TOWARDS A VISION OF INTEGRATED CARE: PUTTING HEALTH CARE IN CONTEXT

Delta Center Convening

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Central City Concern

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Objectives

- Using homelessness as an example, understand the role of health care in the context of structural drivers of a major social issue
- Familiarize ourselves with a model to segment and support populations affected by homelessness
- Discuss barriers and opportunities to develop integrated models to support these populations

Putting our Care in Context

Affordable Housing
Meaningful Wage Employment
Structural Racism
Substance Use Disorders

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How's it going?

"The barrier to change is not too little caring; it is too much complexity."

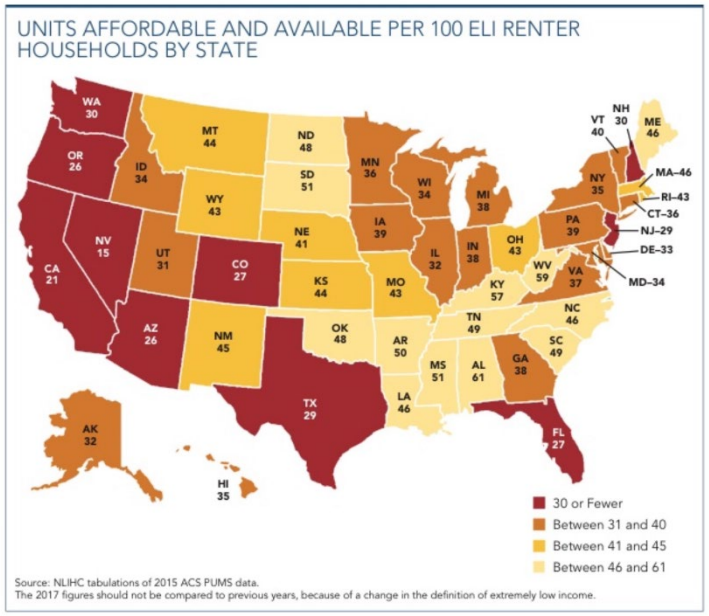
What Do We Mean by Complexity?

How many of your CHC's and CMHC's take care of patients who struggle with…

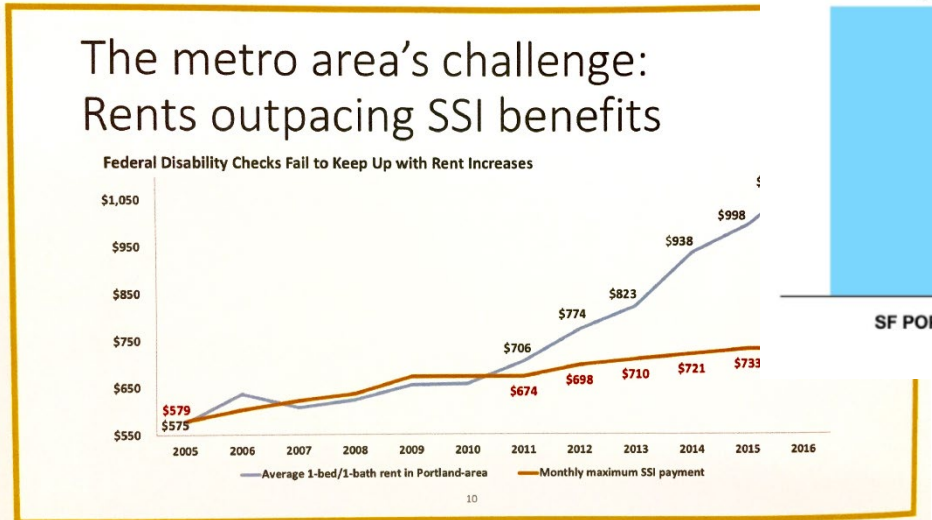
- **Paying their rent?**
- **Finding a job that pays the bills?**
- **Encountering racism and discrimination?**
- **Facing barriers because of a criminal history?**
- **Using alcohol or drugs for physical or psychological safety?**
- **An inter-generational story of poverty and trauma?**
- **Profound isolation and loneliness?**

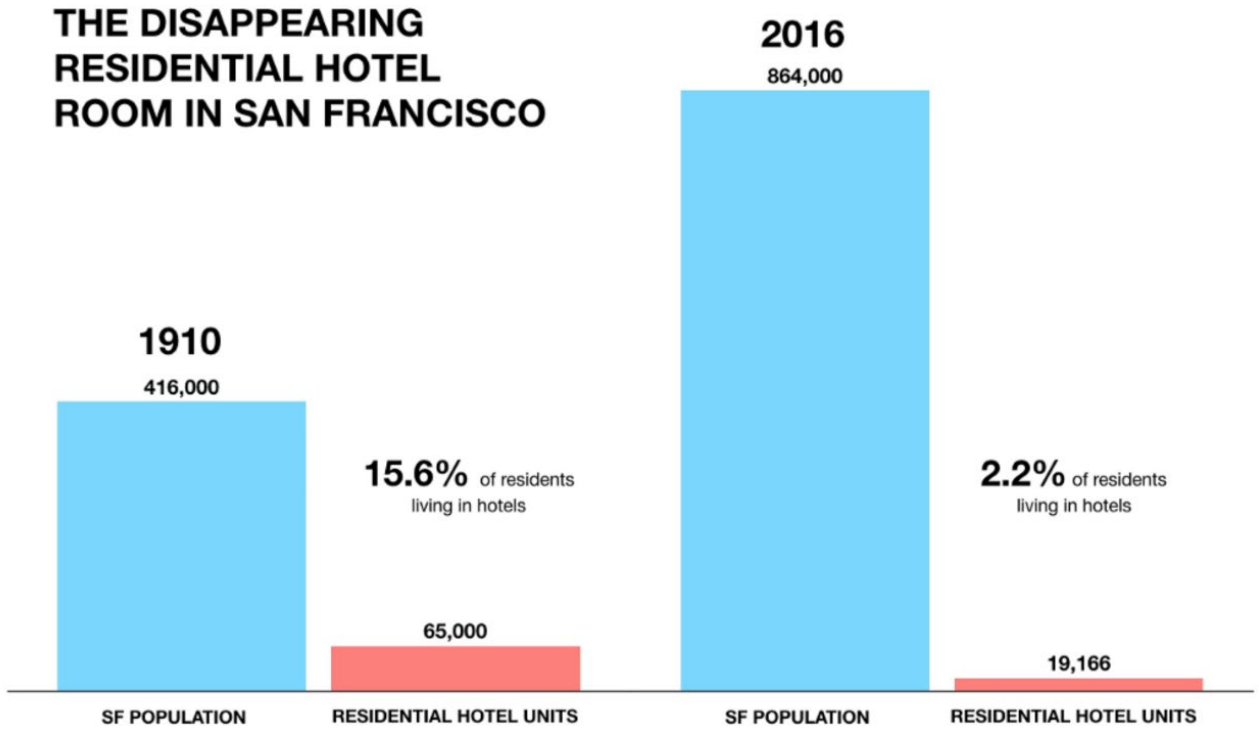
Do the staff in your centers struggle with some or many of these same things?

Absence of Affordable Housing



Income vs Rent





Sources: Paul Groth, *Living Downtown*; Bay Area Census; US Census Bureau; SF Planning Dept. *2015 San Francisco Housing Inventory*. Courtesy: Panoramic Interests

