2007 Year-end Status Report
Housing Health Outreach Team

Public Health
Seattle & King County

The Housing Health Outreach Team (HHOT) is an interdisciplinary health team that provides services in selected permanent supportive housing (PSH) sites for formerly homeless adults in Seattle. Nationally, studies have shown that PSH has positive impacts on health, including decreased emergency room visits and hospital inpatient days, decreased use of detoxification services, and increases in the use of preventive health care services.[1]

In an effort to address the health disparities of individuals with a history of homelessness and support them in retaining stable housing, the HHOT team was launched in 2007 through a community funding partnership. The HHOT team provides services in "housing first" projects, which place vulnerable homeless individuals into housing with intensive on-site services. The HHOT team is also deployed into other selected PSH sites with high levels of unmet health care needs, such as sites experiencing high levels of 911 calls.

HHOT Partners

Project oversight:	Public Health – Seattle & King County/Health Care for the Homeless Network
Service providers:	Puget Sound Neighborhood Health Centers/Pike Market Medical Clinic (PSNHC) Evergreen Treatment Services/REACH Program
Housing providers:	Archdiocesan Housing Authority (AHA) Downtown Emergency Service Center (DESC) Plymouth Housing Group (PHG)
Funders:	City of Seattle Human Services Department King County Veterans and Human Services Levy (effective 2008) Washington State Division of Alcohol and Substance Abuse/King County Mental Health Chemical Abuse and Dependency Services Division (DASA/MHCADS) United Way of King County Medicaid Administrative Match
Total budget (2007):	$230,493, not including DASA/MHCADS funds (partial year operations)

Source: PSNHC Photo / John Brecher

Medical care has been shown to be an effective engagement tool with homeless and formerly homeless individuals, since clients are able to receive immediate care for physical health issues and begin to develop a positive trusting relationship with a health provider. HHOT services are expected to increase stability in housing and reduce the number of people who return to homelessness, as well as decrease reliance on costly emergency services.

[1] Corporation for Supportive Housing. www.csh.org

Team composition

Registered nurses	2.5 FTE (additional 0.8 FTE added in 2008)
Chemical dependency staff	2.0 FTE
Mental health staff	1.0 FTE (added in 2008)
Nurse practitioner	0.5 FTE
Supervision	0.3 FTE
Physician	0.2 FTE

Working as part of an interdisciplinary team means that referrals come from housing staff, as well as the between medical and chemical dependency providers. The medical and chemical dependency (CD) providers meet as a team twice per month. The medical team also meets for clinical support on alternating weeks. The team meetings focus on administrative updates, site updates, case consultations, and on collaboration and referral issues such as coordination with the Pike Market diabetic nurse, King County Care Partners, Tobacco Prevention, Public Health Downtown Clinic, and veteran systems.

2007 Outcomes

Engaged over 400 individuals. Of the 408 unduplicated clients served from May through December, 2007, 381 were seen by a nurse or other medical provider on the HHOT team, and 81 were seen by a chemical dependency provider. Fifty-four residents (13%) were seen by both a chemical dependency and medical provider.

Medical providers engaged with each client an average of four times, ranging from 1 to 33 visits per person. This may reflect the range of services, from screenings to more in-depth support for people with complicated medical histories. The medical providers engaged with 45% of the clients three or more times.

CD providers engaged with each client an average of five times, ranging from 1 to 17 visits per person. They engaged with 65% of the clients three or more times, which shows a relatively high level of continuing interest in working with a CD provider on the part of residents.

49% of clients with chronic conditions set a self-management goal (target was 45%). At least 209 clients (51%) have chronic conditions. Of the 381 seen by the medical providers, 49% set a self management goal. The most common chronic conditions were: substance use related, mental health, hypertension, and diabetes.

Self-management support[2] refers to a way of working with people to help them improve their health. Patients are actively involved in identifying small and achievable steps they will take. The health provider then works with them to discuss challenges and successes along the way. For example, a patient may

Source: PSNHC Photo / John Brecher

[2] Institute for Health Care Improvement's Chronic Care Model. For more information: www.improvingchroniccare.org or http://www.healthdisparities.net/hdc/html/home.aspx.

decide to read a pamphlet to learn more about their condition, or a diabetic patient may decide to exchange one food for another for the week.

35% were linked to primary care services (goal was 40%). A major goal of the team is to link individuals with primary care services. Since May 1, 2007, 132 clients attended appointments with a primary care provider based on referrals and assistance from the team. Although information is only suggestive at this point, medical and housing providers have identified challenges in assisting residents to attend appointments, such as accompanying residents with cognitive impairments. HHOT providers and housing staff work together to fill these gaps as they are able, although the need surpasses the capacity at this point. Additional support such as developing stable systems in all HHOT sites to remind people of appointments may help increase this outcome.

