from the streets to home

utilizing an integrated street outreach team to apply a Housing First model

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agenda

- Homelessness in Pima Co.
- Housing first model
- Street to home program
- Preliminary findings
- Q & A
- Additional resources
homelessness in Pima County
Housing First
Housing First for veterans

HUD-VASH Housing First Veterans Initiatives

76,329 homeless veterans
56% reduction in 3 years

54% reduction inpatient
32% reduction outpatient
Housing First in 5 Cities
(N=2,215)
different sizes and populations

Vancouver
Pop: 578,000

Winnipeg
Pop: 633,000

Toronto
Pop: 2,503,000

Montreal
Pop: 1,621,000

Moncton
Pop: 107,000

AT HOME/
CHEX SOI
2009-2014
Annualized Number of Chronically Homeless Individuals, Utah 2005-2015

91% DECREASE SINCE 2005

if 100 people.....

Tucson Emergency Shelter

OPCS LBBH

- 100
- Perm Housing
- Remain Housed

100
21
12
69
52
It’s not only morally sound, it’s a financially sound choice…

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<th>Mean Cost Pre-Admission</th>
<th>Mean Cost Post-Admission</th>
<th>Percent Change</th>
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<td>Total</td>
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Data source: Veterans Health Administration (VHA) Decision Support System (DSS)
where is this working?

ended **chronic** homelessness

- Bergen County, NY
- Lancaster County, PA
- Rockford, IL

ended **veteran** homelessness

New Orleans, LA, Houston, TX, Mobile, AL, Troy, NY, Saratoga Springs, NY, Flagler County, FL, Lancaster City & County, PA, Cumberland County/Fayetteville, NC, Winston-Salem, NC, Las Cruces, NM, Syracuse, NY, Las Vegas, NV, Commonwealth of Virginia, Schenectady, NY, Rochester, NY, Albany, NY, Rockford, IL, Philadelphia, PA, Mississippi Gulfport/Gulf Coast Regional CoC, Montgomery County, MD, Volusia County/Daytona Beach, FL, State of Connecticut, Reading/Berks County, PA, Lynn, MA, Des Moines, IA, San Antonio, TX, Terrebonne Parish, LA, Hattiesburg, MS, Long Island, NY, Bergen County, NJ, Austin, TX, Middlesex County, NJ, Buffalo/Western New York, State of Delaware, Dayton/Montgomery County, OH, DeKalb County, GA, Portland/Gresham/Multnomah County CoC, Shreveport, LA, Riverside, CA, Santa Fe, NM, Chattanooga, TN, Fort Myers/Lee County, FL, Southwest Minnesota CoC (MN-511), Nashua, NH, Punta Gorda/Charlotte County, FL, Akron/Barberton/Summit County, OH, LaCrosse, WI, Scranton/Lackawanna County, PA, Lehigh Valley, PA, Massachusetts Balance of State CoC, Will County, IL, Lowell, MA, Northwest Minnesota CoC, Moorhead/West Central Minnesota CoC, Kent County, MI, Dutchess County, NY, Atlanta, GA, Kansas City (MO & KS)/Independence/Lee’s Summit/Jackson, Wyandotte Counties CoC, Pittsburgh/McKeesport/Penn Hills/Allegheny County CoC, Nebraska Balance of State CoC, Delaware County, PA, Beckley, WV/Beckley VAMC Catchment Area, including City of Beckley and Raleigh, Fayette, Nicholas, Summers, Greenbrier, Monroe, Pocahontas, Wyoming, Mercer, McDowell and Clay counties, Norman/Cleveland County, OK, Kittitas County, WA, Miami-Dade County, FL, Lincoln, NE, Jackson/West Tennessee Continuum of Care, Little Rock, AR, Northeast Minnesota Continuum of Care
Street to Home (SHP) program model
integrated care & street outreach
The purpose of the Street to Home Program is to integrate behavioral health treatment and services for substance use disorders (SUD), co-occurring mental health and substance use disorders (COD), permanent housing, medical services and referral, and other critical services for individuals and families experiencing homelessness utilizing evidenced-based practices and harm reduction principles.