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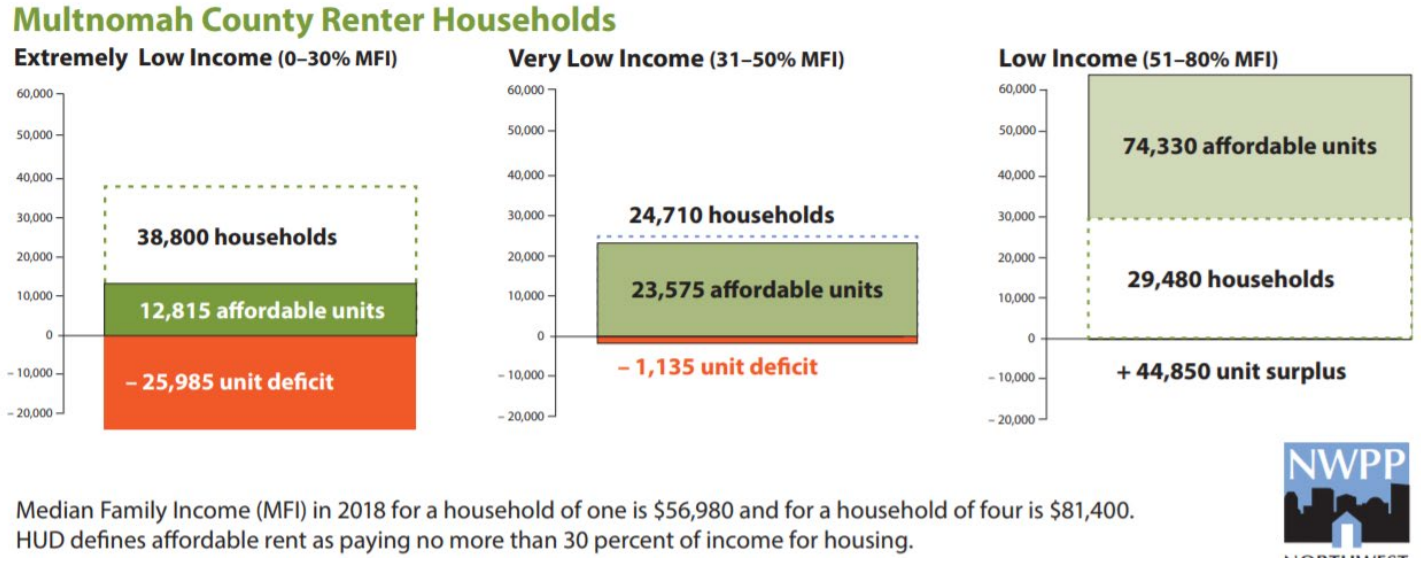
Absence of Affordable Housing

What We Need



Median Family Income (MFI) in 2018 for a household of one is $56,980 and for a household of four is $81,400.
HUD defines affordable rent as paying no more than 30 percent of income for housing.

What We Build

- Market: 4,669 units under construction.
  - .5% affordable at 60% MFI.

2015: City of Portland produced 182 units of affordable housing.

174 were at 60%

8 were at 0-30%

Prior three years: Averaging 300 units per year

Over 90% of delivered at 50%MFI or above.

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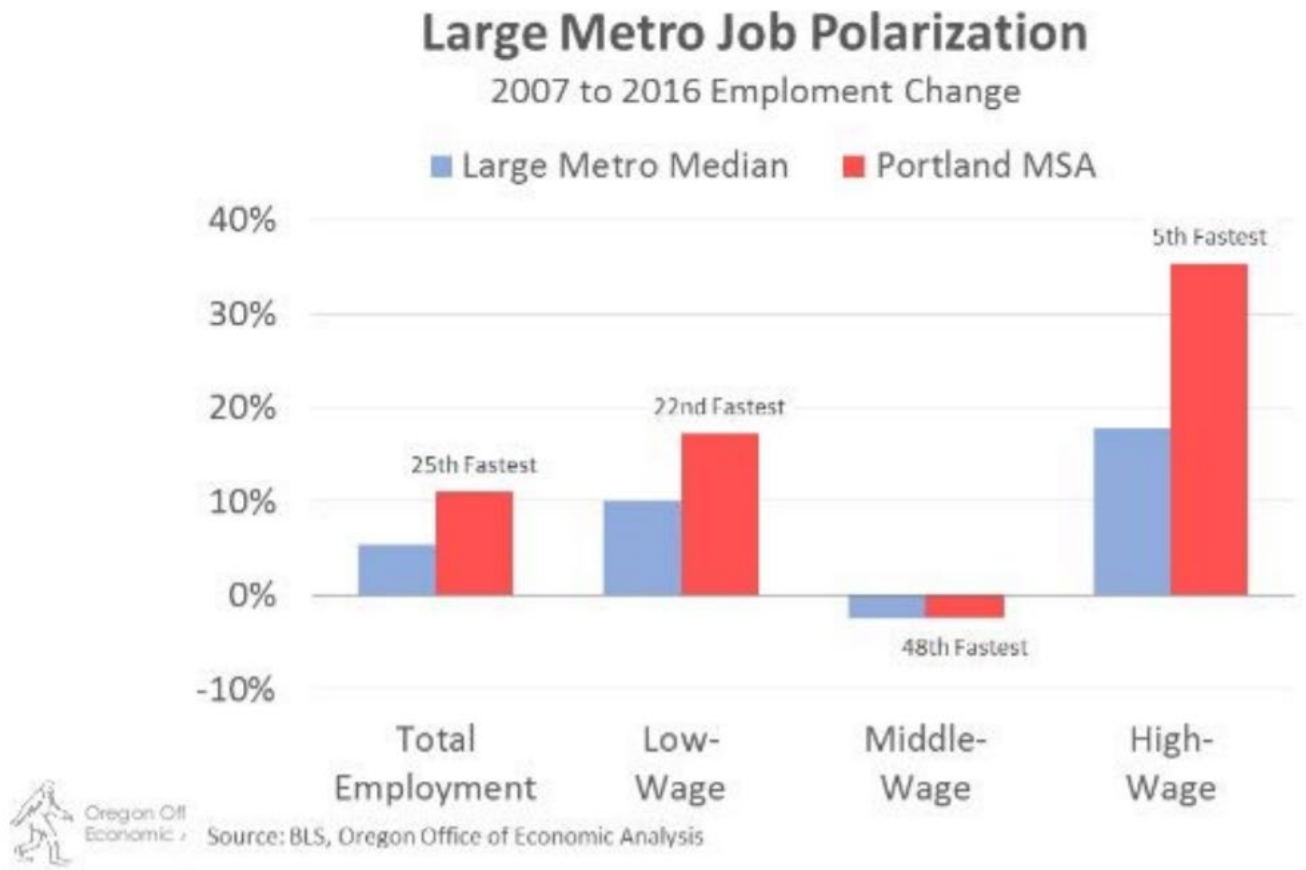
Absence of Meaningful Wage Jobs



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Structural Racism and Discrimination

Figure 1: Rate of incarceration in jail per 1,000 individuals, June 30, 2014

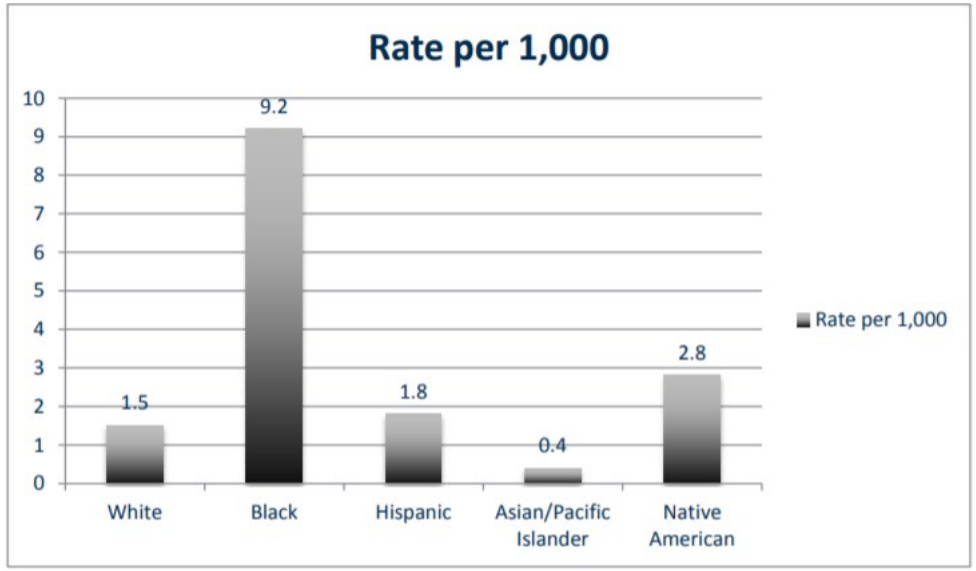
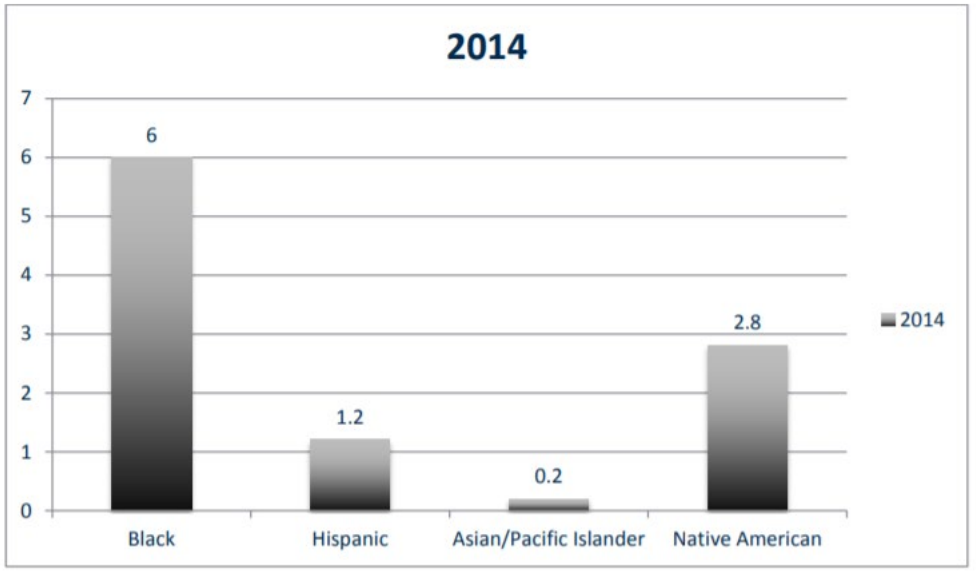


