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TRANSCRIPT - GR 03 21 25 **"Housing & Health: How Can We Help Patients Experiencing Homelessness?"** guest speaker Matthew Allen, MD, University of Virginia

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Internal Medicine Grand Rounds

- All right, everybody. We'll get started with grand rounds in a few minutes. But match day, of course, starts at noon this 1st year that we've had grand rounds starting at 1215. So, as we, you know, kill a little time waiting for the rest of the audience to come in excited to show you before grand rounds. This is usually after grand rounds, our match class. So we'll be calling this crew this afternoon but yeah, really outstanding group that we're excited about, we have a you'll see a few familiar faces and 3 Uva students staying here in categorical and 2 in the preliminary track. The ophthalmology match happened last month already. And then that's the neurology match. So thanks to everyone for your engagement and work throughout, a long recruitment fall and winter, and really outstanding Job from the chiefs. Thank you for your incredible energy and work in recruiting this great class.
- Yay, everyone and we'll just go back to waiting a few more minutes before Dr. Al speaks.
- Okay.
- Oh, I did not.
- If everything's apart all right. Well, shifting gears back into grand rounds from match day. We're delighted to welcome Dr. Matt Allen to speak with the Department on his grand rounds, housing, and health. How can we help patients experiencing homelessness.
- Take us through our Cme slides Dr. Allen's presentation objectives no disclosures. And then today's activity code. You'll look for your email faculty from Tony Brinkman after the lecture gets started, and welcome Dr. Hasan to introduce Dr. Allen.
- So good afternoon, everyone. It's my distinct pleasure to introduce our ground speaker for today. Dr. Matt Allen, so a native of Northern Virginia, Dr. Allen, majored in psychology at Uva, and then went on to work for the Peace Corps for community Health programs in Fiji. For 2 years after that afterwards he attended Medical school at the University of Pittsburgh and completed his Internal Medicine Residency training in the primary care track here at Uva.
- He's now an attending at university physicians, orange caring for our Central Virginia residents in the primary care setting.
- Dr. Allen 1st became involved in homeless healthcare during residency, when he helped one of our medical students start the inpatient, homeless consult service which he now continues today in a supervisory role, and he remains committed to serving our community, including taking ownership as the lead, attending at the Haven clinic, which is our primary outreach clinic, helping with the early stages of starting the shelter clinic which is our domestic violence, clinic and starting a program to provide temporary cell phones to admitted patients experiencing

homelessness which is about to become a hospital-wide program run by population health and interactive home monitoring.

- So we're really delighted to have him speak with us today about patients experiencing homelessness. So please join me in welcoming Dr. Allen.
- Hey?
- Well, Shana, thank you for that very kind introduction congrats everyone who matched. Today.
- I'll say right off the bat. I feel pretty under qualified to give this talk. I'm really not a big name in this field, not even a small name in this field.
- Someone who is a big name in this field incidentally, will be coming here in a couple weeks to give Medical Center hour. This is Dr. Jim O'connell. He's the founder of Boston's Healthcare for the homeless program a program that's really set the gold standard in this field. So if y'all can make it to this talk he's great. I would highly recommend it.
- Want to talk to you all about a lot of things today, but my main goals are to kind of just 1st give you a sense of the scale and the scope of the homelessness crisis. Here in America help you become more familiar with the resources we have in our community to help these folks and then discuss what we could be doing better to meet these patients needs, both at an institutional level, a community level and on an individual level.
- I have no disclosures. I do have to start with terminology, even though it's a bit of a landmine right now you'll see a lot of potential alternatives to the traditional term homeless out there. Most of these are well, attention attempts to find a less stigmatizing term in the word homeless. I've seen various iterations of this. I once saw an er note describe a patient as domicile challenged.
- Personally, I think it's okay to use the word homeless. Most major organizations doing this work use the word homeless. If you ask the average person on the street. What their situation is, they would say, homeless.
- And personally, I think we kind of obfuscate what is a horrific experience with sanitized academic terms.
- I do prefer to use person-centered language. I'll be using Peh as an abbreviation throughout my slides for brevity's sake.
- Okay, so what are the top line numbers?
- All this data comes from HUD department of housing and urban development.
- The current count by their data, is about 770,000 people. These numbers have been on the rise. Recently
- I would ignore 2021 on this graph that was almost certainly an undercount related to the pandemic jurisdictions couldn't do their normal counting procedures.
- What are the normal counting procedures? I'm going to be referring to this data a few times in these slides. So it's worth going over.
- So these numbers come from something called a point. In time. Count HUD breaks up America into these variously sized jurisdictions. They call them Cocs every January they're asked to do a census. There's no standard methodology as to how they do this census, but in general, what they're doing is counting everyone in a shelter.
- counting everyone they can find outside and they may or may not include people that they just know are homeless by name, just because they access certain services in the community.

