

Potential Barriers to Success

#1: The economy is experiencing a serious downturn. Human needs and the costs of meeting those needs are increasing while available funding from ALL sources is decreasing.

#2: Homelessness is a dynamic, multi-dimensional problem and forecasting models are challenging for even sophisticated economists. The Continuum of Care proposes to tackle housing assessments with economic, growth, labor, and industry projections. Sector members will need to remain focused on developing a simple, usable tool that provides a numerical basis for projecting housing needs over the next 3-5 years. The goal cannot be to create a perfect tool. The goal is to quantify a series of weighted factors that provide the basis for realistic projections and enables agencies to move forward proactively rather than reactively.

#3: No matter how “welcoming” the individual homeless and housing service providers wish to be to those in the community, resources and other limitations and restrictions on each agency almost always result in certain eligibility requirements for prospective clients. For example, some agencies can serve families while others can serve only individuals. Some agencies have special resources and expertise to deal with serious mental/emotional disorders and some do not. Some agencies can provide emergency short-term shelter only and some can provide longer but still time-limited housing. These constraints necessitate extensive coordination and cooperation among service providers. Agencies and funders need to combine resources, when possible, to meet the special needs of those clients who cannot be served by any one agency alone. Unfortunately, gaps remain, not only in the number of housing units available versus the number required but also in the types of services and support that can be provided even by collective cooperation.

Meeting HUD Priorities

The housing sector specifically supports the following HUD Priorities.

HUD Priority	
A	Providing increased homeownership and rental opportunities for low- and moderate-income persons, persons with disabilities, the elderly, minorities, and persons with limited English proficiency.
B7	Make communities more livable.
D	Providing full and equal access to grassroots, faith-based and other community organization to HUD program implementation.
F1	Creating affordable housing units, supportive housing, and group homes.
F2	Establishing set-aside of units of affordable housing for the chronically homeless.
F5	Establishing counseling programs that assist homeless persons in finding housing, managing finances, managing anger, and building interpersonal relationships.
F6	Providing supportive services, such as health care assistance that will permit homeless individuals to become productive members of society.
F7	Providing service coordinators or one-top assistance centers that will ensure that chronically homeless persons have access to a variety of social services.

H2	Building new or rehabilitate existing single-family homes to Energy Star standards for new homes, or include combined heat and power in multifamily properties.
H3	Meeting the requirements for Energy Star qualified New Homes for gut rehabilitation or new construction of low-rise multifamily housing.
I1	Providing low- and moderate-income households with information on FHA products as safe consumer alternatives to reduce costs and reliance on subprime lenders.
I2	Providing consumers with information on Fair Lending and discriminatory lending practices in languages appropriate to the clientele being served.

In addition to meeting HUD priorities, all agencies must work toward adjusting some of HUD's more restrictive policies that block providing timely and cost-effective help to the homeless. One of the more important of these is broadening HUD's definitions of "homelessness" so that service agencies can intervene earlier in the cycle leading to homelessness. These include loosening the restrictions regarding living in overcrowded conditions and allowing housing and services to families about to be evicted before they go to court. The goal is to allow for homeless prevention and earlier intervention thereby creating more positive results.

SECTOR 2: HEALTHCARE

Overarching Goal

The sector will be a streamlined healthcare system comparable to any in the United States. An integrated and seamless continuum of physical and mental health services will offer timely access for all homeless regardless of ability to pay. Open access and an integrated model of care will lessen the burden of caring for the homeless in Colorado Springs by decreasing Emergency Department visits and hospital admissions. This goal will be achieved by providing comprehensive evidence-based treatment, increased availability of specialty services, effective healthcare screening, and preventative measures in the homeless setting.

Sector Description

The healthcare sector provides physical and mental healthcare to the homeless population. A comprehensive primary care system should include prevention services, screening, immunizations, assessment, psychiatric services, individual and group therapy, paraprofessional and peer support services, medication and med monitoring services, service coordination, comprehensive service planning, support groups, education groups, and advocacy services.

Acute care reflects the need for immediate action and services should include testing and assessment, medication provision, short-term care or hospitalization. Behavioral health acute care includes short-term rehabilitation or stabilization services which may include hospitalization and detox services (5 to 10 days), community liaison services and discharge planning, and follow-up, partial hospitalization/day-treatment programs, community stabilization units, outreach services, psychosocial rehab services, supported employment, and mobile crisis response teams.

Many homeless suffer with chronic diseases such as diabetes, chronic obstructive pulmonary disease, and alcoholism. These diseases require long-term care and monitoring. Treatment of the chronically ill should include case coordination, paraprofessional services, consumer run drop-in services, self-help groups/services, outreach services, psychosocial rehab services, supported employment, advocacy services, social/recreational support services, Integrated Dual Disorder Treatment teams, psychiatric services, individual and group therapy, paraprofessional and peer support services, medications, and medication monitoring services.