Figure 2: Relative Rate Index (RRI) of the Multnomah County Jail Population, 2014



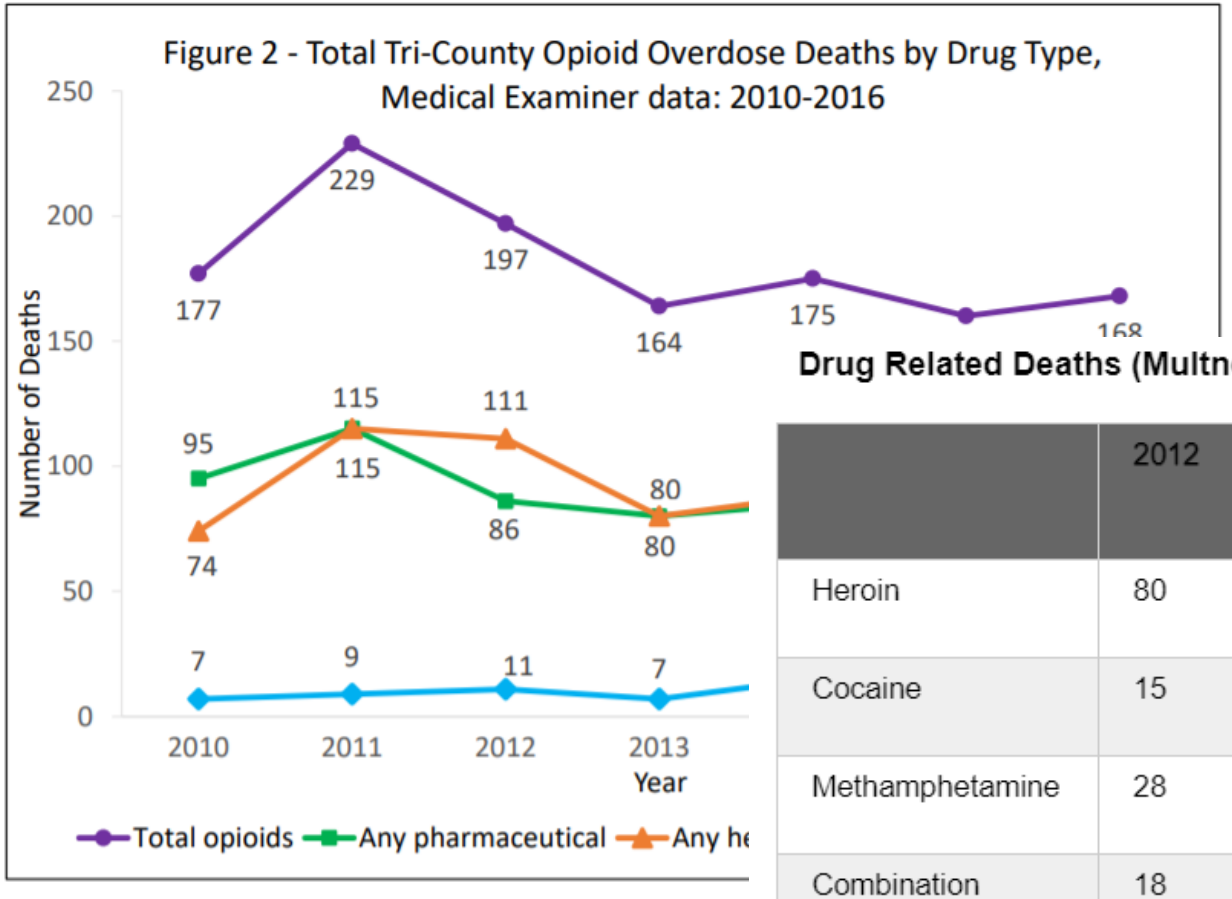
For every 1,000 White adults in Multnomah County, there are 1.5 White adults in jail.
For every 1,000 Black adults in Multnomah County, there are 9.2 AA adults in jail.

AA adults are 6.0 times more likely than Whites to be in jail (9.2/1.5 = 6.0)
Native Americans are 1.8 times more likely than Whites to be in jail

A study in 2015 found that African Americans in Oregon were convicted of felony drug possession at more than double the rate of white offenders.

Ferguson J. Safety + Justice Challenge. https://multco.us/file/48681/download

OPIOIDS AND METHAMPHETAMINES



Tri-County Opioid Safet

Drug Related Deaths (Multnomah County)

	2012	2013	2014	2015	2016	Five year Trend
Heroin	80	65	54	48	64	-20%
Cocaine	15	9	10	19	20	+33%
Methamphetamine	28	45	35	60	70	+150%
Combination	18	18	14	24	32	+78%
Total	103	102	85	103	121	+17%

Source: Oregon State Police, Medical Examiner Division.

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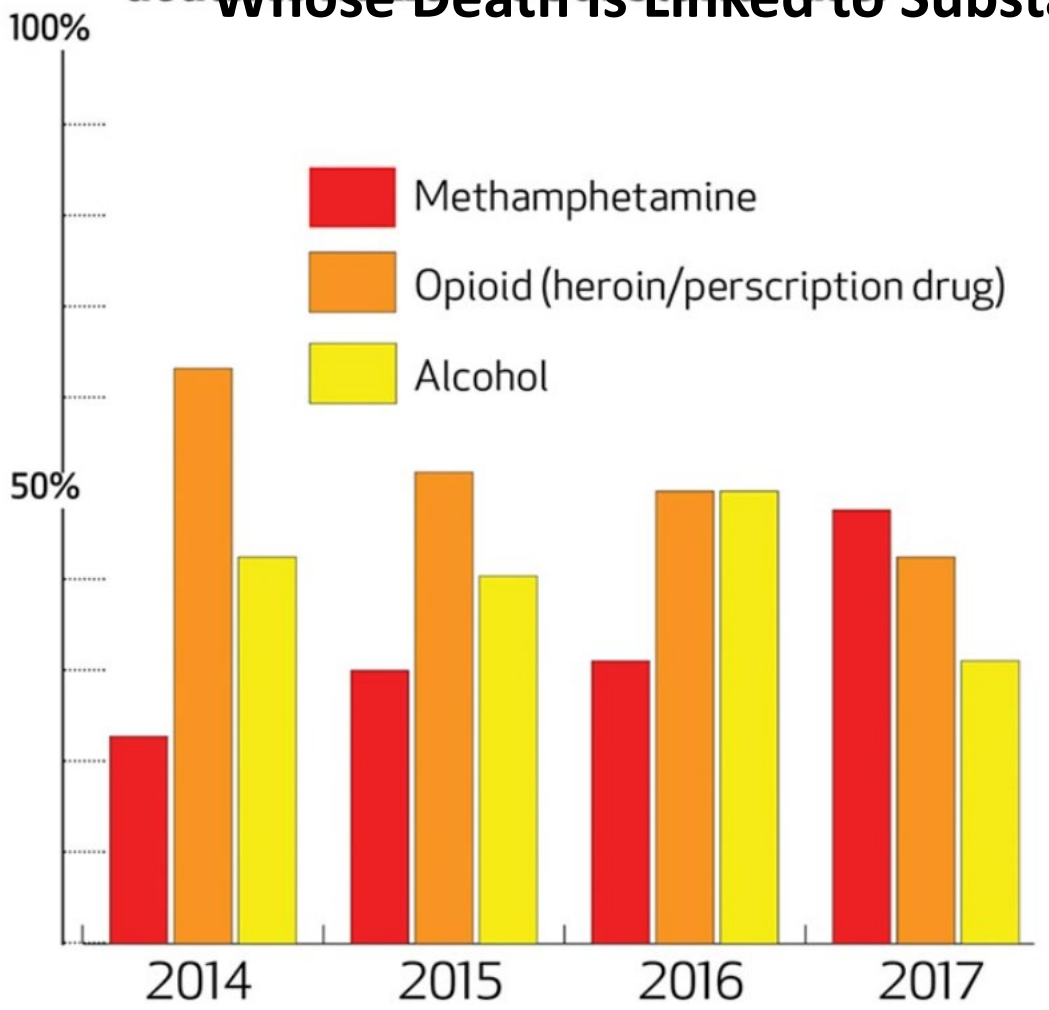
RISE IN METH-RELATED DEATHS AMONG HOMELESS

Cause of Death for Homeless People in Multnomah County Whose Death Is Linked to Substance Use



SOURCE: MULTNOMAH COUNTY MEDICAL EXAMINER

"Meth helps me stay awake so I have less chance of being victimized on the street."