- Note, who's not getting counted here people living in their car not getting counted there people who are couch surfing, not getting counted and people who are in a less visible location outside are not getting counted. This also tends to miss people who are temporarily homeless.
- If you're homeless from April to August, you don't get counted here.
- So there's a lot of criticism of this data mostly that it's a gross undercount. Just to illustrate this. This is some data from the homeless consult service. They've been following patients for 3 years now and they ask a standardized questionnaire to each patient. So what they've seen in their data of all the patients we've seen at Uva. About half of our patients would not be counted by a pit count. They're either couchsurfing or in their car. Similarly, less than half of patients actually meet. The definition for chronic homelessness again would be very likely to get missed by a pit count.
- We have other sources of data that put the one year prevalence of homelessness closer to 1%, one and a half percent of the population that would put this number, you know more in the millions, 2 million 3 million, something like that.
- So likely a big undercount.
- We do get some limited demographic data from the pit counts just a couple of things. I'll highlight here.
- 145,000 homeless children. Not gonna be talking much about children today, but it's a tragedy. Families make about a 3rd of people experiencing homelessness among single people, generally middle aged people. People in their thirties, forties, and fifties make up the majority.
- And indeed, people of color tend to be overrepresented in this population.
- So let's talk about what we know about some of the health outcomes of people experiencing homelessness.
- We'll start with mortality. The biggest study that tends to be cited on this question came out of Boston from the healthcare for the homeless group up there. They followed about 400 of their patients prospectively over 10 years.
- They found that about a 3rd of the patients they followed died during that 10 year period, at an average age of 53, and when they compare that to the general Massachusetts population they died at a tenfold higher rate.
- There's a similar study done out of the Va. They looked at younger veterans, experiencing homelessness compared them to housed peers. Again. They found about 20% of that population died in a 10 year period and while many of them died of traditional causes, there are much higher rates of things like suicide, homicide, overdose accidents, much more common in this population in terms of medical conditions.
- I think most of the things on this list will come as no surprise to anyone in this audience. Conditions like cirrhosis, copd communicable diseases, all more common in this population. Some conditions you won't see on this list. Diabetes, hypertension. Cbd, not necessarily more common in this population.
- They have a tendency to have worse outcomes and worse control, but not necessarily more common in terms of mental health and substance. Use disorders.
- Of course, we all know people experiencing homelessness are more likely to struggle with either of these issues. I think it's worth taking a pause, though, here and flipping this data around just to note that the majority of people experiencing homelessness do not have either of these issues.
- It's also worth considering.

- The two-way street of causation here, because these conditions can make it more likely for you to become homeless. But homelessness can also make it more likely for you to develop these conditions.
- To kind of illustrate this.
- This is some data from a very large statewide survey that was done in California, of people experiencing homelessness they found that when they interviewed people there was a wide range of responses into how people change their substance, use patterns. There were a lot of people who increased their use after they became homeless, to stay more alert, to cope with the stresses of homelessness. But just as many, if not more, people actually decreased their use in terms of utilization.
- Again, probably no surprise to most people. Several studies have shown that on average, people experiencing homelessness tend to use the er more than their house counterparts. But again, I kind of want to put an asterisk on this. This is a study out of Oakland where they followed homeless adults over a 6 month period, just kind of oriented. To this graph the blue bar on the bottom left is basically showing that half the people in this cohort. Use the er 0 times in the 6 month period and then if you flip it around, look at the purple and the yellow on the top right, you'll see that about half of the er visits of this whole cohort are being driven by about 6 or 7% of the whole cohort. So all this is to say, not everyone experiencing homelessness is a super high utilizer of the er readmissions.
- Indeed, people experiencing homelessness.
- Do you have a higher rate of readmission, but again, want to put a little asterisk here.
- New York has a much lower gap between housed and unhoused folks, and their readmission rates.
- Authors could only speculate as to why this was. But New York City, which is where most people experiencing homelessness live in New York has a very unique court mandated policy that you have to provide shelter to all individuals who are homeless, no matter what.
- That's probably why they have better outcomes here just speculation. But all this is to say that there are things we can do to reduce these disparities in this population. I'm going to be talking more about that later.
- I think everyone here can appreciate why people experiencing homelessness have poor health outcomes. But I also think it's worth just putting all the reasons onto one slide.
- Just so you can see the tremendous number of barriers people experience to try to get health care. How can you manage diabetes if all you can afford is a hot dog and chips from seven-eleven. If you can't keep your insulin cool, your Meds are being stolen. You don't have a phone to call your Pcp. You don't have a Pcp. At all.
- This is extraordinarily difficult for people and I think that's just worth saying out loud, because I often see notes from other providers saying like this patient's not interested in his health, and I think that's a very unfair accusation for a lot of these folks.
- I want to take a little detour away from healthcare and talk about the research about what actually puts people into homelessness.
- The reason for that being. If you really want to help patients experiencing homelessness? It starts with cultivating empathy for this population, and having a better understanding of how they got in this situation. In the 1st place now everyone

has their own story. If you've met one person experiencing homelessness, you've met one person experiencing homelessness. But

