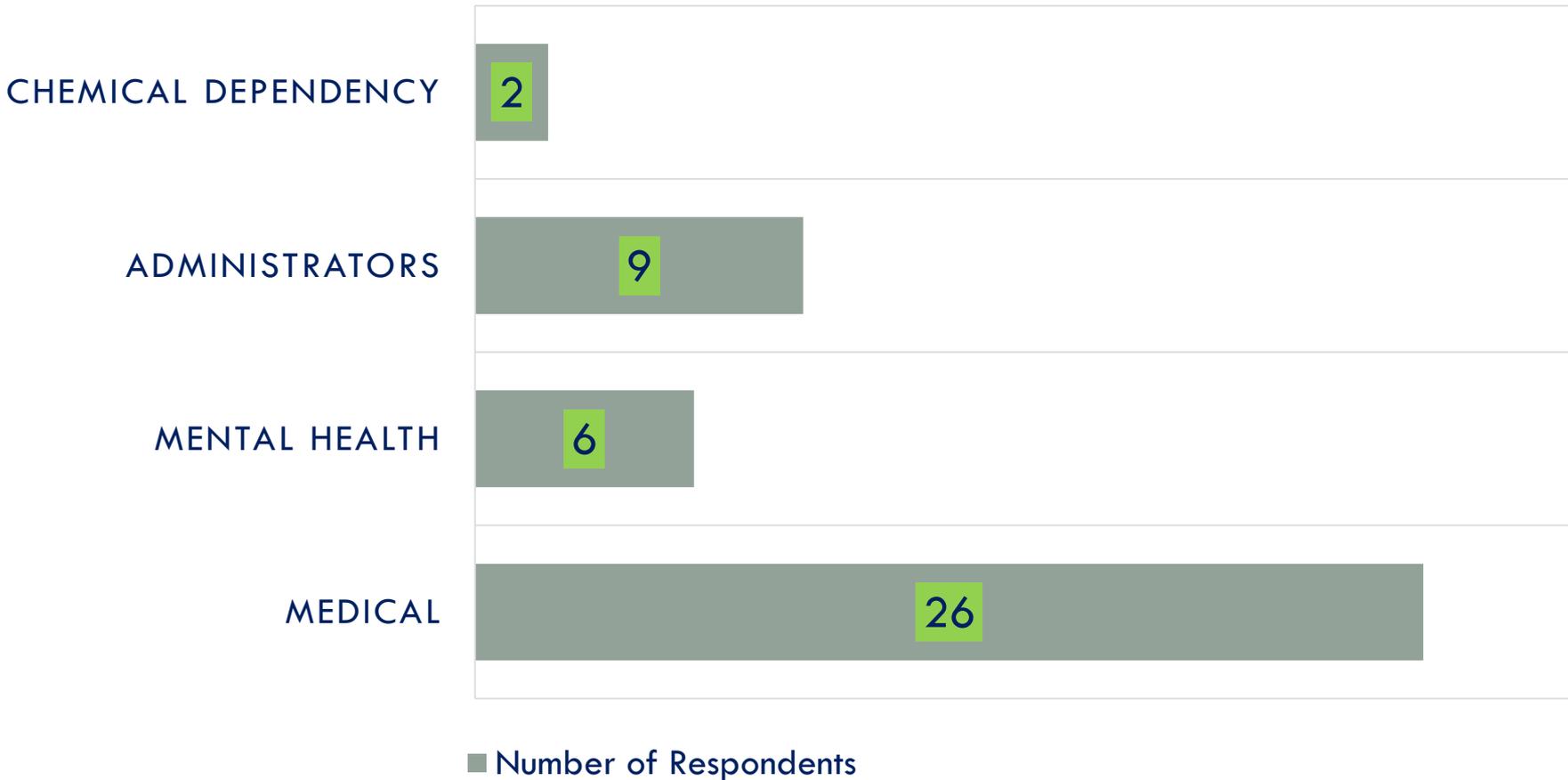
METHODS:

- Anonymous on-line survey:157 providers were sent an invitation via Survey Monkey between November and December 2016. Response rate was 20% (n=32).

- Semi-structured interviews: HCHN's Data and Evaluation Manager and Clinical Quality Lead conducted 11 in-person and phone interviews using Rapid Feedback Evaluation (RFE) techniques between January and February 2017.

CONFIDENTIALITY & CONSENT: Verbal consent was given. No names or organizational affiliations are connected in report.

