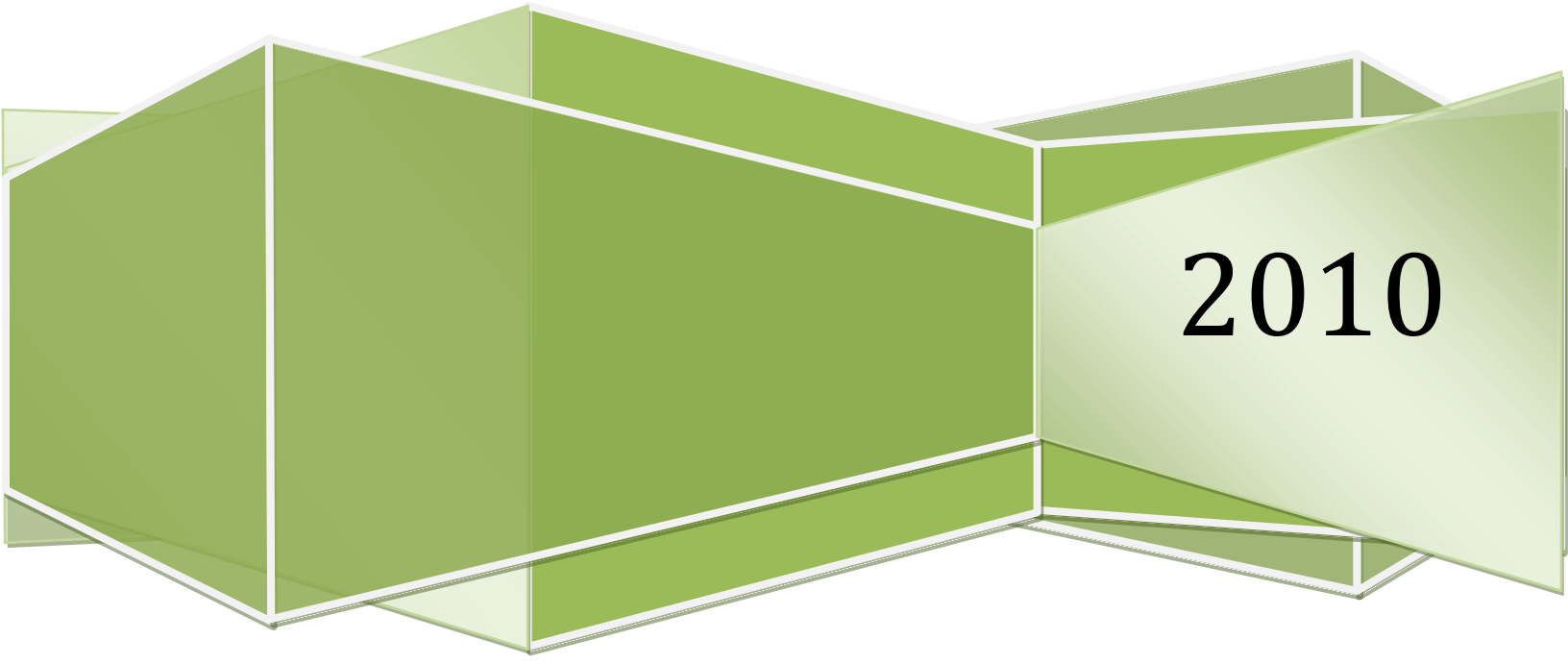
National Health Care for the Homeless Council

Knowledge and Skills Needs Assessment:

Identifying the Needs of the HCH Field



Preface

Dear Colleagues,

Providing health care to people without homes is a complicated undertaking. Daunting social determinants of health and distressing system inadequacies challenge patients and providers alike. Extraordinarily poor health conditions confront a health care workforce that sometimes is not well prepared and often is poorly resourced for the task.

This needs assessment comes at a time when the federally funded Health Care for the Homeless (HCH) Program is poised for remarkable growth, due to the generosity of the American people as expressed in the health care reforms of 2010. Sadly, that growth is necessary due to increasing homelessness in our country as we struggle with a long recession.

This document is intended to help guide the National Health Care for the Homeless Council and others as we develop training and technical assistance to support and improve HCH. It records and interprets the observations of hundreds of clinicians, program administrators and clients of HCH projects throughout the country. We are grateful for their honest input, and especially for the strength of our neighbors without homes who participated in this work.

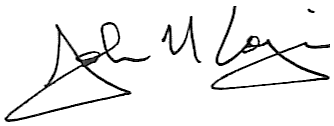
The Research Team of the National HCH Council developed this report. Darlene Jenkins, DrPH, and Patrina Twilley, MSW, deserve particular credit for their creative, determined work.

The Health Resources and Services Administration (HRSA), US Department of Health and Human Services, provided support for this needs assessment project through a Cooperative Agreement with the National HCH Council, though the opinions expressed are not necessarily those of HRSA.

As we have for numerous prior publications, we hope that this document will help bring about the day when mass homelessness in America is but a bad memory.

Peace,

John N. Lozier, MSSW
Executive Director



September, 2010

Table of Contents

Executive Summary

Since 1997, the National HCH Council has provided training and technical assistance to Consolidated Health Centers and other organizations through a Cooperative Agreement with the Health Resources and Services Administration (HRSA). In 2010, the Council conducted a knowledge and skills needs assessment to help focus its work with the HCH field. Several hundred administrators, clinicians and consumers affiliated with HCH grantees and Medical Respite programs participated in three stage processes of key informant interviews, focus groups and online and paper surveys. The majority of respondents were Caucasian females age 50 and older who have worked 10 years or more serving people experiencing homelessness.

This executive summary provides an overview of the report's key findings. Additional topics and more complete explication may be found in the body of the report.

Findings with Training and Technical Assistance Implications

- Of the administrators who responded, 25% have clinical responsibilities in addition to their administrative duties. This includes physicians, nurse practitioners and social workers.
- Administrators seek learning opportunities that provide them with professional training skills in the areas of management, organizational leadership, budgeting, and team building.
- Administrators and clinicians alike are interested in developing knowledge and skills that can forge effective collaborations. The administrators focused on collaboration building as a means to engage in and form alliances with other community programs, stake holders, and government. Clinicians desired collaboration skills to assist in working with hospitals, law enforcement and other social service agencies to foster interdisciplinary care and continuity of care among programs.
- When specifically asked about areas of training needed by members of their staff, the most frequent responses given by administrators were: (1) skills to work with high risk and vulnerable populations; (2) learning opportunities for front-line staff; and (3) greater knowledge of the integration of primary care and behavioral health.
- Both administrators and clinicians feel that providing learning opportunities for front-line staff (support staff) is important, as in many instances front-line staff are the first to engage a consumer seeking health care services at a facility. These needs include (but are not limited to): cultural sensitivity, diversity, conflict management, and de-escalation training.
- Clinicians focused on professional skill building needs in most of their responses. Clinicians' frequently identified interest in: interdisciplinary care, integration of preventive care into primary care and behavioral health, skills for providing care to medically complex patients with co-morbidities, motivational interviewing, and mentoring skills.
- The majority of all professional participants seek advanced level learning opportunities that go beyond introductory level courses, and reflect new and emerging evidence-based practices. Workshops, conferences and face-to-face learning opportunities are preferred, with the understanding that, webinars and interactive on-line offerings learning opportunities may be more realistic for time challenged professionals.
- Respondents frequently noted a need for learning opportunities that focus on HRSA requirements and governance of HCH projects.
- Fifty –four percent of the workforce at most HCH projects are 50 years or age and older. Work force development and succession planning are needs recognized by those who work in HCH projects.

- Respondents frequently mentioned needs in the areas of budgeting and fiscal sustainability.
- Most respondents are familiar with the Patient-Centered Medical Home concept of Meaningful Use requirements, but are interested in learning more about how their projects may become accredited as a medical home.

Major Findings with Policy and Research Implications

- Sixty-two percent of administrators stated that their program did not have a policy/advocacy staff member (at least part-time), although administrators, clinicians and consumers all stated that advocacy was important and that acquiring the skills to advocate for themselves and others is a topic of interest.
- Consumers who had utilized medical respite care services had a positive experience. However, three-quarters of administrators who responded to the survey reported that their program did not offer medical respite care citing start up limitations as the main barrier to establishing a medical respite program. Understanding the benefits of medical respite care, identifying funding sources for beginning and sustaining a medical respite program is a specific need.
- Understanding and demonstrating the efficacy of the HCH Model of Care is a research interest of most respondents.

Next Steps

These findings will complement other input as the National HCH Council develops its annual objectives, specific learning opportunities, and an updated research agenda.

Introduction

The National Health Care for the Homeless (HCH) Council is a national non-profit, membership organization comprised of service delivery agencies, individual providers, and persons who have experienced homelessness. Originating from the U.S. Conference of Mayors, the Pew Charitable Trust, and Robert Wood Johnson Foundation's Health Care for the Homeless Demonstration Program in the mid-1980's, the Council is now in its 25th year. The Council provides training and technical assistance to Consolidated Health Centers and other organizations through a Cooperative Agreement with the Health Resources and Services Administration (HRSA) within the U.S. Department of Health and Human Services. The Council serves over 200 HCH projects nationwide that provide health care services to over one million people who are experiencing homelessness.

HCH grantees exemplify a variety of structural models. Some are freestanding facilities, such as clinics, medical respite care programs, drop-in centers, and residential units. Others provide services in hospital-based clinics, shelters, and/or outreach locations, sometimes employing mobile units. HCH projects can also be linked with Community Health Centers (CHCs), Migrant Health Centers, and Ryan White Care Act grantees. They receive oversight from various local, state, and federal entities, licensing and accreditation organizations, hospital systems, and community-based organizations.

Like other health centers that receive funding under section 330 of the Public Health Service Act, HCH grantees are obligated to provide certain services, either directly or indirectly. Comprehensive services required of all HCH grantees are: primary health care, outreach to inform homeless individuals of the availability of services, substance abuse services, emergency services, mental health services (direct provision or referral), case management, referral for inpatient hospitalization, and assistance in obtaining housing and establishing eligibility for other public benefits. Optional services include: restorative dental care, vision and eyeglasses, specialty care, complementary and alternative medicine, employment/job training, and medical respite care. [1]

[1] Health Resources & Service Administration. "The Health Center Program: Section 330 of the Public Health Service Act", http://bphc.hrsa.gov/about/legislation/section330.htm#h

Learning Goals of the National HCH Council

The Council is committed to providing high-quality, evidence-supported learning opportunities to improve health care services provided to individuals experiencing homelessness. Learning opportunities refer to activities that seek to positively influence a person's knowledge, attitude, abilities or skills and include both formal and informal training. Technical assistance (TA) also occurs within this learning framework. The Council's learning opportunities reflect what has been learned through practice and research in the field of homeless healthcare, and is delivered to learners in a coherent and accessible format. Information seminars, webinars, newsletters, workshops, on-line learning, factsheets, clinical guidelines, monographs, case reports, self-study, and on-site technical assistance are structured methods to support the development of needed knowledge.

The Council's learning opportunities support professional and career development in the HCH field (including clinicians, administrators, support staff, volunteers, consumers, and advisory groups). While the Cooperative Agreement with the Health Resource and Services Administration (HRSA) funds the Council to target HCH grantees, the learning opportunities and resources produced by the Council are also relevant and valuable to other social service organizations and to members of the general public interested in issues related to health care and homelessness.

Training is an essential element in developing the technical expertise and the skills required for management, leadership, and providers delivering health services to individuals who have medically complex health issues, in an intricate, multifaceted health care for the homeless project. Within a training opportunity, HCH workers have the chance to examine their prior knowledge, existing attitudes, and work experiences that are relevant to the training topic. The Council's "Learning Team" uses six basic steps as guided by the American Society for Training and Development literature (ASTD) to develop learning opportunities. These steps (also known as ARDDIE) include:

- Assess,
- Research,
- Design,
- Develop,
- Implement,
- and Evaluate[2]

TA is a service directed at increasing the capacity of grantee organizations to engage in continuous quality improvement of their services and effectively serve people without permanent housing. TA services can include consultation via telephone to meet urgent technical assistance needs, as well as on-site assessment and consultation for program needs that require more attention. TA is designed to address the needs of individual grantees or communities that are developing HCH initiatives (e.g. New Access Point applications to HRSA), projects dealing with specific HCH performance issues, or projects needing support during the start-up phase of an initiative. TA is distinguished from training programs in that TA addresses a broader audience on topics of more general interest.

[2] Ruark, B.E. (2008). ARDDIE is In, ARDDIE is Out, T+D, July.