The program Navigator, Family Nurse Practitioner and Peer engage individuals and families during street level outreach, assisting them with enrollment and resources for health insurance, Medicaid, and mainstream benefit programs such as Supplemental Security Income (SSI) - Social Security Disability Insurance (SSDI) - Temporary Assistance for Needy Families (TANF) - Supplemental Nutrition Assistance Program (SNAP) and other benefit and service programs to assist them in obtaining stability on their journey to eventual permanent housing.
street outreach

• The Street to Home Navigator, Family Nurse Practitioner and Peer Guide encounter unsheltered homeless individuals and families in the community in:
  • parks
  • ditches
  • desert areas
  • shelters
  • drop-in centers
  • soup kitchens
  • anywhere that homeless individuals and families frequent in the Tucson area

• Assessments are conducted to determine vulnerability
navigator assessment & housing referral

- VISPDAT assessment
- coordinated entry housing referral
- assessment for immediate access to emergency shelter
- referral and information to wrap-around services
The first assessment administered by the Navigator is the VISPDAT – Vulnerability Index Service Prioritization Decision Assistance Tool. Domains include:

- **Homelessness** – frequency, span and history
- **Hospitalizations** – ER visits, crisis and detox services
- **Legal matters** – police contacts, jailing's, attacks or pending legal issues
- **Mental Health Status** – harm to self or others
- **Socialization**

score determines housing eligibility
navigation process

• Navigator uses VISPDAT Score to determine individual or family eligibility for immediate emergency shelter placement (14+ in most cases)

• Upon entry of VISPDAT in Homeless Management Information System (HMIS) Navigator also completes a referral for housing through Coordinated Entry

• Navigator begins housing placement process through Section 8 or another housing resource in the community or Coordinated Entry Referral

• Navigator assists individual or family to collect proper documentation for housing, i.e. birth certificates, I.D.’s, Social Security Cards, etc.
family nurse practitioner
medical & behavioral health screening

- non-emergent medial treatment
- vitals
- PHQ-9
- CAGE-AID
- referral to detox, MAT, specialty provider or PCP
FNP assessment

• The second set of assessments is administered by the Family Nurse Practitioner
  • Initial medical screening includes:
    - vitals Screening
    - family/medical history
    - check for current enrollment in Medicaid/Healthcare
    - minor wound care
  • PHQ-9
    - determines current state of mental health
    - check to see if they are registered w/ BH Provider
    - refer to BH as necessary or crisis services
  • CAGE-AID
    - determines if there is a substance abuse issue
    - assists FNP in course of action for harm reduction or referral to tx services and detox if necessary
FNP process

• medical Assistance collects family history & medical history
• FNP/MA administers PHQ-9 & CAGE-AID
• medical team uses MI and SBIRT model to assist client in determining best course of action for harm reduction, detox or treatment services if needed
• medical team refers client to specialty provider if necessary or refers them to necessary follow ups or ER
• client referred for blood work and entire physical exam, including immunizations if necessary
peer guidance & engagement

- **shares experience** with other unsheltered homeless individuals and families
- **encourages** peers to engage with Street to Home outreach team
- offers **ongoing encouragement** to peers during the shelter and housing process
- **engages** unsheltered homeless community in a joint effort with Street to Home outreach team
peer process

• Navigator, FNP/Medical Assistants and Peer walk the street in areas the peer states are frequented by unsheltered homeless persons

• Peer approaches homeless persons and shares a little about medical, behavioral health and housing resources available in an attempt to gain trust.

• Peer introduces outreach team to homeless persons and bridges the gap to start assessment and screening processes.

• Navigator is in constant contact with Peer around housing and medical/behavioral health services for persons that do not utilize shelter, but are candidates for Street to Home Program.
case study: “Jack”
Jack’s experience

- Jack – 58 YO male, introduced to OPCS Navigator by a Peer while conducting street outreach. Had been sleeping in his truck for previous 3 yrs after becoming homeless as a result of alcohol abuse.

- Assessed by Navigator through VISPDAT, and scored high enough to enter Low Demand Shelter. Also assessed by El Rio medical team for immediate non-emergent medical issues, vitals, PHQ-9 and CAGE-AID. Given instructions and referral to follow up with PCP at El Rio for existing medical conditions that hadn’t been addressed during homelessness.

- Entered Low Demand Shelter same day

- A few days after entering Low Demand Shelter met with the Employment Recovery Coach (ERC) and began engaging in employment services. As a result of meeting with the ERC:
  - referred to the Gift of Sight Program sponsored by Lens Crafters, and was able to get a new prescription and glasses
  - able to get funds through OPCS Home Funds to pay for his certification renewal as a Sterilization Technician.
Jack’s experience (cont’d)

• Jack participates in 1:1 therapy sessions to deal with his alcohol use disorder

• Participates in life skills groups, learning to cook healthy meals and make dishes with sparse ingredients, budgeting skills, and other daily living skills.

• Addressing his health issues and is scheduled for surgery to remedy an issue that has caused him severe pain for some time, and he will have a safe, clean place to recover post-surgery.

• Received a Section 8 housing voucher in June 2016 and is currently searching for an apartment with assistance from the SHP Navigator and LDS Recovery Coach; will soon be moving into permanent housing after only 6 weeks off the street.

