Healthy Release

Health Centers Working to Improve Health and Housing Outcomes for Justice Involved Populations

National Health Care for the Homeless Symposium
Washington DC, June 22, 2017

Presenters Today

- Kim Keaton, Senior Program Manager, Strategy & Impact, CSH
- Frances Isbell, CEO, Houston Healthcare for the Homeless
- Bethany Weber, MSW, LSW, Program Manager, Greater Cincinnati Behavioral Health Services

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Setting the Stage

Kim Keaton

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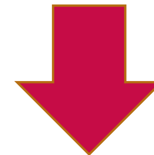
Health Challenges of Incarcerated and Formerly Incarcerated Populations

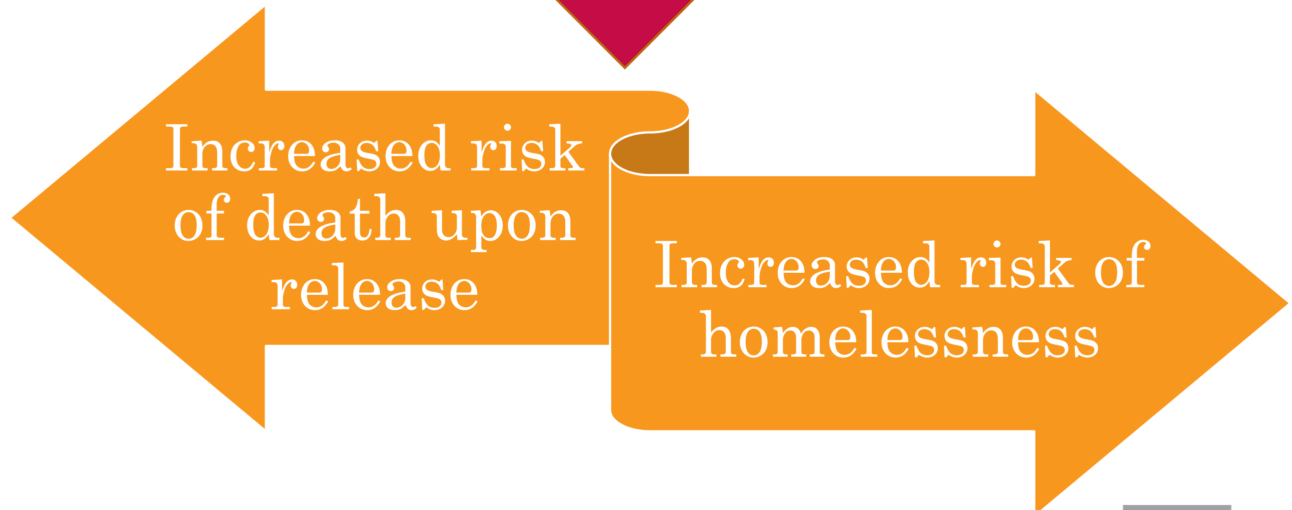
~19% of jail inmates have history of homelessness prior to arrest; 11% homeless after prison release

>46% of jail inmates have substance use disorders

14% prison and 26% jail with serious psychological distress

Higher rates of chronic health conditions (5x HIV)





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Role of Health Centers

It's simple, really

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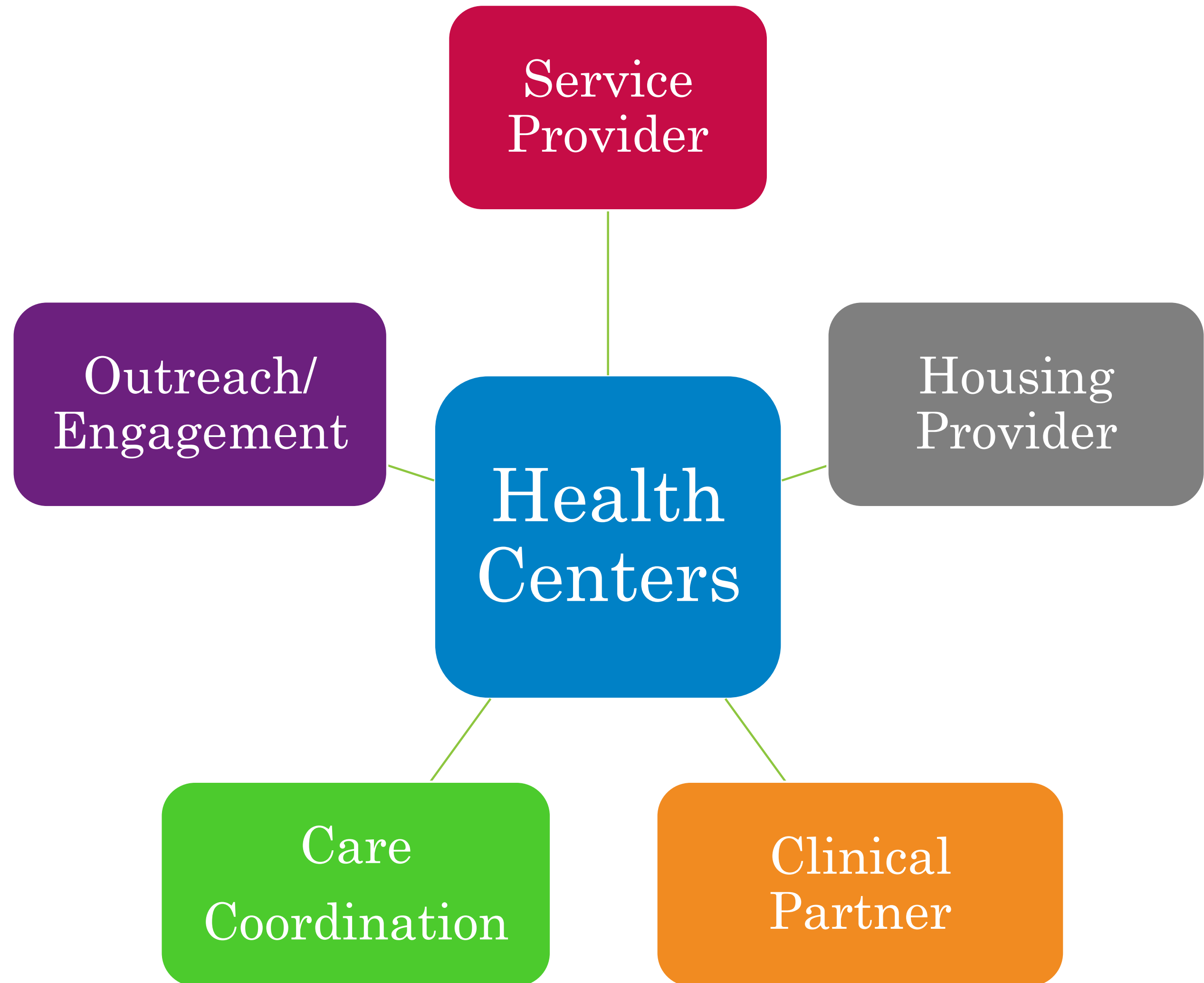
Roles for Health Centers in Supportive Housing Parnterships



