

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**ACCESS TO COMMUNITY HEALTH
CENTERS BY HOMELESS PERSONS**



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Inspector General

JULY 1996
OEI-07-95-00060

EXECUTIVE SUMMARY

PURPOSE

To determine the extent that Federally funded community health centers serve homeless people and how such services can be improved.

BACKGROUND

This survey was requested by the Office of the Assistant Secretary for Planning and Evaluation, (ASPE) representing the Secretary of the Department of Health and Human Services as a member of the Federal Interagency Council on the Homeless.

Community health centers (CHCs) are health clinics that provide comprehensive family-oriented preventive and primary health services to medically underserved, disadvantaged populations experiencing financial, geographic, or cultural barriers to care. There are 623 Federally supported centers in the U.S. and its territories which serve over seven million people.

We selected a random sample of 72 urban centers. We then obtained the names and addresses of homeless shelters in each of their service areas. We did not gather information from centers which received grants under the Health Care for the Homeless Program since these programs are funded to serve the health care needs of homeless persons.

We mailed surveys to the sample of centers and homeless shelters. These surveys focused on barriers on accessing services, outreach services to the shelters, referrals of homeless clients, treatment services, and case management for homeless persons. We received surveys from 50 centers and 98 shelters in 46 cities.

We also conducted on-site visits at 6 cities with 7 CHCs and 16 nearby shelters. At these cities we interviewed center management and the directors of homeless shelters to supplement and clarify information from the surveys.

FINDINGS

Two Thirds of the Community Health Centers Provide Outreach Services for Homeless People

We found that 64 percent (32 of 50) of the CHCs provide outreach services for homeless people. These services include sending staff to homeless shelters, and/or contacting homeless shelters to provide information on services available. However, we found that for 13 of these centers at least one nearby shelter reported that the centers do not send staff to their shelter.

It is possible that in 9 of the 18 cities where centers did not provide outreach services the health care needs of homeless persons might be served because a specific Health Care for the Homeless Program, funded under a Federal Section 340 Public Health Service grant, exists in those cities. However, the remaining nine cities had neither a Health Care for the Homeless Program nor outreach from the local center.

Community Health Centers Provide A Wide Range Of Treatment Services To Homeless People

The CHCs provide a broad range of treatment services such as acute medical examinations and treatment, screening services for tuberculosis, hypertension, sexually transmitted diseases, and preventive services including well child care, immunizations, comprehensive physicals, prenatal monitoring, and dental. They also provide prescription drugs, laboratory, and radiology services.

Nevertheless, The Centers Face Significant Barriers In Providing Services

Sixty-nine percent (34 of 49) of the CHCs reported that barriers existed with homeless persons obtaining services from the center. The most significant barriers are the lack of available transportation, the center's hours of operation, the clients' inability/unwillingness to follow through on a plan of care, unavailability of necessary services in the community, and the transient status of homeless persons. Fourteen percent adapted their treatment or screening protocols to meet the needs of homeless clients.

Some Homeless Shelters Do Not Refer Clients To Nearby Health Centers

Twenty-eight percent (27 of 97) of the shelters reported they did not refer clients to the centers for health care services. The remaining 70 homeless shelters did. Shelter clients used public transportation, shelter bus tokens, or their own transportation to travel to the centers. Others walked, relied on family and friends, or in some cases used an ambulance.

OPPORTUNITIES FOR IMPROVEMENT

The findings in this report reflect a greater potential for Community Health Centers helping homeless people and suggest that better communication between the Health Resources and Services Administration (HRSA) and the centers, and between the centers and homeless shelters could have a positive impact on access to medical services for homeless individuals.

HRSA can pursue improvements in services offered homeless people in the Community Health Center program by building on its existing efforts. This might include:

- Developing and disseminating materials about effective practices.

- Holding workshops and training sessions for community health centers.
- Emphasizing the responsibility to lessen all barriers which diminish the ability to serve homeless persons who present themselves to the clinic (e.g., hours of operation, transportation to the center).
- Encouraging periodic contact between management of the health centers and the shelters.