Knowledge & Skills Needs Assessment Project: Statement of Purpose

The Council has traditionally assessed training and TA needs by gathering information from the memberships that represent different constituencies of the HCH community. These include the National Consumer Advisory Board (NCAB), HCH Clinicians' Network, Respite Care Providers Network (RCPN), and the Governing Membership of the National HCH Council. Other sources of information have included reports on peer-to-peer TA visits, evaluations of trainings, the National HCH Conference, requests from HCH grantees and the Office of Minority and Special Populations (OMSP). Priorities for Council activities are set by active leaders from the HCH field who participate in the Council's annual Governing Membership Retreat.

During the 2009- 2010 fiscal year, the Council embarked on a more formal approach to assess the needs of the HCH field. This knowledge and skills needs assessment process was developed to achieve the following:

- Understand specific knowledge, skills, and core competency gaps among HCH providers
- Identify particular target audiences
- Identify the different learning preferences of target audiences
- Document the extent of agency administrative support for training and technical assistance intervention
- Assess the potential impact of training and technical assistance interventions on specific clinical outcomes

The Council's knowledge and skills needs assessment was conducted in three different ***stages***. In the first stage, key informants were interviewed. In stage two, focus groups were conducted; and in stage three surveys were administered to three groups: administrators, clinicians, and consumers. The primary purpose for targeting three different groups for the survey portion of the knowledge and skills needs assessment was to identify areas where the Council can provide training and technical assistance to individuals who govern and provide health care services at organizations serving people who are homeless. It is hoped that these efforts will increase the efficiency and effectiveness of the health care services delivered and ultimately improve the health status of the vulnerable individuals we serve.

Needs Assessment Methodology

Stage 1: Key Informants

In September 2009, key informants were interviewed to provide a basic understanding of the broad needs of administrators, clinicians, and individuals experiencing homelessness. Key informants were identified by the Council's Executive Director and Technical Assistance Coordinator as individuals known to have expertise in specific areas related to health care for the homeless. The key informants included: HCH administrators, clinicians, and consumers. Each key informant was interviewed by phone with questions tailored to their professional discipline and background. The objectives of the key informant interviews were to identify:

1) Needs that could be addressed with cooperative agreement resources in the areas of learning, technical assistance and education for people providing care to persons experiencing homelessness.
2) Assets of the people who work in the HCH field.
3) Collaborations, partnerships and resources needed or utilized by the HCH grantees.

Stage 2: Focus Groups

In October 2009, the Council conducted two focus groups with HCH administrators, clinicians and consumers in Nashville, TN during an annual planning meeting of the organization. The purpose of the focus groups were to assess the learning needs of individuals who work with people who are homeless and the technical assistance needs of organizations that provide health care to persons who use their services. The focus groups also served as a follow-up to the themes that had been identified in the key informant interviews. All persons attending the planning meeting were invited to participate and representatives from various disciplines were equally divided between the two groups. There were a total of 22 participants in both focus groups.

Each focus group followed the same format. The participants responded to a series of questions related to their experiences in order to identify: 1) the main skills needed of someone working within the health care delivery system for people experiencing homelessness and 2) technical assistance needs of organizations that provide services to individuals experiencing homelessness.

Both focus groups were recorded using digital recording software. The recordings were later transcribed by an HCH staff person not involved with the focus group or key informant process. Transcripts were then reviewed and analyzed. Prominent themes were identified in participant discussion and subcategories were respectively assigned.

Stage 3: Survey

In December 2009, HCH administrators, clinicians, and consumers affiliated with the Council were informed of a forthcoming questionnaire which would serve as the final stage of the knowledge and skills needs assessment process. The questionnaires were developed based on results of the key informant interviews and focus groups to gain valuable information from a nationally representative sample of the Council's three main constituencies. Three different versions of the questionnaire were developed with each one tailored to a specific constituency. Administrators of programs were included in "Group 1" of the process, Clinicians in

"Group 2", and Consumers in "Group 3". There were individuals who fell into more than one category and were therefore encouraged to fill out surveys in each grouping relevant to their background. Respondents in all three groups received an electronic survey which was sent to them via email. All participants (with the exception of consumers, were given two weeks to respond to the survey on-line before it was closed. In reference to Group 3, due to inaccessibility of computers and email among persons experiencing homelessness, it was not appropriate to use the electronic surveying methodology to gain consumer participation. Therefore, the National HCH Council sent an email to various leaders in the HCH field asking for their assistance in getting as many consumers to participate as possible. In response to this request, various National Consumer Advisory Board (NCAB) members and CAB's affiliated with HCH organizations, received and distributed paper versions of the consumer survey.

Results

Stage 1: Key Informant Findings

A total of 10 key informants were interviewed. Key informants were administrators and clinicians employed by HCH and Projects for Assistance in Transition from Homelessness (PATH) programs. Key informants described specific skills needed by HCH and PATH providers and also discussed the health care needs of consumers.

Administrators

A prevailing theme that emerged from the key informant interviews with administrators was the need to assist managers in developing better organizational and management skills. One administrator stated:

> "An organization may have good clinicians, but they need a good manager who appreciates them and can keep the organization strong. We get people that know direct service, but don't know how to manage. The greatest need is to train on the basics of management (e.g. how to comply [with] regulations, sustainability and development of middle management. Something like a 6- week course to apply a model would be good."

Several administrators described training and skill building in the areas of clinical and program management as necessary for understanding the context of their work. Others stressed the importance of having a thorough understanding of the HCH model of care of systematic issues related to poverty. One interviewee felt that a refresher course in outreach was needed for all administrators.

A training need that was consistently voiced was the need for "team building"; specifically, the need for the development of skills on how to make teams work well together within a health center with special emphasis on interdisciplinary teams. Administrators saw this as an important step in enabling staff to establish a cohesive system of working together to improve the delivery of services to clients and a more efficient way to deliver health services in a resource poor environment.

Work force development and succession planning was a topic that many thought was needed as a training or as part of an orientation for administrators. Key informants suggested that trainings and orientations concentrate on developing broader governing and central leadership skills for managers. They felt that workforce development and succession planning would take a commitment of time, energy, and resources, not only on the trainer's behalf but for the trainees as well.

Within the topic of workforce development, mentoring was also emphasized. All administrators interviewed stated they became involved in the work of the Council due to someone mentoring them. One administrator stated that the founding director of her HCH program was committed to succession planning and took her by the hand and mentored her. Another stated that her boss brought back a Clinicians' Network membership application from the annual National HCH Conference and asked her to join. One administrator stated "peer mentoring for leaders" would be a good area of concentration for a course, so that up and coming leaders would have a peer to orient them to their new roles and responsibilities.

When asked about the training needs of their employees, some of the key informants felt that *all* employees should be oriented to the HCH model of care and there was a need to balance between introductory level education and higher level education. Other development opportunities that administrators identified for employees included: health coaching, motivational interviewing as part of case management, and interdisciplinary chronic care management.

Several administrators stated that for their own professional growth they would be interested in developing skills on how to incorporate advocacy into their daily work activities with time management as a challenge.

Administrators seemed to favor webinars and interactive online courses as their learning methods of choice. Webinars and interactive online courses were the suggested method for learning about adapting your practice. One administrator described the value of learning opportunities that involved face-to-face interaction. In-person learning opportunities are part of the attraction for both the National HCH Conference and regional trainings. One administrator located on the west coast stated she would love to see more "regional trainings." All stated that offering CEU's makes training more attractive.

<u>Clinicians</u>

Key informants representing clinicians focused more on professional skill needs as opposed to program management skill needs and/ or organizational TA needs. Clinicians did express the need to have the support from their program management staff to develop their own personal development and leadership skills. One interviewee stated that he would like training that involved more interaction between administrative and clinical staff; "Our program has 12 clinical sites that are providing care. There is a disconnect between the manager and those in the clinic [who provide care]. We need training on strategies on how to bridge that gap between management and clinicians."

Clinicians identified several areas for professional skill building. These areas included:

- Working with difficult clients who have challenging behavioral issues,
- Working in less optimal situations (with limited resources),
- Dealing with burnout issues,
- Implementing clinical practice guidelines within every day practice, and
- Utilizing an integrated or team care approach.

Clinicians also voiced an interest in learning more about integrated multidisciplinary care and developing skills in forming collaborations. Clinicians indicated skills in collaboration building were important for conducting discharge planning with hospitals and in working across agencies such as law enforcement and other health and social service programs. Clinicians felt that these collaborations would enhance the health outcomes for their patients.

One clinician expressed the need for empathy training for those who serve people experiencing homelessness. This clinician stated, "Case management is more [than] case managing." Motivational Interviewing was also noted as a key educational need; "people in HCH need to be trained on how to engage patients and how to make a person want to get care from you." Other learning opportunity topics included: engaging and sustaining a Consumer Advisory Board (CAB), engaging the research community for HCH

clinical outcome measures, and collaborating with academic institutions to pursue similar HCH research interests.

All the clinicians felt that various methods of training were needed, as learning requires ongoing work. Preferences included webinars, didactic assignments, and interactive processes. One clinician stated emphatically that his preferred method of learning was face-to-face. It was stated, "I'm kind [of] old school and like regional trainings to get face time with folks."

Consumers

When consumers were asked about the training needs for those providing HCH services, the overwhelming response was that HCH staff should learn the skills of mentoring. One consumer stated that the reason that he became an advocate was because a physician took the time to mentor him.

Consumers expressed the following comments which reflected main training needs for HCH staff and clinicians:

- "All clinicians should be taught motivational interviewing, harm reduction and be aware of critical time intervention".
- "It is important that staff have training around how to treat people with dignity. Many who work in HCH don't feel that consumers have anything to offer, especially those in the social work area. They think that they have a BS or a MS that gives them something, but experience can be education too. It must be recognized that consumers can be trained to advocate for themselves, to speak and tell their stories. People must recognize the consumer with potential and be willing to work with that person".

In terms of program management skills, consumers stressed the importance of recognizing opportunities to provide an orientation to consumers (especially those who are newly without homes), on services that are available to them.

All 10 key informants were asked to describe priority areas of learning for the Council. The responses are provided below:

- "Permanent Supportive Housing - The Council needs to show HCH programs how to support this concept because it takes a lot of resources. We need to find or develop models of successful programs for this."
- "Governance - The Council staff needs to provide training to HCH grantees on how to meet the requirements by HRSA around the issue of governance and setting up new programs and evaluation of governance by existing programs."
- "Find a Niche - The Council needs to define its work as vital and know how to prioritize and shift to what is important. The important thing to know is: *what* we do, and *why* we do it."
- "The Council must give programs an opportunity for improvement. TA must be an individual assessment that provides the best method for that project. New programs need to become familiar with the Council, regulations for program operation, and what is in grant applications. Older programs need to revisit expectations, look at their collaborations, acquisitions or additional funding opportunities to help with sustainability. Also there is a need to develop a succession plan for retirement and how to evaluate the success of the plan."

- "One thing that must be recognized is that there is a vast informal network among the HCH community. If you call other programs or other administrators, there is a wealth of information available. The Primary Care Association (PCA) operates differently and in some instances is not able to provide the type of information that HCH programs need. The Council should recognize this strength of the network and capitalize on it."

Stage 2: Focus Group Findings

The focus groups represented a broad range of HCH expertise. The discussion revealed similar perceptions of the learning needs of the HCH community. The following summarizes some of the learning needs and areas to focus clinical measures identified in the focus group discussions:

Main skills and knowledge needed:

- Effective collaboration/understanding your role ("team approach"; sharing resources and referrals)
- Motivational interviewing (active listening/engagement skills)
- Client centered care
- Shared philosophies of care among staff (mission alignment—hiring people who are dedicated to mission and values of organization)
- Consensus decision making
- Self-care for staff
- Understanding HRSA regulations (standards, rules, and eligibility criteria)
- Training or guidance for "newbies" in the field
- HCH 101 (as a requirement for HRSA Project Officers)
- Consumer governance (forming a CAB—consumer insight valuable to practice)
- Addiction training/Soboxone training (for opiod addiction)
- Serving "newly" homeless individuals
- Traumatic brain injury knowledge
- Personality disorder training
- Cultural Competency (bridging the communication gap between client and provider)

Efforts that would improve the field of HCH:

- More involvement from Health Resources and Services Administration (feel a disconnect)
  - *Constituents want HRSA to better understand what they do*
  - *Constituents want HRSA to focus more on the needs of people working in HCH*
  - *Constituents want HRSA to understand the concept that housing is health care*
  - *Constituents feel that HRSA employees need basic Health Care for the Homeless training(e.g. HCH 101)*
- More collaborative relationships with Community Health Centers
- Improved system for patients completing paperwork for services
- Increased knowledge and access to resources and referrals for people experiencing homelessness or those assisting individuals who are homeless (including active outreach efforts to individuals not currently utilizing services)
- Exploration of the various definitions and origins of homelessness
- Utilization of Electronic Medical Records (EMR) - how to structure and actually use the data
  - Collaboration with Public Health Departments to share homeless specific data
- Implementation of the continuum of care model - including the Patient Centered Medical Home concept

Areas to focus development of clinical measures:

- HIV/STD testing (youth population)
- Immunizations (youth population)
- Housing (affordable/permanent/stable/supportive)
- Substance abuse recovery/support
- Access to medical care
- Access to specialty care (mental health, substance abuse services, psychiatric care, physical therapy, dietician counseling, etc.)
- Treatment for traumatic brain injury
- Dental care/oral health
- Improved health status for patients with diabetes
- Access to medications for patients with mental illness
- Improved client perception of medical care/medical home
- Smoking cessation

Stage 3: Survey Findings

The following sections report the findings identified in the survey segment of the needs assessment process. These survey findings will remain the focus for the remainder of the report. Respondents who participated in this survey were from both HCH and non-HCH programs.

