Social Determinants of Health and the Health Care Needs of Those Experiencing Homelessness

A presentation to the 2019 CHCAMS 32nd Annual Conference by the Corporation for Supportive Housing (CSH), National Health Care for the Homeless Council, and Coastal Family Health Center

August 2, 2019
Panelists

• Tom Stubberud, MPH – Sr. Program Manager, Corporation for Supportive Housing

• Lauryn Berner, LMSW, MPH – Research Manager, National Health Care for the Homeless Council

• Honora Slagel, BS – Health Care for the Homeless Case Manager, Coastal Family Health Center
Introduction & Framing

Tom Stubberud, MPH
Senior Program Manager, CSH
Advancing Housing Solutions That

Improve lives of vulnerable people
Maximize public resources
Build strong, healthy communities
GOALS:
• Foster and expand Health Center collaboration with other health system stakeholders, and supportive housing
• Improve healthcare outcomes for extremely low-income individuals who frequently use crisis systems, have housing instability, and lack a connection to primary and preventive care services.

COLLABORATIVE PARTNERS:
National Health Care for the Homeless Council, NACHC, HRSA BPHC and other NCAs

Visit us on the Web: www.csh.org/hrsaTA
Frequent User System Engagement

Communities spend billions on services that bounce vulnerable people between crisis services. CSH's FUSE model helps break the cycle while increasing housing stability and reduces multiple crisis service use.

Data-Driven Problem-Solving
- Cross systems data match
- Track Implementation
- Measure outcomes, impact and cost effectiveness

Policy and Systems Reform
- Convene multi-sector working group
- Troubleshoot housing placement and retention barriers
- Enlist policymakers to bring FUSE to scale

Targeted Housing and Services
- Create supportive housing, develop recruitment process
- Recruit and place clients into housing, stabilize with services
- Expand model and house additional clients

CSH.org/fuse
Break the Institutional Circuit

- EMT
- Jails/Courts
- Street
- Health Centers
- Substance Use/Detox
- Psychiatric Hospitals
- Hospital
- Shelter/Trans. Housing

Arrow indicating the flow of the circuit
Targeting Supportive Housing: Roles for Health Centers

Health Centers
- Service Provider
- Housing Provider
- Care Coordination
- Clinical Partner
- Outreach/Engagement

Link to Los Angeles 10th Decile Project
Link to Washtenaw MI FUSE
Link to Healthcare for the Homeless Houston
Link to Orlando’s Housing the First 100- Orange Blossom Family Health
Framing the Issue – Data

• It’s vital to understand more about individuals who are experiencing homelessness

• Among all MS CHCs
  • 12,765 homeless patients (2017)

• Among Mississippi’s Health Care for the Homeless (HCH) grantees
  • 10,450 homeless patients (2017)

• Are homeless patients being properly identified in Mississippi’s CHCs?
  • 4 CHCs reported 0 homeless patients or left the field blank
  • 3 additional CHCs reported a total of 4 homeless patients combined

Source: 2017 UDS (https://bphc.hrsa.gov)
Framing the Issue –
Social Determinants of Health

• Social Determinants of Health (SDoH)
  • Conditions in the environments in which people are born, live, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. — Office of Disease Prevention & Health Promotion

• Examples of SDoH
  • Availability of resources to meet daily needs
  • Access to educational, economic, and job opportunities
  • Access to health care services
  • Quality of education & job training
  • Transportation options
  • Public safety

• These are just a few examples, but....
  • Think about the impact that each of these elements would have on individuals experiencing homelessness.
Thank you!

Tom Stubberud, MPH
Senior Program Manager
CSH – Corp. for Supportive Housing

Tom.Stubberud@csh.org
Homelessness & Health: A National look at Housing as a Social Determinant of Health

Lauryn Berner, MSW, MPH
Research Manager,
National Health Care for the Homeless Council
National Health Care for the Homeless Council

- National Cooperative Agreement with the Health Resources Services Administration (HRSA)
- Provides Training and Technical Assistance to all health centers, PCAs and HCCNs who serve individuals and families experiencing homelessness
- Education, Research, Policy, and Advocacy
- Membership organization
  - 225+ organizational members
  - 4,355 individual members spanning providers, consumers, and advocates
- Website: www.nhchc.org
Define: Homeless