Community Health Centers themselves should improve communication with homeless shelters. Some ways to accomplish this include:

- Identifying all homeless shelters that exist in their service areas. The city task forces, coalitions, or networks on homelessness are valuable resources.
- Providing, on a routine basis, information to those homeless shelters in their service areas on services available and locations.
- Conducting periodic meetings with homeless shelters to discuss the medical needs situation in their area, the barriers that exist, and means to best address those barriers.

AGENCY COMMENTS AND OIG RESPONSE

We received written comments from both HRSA and ASPE. HRSA concurred with our suggestions and will develop an action plan to implement them. ASPE commented on the importance of the findings, but raised some questions and made recommendations for additional analyses. As they requested, we clarified our use of the terms "homeless" and "outreach." Their suggestions for additional analysis of such topics as referral patterns, service coordination, emergency services, case management, and actions taken to address barriers are important. Unfortunately they are beyond the scope of our study, which was limited primarily to ascertaining whether and to what extent the community health centers funded by the Federal Government were actively involved in serving homeless individuals. Copies of their comments are attached.

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INTRODUCTION

PURPOSE

To determine the extent that Federally funded community health centers (CHCs) serve homeless people and how such services can be improved.

BACKGROUND

This survey was requested by the Office of the Assistant Secretary for Planning and Evaluation, (ASPE) representing the Secretary of the Department of Health and Human Services as a member of The Federal Interagency Task Force on the Homeless.

Homeless People

Homeless people are a heterogenous group of men, women and children. They include long term street dwellers, residents of homeless shelters and temporary living quarters, the chronically mentally ill, the economically disadvantaged, single men and women, the physically abused, families with children, as well as runaway and castoff youths.

Homeless individuals have a variety of health care problems, including a high incidence of mental illness and substance abuse/alcohol disorders. In over half of the cases, they are without health insurance to cover medical care for physical and emotional problems.

Community Health Centers

CHCs are health clinics that were first funded by the federal government as part of the "War on Poverty" in the mid-1960's. Originally managed under the Economic Opportunity Act, the neighborhood health center program was transferred to the Public Health Service in the early 1970's. Centers are located in each of the 50 States, the District of Columbia, and the U.S. Territories and Possessions. The authorizing legislation is Section 330 of the Public Health Service Act, Public Law 94-63.

The centers provide comprehensive family-oriented preventive and primary health services to medically underserved, disadvantaged populations experiencing financial, geographic or cultural barriers to care. They tailor services to meet the specific needs of the community and special populations that include homeless persons, people infected with HIV/AIDS, the elderly, and substance abusers.

There are 623 Federally supported CHCs in the United States and its territories. Serving over seven million people, they are a significant component of the health care services industry in this country. An estimated 61 percent of center users are

members of minority groups (27 percent African American, 27 percent Hispanic, and 7 percent other). Also, about 63 percent have incomes under the poverty level and another 22 percent are between 100 and 200 percent of poverty.

To fulfill the provisions of the Public Health Service Act (42 USC 254c), the centers must, either through its staff and supporting resources, or through contracts or cooperative arrangements:

- Serve areas designated as medically underserved;
- Provide basic primary medical care services plus support and facilitating services appropriate for the target population;
- Have a governing board where the majority of the members are users of the centers' services; and
- Adjust the cost of services to the patient's ability to pay.

The support services that supplement basic services include mental health services, dental services, eye examinations and glasses, podiatry services, ambulatory surgical services, health education services (including nutrition education), and other services appropriate to meet the health needs of their medically underserved population.

Medical services are provided to homeless individuals who present themselves to the center for care. Charges for services are based upon income of the patient. As such, homeless individuals are served as are other patients who utilize the center for medical care.

Correspondingly, Health Care for the Homeless Programs (Section 340 of the Act), which were not the subject of this study, receive targeted funds and thus should be more able to conduct outreach and deal with the complex problems of individuals living on the streets and in other nontraditional settings.

METHODOLOGY

Inspection Focus

The inspection focuses on how CHC's can best service the health care needs of homeless persons.