"I started using meth at age 13. It would help me stay awake until my abusive stepdad went to sleep."

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So what are we talking about?

What we are trying to address in physical and behavioral care is often the culmination of many factors

1. **Identify the problem(s) you are trying to solve…you will likely need to do considerable segmentation**
2. **Consider the structural factors that drive that problem**
3. **As you design, implement and improve these models, think about if and how you are addressing those structural drivers**
4. **In addressing those drivers, ask yourself: is a traditional CHC or CMHC best equipped to address these drivers? If not, who is better equipped to do this, and how can we support them?**

Examples

Brief Overview of Central City Concern

The Imani Center + Flip the Script

Fourth Dimension

The SUMMIT Team

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WHAT DRIVES HOMELESSNESS?

Individual Factors

Early childhood adverse experiences

Serious Mental Illness

Substance use disorders

Personal history of violence

Youth: family conflict and victimizations, non-heterosexual sexual identify, having been in the childhood welfare system

Criminal justice system interaction

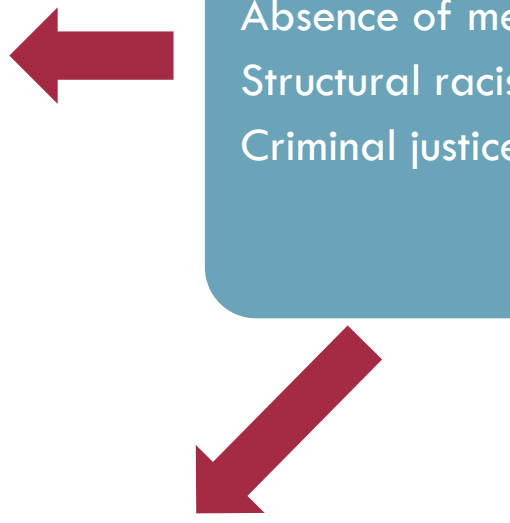
Structural Factors*

Absence of affordable housing

Absence of meaningful-wage employment

Structural racism and discrimination

Criminal justice system



*When structural factors become more pronounced, individuals with fewer individual vulnerabilities become homeless and rates of homelessness rise

Fazel et al *Lancet* 2014

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CENTRAL CITY CONCERN'S APPROACH

Direct access to housing which supports lifestyle change.

Integrated health care services that are highly effective in engaging people who are often alienated from mainstream systems.

HOMELESSNESS

Individual Factors	Structural Factors

Attainment of income through employment and/or accessing benefits.

The development of peer relationships that nurture and support personal transformation and recovery.

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EXAMPLE 1:

- African-Americans are over-represented among homeless in Multnomah County by a factor of 2 (16.2% vs 7%):
  - Mass incarceration of people of color
    - More difficult to get housing & employment upon re-entry
      - More difficult to engage in SUD and mental health care
        - Mainstream care is not culturally responsive
          - Higher rates of recidivism

FLIP THE SCRIPT

A partnership between Employment, Housing and Criminal Justice partners

Culturally specific program for African-American men and women exiting incarceration

Goals of FTS:

1. Reduce racial disparities in reentry service outcomes (employment, average income at exit, and rent-responsible housing)

2. Engage AA participants in advocacy to identify common struggles and needed system changes

3. Reduce recidivism overall, and eliminate disparate rates of recidivism between racial and ethnic groups

4. Demonstrate a positive return on investment for the community.

Flip The Script Staff, left to right: Advocacy Coordinator Billy Anfield, Housing Specialist Lisa Bonner Brown, Employment Specialist David Jefferson, and Peer Support Specialist Ronald Williams.

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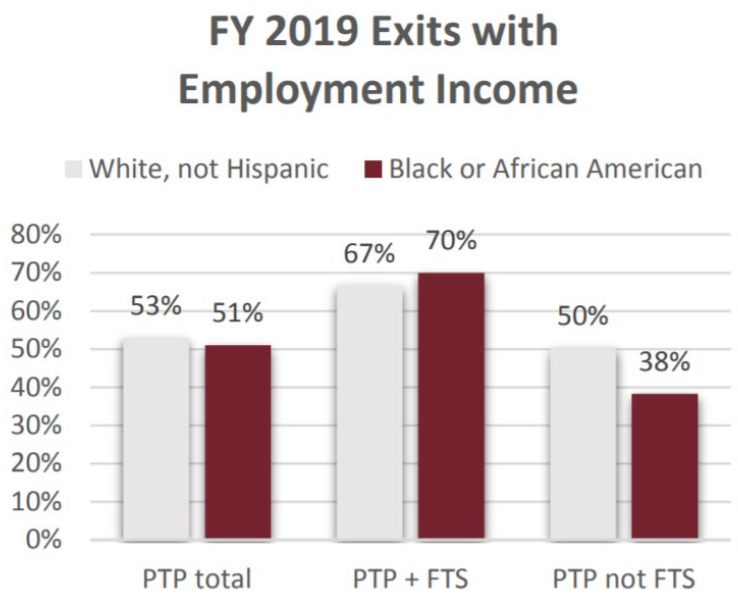
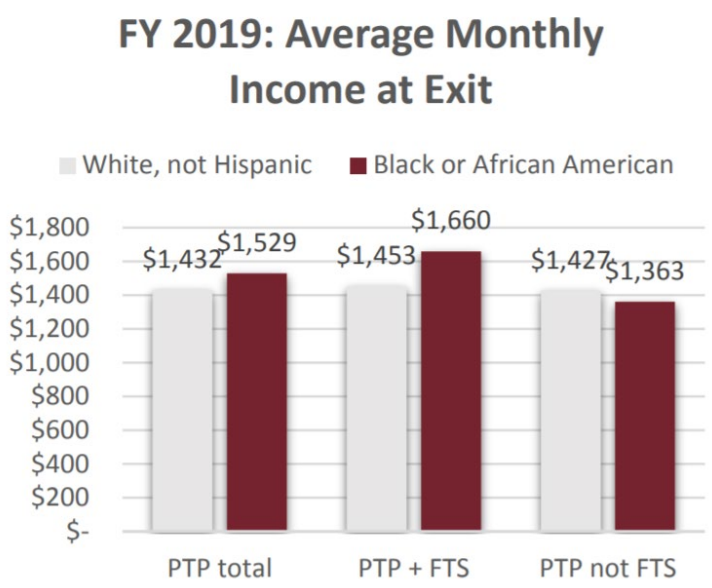
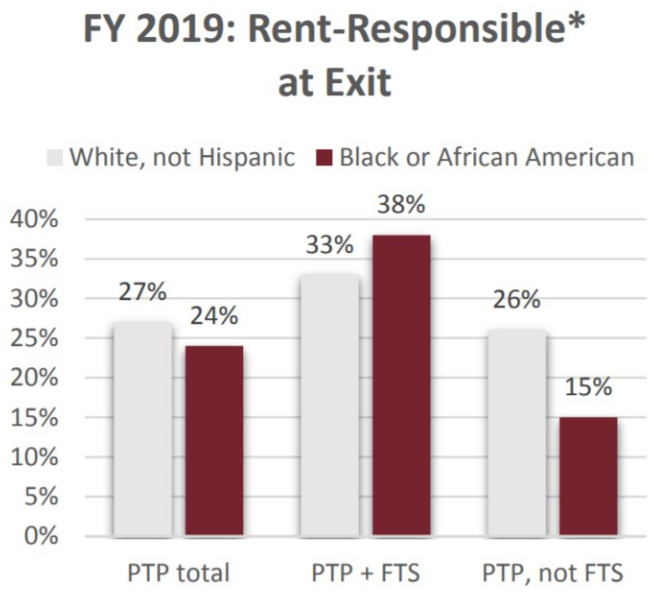
Flip the Script Outcomes







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Flip the Script Advocacy: What the Clients Said

1. Lack of affordable housing outside of former neighborhoods
2. Pre-Release services – improve connection to reentry resources
3. Enhance culturally specific and trauma informed parole & probation supervision
4. 4. Mental health assessment and medication access upon release
5. Connection to substance use disorder treatment upon release

Representative Jennifer Williamson listens to recommendations from FTS Advocacy Team member Patrick A.

