Homelessness, Health and Integrating Care: Options for Integrating Behavioral Health, Medical Care, and Housing

A FOCUS ON SACRAMENTO COUNTY

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ORIGINS OF THIS PROJECT

- Growing concern about the problems of people experiencing homelessness in Sacramento and across the state
- Widespread community recognition of the importance of addressing these problems
Stories

KB – an unhoused patient on Suboxone
- It took many weeks to get her insured and into clinic
- She stabilized on medication, but was arrested for illegal camping
- Went into withdrawal in the Sacramento County jail
- Released a couple days later and did not reconnect with care

TL – 19 yo transgender woman, frequent user of Emergency Dept.
- Lives in a shelter, no primary care
- Type I Diabetes, anxiety, depression, PTSD
- Hospitalized for diabetic ketoacidosis twice
- Mental health urgent care clinic always sends her to ED because of her diabetes
- Comes to ED for insulin, help with anxiety
Today’s Presentation – Overview

- Demographics
- Available Services
- Sacramento Stakeholder Observations
- Models of Integrated Care in other cities
- Rapid Evidence Review
- Conclusions and Recommendations
Who are the People Experiencing Homelessness in Sacramento?
The homeless population in Sacramento is increasing

People experiencing homelessness on any given night

Sacramento PIT Counts: 2015-2019
Homelessness in Sacramento County, Results from the 2019 Point-in-Time Count. California State University, Sacramento and Sacramento Steps Forward
Duration of homelessness

- **59% Long term**: *Homeless more than 1 year*
- **30% Chronically homeless**: *Long term or >4 episodes in 3 years and have a disability (mental health, SUD, cognitive disorder, chronic illness)*

Source: Homelessness in Sacramento County, Results from the 2019 Point-in-Time Count. Sacramento Steps Forward and California State University, Sacramento.
Demographic description of Sacramento homeless population in 2019

62% Male

Age (years)

- <18: 12%
- 18-44: 47%
- 45-65: 38%
- >65: 3%

Unaccompanied Youth: 8%
Families: 20%
Individuals: 72%

Type of household 2019

Source: Homelessness in Sacramento County, Results from the 2019 Point-in-Time Count. Sacramento Steps Forward and California State University, Sacramento.
Sacramento HMIS Data

~ 3,700 adults in HMIS system

~ 2,000 adults have 2+ conditions:
  - Mental illness,
  - Physical health conditions,
  - Substance use disorders

Based on Sacramento HMIS data, Fall 2019.
Emergency Care Use By Adults Who Are Homeless in Sacramento

In the past 6 months:

• 53% visited an Emergency Room 1-4 times
• 14% visited an Emergency Room 5 or more times
• 30% went to an Emergency room for mental health reasons
• 20% were taken against their will to a hospital for mental health reasons
Summary

- About 2,000 people experiencing homelessness are considered to be severe acuity
- Over 1,600 meet the definition of chronically homeless
- They require
  - Coordinated care
  - Intensive support
Services available to Sacramento residents experiencing homelessness:

- Housing
- Health care
- Mental health care
- SUD treatment
- Social services
- Services coordinated through the criminal justice system

Lack of a real time comprehensive services inventory or an electronic social health information exchange makes a comprehensive view of services or coordination of services very difficult.
Housing 2018

Emergency Shelters
(reapply nightly for a bed)
- 32 emergency shelters
- 891 year-round beds
- Railroad shelter closed (2019) with loss of 200 beds

Emergency Shelters
(2019)

Transitional Supportive Housing
(up to 24 mos w/ wrap-around services)
~15 programs with ~600 beds
(decline from 899 beds in 2015)

Rapid Re-housing
(short-term rental assistance; no services)
- Increased beds from 358 (2015) to 732 beds (2018)

Rapid Re-housing
(2018)

Permanent Supportive Housing
(case management in housing unit)
- ~33 programs with 2,933 beds
  (no change from 2015)

Permanent Supportive Housing
(2018)

3899 people living outside January 2019
Health Care

- 4 large health systems
  - Emergency care
  - Hospitalization
  - Limited primary and specialty care
- FQHCs-Community Clinics
  - Primary care
  - Behavioral Health
  - MAT
- Medical Respite Shelters
Mental Health Care Options in Sacramento County

