Overcoming Health and Housing Challenges for Justice-Involved Populations

National Health Care for the Homeless Symposium
Minneapolis, MN, May 17, 2018
Health Needs of Justice Involved Populations

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SENIOR DIRECTOR OF PROGRAMS
NATIONAL HEALTH CARE FOR THE HOMELESS COUNCIL
Prevalence of Health Conditions

- Substance Use Disorder and Active Tuberculosis
- Hepatitis C
- Serious Mental Illness
- HIV

Source: Davis and Pacchiana 2004, Steadman et al. 2009; Karberg and James 2005
Traumatic Brain Injury
“An Unrecognized Problem”
Adapted Clinical Guidelines

Adapting Your Practice

Recommendations for the Care of Patients Who Are Homeless or Unstably Housed Living with the Effects of Traumatic Brain Injury

National Health Care for the Homeless Council
Overview of Roles for Health Centers

Kim Keaton
What do we know about the relationship between homelessness and incarceration?

1. **Criminalization of homelessness**

2. **Arrests, and re-arrests for minor infractions**

3. **Lack of housing reduces impacts health care**

4. **Lack of stable housing increases likelihood of recidivism**

5. **Criminal history as barrier to accessing housing**

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HRSA asked CSH and NHCHC to explore the health and housing needs of justice-involved populations

We interviewed several programs across the country

The resulting paper, called “Stopping the Revolving Door: How Health Centers Can Serve Justice-Involved Populations” is under review at HRSA now
Three overall types of programs emerged

1. **Contracts with jails to provide health care**
2. **Coordination upon release – provide medication, appointments for care immediately following release**
3. **Provide support services and health and behavioral health care to people in supportive housing**
Determining Housing Need in Justice-involved Populations
Health Centers and Supportive Housing for Frequent Users

Working together to implement a FUSE initiative in your community

A CSH Self-paced Training
Promoting healthier communities through compassion and comprehensive health and human services, regardless of ability to pay

Anne Feczko, MSN, CNP
Learning Objectives

- How and where Unity Health Care serves justice-involved populations
- Barriers & solutions: health and housing
- Case study
Health Care for the Homeless Project founded

1985

Obtained federal funding

1987

Expanded to two FQHC community health centers

1996

Assumed operations of Alliance health centers, pharmacies, and Phoenix Center

1997

Changed name to Unity Health Care, Inc.

2001

Unity received DOC contract for the District

2006

Opened Reentry Health Care Center

2008

Unity celebrates 25 years of service

2010
Where do we meet justice-involved individuals?

- DC Department of Corrections (DOC)
  - History of contract
  - Funding structure
Where do we meet justice-involved individuals?

- DC Department of Corrections (DOC)
  - Staffing model
  - Discharge planning, including for homeless individuals
  - Advantage of locating providers “half and half” jail and CHCs
Where do we meet justice-involved individuals?

- **Re-Entry Health Center**
  - Located within Anacostia Health Center in Southeast DC
  - Serves patients residing at 2 DC halfway houses who have recently returned from federal facility or DOC
    - Easily accessible by bus but Unity also provides van service
    - Halfway houses are operated by private owners contracted by Federal Bureau of Prisons and DC Department of Corrections
Re-Entry Health Center
Where do we meet justice-involved individuals?

- **Re-Entry Health Center**
  - Full-time case manager meets with every patient for intake and ongoing as needed
  - 2 nurse practitioners provide 24 hours per week
  - Care coordinator communicates with patient, medical team, halfway houses, and NaphCare
  - Dedicated re-entry medical assistant and nurse
  - Other staff aware of health needs specific to re-entry population
Barriers & solutions

- During incarceration at DOC
  - Obtaining records from prior incarceration facilities
  - Health challenges inherent to the environment
  - Federal inmates still require approval from BOP for medical procedures
  - Unknown release dates from jail
  - Transfers to other incarceration facilities
  - Evolving social networks
Helpful resources

- Federal Inmate Locator: [https://www.bop.gov/inmateloc/](https://www.bop.gov/inmateloc/)
- Instructions on obtaining Bureau of Prison medical records: [https://www.bop.gov/foia/#tabs-5](https://www.bop.gov/foia/#tabs-5)
Federal Bureau of Prisons – FOIA Resources

