Nursing Role(s) on a Housing First ACT Team & Promoting Community Integration

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COLORADO COALITION FOR THE Homeless

Creating Lasting Solutions

GOALS

Gain understanding of Nursing Role within Colorado Coalition for the Homeless Housing First Program

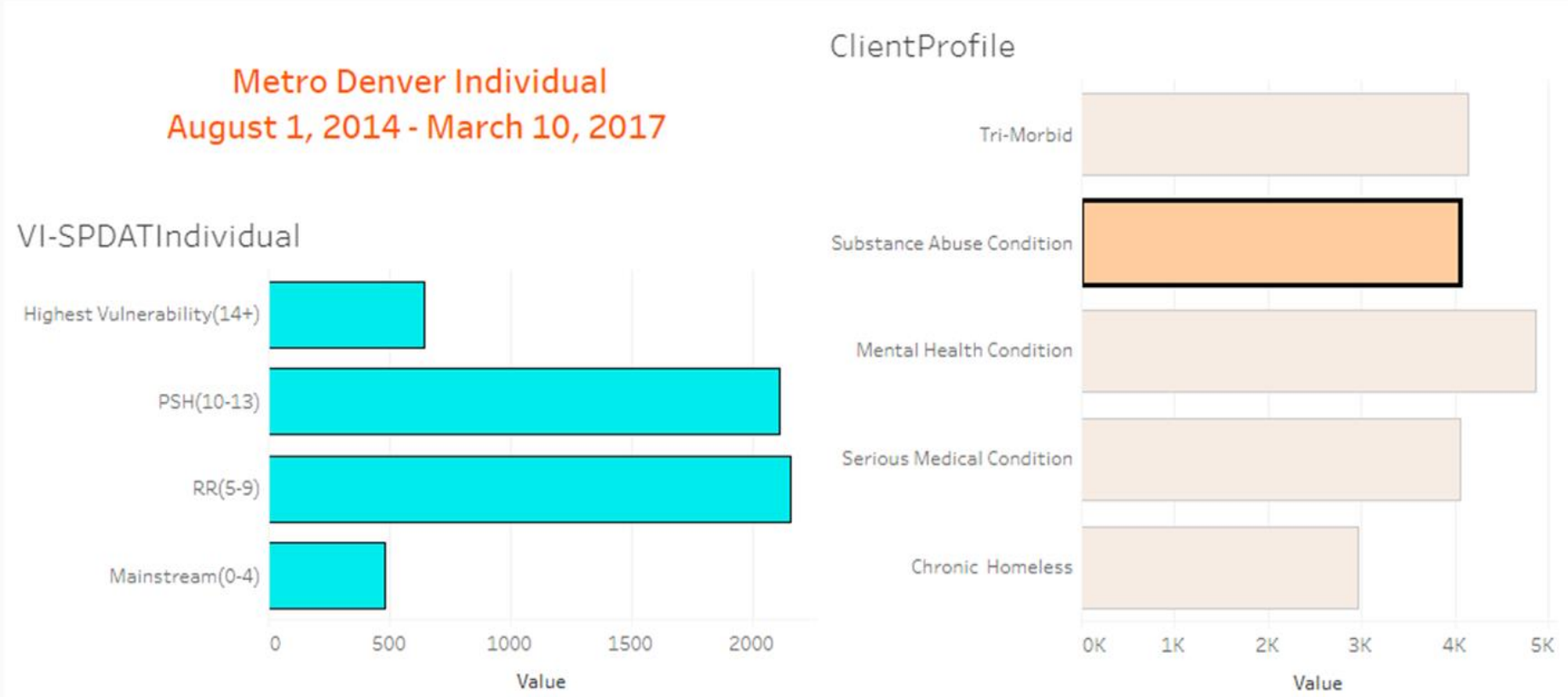
Gain understanding of potential challenges and strategies to help overcome obstacles for Housing First ACT Team for Nurses

Gain understanding of ways to integrate community health resources into everyday client care

Nurses Role at Colorado Coalition for Homeless Housing First Program

ONE HOME-Coordinated Entry
Housing Intake Placement-HIPs

This data includes anyone over the age of 25 who is unaccompanied (no children) that is experiencing literal homelessness that has completed the VI-SPDAT reflects responses between 2014 and March 2017 in the OneHome system.