- Intensive mental health care services:
  - Crisis service units (~32 beds)
  - Inpatient acute psychiatric hospitals (~554 beds)
  - 7 crisis residential programs (~78 beds)
  - 3 mental health respite programs (~18 beds)
  - Criminal justice system (34 beds in 2 jails)

Estimated shortage of 600 psychiatric beds in Sacramento County despite an additional 120-bed facility opening in 2020.
Mental Health Care Options in Sacramento County

- Outpatient mental health services
  - Low, medium and high intensity outpatient services

- 8 agencies provide Full Service Partnerships
  - “Whatever it takes” to support permanent housing, employment, and health care.
  - Served 504 clients who were homeless in 2017-18
Substance Use Disorder (SUD) Treatment

- Major SUD problems among people experiencing homelessness
  - Opioids – amenable to outpatient MAT after induction
  - Alcohol – MAT less effective but available, withdrawal can require hospitalization
  - Meth – No MAT available. Limited evidence for contingency management

- For people who are homeless, inpatient (residential) treatment may be essential, especially for meth and alcohol
SUD Treatment

- 47 Sacramento facilities are DHCS-certified to provide SUD treatment
  - 6 of these facilities offer incident medical services (98 beds)
- Homeless individuals must use County Drop-In Center for assessment before referral
- County system refers homeless individuals to one of 14 facilities
- People without private insurance, including those who are homeless, have very limited options for residential treatment
- The County Drop-In Center operates the waiting lists, which are long for residential treatment
Sacramento Criminal Justice System

- County Sheriff: Homeless Outreach Team (HOT)
- Police Department: IMPACT Team
- County Jail: overburdened psychiatric unit
  - 97% increase in psych cases 2004-2018
- Sacramento County Court System:
  - Mental Health Diversion: case management and housing resources
    - Flexible Supportive Rehousing Program (250 clients with highest system contact rates);
    - Flexible Housing Program (80 homeless candidates with pending misdemeanors)
  - Expungement Clinic - removes criminal records for qualifying individuals who perform public service
Summary: Services Available in Sacramento

- Multiple services and many service providers
- Fragmented, hard to navigate
- No communication platform linking service providers or case managers across silos
- Especially limited capacity
  - shelters, housing
  - treatment for severe mental illness
  - residential SUD treatment
Stakeholder Feedback about Needs, Capacity, and Options in Sacramento

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Data Collection & Analysis

- July 2019 to October 2019:
  - Interviewed 35 people from 24 hospital systems, social service and public agencies
  - Conducted two focus groups
    - Criminal justice cabinet
    - System advocates (i.e. people with lived experience)

- Open-ended question sets
  - Most recorded, unless interviewee preferred no recording

- Online, confidential, follow-up survey (15 respondents)

- Analyzed notes, memos, and interview recordings and transcripts to identify patterns and themes
Crisis Intervention Framework

- There are a lot of intervention points
- The organizations involved represent a tremendous allocation of resources
- The intervention field is varied and complex
- Landing points are often isolated within crisis domains
Challenges to be Overcome

**INSUFFICIENT CAPACITY IN MULTIPLE INTERVENTION DOMAINS**

- In-patient psychiatric
- Permanent supportive housing
- Affordable market housing
- Detoxification, substance abuse treatment

**LIMITED COORDINATION, COMMUNICATION, AND ORGANIZATION**

“The lack of coordination between the county and the city has been a big barrier.”  
- health system respondent

“[various elements] have too many philosophical pieces and no thought leader.”  
- social service respondent
Specific Impacts of Limited Coordination

- Data sharing and communication gaps
- Broken or non-existing service pathways
- Redundancy and inconsistent practice standards
- Regulatory and funding misalignments

“I feel the way they are implementing [data systems] is holding us back... We’re mandated to put data into a system that won’t talk to anything else [the hospitals, or other service providers].”

– Social service respondent

“Data sharing at the system level is very hard.”