ANALYSIS: HCHN's Data and Evaluation Manager identified themes with Grounded Theory techniques. Existing data from providers was also weighted. Sources included site visit notes, and minutes from agency and provider meetings and trainings.

PROVIDER CATEGORIES: COMBINED SURVEY AND INTERVIEW PARTICIPANTS

Chart:
- CHEMICAL DEPENDENCY: 2
- ADMINISTRATORS: 9
- MENTAL HEALTH: 6
- MEDICAL: 26

■ Number of Respondents

- As noted in the Limitations section, additional interviews and provider data analysis are planned for 2018. Direct Outreach Worker insights are unrepresented here.
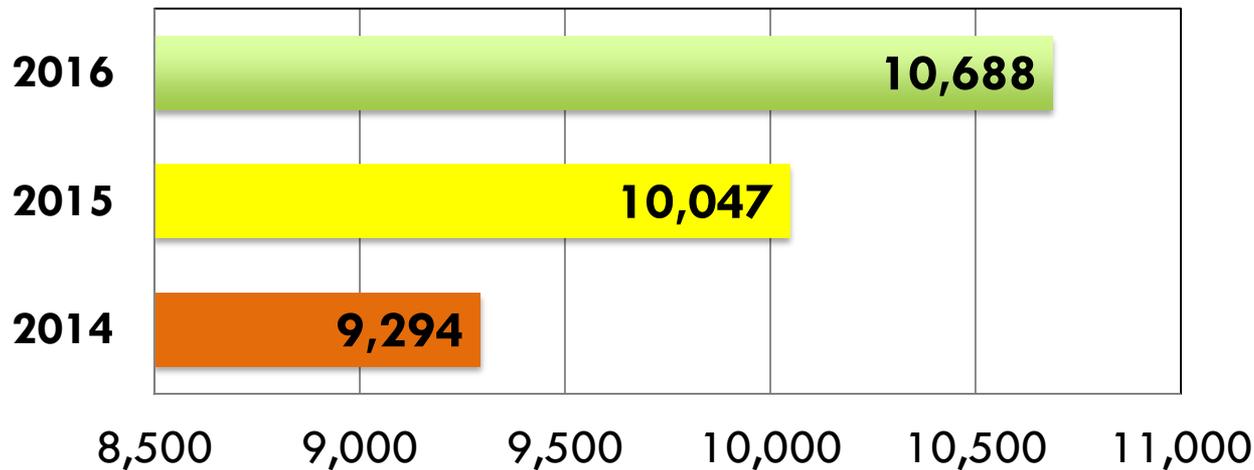
HCHN DATA

PATIENT POPULATION AND PERFORMANCE INDICATORS

* Source for all HCHN information presented is the Uniform Data System (UDS)

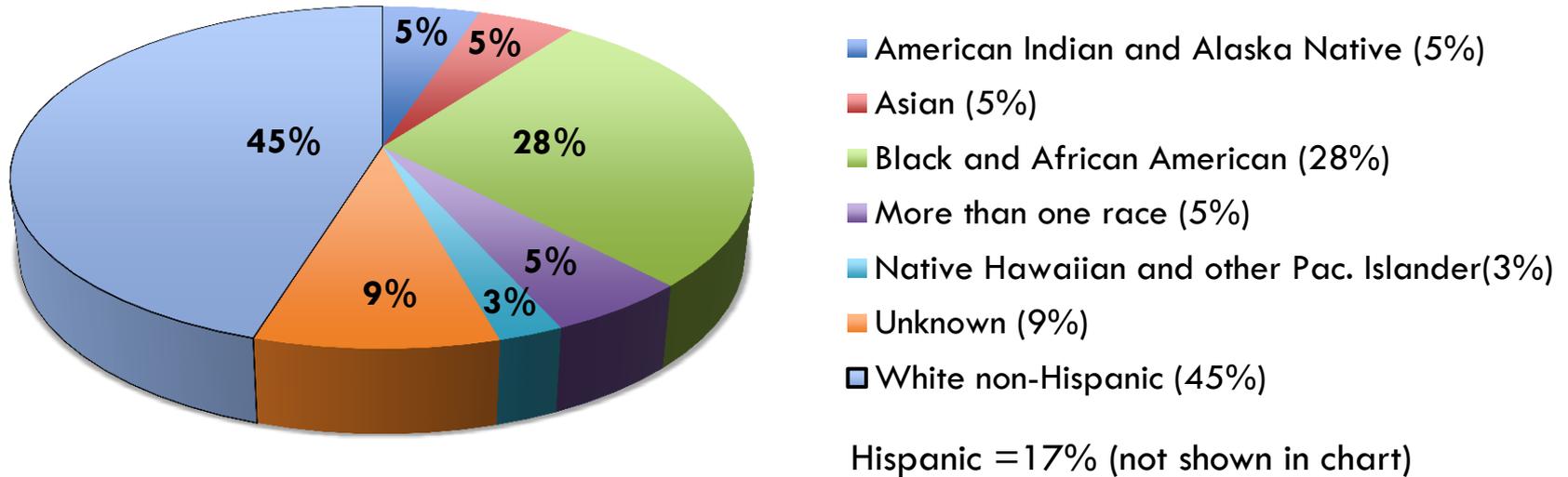# Total Patients – Health Care for the Homeless Network

