Serving People Experiencing Homelessness: Best Practices from Departments of Public Health

June 2024

Homebase

Homebase

ADVANCING SOLUTIONS TO HOMELESSNESS

- Subject matter expertise in homelessness and cross-system coordination
- Work at the federal, state, and local levels with an emphasis in California
- Assist communities and agencies to establish systems and programs needed to help people experiencing homelessness achieve housing stability and improve health and wellness

Saadiqah Islam, *Policy Analyst*

Alissa Weiss, *Directing Analyst*

Innovative Thinking & Solutions

Transformational I Strategic I Practical

Background

- Housing is a crucial social determinant of health and health care access is critical for maintaining housing
- People with complex care needs often touch the public health, health care, and homeless systems of care; collaboration is vital
- Many of the key players in homeless systems of care are county-based
- **CDPH is working to strengthen the connection between Local Health Jurisdictions and homeless systems of care**
- Surveys, interviews, and listening sessions surfaced incredible work – and a desire to learn more
- Effective cross-system collaboration and partnership requires cross-system education

Agenda

- ✓ Multi-Disciplinary Teams: Tulare County DPH
- ✓ Enhanced Care Management and Community Support: San Luis Obispo DPH
- ✓ Data Sharing Agreement: Los Angeles DPH
  - **Q&A and Discussion**
- ✓ Nurses in Shelters & Permanent Supportive Housing Sites: San Francisco DHP
- ✓ Mobile Health Clinics: Madera DPH
- ✓ Maternal and Adolescent Health & Mobile Clinics: Sacramento DPH
  - **Q&A and Discussion**

Tulare County Public Health Homeless Efforts

Michelle Reynoso, Public Health Manager

Sarai Guido Esparza-Public Health Program Coordinator

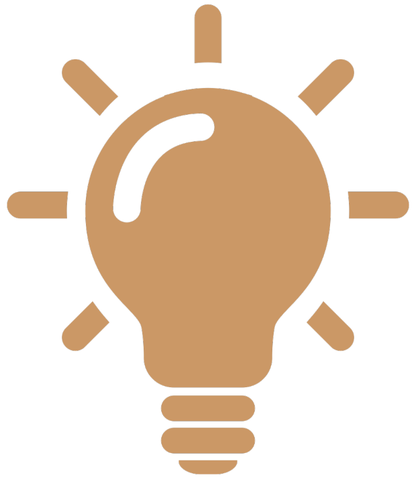
HHSA Public Health

Accredited 2020

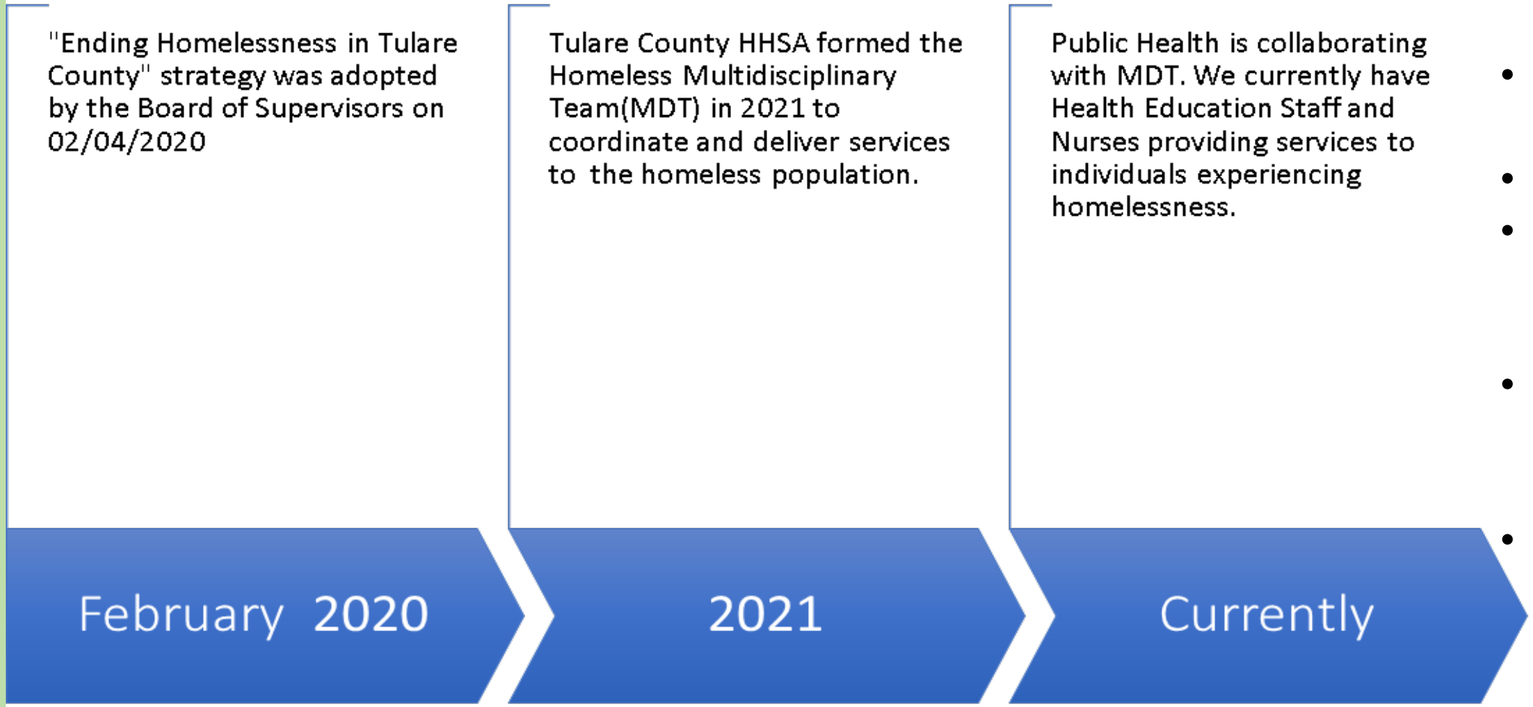
Last revised: 06/05/2024

Agenda/Objectives

- Tulare County Health and Human Services Agency efforts to address homelessness
- Tulare County Homelessness Data
- Public Health Efforts
- Feedback and Questions?



Tulare County HHSA



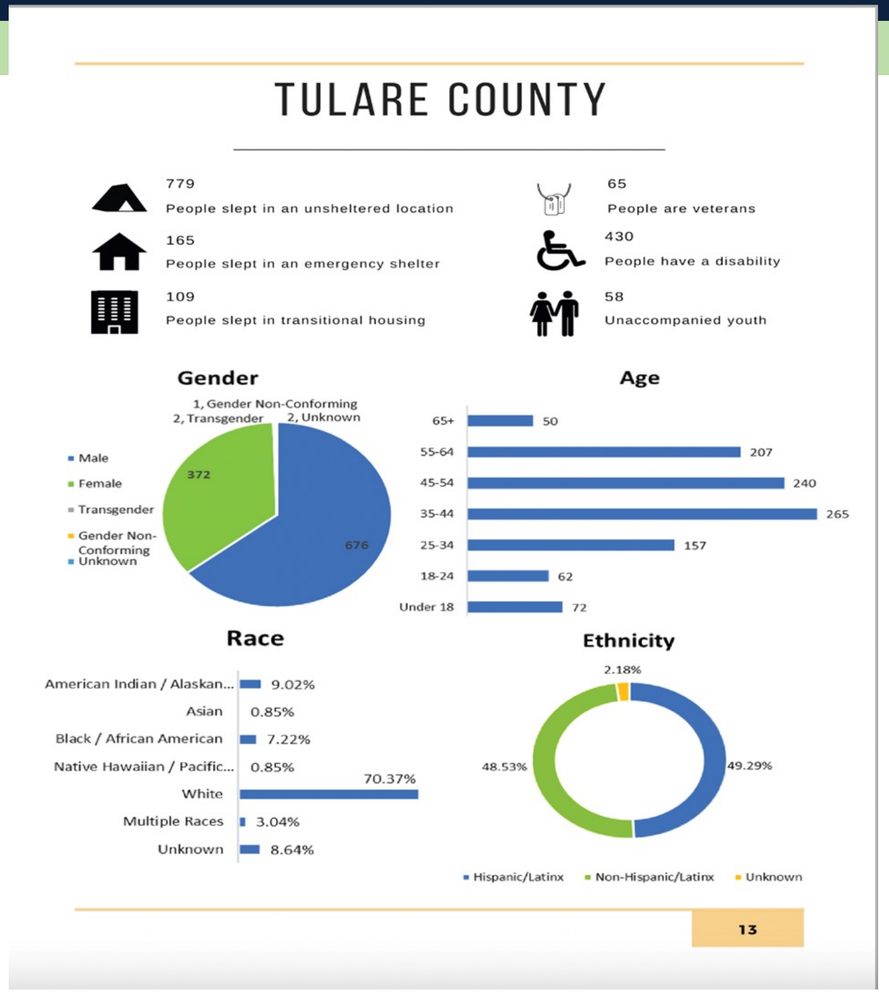
- An effort to overcome the homelessness crisis
- Collaborative effort
- Coordinated approach to address the complex health needs of the homeless population.
- Health education to raise awareness about important health issues and to promote healthy behaviors
- Connect individuals with the necessary health resources.