Senator Ginny Burdick (center) with FTS Advocacy Work Team members, CCC's Peer Support Specialist Ronald Williams (left), Community Outreach Coordinator Gary Cobb (second from right) and FTS Advocacy Coordinator Billy Anfield (right).

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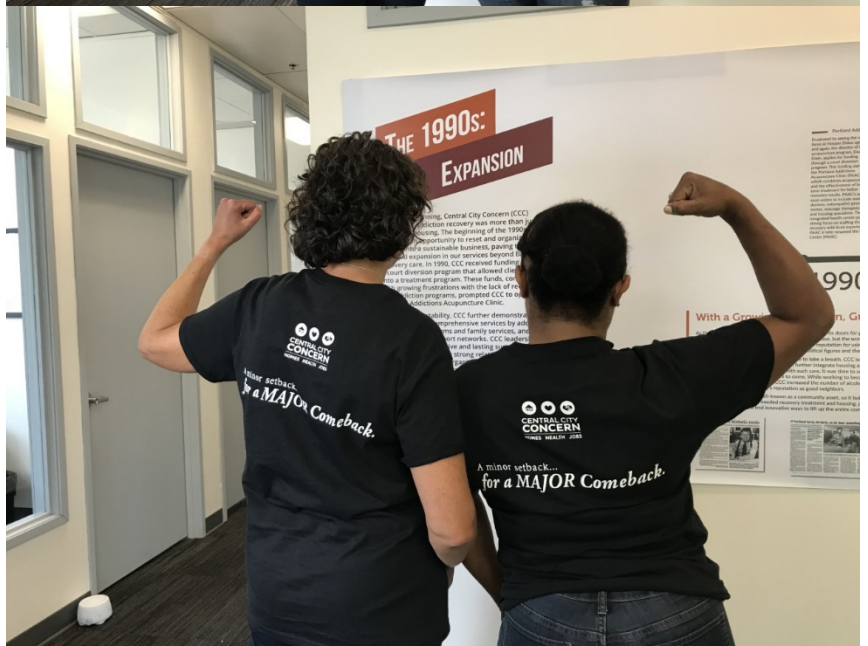
How to Fund Flip the Script?

- **Developed community of stakeholders:**
  - Joint Office of Homeless Services (City and County)
  - Department of Community Justice
  - Meyer Memorial Trust
  - Department of Corrections
- **These partners developed funding and data model**



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EXAMPLE 1:

- African-Americans are over-represented among homeless in Multnomah County by a factor of 2 (16.2% vs 7%):
  - Increased rates of incarceration
    - More difficult to get housing & employment
      - More difficult to engage in SUD and mental health care
        - Mainstream care is not culturally responsive
          - Higher rates of recidivism

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Portland/Multnomah County Point In Time Count, February, 2017

Mainstream Care is not Culturally Responsive Care

Treatment among communities of color is hindered by:

- Historical distrust of mainstream medical institutions
- Relative lack of treatment professionals from communities of color
- Culturally inappropriate settings and protocols
- Geographic distribution of treatment centers, even within metropolitan areas
- Complexities of enrolling in and using insurance

Treatment among communities of color is facilitated by:

- Investment in culturally-specific organizations
- Development of workforce that reflects served community
- Culturally appropriate settings and protocols (eg. longer duration of treatment, focus on intersection of race/culture, identity, oppression and resilience)
- Geographic distribution of treatment centers, even within metropolitan areas
- Community-based outreach

Substance Use Disorders in Oregon – Prevention, Treatment & Recovery.
Oregon Substance Use Disorder Research Committee, November 2017

The Imani Center at CCC

Cultural Healing
This group will explore cultural heritage issues pertaining to the African and African American experience as it relates to mental health and addiction, with particular emphasis on culturally specific themes. Specifically, the Cultural Healing Group will use the Creating Safe Spaces curriculum which is a trauma-informed, culturally specific mental health curriculum, as well as other teaching methods to present the group materials.

What's Your Plan
This group is centered on the idea that in order to be successful in recovery clients must have a plan. In this group, clients will learn how to write out their weekly plan for recovery with particular emphasis placed on their Care Plans. Clients will also learn new skills each week to support daily success.

Seeking Safety
This is a trauma and recovery group which focuses on Cognitive Behavioral Therapy as a central part of group therapy treatment. Seeking Safety is an evidenced-based curriculum that teaches clients a wide array of safe coping skills including but not limited to how to manage PTSD symptoms, cope with emotional pain through grounding techniques, and identify characteristics of safe and healthy relationships.

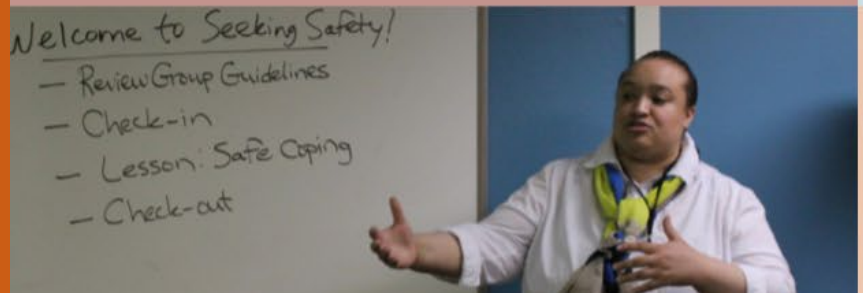
Soulful & Centered Moments
The purpose of this group is to reduce clients' stress and anxiety through teaching the practice of Mindfulness-Based Stress Reduction, which is an evidence-based treatment modality. Mindfulness-Based Stress Reduction was originally developed by Jon Kabat-Zinn and has been proven to produce positive health benefits and positive mental health outcomes in those that practice daily.

F.O.C.U.S.
The F.O.C.U.S. (Freeing Ourselves from Careless hostility and Understanding Systemic racism) group assists clients in learning Dialectical Behavior Therapy skills to effectively manage their anger from the Anger Management Workbook on the following areas: Investigating Attitudes About Anger, A New Perspective on Anger, Acknowledging Complexities of Anger, and Changing Your Experience of Anger. The group also uses the Getting Control of Yourself video. Each passage has a brief video segment that accompanies it and a lesson on Post Traumatic Slave Syndrome (PTSS), which explores the impact that intergenerational trauma and racism has had on African American people. The F.O.C.U.S. group discusses PTSS particularly as it relates to unresolved anger issues.

Empower You
This group is a Relapse Prevention-focused group designed to equip clients with tools to help them remain clean and sober in the community. Even more, this group will to teach clients how to both express and manage their feelings in terms of race regarding entering/ re-entering the workforce, making healthier decisions, and being productive members of society. Specifically, topics covered will be discussed in a culturally sensitive manner with particular focus on relapse prevention.

The Recovery Process
This group is a Relapse Prevention-focused group designed to equip clients with tools to help them remain clean and sober in the community. Even more, this group will teach clients how to both express and manage their feelings in terms of race regarding making healthier decisions and being productive members of society. Specifically, topics covered will be discussed in a culturally sensitive manner with particular focus on relapse prevention and mental health challenges in the early stages of recovery.

Women In Transition
This is a gender-specific group for women only. The group is designed to address both mental health and addictions issues with a strong emphasis on empowerment and connection with each other.



Positive Changes
This group is specifically designed to utilize the Cognitive Self Change model to support clients in learning life skills necessary to decrease their criminogenic factors. In addition, this group teaches additional life skills such as budgeting and renting, and provides clients the opportunity to complete Rent Well.

Men In Transition
This is a gender-specific group for men only. A wide spectrum of topics related to men and recovery will be discussed.

