Homeless Resource Team

PRESENTERS: MIRANDA MILLER, ANITA EARL, CHIHO SAKAMOTO GUNTON

Pilot Summary

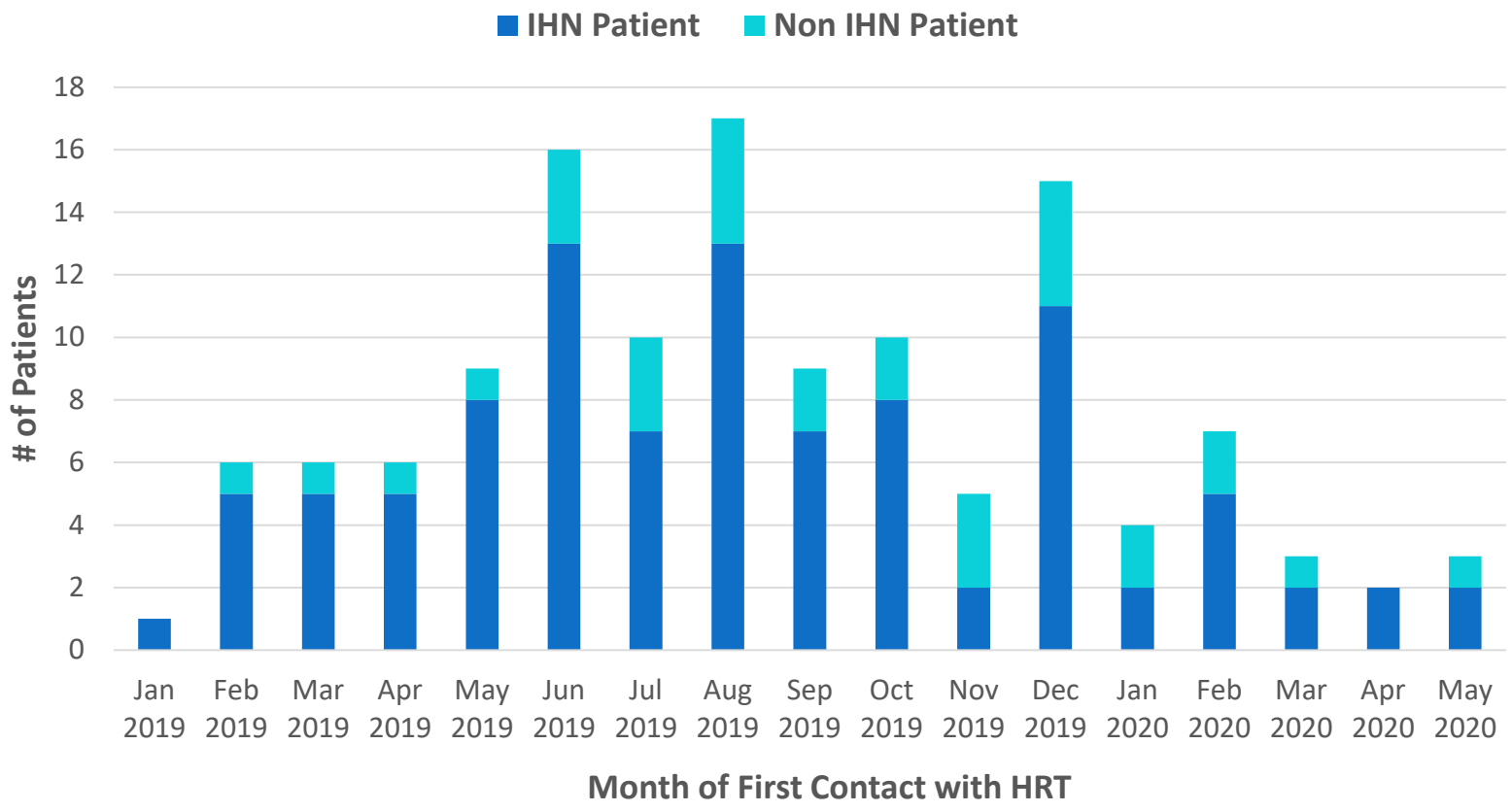
- January 2019 to June 2020
- Budget: $188,075
- Partners: Samaritan Health Services (SHS); Benton County Health Department (BCHD); Corvallis Housing First; Community Services Consortium; CHANCE
- Key activities: hired SHS Licensed Community Social Worker (LCSW) focused on homeless outreach; biweekly meetings between SHS & BCHD; monthly meetings with broad range of community partners that serve the homeless population in Benton County
- Goals:

1) Facilitate placement into permanent supportive housing for patients with homelessness and chronic medical conditions
2) Increase primary care utilization decrease emergency department (ED) utilization among homeless adults with chronic medical conditions
3) Improve healthcare providers' knowledge and sensitivity about caring for patients with homelessness.