Group 1: Administrators

In January 2010, administrators were asked to participate in the third stage of the Council's needs assessment process, and were targeted as Group 1. The questionnaire was designed for HCH coordinators, executive directors, medical respite coordinators, and other administrators working in HCH projects. A total of 285 administrators responded out of 1099 that were invited. Representation was wide spread, with responses from nearly all 50 states in the U.S., the District of Columbia, Puerto Rico and Canada. The following states were most represented: California (13%), Massachusetts (7%), Florida (6%) and Texas (5%).

Demographics

Table 1 presents the demographic data of respondents in this survey. Females represented approximately three-quarters (74%) of the respondents. While the majority were at least 40 years of age, more than half the total number of respondents (54%) reported being 50 years or above. Nearly 75% of respondents, identified as Caucasian. African Americans and Latinos collectively represented an additional 21% of the respondents. For educational level, half of the respondents had obtained at least a Master's degree.

TABLE 1 – Respondent Demographics (N=285)[3]

Characteristic		n[4]	%[5]
Gender			
Female		212	74
Male		73	26
	Total	285[6]	100%
Age			
50 years or above		153	54
45-49		45	16
40-44		35	12
35-39		28	10
30-34		17	6
25-29		7	3
20-24		0	0
Under 20 years		0	0
	Total	285	100%

[3] N represents the total number of respondents who participated in the survey.

[4] n represents the total number of respondents who provided an answer to a given question.

[5] Presented as valid percentages retrieved from PASW (Predictive Analytics Software); Percentages may not sum to 100 as a result of rounding or item non-response.

[6] Total is presented as the number of survey participants that responded to a particular question.

TABLE 1 cont'd – Respondent Demographics (N=285)

Characteristic		n	%
Race/Ethnicity			
Caucasian/White		209	73
African American/Black		42	15
Hispanic/Latino		17	6
Asian/Pacific Islander		7	3
Bi-racial/Multi-racial		4	1
Other		4	1
American Indian/Alaskan Native		2	1[7]
	Total	285	100%
Education			
Master's degree		142	50
MD		38	13
Some college/Associate's degree		28	10
Bachelor's degree		27	10
Some post-graduate coursework		23	8
Ph.D.		19	7
Master's degree and MD		4	1
High school or equivalent		3	1
Some post graduate coursework and MD		1	0
Vocational/ Technical school		0	0[8]
	Total	285	100%

[7] Actual weighted percentage was an estimated 0.7% who identified as American Indian/ Alaskan Native.

[8] Actual weighted percentage was an estimated 0.4% who identified Vocational/ Technical school as their highest level of education attained.

Homeless Health Care Background and Experience

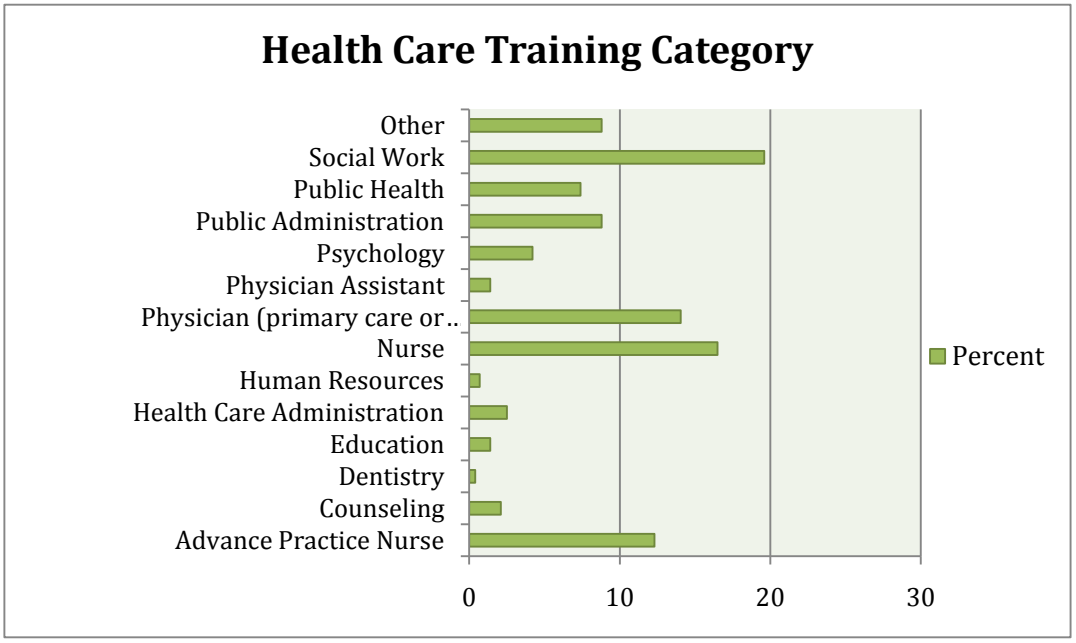
Half of the respondents reported they have worked in the health care for the homeless field for 10 years or more (Table 2). The most represented administrative roles for this survey were program administrator (26%), executive director (18%), and Health Care for the Homeless Coordinator (14%). Based on the qualitative responses, it appears that approximately 25% of the administrative respondents have clinical duties incorporated in their roles, including those of physicians, nurse practitioners, and social workers.

The most commonly reported health care training categories included: nurses, social workers, and physicians (Figure 1). Dentists and Human Resources representatives were least represented on this survey. Cross-tabulations showed that nurses involved in this survey were most often classified as "HCH Coordinators" (31%), physicians as "Medical Directors" (89%), and social workers as "Program Administrators" (27%).

TABLE 2 - Professional Characteristics of the Sample (N=285)

Characteristic		n	%
Years working with homeless			
10 or more years		146	51
5-9 years		70	25
0-4 years		69	24
	Total	285	100%
Job classification			
Program administrator		74	26
Other		62	22
Executive director		51	18
HCH coordinator		39	14
Medical director		28	10
Program director		14	5
Medical respite coordinator		8	3
RN site manager		9	3
	Total	285	100%

Figure 1


Health Care Training Category
Other
Social Work
Public Health
Public Administration
Psychology
Physician Assistant
Physician (primary care or..
Nurse
Human Resources
Health Care Administration
Education
Dentistry
Counseling
Advance Practice Nurse
0
10
20
30
Percent

Health Care Program Characteristics

Nearly half (47%) of administrators in this survey reported operating their program in conjunction with a Community Health Center (CHC). Stand-alone facilities and shelters were also commonly reported program types (Table 3). Administrators were asked the total percentage of clients served at their program who were currently insured through Medicare or Medicaid. Slightly less than half reported 25% or less of the clients served at their clinic were insured through Medicare or Medicaid. Approximately 10% of respondents indicated they did not track this information. More than half (62%) of all administrators involved in this survey reported they did not have anyone on staff (at least part time) dedicated to policy/advocacy work.

TABLE 3 – Health Care Program Characteristics of the Sample (N=285)

Characteristic		n	%
****HCH Program type**			
Community Health Center		133	47
Stand-alone		38	13
Shelter		30	11
Parent organization		25	8
Public health department		19	7
Other		12	4
In a hospital		9	3
Multiple sites		8	3
Mobile unit		6	2
Medical respite center		3	1
Free clinic		2	1
	Total	285	100%
Medicaid/Medicare[9]			
0-25%		132	46
26-50%		64	23
51-75%		32	11
76% or more		31	11
I do not track this		26	9
	Total	285	100%
Policy staff[10]			
No		177	62
Yes		108	38
	Total	285	100%

Medical Respite Care

Nearly three-quarters (72%) of respondents reported their program did not offer medical respite care. Those respondents who reported no medical respite services were asked to describe any barriers encountered in developing a medical respite program at their site. These responses were interpreted through qualitative data analysis and placed in five major categories. The categories identified include: start-up limitations, medical respite care not a strategic planning priority for the organization, limited "buy-in"

**Note: "Program type" categories are not distinct. For example, a CHC might have multiple sites. Also, multiple respondents from the same organization may have participated in the survey.

[9] Percent of clients served at HCH projects that are insured through Medicaid/ Medicare

[10] Programs that have at least one part time staff person dedicated to policy/ advocacy work.

from providers and community partners, medical respite care needs already being addressed elsewhere, and a lack of awareness of respite models (Table 4).

TABLE 4 – Medical Respite Programs and Barriers (N=285)

Characteristic		n	%
Medical respite care program			
No		204	72
Yes		81	28
	Total	285	100%
Medical respite barriers[11]			
Start-up limitations		106	
Respite not a strategic planning priority		36	
Limited buy-in		22	
Respite needs being addressed elsewhere		18	
Lack awareness of respite models		11	
	Total	194[12]	

Respite start-up limitations
Limited funding (79)[13]
Lack of fixed location/ or space (28)
Staffing limitations (27)
Inadequate resources (17)
Lack time to dedicate to program development (6)
Need a current needs assessment (3)

Respite not a strategic planning priority
Never considered or attempted (12)
Not part of agency mission/goals (8)
Other agency priorities (5)
New start program/ challenge not taken on (5)
No perceived need for medical respite (5)

Limited buy-in
Lack provider and/ or community buy-in (22)

Respite needs already being addressed
Already a medical respite program in local community (14)
Respite beds are provided by local hospital/ shelter (7)

Lack awareness of respite models
Not familiar with medical respite care (5)
Need technical assistance (5)
Unclear of benefits/ value not seen (1)

[11] The following barriers represent the five categories interpreted through qualitative data analysis. See sub-categories created below for specific information related to each category.
[12] Total number (n) may not sum to 204 (total number of respondents who said no) as a result of item non-response or individuals who claimed a response of "unknown" or "N/A".
[13] Indicates the total number of times this specific type of response was provided by a respondent.

Start-up limitations were frequently presented as a barrier, with more than half the respondents identifying some difficulty in this area. The most commonly mentioned start-up limitations included: limited funding, lack of fixed location/or space, staffing limitations, and inadequate resources. When respondents reported they did not feel medical respite was a strategic planning priority, the most frequently cited responses were: medical respite had never been considered or attempted at their site and that medical respite was not part of the agency's mission or goals. Respondents who reported they had limited buy-in to start a medical respite program often stated that their health care providers were "already overloaded" and that community partners were not supportive of this endeavor.

Consumer Advisory Board

Over half (56%) of the respondents reported their program had an active Consumer Advisory Board (CAB). Responses related to CAB barriers were interpreted through qualitative data analysis. The themes identified were: start-up limitations, no perceived need for a separate consumer board, and transient nature of population (Table 5).

TABLE 5 – Consumer Advisory Boards and Barriers (N=285)

Characteristic		n	%
Consumer Advisory Board (CAB)			
Yes		159	56
No		124	43
	Total	283	100%
CAB barriers			
Start-up limitations		51	
No perceived need		33	
Transient nature of population		17	
	Total	101[14]	
CAB start-up limitations			
Limited time for planning (21) [15]			
Not enough staff to help implement (20)			
Site small/ no space available for group (12)			
Lack funding (7)			
Logistical issues due to program set-up (5)			
No perceived need			
Already have consumer representation on board (33)			
Transient nature of population			
Interest/attendance not continuous (15)			
Consumer recruitment difficulties (2)			

[14] Total number (n) may not sum to 124 (total number of respondents who said no) as a result of item non-response or individuals who claimed a response of "unknown" or "N/A".

[15] Indicates the total number of times this specific type of response was provided by a respondent.

Start-up limitations were commonly presented as barrier, with nearly half the respondents identifying some difficulty in this area. Of those who indicated start-up limitations, respondents indicated most often they had limited time for planning and not enough staff to help implement the consumer board. When respondents stated they did not feel there was a need to start a CAB, it was often because they already had consumer representation on their governing board and did not feel it was necessary to develop a separate board lead exclusively by consumers. Respondents indicating the transient nature of people experiencing homelessness as a barrier identified retaining consumer interest and establishing consistent attendance at CAB meetings as areas of difficulty.

Identification materials

More than one-third (34%) of respondents indicated they had funds specifically allocated to obtain birth certificates and other identification materials for homeless clients served at their project (Table 6). Respondents were also asked how they were able to finance this service. Responses were analyzed through qualitative data analysis and segmented into the following categories: program budget funds, funds provided through a local partnership, and an outside funding source.