- I think the research on this topic does point to a common theme.
- Going back to that large study in California where they they interviewed thousands of people experiencing homelessness across the state they 1st asked. The question is, where did people start before they became homeless?
- Notably about half of people did not have any sort of formal housing. To begin with, they were kind of in a precarious situation. They didn't have their name on a lease, living with friends, doubling up things like that about a 3rd of people did have their name on a lease, but these were folks at very low incomes, particularly for the State of California, spending about half their income on rent and then about 20% were coming straight out of an institutional setting into homelessness, usually from a correctional facility.
- Now, this one's a little bit hard to see. But basically, if you ask people, why did you become homeless?
- There's a wide range of answers. Typically people cite some sort of social reason I got in a fight with my roommate, and I couldn't stay there anymore. But when they did more in-depth interviews with a subset of these folks. They found that economic health social reasons tended to interact and compound on each other. For example, someone may have experienced some sort of economic shock a job loss, a big hospital bill, and that put them into a precarious housing situation. And then, at some point, some sort of interpersonal conflict related to that precarious housing.
- It's just kind of a straw that breaks the camel's back now.
- Not everyone who loses their job or gets in a fight with their roommates becomes homeless. So I think it's worth asking a different question, not what are the individual risk factors for homelessness, but what are the environmental risk? Factors for homelessness. And to frame that question, I'll start with this graph.
- Now, homelessness is often characterized as an issue of poverty, mental health, addiction. The problem with that line of argument is that it doesn't really explain this chart. Very well.
- Do people in New York City?
- Are they 3 times more likely to have a substance use disorder than people in Philly are people in DC. Twice as likely to have a serious mental health issue relative to Baltimore?
- It doesn't quite add up. So what does explain these differences?
- I'm gonna share a few graphs from Greg Colburn. He's a homelessness researcher in Seattle.
- To Orient. Y'all, these are all linear regressions.
- That little r squared number is called a coefficient of determination. Basically, what proportion of y is explained by X, the flatter the line, the less of a relationship, the more diagonal of a line, the stronger the relationship.
- So 1st looked at substance, use disorders and homelessness and, as you can see here. There's not a very strong relationship at all. Now with a caveat here he had to use state level substance, use disorder data against coc level homelessness data. So it's not a perfect match. But to provide a clear example of this.
- Does anybody know which state in America has the highest rate of homelessness per capita.
- No, no, per capita. The most people live there but quick half. Nope Hawaii

- Hawaii has the highest rate of homelessness in America however, Hawaii also has the lowest rate of opioid use disorder. One of the lowest rates of alcohol use disorder, and one of the lowest rates of serious mental illness in the country.
- So this is where that the line of argument about substance use disorders. Time tends to fall apart.
- Holburn looked at a lot of different arguments. One that's often mentioned as I alluded to. California has about a 3rd of the nation's homeless population, and a common narrative about this is because the weather is nice there.
- It's a tidy narrative until you just think about it a little bit. New York, Boston, Seattle have terrible weather and very high rates of homelessness.
- So no relationship here.
- Well, what about poverty?
- Indeed, there is a relationship. But don't be fooled here. This is an inverse relationship so highly affluent. Coastal cities have very high rates of homelessness, while high poverty, cities like Detroit and Cleveland, have much lower rates of homelessness. So this is tricky on an individual level.
- Poverty raises your risk of homelessness, but on a community level homelessness thrives in wealthier communities.
- So why is that?
- It's this? Or at least this is what he would argue.
- Colburn would argue, this is about housing costs. There's a clear relationship between the Median rent in a community and its rates of homelessness in places where housing is expensive, you see very high rates of homelessness as a corollary to this he also showed this in relationship to rental vacancy rate in places where the housing market is tight costs go up, people have trouble finding affordable housing.
- So if you go back to this chart, it starts to make a little bit more sense.
- You have you know, these industrial midwestern cities who've had population decline, so they have more housing than they do people. So the housing market's not tight. And so, even in poverty areas like Detroit homelessness. Is not that high?
- Then you have the big elite coastal cities, New York and Boston.
- They have a huge mismatch between their housing supply and their housing demand. They have very high rates of homelessness.
- And then you have these new booming cities in the Sun Belt, Houston, Dallas, Charlotte Vegas.
- Their population is going up, but they've also allowed developers to kind of build ad lib. And because of that, their homelessness rates are not yet that high.
- So to put it simply, homelessness is a housing problem.
- Colburn's is not the only research to demonstrate this. This is from another paper.
- Zri stands for zillow rental Index. Basically the Median rent in a community.
- So on the X-axis Median rent as a percentage of income on the Y homelessness rate.
- And you can see there's an inflection point at 30%. That's right in line with the classic financial teaching. And if you're spending more than 30% of your income on housing, you're in trouble. Unfortunately, as the years go by, more and more Americans are finding themselves in trouble.
- Rents are skyrocketing across the country. Incomes are not so to summarize most homelessness. Researchers would argue that the problem is basically that we're in

a game of musical chairs high cost and low supply make housing a competitive game that we all have to play.