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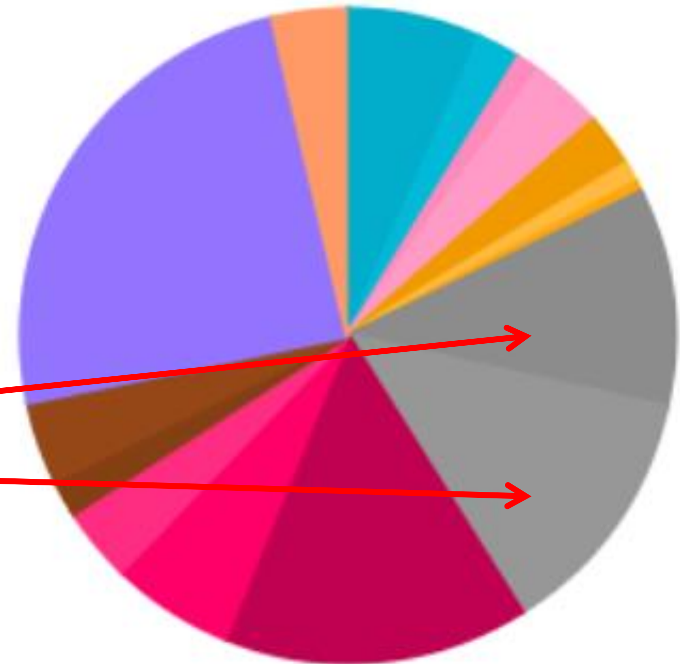
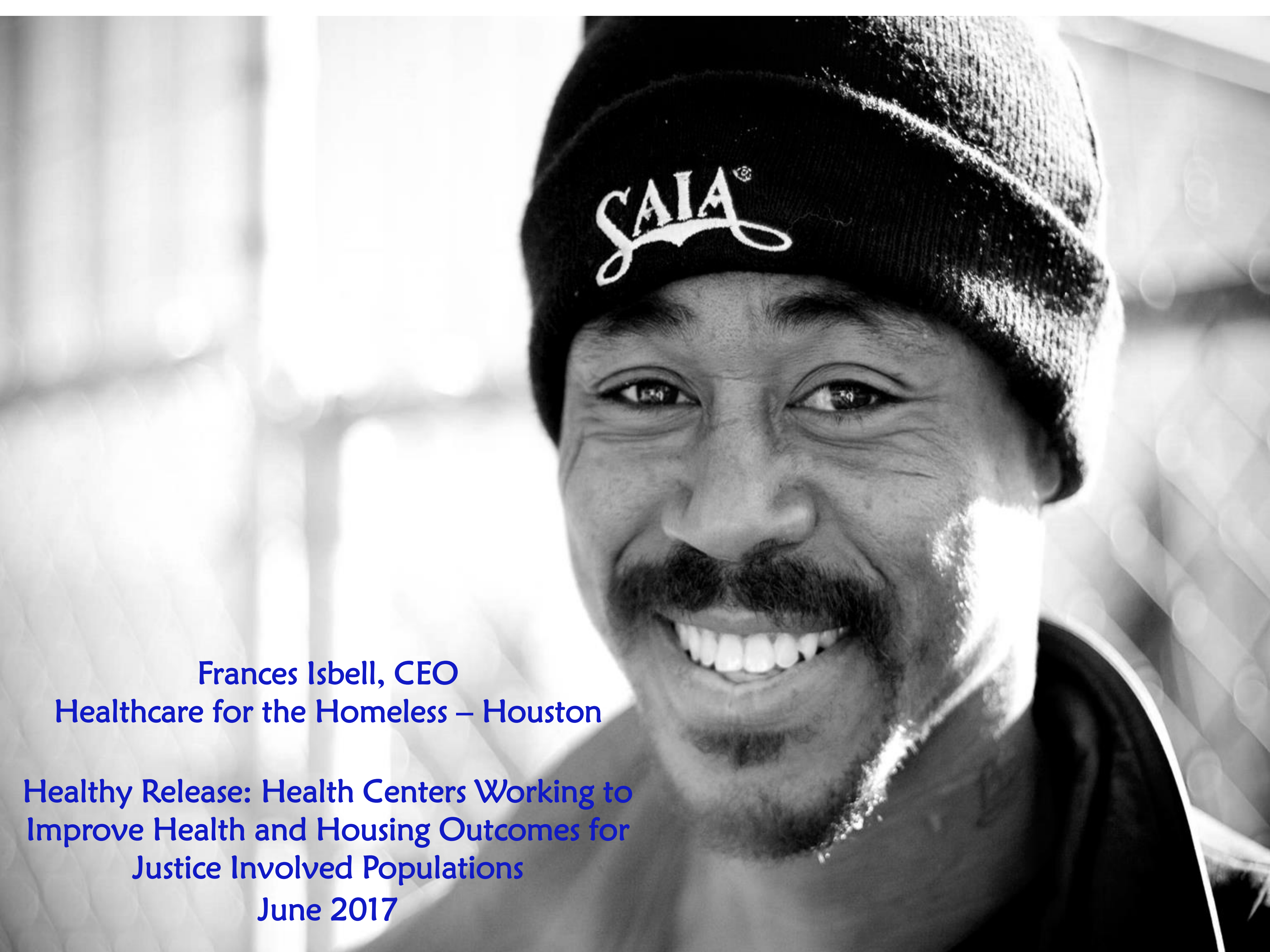
Determining Housing Need in Justice-involved Populations