Respondents most commonly mentioned that funds for identification materials were included in their program's budget. When respondents referred to funds being provided through a local partnership, they often described relationships, such as a "referral relationship" with an outside project. Respondents also mentioned outside funding sources for this service. These sources included: donations (including employee contributions), fundraising dollars, insurance reimbursement funds, local/federal funding sources, and social service programs (ID clinics) held weekly on site.

TABLE 6- Identification Materials (N=285)

Characteristic		n	%
Funds allocated for identification materials			
No		178	66
Yes		92	34
	Total	270	100%
Identification materials funding source			
Program budget funds		38	
Funds provided through local partnership		18	
Outside funding source[16]		16	
	Total	72[17]	

Medical Home

Almost 90% of respondents had some knowledge of the Patient-Centered Medical Home model and nearly one-quarter (24%) had extensive knowledge of the subject matter (Table 7). Approximately 75% indicated they would be interested in learning more about the Patient-Centered Medical Home model and how to become accredited.

[16] Sources take account of donations (including employee contributions), fundraising dollars, insurance reimbursement funds, local/ federal funding source(s), and social service programs (ID clinics) held weekly on site.

[17] Total number (n) may not sum to 92 (total number of respondents who said yes) as a result of respondents not being sure of the funding source, item non-response, or responses that could not be categorized into any of the above listed categories.

Electronic Records System

Almost 40% of the respondents reported their programs did not utilize an Electronic Medical Record (EMR) or Electronic Health Record (EHR) system[18] at their project (Table 7). Respondents were allowed to provide comments regarding their electronic records usage. A qualitative analysis of the comments found that a number of respondents were in the process of transitioning to an EMR. While most respondents did not indicate a timeframe for implementation, several reported their EMR would be active within the next 12 months.

TABLE 7- Health Program Structure Characteristics of the Sample (N=285)

Characteristic		n	%
Medical Home model			
Somewhat familiar with model		135	50
Extensive knowledge of model		66	24
Very little knowledge of model		41	15
Not at all familiar with model		24	9
Other		5	2
	Total	271	100%
Interested in Medical Home and how to become accredited			
Yes		200	74
No		70	26
	Total	270	100%
Electronic records system			
EMR or EHR not used at site		98	37
Utilize both EMR and EHR		75	28
Utilize an EMR only		50	19
Utilize an EMR system and paper records		41	16
	Total	264	100%
In process of implementing an EMR			
No time frame specified (22)[19]			
EMR active within the next 12 months (19)			
EMR active in 18 months (8)			
EMR active in 2-3 years (4)			

[18] An EMR is an electronic record of information related to an individual's health, gathered and managed by clinicians and staff in one organization. As an extension of EMR, the EHR is a comprehensive electronic record of health information that is gathered collectively by more than one organization in order to share information related to an individual's health and the type of care provided. An organization cannot operate an EHR system without the existence of an EMR.

[19] Indicates the total number of times this specific type of response was provided by a respondent.

Best Practices

The term "best practice" can be used to describe any method or way of doing things that is believed to be effective at yielding desired outcomes. Best practices are not necessarily based on evidence in literature and can therefore be a matter of perception. Best practices have also informally been referred to as "promising practices."

Respondents identified best practice standards utilized by their programs that reflect comprehensive health care services for clients experiencing homelessness. These qualitative responses were analyzed and segmented into the following categories: best practice standards, best practice methods, and best practice services (Table 8).

TABLE 8- Best Practice Standards of Care (N=285)

Characteristic		n[20]
Best practice standards		
Integration of primary care and behavioral health		54
Multidisciplinary care approach		34
Inherent value for patient		25
Utilization of evidence-based practices		23
Continuity of care		18
A focus on prevention		15
Advocacy/policy development		9
	Total	178
Best practice methods		
Case management		44
Effective collaboration		33
Open access scheduling/walk-in's		17
Patient Centered Medical Home (PCMH)		12
Electronic patient record keeping		10
Tracking performance measures		9
	Total	125
Best practice services		
Outreach		66
Dental care		24
Housing support		20
Links to resources and referrals		18
Operation of a multi-service center		15
Screening and vaccinations		15
Specialty care		10
Wrap around services		7
	Total	175

[20] Indicates the total number of times this specific type of response was provided by a respondent.

Best practice *standards* were interpreted as "standards of care" or benchmarks of achievements which are based on a desired level of excellence and are essential to operating an HCH project. These standards or guidelines determine what a HCH provider or HCH project should do in delivering health care services. Best practice *methods* were interpreted as processes implemented to achieve successful outcomes in serving individuals experiencing homelessness; with a method being a technique or methodology that, through experience and research, has proven to lead to a desired result. Lastly, best practice *services* were interpreted as activities that directly impact the well-being of all patients served at these programs.

Best Practice Standards

When describing best practice standards utilized at programs, respondents most commonly mentioned integrated primary care and behavioral health and the coordination of care between different providers (i.e. multidisciplinary care approach). Other reported responses include: value for patient (e.g. positive regard for all patient's well being, meeting clients "where they are", being culturally sensitive, and demonstrating respect); utilization of evidence-based practices in delivering services; a focus on individuals "at risk" for homelessness and other preventive measures; movement toward clients having a consistent medical provider each visit (i.e. continuity of care); and active engagement in client advocacy and policy development.

Best Practice Methods

On-site case management was the most commonly reported best practice method used in delivering services to persons who are homeless. Specifically, shelter-based nurse case management and integrated case management services were mentioned. Respondents also indicated collaboration as a best practice method. Respondents reported the importance of maintaining close relationships with local hospitals, shelters, and other homeless service agencies in the community. Other methods employed by health centers included: open access scheduling or walk-in availability, Patient Centered Medical Home concept, electronic patient record keeping and tracking performance measures.

Best Practice Services

The most common best practice services described by respondents, was the practice of providing outreach services. Additional services mentioned were: dental care, housing support, provision of client referrals for services and resources not provided at project sites, operation of a multi-service center or "one stop shop" where patients are able to receive integrated models of care at one site, providing regular patient screenings (i.e. health and STD screens), specialty care, and wrap around services.

Administrator Perspective on Staff Training Needs

Administrators were asked to identify professional development areas that would require specialized training for members of their clinical staff. While most responses to this question were very popular, the top three responses were:

- Skills to work with high risk and vulnerable populations (e.g. injection drug users, sex workers, transgender people etc).
- Learning opportunities for "front-line" staff (e.g. administrative assistants, desk clerks, intake workers, etc.) who are first to interact with a client.
- Greater knowledge on the integration of primary care and behavioral health (Table 9).

Other areas mentioned by respondents where staff could develop knowledge and skills included: accessing services, improving cultural sensitivity, and enhancing social functioning of persons who are homeless.

TABLE 9- Clinical and Front-Line Staff Learning Needs (N=285)

Characteristic	n	%
Specialized training for staff		
Skills for working with high risk and vulnerable populations	179	63
Learning opportunities for front-line staff	176	62
Greater knowledge on the integration of primary care and behavioral health	169	59
Advanced skills and knowledge in accessing services	162	57
Cultural sensitivity skills	159	56
Skills to enhance social functioning of homeless clients	133	47
Skills for working in teams with staff from other disciplines	130	46
Advanced policy/advocacy skills	91	32
Other	13	5
Training needed for front-line staff		
Cultural sensitivity/diversity training (31) [21]		
Conflict management skills/de-escalation training (28)		
Client engagement/effective communication skills (19)		
Stress management/avoiding burn-out (14)		
Increased customer service skills (14)		
Client centered interviewing skills (11)		
Skills to work with patients with mental health issues (10)		
Increased understanding of homeless issues and barriers to care (10)		
Basic advocacy skills (7)		

[21] Indicates the total number of times this specific type of response was provided by a respondent.

Support staff training

As a follow-up, administrators were asked to indicate specific learning opportunities that would be beneficial to their front-line staff. These responses were interpreted through qualitative data analysis and segmented into categories. Most common among the responses was the need for front-line staff to receive cultural sensitivity or diversity training. Conflict management and de-escalation trainings were also frequently mentioned as trainings that would be beneficial for front-line staff. Respondents often stated this type of training would assist front-line staff in dealing with difficult clients who need services. Other training areas identified included: client engagement skills, communication skills, stress management, customer service skills, client centered interviewing skills, working with patients with mental health issues, understanding issues related to homelessness and barriers to care, and basic advocacy skills.

Administrator Perspective on Training Needs and Learning Opportunities

Survey participants were asked how they keep their knowledge and skills current regarding the work they do with individuals experiencing homelessness. Nearly 70% reported they use resources provided on the National HCH Council's website, (including publications, newsletters, toolkits, etc). Journals and publications (60%) and the annual National HCH Conference (59%) were also commonly identified methods used to keep their knowledge and skills current (Table 10).

Responses related to preferred methods of learning were also collected and later interpreted through qualitative data analysis. Respondents most commonly reported a preference for conference workshops and seminars. On-line trainings and webinars were also mentioned frequently as a preferred learning method. Other preferred methods of learning mentioned included: newsletters, face-to-face learning opportunities, and scholarly journals and monographs. Cross-tabulations of the data indicate that nearly half of all respondents who prefer face-to-face trainings do indeed keep their knowledge current by engaging in Council face-to-face learning opportunities and technical assistance services.

TABLE 10- Learning Needs Characteristics of the Sample (N=285)

Characteristic	n	%
How knowledge and skills kept current		
Resources provided on the National Health Care for the Homeless Council website[22]	197	69
Journals and Publications	172	60
Annual National Health Care for the Homeless Conference	167	59
Other conferences specific to vulnerable populations	155	54
Trainings and resources provided by other organizations[23]	141	50
National HCH Council face-to-face learning opportunities and technical assistance services	65	23
Other methods for continuing education and development	56	20
Preferred method of learning		
Conference workshops (119)[24]		
Online trainings and webinars (83)		
Newsletters (68)		
Face-to-face learning opportunity (64)		
Scholarly journals and monographs (46)		
Lecture style presentations (Seminars) (18)		

[22] Resources include publications, newsletters, tool kits, etc.

[23] These organizations target administrators working with vulnerable populations.

[24] Indicates the total number of times this specific type of response was provided by a respondent.

Continuing Education Credit

One-third (34%) of respondents indicated that continuing education credits (e.g. medical, nursing, and general education credits) were very influential when selecting learning opportunities and determining quality (Table 11).

TABLE 11- Continuing Education Credits (N=285)

Characteristic		n	%
Continuing education credits[25]			
Very influential		82	34
Somewhat influential		57	23
Not necessarily determinant of quality but may influence decision		41	17
Not at all influential		64	26
	Total	244	100%

When looking at the relationship between preferred learning methods and influence of accredited learning opportunities, conference workshops is the most preferred learning method across the board.

Preferred methods of learning by Influence of education credits offered

Preferred method of learning	Influence of education credits offered			
	Very influential	Somewhat influential	Not necessarily	Not at all influential
Scholarly journals and monographs	20%	19%	20%	23%
Online trainings and webinars	36%	32%	38%	42%
Conference workshops	**50%**	**55%**	**63%**	**47%**
Face to face learning opportunities	26%	26%	30%	32%
Newsletters	43%	28%	20%	21%
Lecture style presentations (seminars)	8%	9%	5%	9%

[25] When selecting learning opportunities that offer quality information, how influential is the offering of CME/CNE/CE credits in making your decision?

Administrator Knowledge & Skills Needed

Survey participants were asked about the personal skills and knowledge needed in order to effectively operate their programs (Table 12). Their responses were analyzed quantitatively and all of the skills and knowledge areas identified were segmented into the following categories of learning need:

- Program management skills and knowledge
- Professional skills and knowledge
- Collaboration skills
- Communication skills
- Personal skills
- Knowledge needs

TABLE 12- Administrator Knowledge and Skills Needed (N=285)

Characteristic		n[26]
Program management skills and knowledge needed		
Effective organizational leadership and development		30
Fiscal management/budgeting skills		22
Grant writing/grants management		13
Fundraising		11
Accessing and maintaining funding		9
	Total	85
Professional skills and knowledge needed		
Cultural competency skills		19
Solid clinical skills		10
Problem solving/conflict-resolution skills		9
Mission driven attitude		8
Skills in working with multiple levels of providers		3
	Total	49
Collaboration skills needed		
Community alliance building		35
Team-based approach		13
	Total	48
Communication skills needed		
Networking skills		31
Public speaking skills (PR)		8
Strong communication/listening skills		3
	Total	42
Personal skills needed		
Compassion		29
Empathy		15
Patience		14
Flexibility		14
	Total	72

[26] Indicates the total number of times this specific type of response was provided by a respondent.