Year

Year	Total Patients
2016	20,443
2015	18,804
2014	16,888

0   5,000   10,000   15,000   20,000   25,000
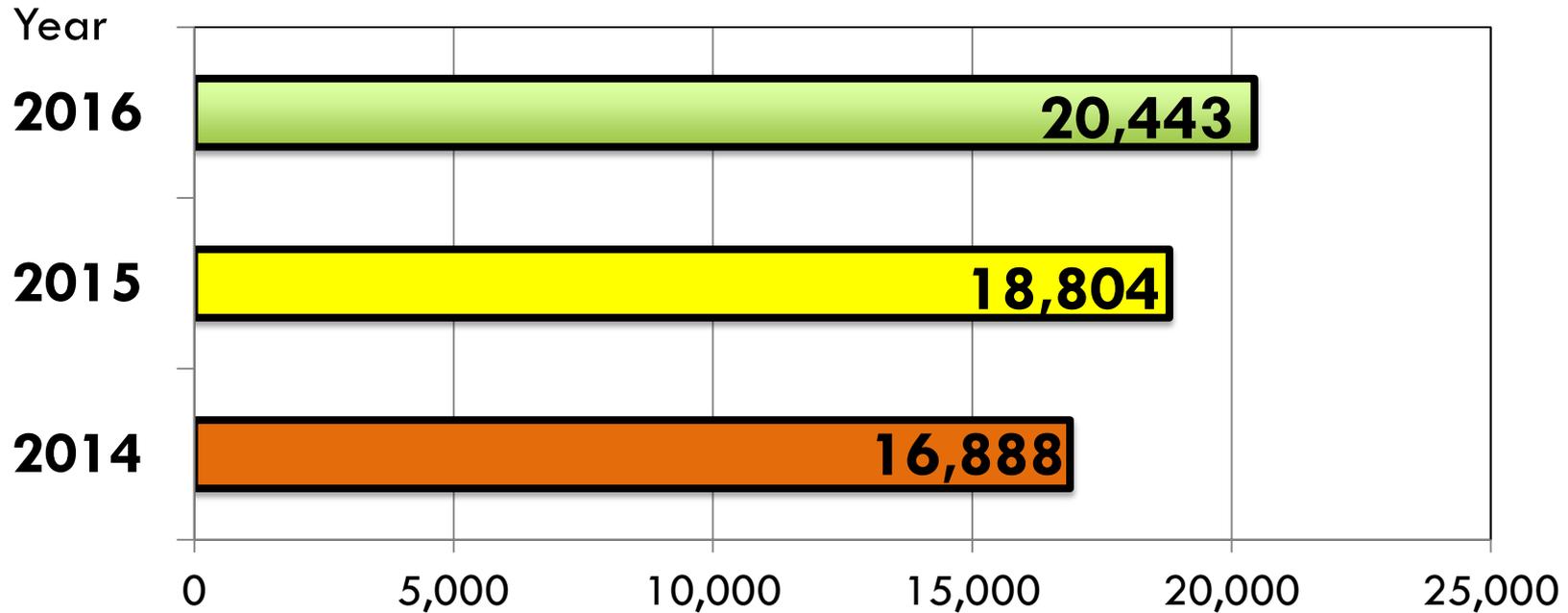
King County One Night Count Comparison – HUD Definition

Year	Count
2016	10,688
2015	10,047
2014	9,294

8,500   9,000   9,500   10,000   10,500   11,000

There are two main federal definitions of homelessness: HUD and HRSA. HCHN follows HRSA's definition which includes individuals at risk, in Permanent Supportive Housing and "doubled up."

