HOMELESSNESS, HEALTH AND INTEGRATING CARE: OPTIONS FOR INTEGRATING BEHAVIORAL HEALTH, MEDICAL CARE, AND HOUSING

RESEARCH BRIEF

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The Sacramento community is seeking solutions to help people exit from homelessness. This brief summarizes findings from the Integrating Care for People Experiencing Homelessness report that presents recommendations based on data about the Sacramento homeless population and services available to them; local stakeholder observations about care quality and access; national models of integrated care programs; and a review of the literature on effectiveness of integrated models and their components.

The goal of the report is to inform discussion among community members who seek innovative solutions to address the challenge of people who are chronically homeless in Sacramento.

**PROBLEM: WHO IS AFFECTED?**

A growing number of people are experiencing homelessness in Sacramento County, a common problem across California and the U.S. During 2019, an estimated 10,000 people in Sacramento County experienced homelessness.

The 2019 Sacramento Point-In-Time Count found that on any given night, 5,570 people are homeless—a 19% increase since 2017. Of those, ~1,600 meet the federal definition of chronically homeless including one or more physical health conditions, substance use disorders, and/or mental health conditions.

Almost 2,000 (53%) of those enrolled in the Homeless Management Information System report two or more conditions. Notably, substance use is not uncommon. The rate of methamphetamine (meth) use among the unsheltered is estimated between 10-25%. Of those who are in county-funded SUD treatment, 43% report meth as their primary drug, followed by heroin (28%), and alcohol (14%). Medication Assisted Treatment (MAT) is not available for meth addiction (only opioids and alcohol). Space for residential treatment is limited, especially for those on Medi-Cal; wait times are long. Meth use exacerbates mental and physical health problems and intensifies behavior that make sustainable housing placement more difficult.
Are the Services for the Homeless Population Sufficient?

Sacramento provides a diverse, but fragmented array of medical and mental health care, SUD treatment, housing, and social services. These services are rarely coordinated or co-located; however, Whole-person care and full-service partnership plans administered by nine agencies that do “whatever it takes” to support high acuity clients are a good example of promising care coordination. Access to housing, mental health and SUD treatment is limited; some programs have extensive waiting lists. The ~800 emergency shelter beds are unable to meet the demand for shelter; transitional and permanent housing are in short supply with waiting lists. Similarly, there are insufficient numbers of inpatient psychiatric beds and inpatient SUD services.

These findings were confirmed by Sacramento stakeholders (35 representatives from health systems, social service providers, people with lived experience, community clinics, and local government) who described the primary challenges as:
1. Insufficient capacity in multiple intervention domains
2. Limited communication or coordination between siloed services.

“There is a capacity issue all around.”
— health system respondent

“There are a number of entities out there doing outreach…then what are the best practices, best standards, and how do we build a more coordinated effort?”
— public agency respondent

National Models for Integrated Care Campuses

Across the country, co-located, integrated service models are being developed. Common characteristics among these programs include a focus on care coordination with transitional supportive housing and co-located treatment services, including mental health care, SUD treatment, and primary care, often provided by a federally-qualified health clinic (FQHC). Highlights include:

| Central City Concern: Blackburn Center | Haven for Hope |
| **Units:** 51 respite care; 10 palliative care; 80 transitional housing; 34 permanent supportive housing in 6-story bldg. | **Serves:** ~975 people in continuum of shelter options (courtyard; emergency shelter, transitional dormitory housing). |
| **Services:** FQHC; pharmacy; mental health and SUD treatment; case management; employment services; housing placement plus commercial space. | **Services:** Medical, dental, vision care; intensive outpatient mental health and SUD treatment; detox/sobering; referrals, job training; jail diversion. |

| New Genesis Project Based Residential Housing | Shattuck Campus |
| Los Angeles, CA (2012) | Boston, MA (opening 2022) |
| **Units:** 106 units | **Units:** ~75-100 permanent supportive housing, emergency shelter |
| **Services:** Permanent supportive housing and wrap-around services for chronically homeless including: continuum of mental health services, co-occurring SUD treatment, and physical health services (labs, imaging, exams, etc.). | **Services:** Outpatient medical services; behavioral health services; urgent psychiatric care; SUD treatment. |

| Downtown Emergency Services Center: Hobson Place | The Conway Center |
| **Units:** 177 permanent supportive housing units | **Units:** 182 permanent supportive housing (families and single adults)/20 dedicated to SUD recovery units |
| **Services:** clinic with integrated mental health and SUD treatment; pharmacy; lab; case management; employment services. | **Services:** FQHC and pharmacy provide 12,000 patients with primary care, mental health and SUD treatment services, dental care. Job training center, shops, and administrative offices. |
**Rapid Evidence Review of Integrated Care**

Results of a literature search for evaluations of integrated care did not yield any rigorous evaluations. Evidence from studies of components of integrated care supports Housing First approaches, intensive case management, assertive community treatment, crisis residential treatment models for mental health crisis treatment, and MAT for opioid use disorders. More limited evidence suggests permanent supportive housing and residential treatment with case management may be effective. Contingency management for methamphetamine use disorder appears promising and should be further piloted and evaluated.

**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, mailing 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 methamphetamine and alcohol use disorders, and treatment for serious mental illness.
- 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 and jails in Sacramento County will continue to be the common pathway for providing care for homeless people in crisis.

**Recommendations**

- Expanded capacity for shelters, transitional and permanent supportive housing, and Board and Care facilities is urgently needed to reverse the rising numbers of people experiencing homelessness in Sacramento.
- Capacity for inpatient, residential, 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 using 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 reduce barriers to care, improve integrated care, and support transition into long-term housing.
- Rigorous evaluations of integrated care programs are needed to assess their effectiveness. Economic analyses can provide estimates of costs and potential benefits of these programs.
Client Crisis Map
(Note: This figure does not represent an exhaustive inventory of services; however, it illustrates enough of picture to inform conversation and a start mapping a total intervention system.)

Client Crisis Map illustrates service entry points from client perspective.
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