Mapping the Road to Healthcare for Vulnerable Populations

Presenters

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Our Foundation: Who We Are

- Partnership Community Health Center (Appleton, WI) and Homeless Healthcare Center (Chattanooga, TN) both work to engage individuals in a holistic manner through various outreach techniques in order to address barriers to care.
Our Foundation: Homeless Healthcare Center

- 30 year old clinic
- Part of Hamilton County, Tennessee’s Health Department
- Serves 3,000 unique individuals per year
- Operates on a walk-in basis
- Offerings include:
  - Primary Healthcare Services
  - Dental Care
  - Behavioral Healthcare
  - Substance Abuse Treatment
  - Case Management
Innovation Leads to Change: “Bringing Healthcare Home”

- **Goal:** address barriers to care as a primary root cause of poverty

- **On May 5, 2016, Partnership Community Health Center opened a full-service clinic at COTS (transitional shelter) in Appleton, WI to provide primary care services to individuals experiencing homelessness or near homelessness:**
  - Med checks
  - Physical exams
  - Sick visits
  - Vaccinations/immunizations
  - Follow-up care after ER visits

- This is a **nationally acclaimed best practice!**
Establishing Patient Relationships Through Outreach

- Through outreach, we establish a relationship with potential patients and educate them on health services offered.
- This is a crucial step in mapping the road to a patient-centered healthcare “home”.
- **Patients play a key role** on the healthcare team:
  - Team members are mindful and accommodate the needs of each individual patient.
Key Barriers to Care

For the vulnerable populations served by both of these health centers, key barriers to accessing healthcare include the following:

- **Trauma & Adverse Childhood Experiences (ACEs)**
- **Transportation** – no reliable vehicle; depend on public transportation
- **Communication** – difficult to contact due to lack of phone or limited minutes
Identifying the Vector
A Closer Look at Adverse Childhood Experiences and Trauma-Informed Care
Published in 1998

Original ACE Study conducted at Kaiser Permanente from 1995 to 1997

Over 17,000 HMO members from Southern California receiving physical exams completed confidential surveys regarding their childhood experiences and current health status and behaviors

Numerous additional studies have been published since then with consistent findings
Significance of ACEs

- Over half of the U.S. population has suffered at least one ACE
- A graded relationship exists between number of ACEs and A) health risk behaviors and B) chronic illnesses and mental illness
- ACEs increase risk for disability and early death
- Consequences of ACEs are broad – affecting the individual victim, family, community, and society
- Lifetime economic burden of child maltreatment = $124 billion
7 Categories of ACEs

- Psychological abuse
- Physical abuse
- Sexual abuse
- Violence against mother
- Living with a substance abuser
- Living with a mentally ill/suicidal person
- Living with a person who has been in prison
Toxic Stress:

- Changes brain architecture, which influences future behavior, learning, and health
- Continual “fight or flight” changes the brain at a molecular, cellular, and circuitry level
- Alterations in DNA are seen
- Excess cortisol is damaging to the brain
Effect of Toxic Stress

- Impaired cognitive and academic functioning
- Alteration in emotional functioning and behavior patterns
Ramifications of ACEs

Examples of health risk behaviors tied to ACEs:
- Alcoholism
- Drug abuse
- Tobacco use
- Overeating
- Suicide attempts
- >50 sex partners
Examples of chronic illnesses tied to ACEs:
- Depression
- Ischemic heart disease
- Cancer
- Chronic lung disease
- Skeletal fractures
- Liver disease
Examples of additional consequences tied to ACEs:

- Disadvantaged socioeconomic status
- Less education
- Increased difficulty maintaining employment
- More likely to report poor health
Ramifications of ACEs
ACEs and Homelessness

![Chart showing the relationship between ACE score and adult homelessness](chart.png)
We need to presume the clients we serve have a history of traumatic stress

- We exercise “universal precautions” by creating systems of care that are trauma-informed
- Includes both direct patient care and general services
We need to treat patients with universal precautions with regards to the possibility of past trauma.

- “He continues to drink alcohol against medical advice.”
- “Her BMI goes up at every appointment.”

To the provider, the behavior is the problem; to the patient with a history of childhood trauma, it is the solution.
Procedures can trigger patients with a history of childhood trauma

Use your “trauma lens”

“She has no-showed for her pap appointment three times; she needs to be discharged from the practice.”

“He continues to cancel his dental appointments; he is noncompliant.”
Partnership Community Health Center: “Bringing Healthcare Home”
Removing Barriers to Healthcare

- Removing barriers to healthcare and introducing health literacy programming empowers patients to become proactive in making necessary changes to improve their health, ultimately helping them move out of poverty.