HOUSING FIRST

- Housing is the priority need for the individual
- Wraparound services to maintain housing stability

CASE MANAGEMENT AND SUPPORTIVE SERVICES

SOCIAL IMPACT BOND

- Randomized control study
- Denver's Social Impact Bond uses funds from lenders in a pay for success program to assist homeless individuals who frequently use the city's resources

Improve level of health and functioning of the individual

BEHAVIORAL HEALTH CARE

- Assertive Community Treatment (ACT) Model
  - Team-based Care
  - Focuses on mental health services
  - BHCM

PRIMARY CARE

- Guided Care Model
  - Assessing medical conditions
  - Link to primary care and community services

INTEGRATED HEALTH ASSESSMENTS

Behavioral Health and SUD

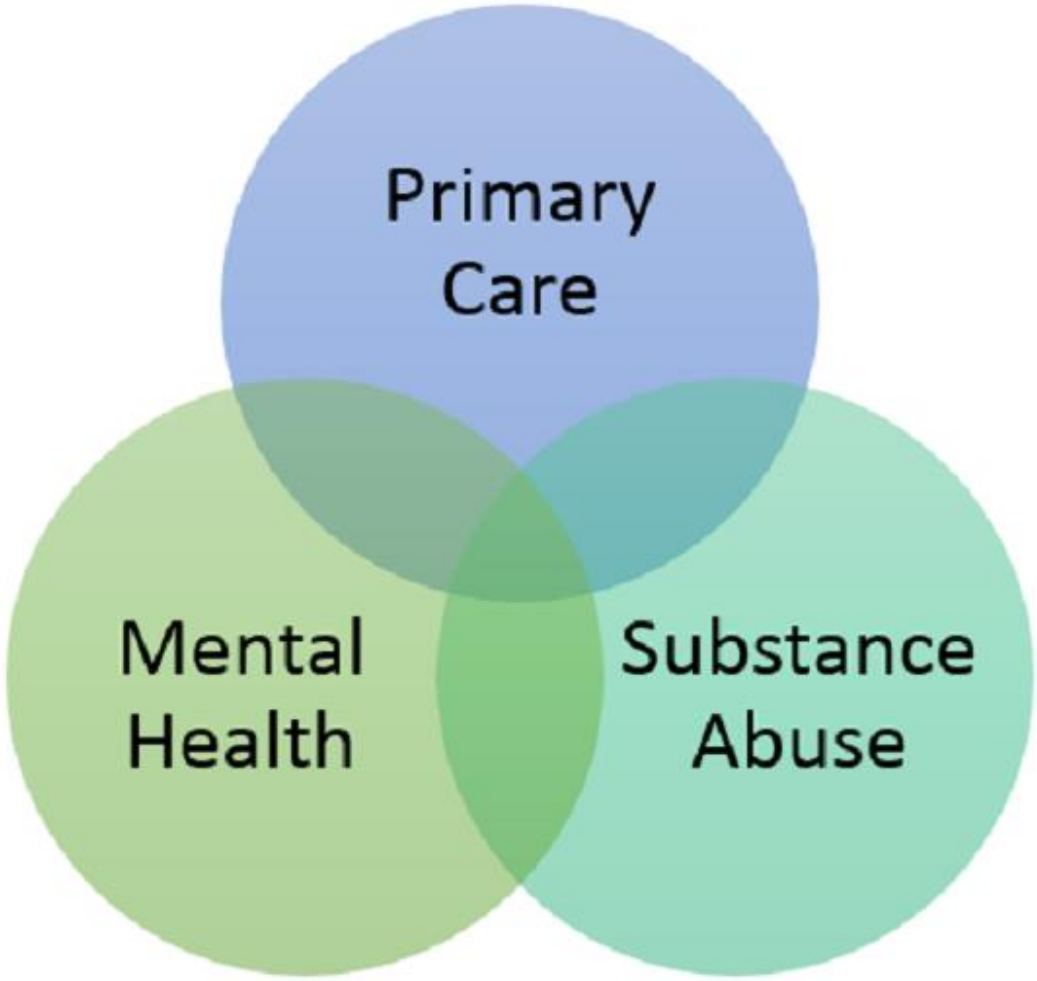
- Consider diagnosis and symptoms
- How does this affect client's ability to manage activities of daily living?

Medical

- Assessments can be formal or informal
- Often need to be connected to care

Psychosocial

- Do they have a support system?
- Are they connected to a community?