– Public agency respondent
Elements to be Retained and Optimized

**Programs**

- Flexible Supportive Re-Housing Program
- Low barrier triage shelter approach
- Pathways to Health + Home
- Interim Care Program (ICP)
Elements to be Retained and Optimized

Infrastructure Elements

- Coordinated entry
- Data sharing agreements
- Collective impact model; shared governance

“My number one goal is to see the creation of a health information exchange (HIE), so that we can better coordinate services.”

- health system respondent
Subjects Warranting Highlight

- Methamphetamine use disorder – lack of effective treatment available
- Experience, ideology, and service philosophy
- Trauma and moral injury

“It’s hard to distinguish between methamphetamine-induced psychosis and organic psychosis…it’s really expensive” [when a person ends up in an in-patient psychiatric facility and substance use detoxification and treatment would have been more appropriate].

- health system respondent
High priority services for an integrated care model

HOUSING
- Transitional supportive care
- Board and care
- Rapid rehousing

OTHER SERVICES
- Integrated jail diversion
- Social services/insurance application assistance

Health services
- Triage screening
- Crisis stabilization
- Detox Center
- Primary care
- SUD treatment
- Outpatient behavioral health
- Case management/coordination

“Our supportive housing program... Could be even more effective if we had access to project-based housing with medical and other services on site.”

“Once safely housed, it becomes much more likely that a person will be willing and capable of working on underlying issues.”

“Case manager social workers need to follow clients to address housing and all bio-pyscho-social needs.”
Take-Aways

- General positive interest in the integrated care campus concept
  - With apprehension, and appreciation of existing efforts

- General support for increasing service capacity, **while also** reorganizing capacity with coordinated system infrastructure development

“I am in full support of funding for housing all homeless citizens, especially WRAP services for people in crisis in the ER or outpatient community mental health clinics...”
- health system respondent

“Much needed. Suggest aligning with Sacramento County’s Behavioral Health Strategic Planning.”
- health system respondent
What can Sacramento learn from other cities with similar challenges?

National Models of Integrated Care
Central City Concern (Portland, 1979)

Blackburn Center (2019)

- Primary care
- Addiction treatment
- Treatment for Hepatitis C
- Mental Health Care
- Pharmacy services
- Acupuncture
- Case management
- Transitional housing
- Permanent supportive housing
- Employment assistance

Image from: https://www.centralcityconcern.org/blackburn
Haven for Hope (San Antonio, 2010)

- Mental health services
  - 16 bed crisis stabilization
- Medical, dental, vision care
- Detox and sobering
- Diversion intake/police drop off
- Men’s, women’s, family, and veteran housing
  - Courtyard shelter
  - Sober-living dormitories
- Comprehensive social & legal services
- Vocational/certificate training programs
- Spiritual services
- Pet kennel

Image from: https://www.havenforhope.org/
The Conway Center (Washington, D.C. 2016)

Single, 7-story LEED building
- 202 affordable housing units
  - 30 families
  - 182 individuals
  - 20 for SUD program participants
- Employment readiness program
  - Adult basic education
  - Soft skills training
- Primary care clinic (FQHC) ~10,000 visits/year
- Case Management
- Personal Assistance/Stress Mgmt.
- Community Clubs

Image from: https://www.housingfinance.com/developments/dc-development-to-combine-housing-job-training-health-care-g
New Genesis (Los Angeles, 2012)

Single, 7-story LEED building

- 106 units of supportive housing
- Integrated FQHC
- Case management
- Mental Health services (group/individual)
- Life skills (job training, money management)
- Collaborative Social Group activities
- Housing First model using harm reduction for addiction
- Commercial space 1st floor

Image from: http://skidrow.org/buildings/new-genesis-apartments/
Downtown Emergency Services Center (Seattle, 1980)  
Hobson Place (2020-2021)

- Crisis intervention/Crisis respite care
- On site medical services
- Assertive Community Treatment
- Outpatient mental health and substance use disorder treatment
- Comprehensive case management
- Emergency shelter
- 177 units of permanent supportive housing for people previously homeless with disability
- Vocational training
- Veterans outreach
- Hygiene facilities

Image from: https://www.desc.org/join-us-to-introduce-groundbreaking-new-housing-and-clinic/
Other Campus Models in Development