Key Outcomes

- 129 total people served by Samaritan's homeless-focused social workers
  - 98 (76%) IHN-CCO members
  - (To reduce the burden of data collection, we did not track clients served by Benton County community health workers/health navigators)
- Of the 129 served:
  - 22% were less than 40 years old, 47% age 40-59, 32% age 60+
  - 62% male
  - 88% have 1+ chronic health conditions (diabetes, COPD, heart failure, kidney disease, coronary artery disease, hypertension, cancer, asthma, obesity)
    - Most common: 42% hypertensive; 34% obese; 26% diabetic

Month of First Contact with HRT



Outcomes: housing

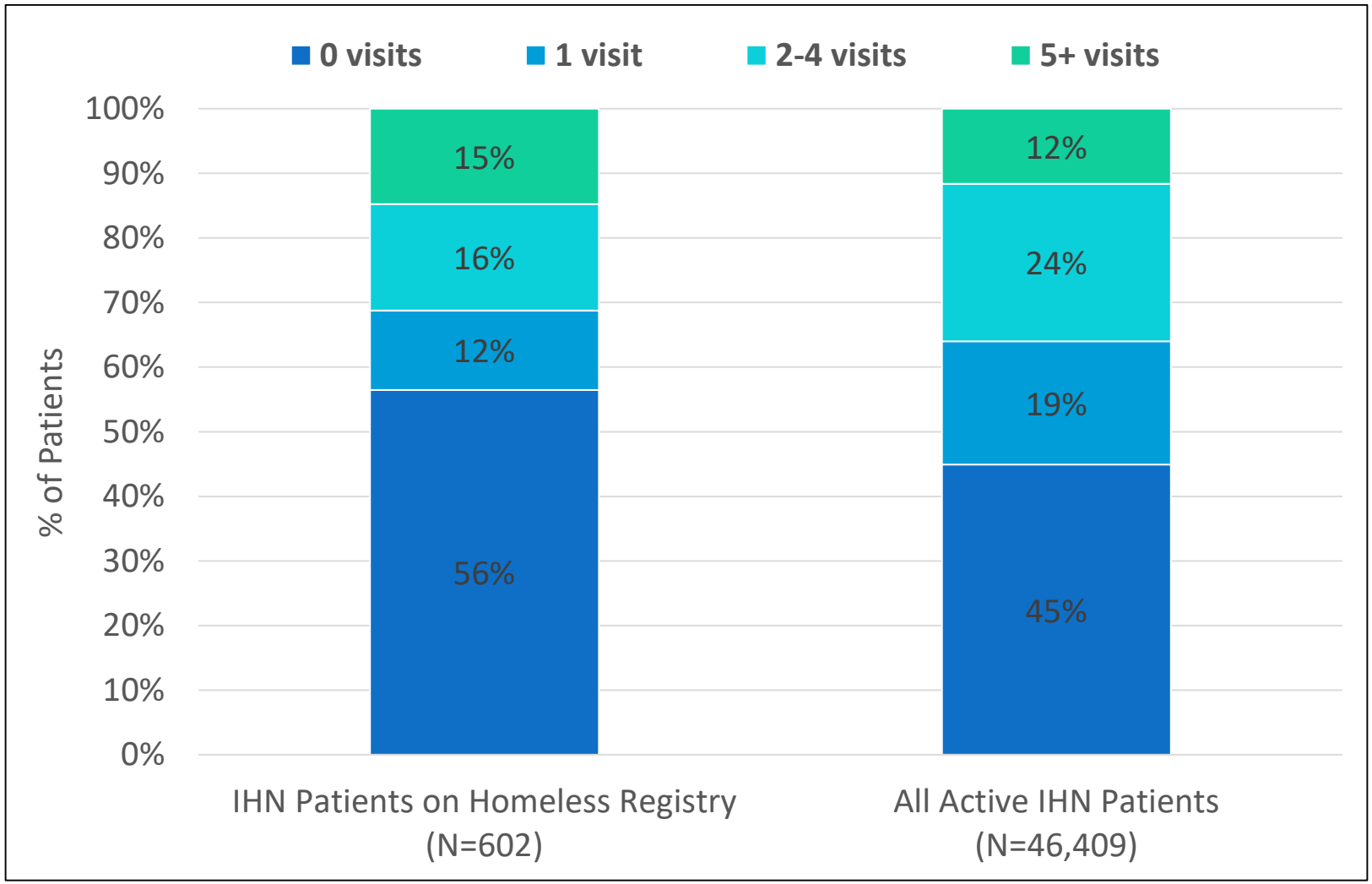
(Goal: Facilitate placement into permanent supportive housing for patients with homelessness and chronic medical conditions)