Race and Ethnicity, HCHN Patients 2014 - 2016

Individuals of color continue to be overrepresented in our patient population

■ American Indian and Alaska Native (5%)

■ Asian (5%)

■ Black and African American (28%)

■ More than one race (5%)

■ Native Hawaiian and other Pac. Islander(3%)

■ Unknown (9%)

☐ White non-Hispanic (45%)

Hispanic =17% (not shown in chart)

King County General Population Demographics

American Indian and Alaska Native: 0.7%

Asian: 15.6%

Black and African American: 6.2%

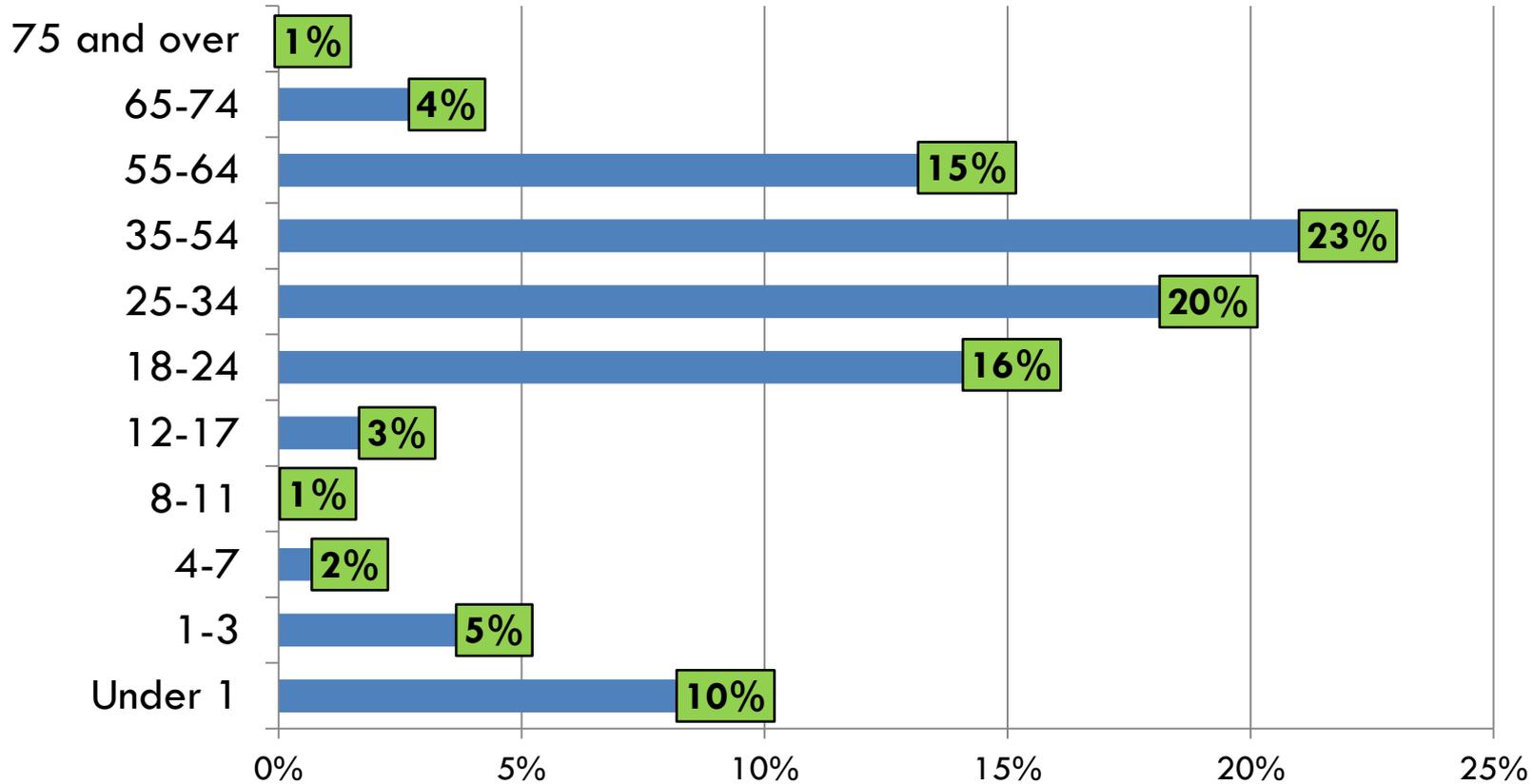More than one race: 5.8%

Native Hawaiian and other Pacific Islander: 0.8%

White (non-Hispanic): 68%

Hispanic =9.3%

Source: U.S. Census Bureau, 2011- 2015 American Community Survey 5-Year Estimates

