INTERSECTION OF HEALTH AND HOMELESSNESS

JULY 2019 – JANUARY 2020 SURVEY RESULTS

NORTHERN MICHIGAN COMMUNITY HEALTH INNOVATION REGION

The Northern Michigan Community Health Innovation Region and the Northern Michigan Coalition to End Homelessness received funding from the Michigan Department of Health and Human Services to systematically address current barriers to ensure that individuals and families experiencing homelessness can be housed quickly and permanently. Grant activities took place between July 2019 and January 2020. As the evaluator for the project, the Center for Healthy Communities at the Michigan Public Health Institute designed a comprehensive partnership survey to study the intersection of Health and Homelessness in Northwest Michigan. Individuals participating in the Coordinated Discharge Pilot Program received a short survey in July on the healthcare and housing system before grant activities began, and in January after their participation in the program. A total of 16 people received the survey, and 13 people took the pre-survey (81%) and 10 people took the post-survey (63%). Demographics reported are from pre-survey responses. This report details the organizational practices among Northwest Michigan practitioners in the Housing and Homelessness sector, and the changes, if any, participants experienced in this time. When appropriate, post-survey responses are shared to highlight change in practices.

WHO TOOK THE SURVEY?

13 respondents are represented in the following demographics, unless otherwise noted.

Respondents represented the following types of organizations:

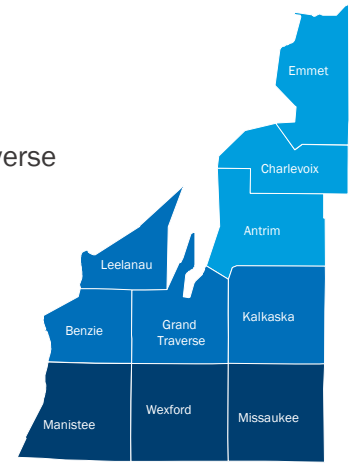
- Housing — 39%
- Hospital — 23%
- Social Service — 8%
- Community Mental Health — 8%
- Health Department — 8%
- Substance Use Disorder Treatment Facility — 8%
- Other — 8%

Roles of participants within these organizations included manager (31%), care provider (23%), case manager (15%) and other roles (31%) such as administrative support, executive, housing navigator, and program coordinator.

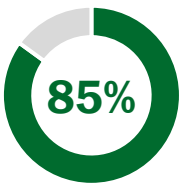
Counties served by respondents:

'Select all that apply' question

- 92% — Wexford
- 85% — Missaukee
- 69% — Manistee
- 38% — Grand Traverse
- 31% — Benzie
- 31% — Kalkaska
- 31% — Leelanau
- 23% — Antrim
- 15% — Charlevoix
- 15% — Emmet



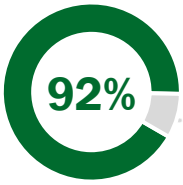
Length of time in their field: 1-5 years --- **31%** **6-10 years --- 39%** 11-15 years --- **15%** 15+ years --- **15%**



interact with patients or clients experiencing homelessness or housing instability

64% interact with patients/clients ***daily or weekly*** (n=11)

60% recheck patients/clients ***daily or weekly*** to learn if they are stably housed (n=10)

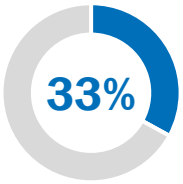


"This is a very gray area. I do not feel responsible to resolve a person's housing instability but do connect them with the right resources to help them and their situation."

believe they/their work have the **responsibility to resolve housing instability** when it is experienced by someone they work with

INTAKE, DISCHARGE, & **REFERRAL SERVICES**

BEFORE GRANT ACTIVITIES *(n=13)*



have a common discharge plan in place for working with patients/clients experiencing homelessness

Discharge Plans were described as:

- *"Making referrals to community agencies, using shelter for short term housing."*
- *"Varies based on client needs. We generally use the same template."*
- *"We provide extensive case management services with housing being the top priority."*
- *"Connect to 844 to get them started in the process. Contacting Adult Protective Services if needed."*

TOP 5 RESOURCES THAT ARE LACKING and would support their ability to provide better care to patients/clients experiencing homelessness or housing instability: *('select all that apply')*

62% --- Lack of patient/client follow-up on referrals

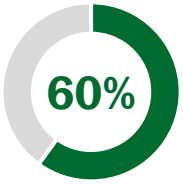
46% --- Lack of patient/client engagement

46% --- Lack of support in working with difficult patient/client behavior

39% --- Lack of agencies/services accepting new patients/clients

31% --- Lack of time within my organization

AFTER GRANT ACTIVITIES *(n=10)*



have a common discharge plan in place for working with patients/clients experiencing homelessness