2 https://www.hudexchange.info/homelessness-assistance/hearth-act/
A homeless individual is defined in section 330(h)(4)(A) as "an individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility (e.g., shelters) that provides temporary living accommodations, and an individual who is a resident in transitional housing." A homeless person is an individual without permanent housing who may live on the streets; stay in a shelter, mission, single room occupancy facilities, abandoned building or vehicle; or in any other unstable or non-permanent situation. [Section 330 of the Public Health Service Act (42 U.S.C., 254b)]

Define Homeless: HHS

An individual may be considered to be homeless if that person is "doubled up," a term that refers to a situation where individuals are unable to maintain their housing situation and are forced to stay with a series of friends and/or extended family members. In addition, *previously homeless individuals who are to be released from a prison or a hospital may be considered homeless* if they do not have a stable housing situation to which they can return. *A recognition of the instability of an individual's living arrangements is critical to the definition of homelessness.*

(HRSA/Bureau of Primary Health Care, Program Assistance Letter 1999-12, Health Care for the Homeless Principles of Practice)

Number of Homeless Patients Across Health Centers

- 1,121,037
- 1,131,414
- 1,151,046
- 1,191,772
- 1,262,961
- 1,361,675

Years: 2012 to 2017
Number of Homeless Patients Across Health Centers

<table>
<thead>
<tr>
<th>Year</th>
<th>All Health Centers</th>
<th>HCH</th>
<th>Non-HCH</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>1,121,037</td>
<td></td>
<td>297,044</td>
</tr>
<tr>
<td>2013</td>
<td>1,131,414</td>
<td>868,059</td>
<td>299,213</td>
</tr>
<tr>
<td>2014</td>
<td>1,151,046</td>
<td>813,331</td>
<td>318,254</td>
</tr>
<tr>
<td>2015</td>
<td>1,191,772</td>
<td>884,172</td>
<td>338,568</td>
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<tr>
<td>2016</td>
<td>1,262,961</td>
<td>932,298</td>
<td>359,665</td>
</tr>
<tr>
<td>2017</td>
<td>1,361,675</td>
<td>949,818</td>
<td>411,857</td>
</tr>
</tbody>
</table>

Legend: All Health Centers, HCH, Non-HCH
Number of Homeless Patients Across Health Centers

<table>
<thead>
<tr>
<th>Year</th>
<th>All Health Centers</th>
<th>HCH</th>
<th>Non-HCH</th>
<th>Left Blank</th>
<th>Reported 0</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>1,121,037</td>
<td></td>
<td></td>
<td>297,044</td>
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</table>

Legend:
- **All Health Centers**
- **HCH**
- **Non-HCH**
- **Left Blank**
- **Reported 0**
People experiencing homelessness have disproportionately high rates of acute and chronic disease and behavioral health conditions and are high utilizers of all components of the health care system. In an era of growing focus on social determinants of health, value-based reimbursements based on risk factors, population health, and better health outcomes, more accurate data on this population is needed to inform clinical and financial decisions.

Emerging health care financing models require much more sophisticated actuarial calculations than previous payment arrangements, often taking into account risk factors such as homelessness. Homelessness also has direct implications for clinical treatment decisions and integrated care models and should be noted in individual patient records. This policy brief provides a rationale for using the ICD-10-CM code for homelessness, outlines the challenges to maximizing this code, and offers strategies to consider to ensure health care providers ask about homelessness and record patients’ housing status. This data is highly relevant to clinicians and administrators at health centers, hospitals, state Medicaid systems, Medicaid managed care organizations, and public health departments.