System

- Chronic Homeless
- Non Chronic Homeless
- Homeless Families
- Child Welfare Families
- Unaccompanied TAY
- Child Welfare TAY
- Justice Involved TAY
- Prison
- Jail
- IDD Waitlist
- IDD Institutional
- IDD Residential
- MH Institutional
- MH Residential
- Aging
- Substance Use





Frances Isbell, CEO
Healthcare for the Homeless – Houston

Healthy Release: Health Centers Working to Improve Health and Housing Outcomes for Justice Involved Populations

June 2017

CLINICAL SERVICES

- **3 Clinics**: stand alone Caroline St. Clinic; shelter clinics at Cathedral Clinic & Star of Hope Men's Development Center
- **Street Medicine Outreach**
- **HOMES**: student-run free clinic
- **Dental Clinic**: 6 operatory clinic

* *HHH serves 7,000 -10,000 people per year*

SPECIAL PROJECTS

- Project Access Transportation Project
- Jail Inreach Project (including the Healthy and Whole Project)
- SB 1185 Jail Diversion Project
- Medicaid 1115 Waiver Project

Jail Inreach Project Background

Several studies have considered the correlations between incarceration, mental illness and homelessness, concluding that coordination of care reduces the cyclical nature of incarceration, emergency department utilization and homelessness

Project Background/cont.

- Jail inmates are frequently released without advance notice, making discharge planning problematic
- Jail inmates are often released in the middle of the night when no services are available
- Quite often, jail inmates are released with no medication and often without prescriptions
- Harris County jail is the 2nd largest provider of behavioral health services in the U.S., with ~1,000 homeless inmates on any given night

Jail Inreach Project Objectives

- Prevent rapid deterioration of mental health status upon release from Harris County Jail
- Reduce rearrest rates and rapid cycling through the jail and emergency centers
- Improve health status of individuals and population
- Develop a more coordinated system of care that supports accessing needed resources

How It Works…

- Collaborative program between HHH, local mental health authority, and jail medical unit – BAA allows sharing of PHI

- CM works with clients while still in jail to develop a release plan; use MI and TTM
  - integrated primary & behavioral health care
  - substance use assessment/treatment
  - housing referrals
  - benefit eligibility
  - transportation

How It Works/cont.

- Client discharged to CM if day-time release arranged
- CM walks client to HHH clinic on day of discharge for continuity care including medications
- Client assigned to a care team
- If client enters PSH, warm hand-off of care coordination to on-site clinical staff

Results

- Over 2,000 clients served
- ~$8M savings to jail; more for city and county
- Those who had been engaged in the program and successfully linked to services for 1+ years:
  - 57.1% reduction in bookings into Harris County Jail per year
  - 57.4% reduction in total number of charges per year
  - 64.8% reduction in average number of days in jail per year
  - 90% of participants were linked to community services

Healthy & Whole Program

- Grew out of the Jail Inreach Project when CM working with female inmates/releasees noted that almost 100% of women had experiences of sexual trauma, human trafficking or prostitution
- Relatively small program, typically >30/year
- Partner with another jail releasee/diversion program that provides temporary housing (up to 9 months) as well as a new specialty court

H & W Program Elements

- Trauma-specific care, including Seeking Safety
- Health: all are seen within 72 hours at clinic
- Health Education: developed curriculum w/ BCM
- Wellness: walking, yoga, cooking classes
- Healing through the Arts:FotoFest's Literacy Through Photography
- Peer Support
- Employment program

H & W Results

- Recidivism: decreased from 20% in 2013 to current 9%
- Healthcare access:
  - 20% reported receiving regular medical care prior to the intervention, 100% reported receiving medical care after the intervention
  - 30% reported they were on medication prior to the intervention, 100% reported being on medication after the intervention
  - 20% said they had a primary care provider prior to the intervention, 90% said they had a primary care provider after the intervention

H & W Results/cont.

- Smoking cessation: 33% quite smoking and 100% of smokers reduced nicotine intake
- 38% improvement in self-perceived health status ("homemade Likert scale")
- No standardized measurement metrics for program. In 2016, received a $300K grant from the Robert Wood Johnson Foundation to evaluate program and develop standardized metrics

Mental Health Jail Diversion Program Eligibility Criteria

- Chronically homeless (as assessed by Houston’s Coordinated Access program)
- 3 or more bookings in Harris Co. jail in 2 years
- Functional assessment at HHH clinic
- Clear HUD, Harris Co. Housing Authority and property management criteria

Evaluation Metrics

- Attrition
- SF-36v2
- DLA-20
- Reduced recidivism
- PHQ-9
- Increased income

Theoretical Models: Primary Care Behavioral Health Consultant

- Considered “extreme” integration
- Pilot project with homeless population
- Behavioral Health Consultant (BHC) will see patients with Primary Care Clinician at “point of care”
- Focus on TTM, MI, CBT and brief interventions
- Moved HHH to Level 6 integration: Full Collaboration in A Transformed/Merged Practice (SAMHSA, *A Standard Framework for Levels of Integrated Healthcare*)