Hospital Emergency Departments currently provide much of the emergent medical care and admissions. Walk-in clinics (e.g., Peak Vista Homeless Health Center, SET of Colorado Springs, Mission Medical) provide quick care and assessment based on complexity and are generally free to the homeless. The Criminal Justice Center provides basic care when homeless clients are jailed. There are some private practice clinics that will see the occasional patient for free but service does not usually include access to specialists. The Peak Vista Community Health Center's Homeless Health Center provides comprehensive medical care and specialty referral. Extended outreach for homeless patients exists directly on the streets and via a nighttime mobile clinic. Specialty services for eating disorders, neuropsychiatry psychology, developmental

disability services, geriatric services, veteran, and youth are almost nonexistent. Communication regarding health care and treatment plans between agencies is inconsistent. Key medical sector providers include the following agencies.

Provider	Services
Peak Vista Homeless Health Center	Physical and dental health care
SET of Colorado Springs	Chronic and acute medical care
Mission Medical Clinic	Physical and dental health care
The Collaborative	access to co-occurring disorder treatment
Harbor House	substance abuse/mental health treatment
Pikes Peak Behavioral Health	mental health/substance abuse treatment
Bridge to Awareness	Substance abuse and co-occurring disorders

Three in five (40%) of survey respondents reported having a serious medical condition in the 2006 Colorado point-in-time homeless count. Based on statistics from the Peak Vista Homeless clinic over half of the 2,300 unduplicated clients seen at the clinic have a physical disorder and a co-occurring behavioral health disorder which frequently interferes with their ability to successfully participate in their health care treatment. An estimated additional 20% of homeless are seen at CATCH (Safety net) Clinics and Emergency Rooms for unmet behavioral health issues.

Progress in the Last Five Years

A significant attempt has been made to provide medical outreach to homeless individuals that cannot access clinics during their collectively limited hours of operation. The fact that many homeless are, in fact, employed, makes afterhours access critical to decreasing hospitals' Emergency Department burden. Some walk-in clinics are trying to adapt to a more primary model of care adopting effective practices from other parts of the country.

Current Gaps and Barriers

Behavioral health service for the homeless have suffered multiple set backs in the last five years. With the loss of the homeless grant in 2004, respite care services were eliminated and the Homeless Outreach team services were slashed. Until 2007, there were no dedicated psychiatric or therapy services available. In 2007, the Health Department announced the elimination of the substance abuse services they offered which eliminated outreach services to over 600 homeless individuals and substance abuse treatment services to over 250.

Currently the Safety Net clinics provide limited behavioral health services and are only willing to treat those without severe mental health issues. Outreach and case management services are provided by RAP (Resource Advocacy Program) for approximately 100 individuals with co-occurring mental health and substance abuse disorders. Pikes Peak Mental Health has one licensed mental health professional providing services, annually, to 25 individuals with severe mental illness, woefully inadequate for the estimated 400 homeless with debilitating behavioral health issues.

Colorado Springs is relatively new in its effort to comprehensively deal with the homeless. There is ignorance regarding the homeless condition by many in the medical field. This lends itself to the following gaps.

- A lack of formal interagency communication and referral processes. For example, when a homeless individual has been an inpatient at a local hospital there is no respite facility at which to continue the healing process upon release. For other homeless with significant medical issues, there is limited access to specialty services such as neurology or orthopedics. The lack of direct interagency communication is also revealed in the shortage of case management/social services, care coordination and outreach services.
- Limited clinic hours due, primarily, to static funding. This exacerbates the Emergency Department revolving door when the homeless use hospitals for primary care.
- A well-constructed, community-wide pain management program for the addicted patient.
- Dental services which are limited to extractions only. There are no reparative or restorative services available to the homeless.
- A lack of community-wide, concerted effort to retro-access benefits for qualifying patients (e.g., Medicaid, Medicare). In addition, the benefits application process is cumbersome and difficult for the homeless with behavioral health challenges (the current Medicaid application is 28 pages long).
- Homeless are frequently unsuccessful in traditional behavioral and co-occurring disorder treatment programs.
- Lack of training for behavioral health professionals in El Paso County on how to work with the homeless. In addition, many health professionals have limited experience working with chronic inebriates and those with severe mental health illnesses.
- Community shortages of psychiatric physicians, Nurse Practitioners and uninsured patient access to psychotropic meds.

- Limited access to transportation services, bus and cab vouchers impact medical service provision.
- Fragmented and restrictive funding streams which could be leveraged to better serve this population (HUD, Medicaid, Mental Health Block Grant, Federal PATH and ADAD).

While the healthcare sector is improving, member agencies are less experienced than communities that have been providing services and developing policy on homelessness for decades. The following pages outline the sector's strategies and action steps for closing gaps.