Sample Selection

We used the Bureau of Primary Health Care's 1994 Directory of Primary Care Programs to identify centers which were funded under Section 330 of the Public Health Service Act. We excluded any centers which also received special funding to operate a Health Care for the Homeless Program.

We selected from the universe of 198 urban Section 330 CHCs a random sample of 72 centers. We excluded rural centers because a random telephone survey of 30 rural centers had shown the majority of them do not serve on-the-street homeless persons or do not have homeless shelters in their service areas. From the sampled centers we obtained the names and addresses of 172 homeless shelters in their service areas. In addition to a mail survey sent to sampled centers we conducted on-site visits to 6 cities with 7 centers and 16 shelters. At these cities we interviewed the centers' management and the directors of homeless shelters to supplement and clarify information from the surveys.

We mailed surveys to the sample of centers and homeless shelters. These surveys focused on the following issues with data pertaining to calendar year 1994.

- Outreach services to the shelters
- Treatment services
- Barriers on accessing services
- Referrals of homeless clients

We received completed surveys from 50 centers and 98 shelters located in 46 cities. Eighty-six percent of the them had a corresponding shelter return a survey. While the surveys were comprised of many closed-ended questions, we also used open-ended questions which provided more in-depth information to explain and expand upon close-ended responses.

We summarized and tabulated the self reported responses to all the survey questions. The responses were quantified to determine such issues as the extent of barriers that prevented access to services, the number of CHCs that provide outreach services to homeless shelters, and the quantity and type of referrals for medical and/or financial services.

Due to survey constraints in our study design we did not examine all health center service configurations that provide medical care to homeless people. Therefore, the total extent of arrangements among shelters and service providers to refer to a particular program because of specific capabilities could not be taken into account. This could have been the case for cities in our study which had Health Care for the Homeless Programs, plus an unknown number of those cities where other programs may also serve homeless individuals.

This report is one of two related reports on health care for homeless persons. A companion report will address the extent that community mental health centers serve the homeless population.

We conducted our review in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

FINDINGS

TWO THIRDS OF THE COMMUNITY HEALTH CENTERS PROVIDE OUTREACH SERVICES FOR HOMELESS PEOPLE

Sixty-four percent (32 of 50) of the centers provide outreach services for homeless persons. These centers sent staff to homeless shelters, soup kitchens, and food pantries. They provided information on services available to homeless clients, assessed needs, provided food and clothing, performed medical services, screenings and triage. They send staff to the majority but not all of the shelters in their service areas. However, we found that for 13 of them, at least one nearby homeless shelter reported that the center did not send staff to their shelter. Also, in our sample of 50 centers we found 48 percent (22 of the 46 cities) have Health Care for the Homeless programs funded by a Federal Section 340 grant. This would mean that such a grantee also operated in the city. We are not, however, aware of the proximity of those grantees to all the homeless shelters.

The remaining centers do not contact or send staff to homeless shelters to conduct outreach. It is possible that in 9 of these 18 cities the health care needs of homeless people might be served because a Health Care for the Homeless grantee program exists in those cities. However, the remaining nine cities had neither a grantee nor received outreach from the local CHC.

Shelter staff identified their outreach needs. Following are examples of some of the outreach services which they feel would be important.

"We are always struggling to help our residents receive needed health care. We would welcome contact from any medical group that can help,"

"Not enough clients are seen due to lack of available physicians' time. There needs to be more medication, casework, aftercare, and outreach to psychiatric patients,"

"Non-emergency transportation should be accessible to shelters for early morning pick-up for sick children to get to the clinic,"

"They only visit our shelter every other week. A lot of times clients have come and gone by the time they make another visit,"

"We need better communication specifically about services they offer and fees required. Evening and Saturday hours would be helpful for the working families who need their services."

COMMUNITY HEALTH CENTERS PROVIDE A WIDE RANGE OF TREATMENT SERVICES TO HOMELESS PEOPLE

The centers provide a broad range of treatment services. The type of services most commonly provided to homeless clients include:

- Acute medical examinations and treatment, e.g. scabies, lacerations, and foot ulcers.
- Screening services for tuberculosis, hypertension, sexually transmitted diseases, and human immunodeficiency virus.
- Preventive services including well child care (Early, Periodic Screening Development and Treatment program), immunizations (adults and children), comprehensive physicals, prenatal monitoring, and dental.