Federal Bureau of Prisons

Avg. wait time (simple requests) 32 Days
Avg. wait time (complex requests) 137 Days
Request denial percentage 41%
Backlog (as of last report) 8938 Requests

Scroll down to view a list of agency contacts, a catalog of information systems, and the agency's FOIA request logs.
Barriers & solutions

- Upon release
  - Obtaining records
  - Assessing literacy level
  - Adjusting to “de-institutionalization”
- Identifying patients
### Incarceration Questions:

<table>
<thead>
<tr>
<th>Name</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Updated:</td>
<td>04/27/2018</td>
</tr>
<tr>
<td>Have you ever been incarcerated?</td>
<td>Yes</td>
</tr>
<tr>
<td>How many times have you been incarcerated?</td>
<td></td>
</tr>
<tr>
<td>What is the longest time you spent incarcerated?</td>
<td></td>
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<tr>
<td>Spend time in DC Jail?</td>
<td>Yes</td>
</tr>
<tr>
<td>DCDC #</td>
<td></td>
</tr>
<tr>
<td>Spend time in prison?</td>
<td>Yes</td>
</tr>
<tr>
<td>Where?</td>
<td></td>
</tr>
<tr>
<td>When?</td>
<td></td>
</tr>
<tr>
<td>Has your partner/family member ever been incarcerated?</td>
<td>Yes</td>
</tr>
<tr>
<td>Have you ever been arrested?</td>
<td>Yes</td>
</tr>
<tr>
<td>Where?</td>
<td></td>
</tr>
</tbody>
</table>
Barriers & solutions

- During halfway house incarceration
  - Coordination with halfway house staff and NaphCare
  - Retaining patients in care after release
Case study

- 52 yo African American female returning from 32 years in federal prison, residing in halfway house past 6 weeks
- Has 1-page medical summary from BOP:
  - HTN, DM, Unspecified abnormal cytological findings in specimens from cervix uteri, Back pain, Costochondritis, Sleep apnea, Hepatitis C without coma, Peripheral neuropathy, Gout
  - Ran out all meds 2 weeks ago: Novolin N, gabapentin, indocin, lisinopril, simvastatin
- Glucometer lost in transit
- BP 174/96, POC A1C 9.1%, non-fasting BG 246
- Normal urine dip, unremarkable physical exam
Case study

- Chief complaint: “I just need my meds and a TB test and my DOT physical.”

- Health maintenance: to order or not to order?
  - “They gave me a physical just before I got out.”
  - “I know they took stool from me a few times... it was in the fall. I never found out about the results.”

- Wait for records or plow ahead?
  - “They said I had hep C but I didn’t have enough viruses to get treated.”
Case study

- What are priorities today?
  - Patient
    - Med refills (values taking medication consistently, identify barriers)
    - TB test (employment or housing)
    - DOT physical (employment)
  - Provider
    - BP!
    - A1C!
    - RECORDS!
    - PREVENTIVE HEALTH CARE!
- What was life like 32 years ago?

References


https://www.unityhealthcare.org

https://doc.dc.gov/

https://www.naphcare.com/
In-Depth Look at the Denver Social Impact Bond Program

Carrie Craig, MSW, LCSW
Director of Housing First and ACT Services
Colorado Coalition for the Homeless
Project Overview

- Provide housing and supportive services to 250 individuals experiencing homelessness identified as the highest utilizers of the city’s emergency services (police, jail, detox and emergency rooms).

- **5 year term** ending in 2021 (Project Launched in February 2016)

- Evaluation: Randomized Control Trial

- Focus on two primary outcomes:
  - Increased housing stability
  - Reduced jail bed days
Main Project Partners

City of Denver
Corporation of Supportive Housing
Enterprise Community Partners
Colorado Coalition for the Homeless
Mental Health Center of Denver
Urban Institute
Private Investors
Colorado Division of Housing
Denver Housing Authority
Colorado Access
Social Impact Bond (SIB) ACT Teams

- Two specialized ACT teams working with 170 of highest utilizers of Denver Jail System
- Coordination with Denver Jail, Corporation for Supportive Housing, Enterprise Group, Investors, MHCD, City of Denver, DPD
- Unique Funding Stream
- Pay For Success model
Financing
Investment Overview

Housing Stability
$4,000,000

Jail Bed Days
$4,634,695

$15.12 per day for stable housing days, (*subtract days In jails)