Funding for Imani

- **Relies on more than Medicaid to support staff and care model:**
  - Peer support specialist
  - Housing case manager
  - Longer episodes of care
  - Emphasis on outreach and engagement
- **Worked with Multnomah County to re-purpose General Fund dollars, aligning with their focus on culturally specific behavioral health services**

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EXAMPLE 2

- Unaccompanied youth are increasing in the homeless population (13% increase in 2 years):
  - Many involved in foster care system
    - High degree of trauma
      - Health care (and recovery) networks are not oriented toward needs and culture of youth

Children under the Age of 18	Count 2015	Count 2017	Change
Ages 5 and younger	145	156	11
Ages 6-11	149	134	-15
Ages 12-17	80	92	12
Total	374	382	8

Unaccompanied Youth	Count 2015	Count 2017	Change
Under age 18	5	14	9
Ages 18-24	261	286	25
Total	266	300	34

Portland/Multnomah County Point In Time Count, February, 2017

FOURTH DIMENSION

- Peer-run organization for anyone 13-35 years old
- Low barrier to entry
- “Any time you need a peer, you get one”

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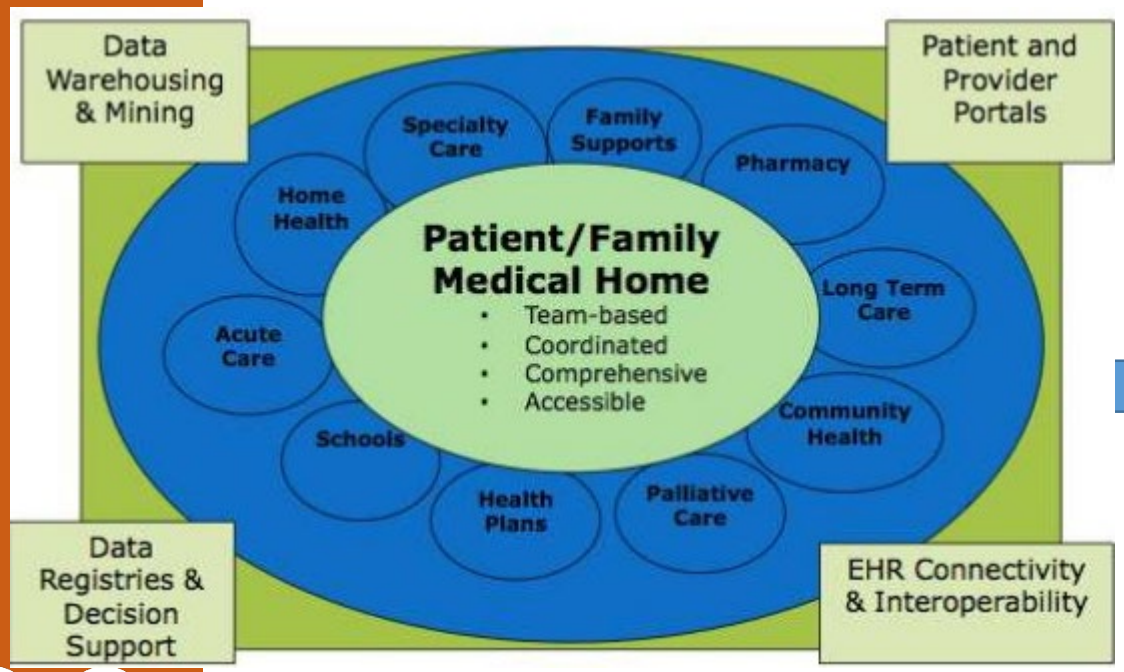
Inverting the health care paradigm…

Health-care Oriented



Recovery-Oriented

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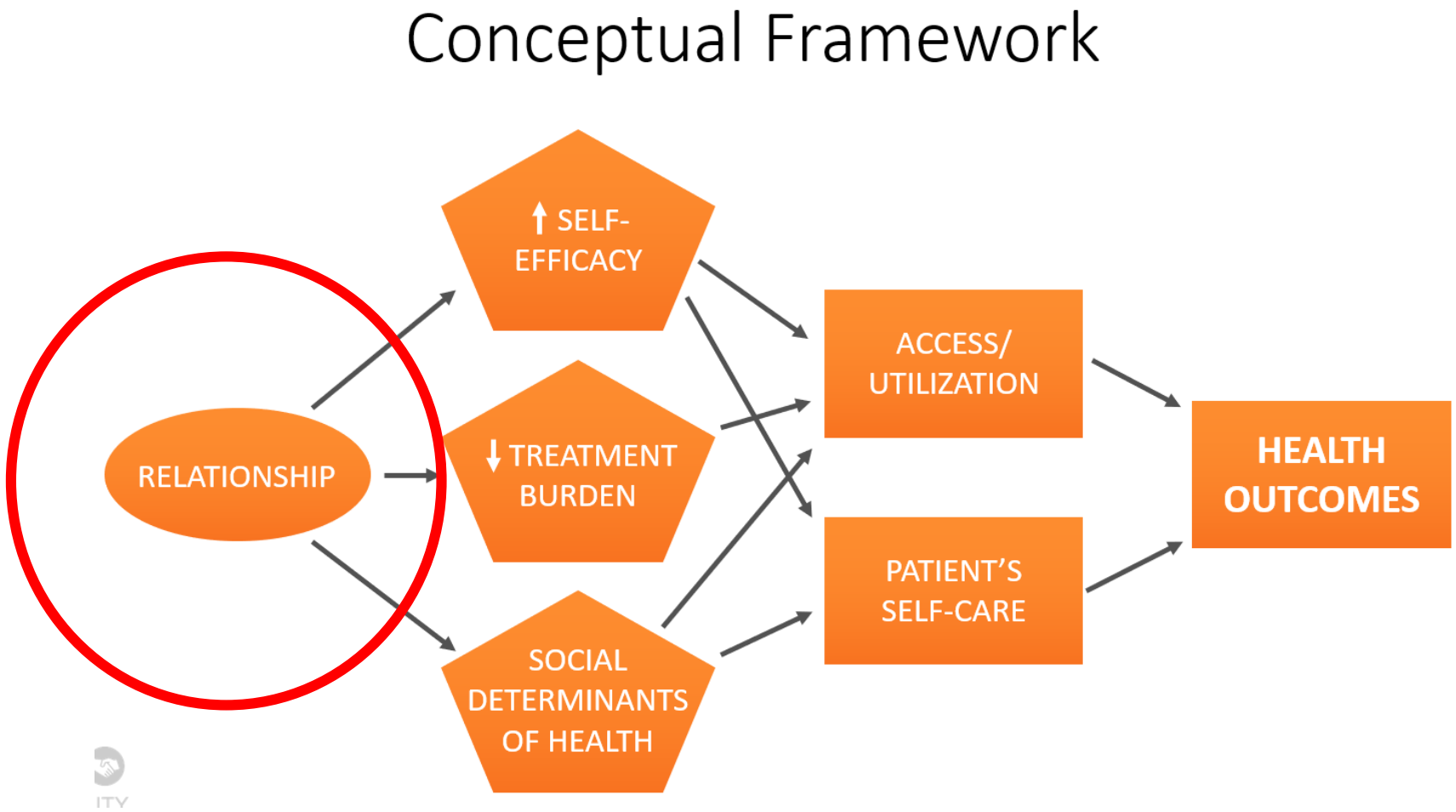
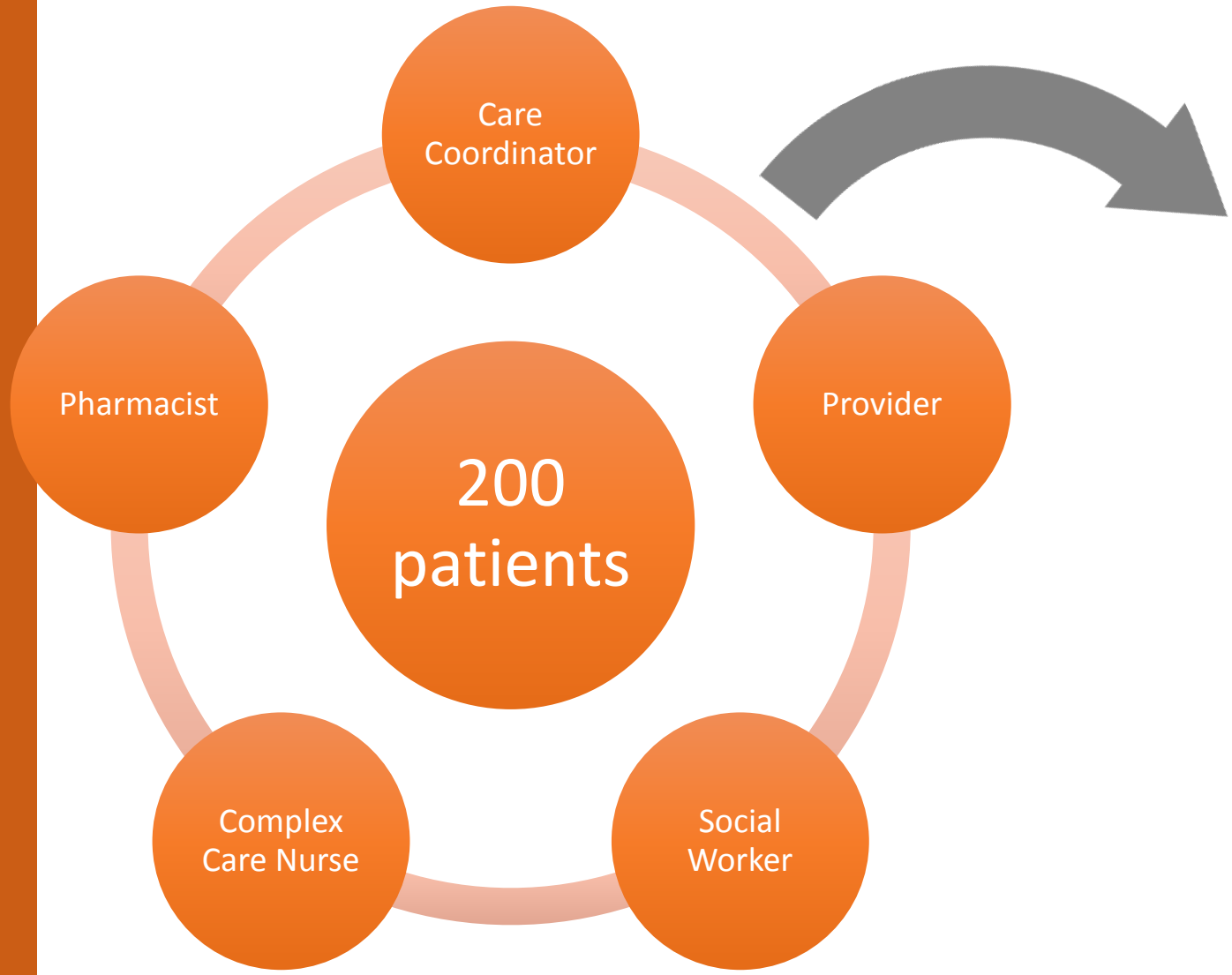
EXAMPLE 3