- Tulare County Task Force on Homelessness purpose is to advise and assist Tulare County HHSA in the efforts to address homelessness issues affecting the community.
- The platform for coordinating existing local services and programs for homeless population.
- Service-delivery.

MDT merging with ECM to CCT
(Community Coordination Team)

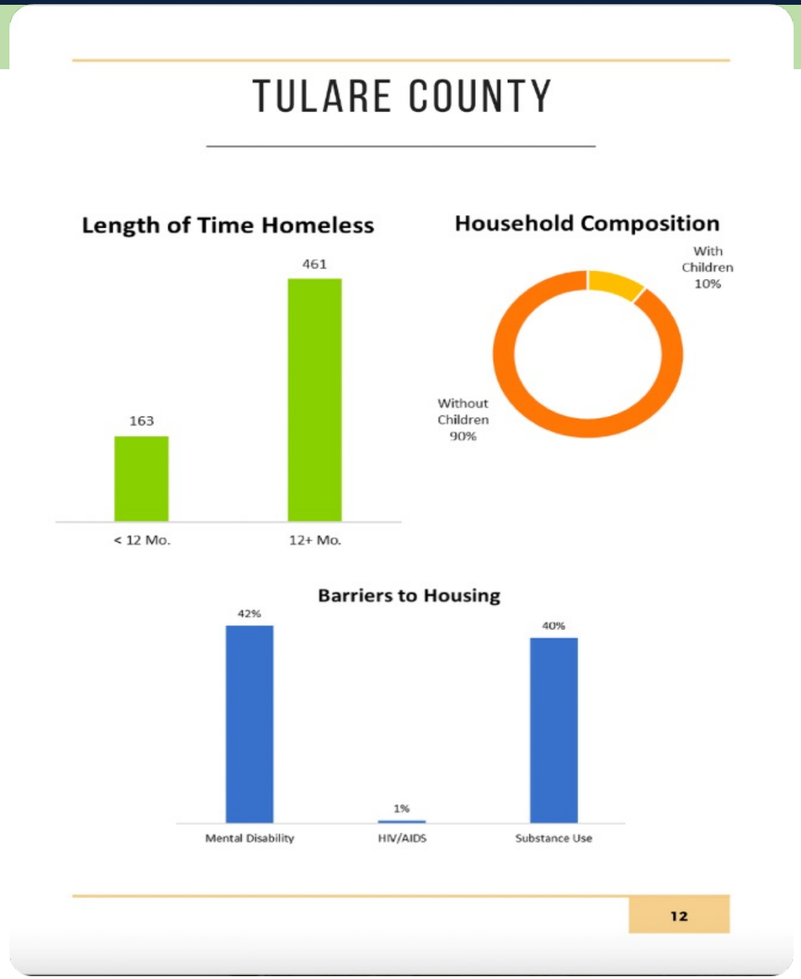
Data

- "Each year, the Kings/Tulare Homeless Alliance (Alliance} conducts a Point in Time (PIT} count of the number of people experiencing sheltered and unsheltered homelessness within Kings and Tulare Counties. Information and data gathered through the PIT count are used by the Alliance and partner agencies to better understand the issues associated with homelessness, including causes, service gaps, unmet housing needs, and homeless trends"



Source: 2023 Point in Time Report

Data



- There is a lack of affordable housing in Kings and Tulare counties.
- 16 % increase in the number of people experiencing sheltered and unsheltered homelessness from 2022-2023.
- 25.51 % increase in the number of people experiencing chronic homelessness from 2022 to 2023.

CCT and Public Health

- **Community Coordination Team:**
- **CalWorks, Behavioral Health, Public Health, Visalia Health Care Center**
- The Community Coordination Team provides a comprehensive range of services to support individuals in need. They offer vouchers for identification, birth certificates, and social security, and assist with applications for Medi-Cal and CalFresh. The team distributes incentives such as bus passes and clothing vouchers and offers substance use counseling. They provide probation assistance and Adult Protective Services (Home Safe) for individuals aged 60 and above.
- Enhanced Care Management (ECM) helps clients connect with medical appointments and treatments, including drug, mental, physical, and domestic abuse care. Additionally, a mental health crisis worker is available to assist those experiencing a 51/50 situation or any kind of mental health crisis.

- Public Health-
- Health Education Staff
- Provide health education and referrals to our prevention and education programs:
  - STD/HIV
  - Smoking/Vaping
  - Nutrition
  - Car Seat Safety Program
  - Family Planning
  - Public Health Resources
- Licensed Vocation Nurse

  Provides health assessments (Depression Screening, physical assessments)

  Provides health education on disease specific issues.

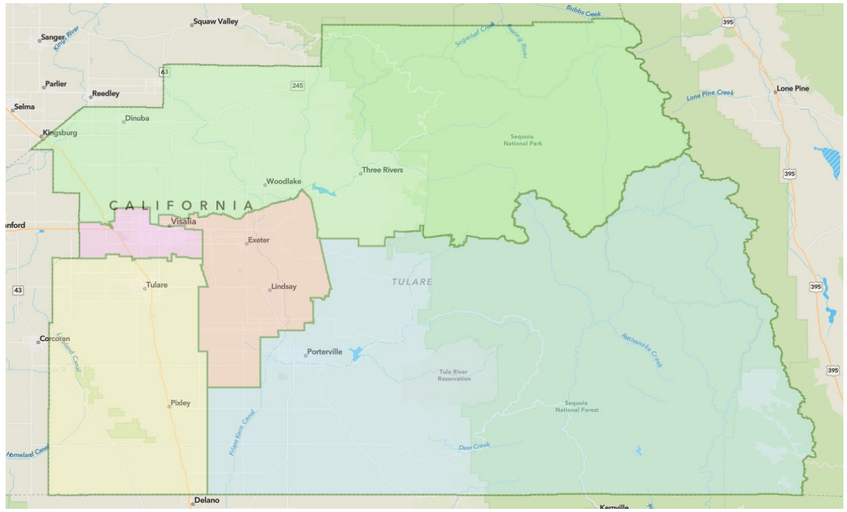
  Makes referrals to access medical services