TABLE 12 cont'd- Administrator Knowledge and Skills Needed (N=285)

Characteristic	n[27]
Knowledge needed	
Knowledge of people who are homeless	45
Understanding the nature and causes of homelessness (12) [28]	
Knowledge of the interaction of physical, behavioral health, and substance abuse issues (10)	
Knowledge of barriers to care for persons who are homeless (6)	
Better understanding of homeless health care needs (6)	
Knowledge of family dynamics and homeless issues (2)	
Knowledge of community resources	36
Policy/ advocacy knowledge	26
Knowledge of funding opportunities	10
Total	117

Program Management Skills and Knowledge

Several respondents indicated an interest in further developing their program management and resource development skills. The most commonly cited response among participants indicating need in this area, was interest in a learning opportunity around effective organizational leadership and development. Respondents also indicated an interest in learning more about fiscal management particularly as it relates to developing and administering a budget. Other learning needs mentioned were: grant writing, fundraising, and accessing and successfully maintaining funding.

Professional Skills and Knowledge

Professional skills and knowledge needs were identified through a qualitative analysis of responses. Respondents most frequently mentioned the need for cultural competency skills to effectively operate programs. Respondents also mentioned the need for clinical skills, problem-solving, and conflict resolution abilities in order to effectively assist individuals who are homeless. Staff commitment to agency mission along with skills in working with multiple levels of providers was also mentioned.

Collaboration Skills

Several respondents mentioned the need for collaboration skills to effectively operate programs. Most commonly reported was the importance of knowing how to engage in community alliance building. Respondents made comments that highlighted the significance of collaborating with other programs, stakeholders, and government. Respondents also mentioned the importance of a team-based work environment in successfully operating their program.

Communication Skills

Survey participants described the importance of strong communication and listening skills in effectively operating their program and serving persons experiencing homelessness. Communication skills such as networking and public speaking skills (as it related to Public Relations) were specifically identified by respondents.

[27] Indicates the total number of times this specific type of response was provided by a respondent.

[28] Indicates the total number of times this specific type of response was provided by a respondent (within this sub-category).

Personal Skills

Among respondents who identified learning needs around personal skills, several specifically mentioned having compassion was necessary to effectively operate their program. Other personal learning needs mentioned were: patience, empathy, and flexibility.

Knowledge Needs

Several respondents described the importance of having a thorough knowledge of homelessness including: understanding the nature and causes of homelessness; knowledge of the interaction of physical; behavioral health and substance abuse issues; knowledge of barriers to care for persons who are homeless; understanding of homeless health care needs; and knowledge of family dynamics as it relates to homelessness. Other areas of knowledge mentioned were: knowledge of community resources, policy/ advocacy knowledge, knowledge of clinical interventions, and knowledge of funding opportunities.

Learning Topics of Interest

When respondents were asked to describe subjects they would be interested in seeing through Council supported learning opportunities, more than half (54%) reported interest in an "advanced" level learning opportunity designed for administrators working with individuals experiencing homelessness (Table 13). It is unclear what is meant by the term *advanced* as this was asked quite openly of respondents. Other popular subjects of interest were: effective collaboration (46%), motivational interviewing (39%), and cultural competency (39%).

TABLE 13- Learning Topics of Interest (n=285)

Characteristic	n	%
Learning opportunity subjects of interest		
An advanced level learning opportunity for administrators working with the homeless	155	54
Effective collaboration	131	46
Motivational interviewing	111	39
Cultural competency	111	39
Introduction to Medical Respite	90	32
Learning opportunities that focus on policy and advocacy skills development	89	31
A beginner level learning opportunity for administrators new to the field	82	29
Consensus decision making	78	27
Incorporating research into practice	71	25
Fostering a positive relationship with HRSA	71	25
Involving consumers in governance (forming a CAB)	66	23
Program governance	68	24
Other administrator related topics	29	10
Additional learning topics of interest		
Non-profit fiscal management[29] (15)[30]		
Collaboration and info-sharing (w/ outside agencies—HCH included) (14)		
Outreach and engagement strategies (11)		
Integrated models of care (9)		
Understanding the characteristics and dynamics of homelessness (8)		

"Other administrator related topics" of interest described by respondents included: fiscal management skills, collaboration and info-sharing, outreach and engagement strategies, integrated models of care, and understanding the characteristics and dynamics of homelessness. These same topics emerged when survey participants described "additional learning opportunities" that would improve service delivery for their patients and enhance program operation. Potential trainings mentioned were primarily around fundraising and grant-writing.

Advanced level learning opportunities and learning around effective collaboration were subjects of interest across job classifications. HCH Coordinators displayed the highest interest (60%) in motivational interviewing learning opportunities when compared to other job classifications. Program Administrators and Program Directors were interested in learning opportunities dealing with cultural competency skills

[29] This includes the capacity to engage in grant writing/ management and fundraising.
[30] Indicates the total number of times this specific type of response was provided by a respondent.

(52% and 58% respectively). More than one-third of Executive Directors and Medical Directors were interested in participating in a medical respite learning opportunity (46% and 43% respectively).

Subjects of Interest by Job Classification

Learning opportunity subject of interest	Job Classification				
	HCH Coordinator	Program Administrator	Executive Director	Program Director	Medical Director
Motivational Interviewing	**60%**	47%	36%	42%	39%
Consensus Decision Making	40%	37%	23%	33%	36%
Program governance	46%	28%	25%	42%	18%
Positive relationship with HRSA	23%	32%	32%	42%	25%
Incorporating research into practice	43%	40%	39%	42%	39%
Cultural competency	40%	**52%**	36%	**58%**	43%
Medical Respite Care	29%	34%	**46%**	42%	**43%**
Consumer governance	46%	38%	23%	17%	14%
Effective collaboration	**54%**	**56%**	**55%**	**50%**	**46%**
Beginner level learning	46%	43%	23%	42%	21%
Advanced level learning	**72%**	**77%**	**59%**	**67%**	**68%**
Policy/advocacy	40%	43%	27%	17%	25%

***The top three subjects of interest per job classification are bolded.*

Group 2: Clinicians

Upon completion of surveying Group 1, clinicians were invited in January 2010, to participate in Group 2 of the survey, designed specifically for all clinicians and medical directors who provide direct services to individuals experiencing homelessness. A wide range of clinicians working in health care for the homeless projects and medical respite programs were invited to participate in this questionnaire – including, but not limited to: physicians, nurses, social workers, and outreach workers. A total of 273 clinicians responded out of the 1309 invited to participate. Representation was broad, with responses from over 40 states in U.S., the District of Columbia, and Canada. The following states were most represented: California (16%), Massachusetts (6%), and Washington (5%).

Demographics

Similar to Group 1, nearly 75% of respondents who participated in the survey were female and slightly more than half (52%) reported being 50 years or above. Just over 75% of respondents identified as Caucasian/White, while over 10% of respondents identified as African American/Black. Master's level degrees were the number one reported level of education completed (41%). The second highest reported degree was a Medical Degree and third highest was a Bachelor's degree (13%) (Table 14).

TABLE 14- Demographics of the Sample (N=273)

Characteristic		n	%
Gender			
Female		198	73
Male		75	27
	Total	273	100%
Age			
50 years or above		143	52
45-49		38	14
40-44		34	13
35-39		32	12
30-34		14	5
25-29		11	4
20-24		1	0[31]
Under 20 years		0	0
	Total	273	100%
Race/ Ethnicity			
Caucasian/ White		207	76
African American/ Black		34	13
Hispanic/ Latino		10	4
Asian/ Pacific Islander		8	3
Bi-racial/ Multi-racial		5	2
American Indian/ Alaskan Native		4	1
Other		4	1
	Total	272[32]	100%

[31] Actual weighted percentage was an estimated 0.4% who identified their age as 20-24 years old.

[32] Total number (n) may not sum 285 (total number of respondents who participated in the survey) as a result of item non-response.

TABLE 14 cont'd- Demographics of the Sample (N=273)

Characteristic	n	%
Education		
Master's degree	112	41
MD	49	18
Bachelor's degree	34	13
Some post-graduate coursework	27	9
Some college/ Associate's degree	22	8
Ph.D.	16	6
Master's degree and MD	10	4
High school or equivalent	1	0[33]
Vocational/ Technical school	1	0[34]
Some post graduate coursework and MD	0	0
Total	272[35]	100%

[33] Actual weighted percentage was an estimated 0.4% who identified High school or equivalent as their highest level of education attained.
[34] Actual weighted percentage was an estimated 0.4% who identified Vocational/ Technical school as their highest level of education attained.
[35] Total number (n) may not sum 285 (total number of respondents who participated in the survey) as a result of item non-response

Homeless Health Care Background and Experience

Three-quarters of respondents indicated they have worked in the health care for the homeless field for five or more years and close to half (42%) of these respondents have worked in the HCH field for 10 years or more (Table 15). Nurses made up 33% of the respondents, physicians (19%), and social workers (13%). Case managers, mental health professionals, outreach workers, physician assistants, and substance abuse counselors separately represented 3-7% of the respondents. Dentists, pharmacists, and students were least represented on this survey (Figure 3).

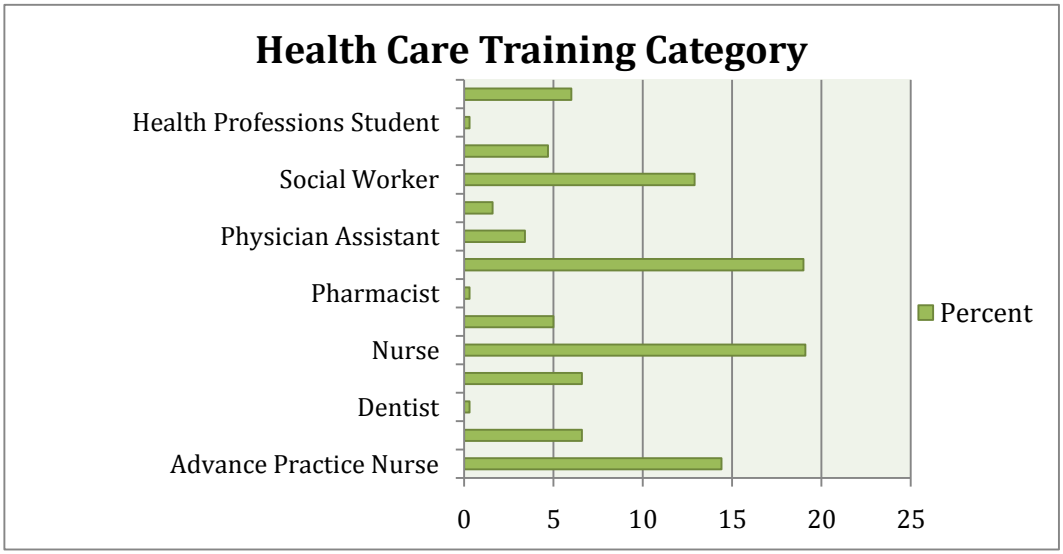
TABLE 15- Professional Characteristics of the Sample (n=273)

Characteristic		n	%
Years working with homeless			
10 or more years		115	42
5-9 years		89	33
0-4 years		69	25
	Total	273	100%
Specialty training program[36]			
No		195	73
Yes		71	27
	Total	266	100%
Health profession training[37]			
No, my training program did not prepare me for the day-to-day challenges		142	53
Yes, my training program prepared me for the day-to-day challenges		126	47
	Total	268	100%

[36] Have you completed a "specialty" training program (e.g. fellowship, residency training, academic training, etc.) in preparation for your work with the homeless population?

[37] Did your health profession training adequately prepare you for the unique challenges of working with persons experiencing homelessness?

Figure 3



Health Profession Training

More than half (53%) of the respondents who participated in this survey reported their health profession training did not adequately prepare them for the unique challenges of working with individuals experiencing homelessness (Table 15). As a follow-up, respondents were asked if they completed any "specialty" training in preparation for working with persons who are homeless. Nearly 75% of respondents indicated they had not completed any type of specialty training.

More than one-third (36%) of respondents who completed a specialty training program participated in a primary care/residency training. About 23% completed an academic training program. Less than one-quarter (21%) completed a fellowship while another 21% considered workshops and conferences as the type of training received in preparation for their work with individuals experiencing homelessness.

The relationship between respondents who indicated completion of a specialty training program and those that felt their health profession training was adequate was examined. Just less than 70% of respondents who completed a specialty training program felt their health profession training adequately prepared them for the day-to-day challenges of caring for persons experiencing homelessness. Conversely, 61% of respondents who reported they had not completed a specialty training program indicated they were not adequately prepared for this type of work. The majority (83%) of clinicians reported they would interested in participating in a training specifically designed for them.

Adequacy of Health Profession training by Specialty training program completed

Health profession training adequate	Completed specialty training	
	Yes	No
Yes, my training program prepared me for the day-to-day challenges of caring for persons experiencing homelessness.	**68%**	39%
No, my training program did not prepare me for the day-to-day challenges of caring for persons experiencing homelessness.	32%	**61%**

Electronic Records Usage

About 30% of respondents reported their programs utilized both Electronic Medical Records (EMR) and Electronic Health Records (EHR)[38] (Table 16). Respondents were allowed to provide comments regarding their electronic records usage. These comments were analyzed qualitatively and it was found that several respondents who indicated not using an electronic system or reported manual reporting of records were in the process of transitioning to an EMR. Several respondents reported their program's EMR would be active within the next 12 months.