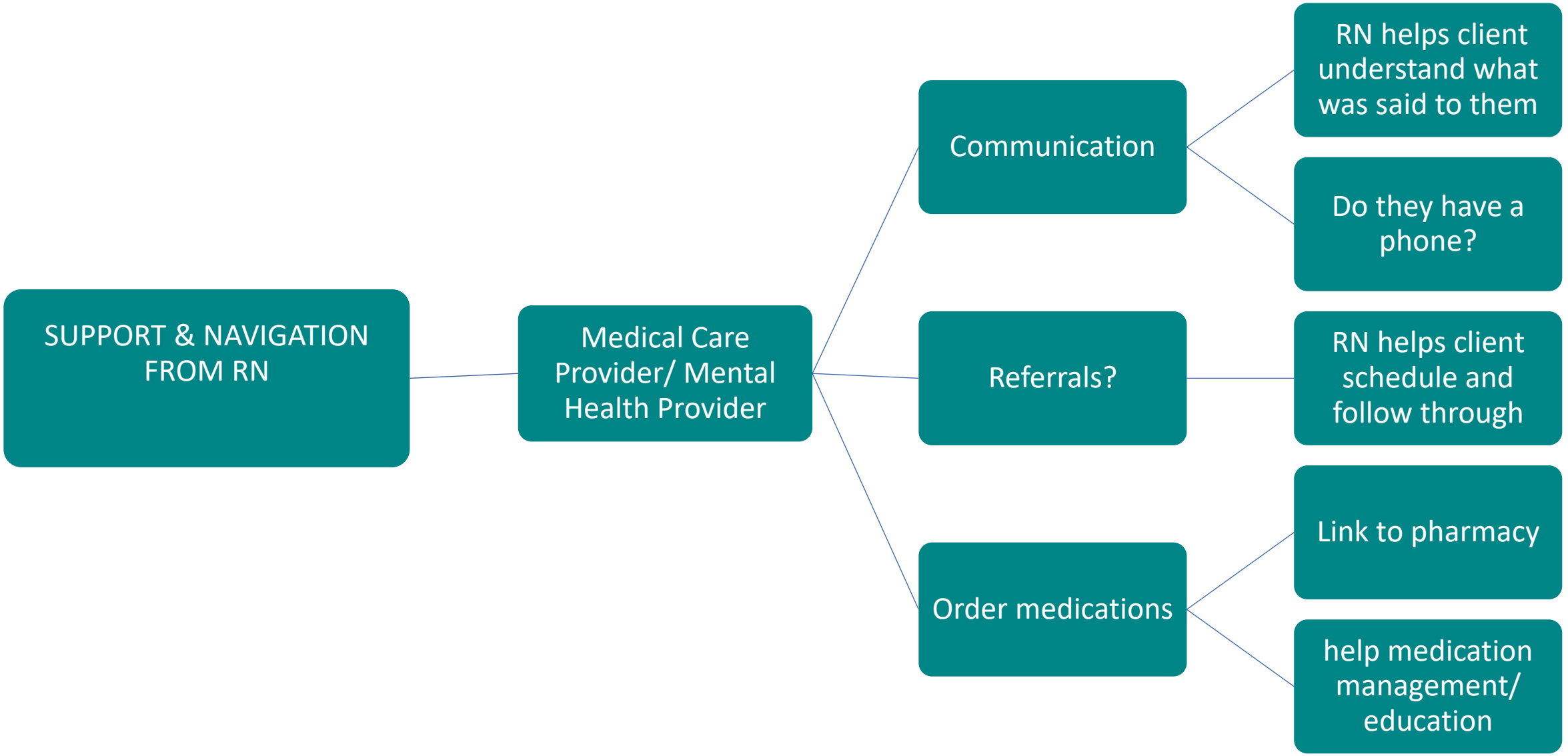
HOW CCH RN'S FUNCTION ON ACT TEAM

- Build rapport
  - Can be done during medical and non-medical activities
- Link to care
  - Primary and specialty
- Assess needs
  - On-going
- Monitor status
- Educate
  - Clients and other ACT team members

LINKING CLIENTS TO CARE

- Nurse/client recognizes need
- RN encourages clients to link to care
- RN helps clients establish/ re-establish care with medical/ mental health provider
- Assesses client's ability to follow through linkage to health care and provides higher level of support if necessary