Discharge Plans were described as:

- *"It's an exit plan that helps individuals prepare for not having a housing case manager."*
- *"Provide assistance with calling 844#. Resources given for the homeless shelter and Adult Protective Services called if needed."*
- *"The plan is based on case to case basis and is coordinated by working with Social Worker."*
- *"We have a written plan that begins upon intake to identify housing needs and link to services."*

TOP 5 RESOURCES THAT ARE LACKING and would support their ability to provide better care to patients/clients experiencing homelessness or housing instability: *('select all that apply')*

60% --- Lack of agencies/services accepting new patients/clients

60% --- Lack of patient/client follow-up on referrals

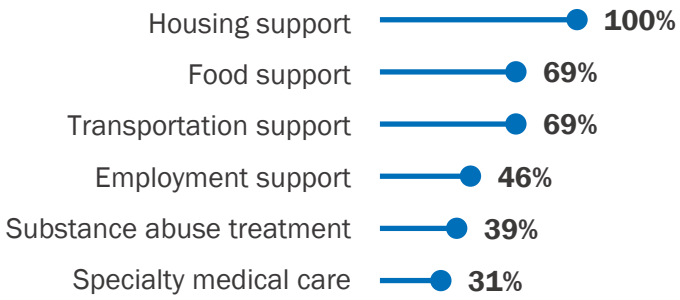
40% --- Lack of support in working with difficult patient/client behavior

40% --- Lack of patient/client engagement

40% --- Lack of time within my organization

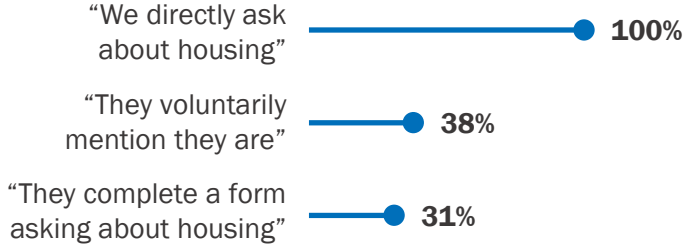
Types of services patient/clients are most frequently referred to:

(pre-survey; n=13; 'select all that apply')



TOP 3 WAYS respondents learn that a patient/client is experiencing homelessness or housing instability:

(pre-survey; n=13; 'select all that apply')



BARRIERS & STRENGTHS TO PROVIDING CARE FOR THOSE EXPERIENCING HOMELESSNESS

BEFORE GRANT ACTIVITIES

BARRIERS that make it difficult to provide care to those experiencing homelessness included:

The majority of respondents said **housing** was the main barrier, some specifically said '**affordable housing**'.

Other responses included:

- *"Little to no options for patients with severe mental illness or behavioral health concerns, any past history of substance abuse and criminal charges (felony)."*
- *"There are no physical places for patients to go if homeless. Only two shelters that are usually full and are not open during daytime hours."*
- *"Large caseloads with insufficient time to find people homeless in the community."*
- *"Availability of housing units people can afford."*
- *"Housing options in the community."*
- *"Lack of housing and resources."*

STRENGTHS that help support providing care to those experiencing homelessness included:

- *"Many of our community agencies have good working relationships and are available to contact with questions on where to send someone and have knowledge about what resources may be available to the community."*
- *"The list of landlords that are willing to work with our agency."*
- *"Community Connections/Community Health Workers provide knowledge insight on where housing is currently available."*
- *"Many agencies work together to help end homelessness in our area."*
- *"There are two shelters in my area that help as well as Oasis."*
- *"Plenty of rental subsidy and support dollars."*
- *"Strong shelter system, day drop in services, daily community meals, food pantries, clothing pantries, etc."*

AFTER GRANT ACTIVITIES

BARRIERS that make it difficult to provide care to those experiencing homelessness included:

The majority of respondents said **housing** was the main barrier, some specifically said '**affordable housing**'.