Among the 23% of respondents who reported utilizing EMR and EHR systems, the majority (82%) of these respondents reported they received adequate training to effectively utilize both systems. There was very minimal response when respondents were asked to indicate any skills and training needed to utilize EMR and EHR and make effective use of the data.

[38] An EMR is an electronic record of information related to an individual's health, gathered and managed by clinicians and staff in one organization. As an extension of EMR, the EHR is a comprehensive electronic record of health information that is gathered collectively by more than one organization in order to share information related to an individual's health and the type of care provided. An organization cannot operate an EHR system without the existence of an EMR.

TABLE 16- Electronic Medical Records and Medical Home (N=273)

Characteristic		n	%
Electronic records system			
EMR or EHR not used at site		120	44
Utilize both EMR and EHR		63	23
Utilize an EMR only		51	19
Utilize an EMR system and paper records		38	14
	Total	272	100%
In process of implementing an EMR			
No time frame specified (11)[39]			
EMR active within the next 12 months (8)			
EMR active in 18 months (4)			
EMR active in 2-3 years (2)			
Medical Home Model			
Somewhat familiar with model		132	51
Not at all familiar with model		52	20
Extensive knowledge of model		43	17
Very little knowledge of model		31	12
	Total	258	100%
Interested in Medical Home and how to become accredited			
Yes		187	73
No		71	27
	Total	258	100%

Medical Home

About 80% of respondents had some knowledge of the Patient-Centered Medical Home model but less than one-quarter (17%) had extensive knowledge of the subject matter. Approximately 75% indicated they would be interested in learning more about the Patient-Centered Medical Home model and how to become accredited.

[39] Indicates the total number of times this specific type of response was provided by a respondent.

Clinical Challenges

Survey participants identified their most pressing challenges in caring for homeless patients (Table 17). Respondents were allowed to identify more than one challenge area. More than three-quarters (77%) reported complex co-morbidities (e.g. simultaneous mental illness and substance abuse diagnoses) as their most pressing challenge. Inaccessibility to specific services ranked second, with 71% of clinicians identifying this as a pressing challenge. As a follow-up to service inaccessibility, 66% of respondents reported access to housing services as their biggest challenge. Access to mental health and substance abuse services were also identified as a challenge by respondents more than half of the respondents.

TABLE 17- Pressing challenges and Inaccessibility (N=273)

Characteristic	n	%
Most pressing challenges		
Complex co-morbidities	211	77
Inaccessibility to specific services[40]	194	71
Clinical challenges – complicated diagnoses and healthcare needs	139	51
High number of uninsured patients	135	50
Other	52	19
Lack of formal training in the skills needed to care for homeless patients	31	11
Inaccessibility to specific services		
Housing	181	66
Mental health services	161	59
Substance abuse and addiction services	152	56
Specialty care	140	51
Financial aid or benefits	127	47
Dental care	124	45
Prescription medications	89	33
Other	32	12

There were no significant differences found when examining the relationship between perceptions of clinicians' most pressing challenges among different health care training categories. Both complex co-morbidities and inaccessibility to specific services were reported as pressing challenges by multiple clinical discipline groups responding to this survey.

[40] Specific services related to inaccessibility are listed below.

Specialized training

Clinicians identified professional development areas that would require specialized training for professional development in their work with people who are homeless. The top five responses were:

- Working with high risk and vulnerable populations (e.g. injection drug users, sex workers, transgender people, etc.).
- Integrating primary care and behavioral health (mental health and substance abuse).
- Advanced skills and knowledge in accessing services (e.g. specialty care, social services, etc.) for uninsured patients.
- Providing care to homeless patients who have experienced traumatic brain injury.
- Enhancing social functioning of homeless patients (Table 18).

TABLE 18- Areas Requiring Specialized Training (N=273)

Characteristic	n	%
Specialized training		
Working with high risk and vulnerable populations[41]	157	58
Integrating primary care and behavioral health	153	56
Advanced skills and knowledge in accessing services for uninsured patients[42]	132	48
Providing care to homeless patients who have experienced traumatic brain injury	131	48
Enhancing social functioning of homeless patients	121	44
Developing advanced policy/ advocacy skills	103	38
Cultural sensitivity skills for working with homeless patients	96	35
Prescribing practices for homeless patients with multiple illnesses or diagnoses	93	34
Working in teams with colleagues from different disciplines	91	33
Prescribing practices for uninsured patients	47	17
Other	15	5

[41] Examples include: injection drug users, sex workers, transgender people, etc.

[42] Services may include (but are not limited to) specialty care and social services.

Preventive Care

Survey participants were asked what they considered to be aspects of preventive care from a pre-determined list of services (Table 19). Nearly 80% of respondents defined preventive care as "counseling patients with specific regard to health topics such as: smoking cessation, physical activity and diet, substance abuse prevention and mental health." An additional 71% of respondents defined preventive care as "screening patients and applying guidelines based on their unique care needs where the evidence supports such interventions."

TABLE 19- Preventive Care Defined and Strategies Used (N=273)

Characteristic		n	%
Preventive care definition			
Counseling patients with specific regard to health topics[43]		216	79
Screening patients and applying guidelines based on their unique care needs		195	71
Incorporating prevention guidelines into primary care delivery		167	61
Advocating for a community focus on prevention		164	60
Including vaccination and immunization education into every encounter		161	59
Not sure		11	4
Other		9	3
Preventive health care strategies used			
Yes		249	97
No		9	3
	Total	258	100%

Nearly all (97%) of the respondents reported incorporating preventive health care strategies into their delivery of care to homeless patients. Respondents provided specific responses on how they were incorporating preventive health care strategies into service delivery. These comments were analyzed qualitatively and segmented into the following categories: individualized treatment plans, medical/psychological screening of all patients, ongoing client education topics, application of promising practices to care, and usage of EMR to track preventive health measures (Table 20).

[43] Topics include (but are not limited to) smoking cessation, physical activity and diet, substance abuse prevention and mental health.

TABLE 20- How Preventive Strategies Used (N=273)

Characteristic	n
Preventive care strategies used in delivery of care[44]	
Individualized treatment plans	108
Medical/psychological screening of all patients	91
Ongoing client education	89
Application of promising practices to care	53
Usage of EMR to track preventive health measures	15
Total	356[45]

Individualized treatment plans

One on one patient counseling during visits (56)[46]
Provide information on nutrition (36)
Provide resources and referrals to patients (hygiene, clothing items, housing, food, etc.) (34)
Focus on patient defined goals (15)
Application of preventive care guidelines (specific to patients needs) (8)
Assess patient risk factors for identified diseases/illnesses (based on age, gender, race, etc.) (8)

Medical/psychological screening of all patients

Vaccines/immunizations (55)
Health screens (blood sugar, hypertension, pap smear, mammogram, etc.) (38)
Mental health (13)
Substance use (drugs and alcohol) (10)
Cancer (10)
Routine lab testing/monitoring (7)
Sexually transmitted diseases (including HIV/AIDS) (6)
Tuberculosis (6)
Hepatitis (4)

Ongoing client education topics

Diet and exercise (48)
Smoking cessation (43)
Diabetes education (21)
Stress management (5)
Hypertension (5)
HIV/ AIDS (3)

Application of promising practices to care

Smoking cessation (38)
Harm reduction (13)
Motivational interviewing (8)
Multi-disciplinary/Collaborative approach to care (8)
Patient outreach (mobile vans) (5)

Usage of EMR to track preventive health measures

EMR based reminders as a guide to scheduled preventive health care strategies (15)

[44] The following strategies represent the five categories interpreted through qualitative data analysis. Respondents specified how they incorporated preventive health care strategies into their delivery of care at their local program. See sub-categories created below for specific information related to each category.

[45] Total N exceeds 273 as a result of respondents identifying more than one preventive care strategy used in their delivery of care.

[46] Indicates the total number of times this specific type of response was provided by a respondent.

The most commonly mentioned prevention strategy was the use of individualized treatment plans. The top reported method of providing an individualized treatment plan for preventive care was one-on-one patient counseling during visits. Respondents reported they provided patients with information on nutrition, exercise, and resources and referrals for hygiene items, clothing, housing, food, etc. Respondents also mentioned the importance of focusing on patient defined goals and evaluating their readiness for care. The application of preventive care guidelines (specific to patient needs) was also mentioned as an individualized strategy.

In terms of medical/psychological screening of all patients, respondents most commonly mentioned the assessment of each patient for updated vaccines and immunizations. Respondents also mentioned completing health assessments on patients, mental health screens, substance use, cancer, STD's, hepatitis, tuberculosis, and other routine lab tests regardless of what the patient is there for.

Some respondents who indicated ongoing client education as a preventive strategy also mentioned providing information on diet and exercise. Respondents stated they discuss healthy eating choices and lifestyle changes that can be made by their patients. Respondents also mentioned educating their patients on smoking cessation, diabetes care, stress management/reduction, hypertension, and HIV/AIDS.

The application of promising practices to care was also mentioned as a preventive strategy by respondents. Smoking cessation was most commonly mentioned among these strategies. Other commonly mentioned approaches included: harm reduction, motivational interviewing, multi-disciplinary/collaborative approach to care, and patient outreach (often through the use of mobile vans).

A small number of respondents also referred to the usage of electronic records to track preventive health measures. This strategy was used to assess gaps in preventive care and served as a prompt to initiate necessary care for each patient on a scheduled basis.

Among the 3% who reported they did not incorporate preventive health care strategies into their delivery of care, 38% of those respondents said they did not have enough time. One-quarter said they were not sure how to incorporate preventive health care strategies and another 25% said preventive health was not relevant to the work they do with persons experiencing homelessness.

Clinical Perspectives on Learning

More than one-third (42%) of clinicians identified conference workshops as their preferred method of learning (Table 21). Slightly more than 25% reported they preferred face-to-face trainings and 11% preferred on-line trainings and webinars.

Keeping knowledge and skills current

Using resources provided on the National HCH Council website (including publications, newsletters, toolkits, etc.) was the most reported method of keeping knowledge and skills current regarding work with people who are homeless, with almost 70% of clinicians responding this way. Another 60% keep their knowledge current by reading journals and other publications.

TABLE 21- Preferred Learning Methods and How Knowledge Kept Current (N=273)

Characteristic		n	%
Preferred method of learning			
Conference workshops		108	42
Face-to-face learning opportunity		68	27
Online trainings and webinars		27	11
Clinical guidelines		17	7
Scholarly journals and monographs		15	6
Case reports		9	3
Health care field magazines		5	2
Other		4	2
	Total	253	100%
How knowledge and skills kept current			
Resources provided on the National Health Care for the Homeless Council website[47]		184	67
Journals and Publications		163	60
Trainings and resources provided by other organizations[48]		148	54
Annual National Health Care for the Homeless Conference		128	47
Other conferences specific to vulnerable populations		118	43
National HCH Council online learning opportunities/ webinars		60	22
Other methods for continuing education and development		45	17
National HCH Council face-to-face learning opportunities and technical assistance services		36	13

[47] Resources include publications, newsletters, tool kits, etc.

[48] These organizations target clinicians working with vulnerable populations

Continuing Education Credit

More than half (54%) of the respondents indicated that continuing education credits (e.g. medical, nursing, and general education credits) were very influential when selecting learning opportunities and determining quality (Table 22).

TABLE 22- Continuing Education Credits (N=273)

Characteristic		n	%
Continuing education credits[49]			
Very influential		139	54
Somewhat influential		86	33
Not at all influential		33	13
	Total	258	100%

When looking at the relationship between preferred learning methods and influence of accredited learning opportunities, conference workshops is the most preferred learning method across the board.

Preferred methods of learning by Influence of education credits offered

Preferred method of learning	Influence of education credits offered		
	Very influential	Somewhat influential	Not at all influential
Scholarly journals and monographs	7%	4%	6%
Health care field magazines	2%	1%	6%
Clinical guidelines	7%	8%	0%
Case reports	2%	5%	6%
Face-to-face trainings	24%	27%	36%
Online trainings and webinars	11%	12%	6%
Conference workshops	**44%**	**41%**	**36%**

[49] When selecting learning opportunities that offer quality information, how influential is the offering of CME/CNE/CE credits in making your decision?

Learning Topics of Interest

When respondents were asked to indicate subjects they would be interested in seeing through Council supported learning opportunities, 66% reported interest in an "advanced" level learning opportunity for experienced clinicians (Table 23). As with the first group of survey respondents, it is unclear what is meant by the term *advanced* as this was asked quite openly of respondents. Other popular subjects of interest were: applying research findings into practice (45%), self care to avoid burn-out (45%), case management for non-case managers (42%), and effective collaboration (41%).