LINKING CLIENTS TO CARE



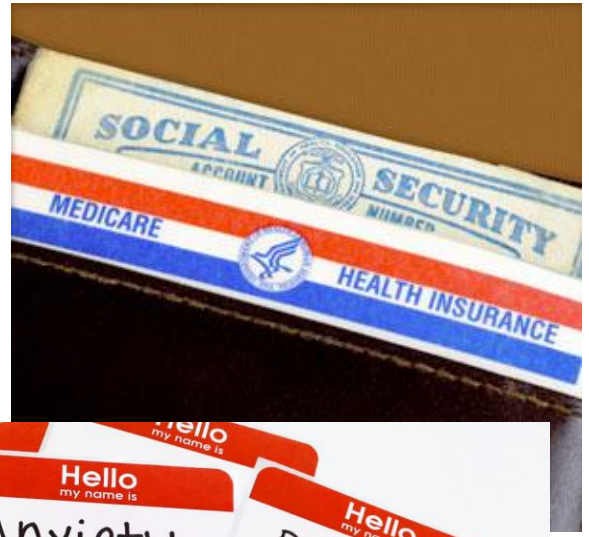
ADVOCATING FOR CLIENTS HEALTH & PATIENT EDUCATION

- Help provider build relationship with client
  - Providers may not be aware of MH & trauma history underlying some of their health behaviors and related
  - Stigma surrounding the homeless
  - Being understanding of barriers
- Health education at appropriate level for client

Potential Challenges and Ways we Overcome Obstacles for Housing First ACT Team Nurses

Challenges

- Clients with mental health conditions following a medical plan of care
- Obtaining benefits like Health Insurance, Food Stamps, and Social Security Disability
- Getting clients an appropriate level of care