  Collaboration with Tulare County-Visalia Health Care Center

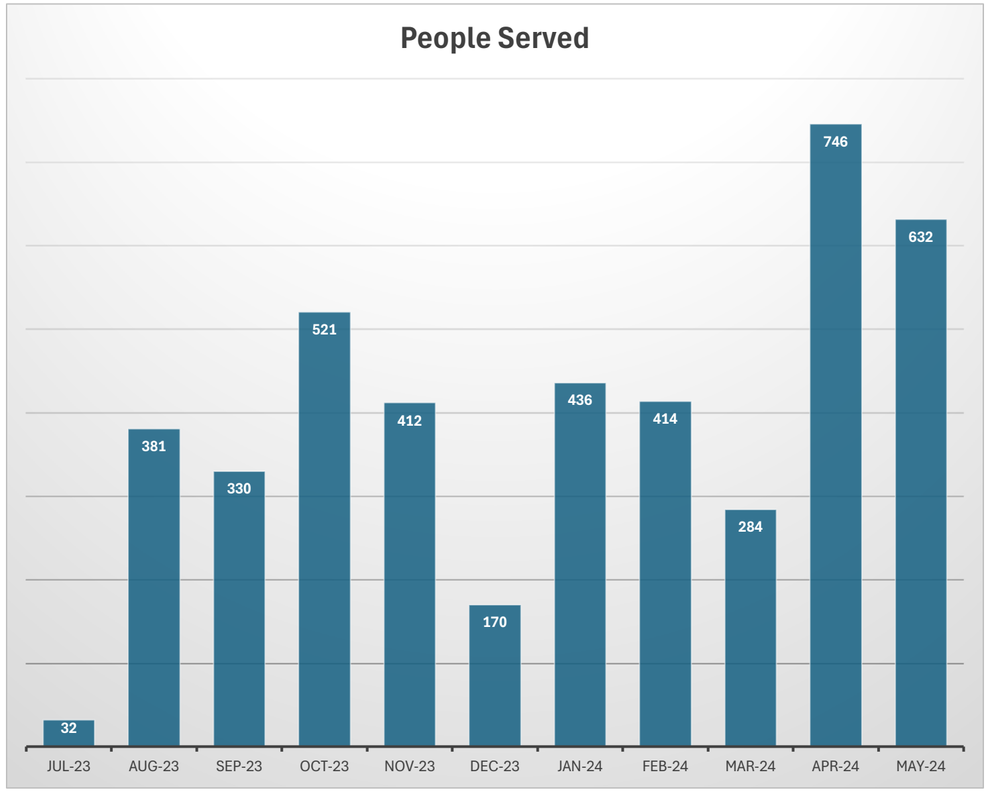
  Referrals are made on HMIS.

Outreach Locations

- Tulare Encampment Resolution Project (TERP) in Tulare. Centennial Park, and Safe Encampment Zone
- Local Initiative Navigation Center (LINC) Visalia- Visalia Rescue Mission
- (LINC) Porterville- Welcome Center (every other week)
- Dream Center Support for Foster Youth (TCOE)
- North and South County Mobile Units



Public Health Efforts



- Services include:
  - Health Education
  - Provision of safe sex materials
  - Referrals to access medical care
  - Referrals to a housing case manager
  - Provision of COVID-19 tests
  - Provided vaccinations
  - Oral health education
  - Assist in the Point in Contact Survey,
  - HMIS- to make referrals to access medical care
  - Arrange transportation to VHCC.

THANK YOU!

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Public Health Program Coordinator
SEsparza@tularecounty.ca.gov

COUNTY OF SAN LUIS OBISPO HEALTH AGENCY

www.slocounty.ca.gov/health

LEVERAGING OPPORTUNITIES

- SLO County Care Coordination Coalition (CCC) – a group of health and human service providers, convening for a common purpose of serving SLO County's hardest-to-serve since ~2014.

- CCC became the steering committee for Whole Person Care (WPC).

- This created the focus for our future WPC collaboration efforts, and eventual conversion to ECM/CalAIM.

“Braided” Funding

- HHIP
- IPP
- PATH Cited
- PATH TA Marketplace
- HHIP Round 2
- County General Fund/MCP ECM/CS Billing

Changing Roles and Partnerships

- San Luis Obispo City Council
  - Appointed in 2021, Elected in 2022

- County Continuum of Care
  HSOC – Homeless Services Oversight Council
  Elected January 2024

In addition to:

- SLO County Public Health Department –
  - Division Manager, Health Care Access
  - Home to Whole Person Care
  - CCC convener
  - Potential lead agency for CIE (?)

Michelle Shoresman

mshoresman@co.slo.ca.us

Integrating COVID-19 Surveillance with local Homeless Management Information System (HMIS) data to Improve Disease Control among People Experiencing Homelessness

Will Nicholas, PhD, MPH
Director, Center for Health Impact Evaluation
Los Angeles County Department of Public Health
June 12, 2024

Homelessness in Los Angeles County at the Start of the Pandemic

- 2020 Point in Time Count for Los Angeles County: **66,436**
  - Sheltered: 18,395
  - Unsheltered: 48,041
- Approximately 500 emergency shelters/transitional housing facilities
- PEH mortality rate >3x greater than LA County as a whole
- PEH historically have high rates of infectious diseases
- **Large vulnerable population needing a targeted and tailored approach to COVID-19 mitigation**

1.https://www.lahsa.org/documents?id=4698-2020-homeless-count-la-county-data-summary.pdf
2.5487 - 2021 HIC And Shelter Count LA COC (lahsa.org)

Need for Rapid Determination of Homelessness among COVID-19 Cases

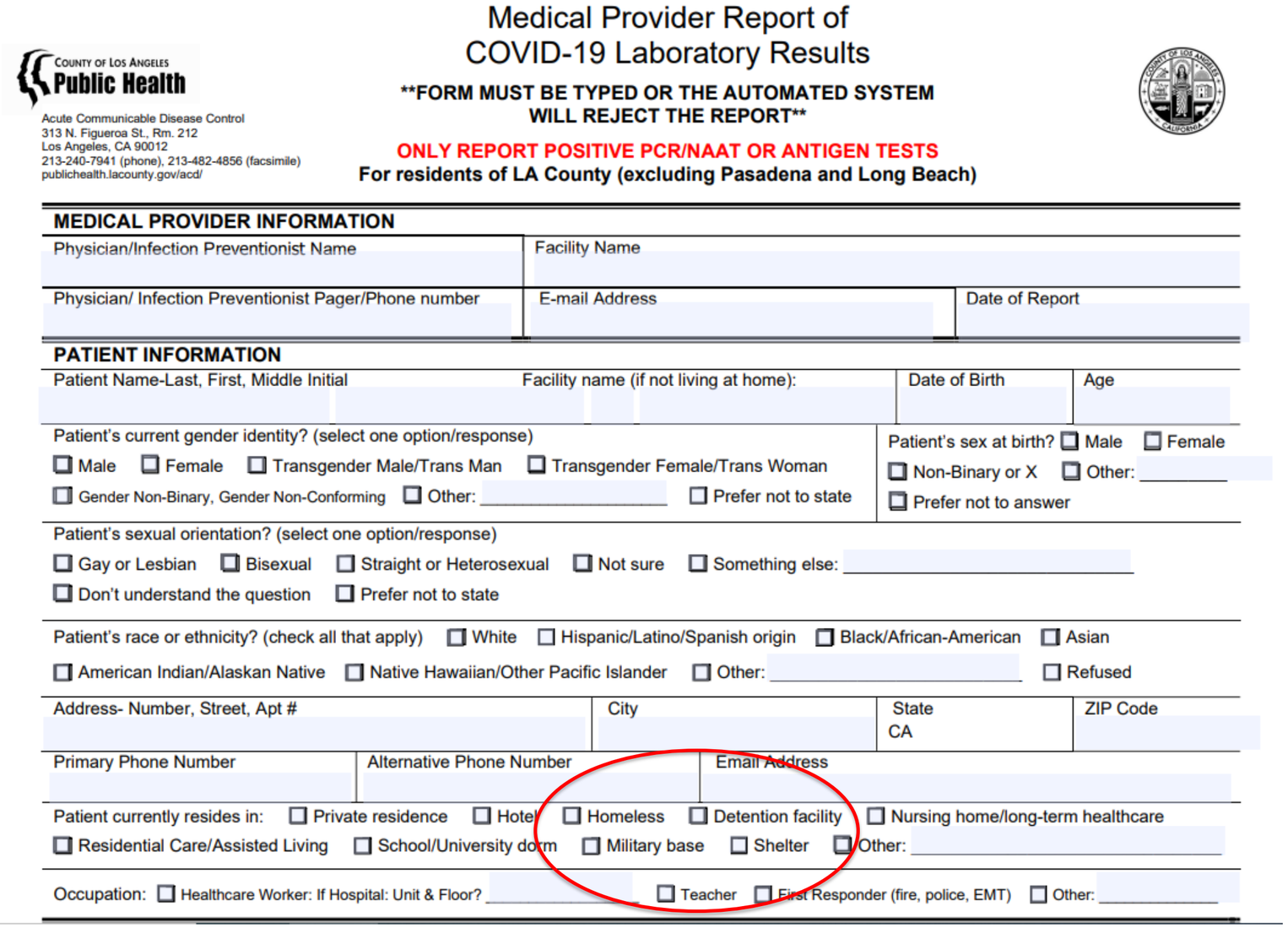
1. To track the course of the pandemic in this vulnerable sub-population (i.e., surveillance)
2. To Prevent and control outbreaks in places where PEH congregate