PCBHC Model

- Evaluations focus on functional assessment, and treatment plans are geared toward functional restoration rather than diagnosis/symptom elimination
- BHC may have several independent sessions with the patient, but goal is to turn follow-up care over to the PCP who will manage the care plan

CLINICAL CASE MANAGEMENT MODELS

- Transtheoretical Model of Intentional Behavior Change (TTM), often known as the Stages of Change
- Motivational Interviewing (MI)
- Harm reduction

STAFFING PER TEAM

- RN Case Manager (providing on-site nursing services and care coordination)
- Director of Social Service and Case Manager Lead (both part time, provide leadership)
- 2 Clinical Case Managers (on-site, Masters level)
- 2 Community Health Workers (on-site and “hands on” healthcare coordination)
- Behavioral Health Consultant and Primary Care Team (at HHH clinics, as needed)

Top Diagnoses

- Substance Use Disorders (81%)
- Chronic Pain/Pain-related disorders (73%)
- Severe Mental Illness (64%)
- Hypertension (44%)
- Diabetes (22%)
- Hepatitis C (24%)

OPTUM SF36$_{v2}$ Health Survey

- A multi-purpose, short-form health related QOL survey consisting of 36 questions measuring functional health and well-being from the patient's point of view
- Yields an 8-scale profile of functional health and well-being scores
- The 8 scales can be combined to assess a Physical Component Summary and a Mental Component Summary

Baseline SF-36$_{v2}$ Scores

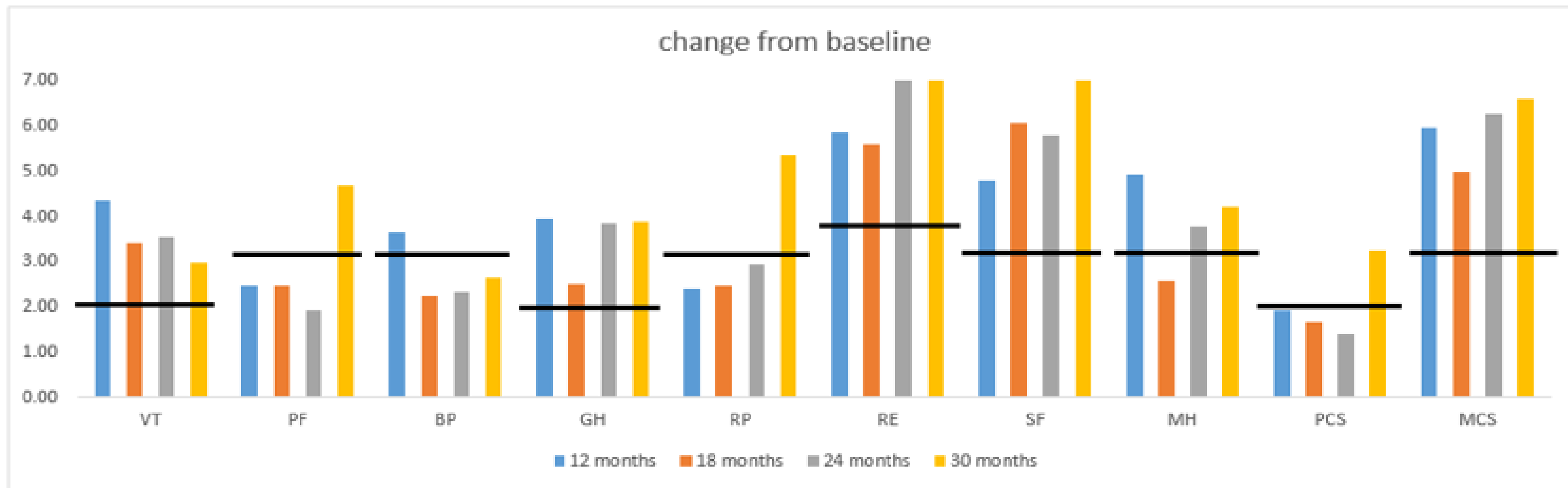
- Scores of 50 reflect the norm, based on age and gender
- Baseline composite scores indicate that on each of the 8 scales, the aggregate scores are significantly lower than the norm-based comparisons
- Baseline Physical Summary score: 47.87 and Mental Summary score: 43.31
- Of the individual scales, the three most disparate scores fell in the areas of Social Functioning, Role Emotional and Bodily Pain

ED Diversion Program

TOTAL ENROLLED and BASELINED: 223

	N=114			N=84			N=63			N=52			
SEARCH	Baseline	12 months	Score difference	Baseline	18 months	Score difference	Baseline	24 months	Score difference	Baseline	30 months	Score difference	MID
VITALITY	45.80	50.15	4.35	44.32	47.75	3.43	44.44	47.98	3.54	45.29	48.26	2.97	2
PHYSICAL FUNCTIONING	40.47	42.95	2.48	39.29	41.78	2.48	40.38	42.32	1.94	39.36	44.07	4.71	3
BODILY PAIN	38.05	41.69	3.64	37.77	40.00	2.23	37.72	40.07	2.34	37.63	40.29	2.66	3
GENERAL HEALTH PERCEPTIONS	40.90	44.86	3.96	41.14	43.66	2.52	41.37	45.23	3.86	42.30	46.19	3.90	2
PHYSICAL ROLE FUNCTIONING	39.39	41.81	2.42	38.18	40.66	2.49	38.37	41.33	2.96	37.77	43.12	5.36	3
EMOTIONAL ROLE FUNCTIONING	36.04	41.91	5.86	34.57	40.17	5.60	33.73	40.97	7.24	32.93	40.97	8.04	4
SOCIAL ROLE FUNCTIONING	37.29	42.08	4.79	35.56	41.64	6.09	34.26	40.07	5.81	34.68	43.75	9.06	3
MENTAL HEALTH	41.12	46.05	4.93	40.28	42.86	2.59	39.74	43.52	3.78	40.50	44.73	4.23	3
PHYSICAL COMPONENT SCORE	40.78	42.71	1.92	40.27	41.94	1.67	41.13	42.54	1.40	40.69	43.93	3.24	2
MENTAL COMPONENT SCORE	40.02	45.99	5.97	38.61	43.61	4.99	37.39	43.66	6.27	38.03	44.65	6.61	3