The Z59.0 Code in ICD-10-CM

The Centers for Medicare and Medicaid Services (CMS) and the CDC’s National Center for Health Statistics (NCHS) have developed official guidelines for coding and reporting of ICD-10-CM data, with a specific chapter dedicated to the factors influencing health status and contact with health services (all Z codes). The ICD-10-CM code for homelessness is Z59.0. The guidelines mentioned above specify that Z codes can be used in any health care setting and “may be used as either a first-listed (principal diagnosis code in the inpatient setting) or secondary code, depending on the circumstances of the encounter.” These guidelines also indicate that while Z codes indicate a reason for an encounter, they are not procedure codes, which are required to describe any procedure performed. Of the

Housing Mix

2017 HCH Patients

- Homeless Shelter: 27%
- Transitional Housing: 13%
- Doubling Up: 31%
- Street: 12%
- Other: 8%
- Unknown: 9%

Total Homeless Patients: 949,818

2012 HCH Patients

- Homeless Shelter: 33%
- Transitional Housing: 11%
- Doubling Up: 26%
- Street: 9%
- Other: 13%
- Unknown: 8%

Total Homeless Patients: 844,297
Total Number of People Experiencing Homelessness: HUD PIT Count

- 2007: 647,258
- 2008: 639,784
- 2009: 630,227
- 2010: 637,077
- 2011: 623,788
- 2012: 621,553
- 2013: 590,364
- 2014: 576,450
- 2015: 564,708
- 2016: 549,928
- 2017: 550,996
- 2018: 552,830

Total US
Total Number of People Experiencing Homelessness: HUD PIT Count

- Total US
- Mississippi

Year: 2007 - 2018

- Total US: 552,830
- Mississippi: 1,377

Graph shows the trend of total number of people experiencing homelessness in the US and Mississippi from 2007 to 2018.
Homelessness & Health

- Poor physical and behavioral health causes homelessness
- Homelessness causes new physical and behavioral health issues
- Recovery and healing are more difficult without housing
- Individuals experiencing homelessness have high rates of acute and chronic illness
## Selected prevalence rates and health outcomes by race.

<table>
<thead>
<tr>
<th>Health Outcome</th>
<th>White, non-Hispanic</th>
<th>Black, non-Hispanic</th>
<th>Hispanic</th>
<th>American Indian/Alaska Native</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy at birth, 2014</td>
<td>79 yrs</td>
<td>75.6 yrs</td>
<td>Not prov.</td>
<td>Not prov.</td>
</tr>
<tr>
<td>Age-adjusted prevalence of diabetes (≥25yrs), 2015</td>
<td>8.1%</td>
<td>13.1%</td>
<td>12.2%</td>
<td>20.9</td>
</tr>
<tr>
<td>Age-adjusted death rate/100,000 from diabetes, 2014</td>
<td>18.6</td>
<td>37.3</td>
<td>25.1</td>
<td>31.3</td>
</tr>
<tr>
<td>Age-adjusted prevalence of hypertension (≥18yrs), 2007-10</td>
<td>28.6%</td>
<td>41.3%</td>
<td>27.7%</td>
<td>Not prov.</td>
</tr>
<tr>
<td>Age-adjusted death rates per 100,000 from persons with CHD &amp; stroke</td>
<td>117.1</td>
<td>141.3</td>
<td>86.5</td>
<td>92</td>
</tr>
<tr>
<td>Estimated rate of HIV infection diagnoses per 100,000 population, (adults≥18 years), 2010</td>
<td>9.1</td>
<td>84</td>
<td>30.9</td>
<td>13.1</td>
</tr>
<tr>
<td>Age-adjusted death rate/100,000 from HIV, 2014</td>
<td>0.9</td>
<td>8.3</td>
<td>2.0</td>
<td>1.2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>% of Total US Population</th>
<th>% of all People Experiencing Homelessness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Hispanic</td>
<td>81.9%</td>
<td>78.4%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>18.1%</td>
<td>21.6%</td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>72.3%</td>
<td>47.1%</td>
</tr>
<tr>
<td>African American</td>
<td>12.7%</td>
<td>40.6%</td>
</tr>
<tr>
<td>American Indian or Alaska Native</td>
<td>0.8%</td>
<td>3.0%</td>
</tr>
</tbody>
</table>

Intersections

People of color

People living/who have lived in substandard housing

People experiencing chronic poverty

People experiencing homelessness

People living with disabilities
Thank you!

Lauryn Berner, LMSW, MPH
Research Manager
L.Berner@nhchc.org
Homelessness & Health Care

A local perspective of providing healthcare to individuals experiencing homelessness

Honora Slagel, BS
Coastal Family Health Center
Coastal Family Health Center

Coastal Family Health Center was founded on the principle that health care should be accessible to all residents of the Mississippi Gulf Coast, and that these health care services should be provided in an effective and efficient manner being responsive to the needs of the population. We have been a part of the Gulf Coast communities for more than 35 years serving the residents of four counties.