Age, HCHN Patients 2014 - 2016

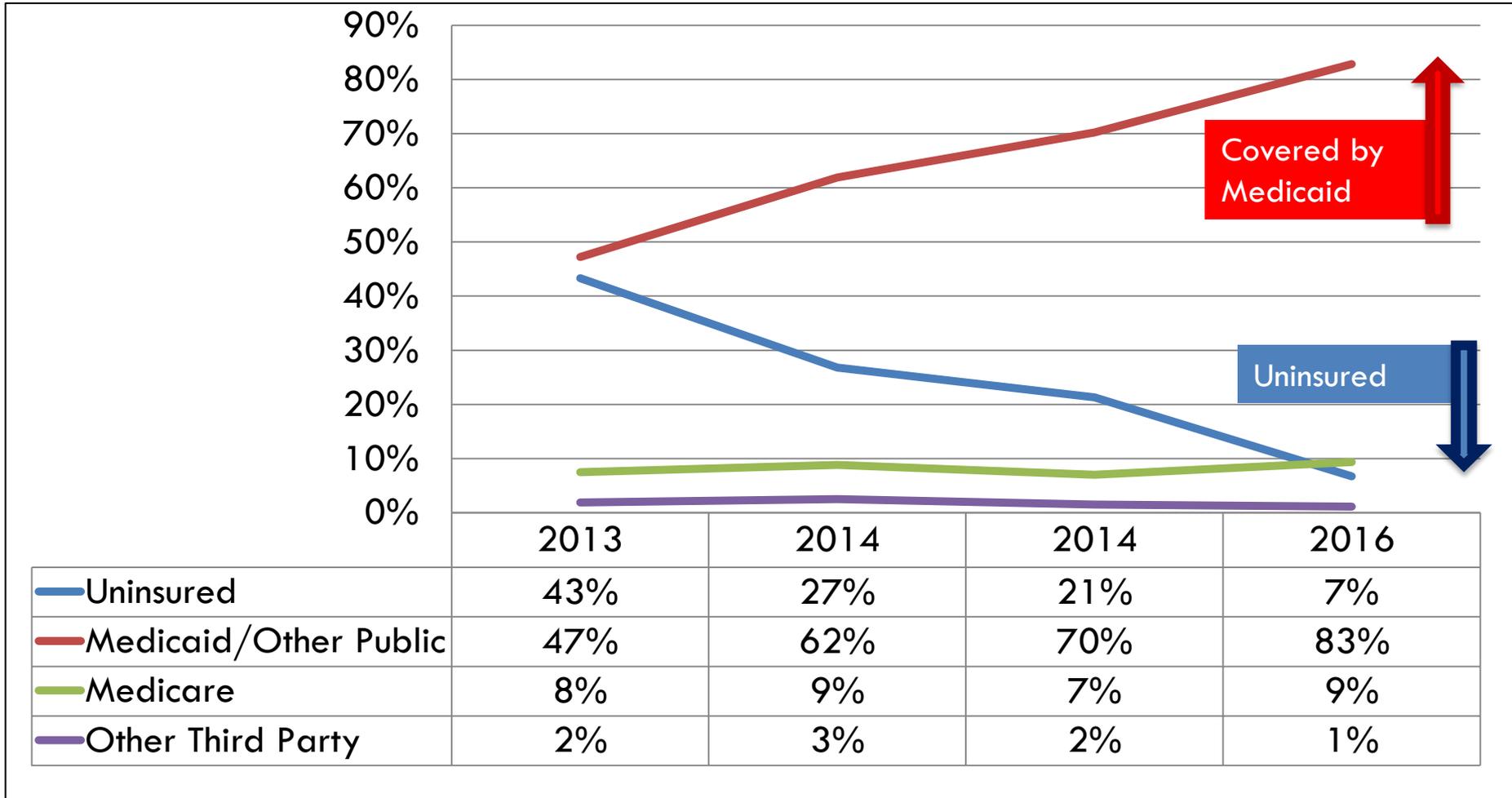Monitoring trends in aging population and among children, youth & young adults

Gender, HCHN Patients 2014 -2016

Female 51%   Male 47%   Transgender 2%

Insurance Status, HCHN Patients 2014 - 2016

Significant decrease in uninsured rates among homeless patients since Medicaid expansion*

	2013	2014	2014	2016
Uninsured	43%	27%	21%	7%
Medicaid/Other Public	47%	62%	70%	83%
Medicare	8%	9%	7%	9%
Other Third Party	2%	3%	2%	1%

* HCHN data on insurance status would include a mix of self-report and confirmed enrollment status during this time period. Re-enrollment challenges and coverage gaps are also current barriers.