Personal Barriers

Domestic Violence

Family Break-up

Mental Illness

Unexpected
or Expensive Bills

Job Loss

Physical Disability

Eviction

Substance Use
Disorder

Broken Systems

Minimum Wage
vs Cost of Living

Generational
Poverty

Access to
Healthcare

Job
Opportunities

Discrimination

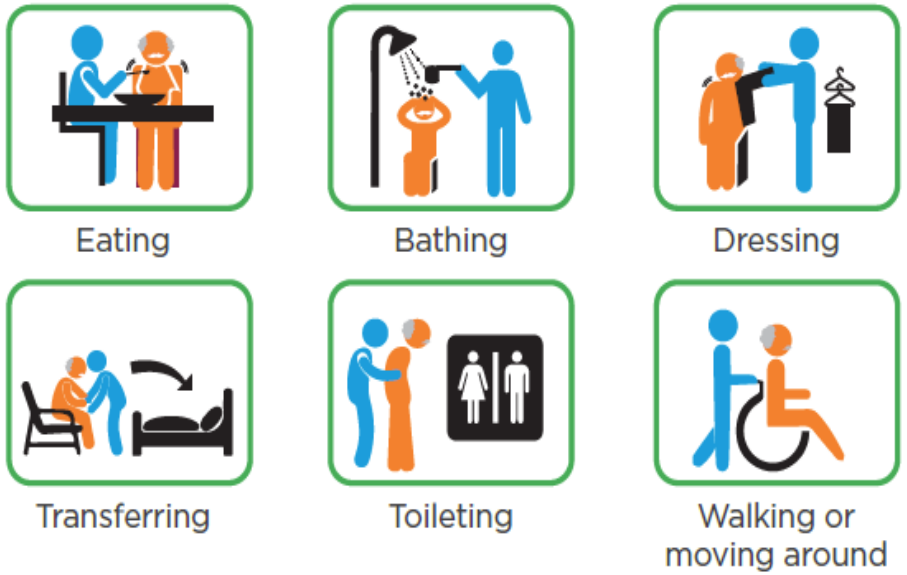
Criminal Justice
System

Affordable
Housing
Shortage

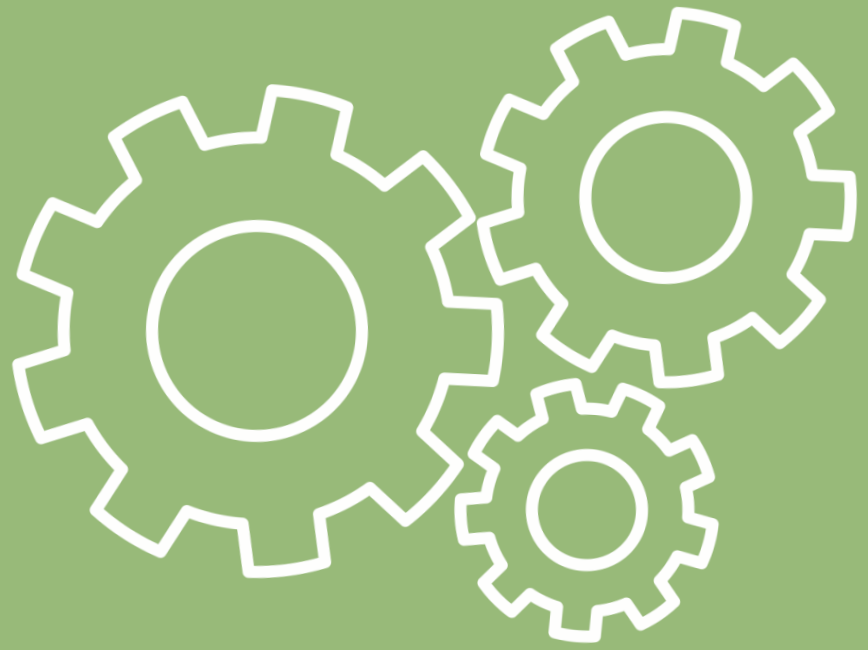
OBTAINING BENEFITS

- Process is difficult for everyone
  - Paperwork is complex and training is often needed but not available
  - It takes a large amount of time to schedule/attend appointments, complete applications and follow up
  - Completing the paperwork and attending appointments is stressful for client
    - Clients have histories of being mistreated/turned down previously
    - Crowded waiting rooms are a trigger for many individuals
    - Providing large amounts of personal information can be a trigger
  - Correspondence is done through the mail
    - What if clients do not have an address?
    - Will the clients open and understand the mail?
- Is trying to get benefits even worth it?
- Whose priority should helping with benefits be?

- Determining appropriate level of care is difficult
  - Weighing client's priorities vs. our priorities for appropriate care
  - Clients want to be seen and capable
    - They hide functioning difficulties from service providers
    - They provide inaccurate information during assessments
  - Cognitive assessments are often needed but not available
    - We can do basic testing like SLUMS
    - Neuropsychiatric testing is difficult to obtain
- Getting clients to understand need is hard
  - Clients opposed to increased services due to financial reasons
    - Pay most of income for Assisted Living and Nursing Facility
  - Clients with dementia or cognitive difficulties don't understand need
    - Getting client tested for competency is hard
- Applying for LTC Medicaid is a long and difficult process
  - Must complete application correctly
  - Must complete functional assessment
  - If approved need to find service providers



GETTING APPROPRIATE LEVELS OF CARE



Ways to Integrate Community Health Resources Into Everyday Client Care

BUILDING TRUSING RELATIONSHIPS AND PARTNERSHIPS

- Accompany clients to appointments, and coordinate with providers to see clients in their home
- Contribute relevant health and social information with client's permission to give a clear picture of client's needs
- Coordinate with outside clinics and act as liaison between all providers across various health systems

COORDINATION WITH HOME AGENCIES

- Identify clients needing extra support at home
- Educate client on services available in the community to assist with higher level of needs
- Coordinate with home-based agencies to ensure client is assessed for services
- Advocate for client's needs with agency staff
- Continue to be liaison between client and home-based agency providing services
- Coordinate transfers of care and discharges from services/hospitals

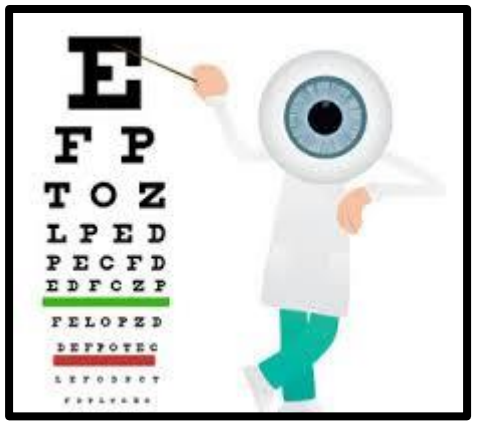
PALLIATIVE CARE / HOSPICE CARE

- Assist client with understanding what these services provide
- Engage client in end-of-life conversation in order to identify client wishes and needs
- Coordinate with Palliative Care/Hospice team to assist with linking client to services
- Advocate, on an ongoing basis, for client's wishes, and work with outside team to overcome any barriers to service

BUILDING RELATIONSHIPS WITH LOCAL COMMUNITY CLINICS AND INTEGRATING HEALTH SERVICES

Face-to-face visits with clients/providers and phone calls to providers to explain our services and how we can support treatment needs

Educate Clients-about our services and how we can assist with care coordination and appointments to other integrated health services at CCH



COLLABORATION WITH STOUT STREET HEALTH CENTER TO MONITOR AND PREVENT RE-HOSPILIZATIONS/ ER VISITS

- Monthly Collaboration Meetings
- CORHIO-Colorado Regional Health Information Organization
- Coordinate PCP/Psychiatric provider post hospital follow-up appointments at SSHC/WEHC
- Coordinate with FNP/Psych provider to outreach and see patients who are not coming in for follow-up

- SSHC Patient Centered Medical Home