

Community Service ISP  
May 1, 2001  
ISP Proposal

Title: Operation Reach Out (ORO), a street outreach to the homeless as an extension of a student-run free clinic

Background:

The Stewart B McKinney Homeless Act defines homelessness as a person who "lacks a fixed, regular and adequate night time residence and; has a primary night time residence that is: (A) a supervised or publicly or privately operated shelter designed to provide temporary living accommodations ... (B) an institution that provides a temporary residence for individuals intended to be institutionalized, or (C) a public or private place not designed for human beings." In 1999 the National Law Center on Homelessness and Poverty estimated that nationally 700,000+ are homeless per night and that 2 million people experience homelessness per year (9). In San Diego, the 6th largest city in the US with a population of 1,224,848 (15), there is an estimated 15,000 homeless in the region and 6,500 homeless in the city of San Diego (3). Homeless demographics vary considerably depending on the location. In San Diego, the homeless population is predominately made up of single adults (64%) with the majority being male (only 8% female) and ranging in age from 27 to 40. With the strong military presence in San Diego, it is not surprising that 40% of the single adult homeless population are veterans. 25% of the homeless population in San Diego is made up of families, the majority of which are headed by single women. There are also approximately 800 chronically homeless youth in San Diego (15). In downtown San Diego there are approximately 3500-4000 homeless with only 2400 sleeping in shelters each night. The remaining 1000-1600 sleep outdoors or in spaces not intended for humans each night (15). It is this group of individuals that one might encounter while walking the streets of downtown San Diego at night.

There has been a steady rise in homelessness over the past 15-20 years due to the growing shortage in rental housing and rising poverty levels. For instance, from 1973 to 1993, 2.2 million low-rent units disappeared and in 1995 the number of low-rent renters outstripped the number of low-rent units by 4.4 million. In addition to a lack of affordable housing, it is also intuitive that poverty and homelessness are inextricably linked. Being poor means an illness, accident, or paycheck away from being on the streets. According to the US Bureau of the Census from 1988, 13.3% of the US population or 35.6 million Americans are in poverty. However, 41% of the aforementioned have income levels less than half of the poverty line! (8). Additional factors contributing to homelessness include domestic violence, mental illness, addiction, and lack of health care. In fact, of 777 homeless interviewed in 10 US cities, 22% said they left their last residency because of domestic violence (10) while 50% of the women heading homeless families are victims of domestic violence (15). Nationally, 20-25% of the homeless have severe or chronic mental illness (10) and in San Diego county there are 1900 severely mentally ill, making up the majority of those chronically homeless (15). With respect to addiction, half of the homeless population has had a substance abuse problem at some point in their lives and it is addiction and mental illness that have the greatest power to trap people in homelessness (7). With 43.4 million people in the US in 1997 with out health insurance (8), it is also no wonder that a national study reported health playing a factor in 13% of people becoming homeless. The same study showed that in the case where health was a factor in becoming homeless, 50% of the time it was a major factor, while 15% said it was the single most important factor contributing to their homelessness. To make matter worse, some 675,000 individuals have lost health care insurance as a result of welfare reform (11).

Not only does health care play an important role in people becoming homeless, but since the homeless have rates of illness and injury 2-6 times the housed population (7), health care becomes critical once people arrive on the streets as well. Poor nutrition, lack of hygiene, exposure to violence and the elements are all problems that the homeless experience. Mortality rates have also been shown to be 3-4 times higher in the homeless population with 75% of all deaths being accounted for by injuries (21%), heart disease (19%), ill-defined conditions (16%), liver disease (9%), and poisonings (8%). Half of all deaths are due to substance abuse (injuries, poisonings, liver disease, etc.) (5). Obviously everyone needs health care and being homeless is no exception, in fact as evidence from the statistics above, being homeless increases your need

for health care. Failing to provide homeless with care similar to others is a form of discrimination and should be unacceptable in a democratic society.