Key Barriers

- Previous **trauma** or adverse childhood experiences (ACEs)
- **Transportation** – no reliable vehicle; depend on public transportation
- **Communication** – difficult to contact due to lack of phone or limited minutes
Most patients seen at the COTS clinic suffer from chronic mental illness that is complicated by a lifetime of trauma and addiction.

Without addressing this need, their physical health does not improve.

In February 2017, we began offering substance abuse counseling at COTS.

In August 2017, we began offering mental health assessments and counseling at COTS. This service is integrated with primary care to ensure we are taking a truly holistic approach to patient care.
Participation in area-wide Poverty Outcomes & Improvement Network Team (POINT) provided the following opportunities to address barriers to care:

- **Connection with other area organizations** that are working to reduce poverty, including those sending patients to the COTS clinic
- **Initiate quality improvement work** that revolves around needs of patients and community engagement
Defining Our Team’s POINT Aims and Change Ideas

PCHC/COTS AIM

1. Number of completed patient appointments is 80% of total available
2. 95% of patients complete a Health Insurance Check-up
3. 75% of patients with no insurance complete an enrollment assistance session
4. 75% of patients needing dental or behavioral health services get a referral

PRIMARY DRIVERS

Building Community Connections & Outreach

- Understanding of resources
- Limited knowledge
- Insurance status
- Need to establish primary care
- Access to dental & behavioral health care

SECONDARY DRIVERS

Patient Needs

CHANGE IDEAS

- Health Insurance Check-Up
- Onsite insurance enrollment
- Health access education & literacy
- 30/60/90 Day Health Plan
- Healthy Hours
- Case/care management & building capacity
Like our community partners, we hope that our efforts will have an impact on ending homelessness in our area.

The case managers at the shelters and transitional housing agencies we serve are an extension of the healthcare team.

Our community partners may recognize a client’s need for healthcare before we can interact through outreach.
Building of “Community” Between Care Team and Patients

- Patients are a key component of our healthcare team, and barriers to care are addressed at an individual level.

- Individual healthcare needs are determined during outreach or prior to each patient’s first appointment via a brief survey called a Health Insurance Check-Up (HICU).

- Based on a patient’s HICU responses, we then work to connect them to services at PCHC:
  - Primary care
  - Dental care
  - Insurance enrollment
  - Behavioral health
# Health Insurance Check-Up (HICU)

**Health Insurance Check-Up**

Name: ___________________________  Today’s Date: ____________________

Date of Birth: _________________  Phone Number: ____________________

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>I NEED health insurance or have questions about my health insurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I NEED a primary care/regular doctor</td>
<td></td>
<td></td>
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<tr>
<td>I HAVE COMPLETED a dental appointment in the past year</td>
<td></td>
<td></td>
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<tr>
<td>I HAVE concerns about my teeth</td>
<td></td>
<td></td>
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<tr>
<td>I WOULD LIKE a Partnership Community Health Center dental appointment</td>
<td></td>
<td></td>
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<tr>
<td>I HAVE COMPLETED a counseling appointment in the past year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My appointment was completed at this location: _________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I WOULD LIKE a Partnership Community Health Center counseling appointment</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes (office use only): __________________________________________________
# HICU Results – Proof that Patients Matter!

<table>
<thead>
<tr>
<th>Metric</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of Patients Completing a Health Insurance Check-Up (HICU)</td>
<td>93%</td>
</tr>
<tr>
<td>Percentage of Uninsured Patients Receiving Enrollment Assistance (based on number reporting no insurance on HICU)</td>
<td>89%</td>
</tr>
<tr>
<td>Referral Rate for Patients Requesting Dental Services on HICU</td>
<td>96%</td>
</tr>
<tr>
<td>Referral Rate for Patients Requesting Behavioral Health Services on HICU</td>
<td>89%</td>
</tr>
</tbody>
</table>
Barriers Provide Learning Opportunities

- Patient barriers provide opportunities for our team members to learn how they can help provide care.
- We never stop putting the patient first, but instead ask ourselves what we would do if we were in their shoes.
To better understand the impact of early trauma on our patients and their complex medical and behavioral health needs, we introduced Adverse Childhood Experiences (ACEs) assessments into our intake process.