- But those with low incomes, physical health conditions, mental health conditions are much more likely to lose the game and they would generally argue that the solution is we need more chairs.
- What does this look like in our region.
- These are the pick counts for the Charlottesville Coc.
- We have a couple of deviations from our normal numbers. 2022 was probably high for a couple reasons. One. The covid eviction moratorium ended in summer of 2021. So eviction spiked homelessness spiked 2. It was probably just easier to count people when we had a shelter called Premier Circle open. I'll be talking more about that later and we had 2024, and that might look like good news. However, all of our local agencies feel like this was a huge undercount for a few reasons. One. The weather was really bad that one night in January 2, we just have a hard time counting folks who are not in the immediate downtown Mall area, and 3, we know from other data sources that these numbers are way higher than our official pit. Count.
- Does Charlottesville have a unique problem with homelessness bit of a tricky question to try to answer.
- I 1st just tried to like, put together, the, you know, homelessness per capita of our Coc. With some of our neighboring cocs, and by this metric. We don't look that bad. We look pretty average in this regard. However, this isn't really a great apples to apples comparison. There's a lot of differences in these cocs in their geography. It's not really fair to compare a Coc that's just a city with a Coc that includes rural and suburban areas in it. So this doesn't really answer that question very well, in my opinion.
- So instead, just following the logic of Colburn's research, I decided to ask a slightly different question does our community create an environment in which people are at high risk for becoming homelessness? So this is data from the census bureau website. This is Median rent of the 3,000 counties and cities in America.
- Obviously, you can see California is very expensive, and this is why a 3rd of the nation's homeless come from California.
- If you zoom in on us you can see the average rent. Now. County is close to $1,600. This is 2022 data. It's almost certainly above it. At this point Charlottesville is a little bit less expensive.
- Again, it's hard to know what to make of this Elmarle County clocks in as Number 1, 20 of the 3,000 cities and counties in terms of most expensive.
- But, again, what does that mean? You can't really compare us to Fairfax. You can't really compare us to Buckingham so to try to do an apples to apples comparison. I looked at other college towns and I made some slightly arbitrary decisions here, but I looked at college towns that were outside of a major metropolitan area that were anchored by a large university that is considered prestigious by us. News. Yes, Virginia Tech is in the top 50 by this metric, and, as you can see, really only Santa Barbara in California beats us out in unaffordability. So I think it's fair to say that for a community like ours we are pretty uniquely unaffordable from a housing standpoint and I think just about everyone in this audience knows that in their bones, if they've attempted to engage with our housing market in the last few years. I myself was a 1st time home buyer in our area. 3 years ago my wife and I were

constantly shocked by the zillow listings we were seeing. And this is just not an environment where people with low incomes are going to have success.

- Let's talk about our shelters.
- We'll start with the haven
- I have to emphasize right off the bat. The haven is not an overnight shelter.
- It is a day shelter. You discharge someone to the haven. You are discharging them to the street.
- Just so. We're clear eyed about that.
- The haven does a lot.
- They provide breakfast.
- They provide shower access supplies, material goods. There's a couple of programs that they manage. The 1st is the homeless information line. It's worth knowing about that. It's the 1st step in accessing any housing resource in our community. It's tricky to navigate. It's just a voicemail you leave a voicemail, and then someone will call you back a couple days later. That's tough for a lot of people.
- They have a few pools of funds that they have for individuals who are at risk of imminent homelessness, or need rapid rehousing. Those pools of funds are very constrained. They tend to run out each month very quickly.
- Pacham is a collective of mostly churches that provide low barrier congregate overnight shelter in the winter months congregate meaning. It's just one big space, you know. A bunch of cots in the church basement.
- Low barrier means that most everyone is welcome.
- You don't have to be sober. You don't have to be working doesn't matter what your criminal record is. You just have to follow a couple basic rules.
- In contrast, the other major shelter in our area is the Salvation Army. It's year round, which is great but it's high barrier. So here they do expect you to be sober. They do expect you to be working or looking for work, and they stays are time limited.
- So this shelter, while it's great, for some does not meet the needs of every person experiencing homelessness in our community.
- Then also worth mentioning the she shelter.
- This is for those who are actively fleeing domestic violence.
- It's a wonderful organization, a great space. They can usually host about 6 or 7 families at a time, and they provide various other support services for them, and they can stay up to 6 weeks.
- So if you add all this up, are all these beds meeting the needs of our community not even close there's a huge deficit here in our area. And just to put objective numbers on it. This is why, I think it's fair to just compare all the Cocs to each other. We're basically dead last in terms of shelter beds per capita in the State of Virginia.
- So what do we need? As I alluded to? We really need a year round, low barrier shelter in our community, we had one, and it was a huge benefit. It was called Premier Circle.
- It was unique in that it was non-congregate. Everyone had their own room in this old, old hotel up 29.
- This all came from pandemic era emergency relief funds.
- There were tons of premier circles that popped up all over the country, hundreds of them however, that funding dried up and for that reason and a couple others, they weren't able to stay open, but they sheltered over a hundred people. It was a huge benefit for this population.