Jack says that he does not know where he would be without the Street to Home Program, OPCS and El Rio. His goal is to become more stable and be in his daughter’s life. He expresses gratitude regularly about the opportunity and hand up that he has been given. He expresses good personal insight about the things that trigger him to drink, and he has learned resources and supports to assist him in his future success.
fidelity monitoring
EBPs

{ motivational interviewing
  screening, brief intervention and referral to treatment (SBIRT)
  integrated, team-based care
  housing first
  medication-assisted treatment (MAT) }
motivational interviewing
Motivational Interviewing Treatment Integrity (MITI) instrument:

- MI fidelity tool used to rate MI recorded interactions or live observations
- Minimum of 10-20 minute work sample
- Work sample submitted to ASU MI webportal: *MyMI*
- Clinicians provided with MITI scores and follow-up coaching session
individualized feedback & coaching

Sample 2 - 1/24/2018

**Relational Skills**
*Average of Partnership & Empathy Ratings*

- **Partnership**: 4
- **Empathy**: 4

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**Technical Skills**
*Average of Cultivating & Softening Rating*

- **Cultivating Change Talk**: 4
- **Softening Sustain Talk**: 3

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You used an empathic, nonjudgmental tone throughout the interview.

Your repeated accurate complex reflections likely left the client feeling heard and understood.

You did well to utilize complex reflections which emphasized the client’s reasons for change.

You might consider avoiding asking the client about the benefits of not changing as this pulls for sustain talk.
user performance metrics

**Relational Skills**
Average of Partnership & Empathy Ratings

- Sample 1
- Sample 2

**Technical Skills**
Average of Cultivating & Softening Rating

- Sample 1
- Sample 2

**% Open Questions**
Percentage of Total Questions Which are Open-ended

- Sample 1
- Sample 2

**% Complex Reflections**
Percentage of Total Reflections Which are Complex

- Sample 1
- Sample 2
screening, brief intervention and referral to treatment
SBIRT fidelity measurement

Brief Negotiated Interview Checklist (BNI Checklist):

• observation of core SBIRT skills (y/n) for outreach team
  • domains:
    − raising the subject
    − provide feedback
    − enhance motivation
    − negotiate a plan
  • submission of work sample, followed by coaching session
integrated care
AIMS Center Patient-Centered Integrated Behavioral Health Care Principles & Tasks:

• completed by FQHC Director of Behavioral Health and OPCS Director of Quality Management
• principles of care:
  − patient-centered care
  − population-based care
  − measurement based treatment to target
  − evidence-based care
  − accountable care
housing first
housing first fidelity

Pathways Housing First Fidelity Scale:

• completed by care and evaluation team; group consensus on ratings

• criterion examples:
  – immediate access to housing
  – scattered-site housing
  – permanent housing subsidies
  – no contingencies for housing outside of standard lease
  – accountable care
medication-assisted treatment (MAT)
medication-assisted treatment training

• half day workshop on medication-assisted treatment
• distribution of MAT pocket guides to clinical staff
• distribution of naloxone kits during street outreach activities (provided by Sonoran Prevention Works)

psychosocial treatments + FDA-approved medications = opioid use disorder recovery
preliminary findings
client acuity & vulnerability

Vulnerability Index – Service Prioritization Determination Assistance Tool (VISPDAT)
  • risk and prioritization screen for homeless individuals
  • range: 0-17
  • average score: 15 (8+ referral for permanent housing)

Patient Health Questionnaire-9 (PHQ-9):
  • depression screen
  • range: 0-27
  • average score: 11
    - moderate depression

CAGE-AID
  • drug and alcohol screen
  • range: 0-4
  • average score: 2
    - score of 1 or above = + screen
program dashboard

utilizing program dashboard to monitor program goals and objectives
Clients are largely white, male and heterosexual.
clients served and housed

**Individuals Contacted**

- **Goal**: 200
- **Actual**: 373

**Individuals Permanently Housed**

- **GOAL**: 30 individuals permanently housed per year
- **total**: 150

**Days from “street” to “home”:**
7-73 days (average of 30.9 days)
Q & A
additional resources
additional resources

• Pathways Housing First: [https://www.pathwayshousingfirst.org/](https://www.pathwayshousingfirst.org/)


• Screening, Brief Intervention and Referral to Treatment (SBIRT) online instruction: [https://courses.cpe.asu.edu/browse/cabhp/courses/cpe-cabhp-003-treatment-for-risky-substance-abuse](https://courses.cpe.asu.edu/browse/cabhp/courses/cpe-cabhp-003-treatment-for-risky-substance-abuse) (or visit cpe.asu.edu and search “SBIRT”)

• MyMI (online MI fidelity checks): [https://cabhp.asu.edu/content/motivational-interviewing](https://cabhp.asu.edu/content/motivational-interviewing)

• Printable MAT pocket guide: [https://cabhp.asu.edu/sites/default/files/mat_printable_guide.pdf](https://cabhp.asu.edu/sites/default/files/mat_printable_guide.pdf)
thank you!

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