Initial data shows that many patients at COTS have had significant exposure to trauma.
ACE Assessment Results

Most common ACEs reported by our patients:

- **56%** - Parents were separated or divorced
- **48%** - Lived with someone who was an alcoholic or used drugs
- **47%** - Parent/adult in household swore, insulted, humiliated or caused fear of physical harm

Finding Your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often or very often**...
   - Swear at you, insult you, put you down, or humiliate you?
   - Act in a way that made you afraid that you might be physically hurt?
   - Yes No
   - If yes enter 1

2. Did a parent or other adult in the household **often or very often**...
   - Push, grab, slap, or throw something at you?
   - Ever hit you so hard that you had marks or were injured?
   - Yes No
   - If yes enter 1

3. Did an adult or person at least 5 years older than you ever...
   - Touch or fondle you or have you touch their body in a sexual way?
   - Attempt or actually have oral, anal, or vaginal intercourse with you?
   - Yes No
   - If yes enter 1

4. Did you **often or very often** feel that...
   - No one in your family loved you or thought you were important or special?
   - Your family didn’t look out for each other, feel close to each other, or support each other?
   - Yes No
   - If yes enter 1

5. Did you **often or very often** feel that...
   - You didn’t have enough to eat, had to wear dirty clothes, and had no one to protect you?
   - Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   - Yes No
   - If yes enter 1

6. Were your parents ever separated or divorced?
   - Yes No
   - If yes enter 1

7. Was your mother or stepmother...
   - Often or very often pushed, grabbed, slapped, or had something thrown at her?
   - Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?
   - Ever repeatedly hit at least a few minutes or threatened with a gun or knife?
   - Yes No
   - If yes enter 1

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   - Yes No
   - If yes enter 1

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
   - Yes No
   - If yes enter 1

10. Did a household member go to prison?
    - Yes No
    - If yes enter 1

Now add up your “Yes” answers: _____. This is your ACE Score.
Scope of our Trauma Lens at COTS

- ACE Questionnaire
- Follow up discussion with provider
- Screening for anxiety, depression, substance use
- Referral for trauma-informed CBT
- Relationship/trust building, empathy
- Tertiary prevention strategies
  - Treatment of chronic illnesses / mental illness
  - Treatment for substance use disorders
Building Trust

- Culture of Caring in the clinic environment
- Acknowledgement of past trauma and how it has affected their lives
- Mutual respect and professionalism
- The patient and provider are on the same level
- Shared decision-making for healthcare decisions
Behind the Scenes: Patient with Severe Trauma

- 33-year-old female staying in a local inpatient treatment facility for opioid addiction presented initially as a walk in for tooth pain

- Patient with depression, anxiety, PTSD, substance use disorder, and a significant history of childhood trauma (ACE score 9)

- No recent pap, no recent labs, no recent immunizations, one month overdue for depo shot, not currently connected with a counselor, and nearly out of psychiatric medications prescribed from jail. No dentist.

- Can only attend appointments when counselors at treatment facility are available to drive her

What would you do if you were her provider?
Behind the Scenes: Our Approach

- **First visit:** arranged for emergency dental the next day (walk in), arranged an appointment for counseling, drew labs, refilled psychiatric medications and prescribed a non-narcotic pain reliever for tooth pain

- **Next visit (1 week later):** completed a formal history taking, gave her a depo shot, administered immunizations, scheduled her for a physical with pap and placed additional needed referrals
  - Patient didn’t complete dental appointment yet because no one was available to drive her for 2 weeks – she had to live with tooth pain during that time due to the restrictions of her living community
Finding Solutions to Communication Barriers

- Some patients don’t have a phone or run out of minutes and can’t receive automated appointment reminder calls or texts

- To address this barrier, we use the following tactics:
  - Face-to-face relationships with patients during regular shelter outreach
  - Scheduling of follow-up appointments when patient is physically present
  - Printed appointment reminder slips the day prior to an appointment
  - Regular email and phone communication with shelter and transitional housing staff
Eliminating Transportation Barriers

- Per our buses and beyond survey, **many patients rely on public transportation** and do not own a reliable vehicle.
- Transportation barriers for residents at the COTS men’s campus are eliminated due to the clinic being onsite.
- To further address this barrier, we use the following tactics:
  - **Educate patients on transportation options**, including MTM (Medical Transportation Management) services for individuals with Medicaid/BadgerCare.
  - **Provide bus passes** to patients in need after completion of their COTS clinic appointment.
  - **Schedule and pay for a cab ride** when other transportation options aren’t feasible.
Eliminating Transportation Barriers

- We have **physically tested the bus routes** so that we can speak from first-hand experience when telling patients how to get to the clinic.
- We tested our latest brochure map out with patients and potential patients so that we could ensure that those we serve could easily locate us.
Behind the Scenes: Domestic Abuse Shelter Outreach