- There are some ongoing discussions about opening a low barrier shelter in the city in Fifeville.
- To keep it brief, those discussions are being held up by some local opposition, as well as some debate about what organization should be running this shelter.
- But the money is there.
- Respite, care also something we could really use. Respite. Care is a 24, 7 shelter with social services and medical services for patients who've been admitted.
- They're healthy enough that they don't have to stay inpatient, but they're too sick to go to a traditional shelter or the street.
- There's over a hundred of these programs across the country.
- Some are managed by nonprofits, some are quasi managed in partnership with academic health systems.
- There have been several discussions at Uva about trying to support respite care in our community.
- I'll just say those discussions have been hung up by where would it be? And who would run it?
- And then permanent supportive housing we could definitely use more of broadly. This is defined as affordable housing. That is, not time limited, and provides ongoing supportive services appropriate to the needs of the tenants. There's really only one major place such as this for people experiencing homelessness. Currently, it's the crossings that's on 4th and Preston by the Wendy's right there it has 60 units.
- Good news is that the site where Premier circle was, they're tearing it down and rebuilding it to be a second permanent supportive housing unit. They're going to have 80 beds there, and that'll be great whenever it's ready.
- Okay, let me finally go back to healthcare.
- I'll start with the question, Does putting a roof over someone's head improve their health outcomes? I hope everyone in the room would agree that that answer doesn't matter, because everyone deserves a roof over their head. But since there's research on the topic, I'll present it here.
- These interventions are tough to study. You can't really, ethically randomize someone to shelter versus no shelter. But you can look at associations for sure. This is a study that surveyed women in Los Angeles who are experiencing homelessness comparing those who were sheltered to those who are unsheltered. And all over this table, across the board you can see the women who are unsheltered or doing much worse on pretty much every metric that they measured.
- Now, at the end of the day, traditional, homeless shelters which are congregate spaces are not exactly spaces that promote health and well-being.
- They're close quarters, they tend to be high stress environments fights are common, thefts are common. I routinely talk to people who say they'd rather sleep outside, and I kind of get it.
- However, non-congregate shelters are different. So how do people do when they're in a non-congregate shelter like premier circle.
- This is a table from a study that looked at patients experiencing homelessness in San Francisco, who were placed in emergency hotel shelters during the pandemic.
- Even if you just ignore the control group for a second, you can see the experimental group. Large declines in er visits, inpatient stays pretty substantial. Drop post hoteling, and this drop was larger compared to a control group that was otherwise similar. But not in one of these hotels.

- In terms of direct health outcomes. There's a different study of people in Chicago who are in these similar kind of hotel-based shelters, and they looked at people who had pre-existing diagnoses of hypertension or diabetes, and they found that people who were in one of these shelters on average had better control of their hypertension and their diabetes.
- There are several reasons why people do better in these spaces.
- Things just get things just go better. When people have their own space, they feel safer. They have more autonomy.
- They have the breathing room to think about more than just surviving. I think this graph really illustrates things. This is also from Greg Colburn, who I cited earlier.
- They looked at a shelter in Seattle that was historically a congregate shelter. But then, in the pandemic they switched to being a non-congregate shelter, and they saw pretty enormous drops and the number of times they had to call police or ems to the shelter.
- One can only speculate on the reasons, but I would probably highlight reduce interpersonal conflict as a key part of that terms of the benefits of long term housing. The 1st thing you have to understand is what's called the housing 1st model.
- A few decades ago there was a major debate over what's best for people experiencing homelessness. Should you try to make them housing ready by making sure that their substance use disorder and their mental health was being treated first? st
- Or do you just give them housing first, st and let the other stuff come later. New York City was one of the 1st to do a head-to-head Rct. Of this they randomly assigned people to receive housing contingent on treatment and sobriety or to receive immediate housing without any treatment prerequisites that the latter is the experimental line. The former is the control line, as you can see housing 1st was a pretty clear winner in terms of keeping people housed long term.
- So if we give people housing, they tend to stay in housing. But does that improve their health outcomes? This is from Chicago, another randomized control trial. They looked at people in the hospital and then randomized them to either discharge, to respite care, followed by placement and permanent supportive housing or control, where they just got standard planning with a social worker.
- They found significant reductions in hospital days and er visits in the folks in the interventional arm.
- I'll just say right here that most of this research on housing interventions in this population focus on utilization.
- There isn't a lot of hard data on health outcomes here but I think that's more likely due to lack of published evidence rather than evidence of lack of efficacy.
- So what's happening at Uva on this front?
- We'll start with the Haven Clinic
- Haven clinic was founded by our own Dr. Ross Berline. He's going to be giving grand rounds next week, so be sure to check that out.
- This is a student run free clinic at the haven.
- What we try to do there is provide as much basic primary care services as we can. It's worth stating here that this is more of a suitcase clinic than a real clinic. We have our laptops, we have a couple boxes of supplies, but we're not doing labs or imaging, or Ekgs or vaccines here.