Chemical dependency engagement at a steady pace. Of the 81 unduplicated clients who engaged with the CD providers, a number of individuals were linked with off-site chemical dependency treatment services. Thirteen individuals linked to inpatient (8 clients) or outpatient (5 clients) chemical dependency treatment.

The chemical dependency providers utilize a harm-reduction approach to help clients maintain focus on their substance use when their housing becomes in jeopardy, and when they decide to make changes in their pattern of use. Ninety-four percent of the CD-engaged residents were still housed at the end of the year. Two individuals who completed inpatient treatment had a temporary stay in clean and sober housing before returning to their apartments.

At least 123 people were linked to other health services. The HHOT providers also talked with clients about their use of nicotine, and provided treatment and referrals to smoking cessation support. In 2007, the CD providers also attended intensive training on working with people with Post Traumatic Stress Disorder. The training program, Seeking Safety, provides tools for facilitating support groups, which the CD team plans to start early in 2008.

Evaluation Results of Housing First Pilot at Plymouth on Stewart

An independent evaluation[3] of a group of housing set-asides was conducted at one of the HHOT sites, Plymouth on Stewart. Called the "Begin at Home" (BAH) program, it demonstrates the positive impact that the combination of housing and health services can have.

"BAH focused on providing housing and support for the highly complex problems of adults being released from the Medical Respite program with at least $10,000 of expenses at Harborview Medical Center within the prior year (n=14), and individuals who had had at least 60 visits to the Dutch Schisler Sobering Support Center within the prior year and who were referred from REACH homeless outreach case managers (n=6). All participants met the federal definition of chronic homelessness, including having a disabling medical or psychiatric condition. The first tenant moved into housing in June, 2006 and the program was at capacity by the end of August, 2006."

Emergency department visits by BAH residents dropped from 191 visits prior to move-in to 50 visits the following year. Admissions to Harborview Medical Center also dropped from 57 prior to move-in, down to 13 the following year. This equates to a 75% reduction in combined charges, which totals $1,192,893.

[3] Debra Srebnik, King County MHCADS. "Begin at Home": A housing first pilot project for chronically homeless single adults. One-year outcomes. Released October 15, 2007.

HHOT challenges. The HHOT model of providing health services within housing programs has several inherent challenges. Some of the buildings do not have a private space for the providers to meet confidentially with clients. This is not ideal for client care, and could possibly decrease the interest of residents to seek services, particularly from the chemical dependency providers. In addition, engaging and building relationships with residents who use illegal substances is a challenge, because such residents tend to be less visible and may not be open to talking with a CD provider in particular, at their residence. The team plans to gather additional information from housing providers and residents in order to identify and reduce barriers to clients accessing services. Other challenges experienced by the team and housing providers include identifying the best way to support clients who need reminders to take their medication, and how to best support clients who need assistance getting to appointments.

Top diagnoses

The following diagnoses (summarized by body system) were addressed by HHOT CD or medical providers during visits with clients. One visit may include more than one diagnosis. Chronic conditions are included in the summary only for visits in which that condition was addressed. In some cases, a client may have had symptoms without a diagnosis so the visit would not be included in the diagnosis summary below.

Forty-five percent of the 640 visits related to substance-use were visits by medical providers, which helps illustrate the overlapping relationship between substance use and medical issues.

Diagnosis or body system		# Visits
Substance-use related		640
Cardiovascular		458
Endocrine		230
Mental health		197
- Psychoses	75	
- Depression	71	
- Anxiety	12	
- Other mental health	39	
Screening visit		93
Respiratory		76

Diagnosis, continued	# Visits
Musculoskeletal	50
Disability – mental or physical	46
Nutrition	44
Skin	38
Neurological	35
Gastrointestinal	34
Kidney	13
Genitourinary	9
Immune	5
Other health issues	98

Services provided by site in 2007

Site – Medical services	Visits	Clients
Frye (AHA)	266	67
Gatewood (PHG)	161	33
Kerner-Scott House (DESC)	113	27
Lewiston (PHG)	107	22
Morrison (DESC)	359	90
Plymouth on Stewart (PHG)	147	23
Scargo (PHG)	48	16
Westlake (AHA)	191	47
Wintonia (AHA)	212	55
Uncoded Location	1	1
Total	1605	381

Site – CD services	Visits	Clients
Frye (AHA)	112	17
Gatewood (PHG)	19	10
Lewiston (PHG)	57	7
Plymouth on Stewart (PHG)	1	1
Scargo (PHG)	51	7
Westlake (AHA)	23	3
Wintonia (AHA)	130	36
Total	393	81

Success stories

In 2007, Phillip,* a long-time heavy alcohol user, gained support from the HHOT chemical dependency provider sited in the building where he lives, which helped him make desired changes in his substance use. At first he talked about wanting inpatient treatment, but missed two chemical dependency assessment appointments arranged by the chemical dependency provider. He successfully completed an assessment after the chemical dependency provider escorted him on the bus to a walk-in assessment appointment at Seattle Indian Health Board. He was referred to Thunderbird inpatient treatment after his detox stay at Recovery Centers of King County. After completing inpatient treatment, he requested extended sober housing with Thunderbird. He is now living in a permanent apartment within a clean and sober environment. This is an example of a positive move from one type of stable housing to another, based on the client's individual needs and choices. The chemical dependency provider on the HHOT team feels his success was enhanced by the continued hands-on attention he was given in his home.