TABLE 23- Learning Topics of Interest (N=273)

Characteristic	n	%
Learning opportunity subjects of interest		
Advanced level learning opportunity for experienced clinicians	179	66
Applying research findings into practice	124	45
Self-care to avoid burn out	124	45
Case management for non-case managers	114	42
Effective collaboration	113	41
Motivational interviewing	104	38
Developing policy/ advocacy skills	98	36
Cultural competency	91	33
Introduction to medical respite care	66	24
Beginner level learning opportunity for clinicians new to the field	62	23
Consensus decision making	55	20
Other clinical topics	20	7

Additional learning topics of interest

Non-profit fiscal management (15)[50]
Promising practices (10)
Support staff training (9)
Integrated models of care (8)
Dual disorders training (7)
Psychiatric levels of care (6)
Multidisciplinary approach to care (6)

Respondents provided a wide variety of responses for "other clinical topics" of interest. Some of the topics mentioned included: children and families experiencing homelessness, substance use management, traumatic brain injury, chronic pain related issues, and mental health related topics.

Survey participants described additional learning opportunities that would improve service delivery for their patients and enhance program operation. These responses were analyzed qualitatively but were not grouped into categories based on the varied nature of the comments. Responses relating to the following topics were found most often: clinical educational opportunities, resource development, training dedicated to front-line staff, integrated levels of care, dual disorders training, psychiatric levels of care, and the multidisciplinary approach to care.

[50] Indicates the total number of times this specific type of response was provided by a respondent.

Resource development learning opportunities identified by respondents included: grant-writing, fundraising, and other creative ways to access and maintain funding. Clinical educational opportunities identified by respondents included: chronic disease management, palliative care, trauma informed care, harm reduction, medical homes, and traumatic brain injury. Trainings on cultural competency, advocacy, and de-escalation were consistently recommended for front-line staff.

Advanced level learning opportunities were of interest across all job classifications. Mental health professionals (74%) and case managers (71%) displayed the most interest in self-care to avoid burn-out learning opportunities when compared to other job classifications. Close to 70% of mental health professionals who participated in this survey were also interested in learning about applying research findings into practice. Social workers and nurses displayed high interest in an effective collaboration learning opportunity (54% and 50% respectively). Almost half of the physicians (47%) who participated in this survey were interested in a learning opportunity to develop their policy/advocacy skills.

Subjects of Interest by Job Classification

Learning opportunity subject of interest	Job Classification				
	Physician	Nurse	Social Worker	Case Manager	Mental Health Professional
Motivational interviewing	40%	42%	43%	47%	53%
Consensus decision making	16%	25%	34%	29%	37%
Case management for non-case mgrs	50%	**56%**	29%	**71%**	53%
Self-care to avoid burn-out	**53%**	**50%**	**54%**	**71%**	**74%**
Applying research into practice	**53%**	**50%**	49%	35%	**68%**
Cultural competency	35%	31%	46%	53%	53%
Medical respite care	21%	35%	34%	24%	32%
Effective collaboration	48%	**50%**	**54%**	47%	42%
Beginner level learning	26%	31%	23%	41%	21%
Advanced level learning	**80%**	**71%**	**77%**	**71%**	**58%**
Policy/advocacy	47%	35%	43%	41%	32%

***The top three subjects of interest per job classification are bolded.*

Group 3: Consumers

In February 2010, Consumers were asked to participate in Group 3 of the Council's needs assessment questionnaire. This survey was designed for individuals or families who were currently or formerly homeless. A homeless person was defined as "an individual or family without permanent housing who may live on the streets, stay in a shelter, mission, single room occupancy facility, abandoned vehicle or building, or in any other unstable or non-permanent situation." A total of 156 consumers were surveyed. The following states were most represented: Florida (49%), Texas (17%), and Massachusetts (11%) respectively. It should be noted that due to limitations is survey distribution, respondents involved in this group participated through existing HCH organizations and are not a universal representation of persons experiencing homelessness.

Demographics

More than half (66%) of the respondents were male and 36% were 50 years or above (Table 24). Nearly half (47%) of the respondents identified as Caucasian/ White and 42% identified as African American/ Black. More than one-third (43%) of the respondents had at least a High school diploma or G.E.D. More than half (57%) of the respondents described their marital status as "single." Less than three-quarters (70%) reported they did not have any children in their care.

Table 24- Demographics of the Sample (N=156)

Characteristic		n	%
Gender			
Male		102	66
Female		52	33
Other		1	1
	Total	155[51]	100%
Age			
50 years or above		56	36
45-49		26	17
40-44		17	11
30-34		16	10
35-39		15	9
25-29		13	8
20-24		12	8
Under 20 years		1	1[52]
	Total	156	100%
Race/ Ethnicity			
Caucasian/ White		73	47
African American/ Black		64	42
Hispanic/ Latino		12	8
Bi-racial/ Multi-racial		2	1
Other		2	1
Asian/ Pacific Islander		1	1
American Indian/ Alaskan Native		0	0
	Total	154	100%

[51] Total number (n) may not sum 156 as a result of item non-response.

[52] Actual weighted percentage was an estimated 0.6% who identified their age as "under 20 years."

Table 24 cont'd- Demographics of the Sample (N=156)

Characteristic		n	%
Education			
High school/G.E.D.		66	43
Less than high school		37	24
Some college/ Associate's degree		35	23
Four year college degree (BA, BS)		13	8
Master's degree		2	1
Doctoral degree		2	1
Professional degree (MD, JD)		0	0
	Total	155	100%
Marital Status[53]			
Single		88	57
Divorced		33	21
Separated		15	10
Married		13	8
Widowed		6	4
	Total	155	100%
No. of children			
0		107	70
1		19	12
2		13	8
3		9	6
Other		6	4
	Total	154	100%

[53] This question did not capture respondents who are in domestic or non-domestic partnerships.

Housing Status and Health Care

Almost half (44%) of the respondents who participated in the survey have experienced homelessness for 1 to 5 years (Table 25). More than 10% of respondents were no longer homeless and 43% of those respondents indicated they experienced homelessness less than one year.

Table 25- Housing Status and Health Care (N=156)

Characteristic		n	%
No. of years experienced homelessness[54]			
1-5 years		67	44
Less than one year		44	29
I am no longer homeless		21	14
6-10 years		12	8
Greater than 10 years		7	5
	Total	151[55]	100%
No. of years homeless prior to housing[56]			
Less than one year		46	43
1-5 years		42	40
6-10 years		9	9
Greater than 10 years		9	9
	Total	106[57]	100%
Receiving services from a local HCH			
Yes		84	56
No		59	39
Not sure		8	5
	Total	151	100%
Type of government assisted benefits received			
None of the above		79	53
Medicaid		33	22
Both Medicaid and Medicare		23	15
Medicare		15	10
	Total	150	100%
PCP that understands their medical history			
Yes, my primary health care provider understands my medical history		96	65
I do not have a primary health care provider		31	21
No, my primary health care provider does not understand my medical history		20	14
	Total	147	100%

Respondents reported whether they currently received services from any local Health Care for the Homeless facility. More than half (56%) reported they were receiving services from a local HCH. At least 5% of respondents were not sure if they were receiving services from an HCH project. About 53% of respondents reported not receiving any type of government assisted health care benefits. It is unknown how many of these respondents have insurance through their employer, military insurance benefits, or is completely uninsured. Less than one-quarter receive Medicaid, 10% are covered by Medicare, and 15% described receiving both Medicaid and Medicare. Respondents aged 24 years or younger were the least likely to be

[54] How many years have you experienced homelessness?

[55] Total number (n) may not sum 156 as a result of item non-response.

[56] How many years were you homeless prior to finding permanent housing?

[57] Total number (n) may exceed 21 as a result of confusion in how to respond to the previous question on the survey.

insured. Nearly 80% of respondents reported having a primary care provider (PCP), and 65% of these respondents reported having a PCP that understands their medical history.

Medical Respite Care

Medical respite care was described to respondents as:

> "Short-term residential care for homeless persons who are too weak or ill to recover from a physical illness or injury on the streets; but who are not ill enough to be in a hospital. Medical respite care facilities are set-up to provide homeless persons a chance to rest in a safe and supportive environment while accessing medical care."

More than three-quarters (80%) of respondents reported they had never received medical respite care services. Among the 20% that had received medical respite care, 73% reported that it had a positive impact on their recovery (Figure 2). Below are a few quotes that were provided from respondents who reported that medical respite had positively impacted their lives:

- *"I stayed in respite for a couple of days until my [medications] balanced and my issues fairly resolved."*
- *"[Medical respite] gave me a better chance to live..."*
- *"I have been sick for a long time and it gave me a chance to rest and recover."*
- *"Helps to have people that sincerely cared..., see the hole you are in and help you out of it."*
- *"I believe it literally saved my life on three different occasions."*

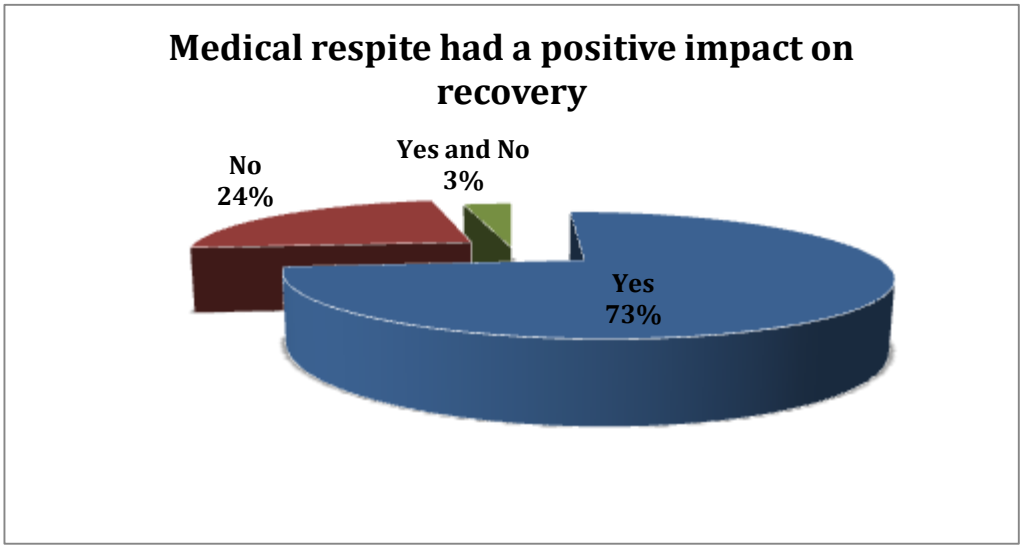


Figure 2

Health Care for the Homeless Services

Respondents were asked several questions regarding the availability and accessibility of certain services in their local area. *Availability* of services referred to the extent to which a service exists in their local community. *Accessibility* referred to how easy an available service is to obtain in the community. These services were chosen based on identified service needs described by administrators and clinicians in Group 1 and 2 of the needs assessment survey process (i.e. Stage 3). Among the services mentioned were: transportation, ID card services, medical care, medical respite care, specialty care (e.g. mental health or substance abuse services), dental care, prescription medicine assistance, and resources and referrals (e.g. food, clothing, and housing assistance).

Availability vs. Accessibility

Overall, respondents reported high rates of availability for services in their local area. Specialty care yielded the highest ratings with 83% of respondents reporting it was available in their local area. However, medical respite care yielded the lowest scores with 40% of respondents reporting they were not sure if this service existed in their local area (Figure 3).

Figure 3

Availability of Services			
	Available	**Not sure**	**Not available**
Transportation	70%	17%	13%
ID card services	64%	21%	15%
Medical care	72%	18%	10%
Medical respite care	49%	40%	11%
Specialty care	83%	14%	4%
Dental care	65%	23%	12%
Prescription medicine assistance	79%	16%	5%
Resources and referrals	78%	17%	5%

In terms of accessibility of services, respondents for the most part rated services as "very accessible" but these percentages were slightly lower than those identified for availability. Specialty care for example, was previously described as being *available* by 83% of respondents. However, when asked how *accessible* specialty care services were, 61% said "very accessible". Medical respite care again yielded the lowest percentage with 33% of respondents describing this service as being accessible. Id card services and dental care yielded the highest percentages for inaccessibility with 10% of respondents identifying these areas as "very inaccessible" (Figure 4).