- 43 IHN-CCO members (44%) were placed in temporary housing
- 16 IHN-CCO members (16%) were placed in permanent housing
- 81 IHN-CCO members (83%) had 1+ barriers to housing resolved

Outcomes: primary care utilization

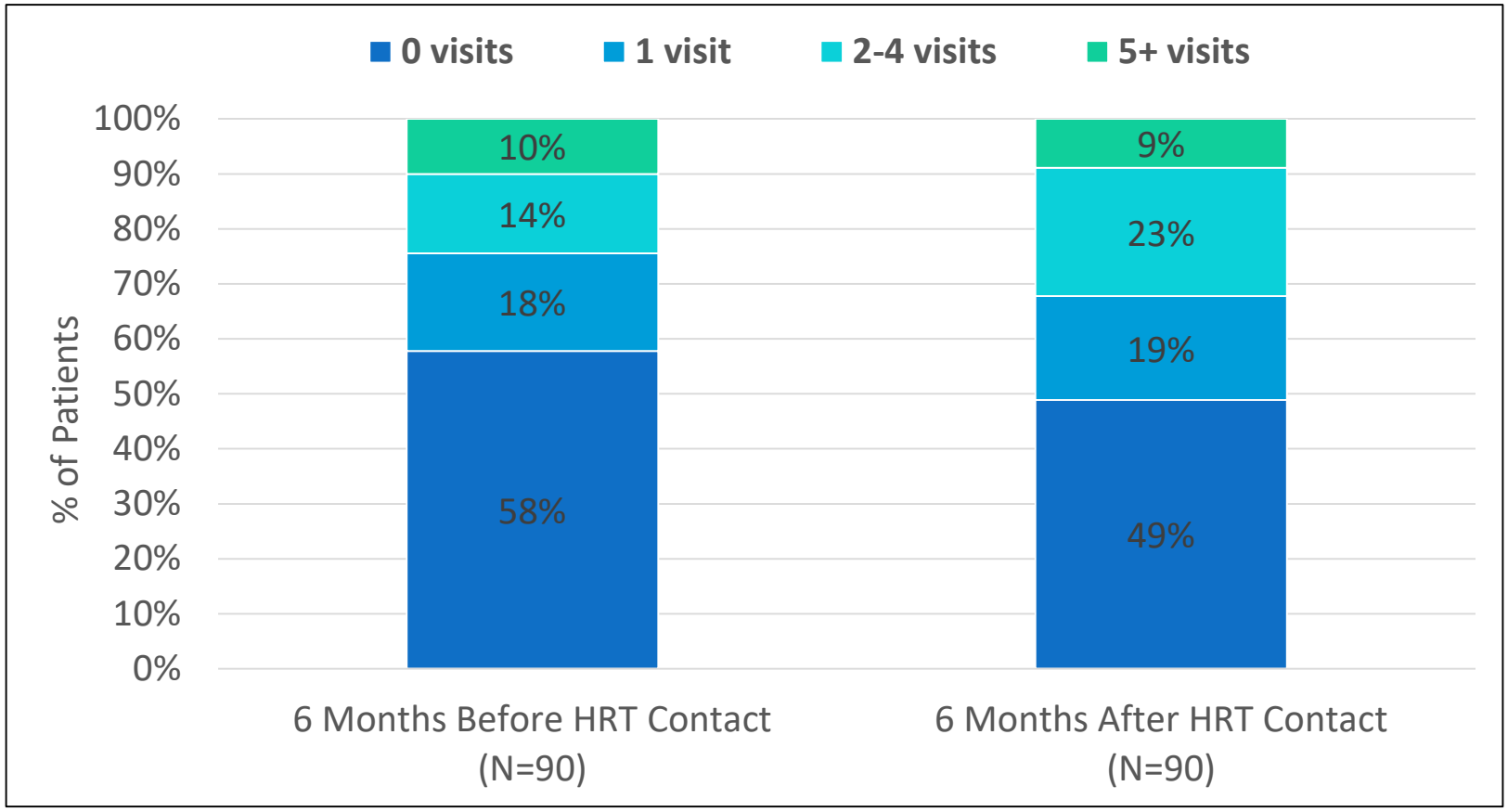
(Goal: Increase primary care utilization & decrease emergency department utilization among homeless adults with chronic medical conditions)