Other responses included:

- *"Consumers are transient and can be hard to find. No Phones."*
- *"Lack of housing/shelter availability. There is only one men's and one women's homeless shelter. They both close during day time hours and are only open after 5pm for individuals to stay."*
- *"Lack of resources or sometimes patient does not meet criteria to access the resources that are available."*
- *"Mental health is by far the biggest barrier, client refusing mental health treatment, client keeping mental health appointment, client being refused mental health treatment from Community Mental Health, lack of Assertive Community Treatment team involvement and/or wrap around services, also affordable housing, and lack of diversion strategies in the community as a whole."*
- *"The need for the individuals to speak directly with someone that can address their housing concerns."*

STRENGTHS that help support providing care to those experiencing homelessness included:

- *"Coordinated entry system set up for homeless families and individuals to call, a full time housing navigator to work with families and individuals who is not getting a housing program, a by-name list that gives us the actual names of every family and individual who have called the central intake number (list is checked daily by navigator), partner agency communication, relationships with partner agencies could be better but is pretty good."*
- *"Community agencies are working toward good communication about what is available and actively working on effective collaboration to connect patients to appropriate resources."*
- *"Community stakeholders are collaborating to provide more options and reduce gaps."*
- *"Homeless shelter, Northwest Michigan Community Action Agency and Adult Protection Services involvement."*
- *"It is a small community so we work together closely to help people. We have a local vulnerable adult network meeting monthly to network with others who may be able to help."*
- *"We currently have a women's and a men's shelter and staff helping the individuals there in gaining housing and or employment."*

LOCAL PARTNERS & ORGANIZATIONS

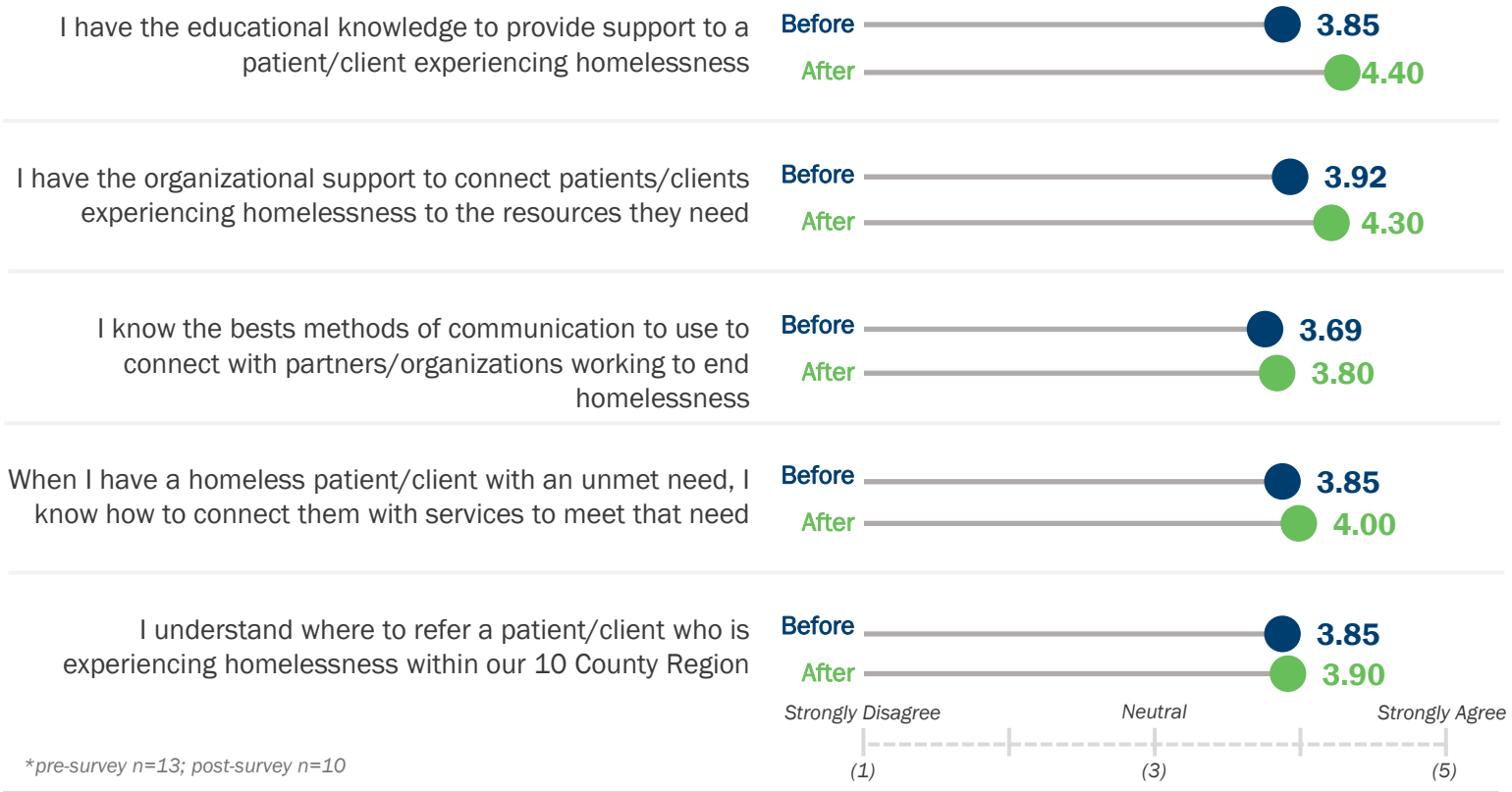
100% of survey participants said they work with local partners/organizations to address the needs of homeless patients/clients. Partners listed included:

- *Adult Protective Services*
- *Central United Methodist Church*
- *Children's Protective Services*
- *Community Connections Program*
- *Community Mental Health*
- *District Health Department #10*
- *Goodwill of Northern Michigan*
- *Jubilee House*
- *Love INC*
- *Love Thy Neighbor*
- *Michigan Department of Health and Human Services*
- *Munson Hospital*
- *New Hope Shelter*
- *Northwest Michigan Community Action Agency*
- *Northwest Michigan Coalition to End Homelessness*
- *Northwest Michigan Supportive Housing*
- *OASIS Family Resource Center*
- *Safe Harbor*
- *Salvation Army*
- *St. Vincent De Paul*
- *Staircase Youth Services*
- *The Father Fred Foundation*
- *Traverse City Police Department*
- *Traverse Health Clinic*
- *Veterans Affairs*
- *Vulnerable Adults Network*
- *Women's Resource Center*

Contact methods used most frequently to connect with partners/organizations that are providing support to patients/clients experiencing homelessness: *(pre-survey, n=13; 'select all that apply')*

Phone --- 100% | In-person contact --- 69% | Email --- 69% | Fax referral --- 23%

BEFORE & AFTER GRANT ACTIVITIES: CHANGES IN KNOWLEDGE & SUPPORT



*pre-survey n=13; post-survey n=10

BEFORE & AFTER GRANT ACTIVITIES – ADDITIONAL INFORMATION REQUESTED

Respondents shared what additional information they thought would better help them serve patients/clients experiencing homelessness. The numbers represent the change in requests from before to after grant activities:

33% --- 11%
Approaches to identify homelessness and housing instability in patients/clients

33% --- 22%
Approaches to work with patients/clients who become agitated

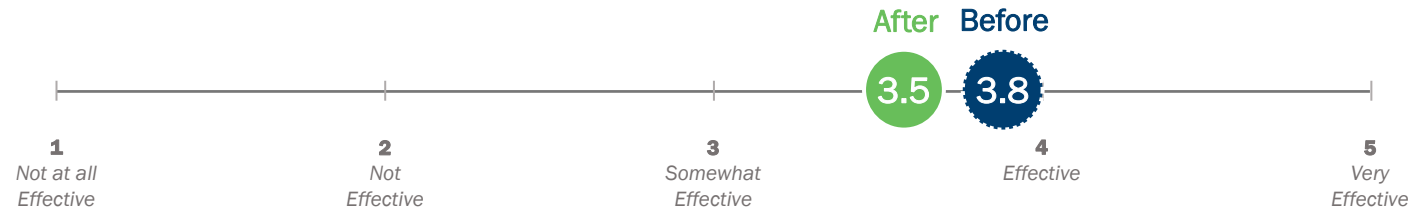
67% --- 33%
Protocols or procedures for referrals to agencies and organizations who can help prevent homelessness

83% --- 44%
Protocols or procedures to adapt care plans based on homelessness or housing instability

BEFORE & AFTER: EFFECTIVENESS & CONFIDENCE WORKING WITH HOMELESSNESS

How EFFECTIVE do you believe your organization is at meeting the health care needs of homeless individuals? *(pre-survey n=13; post-survey n=10)*

How EFFECTIVE do you believe your organization is at connecting patient/clients experiencing homelessness to resources that can prevent or resolve homelessness? *(pre-survey n=13; post-survey n=10)*



How CONFIDENT do you personally feel when working with patient/clients you believe are experiencing homelessness? *(pre-survey n=13; post-survey n=10)*

KEY THEMES

The Homeless Response System Survey revealed some key insight into the intersection of health and homelessness in Northwest Michigan. Based on survey results from before and after grant activities took place, the following key themes showed up in the data:

Having a **common discharge plan** in place at their organization **increased** after the grant activities took place.

Respondents reporting having a plan increased from 33% to 60%.

Affordable housing is a **main barrier** to providing care to those experiencing homelessness.

Almost all respondents listed housing as a top barrier.

Respondents rated their organization as **more effective** at **meeting the health care needs of homeless individuals** after the grant activities took place.

Effectiveness (1 “not at all effective” to 5 “very effective) increased from 3.1 to 3.5.

For more information about the survey results, please contact:

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