As shown below, a significant number of CHCs also provide other services which are available to any homeless patient.

<u>Number of CHCs</u>	<u>Type of Services</u>
40	Laboratory services
34	Prescription drugs
26	Radiology services
19	Mental health counseling
8	Substance abuse treatment

Thirty-one of them reported the percent of treatments that were associated with emergencies. The responses ranged from 1 to 90 percent, with an overall average of 15 percent of treatments being related to emergencies.

The typical center in our sample operated with a budget of \$4.4 million, treating an average of almost 15,000 persons/users annually. There was an average of 264 homeless clients served out of an estimated 500 homeless persons in their service area. Approximately 3 percent of their annual budget goes toward the operating costs for serving homeless clients. In addition, for those centers who reported both the total number of persons served and the total homeless clients served, approximately two percent of the total were homeless.

All centers receive funding from Federal grants, with supporting funds from State and local grants. One-third (34 percent) also rely on foundations and donations. Other sources of revenue include third party payers, like Medicare, Medicaid, and patient payments. Some conduct fund-raising and United Way campaigns as well.

Fifty-eight percent of the CHCs' clients are single adults over age 20, with over half of them having no insurance.

The centers reported that at the time of their first encounter, homeless clients were living in the following locations (in descending order): emergency shelters, family/friends, motels, and on the street.

NEVERTHELESS, THE CENTERS FACE SIGNIFICANT BARRIERS IN PROVIDING SERVICES

While most centers provide services for homeless persons, nevertheless, the centers have reported significant barriers in reaching them. A number of centers were not able to report how many homeless persons they serve. However, the figures we do have document that centers are not reaching all of the homeless population in their service area.

Sixty-nine percent (34 of 49) of the centers reported that barriers exist for homeless people in obtaining services. The most significant barriers (in priority order as reported by CHCs) are:

- (1) The lack of available transportation
- (2) The center's hours of operation
- (3) Transient status of homeless individuals makes it difficult to establish a plan of care (e.g., outreach, transportation)
- (4) Clients' inability/unwillingness to follow through on a plan of care
- (5) Other necessary services not available in the community (e.g., affordable housing, mental health services)

In general, the shelter responses to barriers paralleled this list. Additional barriers reported by the shelters include the clients' unwillingness to go to the center for services and the client not staying long enough in the shelter.

Many centers indicated that they attempt to address barriers in making services more accessible to homeless clients. The following number reported specific services or procedures implemented to address barriers.

<u>Number of CHCs</u>	<u>Actions to Address Barriers</u>
22	Provide transportation to the center
20	Changed their hours and/or extended the hours of operation
19	Improved availability of telephones
8	Provide services at alternate sites (e.g. an off-site clinic)

Fourteen percent (6 of 44) of the centers adapted their treatment or screening protocols to meet the needs of homeless clients. Some of these efforts include:

- Addressing as many health needs as possible at the initial appointment.

- Adjusting any follow-up plan to consider how the needs of homeless clients will impact treatment or follow-up.

SOME HOMELESS SHELTERS DO NOT REFER CLIENTS TO NEARBY CENTERS

Twenty-eight percent (27 of 97) of the homeless shelters reported they did not refer clients to centers for health care services. Reasons reported (in priority order) include:

- (1) They were not aware of the center
- (2) They use an existing Health Care for the Homeless program
- (3) Clients will not access a center due to long waits for appointments
- (4) The center is in a different area of town
- (5) Clients will not go there due to safety concerns
- (6) The center is not a member of the local homeless coalition
- (7) Centers have not been receptive to homeless individuals

The remaining homeless shelters referred their clients to centers. Shelter clients used public transportation, shelter bus tokens, or their own transportation to travel to the center. Others walked, relied on family and friends, or in some cases used an ambulance.