Context: primary care visits in 2019



Primary care visits for IHN-CCO members helped by HRT*

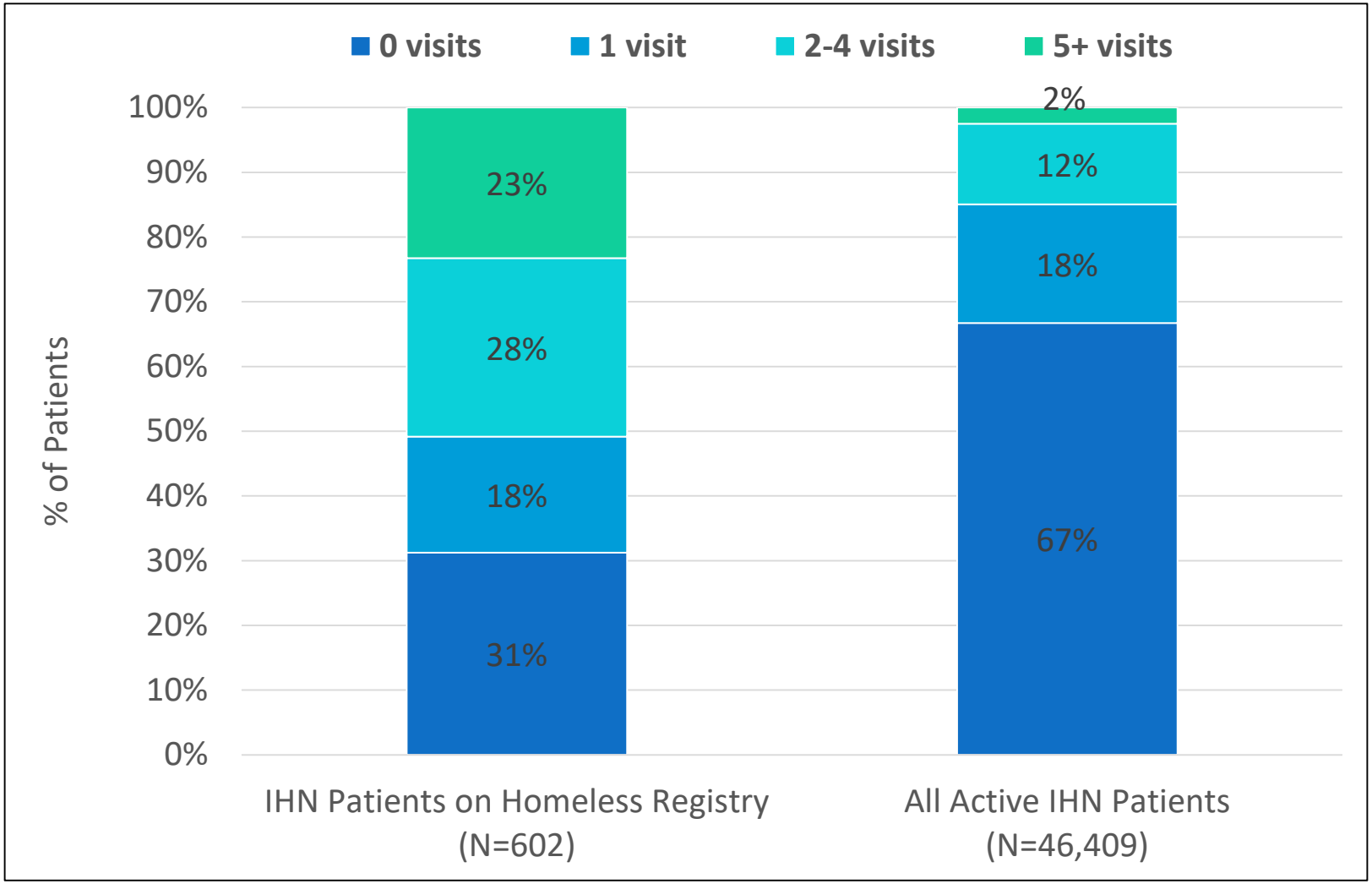
*8 members excluded due to insufficient follow-up time



