Homeless Resource Team

January 2019 – June 2020

Summary:
This pilot created a Homeless Resource Team including a case manager, Health Navigator, and Homeless and Vulnerable Patient Committee to achieve the following goals:

- Facilitate placement into permanent supportive housing for patients with homelessness and chronic medical conditions.
- Increase primary care utilization among homeless adults with chronic medical conditions.
- Decrease emergency department utilization among homeless adults with chronic medical conditions.
- Improve healthcare providers' knowledge and sensitivity about caring for patients with homelessness.

Budget:

- **Total amount of pilot funds used:** $188,075
- **Please list and describe any additional funds used to support the pilot.**
  No additional funds; in-kind support from Samaritan, Benton County Health Dept, and community partners

B. Provide a brief summary of the goals, measures, activities, and results and complete the grid below.

Goal	Measure(s)	Activities	Results to Date
Document all IHN-CCO members served by the pilot.	IHN-CCO members served by the pilot.	Track members served & submit documentation to IHN-CCO	98 IHN-CCO members served
Actively participate in at least one DST workgroup; DST recommends Social Determinants of Health.	Attend either by phone or in person.	Participation in workgroup	Pilot representatives contributed & provided leadership to SDOH and Care Coordination workgroups in 2019-2020.
Facilitate placement into permanent supportive housing.	A) Proportion of adults served who are placed into permanent housing. B) Proportion of adults served with one or more barriers to housing resolved.	HRT outreach & coordination, and monthly Homeless & Vulnerable Patients Committee meetings	A) 16 IHN-CCO members (16%) were placed in permanent housing B) 81 IHN-CCO members (83%) had 1+ barriers to housing resolved
Increase use of primary care services.	A) Number of primary care visits before & after engagement with the pilot (for patients served). B) Trend in number of primary care visits among the homeless population as a whole. C) Trend in number of primary care visits among all Samaritan patients.	HRT outreach & coordination, and monthly Homeless & Vulnerable Patients Committee meetings	Among IHN-CCO members served, 58% had not seen primary care in the prior 6 months; in the 6 months after contact, 51% had at least one primary care visit. Among all IHN-CCO members identified as homeless in SHS Epic, 56% did not have a primary care visit in 2019; among all IHN-CCO members in SHS

			Epic, 45% did not have a primary care visit in 2019.
Decrease emergency department (ED) use.	A) Number of ED visits before & after engagement with pilot (for patients served). B) Trend in number of ED visits among the homeless population as a whole. C) Trend in number of ED visits among all Samaritan patients.	HRT outreach & coordination, and monthly Homeless & Vulnerable Patients Committee meetings	Among IHN-CCO members served, 58% had not seen primary care in the prior 6 months; in the 6 months after contact, 51% had at least one primary care visit Among all IHN-CCO members identified as homeless in SHS Epic, 67% had 1+ ED visit in 2019; among all IHN-CCO members in SHS Epic, 33% had 1+ ED visit in 2019.
Improve primary care providers' knowledge and sensitivity about providing care for homeless adults.	Primary care providers will report more knowledge of the issues related to providing care to homeless adults and available resources for support.	Multiple presentations to SHS physicians & staff	Positive feedback & increased referrals to HRT from SHS clinicians
Improve drug adherence rates.	Primary care clinic coordinators, Hospital case manager and hospital Licensed Clinical Social Worker (LCSW) will work directly with the patients, in contact at least once per month and seen once quarterly.	Requires IHN-CCO data	Analysis not yet started
Decrease incarceration rates.	Primary care clinic coordinators, Hospital case manager and hospital LCSW will work directly with the jail nurse to monitor/track rates of patients served and their incarceration.	HRT outreach & coordination, and monthly Homeless & Vulnerable Patients Committee meetings	20 IHN-CCO members served had spent 1 or more days in jail in the 6 months prior to contact with HRT; of these, 50% (N=10) had 0 jail days in the 6 months after contact. Among all IHN-CCO members served, average days in jail dropped from 5.4 in the 6 months prior to 3.4 in the 6 months after contact with HRT.

C. What were the most important outcomes of the pilot?

Helping vulnerable members of our community; strengthening relationships between organizations that serve the homeless population; increasing physicians and medical staff's awareness of people's needs and struggles.

D. How has the pilot contributed to Triple Aim of improving health; increasing quality, reliability, and availability of care; and lowering or containing the cost of care?

Health outcomes have definitely been improved among clients served by the pilot, as a result of direct outreach and facilitating appropriate medical care. By increasing utilization of primary care services, we expect that we have lowered the cost of care by preventing acute ED or hospital visits.

E. What has been most successful?

At the program level – adding another LCSW at Samaritan to be focused on homeless outreach was instrumental in increasing bandwidth; the collaboration between Benton County health navigators and Samaritan LCSWs to care medical care for people who need it; building partnerships with other agencies

At an individual level – helping clients address their trauma so they can make sense to their emotions and behaviors; being able to address some immediate needs that are difficult to fill with standard resources (e.g. phone, phone minutes – even though there is a lifeline government assistance, it takes time to get it and also have to have a physical address and go through the verification process for most of people, even properly-fitting shoes (important for people who spend a lot of time on foot!).

F. Were there barriers to success? How were they addressed?

There are many unresolved barriers to helping homeless clients: delays in establishing care with a primary care clinician; limited transportation to urgent care clinics (compared to going to the ED); limited access to mental health treatment and substance abuse interventions; housing availability, particularly low-barrier housing.

We did our best to address these barriers by leveraging networks & resources to find solutions wherever possible. The flexibility provided by this pilot project to cover expenses that would have been difficult to cover through existing mechanisms was instrumental in addressing some barriers.

G. How readily would the pilot be scalable or replicable? Describe cautions and considerations when considering scaling, or replicating the Pilot. (i.e. Success dependent on personality/skills set, or activities appropriate under certain conditions like size, target population, etc.)

We have had preliminary conversations about expanding to Linn and Lincoln counties; barriers including funding for outreach positions. It's unlikely the our exact model will be replicable in other counties but the core idea of improving collaboration between Samaritan (or other clinical partners), county health departments, and community-based service agencies is definitely scalable.

H. Will the activities and their impact continue? If so, how? If not, why?

Yes – the LCSW position has been sustainably funded via cost-share between IHN-CCO and Samaritan's Care Hub; monthly meetings between pilot partners are ongoing.