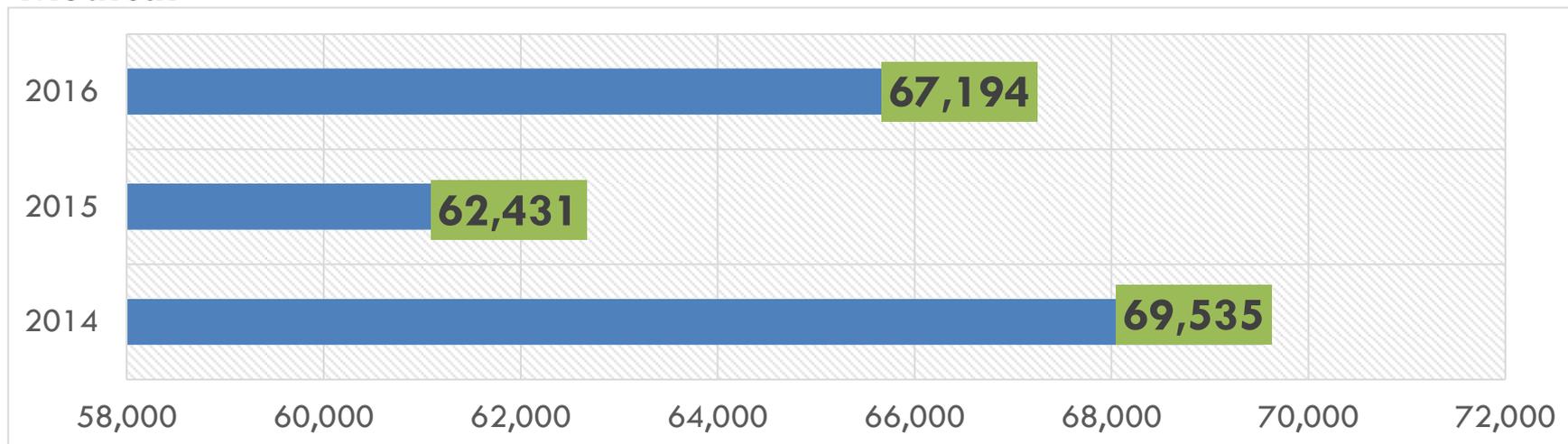# Frequent Health Conditions, HCHN UDS Patients 2014 - 2016

* High chronic disease burden with co-occurring substance use and mental health disorders