Outcomes: Emergency Department (ED) utilization

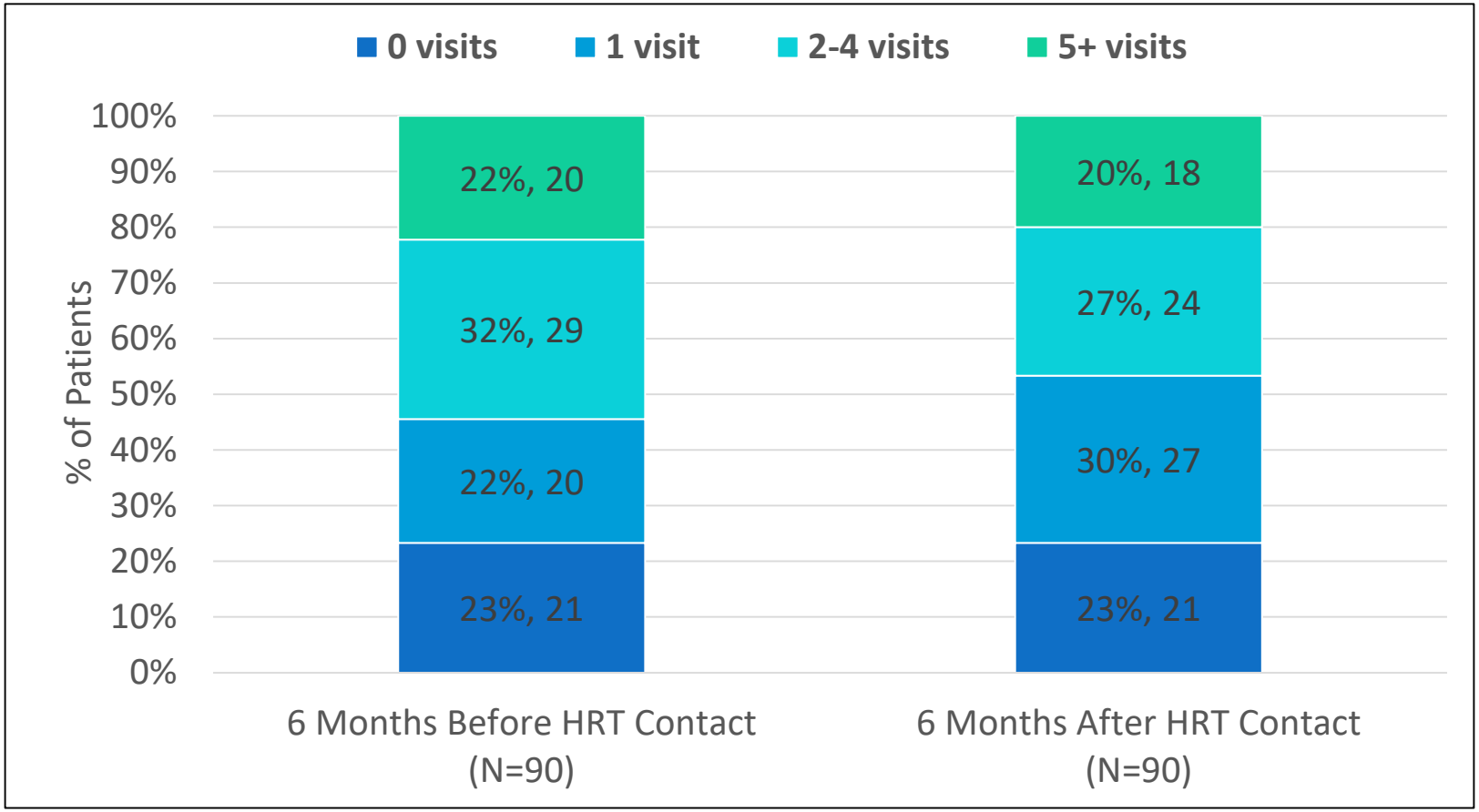
(Goal: Increase primary care utilization & decrease emergency department utilization among homeless adults with chronic medical conditions)