OPPORTUNITIES FOR IMPROVEMENT

The findings in this report reflect a greater potential for CHCs helping homeless people. Better communication between the Health Resources and Services Administration (HRSA) and the centers, and between the centers and homeless shelters could improve access to medical services for homeless individuals. Therefore, we suggest that:

HRSA SHOULD PURSUE IMPROVEMENTS IN SERVICES OFFERED HOMELESS PEOPLE IN THE COMMUNITY HEALTH CENTER PROGRAM BY BUILDING ON ITS EXISTING EFFORTS. Examples include:

- Developing and disseminating materials which outline "best practices" from the Community Health Center program and, as applicable, the Health Care for the Homeless Program to improve outreach and referral techniques to serve homeless persons.
- Holding workshops and training sessions for Community Health Centers as part of the Bureau of Primary Health Care's program presentations.

HRSA SHOULD PROMOTE WIDESPREAD COLLABORATION BETWEEN CHCs AND NEARBY SHELTERS.

HRSA could do this by such activities as:

- Emphasizing the responsibility of CHCs to lessen all barriers which diminish the ability to serve homeless persons who present themselves to the clinic (e.g., hours of operation, transportation to the center).
- Encouraging periodic contact between management of the center and shelters to assess the homeless populations' medical needs, and possible solutions to addressing those needs.
- Ensuring that national associations representing homeless shelters are provided listings of CHCs nationally. This will permit these organizations to further disseminate the information to local homeless shelters.

CHCs SHOULD IMPROVE COMMUNICATION WITH HOMELESS SHELTERS.

Some ways to accomplish this include:

- Identifying all homeless shelters that exist in their service areas. The city task forces, coalitions, or networks on homeless populations are valuable resources.
- Providing, on a routine basis, information to those homeless shelters in their service areas on services available and locations.

- Conducting periodic meetings with homeless shelters to discuss the medical needs situation in their area, the barriers that exist, and means to best address those barriers.

AGENCY COMMENTS AND OIG RESPONSE

We received written comments from both HRSA and ASPE. HRSA concurred with our suggestions and will develop an action plan to implement them. ASPE commented on the importance of the findings, but raised some questions and made recommendations for additional analyses.

One of ASPE's questions relates to the definition of "homeless". We found no uniform or standard definition of this term. For example, some include those individuals who reside in transitional housing while others do not. Similarly, some would include those who are temporarily staying with friends or relatives but who otherwise would be homeless, while others would not consider such individuals as homeless. In preparing our survey we consulted with staff of both HRSA and ASPE and agreed to gather information using a broad definition. We explicitly asked the Community Health Centers to identify the conditions under which their homeless clients lived, including those temporarily staying with friends and relatives. We modified our report to make this clear and have provided staff of HRSA and ASPE with a summary of responses which we received from the centers on this matter.

Similarly, ASPE requested us to include a definition of "outreach" and the types of activities it includes. We modified our report to provide a fuller description of the kinds of outreach activities provided by the centers and needed by the shelters.

ASPE requested analysis of additional topics, such as referral patterns, service coordination, emergency services, case management, and actions taken to address barriers. We agree that these are all very important topics. Unfortunately they are beyond the scope of our study. In our early consultations with both ASPE and HRSA staff we agreed that our review would be limited primarily to ascertaining whether and to what extent the community health centers funded by the Federal Government were actively involved in serving homeless individuals. We also expected to identify issues for further study, such as those described by ASPE in their comments. Nevertheless, even though we did not gather extensive data on these subjects, our staff are available to provide insights on these or other such topics based on their observations and impressions from their site visits.

The full text of HRSA's and ASPE's comments are attached. We appreciate their advice and assistance in this study.

AGENCY COMMENTS



Health Resources and
Services Administration
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MAY 8 1996

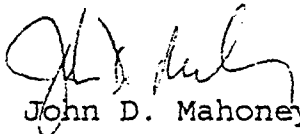
TO: Inspector General, OS, DHHS

FROM: Deputy Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report "Access
to Community Health Centers by the Homeless"
OEI-07-95-00060

This is in response to your March 22, 1996, memorandum requesting comments to the draft report, "Access to Community Health Centers by the Homeless." We concur with the OIG's suggestions that HRSA should: 1) pursue improvements in services offered homeless people in the Community Health Center (CHC) program by building on existing efforts, 2) promote widespread collaboration between CHCs and nearby shelters, and 3) determine how CHCs should improve communication with homeless shelters. HRSA will develop an action plan, including target dates, to implement the suggestions and will take into consideration the examples the OIG offered concerning their implementation.