<table>
<thead>
<tr>
<th>Organization</th>
<th>Amount</th>
</tr>
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<tbody>
<tr>
<td><strong>Housing Stability Lenders</strong></td>
<td></td>
</tr>
<tr>
<td>Northern Trust Company</td>
<td>$3,000,000</td>
</tr>
<tr>
<td>The Denver Foundation</td>
<td>$500,000</td>
</tr>
<tr>
<td>The Piton Foundation</td>
<td>$500,000</td>
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<tr>
<td><strong>Jail Bed/Day Reduction Lenders</strong></td>
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<tr>
<td>Laura and John Arnold Foundation</td>
<td>$1,700,000</td>
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<tr>
<td>The Colorado Health Foundation</td>
<td>$1,000,000</td>
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<tr>
<td>The Ben and Lucy Ana Fund at the Walton Family Foundation</td>
<td>$1,000,000</td>
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<tr>
<td>Living Cities Blended Catalyst Fund</td>
<td>$500,000</td>
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<tr>
<td>Nonprofit Finance Fund</td>
<td>$434,696</td>
</tr>
<tr>
<td><strong>TOTAL INVESTMENT</strong></td>
<td>$8,634,696</td>
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Expected Payment: Approximately $9.6 million, which equates to a combined annualized rate of ~ 3.5%

- Minimum Payment: $0, investors lose 100% of investment
- Maximum Payment: Approximately $11.4million (outcome levels at 100% housing stability, 65% jail bed reduction)
Pay for Success Model

Pay for Success
(a.k.a. Social Impact “Bonds”)

Upfront Working Capital

Pay for Success Contracts
SIB in Action
Why This Group?

• Each year, 250 chronically homeless individuals in Denver account for:
  • 14,000 days in jail
  • 2,200 visits to detox
  • 1,500 arrests
  • 500 emergency room visits

• The average yearly cost to taxpayers is $29,000 per individual, resulting from jail days, police encounters, court costs, detox, ER and other medical visits.

• Each year, the City spends approximately $7 million on 250 individuals to cover the expenses above.
Housing Intake & Placement + ACT Team

Finding the Flow - Homeless to Home

**HIPS**
- Initial Outreach and Engagement
- Eligibility Assessment
- Housing subsidy paperwork
- Vital Documents
- Health Insurance
- Goal setting
- Housing Navigation & Placement
- Transfer to ACT Long Term Services

**SIB ACT TEAM**
- Case Management
- Mental Health Care
- Substance treatment Services
- Nursing care
- Psychiatric Treatment & Medications
- Educational and Vocational Services
- Benefits Acquisition
- Peer Mentoring and Support
- Long-term ongoing care
Denver will Pay for Outcomes in Two Areas

(1) Housing Stability
- City only pays if a participant spends at least one year in housing.
- Thereafter, payments made on days in housing minus days spent in jail.
- If participant does not meet one year threshold, they can replace that unit with a new participant.

(2) Jail Bed Day Reduction
- Payments made based upon the percentage reduction seen between participants and non-participants over 5 years.
- No payments made below 20% reduction.
- Maximum payment at 65% reduction.
Outcomes and Lessons
Early Outcomes

- To date **all 250 people** have been housed through the project (currently at 274)
- Most people housed in the project have been homeless for **3+ years, longest homeless history of 32 years** (84% male, 16% female)
- After 6 months of housing, 95% of people **did not exit** the program
- After one year, 89% of people had **no exits**
  - This compares favorably to the evidence base which says on average 80% of people stay in SH for one year or more.
- After being in the project for one year or more, participants spent **8 days** in jail (prior average jail time was 77 days)
Lessons Learned

- Participants are **getting and staying** housed
- Importance of **community and interdepartmental collaborations**
  - Denver PD, Sheriff’s Department, Judges, Probation & Parole
  - Street Outreach, Health Center, Property Management
- Service provider **presence at court** has helped to reduce sentences for program participants
- Jail **In-Reach** is critical
- High vulnerability of population—need for **linkage to healthcare**
- Importance of **Flex Funding** for Property Damages and Client Needs
- Build up **stock of units** prior to start of program, Client choice is critical
- Importance of **community building** for program participants:
  - Focus with RDL building - “Get to know your neighbor” events
  - Group social outings
  - Temporarily housing participants in close proximity
  - Community Governance Boards
Questions?