Context: ED visits in 2019



ED visits for IHN-CCO members helped by HRT*

*8 members excluded due to insufficient follow-up time



Outcomes: providers

(Goal: Improve healthcare providers' knowledge and sensitivity about caring for patients with homelessness.)

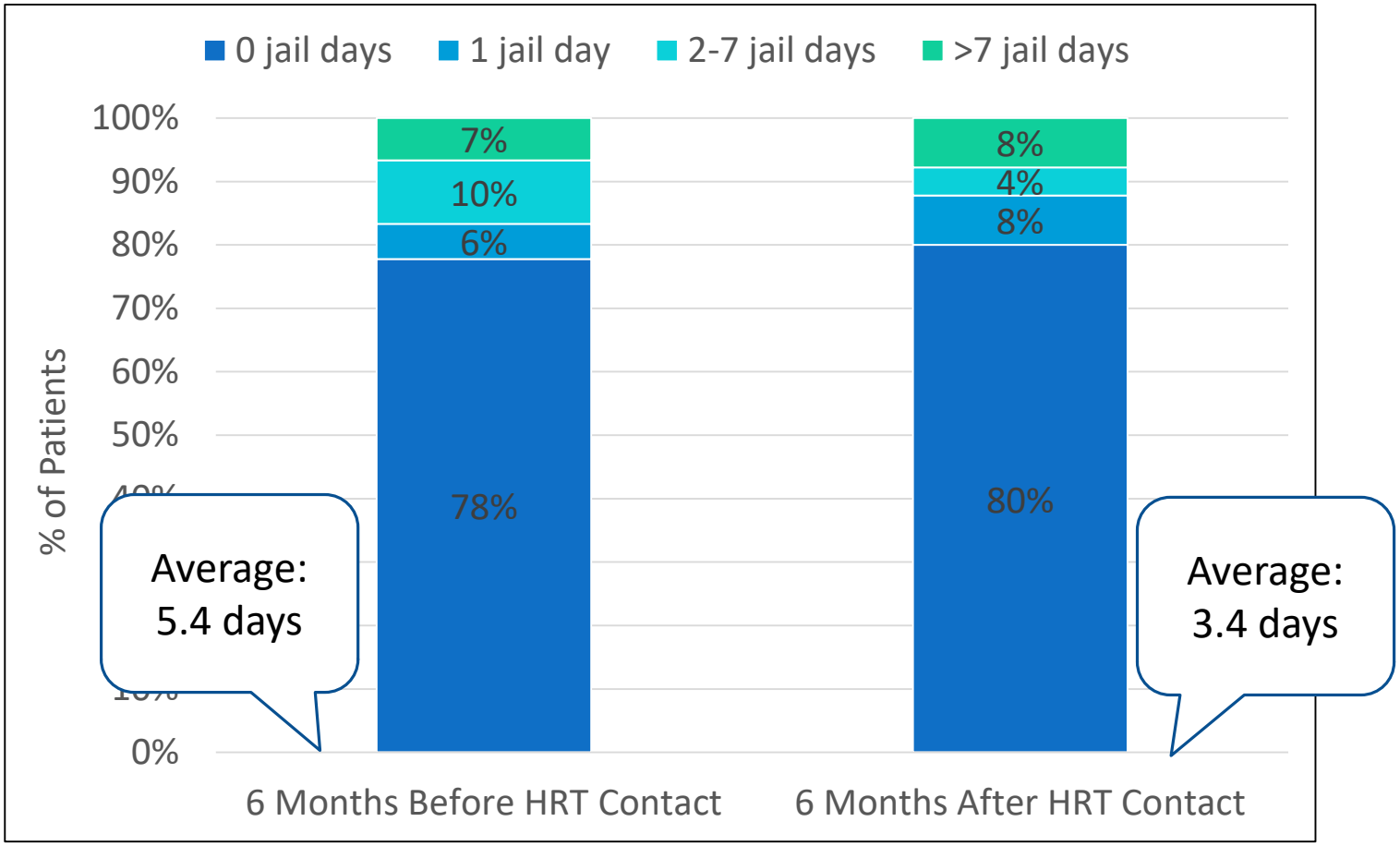
- Multiple trainings & didactic sessions were held for Samaritan physicians, residents, and staff. Samaritan LCSW has spoken to most medical residents and various medical teams at the hospital about the demographics of our community's homeless population, the treatment challenges and the community resources that are available.
- The response has been very warm and appreciative as this grant funded endeavors to provide a direct resource for medical staff to utilize when faced with a patient who is unhoused and has many social determinant of health concerns. Appreciation for sharing a trauma informed lens and humanizing these patients' struggles.