There is one federally funded health care program for the homeless, Health Care for the Homeless (HCH). HCH provides primary health care for the homeless by funding local agencies and programs. The city of San Diego also has several homeless service programs including the Winter Shelter Program, which began in 1993 and served 4630 homeless in 1999-2000 by providing 550 beds in three locations from 12/15 through 3/15 of the calendar year. The city is also planning to complete a short-term transitional housing project in 2001 which entails remodeling the Days Inn on Cortez Hill into a 150 bed facility. In addition to this, the city contracts with St. Vincent De Paul, the Solutions Consortium, and the Vietnam Veterans to operate shelters. Numerous other agencies also exist in San Diego to provide assistance to the homeless, many of which are listed in Table 1 (6). However, despite these services, there are only about 2400 shelter beds in down town San Diego. With approximately 3500-4000 homeless, that leaves 1000-1600 individuals homeless and on the streets (2). In addition to the fact that there is simply not enough assistance, many homeless will not access the services that are available for various reasons. Common barriers include transportation, denial of health problems, lack of awareness of available resources, unaware of severity of problem, or active avoidance due to fear or disgust of large institutions (7). Outreach is designed to attempt to engage this population which may be under served by existing agencies.

The great need to seek out this homeless population is demonstrated by a survey of 8 ACCESS programs which showed that of the homeless engaged, 77% were engaged by mobile methods, as opposed to only 33% by fixed methods (4). Furthermore, a study in Los Angeles showed that without a street outreach component, only 16% of the homeless were identified (1). To address this problem, the city of San Diego has developed the Homeless Outreach Team (HOT) which includes 4 police officers, 2 county social workers, and 2 psychiatric emergency response team members. This team provided care, resources, and assistance to 700 individuals in the year 2000. This multi-disciplinary street outreach approach has been successful in other parts of the country as well, including Operation Safety Net (OSN) in Pittsburgh, Pennsylvania. OSN began when Dr. Withers started making "street rounds" with his formerly homeless partner, Mike Sallows, in May 1992. OSN now has 14 teams made up of medical and formerly homeless volunteers that walk the streets each night of the year providing sensitive and flexible access to health care to those on the streets. OSN also provides the street homeless with 24-hour on-call access to medical personnel and a full-time case management and advocacy staff (12). A similar program, Safe Haven, has experienced great success in Honolulu where, workers perform outreach and then continue as case managers. Other programs like New York's project HELP and Chicago's Mobile Assessment Unit (MAU) have sought to engage the street homeless using a "find and link" method. This method functions only to link street homeless to traditional mainstream services, without providing any follow-up support (scheduling appointments, providing transportation, advocacy, etc.) This "find and link" model has not been as successful as the continuous model demonstrated by the HOT, OSN, and Safe Haven programs mentioned above. For example, one study evaluating the "find and link" method found only 22 clients receiving treatment after 430 eligible referrals (4). After reviewing the literature, successful street outreach programs seem to have several attributes in common: (A) peer based outreach...(B) community partnership...(C) realistic and attainable initial goals.

Homelessness is often talked about as a problem to the city, when in all actuality it is a problem to the person without a home. These people without a home are at greater risk for injury, disease, and death than the housed population. Although there are many operating agencies providing assistance to the homeless here in San Diego, many homeless will not access this assistance. Thus, there is a need to move away from traditional methods of delivering health care and move towards developing health promotion in the context of ways that homeless seek, or don't seek for that matter, health care (14). It is in this spirit that Operation Reach Out (ORO) is proposed.

Definition:

What are the goals of the project?

The primary goal of the project is to develop trust, care for immediate needs, and provide linkages to service and resources to the homeless encountered on the street. Specific goals are as follows:

1. Compile a peer based street outreach team as an extension of the Free Clinic at 3rd and Ash to walk the streets one night per week.
2. Locate homeless individuals on the street while maintaining the safety of the team.
3. Establish a personal connection with those encountered on the streets, providing a foundation upon which needs can be assessed and met.
4. Organize and secure a supply of blankets, food, clothing, sunscreen, personal hygiene items, condoms, and basic medications (anti-hypertensive, diabetes, topical steroid skin creams, etc.).
5. Build a cooperative relationship with existing homeless services in the downtown area so as to be able educate the homeless encountered about available resources as well as to facilitate their engagement and adequate follow-up.
6. Develop a database which tracks those encountered on the streets which is accessible to the 3rd and Ash Free Clinic.
7. Evaluate effectiveness of intervention by tracking the number of homeless on the street encountered, quality of relationship developed with the outreach team, type and degree of service accepted, number of encounters with other service providers.
8. Develop this project as a permanent and additional arm to the existing Free Clinic at 3rd and Ash.