- meets or exceeds MID

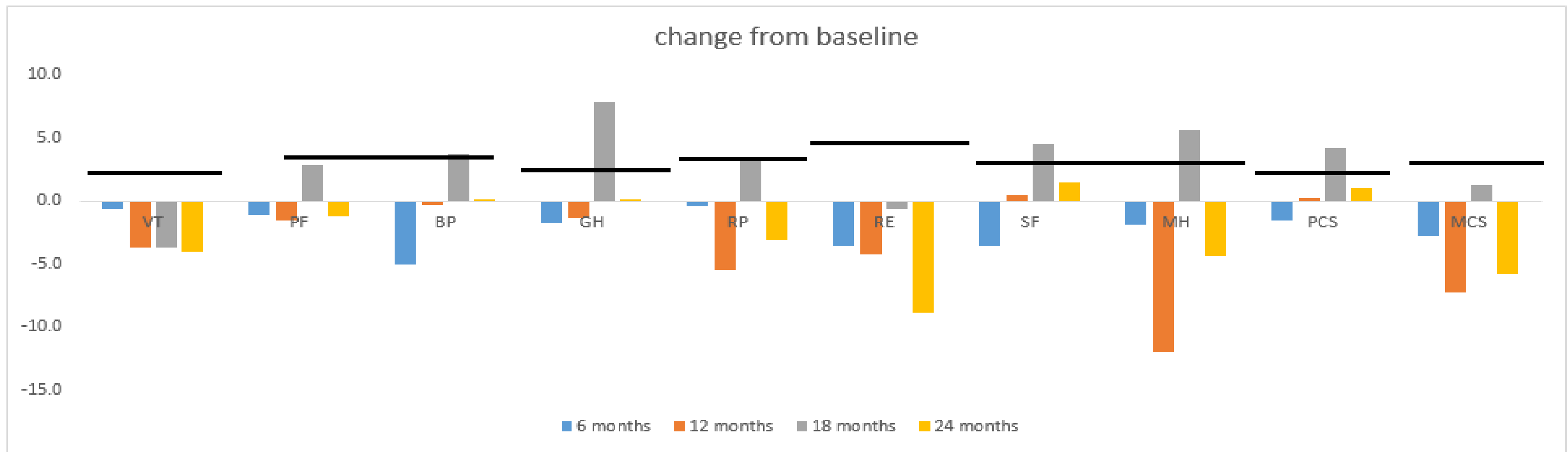


Jail Diversion Program

TOTAL ENROLLED and BASELINED: 73

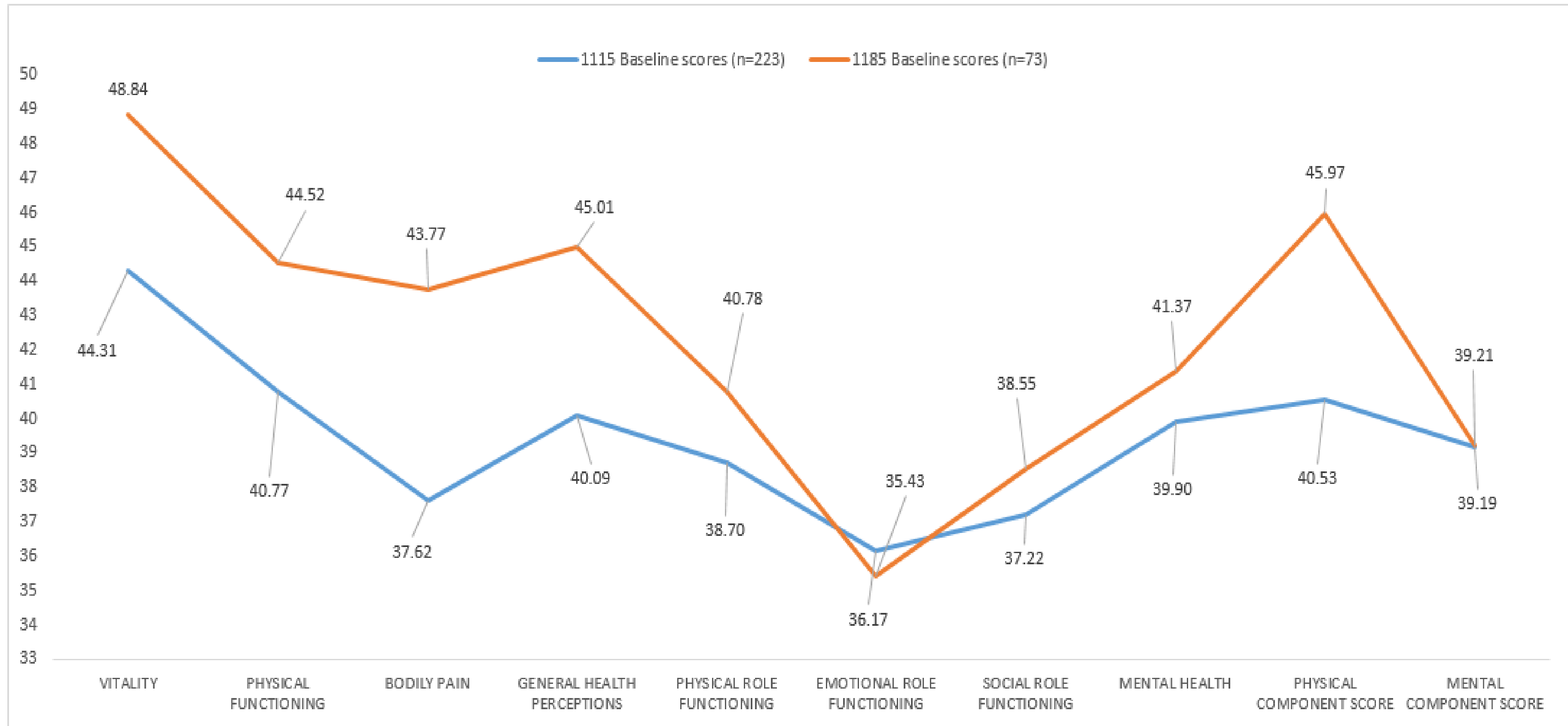
	N=23			N=12			N=6			N=11			
SEARCH	Baseline	6 months	Score difference	Baseline	12 months	Score difference	Baseline	18 months	Score difference	Baseline	24 months	Score difference	MID
VITALITY	51.82	51.14	-0.68	55.21	51.57	-3.64	44.29	40.64	-3.64	52.09	48.12	-3.97	2
PHYSICAL FUNCTIONING	47.42	46.33	-1.10	47.56	45.98	-1.58	39.85	42.65	2.81	47.85	46.70	-1.14	3
BODILY PAIN	49.28	44.22	-5.05	45.04	44.76	-0.28	41.27	45.00	3.74	46.33	46.48	0.15	3
GENERAL HEALTH PERCEPTIONS	43.81	42.07	-1.74	47.05	45.74	-1.31	37.92	45.86	7.94	47.08	47.26	0.17	2
PHYSICAL ROLE FUNCTIONING	43.12	42.69	-0.43	47.06	41.55	-5.51	37.67	40.93	3.26	45.94	42.83	-3.12	3
EMOTIONAL ROLE FUNCTIONING	40.33	36.78	-3.55	41.63	37.41	-4.21	32.56	31.91	-0.65	42.80	33.97	-8.83	4
SOCIAL ROLE FUNCTIONING	42.86	39.30	-3.56	40.49	40.94	0.45	30.49	35.03	4.54	36.52	38.01	1.49	3
MENTAL HEALTH	44.62	42.78	-1.83	46.96	34.99	-11.97	32.18	37.81	5.63	43.61	39.26	-4.35	3
PHYSICAL COMPONENT SCORE	47.87	46.31	-1.56	48.12	48.45	0.32	42.84	47.09	4.25	48.72	49.77	1.04	2
MENTAL COMPONENT SCORE	43.31	40.58	-2.73	45.01	37.72	-7.29	32.08	33.36	1.28	42.04	36.19	-5.85	3