- **Where to get data on housing status?**

Limitations of Conventional Case and Contact Tracing

- Electronic lab reports don't contain information on homeless status
  - For cases who are homeless, accurate contact info may not be available
- Other sources of case data include housing status but only represent a subset of all cases reports:
  - Medical Providers (Case Report Form)
  - Hospital data (Address data and ICD-10 codes)
- **Need to know: 1) if case was homeless at time of infection, and 2) shelter address (if residing in a shelter) for contact tracing and outbreak prevention/management**

COVID-19 Provider Case Report Form



County of Los Angeles Public Health

Acute Communicable Disease Control
313 N. Figueroa St., Rm. 212
Los Angeles, CA 90012
213-240-7941 (phone), 213-482-4856 (facsimile)
publichealth.lacounty.gov/acd/

Medical Provider Report of COVID-19 Laboratory Results

****FORM MUST BE TYPED OR THE AUTOMATED SYSTEM WILL REJECT THE REPORT****

ONLY REPORT POSITIVE PCR/NAAT OR ANTIGEN TESTS

For residents of LA County (excluding Pasadena and Long Beach)

MEDICAL PROVIDER INFORMATION

Physician/Infection Preventionist Name | Facility Name

Physician/ Infection Preventionist Pager/Phone number | E-mail Address | Date of Report

PATIENT INFORMATION

Patient Name-Last, First, Middle Initial | Facility name (if not living at home): | Date of Birth | Age

Patient's current gender identity? (select one option/response)
☐ Male ☐ Female ☐ Transgender Male/Trans Man ☐ Transgender Female/Trans Woman
☐ Gender Non-Binary, Gender Non-Conforming ☐ Other: _____ ☐ Prefer not to state

Patient's sex at birth? ☐ Male ☐ Female
☐ Non-Binary or X ☐ Other: _____
☐ Prefer not to answer

Patient's sexual orientation? (select one option/response)
☐ Gay or Lesbian ☐ Bisexual ☐ Straight or Heterosexual ☐ Not sure ☐ Something else: _____
☐ Don't understand the question ☐ Prefer not to state

Patient's race or ethnicity? (check all that apply) ☐ White ☐ Hispanic/Latino/Spanish origin ☐ Black/African-American ☐ Asian
☐ American Indian/Alaskan Native ☐ Native Hawaiian/Other Pacific Islander ☐ Other: _____ ☐ Refused

Address- Number, Street, Apt # | City | State CA | ZIP Code

Primary Phone Number | Alternative Phone Number | Email Address

Patient currently resides in: ☐ Private residence ☐ Hotel ☐ Homeless ☐ Detention facility ☐ Nursing home/long-term healthcare
☐ Residential Care/Assisted Living ☐ School/University dorm ☐ Military base ☐ Shelter ☐ Other: _____

Occupation: ☐ Healthcare Worker: If Hospital: Unit & Floor? _____ ☐ Teacher ☐ First Responder (fire, police, EMT) ☐ Other: _____

HMIS—Potential game changer for PEH surveillance

- Established emergency agreement with LA CoC (LAHSA)
  - Users signed confidentiality agreements and were trained

<u>Process:</u>

- Cumulative HMIS client profiles matched daily against COVID-19 case database to produce daily dataset of cases with HMIS profiles
- This dataset joined with daily HMIS file of current shelter residents (with address info) to assist with shelter-based contact tracing
- HMIS data supplemented with other sources of data on potential PEH cases for more complete accounting of PEH status of COVID-19 cases

Additional Sources of Data on PEH status of Cases

- Rosters of cases/contacts referred to LA County Quarantine/Isolation housing
- Case/contact interviews of those who reported experiencing homelessness
- Hospitalization records
- Provider reports
- Line lists from outbreak investigations in homeless settings
- Direct reports from shelter staff, testing partners
- **Having all these other sources of data allowed for an evaluation of the added value of HMIS for COVID-19 surveillance of among PEH**

Homelessness Criteria

- Meets U.S. Department of Housing & Urban Development (HUD) definition of homelessness
  - Sleeping in places not meant for human habitation
  - Sleeping in interim housing and/or emergency shelters
- Additional Criteria
  - Couch Surfers
  - Families with children with unstable housing
  - Domestic violence victims

COVID-19 Surveillance in People Experiencing Homelessness

Summary Report of COVID-19 in People Experiencing Homelessness (PEH)

11/1/2021 to 11/7/2021 **

Lab Confirmed Cases	New Cases	Total Cases
First Infections	100	9,403
Presumed Reinfections*	1	223
Total PEH Cases[3]	**101**	**9,626**
Verified PEH[1]	68	8,366
Presumed PEH[2]	33	1,260
Total PEH Cases[3]	**101**	**9,626**

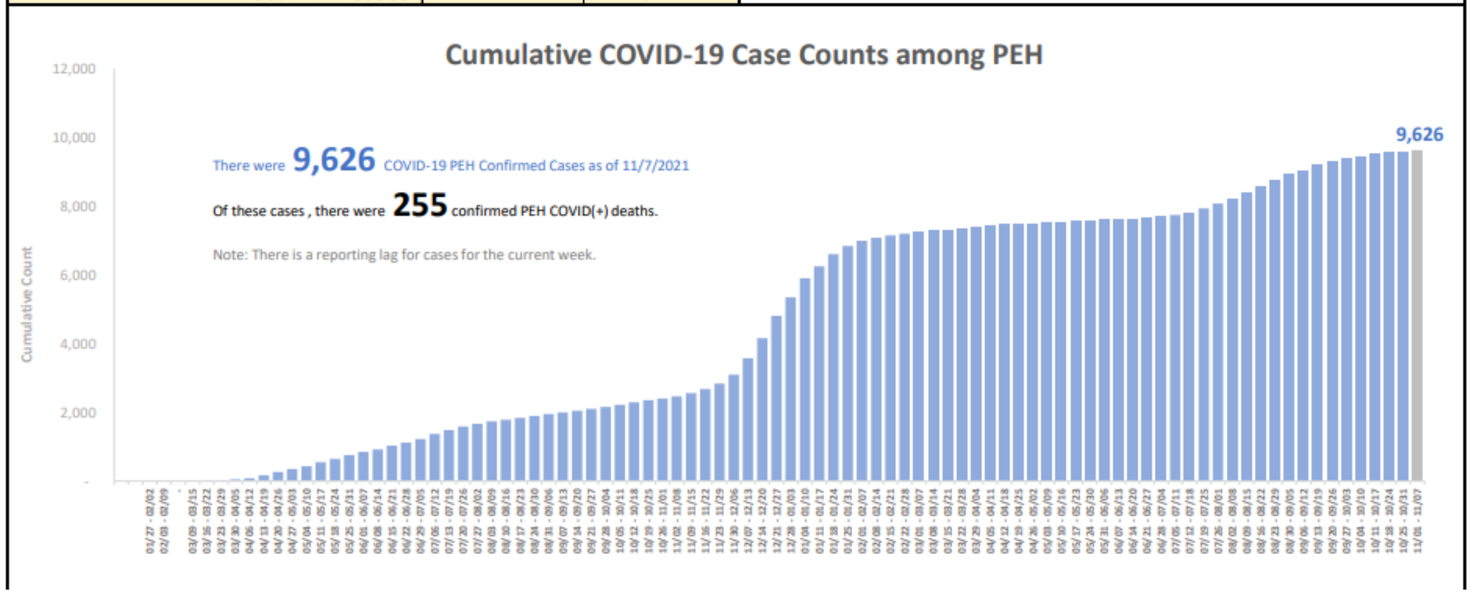
Note:
1. Homelessness status and COVID-19 cases verified as of 5 PM on 11/7/2021.

2. Presumed PEH are those whose homelessness status is still under investigation.

3. PEH totals and breakdowns include both verified PEH cases and presumed PEH cases unless otherwise specified, and does not include staff at shelters and other facilities.

* Presumed reinfections are repeat positives 90 or more days after the previous infection.