- A lot of what we do is try to foster trust in Uva providers, which there is a huge lack of in this population, and then try to plug people back in to the traditional healthcare system and try to help them with whatever barriers they have to doing so subsequently. There's several other specialties that have gotten involved. They're a huge help. We have a psych resident come out once a week, help with medication management. I definitely want to shout out the addiction team that includes an Rn. A social worker and a physician who are out there each week that are doing Obot.
- They're doing health and housing navigation services. They've been a huge health.
- And then recently, another group of medical students has been able to get gynecology to come out there once a month and provide women's health services.
- Another new initiative that we started seeing patients at the she shelter.
- This idea had faced a lot of logistical hurdles. It's taken years to come to fruition. So we're really excited to be out there. Now.
- Health nav. This is another Med Student led initiative. It's a group of volunteers that go out to the Potcham shelters in the winter, and then they're at the Haven when we're at doing Haven clinic trying to help patients with what we call health navigation tasks things like scheduling a Medicaid cab, navigating a refill request, filling out a Uva financial assistance application. Whatever patients need.
- Then I want to talk about the homeless Consulate service.
- This is our program. On the inpatient side.
- It was founded by a medical student, Jacqueline Carson. A couple years ago she had a personal background in working in homelessness services, and she noticed during her clinical rotations, a lot of patients getting discharged to the streets a lot of misunderstanding about the shelters and resources in our communities. So she kind of just took things into her own hands and started this whole thing from scratch with very little permission from anybody, and it's really expanded quite a bit from there. It's an all volunteer student run service. You page them.
- They'll go do an in-depth standardized interview with the patient, and then they'll try to help them with what they can as best they can.
- When this 1st got started it was really focusing on trying to connect patients to the premier circle shelter. Now that that's closed, they're more in the business of just giving people stuff.
- Cell phones are probably our most popular item, and we're super excited. That pop health is now has the funding and infrastructure to make cell phone distribution a more extensive hospital-wide program, very excited about that trying to connect people to the Haven clinic. If they need discharge, follow up, or they don't have ready access to their Pcp. That's 1 of the biggest things they do, too.
- We try to offer as much as we can, but sometimes all someone needs or wants is a sleeping bag, and that's fine, too and I'll just add here that since we started this we've had over 100 students rotate through this. It's a really great hands-on experience getting an in-depth understanding of social determinants of health. And the students just bring such great medicine. It's great energy to this. It's like. It's guerrilla medicine. They're just kind of doing what they think is best. They're not constrained by bureaucracy, and that's kind of what I love about it.
- To ask another question do tailored, homeless healthcare interventions improve outcomes. When I was asked to give this presentation, I thought I would be spending a good bit of time. On this, however, there's not a ton of published literature on this topic, at least in terms of hard outcomes. There's a lot of qualitative descriptive survey-based research, that kind of stuff insofar that there are published

data on health outcomes. It tends to look like this. This is internal data from the Haven clinic or we just looked at encounters after they had a visit at the clinic and encounters from before they had a visit at the clinic. You can see they had pretty big drop in er encounters here. Now I think it's fair to consider that there might be some confounders that can skew these kind of pre post comparisons. But anecdotally these outcomes seem plausible to me.

- As I mentioned, there's some limitations on what we can do at the Haven clinic, but a lot of what people need is fairly straightforward. Often it's like, I just need a refill of my kepra. I just need a refill of my Seroquel. I just need an antibiotic for an early cellulitis. Those are all things that can stave off some of these er visits alright. So instead of like dumping more charts on. Y'all, I decide at this point I'll just tell a story. So in January of 2024, we saw a young man 25 years old.
- One of the students coaxed him upstairs. He didn't really want to come upstairs, but he was ill. He had viral Uri symptoms.
- We weren't expecting to do much for him. So the student went back and started taking a history, and then one of the residents just kind of started digging through his chart. His chart had literally nothing in it except one Pdf. In the media tab.
- And this Pdf. Showed this.
- And when we looked at this we're like what is P is P. Positive is P. Pending.
- We kind of knew in our bones that it meant positive. What was the problem here is that the patient had no idea about this and this test had happened a year, you know, a year or 2 prior to us. Seeing him.
- So we game planned a little bit. The Resident went back there and saw them. This was Dan Patterson, current cardiology fellow. So shout out to him, we talked him through it. We emailed the Ryan White team. He got an appointment. 8 days later he got started on Big Tarvy within a month of this and looking through his chart. He kind of had an up and down year from a mental health perspective, but as of December he's in housing now, stably, and he's undetectable, which is great and you know, had he not seen us that day, I don't think he would have ever found out about this until he developed aids, so I think this really speaks to the power of just trying to meet patients where they are, and the impact that can have.
- So going back to the title of this presentation, how can we help at an institutional level?
- Continuing to invest in these kind of outreach programs is key. So we can meet people where they are. We've made a lot of strides in this last few years between all the shelter clinics I mentioned, we're now partnering with a community health worker program. I'm sure you all have heard about this mobile caravan that has started going out to our more underserved neighborhoods. All good stuff. I think the next frontier, for our team would be street medicine.
- There's over a hundred street medicine programs across the country. It would be great if we had one of them.
- I think this is really important, because the majority of people experiencing homelessness in our area do not go to the haven or engage with it at all. This is data from the homeless conflict service, and I talk to people routinely who say, I don't like going to the haven. I don't want to walk in there. So this could be a huge benefit to a lot of people.
- As I mentioned, respite. Care would be a huge win if we could get it.