- meets or exceeds MID

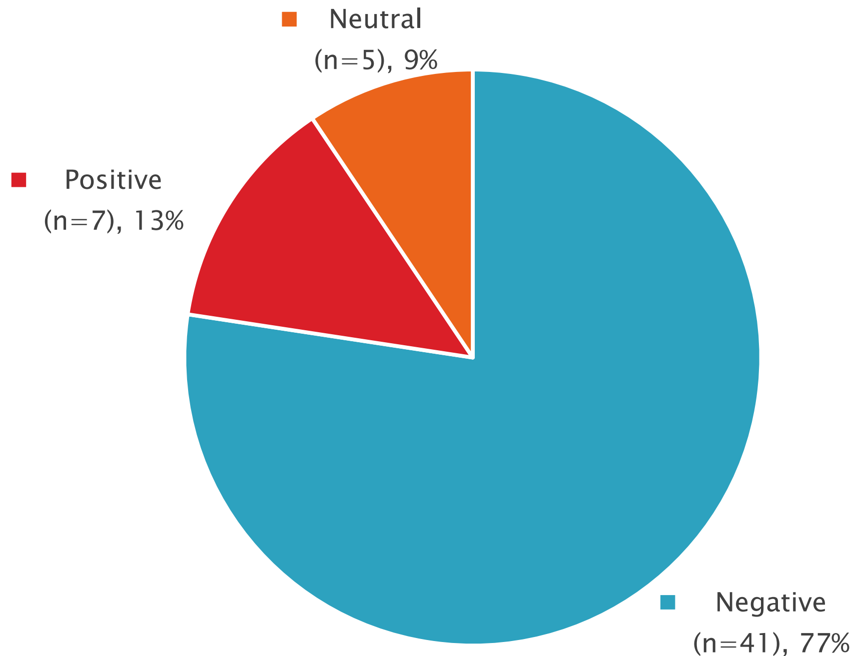


Baseline scores – Jail vs. ED Diversion Programs

	VITALITY	PHYSICAL FUNCTIONING	BODILY PAIN	GENERAL HEALTH PERCEPTIONS	PHYSICAL ROLE FUNCTIONING	EMOTIONAL ROLE FUNCTIONING	SOCIAL ROLE FUNCTIONING	MENTAL HEALTH	PHYSICAL COMPONENT SCORE	MENTAL COMPONENT SCORE
1115 Baseline scores (n=223)	44.31	40.77	37.62	40.09	38.70	36.17	37.22	39.90	40.53	39.19
1185 Baseline scores (n=73)	48.84	44.52	43.77	45.01	40.78	35.43	38.55	41.37	45.97	39.21



Attrition Rates (28%)



1. Jail, prison, or juvenile detention facility (58.5%, n=31)
2. Emergency shelter, including hotel or motel paid for with shelter voucher (7.5%, n=4)
3. Permanent housing for formerly homeless persons (such as: CoC project; or HUD legacy programs; or HOPWA PH) (5.7%, n=3)

Reasons for Departure

Top Three Reasons

GENERAL DISCUSSION POINTS

- RN critical in on-site teams
- Initial spike in not only SMI acuity but also in physical health crises
- Change takes time but it does happen
- Mental health may be more malleable or the programmatic components may better target mental health indicators
- Some patterns of change may look different for male and female clients