- **At Old Town Clinic, a Healthcare for the Homeless Clinic, 20% of clinic population have extraordinary degree of medical and behavioral health complexity, with disproportionate utilization of outpatient and inpatient resources**



Summit Team Model



Allows more time to:

- **Build relationships**
- Outreach
- Provide timely support
- Increase access to team
- Smooth transitions of care

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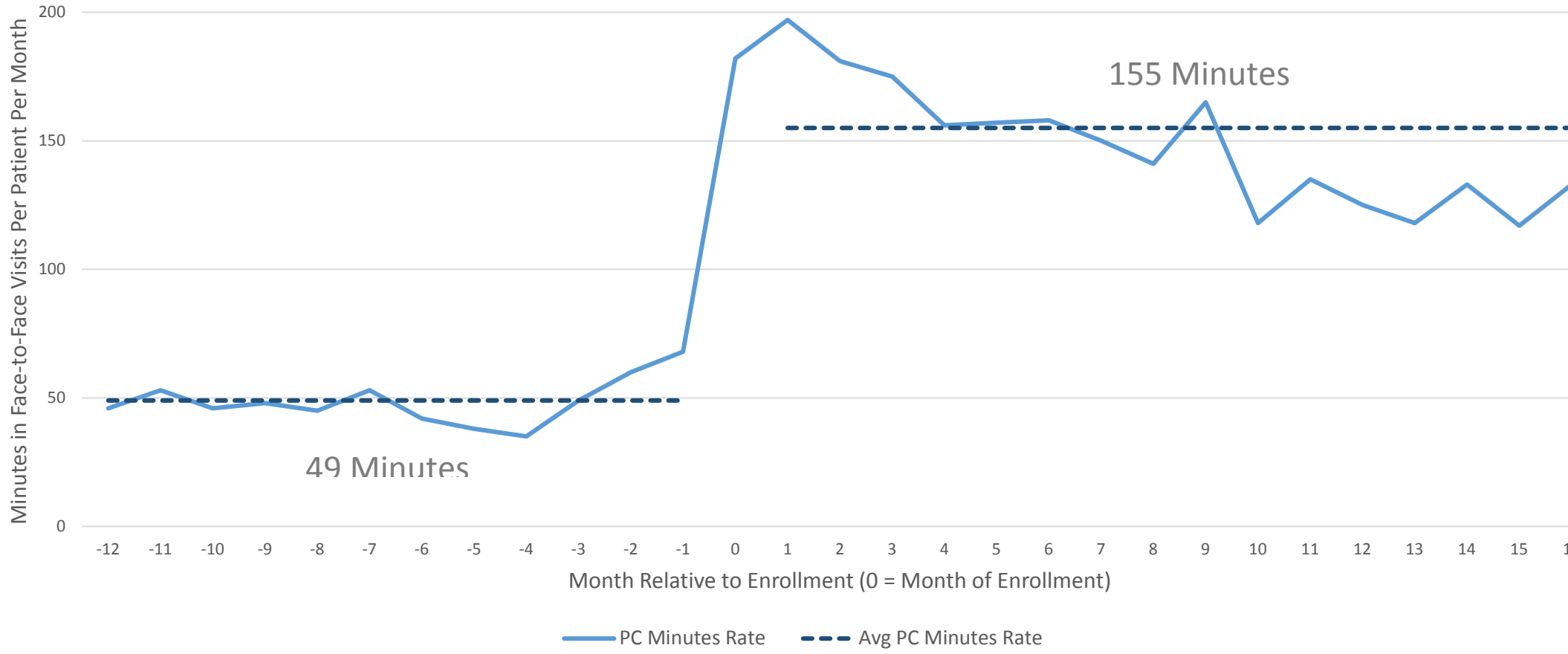
Summit Outcomes: Engagement



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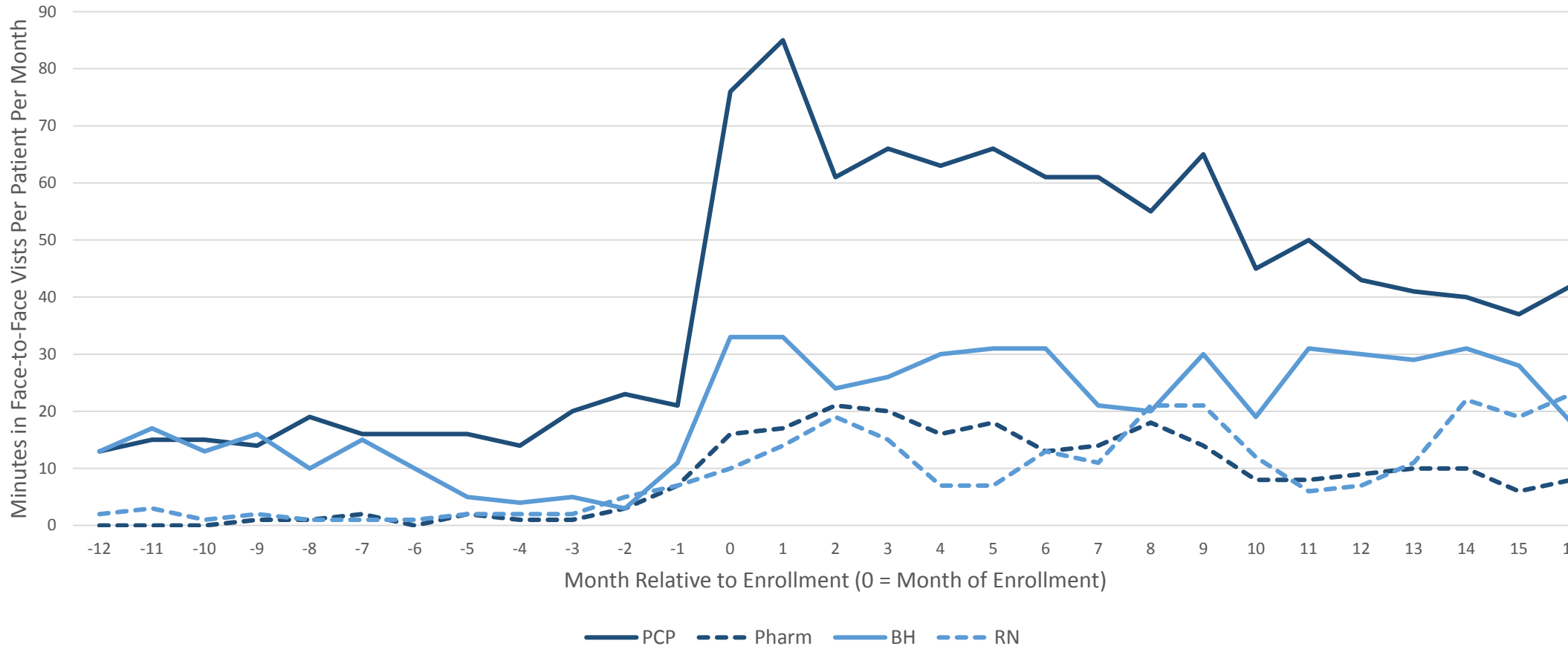
Engagement by Provider Type