- **Patient X** residing in domestic abuse shelter is experiencing **severe tooth pain** and needs dental care ASAP
- Due to no immediate dental openings and patient’s work schedule, next day walk in and wait (WIAW) is the only option
- **Numerous barriers to care:**
  - High likelihood of **previous trauma** due to place of residency
  - Relies on public transportation but has **no money for bus pass or cab ride** – previously stated she missed scheduled dental appointment due to lack of transportation
  - No phone – can’t call to follow-up

What would you do to ensure this patient receives care?
Modifying Outreach Services to Fit Individual Patient Barriers

- For Patient X, we took the following measures to connect her to care:
  - Scheduled and paid for a next-day cab ride so she could do WIAW
  - Gave info on future transportation options
  - After meeting with patient during outreach, connected with schedulers and booked a last minute dental opening that lined up with expected arrival time via cab
  - Confirmed with PCHC dental facility that patient arrived for visit
To further address barriers to care, we provide patients with health literacy education through “healthy hours”.

Some of our healthy hour topics/activities have included:

- Marketplace Bingo
- Dental Jeopardy
- Celebrating Bright Spots
- Counseling Fact or Crap
- Preventive Health Care Bingo
- Prescription Assistance
- Medical Transportation
For every new barrier to care that we come across, we start a new PDSA cycle in order to find the best solution.

**PDSA**: Quality improvement tool to test a small-scale change (plan, do, study, act)
Expanding Our Nurse Practitioner Hours at COTS

- The findings from our initial PDSA cycles guided the interventions for expansion of the COTS clinic project.

- In **March 2017**, we extended the hours of one of our nurse practitioners and are now seeing patients 2 full days per week, instead of 1.5 days.

- In response to the need to grow our patient base, we began providing **onsite blood pressure checks and appointment scheduling** at a local emergency shelter.
Objective of this PDSA Cycle: Book Warming Shelter patients for COTS clinic appointments and PCHC dental appointments as a result of onsite appointment scheduling and blood pressure checks.

**The Change or Idea:**
We would like to expand our patient base at COTS. We have also been seeing a big need for dental services and are seeking to cut down on communication barriers to care. Many at Warming Shelter don’t have a phone to schedule an appointment.

**ACT:**
Because having access to scheduling dental appts onsite was such a huge success, we will try to coordinate this on a monthly basis with our regular outreach efforts at Warming Shelter.

**PLAN:**
Amber, Trish, Jill and Brigette will do outreach at Warming Shelter on 7/17/17 in order to address needs for primary care and dental services. HICUs will be handed out to determine these needs. Amber will schedule COTS clinic appts & Brigette will schedule dental appts. Jill will do blood pressure checks.

**STUDY:**
The signs and use of 2 different tables helped us to stay more organized than at previous outreach sessions. **We scheduled 5 COTS clinic appointments (4 new patients) and 6 new patient dental appointments.** One individual commented that he would not have called on his own to schedule a dental appt. This additional scheduling was well-received.

**DO:**
Tables were set up at Warming Shelter for blood pressure checks and appointment scheduling. HICU responses helped us determine which type of appt we needed to schedule. We placed signs out to point people in the direction of the service they wanted.

**What question(s) do we want to answer?**
By providing appt scheduling & blood pressure checks onsite, can we persuade Warming Shelter clients to seek care?

**Prediction(s):** We will book at least 3 appointments at the COTS clinic and 3 new patient dental appointments.
Success by the Numbers

Each patient seen = 1 or more barriers to care addressed!

<table>
<thead>
<tr>
<th>Cumulative COTS Clinic Outcomes</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Appointments Completed</td>
<td>1,210</td>
</tr>
<tr>
<td>Primary Care Patients Seen</td>
<td>315</td>
</tr>
<tr>
<td>Health Access Education Sessions Completed</td>
<td>360</td>
</tr>
<tr>
<td>Number of Clients Receiving Health Access Education</td>
<td>158</td>
</tr>
<tr>
<td>Number Gaining Insurance or Prevented from Loss of Coverage</td>
<td>64</td>
</tr>
<tr>
<td>Counseling Appointments Completed (Note: Began offering counseling at COTS on 8/24/17)</td>
<td>76</td>
</tr>
<tr>
<td>Counseling Patients Seen</td>
<td>36</td>
</tr>
</tbody>
</table>
Survey Results Confirm Patient Involvement and Mindful Care Team

- 93% of primary care patients agree that their healthcare team involved them in decisions about their care!