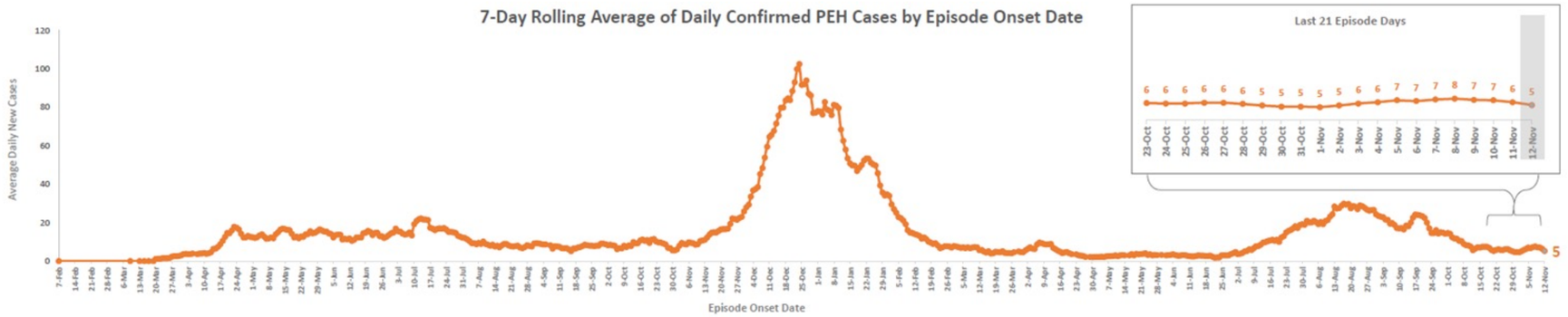
** Data for hospitalization outcomes are undergoing quality assurance efforts and are not included in this weeks report.



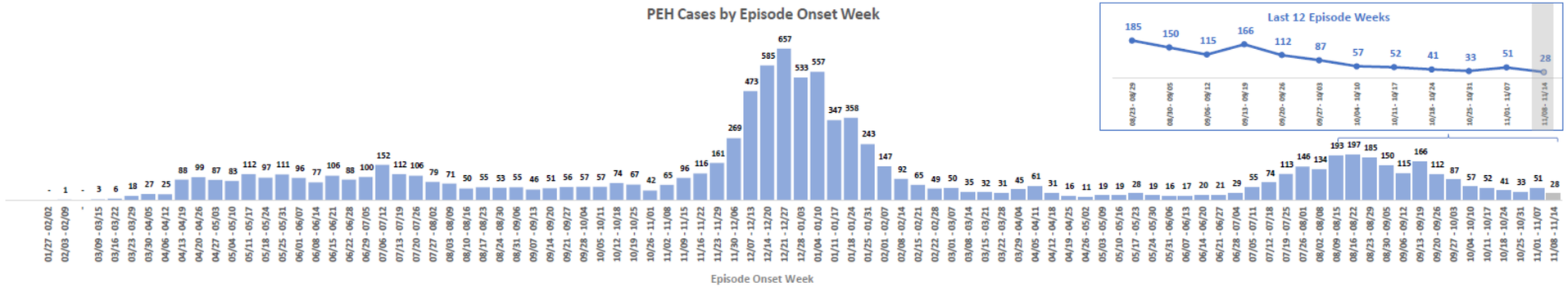
SummaryReport_People_Experiencing_Homelessness.pdf (lacounty.gov)

1.http://publichealth.lacounty.gov/media/Coronavirus/docs/SummaryReport_People_Experiencing_Homelessness.pdf

COVID-19 Surveillance in People Experiencing Homelessness



Note: Rolling Average is the unweighted average of daily new PEH cases for each 7-day period. Lightened lines represent data that are incomplete for the current week due reporting lags and pending investigations.
Shaded grey bar represents data that are incomplete for the current week due reporting lags and pending investigations



Note: Shaded grey bar represents data that are incomplete for the current week due reporting lags and pending investigations.

PEH COVID-19 Cases (n=10,586), by Primary Source of PEH Identification, 3/30/20—12/20/21

Data Source	Number	Percent
HMIS	2801	26.5
Q/I Logs	1877	17.7
Case Interviews	749	7.1
Hospital Admission Data	573	5.4
PEH Provider	3659	34.6
Unknown	927	8.8
TOTAL	**10,586**	**100**

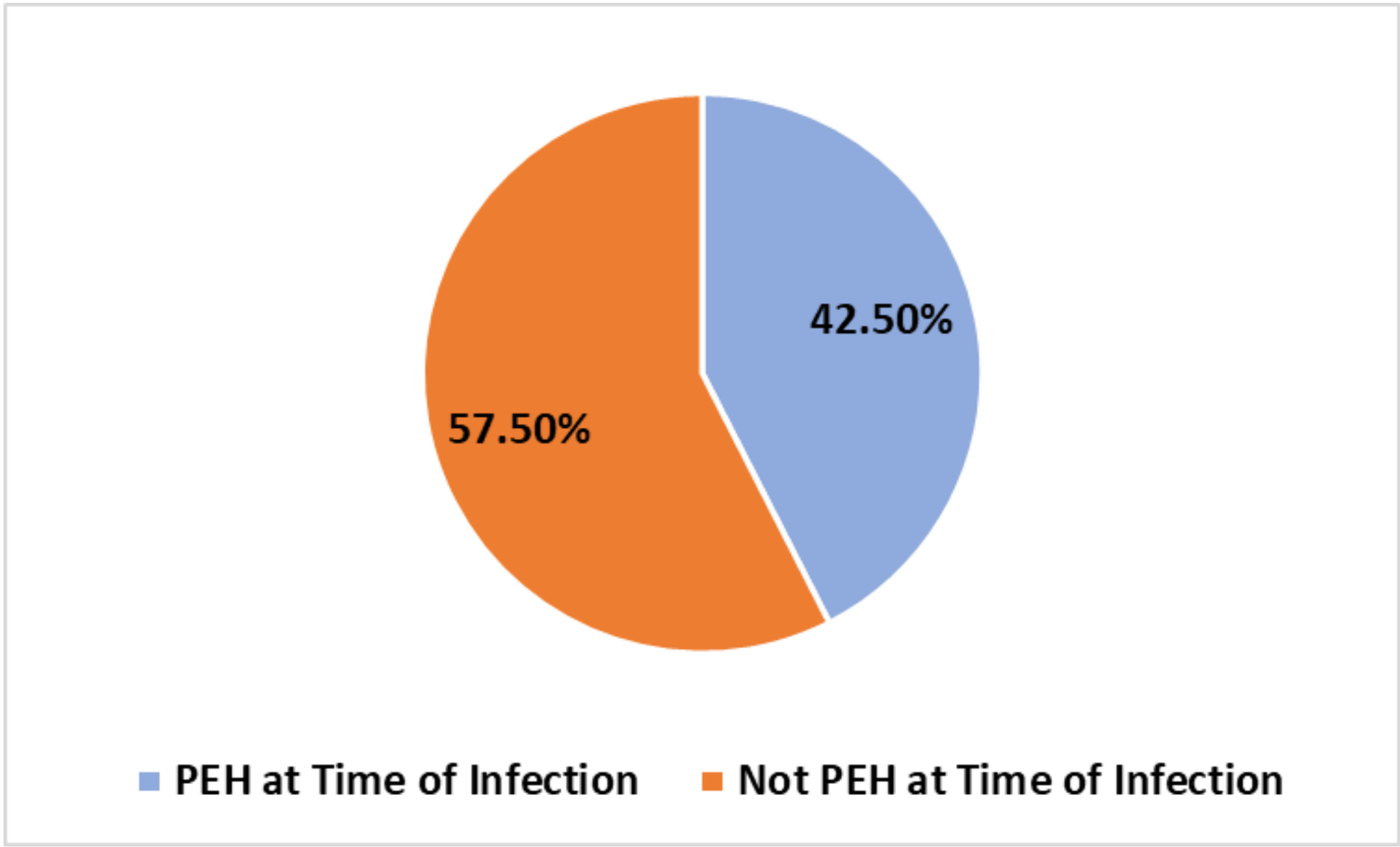
Source: Jones PS, Yeh KW, Brosnan HK, et. al. Evaluation of the Homeless Management Information System for COVID-19 Surveillance Among People Experiencing Homelessness. *Journal of Infectious Diseases*. 2022:226 (suppl 3) s327-s334.