- Another thought here is, you know, we've started screening every patient who's admitted for housing, insecurity and various other Sdohs. Can we, as a hospital, actually be involved in preventing homelessness.
- I think we could. It's so much cheaper to just cut someone a 1 month rent check than it is to try to pull someone out of homelessness once they found themselves in it. So I think there's a dollars and cents case to make for this. I didn't make up any of these ideas. There are other academic health systems that do this.
- And I'll also mention there are some health systems that have actually gotten in the game of housing.
- I understand there's plenty of arguments that that's not our lane, not our role. But I'm just saying it can be done.
- Homelessness, I know, just feels like this big, unsolvable problem that no one individual could possibly make an impact on.
- I think that sense of helplessness kind of paralyzes people and limits engagement on this issue.
- I think it even limits people being willing to look at the problem in the face. If I could ask one thing of. Y'all, it would be just to make eye contact with people you see on the downtown Mall acknowledging someone's humanity really does make a huge difference here and even if you have money to give, you might ask yourself.
- What's a hundred bucks? Gonna do you know that's not going to put someone in housing? But it could fund breakfast for dozens of people who are looking for a hot meal at the Haven, and I think it's just worth saying out loud that that breakfast matters.
- Breakfast is not getting anyone off the street, but it matters not. Everything we have to do has to be about root causes. Trimming. The branches can still help.
- But if you're interested in root causes and you've been following the theme of my presentation you'll understand that homeless healthcare at its core is a housing problem.
- So if you really want to get to the root cause, it's housing.
- Fortunately, this is one of the few issues that really falls on local governments. So your individual voice can make a really big difference here.
- So just to summarize this whole debate for decades housing debates have really been dominated by people that you've probably heard disparagingly referred to as nimbys, not in my backyard folks who try to veto further housing development in their communities. For various reasons this has led to a counter movement called the Yimby's yes, in my backyard, who really want local governments to prioritize affordable housing and increase the housing supply and increasing the housing supply really comes down to zoning regulations. Charlottesville just went through a pretty contentious process of updating its zoning ordinances, but ultimately it was a victory for Team Yimby and I'm aware that using the word zoning is just going to make your eyes gloss over for most of you, but I do want to argue that getting involved in these processes is really one of the highest yield things you can do to try to address homelessness and housing insecurity in our region and that brings us to the county which is currently in the process of updating its own zoning map. I know many of your county residents.
- My take on. Why the county is so expensive.
- The county is kind of an inherent dilemma, you know. We draw people who want to live in a low density community away from cities, away from big suburbs.

- But those people like me also want to be 10 min away from the downtown mall, and if a large number of people want to live in a very small area, that is low density, that creates an inherent scarcity of housing.
- This map on the right shows all the places in the county where you're allowed to build anything besides single family houses. That's not a lot of land to work with. And even if you don't like the idea of developing the county further.
- I hope you'll at least accept the premise that this is a constraint on our ability to create more housing. You can only build out or up and I would ask you to consider whether this situation is compatible with a thriving community.
- How can we attract nurses and teachers to this area if they can't afford the rent?
- Why would our children and grandchildren want to live here if they could never afford to buy a house here just food for thought for the county residents in the audience.
- So if you want to get more involved, a couple of places. You can start learn more about housing policy.
- I love the Atlantic's good on paper, podcast it's excellent. They have a couple episodes on housing that are really helpful here you can get updates from the County Planning commission so you can follow along when all these meetings are happening liveable. Seaville is a great organization advocating for affordable housing.
- And if you want to say email, your local rep on the Board of Supervisors, then kind of walk you through, how to do it and then actually going to a meeting.
- It's not that scary. I went to my one myself last month. I got coaxed into speaking it went okay.
- The bar for a quality. Public comment is very low, and when they hear you're a doctor, their ears do perk up. So like, I said, this is a place where you can have an impact.
- I'll leave it at that, and I'll take questions.
- Great presentation. Thank you so much.
- But I did sit on the homeless board for the county and city. I can tell you that one person can make a difference because you've done so. We've seen some of the activities you've been involved with. You can really make a change. So I'd like to applaud you for that question I have is, I think, what comes up, perhaps myself when I ward attend is when you do have that sort of refractory, homeless patient taken care of, and you've got the case, manager saying, Put them on the street. But what would you advise us as house staffing doctors and advocates to do in those situations. I mean, that's a really tough question to answer.
- I think, as you all saw at the end of the day, there just isn't a lot of places for these people to go you in terms of logistics. Of that you can touch base with the homeless consult service.
- There's a very limited number of hotel spots for some of these folks. That's not exactly a publicly known resource, but
- I think it really just starts with empathy like, I said, and trying to combat some of those stigmas but I I don't have a good solution to that, because there's so many structural barriers in our community right now.
- Thank you for your talk. So earlier in your talk, you mentioned how a lot of our population in particular. You know, the majority of them are actually living with other people, or in their car, in some sort of sheltering situation. But prior to being out on the street and I was sort of reflecting on meeting. I was in multidisciplinary rounds

last week, and we had a patient who was living with his friend. There was a comment from social worker that he was homeless, and another voice in the room was like, well, he has a shelter over his head, so he's not technically homeless.