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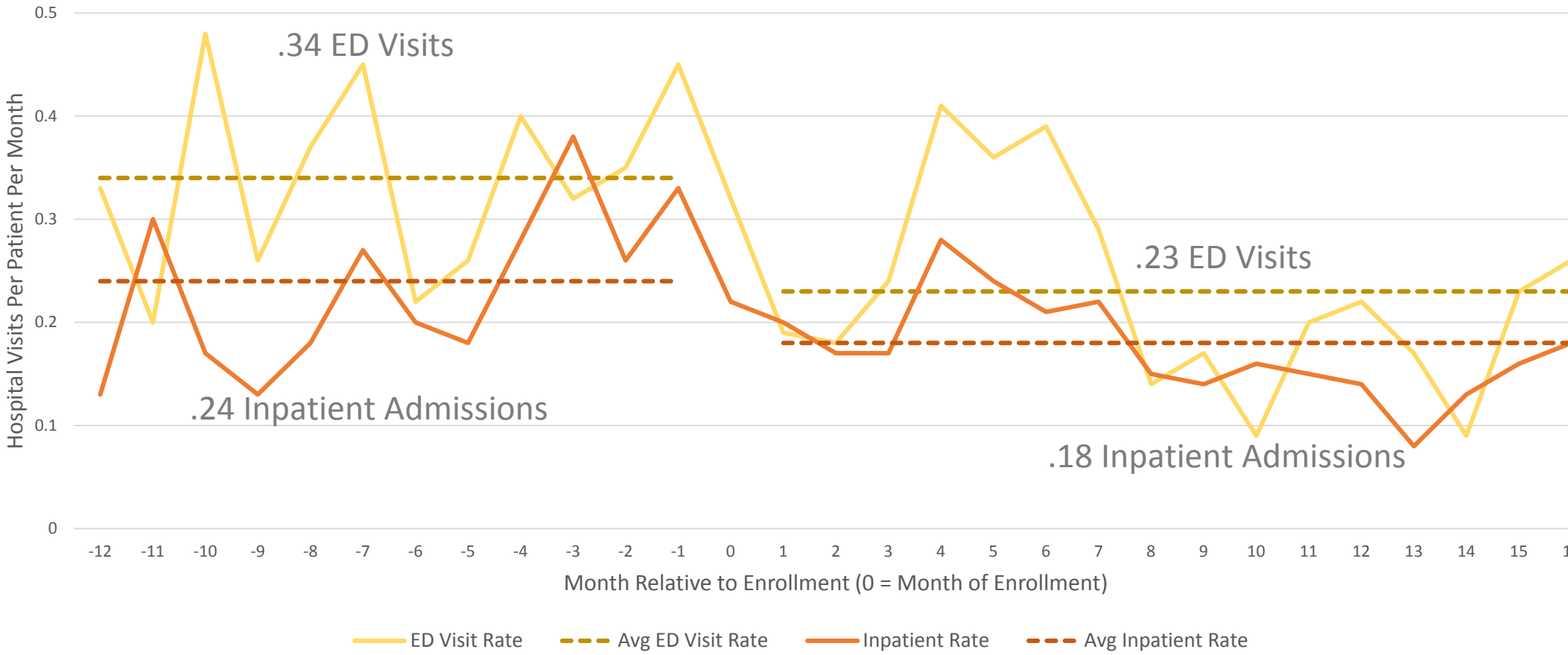
Hospital Utilization: ED Visits and Inpatient Admissions



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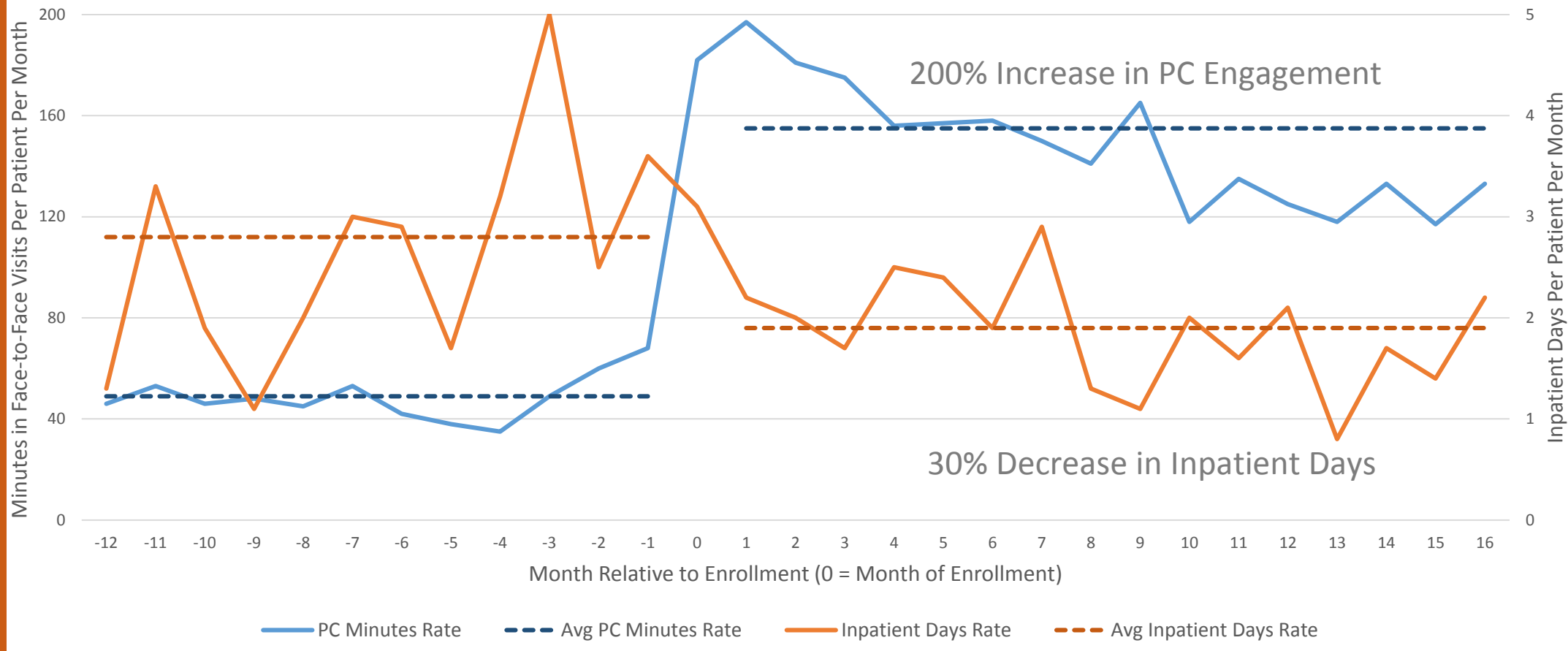
Provider Engagement vs. Hospital Utilization



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Eliminating Barriers to Integration

Payment

Workforce

Language and Power

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Payment Issues/Possible Solutions

- **Structural deficit:**
  - Dependent on shrinking City/County funding for non-Medicaid services (property tax limits, Public Employee Retirement Benefits)
  - Need sustained, flexible revenue sources independent of Medicaid
- **Increased competition in Medicaid market, meaning more administrative burden, less relationship with payer:**
  - Non-profit payers, one per community
- **Value-based payment with mis-aligned outcomes**
  - Index the outcomes of interest to the needs of specific populations
- **No cross-sector value propositions. Who else should be in this room today to address these needs?**

Workforce Issues/Possible Solution

- **Very difficult to find and retain culturally specific providers and staff:**
  - Collaborate with educational institutions and funders to support education and professional development of diverse populations, particularly those that reflect the community you serve
  - Support Diversity, Equity and Inclusion as fundamental to organizational values, program design, training and development
- **Many of our staff are impacted by the same structural and individual forces our patients face:**
  - Collaborate with affordable housing developers or Real Estate Investment Trusts to create affordable workforce housing
  - Invest in job-related training assistance for staff to advance professional development
  - Advocate at state level to remove overly restrictive background checks

Language and Power*

- **The term 'social determinants of health' subordinates and medicalizes structural issues such as poverty, racism and inter-generational trauma:**
  - Use language that puts health care in its appropriate context
  - Center the experience and expertise of those outside health care

- **Community-based organizations are historically neglected or undermined by mainstream health care (even the Safety Net!):**
  - If something in the community is working well, support or divert resources to it; do not attempt to replicate it, poach scarce staff, or create dependence with year-to-year grant-based funding
  - Support policy and advocacy efforts driven by the clients of CBO's, CHC's and CMHC's

*My organization is culpable of all these things

CONCLUSION

Think about Truly Integrated Care as:

- **Looking deeply at root causes and ensuring those are being addressed**
- **Understanding the role health care can and should play**
- **Supporting the places and people where recovery matters most**

QUESTIONS AND DISCUSSION

Thank you!

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