PEH COVID-19 Case, by Primary Source of PEH Identification, 3/30/20—12/20/21

Data Source	% Sheltered	% Unsheltered	% Unknown
HMIS	54.1	18.5	27.4
Q/I Logs	55.9	40.2	3.9
Case Interviews	53.5	39.9	6.5
Hospital Admission Data	25.0	31.1	44.0
PEH Provider	71.1	16.2	12.8
Unknown	51.1	38.9	9.6
TOTAL	**58.4**	**25.5**	**16.0**

Source: Jones PS, Yeh KW, Brosnan HK, et. al. Evaluation of the Homeless Management Information System for COVID-19 Surveillance Among People Experiencing Homelessness. *Journal of Infectious Diseases*. 2022:226 (suppl 3) s327-s334.

All COVID-19 Cases Who Matched with HMIS Profiles, 3/30/20—12/30/21 (N=12,589)



Source: Jones PS, Yeh KW, Brosnan HK, et. al. Evaluation of the Homeless Management Information System for COVID-19 Surveillance Among People Experiencing Homelessness. *Journal of Infectious Diseases*. 2022:226 (suppl 3) s327-s334.

Table 2: Age- and Gender-Adjusted Mortality Rate Ratios (MRRs)*: PEH Compared to LA County Population (2021 and 2022 Combined)

Cause of Death	MMR
All Causes of Death	**3.9**
Drug and Alcohol Overdose	40.5
Coronary Heart Disease	4.3
Transportation-Related Injury	18.3
Homicide	17.7
Suicide	8.4
COVID-19	1.7

*The MRR is the mortality rate among PEH divided by the mortality rate in the total LA County population

Source: LA County Department of Public Health. Mortality Rates and Causes of Death Among People Experiencing Homelessness in LA County . May 2024.

Summary/Conclusions

- HMIS was an essential tool for COVID-19 surveillance and mitigation among PEH
- HMIS alone was insufficient as a single source for ascertaining PEH status
- Other data sources were critical as well as strong partnerships with medical providers, particularly for unsheltered PEH
- Use of HMIS program data helped narrow down profiles to PEH at time of infection, although the data were not always up to date.
- **Recently executed expanded DUA with CoC (LAHSA) for use of HMIS data for prevention efforts related to all reportable diseases and conditions.**

QUESTIONS?
(Part 1)

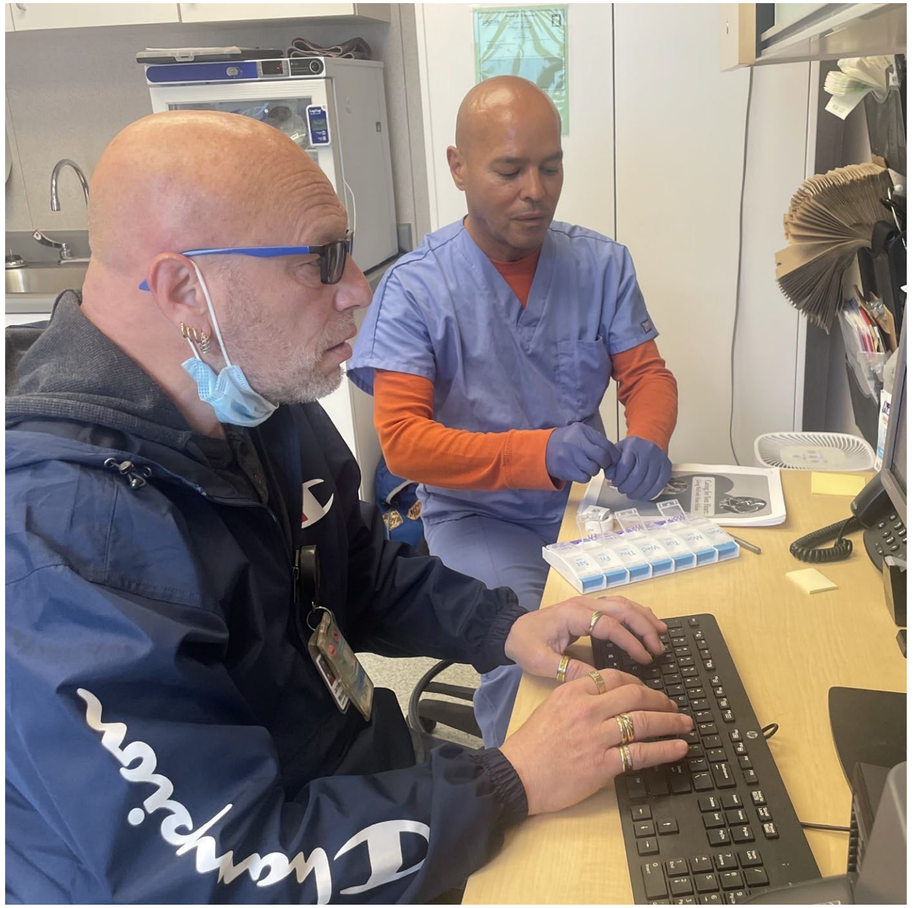
Bringing Services to Shelters and PSH

SF Department of Public Health
Whole Person Integrated Care

Rev. 6/2024

Shelter Health

- **Population of focus:** People experiencing homelessness in Shelters and Navigation Centers.
- **Staffing Model:**
  - 0.5 FTE nurse and Health Worker per 100 clients. Team is about 20 FTE's. Mobile Behavioral Health services.
  - Current staffing presence per site ranging from 1-5 daysweekly.
  - Funded by the Department of Homelessness and Supportive Housing
- **Clients Served:** Approximately 3,000 guests across 20+ shelters, and Navigation Centers



Shelter Health - Stabilize

- Provide emergency and urgent care on-site then triage to the appropriate level of care (e.g., ER, urgent care, primary care).
- Support clients to meet their health goals during their stays in shelter.
- Connect clients to ongoing primary care and behavioral health services.
- Connect eligible clients to palliative care (medical care for people living with serious illnesses).
- Population health/infectious disease follow up
- Education for shelter staff about health care issues/impact on behavior

Shelter Health - Types of Care

- **Types of care**
- On-site testing for infectious diseases (e.g., COVID, TB, HIV, Hep C, STIs/STDs)
- Chronic disease management
- Case management/care coordination
- Wound care
- Medication management
- Immunizations
- Harm reduction (engaging directly with people who use substances to prevent overdoses)
- Support with medications for opioid use disorders (MOUD) for patients with substance use disorders including Telehealth visits to initiate buprenorphine starts