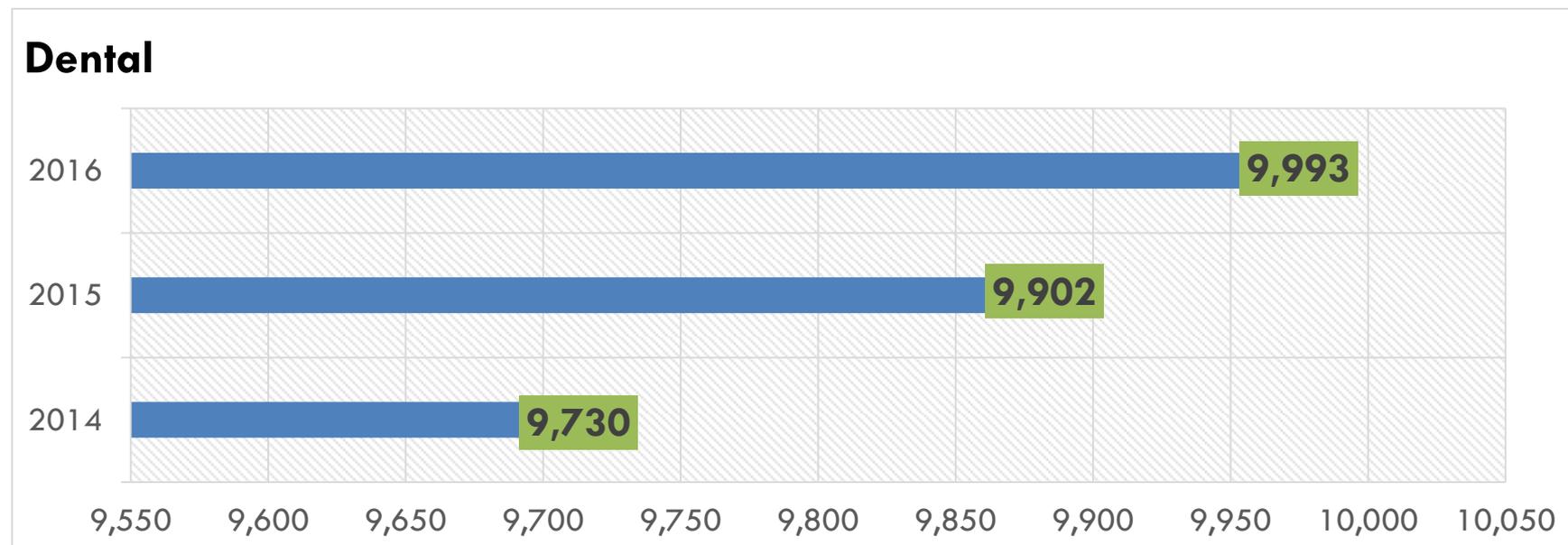|	Numbers of UDS Visits by Diagnosis Regardless of Primacy	Total Visits	Patients
1	Other substance-related disorders (excluding tobacco use)	28,068	3,630
2	Other mental disorders (excluding drug or alcohol dependence)	23,297	5,514
3	Depression and other mood disorders	19,285	4,278
4.	Anxiety disorders including PTSD	14,890	2,454
5	Hypertension	11,624	3,219
6	Diabetes mellitus	11,500	3,620
7	Tobacco use disorder	9,472	3,629
8	Alcohol related disorders	9,417	2,630
9	Heart disease (selected)	4,863	1,018
10	Chronic obstructive pulmonary disease	2,628	825
11	Asthma	2,589	1,125
12	Hepatitis C	2,385	816

* UDS reporting has defined measurement parameters. Not all HCHN patients or data are included.

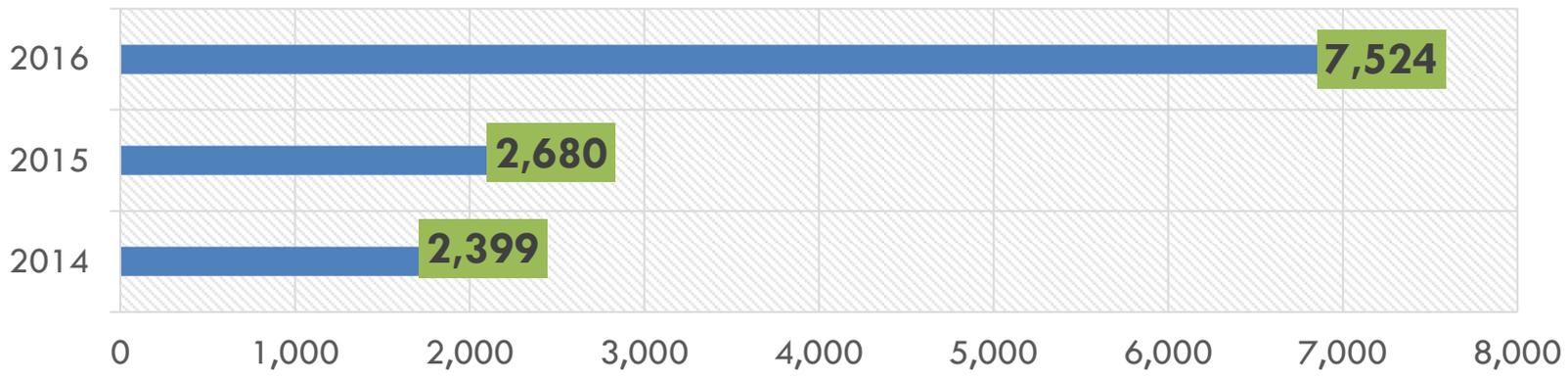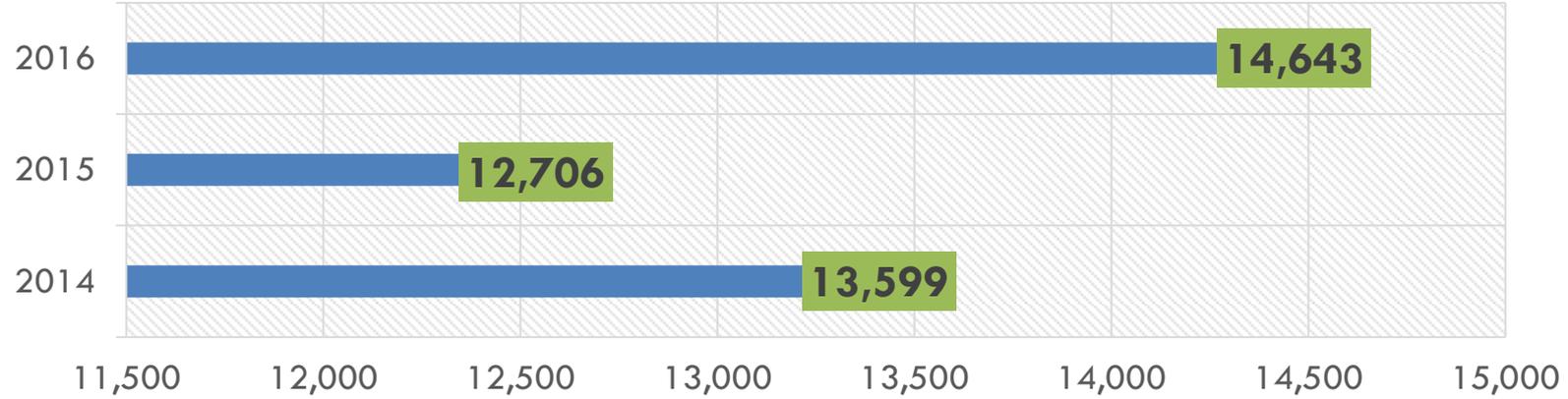# Cumulative Visits by Selected Service Category, HCHN Patients 2014 – 2016