**Mission Statement**

Coastal Family Health Center strives to provide quality, comprehensive patient-centered care to the community regardless of one’s economic status.

**Vision**

Coastal Family Health Center will have a significant impact on the health and well being of the communities we serve. To this end, we will work with others to ensure a creative and cost-effective range of health/social services that are accessible to all.

**CORE VALUES**

Dignity  Justice  Service  Excellence  Stewardship.
Coastal Family Health Center

- 14 Clinics

- 22 Service Sites (including school-based health, in-house pharmacies, and a mobile medical/dental unit)

- We serve 7 Coastal counties and are preparing to expand into an 8th

- In 2018 we saw approximately 32,000 unduplicated patients
Homelessness or unstable housing is a significant social determinant of health. Homeless patients may be predisposed to worse health outcomes due to poor living conditions and food insecurity. Additionally, these patients also tend to have limited resources for self-care. For example, a homeless patient with diabetes may have difficulty managing this condition without an appropriate place to store insulin and access to nutritious food.

Homeless patients may also reside in hard to reach places (e.g., heavily wooded areas) or be very transient and have little or no transportation. These access issues create challenges for health care providers in reaching homeless patients and establishing the patient-provider relationships necessary for effective treatment.
Side effects of homelessness can create difficulty completing daily activities, accessing healthcare, obtaining employment, maintaining relationships etc.
Health Care for Homeless Program Lowering Barriers to Health Care

• Health Care for the Homeless Program, HCH is a major source of care for people experiencing homelessness in the United States and serves patients who live on the street, in shelters, in transitional housing, or doubling up.

• Enables patients to have the support of case management and access to other homeless service agencies

• Ensures access for individuals experiencing homelessness to primary care and related services through integrated systems of care.

• Through community outreach efforts patients are more likely to keep up with their appointments and less likely to fall in and out of care
Identifying our Patients

• For the 2018 UDS, Coastal Family Health Center (CFHC) reported providing services to a total of 31,087 patients organization-wide.
  • 3,395 of these patients identified as being homeless (11%)

• Homeless Patients are identified in several ways
  • Self-reporting
  • Outreach Coordinator
  • Referral Source
  • Point in Time (PIT)
Services Offered through CFHC

Primary medical care for all ages to include:

- Annual physical exams (adult and child)
- Laboratory testing
- Pediatrics
- STD testing and treatment
- Chronic disease management
- Women’s health services
- Referrals to specialty care
- Pharmacy
- X-Rays and mammograms

Additional Services:

- Behavioral Health
- Dental
- Optometry
- Ryan White Services
- Infectious Disease
- Transportation Services
- Supportive services & assistance
- Health care navigation and case management.
- Assistance with obtaining affordable health insurance coverage options information

Some of the services are for established patients only and may have limitations
Medical problems common among homeless people

- Infectious diseases: HIV, TB, STD's, respiratory infections, infestations (scabies, lice, etc.), skin infection chronic viral hepatitis.
- Psychiatric disease: Underlying severe mental illness, undiagnosed mental illness, post traumatic stress disorder and other resultant mental illness from homelessness.
- Substance abuse related illness: Permanent sequelae of substance abuse, brain dysfunction liver disease, lung and heart disease.
- Chronic diseases: diabetes, hypertension, COPD.
- Diseases of neglect: nutritional problems, dental disease.
HCH Program: Number of Patient & Services 2016 - 2018

Homeless Patients

HCH Productivity by Service Type & Year

Medical
Dental
Optical
Mental Health
Overcoming the challenges to provide treatment

• Availability in communities where homeless people are.
• Attempt to provide immediate necessities and practical help (referrals for housing, food, immediate medical care) along with education on prevention and referral to continuity medical care.
• Recognize homelessness by asking patients about their "living situation" and the security/insecurity of their housing.
• Use a multidisciplinary team approach when available and be knowledgeable of resources in the community.
• Providers may need to take a more aggressive advocacy role than they may be accustomed.
• Flexible scheduling and drop-in availability.
• Educate support staff about problems of homelessness and caring for diverse populations in nonjudgmental manner.
• Avoid sense of exclusion in clinic setting and staff manner.
• Strong community partnerships.
Overcoming the challenges to provide treatment

• The approach must be creative when treating the patient. The provider must rely heavily on the case manager, nurse, outreach and support staff to best meet the needs of the patient. As homelessness persists in our country, providers should look to other alternatives as they work to provide comprehensive care, improve health outcomes and reduce health care costs.