Shelter Health - Transition

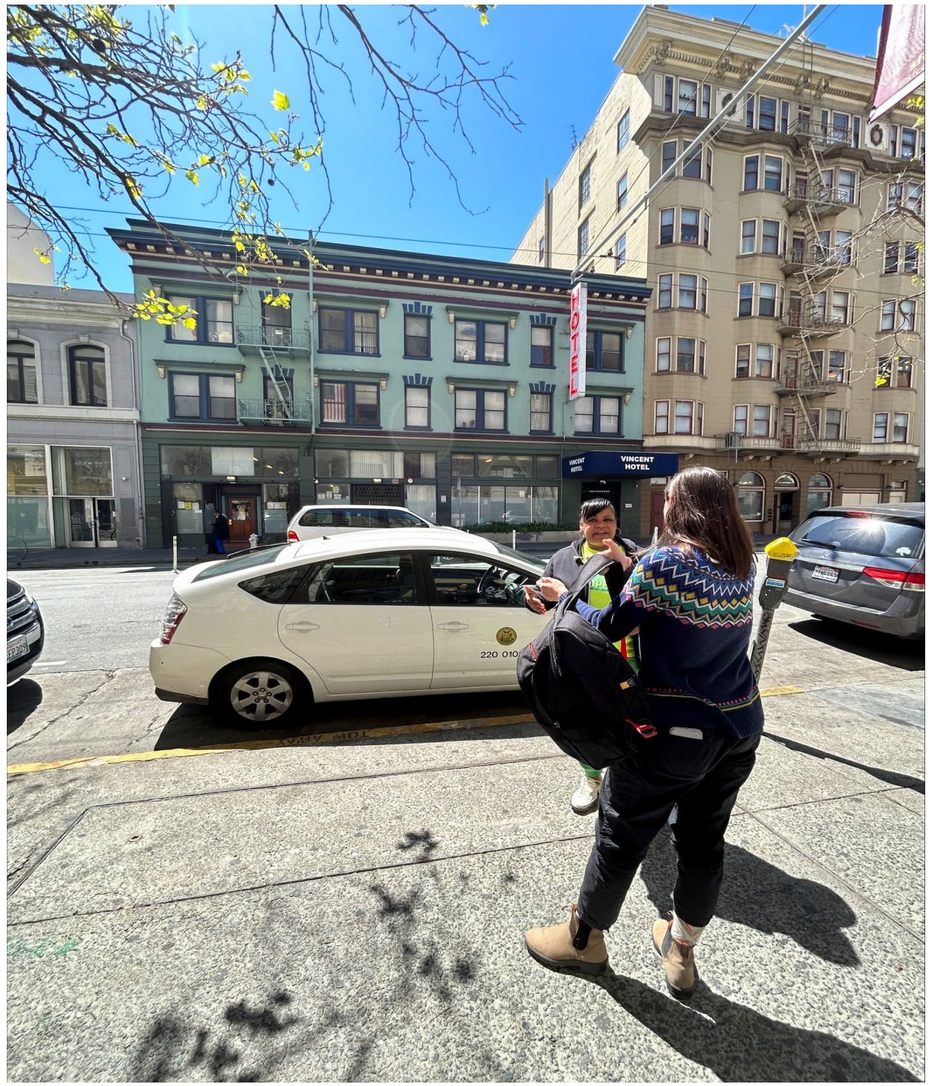
- **Transition**
- Prepare clients to transition out of shelter into permanent supportive housing or other appropriate arrangements.
- Help clients get set up with wrap-around services that will follow them into their next living situation.
- Assist with advocacy toward higher levels of care (e.g., Medical Respite, Board and Care, Residential Care)

Permanent Housing Advanced Clinical Services (PHACS)

100+ buildings serving over 9,000 tenants

Multidisciplinary team of 20+ behavioral health clinicians, nurses, nurse practitioners and health workers providing:

- Non-urgent, short-term direct care for PSH residents), soon expanding behavioral health services.
- Consultation, coaching and training for the community based organization staff on-site
- Connection and linkage to long-term, ongoing support
- Care coordination and Enhanced Care Management (ECM) services
- Funded by Prop C, a business tax for homeless services



Permanent Supportive Housing Nursing: 11 PSH sites serving 1,000 tenants

- **Staffing Model:**
  - 0.3-1.0 FTE nurse located at 11 PSH sites, 1-5 days/wk
- **Service include:**
- Chronic care management/consultation
- Linkages
- Medication adherence support
- Triage
- Direct nursing care.
- Funded by the Department of Homelessness and Supportive Housing

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Bringing Public Health To You

MADERA COUNTY
PUBLIC HEALTH

MADERA COUNTY 311 AT YOUR SERVICE

Mobile Health Mission Statement

To provide comprehensive services to our underserved residents and those with limited access through innovative technology and equitable services. Our commitment to excellence and compassion drives our efforts to ensure residents have access to care.

Goals:

- ✓ Provide preventative healthcare services and education to improve overall health outcomes
- ✓ Deliver timely and appropriate care to reduce health disparities.
- ✓ Collaborate with partners to ensure that services are integrated.

Menu of Services:

Wellness Checks

- Blood Pressure Checks
- Body Mass Index (BMI) Assessment
- Health Service Referrals

Immunization Services

- Adult Preventative Vaccines
- Child & School Vaccines
- COVID-19 Vaccines
- Annual Flu Vaccines

Health Screenings

- Glucose Testing
- A1C Testing
- STD Testing
- HIV Testing

Public Health Awareness

- WIC Services
- Diabetes Prevention
- Healthy Eating
- Many more programs…

Resources and Referrals

- Benefits Enrollment Assistance
- Community Resources
- Naloxone Training and Distribution

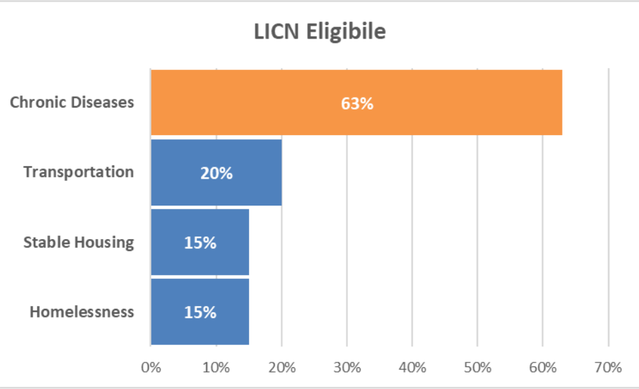
Community Collaboration/Engagement

@MADERACOUNTY

maderacounty.com

Best Practices

Number of Events by Month		
Services	**March**	**April**
Wellness	10	18
Canvassing	2	6
One-Stop Shop	0	0
Education	5	4
TB Event	0	0
STI	3	2
Total:	**20**	**30**



- ✓ Collaborations with other agencies.
- ✓ Location
  - Hours
  - Hot Spots
  - Services
- ✓ Case management and incentives.
  - Food
  - Water
  - Phone Charging Station
- ✓ Screening Questions
  - Transportation
  - Housing
  - Chronic Disease

Questions?