Daniel,* a resident with a mental illness, found relief from medical symptoms through assistance from the HHOT medical team in 2007. When he first met the HHOT nurse where he lives, housing staff reported that Daniel had frequented the emergency room once or twice per week for the past year, and had multiple hospital stays. His primary complaint was chest pain, but he had no diagnosable cardiac problems. Like many individuals with mental illness seen by the HHOT team, Daniel was reluctant to attend off-site primary care appointments. The HHOT nurse referred Daniel to the physician on the HHOT team who came to his home to visit him. After a thorough medical work-up and gaining a better understanding of his overall condition, she prescribed a treatment. Daniel has not complained of chest pain or been to the hospital since.

* Client names were changed

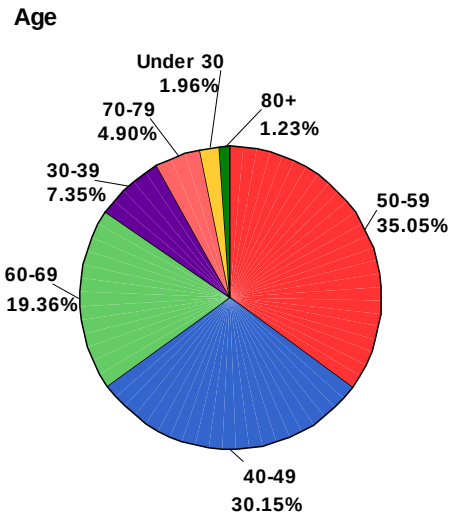
Housing provider perspective

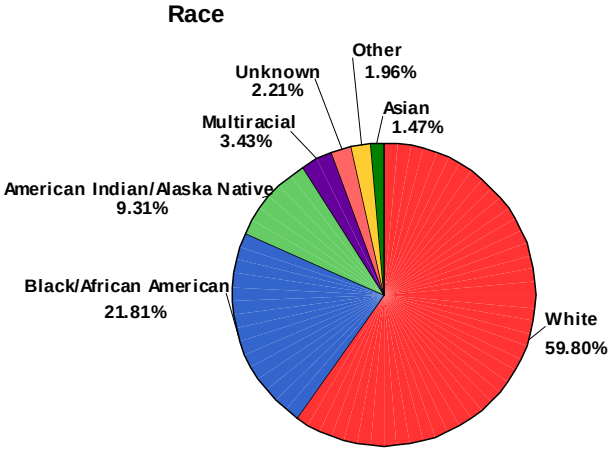
"I know without a doubt that there are a number of tenants who would not have gotten care or would not have gotten adequate care if it hadn't been for the presence of the HHOT team. Because they have become a familiar presence in the building, tenants who otherwise would not seek medical or CD services are beginning to come out of the woodwork and seek services from these friendly and approachable people. I hope that funding for this program continues because it is making a world of a difference!"

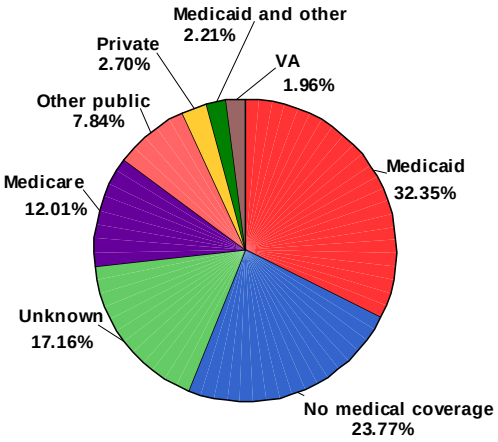
- Allison Vrbova, Scargo Housing Case Manager
Plymouth Housing Group

Source: PSNHC Photo / John Brecher

Demographics







Seventeen clients (4% of those above) also reported their ethnicity as Hispanic.

Gender	Clients	
Male	299	73%
Female	109	27%
Total	408	100%

At least 49 clients (12%) have served in the U.S. military. We expect the actual number for is higher, and are working with HHOT providers to ensure they capture this required information.

HHOT Steering Committee members: Rosemary D'Agrosa (PSNHC), Kelley Craig (ETS), Shelley Dooley (AHA), Chloe Gale (ETS), Margaret King (DESC), Chris Hollinger (PHG), and Kim Von Henkle (City of Seattle).

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