GCB RE-ENTRY SERVICES

Bethany Weber, MSW, LSW
Program Manager, GCB Forensic Re-entry ACT Program

Greater Cincinnati Behavioral

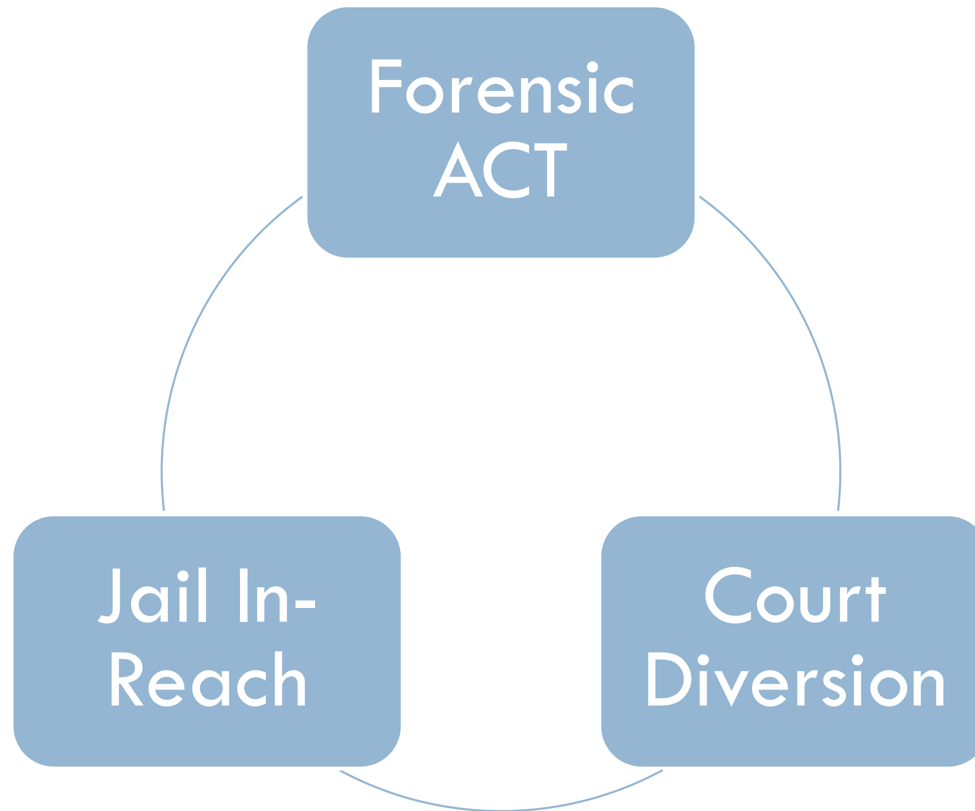
- Community Mental Health Agency in Hamilton County
- Founded in 1971- recently merged with two local organizations
- More than 600 employees
- Serve approximately 15,000 individuals per year
- Holistic comprehensive services

GCB MISSION:

To ensure people with mental illness, addictions, and related challenges lead healthy and productive lives.

Greater Cincinnati
Behavioral
Health Services

Overview of Re-entry Services



Community Need in Hamilton Co.

- 2nd largest prison population in Ohio
- 3rd largest population on PRC in 2016
- Almost half of the PRC population categorized as very high/high-moderate risk level
- Receives 8% of all Community Linkage referrals in Ohio

Forensic Assertive Community Treatment

- Established in 2002 with grant from OhioDRC
- Overview of population served
- Main Components:
  - Community Linkage pre-release identification
  - Collaborative referral meetings
  - Outpatient services provided based on ACT & IDDT model
  - Integration of a dedicated parole officer
  - Steering Committee with partnering agencies
- Outcomes Tracked

How does it work?

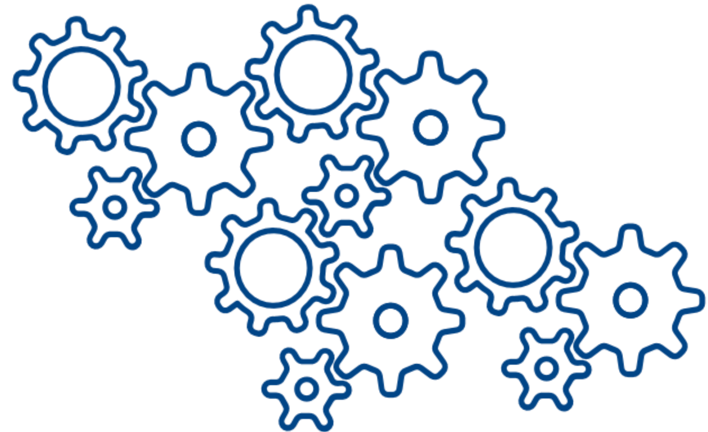
Stakeholders	Funders

Stakeholders

- Local
  - Mental Health Board
  - APA
  - Jail/court system
  - Community
- Regional
  - OhioDRC & OHMAS