Outcomes: incarceration

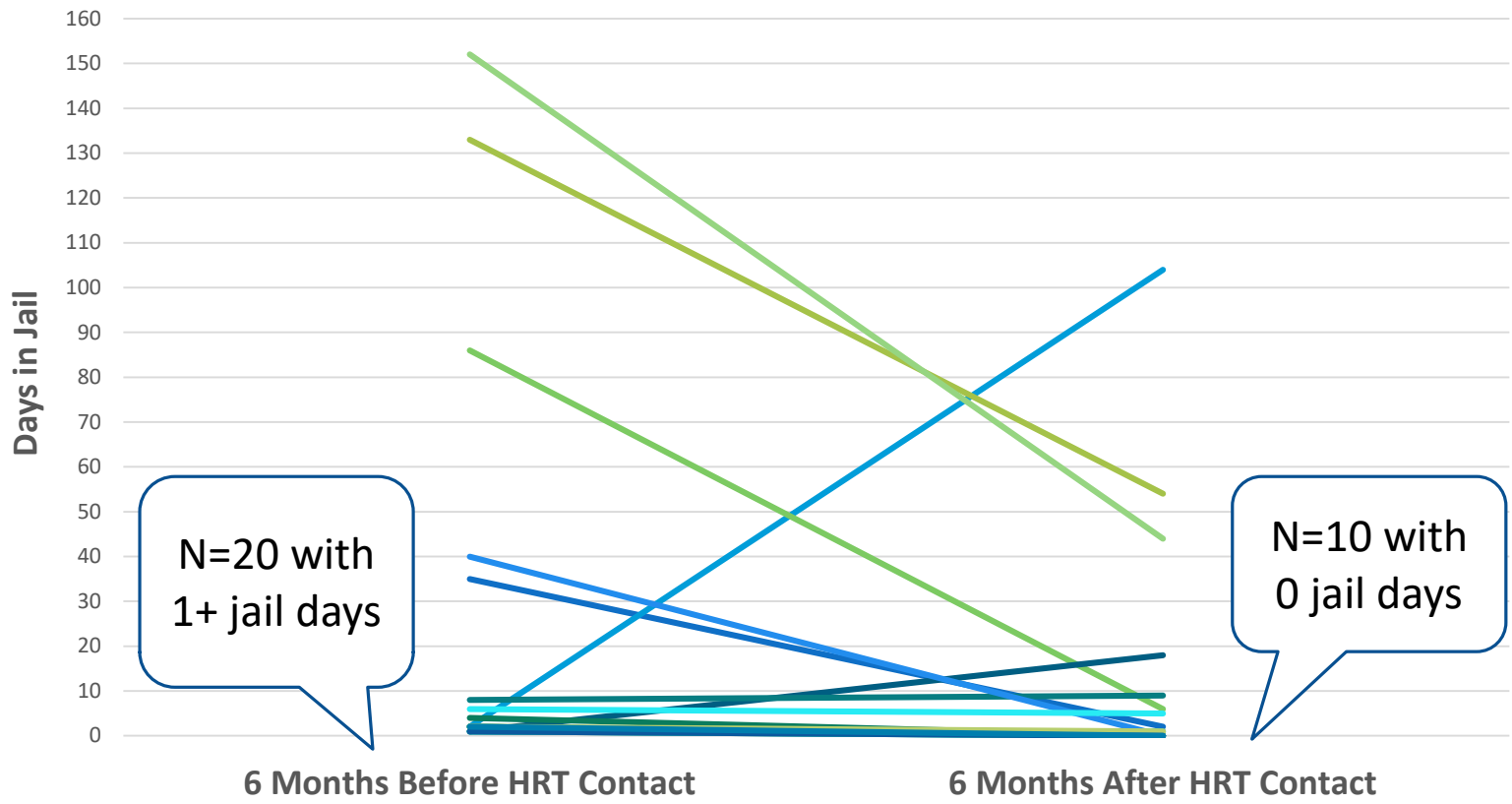
Goal: Decrease incarceration rates

Of the 98 IHN-CCO patients helped by the HRT, 8 were excluded because they did not yet have 6 months of follow-up data available.

Incarceration among IHN-CCO members helped by HRT



Incarceration among IHN-CCO members helped by HRT with 1+ jail day in 6 months before contact



Successes

- Community partnerships
  - Relationships between Samaritan, Benton County, Corvallis Housing First, CHANCE, CSC, and other partners have been strengthened by regular meetings to discuss specific client needs and broader community needs

- Samaritan workflows
  - Increase in referrals
  - Closed loop process – medical providers can see follow up & patient benefits

Successes: client highlights

- A Samaritan OB provider referred a homeless pregnant couple to us for housing, food, cleanliness and emotional support. The pregnant young woman has several neurodiverse character traits that made it difficult to tolerate medical interventions. We were able to get transitional housing for them both, figure out a strategy that offered a positive medical experience and offer transportation and food. We met with the patient several times to provide trauma debriefing and problem-solve next steps for her and her significant other. She tolerated intervention and allowed herself to have hope because she was treated with normal dignity and offered understanding.
- 64 year old vet, referred from Daytime Drop-in Center; spent 10 days in the hospital for heart failure. Arranged for discharge to micro-shelter, but had difficulty complying with meds and appts. PCP requested weekly appts to manage compliance. After multiple conversations with LCSW, patient was able to think about his behavior and choices; pill organizer improved med adherence. Now – more interest in managing HF, diet improved. PCP only meets monthly.

Successes: client highlights

- A woman with chronic health challenges had relied solely on the emergency room for healthcare; since initiating contact, we have helped her access primary and specialty care, provided medication assistance, attended several medical appts with her and provided nutritional supplementation. She has not been to the ED since. She had a reparative procedure that has improved her mobility by 80 percent. She goes to the gym daily and is hoping to return to work. Most importantly, she is now able to talk about her trauma and receive the validation and support necessary to reduce its effect on her life.

