Using Community Health Workers to Improve the Health of Homeless Individuals

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Chronic homelessness is a major public health issue that decreases life expectancy by approximately 30 years (Vázquez et al. 2005, 35-56). This decrease is due, in part, to inadequate access and use of preventative health services and a five-fold increase in reliance on emergency medical services over housed individuals (Aspinall, 2014). Our organization, Up and Running Healthcare Solutions, partnered with the Bethesda project, a Philadelphia-based nonprofit homeless care provider, to implement an innovative solution to address this social issue. The Bethesda Project actively houses 2,000 chronically homeless individuals in Philadelphia yearly; 60 percent of the residents served have mental illnesses identified by staff, 65 percent have serious medical conditions, and 45 percent have a history of addiction-related factors that increase their risk for poor health outcomes. The national and local statistics of homelessness are alarming and we sought to address this major issue (Zlotnick and Zerger 2009, 18-26; Kushel, Vittinghoff, and Haas 2001, 200-

206; Bernstein et al. 2015, e60; Koegel et al. 1999, 306-317; Jones et al. 2009, 69-77; Henwood et al. 2017, 1-4; Levitt et al. 2009, 978-981) . Homeless individuals are among the most vulnerable experiencing a myriad of health disparities and inequities that adversely impact quality of life.

We were first exposed to homelessness when we were nursing students at the University of Pennsylvania (Penn). It started during Ian's Sophomore year of college. He had recently joined Old First Reformed Church, a congregation that focuses on outreach ministry with Philadelphia's homeless individuals in partnership with the Bethesda Project. As he became more familiar with the population and gained their trust they began to present him with their health questions. A lot of questions went above the scope of what two years of nursing education could handle, however the majority of issues were resolved through referrals to primary and mental health care.

At the time, we both worked at the Center for Health Equity Research at Penn's School of Nursing. We worked separately at the time, Marcus with Dr. Janet Deatrick focusing on advancing health equity research and Ian with Dr. Terri Lipman on community based fitness solutions to improve health outcomes. Ian applied for and received a research grant from the Office of Nursing Research to study factors impacting the delivery of health to homeless individuals in Philadelphia. With both of us having an interest in health equity and developing a solution to

address homeless health, we applied for a position in the highly competitive Philadelphia Social Innovations Lab (PSIL). Marcus believed this idea incubator could be the springboard to turn the theoretical results of the research study into practical improvements in health for homeless individuals.

We worked through PSIL to further develop our fledgling proposal into a fundable and sustainable model for care delivery. Over the course of the program, we learned a variety of social enterprise, financial, and entrepreneurial competencies from leaders in social and health care innovations. PSIL equipped us with the skills necessary to further develop our idea to improve healthcare delivery and address health disparities for homeless individuals. With the help of experts in the field at PSIL we refined our pitch, addressed possible problems, and prepared for our final presentation alongside other upcoming social innovators in Philadelphia.

Following our time with the PSIL, we prepared to apply for the President's Engagement Prize, a $100,000 grant available to graduating seniors at Penn to launch a social innovation to engage with the community on a local, national, or global level. More than 50 people applied for this prestigious prize and our project, Homeless Health and Nursing: Building Community Partnerships for a Healthier Future, was one of the three selected for funding.

This award enabled us to establish Up and Running Healthcare Solutions, a homeless healthcare case management organization. Our program of services provides individuals experiencing homelessness in Philadelphia with the tools, partnerships, and support that they need to achieve their health goals.

This organization seeks to mitigate the effects that the social determinants of health can have on homeless individuals' health. These social determinants include the factors of where people live, work, sleep, play, and pray and the subsequent impacts on their health. Up and Running Health addresses these determinants using Community Health Workers, specially trained community members who understand homeless healthcare delivery on a personal level. Community Health Workers are individuals that have the unique ability to gain trust and build therapeutic relationships due to their deep understanding of the community's needs, values, and beliefs.

Our model is unique because it was developed primarily from the voices of the homeless individuals that it serves through focus groups and ongoing feedback. While the academic literature on homeless healthcare is well developed, it often leaves out the voices and personal experiences of homeless individuals. We integrated the lived experiences of these homeless individuals with existing academic knowledge to create a program that will be successful at providing for the needs of this

population.

Up and Running Health collaborates with the Bethesda Project to better serve the homeless individuals of Philadelphia. This collaboration allows us to provide complimentary packages of service to this population. The organization seeks to work with individuals who have fallen into homelessness to assist them in achieving their health goals as one step toward an improved quality of life.

Up and Running Healthcare solutions currently employs three Community Health Workers who serve as the hands and feet of our healthcare initiative. The organization provides healthcare in three distinct ways:

1. **Individual Medical Case Management**
   This aspect of our program consists of daily CHW interactions with a defined cohort of clients who require continuous intensive case management. CHW partners closely with these individuals to determine the unique challenges that they face in receiving adequate care and develop personal health-based goals. Our CHW's serve as a patient advocates and care coordinators.
2. **Confidential Support Groups**
   A large portion of the population served through the Bethesda Project have expressed difficulty in coping with mental health and substance abuse. Each week, two groups are conducted focusing on specific topics

related to mental health and addiction. These groups are predicated on confidentiality and allow for the homeless individuals to share their thoughts, opinions, and feelings in a safe space. These groups are conducted when the shelter is open to the general population including those who do not reside at the Bethesda Project. This allows our organization to have a wider reach among the community.

3. **“Ask the Nurses” Table**
   This is designed as a space to allow individuals at the Bethesda Project to seek more advanced health education. The purpose of this program is to provide a space where the individuals can talk to the nurse leaders of Up and Running Health to ask more complex health questions.

Our program is currently in the pilot stage, but has already shown promising results. Homeless individuals are among the highest utilizers of emergency medical services and our program prevents unnecessary emergency department visits and inpatient admission through active care coordination and education. With the use of community health workers, we can decrease emergency medical costs and bolster the role primary care plays in individuals' lives.

Our next steps will be to establish a plan to sustain our organization after our seed funding from the President’s Engagement prize have been expended. Throughout this period, we will be leaning heavily on our experiences and

expertise gained from the PSIL. We have established a partnership with Philadelphia VIP, a pro-bono legal service organization, to work toward gaining 501(c)(3) tax-exempt status. This will allow us to seek out larger grants to continue providing this vital service. We have also partnered with the National Nurse-Led Care Consortium (NNCC) to work with public health nurse leaders throughout Philadelphia that provide care to vulnerable populations and have a focus on ameliorating the social determinants of health. This partnership has allowed us to identify care systems that work for homeless individuals, who require a unique level of provider support, care coordination, and education. In addition, NNCC is actively engaged in the development of our organization's strategic plan and sustainability model.

Another important future step for Up and Running Health will be to establish effective methods to evaluate the impact that our organization has had. This will take place through a series of defined factors to indicate the progress that individuals are making as well as the community served as a whole. We have worked with the community and existing academic literature to create a system of documentation that will provide the information needed to evaluate the effectiveness of the program and disseminate it to prospective funders, the academic community, and the individual's whom we are serving.

Our program seeks to transform the way we think about homeless healthcare. Our healthcare system has begun to

shift its focus to preventative care, however community-based programs are still lacking and underfunded. These programs provide much needed support to educate and empower individuals and community members. Our program provides a cost-effective community based program to empower individuals and communities to take control of social determinants affecting both their health and the community’s. Innovative solutions such as ours can begin building a culture of health locally and globally.

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