Contact Us

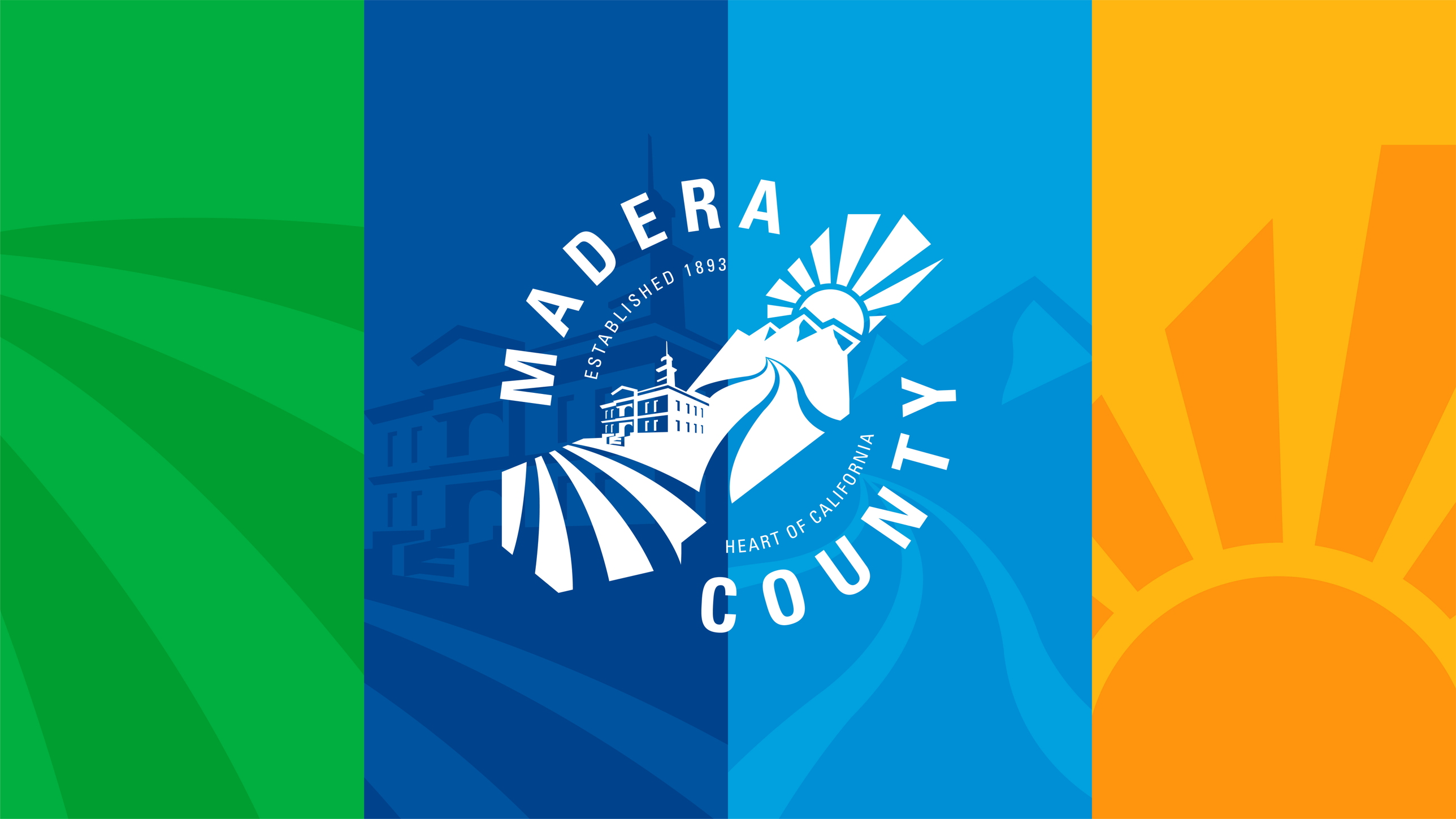
Phone
559-675-7893

Website
MaderaCounty.com/MobileHealth

Email
DPHMobileServices@MaderaCounty.com

See locations by scanning the QR code below or visiting our website

Scan Me


MADERA
ESTABLISHED 1893
HEART OF CALIFORNIA
COUNTY

Public Health

Sacramento County Wellness Without Walls & Community Nursing Encampment Team

SACRAMENTO COUNTY

SACRAMENTO COUNTY PUBLIC HEALTH

Promote • Prevent • Protect

Wellness Without Walls (W3) Mobile Clinic

SACRAMENTO COUNTY PUBLIC HEALTH
Promote • Prevent • Protect

WELLNESS WITHOUT WALLS

- Partnership b/w Public Health & Primary Health
- Funded with Ending the HIV Epidemic dollars & additional braided funds
- Collaboration b/w **Public** county programs, U. C. Davis School of Nursing & **Private** CBOs, pharmacies, businesses, donations
- Provide primary care services, wound care, Narcan, management of chronic health conditions, rapid HIV, HCV, and Syphilis testing (including confirmatory blood draws as needed), and extragenital screening for Chlamydia and Gonorrhea.
- Served a variety of audiences, primarily unhoused communities, also individuals who have been involved in sex work, transition-aged-youth, and new arrivals to the U.S. and/or refugees

Sexual Health Promotion Unit
SACRAMENTO COUNTY

Observations

- The importance of serving *the pets* along with *the people*
- The need for more resources to treat **methamphetamine** use disorder
- Consistency is key to building trust w/ patients…we love routines!
- This work takes a **team** approach

Goal of the Community Nursing Program

The Community Nursing program seeks to bridge the gaps in healthcare delivery to Sacramento County residents while considering the social determinants of health to achieve positive health outcomes and decrease health disparities.

Target Population

Encampment Team:

Unstable Housing and 1 of the following criteria-

- Pregnant
- High-risk medical conditions or developmental delays, pregnancy and/or delivery complications impacting the infant, caretaker support/assistance needed, etc.
- Individuals and families that are high utilizers of the medical system and/or have barriers to accessing care.

Social Determinants of Health

According to the World Health Organization (WHO):

*"The social determinants of health (SDH) are the **non-medical factors** that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life… **Research shows that the social determinants can be more important than health care or lifestyle choices in influencing health**."*

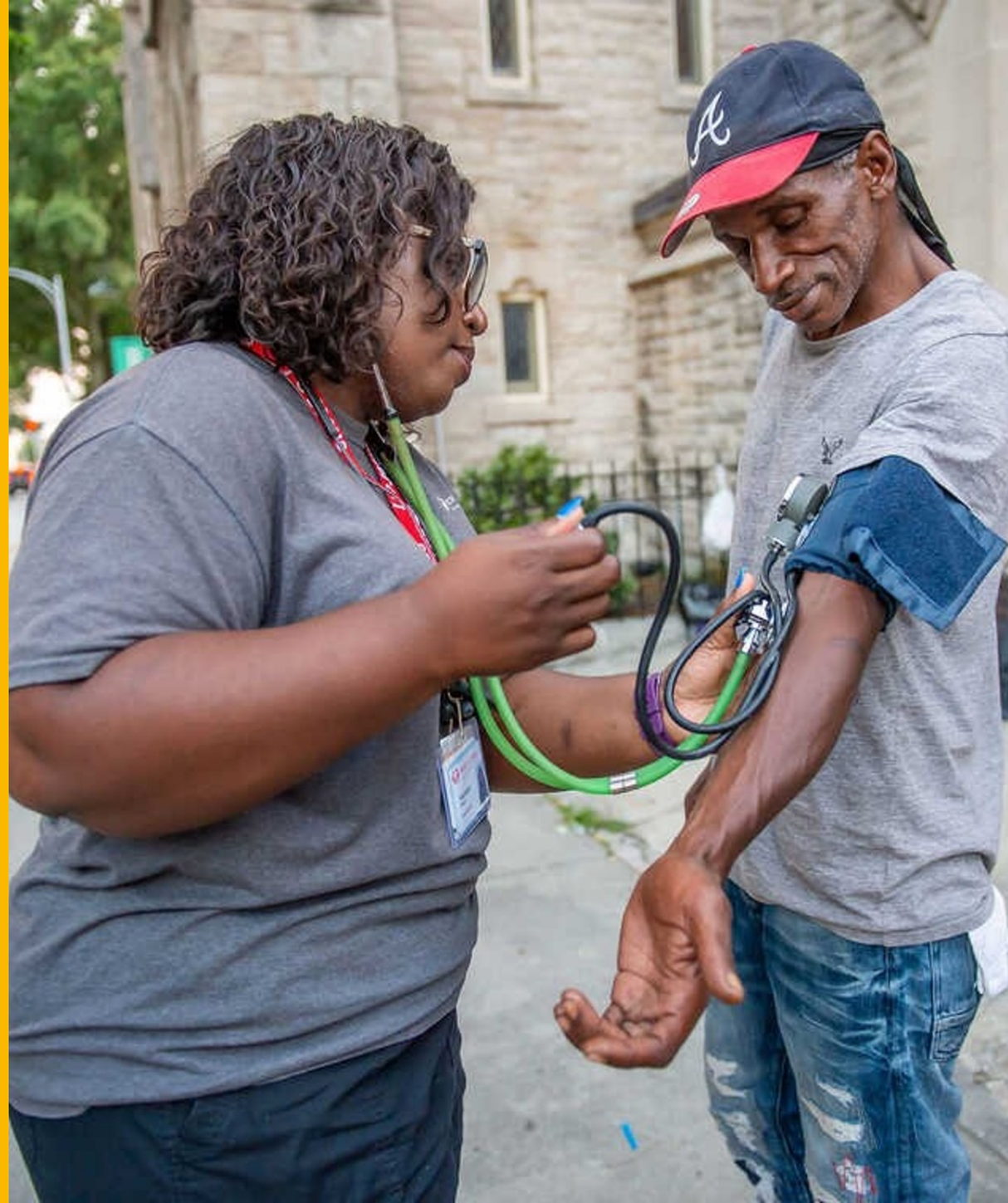
Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved [2023], from https://health.gov/healthypeople/objectives-and-data/social-determinants-health

Encampment Challenges

- Unable to hire Limited Term Public Health Nurse (PHN)- lack of interest
- Barriers to case management (closed loop referrals) due to transient nature of unhoused population.

Encampment Successes

- Goal 210/ Actual 1,067 “enrolled” in the program
- 1,317 referrals provided to clients for services such as housing, DHA, Medical/ Dental/ MH, SSI, etc.
- Rapid Syphilis testing readings
- PHN prescription pick-ups for W3 Providers.
- Wound care education and supplies.
- Nurse Leadership Food Drive



QUESTIONS?
(Part 2)

Upcoming Webinar Opportunities

- **Understanding CalAIM's New Enhanced Care Management and Community Supports for LHJs**
  - June 12th – 9:30 – 11:00 am
  - https://homebaseccc.zoom.us/meeting/register/tZYrdOqtrzgqE9FQSJYG8z6Zo7eo8cXGQm8U

Final Thoughts or Questions?

Reach out to us at

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