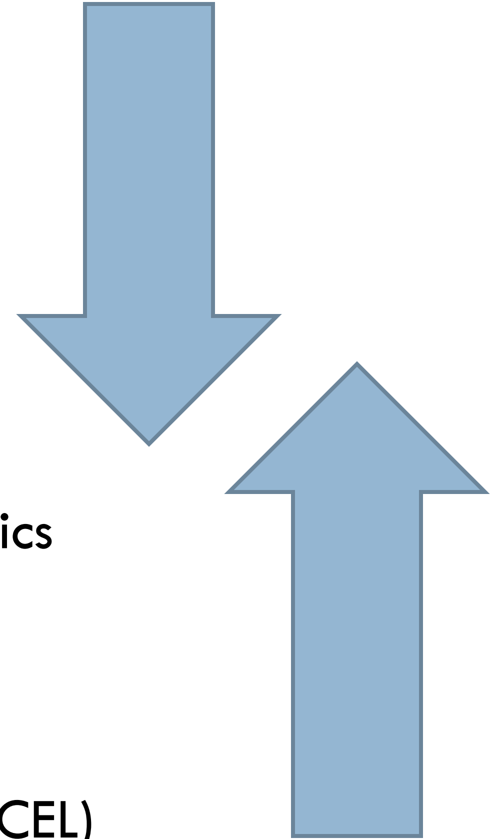
Funders

- OhioDRC
- Mental Health Board
- Medicaid/Medicare

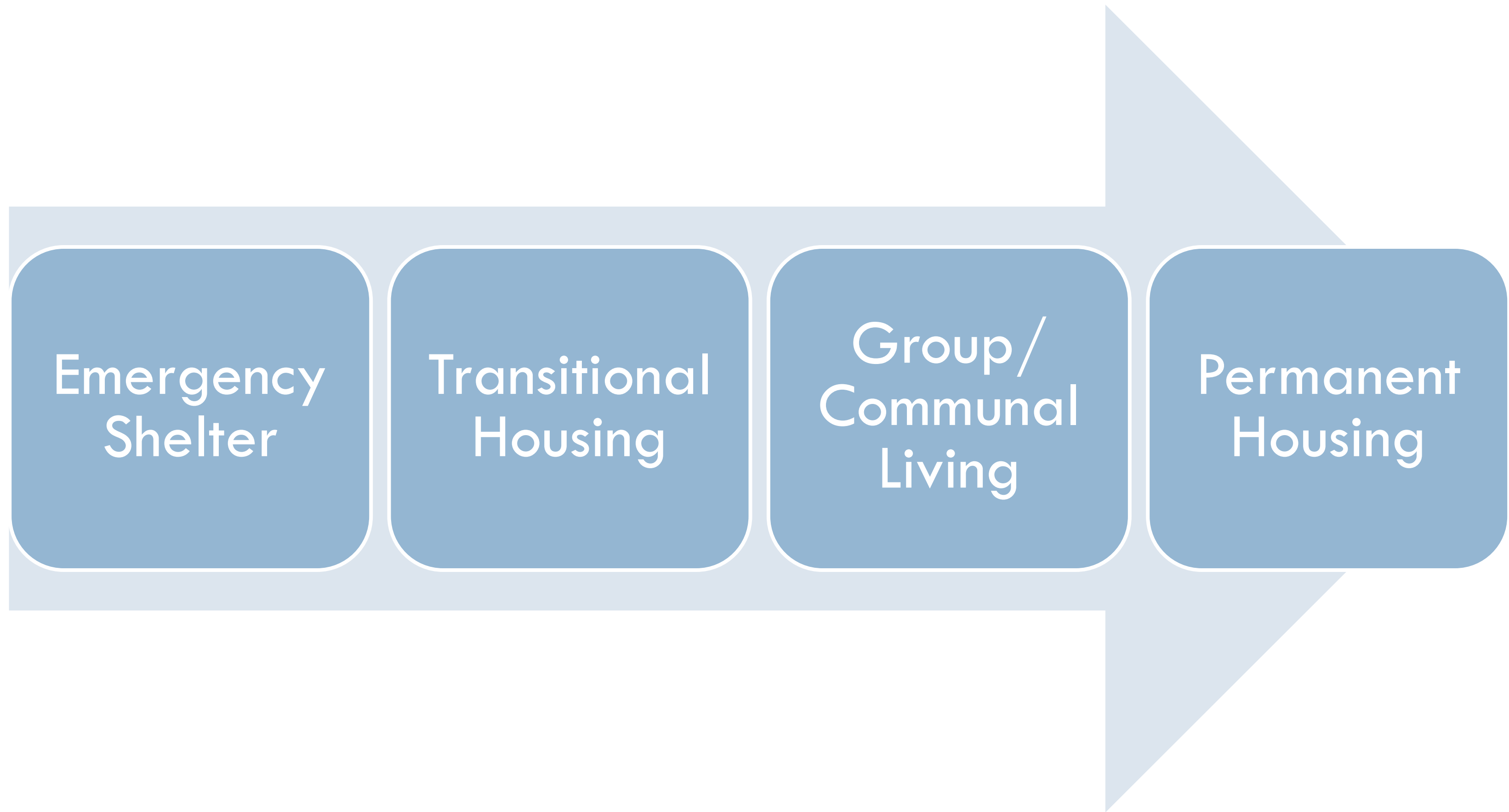


Challenges/Successes in Housing

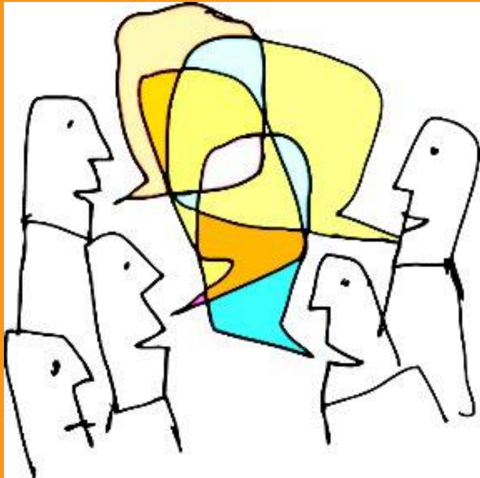
- Challenges:
  - Re-entry transition
  - Sex offender geographic restrictions
  - Felony criminal records
  - Income limitations
  - Housing First principles
- Successes:
  - Direct service team dynamics/characteristics
  - Collaboration with APA
  - Positive landlord relationships
  - Creative housing options
  - Local Housing subsidy programs (RHO/EXCEL)



Partnerships for Housing



Q & A



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