Additionally, attached is a marked-up copy of the draft report with editorial and margin comments for the OIG's consideration.


John D. Mahoney

Attachment



MAY 10 1996

TO: June Gibbs Brown
Inspector General

FROM: Assistant Secretary for Planning and Evaluation

SUBJECT: Comments on the OIG Draft Report: "Access to Community Health Centers by the Homeless," OEI-07-95-00060

Thank you very much for the opportunity to review the above referenced draft. Knowledge about the extent that Federally funded community health centers (CHCs) serve the homeless and how such services can be improved is highly important. In general, we found the report comprehensive: it addressed outreach services to shelters, treatment services, barriers to accessing services and the referral of homeless clients. The reported barriers to services and reasons given by shelters for not referring clients to centers for health care services is important. We did, however, have some concerns and recommendations.

1. **Definitions:** Absent were definitions of homeless and outreach. Without the definitions, the findings become obfuscated. For example, the report states that over two-thirds of the homeless clients treated were staying in an emergency shelter or *living with family or friends*. We had not included the latter group in our definition of homeless--did the CHCs write this in as an "other" category? The definition of homeless is of critical importance, particularly, as it is used as part of the rationale for excluding rural centers (i.e., the majority of rural centers do not serve "the normal on-the-street homeless.") We are not sure of what is meant by "normal" we surmise that the report is referring to persons who are literally homeless.

The finding that some centers did not send staff to shelters could be better interpreted if there was a definition of outreach services and the types of activities it included. As it reads now, outreach includes providing information on available services, visiting shelters, having contact with homeless people, non-emergency transportation, and hours of service.

2. **Exclusion of rural centers.** With regard to the probe which led to the exclusion of rural centers, more information about the probe is needed to add clarity and justification for their exclusion. How was the probe conducted? Did it consist of site visits and/or conversations with key informants? We recommend you provide more information on the probe used to exclude rural centers.

3. **Referrals.** The reports cites constraints on the survey design as the reason for not being able to take into account the total extent of referral patterns. If there any data that could shed some light on the types of services to which shelters report making referrals, (and where CHCs rank in relationship to other types of services) please provide them.
4. **Service coordination.** Mentioned in a couple of places is the co-location of Health Care for the Homeless (HCH) programs in the same community. If these data permit, please report on referral activities and other service coordination activities in places where HCH programs are co-located.
5. **Emergency services and case management.** An interesting finding is the reported percentage of emergency services provided to homeless clients. A related question is whether these were in fact "true" emergencies or were persons accessing primary health care through the emergency room. If data are available on the nature of the emergencies, we request that they be reported.

Additionally, did any of the centers report providing case management services? If so, report the percentage which provide case management services.

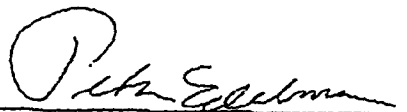
6. **Barriers.** Important findings were presented on the actions taken to address the barriers to service. A fairly common reported action was the "improved availability of telephones." Please clarify what is meant by the action (e.g., were 1-800 numbers or hot lines added or were telephones made available within the communities)?

If the data permit, please report comments made by respondents on the effects of actions to address barriers (e.g., increased access to services, improved quality in screening, increased service usage, etc.).

If the data permit, report on the difference in the barriers identified by CHCs and those identified by shelters?

7. **People focused language** (rather than illness and homeless focused). The report consistently refers to homeless persons as "the homeless" and persons with chronic mental illness as "the chronically mentally ill." We recommend you revise the terminologies to read: homeless persons or homeless people, and persons with chronic mental illness.

We hope the comments and recommendations will be useful and look forward to receiving the final report.



Peter B. Edelman