• CFHC offers a walk in clinic with “same day” appointment spots, one day a week for patients on the HCH Program to seek medical care.
Thank you!

Honora Slagel, BS
Case Manager

hslagel@coastalfamilyhealth.org
What Can My Organization Do?

- Training
- Partnerships
- Prioritize SDOH and Equity
- Use Your Data
Community Health Centers can Engage more around Addressing the Needs of Those Experiencing Homelessness

• Continuum of Care: A regional or local planning body that coordinates housing and services funding for homeless families and individuals.

• Learn about and/or join your local/regional CoC

  • Benefits of becoming a member of the CoC
    • Opportunity to establish collaborative partnerships with providers of homeless services
    • Increase awareness among all CoC members of services provided by CHCs/FQHCs
    • Enhance CoC contacts throughout the state
    • Map of CoC by county
Homeless CoC Service Organizations in MS

- [https://www.hud.gov/states/Mississippi/homeless/servicegroups](https://www.hud.gov/states/Mississippi/homeless/servicegroups)
  - Provides a statewide list of lead agencies responsible for coordinating HUD’s homeless programs. A CoC lead agency can identify homeless assistance resources in your area provided by the Department of Housing & Urban Development.

- Central MS-500 Continuum of Care (Hinds, Rankin, Copiah, Warren, and Madison Counties; City of Jackson)
  - Chair: Ben O. Washington
    - Vicksburg, MS 39183
    - Work: (601) 638-8559
    - bwashington@vicksburgha.org
  - Vice Chair: Robbie Smith (Mississippi Housing Partnership)
    - 1217 N. West St, Jackson, MS 39225
    - rsmith1217@Comcast.net
Homeless CoC Service Organizations in MS

• Mississippi United to End Homelessness Continuum of Care (Balance of State)
  • (601) 960-0557
  • Chair: Martha Mitternight
    • martha556@yahoo.com
  • Vice Chair: Ivie Pulliam
    • ivie@semrhi.com

• Open Doors Homeless Coalition (MS Gulf Coast Region)
  • (228) 604-2048
  • President: Kenney Washington
    • kwashington@thebackbaymission.org
  • Vice President: Dena Wittmann
    • dwittmann@hancockhrc.org
CHCs/FQHCs and the Point In Time Counts

• Volunteer for the Point In Time (PIT) Count
  • Count of homeless, both sheltered and unsheltered conducted statewide

• Survey required by HUD and conducted every 2 years only for a specific 24-hour period of time

• Gives a reflection of how many persons are homeless on any given night in our state

• Conducted in order to bring federal resources into the state to address issues of homelessness in our communities

• Funded from the United States Department of Housing and Urban Development (HUD) through Continuum of Care Process
COUNT DISTRIBUTION

REGIONAL COALITION TOTALS
NORTH CENTRAL 22
DELTA 73
NORTHEAST 130
EAST CENTRAL 119
SOUTHWEST 30
PINE BELT 186

560 PERSONS COUNTED
263 UNSHELTERED
297 SHELTERED

KEY
100 = Number of persons counted (sheltered + unsHELTERED)

MISSISSIPPI BALANCE OF STATE CONTINUUM OF CARE | MSBOS.ORG
QUESTIONS
Promising Practices for Health Centers Serving Youth Facing Homelessness


Improving Health for Medically Complex Patients: Medical Respite and Supportive Housing


Health Centers and Coordinated Entry

CSH Website pages
HRSA NCA – [http://www.csh.org/hrsata](http://www.csh.org/hrsata)
FUSE Resource Center [http://www.csh.org/fuse](http://www.csh.org/fuse)

**FUSE Research**
- [http://www.csh.org/fuse-map/fuse-research-evaluations/](http://www.csh.org/fuse-map/fuse-research-evaluations/)

**FUSE Partnerships: Orlando, Houston, LA, Washtenaw**