Excellent care; I am treated as a person and not a chart.

They are down to earth, very friendly and made me laugh a lot. It put me at ease.

My doctor and I have worked together to change how I feel.

I like the fact that I’m not treated different because of income status.

Gave honesty, kindness and options, along with respect towards my wishes.
Teaching Patients How to Advocate for Their Healthcare Needs

- WI State Representative Jim Steineke visited the COTS clinic
- Patients talked to him about addressing barriers to healthcare
- Patient attended BadgerCare waiver hearing to voice concerns
- Patients communicated with members of Congress about the importance of our services in an effort to fix the Health Center Funding Cliff

While addressing barriers, we teach patients how to advocate for themselves!
Homeless Healthcare
Chattanooga, TN
Starting Fresh

- Started in August 2016
- 2016 PIT unsheltered count = 77
- Little to no outreach presence in encampments
Service Area

- Hamilton County, TN
- Southeast Tennessee
- 576 square miles
- Over 350,000 population
- Includes both urban and rural areas
Making Mistakes

- Wasted a lot of time
- Found very little people
- Didn’t know what to say when we found them
You Never Know What You Will Find
The Importance of Outreach

- People don’t always come to you for help
- Waiting for the clients to come to you can be fatal
Team Effort

- All staff can have an outreach attitude
- Don’t go through the world with blinders on
- We begin to learn how ineffective we can be
- Be mindful of the best use of your time
Story of Bobby
How Did He Get There?

- In and out of jail and the Emergency Room
- Lack of communication between systems
- Fallen through the cracks
What Did We Do?

- Through a team effort, we were able to apply for benefits and place him in a nursing home
- Needed to know where to look for him
Learned Approach

- Provide information
- Leave cards
- Give respect and distance to people
- Ask to approach
Learned Context

- Outreach puts people in their own context
- Better understand the story of the individual
- Agency reputation comes heavily into play
Remembering Where You Went
Putting Everything Together
Mapping Encampments

- Camp under Bridge
- Behind Building on Lot
- Under 11th St Bridge
- Camp on tracks, walk
- Camp by tracks down
- Camp by Tracks, walk
- Camp in woods, Off
- Tent City (Multiple P...
G.11 #2: *Abandoned* off spring creek

-Visited 8/3/17: Abandoned and Overgrown

35.00314, -85.21851
Planning

- Map allows outreach workers to plan out their routes
- Other people know exactly where you will be in the event of an emergency
Coordinate Outreach Efforts

- Use zones to split up coverage of large locations
- Share information in an easy to understand way
Track Trends in Location

- Coordinates from locations allow Outreach workers to look at a client’s location over time
- Plan locations for other services
Finding New People
Free software

Relatively easy to use
Results From Efforts

- Total unsheltered for 2017 - 217
- Network and mapping system established for future outreach workers
- People found and their stories heard
Lessons Learned: Understand the Context of Your Clients

- People’s lives don’t start and stop when they come into your office
- People have stories that often are not shared
Lessons Learned: Remember to Pass on What Works

- A program is only as good as its longevity
- Who is going to carry on the work once you leave?
Lessons Learned: Our Patients Experience Several Barriers to Care

- Before we connect individuals to care, we need to address the key barriers that are preventing them from receiving care
  - Trauma/ACEs
  - Communication
  - Transportation

- Just because we schedule someone for an appointment doesn’t mean that we have successfully connected them to care
  - Patients need someone to advocate for them until they learn how to advocate for themselves, whether it’s leaving an appointment reminder, scheduling a cab ride, etc.

- The best appointment completion results have occurred when team members follow up to address any barriers
Lessons Learned: Relationships with Patients and Community Partners Matter

- Relationships between patients and their care team are extremely important, especially for those with past trauma
  - Patients are an important part of the care team – ask them what their needs are and how you can help
  - When patients feel valued and listened to, they are more likely to come back for a follow-up appointment
- Relationships with community partners need to be maintained in order to ensure that patients are receiving the care they need
  - When patients have a communication barrier to care, relationships with shelter staff can help to bridge the gap
Lessons Learned: Improvement
Work Never Ends

- Initial failure lays the groundwork for future success
- It takes failing multiple times before you recognize something as a barrier to care
- There’s always something we can change to get better results
  - When one PDSA/improvement cycle ends, another one begins
- The day we stop trying to improve our work is the day we stop caring for our patients
“The work goes on, the cause endures, the hope still lives and the dreams shall never die.”

Edward Kennedy
Questions?

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