- **SHATTUCK CAMPUS REDEVELOPMENT**
  - (Boston, 2022)
  - Redevelopment of 485 acres (former MH hospital and clinic)
  - Continuum of mental health, substance use and primary care services, permanent supportive housing (75-100 units), emergency shelter and wrap-around supportive services

- **DOUGLAS COUNTY, KS**
  - (Proposed, 2019-2021)
  - Recovery center with Crisis Unit (14 beds), Detox, Transitional Housing (12 beds), Permanent Supportive Housing (10 apartments)
  - Adjacent to community health center, mental health center, and hospital

Integrated Models with Co-located services

- People who are chronically homeless require multiple, often intensive services
- Other cities facing similar challenges are developing models of integrated, co-located care
- Co-located services may be on site with shelters and supportive housing, or housing may be dispersed in the community
Rapid Evidence Review of Integrated Care
What do existing studies tell us about the effectiveness of integrated care or its components?

- Searched PubMed, PsychINFO, Google Scholar
- Focused on systematic reviews and randomized controlled trials
- 792 abstracts reviewed; full text of 101 papers
- Literature largely considered poor quality
- Studies looked at diverse outcomes (days homeless, short-term health, health care utilization, quality of life)
Sparse evidence about the effectiveness of co-located, integrated care models

Components with stronger evidence of effectiveness:
- Housing First model
- Intensive case management
- Assertive community treatment
- Crisis residential treatment
- Medication-assisted treatment for SUD (opioids)

Some evidence of effectiveness:
- Permanent supportive housing (i.e., Treatment First model)
- Residential treatment + case management

Potentially promising interventions:
- Full Service Partnerships
- Contingency management (methamphetamine)
THE WORLD'S BIG SLEEP OUT

LONDON

EDINBURGH

NEW YORK
Conclusions

- The population of people experiencing homelessness in Sacramento has grown steadily for the past 5 years; at least 1,600 are chronically homeless.
- Sacramento has many services for people who are chronically homeless; however, most services are siloed and fragmented. Service providers do not have integrated electronic records to track utilization across silos.
- Without consistent methods of communication (phone, address) or ready access to transportation, people experiencing homelessness have difficulty navigating this complex system.
- Local innovative programs such as criminal justice diversion programs, Full Service Partnerships and Pathways to Health and Home warrant expanded capacity.
- Capacity is inadequate, particularly for housing (temporary or permanent), residential treatment of amphetamine and alcohol use disorders, and treatment for serious mental illness.
Conclusions

- Cities around the U.S. are building innovative models of co-located, integrated care for people experiencing homelessness. Evidence of their effectiveness is limited, largely due to their recent development.

- There is evidence of effectiveness for components of integrated care; notably for supportive housing.

- Sacramento stakeholders expressed interest in integrated, co-located services and expanded housing capacity, but also expressed concerns about loss of resources for existing services.

- Expanding housing and services capacity and integrating care require a substantial investment of resources.

- Funding sources for integrated care models vary greatly and include health system, foundation, and philanthropic support; most models depend on at least partial government financing.

- Until resources are invested to expand capacity and improve coordination of services, emergency departments in Sacramento County will continue to be the common pathway for providing care for homeless people in crisis.
Recommendations

- **Expanded capacity** for shelters, transitional supportive housing, permanent supportive housing, and Board and Care facilities is urgently needed to reverse the rising numbers of people experiencing homelessness in Sacramento County.

- **Capacity for inpatient and intensive outpatient care of serious mental illness and substance use treatment** for people experiencing homelessness must be expanded. Pilot programs for treatment of methamphetamine use disorder with contingency management are urgently needed.

- **An integrated communication system**, such as an electronic Social Health Information Exchange that supports communication across housing, clinical care and social services, would improve the effectiveness of services for people experiencing homelessness.

- **Co-located services linked to expanded housing capacity** (onsite or elsewhere in the community) could improve integrated care and support transition into long-term housing.

- **Rigorous evaluations** of integrated care programs are needed to assess effectiveness. Economic analyses will provide estimates of costs and potential benefits of these programs.
QUESTIONS?