- A gentlemen was recently diagnosed with cancer and unwilling to receive life-saving treatment due in part to shame about his lack of hygiene. We were able to get him clean clothes, temporary and then permanent housing, a diabetes case manager and life saving cancer treatment. He described the robust support he received as: "…it is like you folks dug me up from out of the ground and brought me back to the land of the living."

Learning Experiences

- Hiring social worker was challenging
- Impact of COVID: shifting needs & shifting resources

Partnerships & Collaboration

- Strengthened relationships between Samaritan & Benton County Health Department
- Community partners (Corvallis Housing First; Community Services Consortium; CHANCE) also deeply engaged & essential to this project's success
- All of our relationships with community partners have changed. We are now on a first name basis and receive emails/calls continuously with opportunities to partner on client care---this level of communication was very rare in the past.
- We accompany the Samaritan Medical Mobile Van at two shelter locations and weekly meet clients at the Daytime Drop In Center. The SORT team offers referrals weekly and we just finished up collaborative efforts with Benton County Police Department's Community Livability Team.
- We have presented to the Housing First Board and work with them daily on medical respite bed placement and emergency COVID housing concerns.

Remaining Challenges

- Expansion to Linn & Lincoln Counties
- Resource limitations (outreach, primary care, mental health / substance abuse treatment)
- COVID likely to increase homelessness
- Many clients have complicated, untreated mental health concerns, plus poor or non existent rental histories. This makes them unlikely candidates for housing. The root causes of homelessness are complex, and solutions are difficult.

Post Pilot Sustainability

- Samaritan homeless outreach social worker position has been sustainably funded via a cost-sharing arrangement between IHN-CCO and Samaritan's Care Hub.

- Regular meetings between Samaritan, Benton County, and community partners are ongoing

Discussion