- So I think and it sort of left the room with this sense of you know. Well, he's living with a friend, so he's good. There's nothing else we need to do in those scenarios from our perspective. Is that still appropriate for us to be consulting the homeless Council service? You know. What should we be? Should we think about folks that are living with other people differently than people living on the street? How would you advise us, you know to advocate for those patients still, yeah, well, I think
- HUD would not call that person homeless. But I think most homelessness. Research would say, that person is homeless, and I think it would be fair to talk to the homeless consult service, because even if they do have a roof over their head, they're in a pretty precarious situation that puts them at high risk for not having a roof over their head, so at least making sure that they're aware of the resources available in the community. Even if they don't have an immediate need at this moment.
- It's totally appropriate. Matt, you're going to have an email in your inbox from Kyle infield who wants to help build the street medicine team. He has a specialty in wilderness medicine, so apparently you can see them on the street or in the woods. But my question for you is, what do you think is necessary to actually get this team built out and moving and anticipating what the pushback will be from the health system. How do you build the argument that going out and seeing these patients is ultimately good from many different metrics for that.
- Try not to get in trouble here. But I think
- Thus far, I mean, we've we've started dipping our toes into this a little bit. The Med school hasn't really seemed to have any opposition to students going outside and talking to people thus far. Strict. Strictly speaking the health system wants us to bill these encounters for various reasons. They destroy the bill on the back end, but they want us to. Bill billing for street medicine is more complicated because it needs there's a Cms place code that you need to set up.
- All this is to say, is like epic billing and compliance. People need to be involved. Set this up in terms of resources.
- I don't know that we need a lot. We've been operating with very little for a while now. I guess that same thing with our suitcase clinic. You know we have stuff to take vitals. We have wound care stuff that's usually a good place to start. I mean, the main thing we're trying to do is build connections and just try to reach people and over time try to plug them back in.
- Oh, to to the traditional healthcare system!
- Would it be great if we had just like a full time social worker, a full time case manager helping out with all these programs. Yes, I think that would probably be the biggest win for us.
- Matt, thanks for your talk. I really appreciated it. And I I think, you've been kind of a model of someone who just cares about people and then goes out and does it, and and spends your time doing that.
- What do you think? Because and you've been doing this since you're a resident, and I'm sure, probably before. What do you think that being so intimately involved, working on the day to day of trying to care for these patients has changed your your view of those people individually as well as globally, people who are homeless.
- That's a great question, I think.

- Yeah, I'll say this like doing this. This work is really what gives me energy. I mean, this is really what combats Burnout for me, because, you know, I see all as a primary care, doctor, I see all these issues in our health system. And this is really just a great opportunity to operate a little bit outside the health system and just take spend more time with people and get to know their stories. You know I can't. It's hard to do that in 20 min clinic visits, when I sit down for an hour with somebody and just hear their story.
- That really just helps cultivate that empathy and that understanding. This was not something I was passionate about coming into med school or residency. I just kind of stumbled into it.
- But since I've had, I'm really glad I did, because it's it's really changed my outlook.
- I didn't come out.
- Oh hey, Dr. Allen! Hi! So I'm just curious. If there is like what long term goals you have, I know, having a full time. Social worker would be awesome. But maybe, are there any like long term goals that you think could be more achievable in the near future? Whether it's turning the haven clinic into maybe more functional clinic. Where we do, we are able to provide vaccines and more testing. What are your thoughts on that?
- I really love those ideas. I really want to pursue them. I think right now. I we are a little bit constrained by the resources we have available to us, plus just the logistical challenges of like, how do you give a vaccine when you don't have a pyxis on site? This is these are tricky things to to overcome.
- But there are lots of communities that have, you know, have an academic health system that have shelter based clinics. It can be done. It's just there's a lot lot of work that would have to be put into it. So
- I know us medical students here. We have like an opportunity to be more involved. And is there anything us as students could do to maybe talk to administration, or any advice for us to help with this problem?
- Y'all are already doing great like, I said, if I didn't make this clear like this is 90% student-led efforts.
- I y'all are running the show. Y'all are doing such a great job. Y'all done enough. And this and I think honestly, that's what's been a little that the flip side of that, though, is that you know, we're kind of relying on an all volunteer service to do all these things, and there's just inherent limitations. With that
- I would recommend volunteering to get breakfast at the Haven. You'll see about half of them are Uma patients, anyway, and they'll recognize you. But it's it actually feels very good, and it's as Matt says, really doing something.
- Get into the rotation very easily.
- I think there's an age I do not know better. I can't say I've ever seen kids there. Okay you can volunteer as a family.
- Yeah to the the health system barrier. And what is difficult.
- Yeah, so so long.
- That's I mean, as you know, this kind of came up with the She Shelter clinic. I can't really follow the medical legal logic that came out of that discussion.
- but he. What he was saying is that there's these medicare enticement laws that basically, are you from trying to solicit? Yeah which that doesn't really make sense to me when there are free clinics like all over the country.
- But all that's to say is, is, it's

- It has led to the general decision that we are supposed to bill these patients, even though we destroy the bill on the back end we're still billing.
- Yeah, it's a very, very, very conservative interpretation. Yeah, not held by many other states.
- Thank you.