Medical

Year	Visits
2016	67,194
2015	62,431
2014	69,535

Dental

Year	Visits
2016	9,993
2015	9,902
2014	9,730

Substance Use

Year	Value
2016	7,524
2015	2,680
2014	2,399

Mental Health

Year	Value
2016	14,643
2015	12,706
2014	13,599

Visit Type	Medical	Dental	Mental Health	Substance Use	Enabling*	Nutrition	Cumulative
Total	199,160	29,625	40,948	12,603	17,173	9,668	309,177

* Enabling includes case management, outreach, eligibility assistance, & interpretation support

References

Slide 3. HRSA stands for Health Resources and Services Administration and is an agency of the U.S. Department of Health and Human Services.

Slide 4. Rapid-Feedback Evaluation
McNall, M., & Foster-Fishman, P. (2007). Methods of Rapid Evaluation, Assessment, and Appraisal, American Journal of Evaluation, 28(2), 151-168.

Slide 4. Listening Sessions were modeled after the World Café and Open Space concepts.
www.theworldcafe.com/key-concepts-resources/design-principles

Slide 8. Three Delays Model is a conceptual framework that outlines barriers to reaching and receiving care.
Thaddeus S., Maine D. (1994). Too far to walk: maternal mortality in context. Soc Sci Med, 38 (8): 1091-1110.

Slide 22. King County DCHS stands for Department of Community and Human Services.
www.kingcounty.gov/depts/community-human-services.aspx

Slide 26. City of Seattle 2016 Homeless Needs Assessment.
humaninterests.seattle.gov/2017/03/03/city-of-seattle-2016-homeless-needs-assessment/

Slide 26. Recommendations for the City of Seattle's Homeless Investment Policy. Barbara Poppe and Associates.
www.poppeassociates.com/thoughts-ideas-and-inspirations

Slide 33. HCHN/Public Health –Seattle & King County Uniform Data System (UDS) Reports and Service Map
bphc.hrsa.gov/uds/datacenter.aspx?q=d&bid=102340&state=WA&year=2016

Slide 34. Seattle/King County Point in Time Count of Persons Experiencing Homelessness 2017.
allhomekc.org/king-county-point-in-time-pit-count

Additional Resources

- All Home and King County's HUD Local Continuum of Care data: allhomekc.org
- National Health Care for the Homeless Council and latest research:
  www.nhchc.org/resources/publications/research-publications/

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