What is innovative about this project?

1. Currently the Free Clinic does not have a mobile component to its health care delivery. By going out into the streets, the Free Clinic will potentially be able to expand its served population.
2. Although this project is ultimately concerned with addressing the health care needs of the homeless encountered on the streets, the initial goal is one of an interpersonal nature. Engagement is the process of reducing fear, building trust and setting the stage to address that persons' needs. This project recognizes that this process takes time. One study of 5 New York outreach programs found that the average length of engagement was 3.9 months (4).
3. This project is not being launched as an independent entity, but rather as an extension of an existing successful health clinic. As a result, Operation Reach Out will have many resources at its disposal, including medications, food, blankets and clothing, not to mention a pool of potential additional volunteers, namely UCSD medical students.
4. Operation Reach Out will depend heavily on the formerly homeless members of the outreach team to find homeless individuals on the street, help provide credibility, as well as identifying dangerous areas, situations and people.

How is this project relevant to a career in medicine?

Homelessness is a part of any community, urban and rural alike. Therefore, as a future family practice doctor, it certainly behooves me to develop skills to serve this population. In addition to that, the experience of identifying a population and its health care needs, developing an intervention to meet those needs, and evaluating the impact of that intervention while involving the community at each step will strengthen my ability to provide health care to all populations in the future (16).

What is the student's role and time commitment to the project?

The student will be responsible for organizing the street outreach team, planning times and dates of outreach, securing supplies for the outreach, becoming familiar with existing homeless services and how to access them, developing a database to describe encounters with street homeless, and to recruit volunteers to continue Operation Reach Out beyond this student's graduation date. The time commitment will be as follows: at least one night per week walking the streets beginning in Fall 2001 through June 2002, as well as setting aside two months in the 4th year to work on the project full-time. I also plan on spending one month in Pittsburgh, Pennsylvania learning firsthand how Operation Safety Net functions, the project that Operation Reach Out was patterned after.

Methods:

1. Organization of street outreach team: Sara Carpenter, UCSD fellow in Community Service, will be asked to serve as the medical professional. Paul Mormon, a formerly homeless individual and staff

member of the First Lutheran Church on 3rd and Ash, will be asked to serve as a guide for the initial outreach team. I will serve as the student on the team responsible for coordinating the activities and supplies of the team.

2. Locating the Homeless: The street outreach team will walk a three block radius, centered on the First Lutheran Church on 3rd and Ash looking for homeless individuals on the street. Under the direction of Paul Mormon and/or other individuals that Mr. Mormon knows, the street outreach team will also visit little known areas where homeless individuals congregate.

3. Engaging the Homeless: Morse describes 4 stages of engagement. The first is setting the stage where the team becomes a familiar face and establishes credibility. The next step involves initial engagement tactics, which include non-threatening small talk and providing incentive items (food, drinks, condoms, etc.). Ongoing engagement tactics follow, which include hanging out and sharing space with clients as well as providing transportation and linking clients to medical care (i.e. at the Free Clinic on 3rd and Ash or other services in the area). The last step that Morse describes is proceeding with outreach/maintaining relationship which involves defining goals and assisting with negotiating service settings (i.e. accompany to appointments) (4).

4. Building a cooperative relationship with other homeless service providers: I will perform site visits to homeless service providers in the area, introduce myself to staff, and familiarize myself with the services provided along with the process of accessing them. This team approach will enable the outreach team to educate the street homeless encountered on available resources as well as allow for improved client follow up since successful outreach cannot be accomplished in isolation (4).

5. Tracking the street homeless encountered: A journal will be kept logging each encounter with the street homeless. Information to be recorded will include: name of individual (if provided), physical description, date, time, and location of the encounter, description of the interaction between the individual and team, needs identified, services provided, information or referrals given as well as contacts with other service providers. This information will allow for evaluation of this project by documenting the number of street homeless encountered, the quality of the relationship established and the extent to which needs were identified and met. This information will also be converted into the form of a chart, which will be accessible to the Free Clinic on 3rd and Ash so as to better serve these individuals when and if they contact this health care provider.

6. Establishing Operation Reach Out as a permanent extension of the Free Clinic on 3rd and Ash: A UCSD medical student will be recruited and trained to oversee Operation Reach Out for the 2002-2003 academic school year.

7. Analysis and writing of the report: The journal recording the encounters with the street homeless will be carefully reviewed to assess the impact of this intervention. A report documenting the results will be written and submitted to the Electives Committee and will also be given to the next student overseer of Operation Reach Out.

#### Evaluation:

The ISP chair and committee members will evaluate each step of the project. First, the committee will evaluate the student's ability to organize and plan this street outreach. The student will provide the committee with monthly summaries of the encounters with the street homeless and illicit input on how to better serve each client on a case to case basis as needed. Six months into Operation Reach Out, the committee will be asked to review the preliminary results and offer guidance on the format of the summary report describing the project and its findings. Once the report has been completed the committee will review it and offer suggestions prior to its being submitted to the Electives Committee. Finally, the ISP committee will evaluate the student's ability to recruit and train a student to oversee Operation Reach Out for the 2002-2003 academic school year.

The endpoints of the project will be defined as follows: the data collection phase will be complete at the end of the 2001 calendar year; the data reporting phase will be complete when the report has been approved by the ISP committee members and submitted to the Electives Committee; and the follow-up phase will be complete when the next overseer of Operation Reach Out has been recruited and trained. The success of the project will be judged on the quality of relationships established with the homeless individuals encountered, the ability to assess and meet needs (whether directly on the street or via referrals to other

service providers), and its development into a permanent extension of the services provided at the existing Free Clinic on 3rd and Ash.

#### References:

1. Burt, Martha R. Demographics and Geography: Estimating needs. 1998 National Symposium on Homeless Research. <http://aspe.hhs.gov/progsys/homeless/symposium/1-demograp.htm>.
2. City of San Diego. Homeless Service Programs. [www.sannet.gov/homeless-services](http://www.sannet.gov/homeless-services).
3. Cunningham H. The City of San Diego, The Manager's Report. November 16, 2000. Accessible from following website... [www.sannet.gov/homeless-services](http://www.sannet.gov/homeless-services).
4. Erickson S, Page J. To Dance With Grace: Outreach & Engagement To Persons On The Street. The 1998 National Symposium on Homelessness Research. <http://aspe.hhs.gov/progsys/homeless/symposium/6-Outreach.htm>.
5. Hibbs J et al. Mortality in a Cohort of Homeless Adults in Philadelphia. NEJM 1994;331(5):304-309.
6. Homeless Assistance Provider Search Results. <http://www.hud.gov/dectorem/h1search.cfm>.
7. McMurray-Avila M, Gelberg L, Breakey W. Balancing Act: Clinical Practices That Respond to the Needs of Homeless People. The 1998 National Symposium on Homeless Research. <http://aspe.hhs.gov/progsys/homeless/symposium/8-Clinical.htm>.
8. National Coalition for the Homeless. NCH Fact sheet #1: Why are people homeless?. June 1999. <http://nch.ari.net/causes.html>.
9. National Coalition for the Homeless. NCH Fact sheet #2: How Many People Experience Homelessness?. February 1999. <http://nch.ari.net/numbers.html>.
10. National Coalition for the Homeless. NCH Fact sheet #3: Who is homeless?. February 1999. <http://nch.ari.net/who.html>.
11. National Coalition for the Homeless. NCH fact sheet #8: Health care and homelessness. June 1999. <http://nch.ari.net/health.html>.
12. Operation Safety Net. <http://trfn.clpgh.org/safenet/pages>.
13. Pollio DE, Thompson SJ, North CS. Agency-Based Tracking of Difficult to Follow Populations: Runaway and Homeless Youth Programs in St. Louis, Missouri. Community Mental Health Journal 2000;36(3):247-258.
14. Power R et al. Health, health promotion, and homelessness. British medical journal 1999;218:590-592.
15. Regional Task Force on the Homeless. August 1999. <http://www.co.san-diego.ca.us/rtrfh>.
16. Rhyne R, Bogue R, Kukulka G, Fulmer H. (1988). Community-Oriented Primary Care: Health Care for the 21st Century. Washington DC: American Public Health Association.