Accessibility of Services					
	Very accessible	**Somewhat accessible**	**Not sure**	**Somewhat inaccessible**	**Very inaccessible**
Transportation	47%	30%	16%	3%	4%
ID card services	47%	21%	20%	2%	10%
Medical care	54%	27%	13%	3%	4%
Medical respite care	33%	18%	41%	4%	4%
Specialty care	61%	22%	14%	1%	2%
Dental care	39%	30%	16%	5%	10%
Prescription medicine assistance	60%	24%	13%	2%	1%
Resources and referrals	58%	23%	13%	3%	3%

Figure 4

Missing HCH Services

In a follow-up question, respondents identified health care services for individuals experiencing homelessness that were missing in their local communities (Table 26). While there were a significant number of survey participants that did not respond to this open-ended question, approximately half provided feedback on services needed for individuals experiencing homelessness within the HCH community. These responses were analyzed qualitatively and categorized by the specific type of service identified. Dental services and housing were mentioned most often as a need. About 14 respondents indicated none of the services for persons experiencing homelessness were lacking.

TABLE 26- Missing Services in HCH Community (N=156):

Characteristic	**n[58]**
Missing HCH services	
Dental services	17
None of the services are lacking	14
Housing	11
Specialty care	5
Prescription medicine assistance	5
Mobile services (outreach)	5
All of the services are lacking	5
Medical respite	4
Primary health care (medical)	4
Transportation	4
Mental health services	4
ID card services	2
Total	80

[58] Indicates the total number of times this specific type of response was provided by a respondent.

Consumer perception of HCH Project Staff and Clinicians

Consumers provided feedback on their overall experience with HCH project staff and clinicians (Figure 5). About 80% of respondents reported that HCH project staff and clinicians treated them with respect when delivering services. More than one-third (43%) strongly agreed that HCH project staff and clinicians try to get a full understanding of their medical history. Just under half (47%) of the respondents strongly agreed HCH project staff and clinicians take time with them during visits to address all of their medical needs. Slightly more than 40% reported that HCH project staff and clinicians judged them as though they had nothing to offer. However, more than 75% of respondents indicated they have generally had positive experiences with HCH project staff and clinicians.

Figure 5

Consumer Perception of HCH Project Staff and Clinicians					
	Strongly agree	**Agree**	**Not sure**	**Disagree**	**Strongly disagree**
HCH project staff and clinicians treat me with respect while delivering services.	51%	29%	13%	3%	4%
HCH project staff and clinicians try to get a full understanding of my medical history.	43%	35%	14%	5%	3%
HCH project staff and clinicians take time with me during my visits to address all of medical needs.	47%	24%	16%	10%	4%
HCH project staff and clinicians judge me as though I have nothing to offer.	22%	19%	27%	11%	22%
In general, I have had positive experiences with HCH project staff and clinicians.	47%	31%	14%	5%	3%

Biggest Challenges

Consumers described challenges in accessing and maintaining health care services (Table 27). These responses were analyzed qualitatively and grouped by topic area. Respondents commented most often that their biggest challenge was not knowing "where to go get to get help." Other top reported challenges described by respondents were: transportation and receiving financial assistance for services such as: doctor visit co-pays, prescriptions, and child care.

TABLE 27- Biggest Challenges in Accessing and Maintaining Health Care Services (N=156)

Characteristic	n
Biggest challenges	
Knowing where to go to get help[59]	30
Transportation	19
Financial assistance[60]	10
Getting follow-up care[61]	5
Long wait times for appointments	4
Being treated differently by others (feeling of being judged)	6
Going through "hoops" or "red tape" to get assistance	5
Service staff lack of concern when attempting to get assistance	2
Total	81

Victim Compensation Fund

The Victim Compensation Fund is a federal government program designed to compensate victims of violent crimes (e.g. rape, assault, homicide, and in some states burglary). If eligible, victims of these types of crimes (or their families), can be financially reimbursed for their medical expenses and other costs related to the crime. [62]

Nearly 90% of respondents indicated that they were not aware of the Victim Compensation Fund. Among the respondents that were aware of the compensation, about 40% reported they did attempt to receive compensation from the government after some type of violent crime. Half of the respondents that reportedly applied for compensation were successful in receiving compensation. When the respondents who attempted to apply for victim compensation were asked to describe the challenges they experienced in their attempt to receive compensation, 80% did not provide a response. Challenges reported were related to not qualifying for compensation and being falsely accused of their involvement with the crime of which they were a victim.

[59] Indicates the total number of times this specific type of response was provided by a respondent.
[60] Examples include assistance paying doctor co-pays, prescriptions, child care assistance, etc.
[61] Respondents indicated they do not have phone access or a place to put reminders for appointments and referrals.
[62] National Association of Crime Victim Compensation Board http://www.nacvcb.org/faq/2.html

Consumer Board and Council Involvement

Nearly 70% of the respondents who participated in this survey reported they were not actively involved with a Consumer Advisory Board (CAB) and never have been (Table 28). Just over 10% indicated they were not actively involved with a CAB but had been in the past. Half of the respondents who reported no current CAB involvement indicated they would be interested in joining a CAB.

TABLE 28- Consumer Board Involvement (N=156)

Characteristic		n	%
Active involvement with CAB			
No, I am not actively involved with a CAB and never have been		100	68
Yes, I am actively involved with a CAB		29	20
No, I am not actively involved with a CAB but have been in the past		17	12
	Total	146	100%
Involved with the Council			
No		117	79
Yes		31	21
	Total	148	100%
How involvement with Council began			
Other		25	36
Through participation on a Consumer Advisory Board		17	25
Through the suggestion of a health care for the homeless staff person		12	17
Through word of mouth from a fellow homeless individual		11	16
Through my own research of health care for the homeless programs		4	6
	Total	69	100%

Survey participants were also asked about their involvement with the Council. About 80% of respondents reported they were not involved with the Council. The remaining respondents who did express some type of involvement indicated how they became involved with the Council. While 25% reported they became involved through their participation in a CAB, more than one-third indicated beginning their involvement with the Council in some "other" way. Based on the qualitative responses provided, there seemed to be some confusion about the question with several of the respondents indicating "unknown" or "not involved yet." Among the responses provided in this category, it was reported involvement began through their involvement in "proposed workshops"; most likely for the annual National HCH Conference. Just under 20% reported their involvement began as a result of a suggestion made by a health care for the homeless staff person.

When respondents were specifically asked how they were involved with the Council, 12% reported they were members of the National Consumer Advisory Board (NCAB). Another 10% also reported participating at a previous National HCH Conference.

Advocacy

When respondents were asked if they felt comfortable advocating for themselves and others experiencing homelessness, 70% reported they were. Out of those individuals who reported they were not comfortable engaging in advocacy for themselves or others, 82% were not actively involved in a CAB and never had been.

Actively involved with a CAB by Comfort engaging in advocacy

Actively involved with a Consumer Advisory Board (CAB)	Comfortable advocating for self and others experiencing homelessness	
	Yes	No
Yes, I am actively involved with a CAB.	28%	2%
No, I am not actively involved with a CAB and never have been.	62%	**82%**
No, I am not actively involved with a CAB but have been in the past.	10%	16%

Interest in Learning Opportunities

Consumers were asked about health care for the homeless learning opportunities (Table 29). Close to half (46%) of respondents reported interest in participating in a training offered on how to help individuals who were *newly* experiencing homelessness. More than 35% of respondents were interested in participating in an advocacy training and another 31% were interested in a learning opportunity regarding how to access health care resources in their community.

TABLE 29- Learning Needs Characteristics of the Sample (N=156)

Characteristic	n	%
Learning topics of interest		
How to help individuals who are "newly" homeless	71	46
Advocacy training	57	37
Accessing health care resources in your local community	49	31
How to start a Consumer Advisory Board	25	16
Other	24	15

Among respondents who indicated being interested in some "other" type of learning opportunity, comments mentioned by respondents included: wanting to "talk with and [give] hope to hope to the homeless", "forming peer run and operated services", "forming [a network] of liaisons", and "do[ing] outreach." Other responses related to public speaking and social anxieties. Some of the comments made were: "people make me nervous", "shyness", and "I don't do public speaking."

Discussion

Research has shown that unstable housing affects an individual's health status. People who are homeless suffer from a wide range of multidimensional medical problems that contribute to excess mortality.[63] Disease severity can be remarkably high because of factors such as extreme poverty, delays in seeking care, barriers to therapy adherence, cognitive impairments, and adverse health effects of homelessness itself.[64] People experiencing homelessness in their forties and fifties often develop health related disabilities that are more commonly seen in people who are decades older.[65] Even within the group of individuals who are homeless, those living on the streets tend to have worse health outcomes than those residing in shelters.[66] Moreover, experiencing homelessness impedes access to health care and complicates the delivery of health services.[67]

A recent study conducted by Baggett et al. (2010) found that individuals experiencing homelessness have many unmet health needs. Data from a national survey of homeless adults were used to determine the prevalence and predictors of unmet need for five types of health services. Unmet needs were most consistently related to being uninsured, but were also influenced by out-of-home placement as a minor, food insufficiency, employment status and vision impairment. The researchers concluded that health services compatible with work schedules and delivered in a flexible format should be available to homeless people who rely on employment as a source of income. They also recommend moving toward a comprehensive model of health care for homeless individuals incorporating vision screening and services to alleviate the burden of this impairment, enhance functionality and improve access to other dimensions of care.[68]

The delivery of health care services to medically complex individuals without homes is an important undertaking. Understanding health care needs and barriers to receiving care is vital to planning effective delivery of health care services to those who are homeless. It is also a process that must be appreciated by the staff who delivers these services.

Overall Findings

Knowledge, Skills, and Core Competency Gaps

Key informants, focus group participants, and those who participated in the various surveys gave direct indications as to the knowledge, skills, and competencies needed for themselves and others in the HCH field. The knowledge, skills, and abilities within the myriad of administrators and clinicians who work in the HCH arena vary greatly as do the different health centers where they serve. The educational preparation for HCH administrators is varied, with the majority being nurses serving as HCH coordinators and social workers as program administrators. Physicians serving as medical directors have both administrative and clinical

[63] Wood D, editor. Delivering health care to homeless persons. The diagnosis and management of medical and mental health conditions. New York: Springer Publishing; 1992.
[64] Ibid
[65] Gelberg L, Linn LS, Mayer-Oakes SA. Differences in health status between older and younger homeless adults. *J Am Geriatr Soc* 1990; 38:1220-9.
[66] Gelberg L, Linn LS. Assessing the physical health of homeless adults. *JAMA* 1989;262:1973-9.
[67] Institute of Medicine, (1988). Homelessness, Health and Human Needs.
[68] Baggett, J. O'Connell et al. The Unmet Health Care Needs of Homeless Adults: A National Study *Am J Public Health.*2010; 0: AJPH.2009.180109v1

responsibilities. This needs assessment looked at knowledge and skills needed in the HCH and medical respite setting. It did not attempt to define core competencies needed by HCH providers.

Target Audiences

The main audiences targeted by this knowledge and skills needs assessment were: administrators, clinicians, and consumers. Within administrators and clinicians, are subgroups which include: nurses (nurse practitioners, advanced practice nurses), physicians, social workers, case managers, mental health professionals, outreach workers, physician assistants and substance abuse counselors. The majority of administrators and clinicians who responded to this needs assessment, have more than 10 years of experience working with people who are homeless. Therefore, opportunities must be offered for the more advanced learner. In addition to this, more than half of all responding clinicians felt their health professional training was not adequate and were interested in participating in training programs specifically designed for clinicians working with individuals experiencing homelessness. Team skill building (including interdisciplinary teams) was identified repeatedly by both clinicians and administrators as a needed skill in the field. The educationally and professionally diverse workforce in the HCH arena would make the above noted trainings a priority.

Learning Preferences of Target Audiences

Preferred learning methods varied as did the audience; however, conference workshops and face-to-face encounters received a favorable response as did webinars and online trainings.

Agency Administrative Support for Training & TA Intervention

All who participated in the knowledge and skills needs assessment were in support of training and TA interventions both on the professional and systems level. Several respondents indicated that finding time to participate in learning opportunities was challenging. In the key informant interviews some clinicians expressed the desire to have more support from program management to pursue professional development learning opportunities. However, to what extent this support is present or absent was not assessed.

Impact of Training & TA Interventions on Specific Clinical Outcomes

The current knowledge and skills needs assessment alone was unable to assess the potential impact of training and TA interventions on specific clinical outcomes. During the focus groups, 12 areas to focus HCH specific clinical outcomes were suggested. Funding has been requested to conduct a pilot study later this year; this may provide some insight into the impact that training and TA interventions would have on any of these identified clinical outcomes.

Survey Findings

Providing training and technical assistance to HCH organizations are important ways to enhance the delivery of health services to people who are unstably housed. Learning opportunities to train administrators and clinicians in HCH projects are critical in increasing the capacity of the primary care system to ensure the delivery of quality services.

The HCH project staff and clinicians who participated in the knowledge and skills needs assessment were very honest in sharing their ideas and comments regarding what the HCH workforce needed in the areas of training, professional skills development, and career development. While administrator survey responses centered on training needs of project staff (including clinicians and front line staff), clinician responses were more grounded in advancing professional skills as HCH practitioners.

In terms of challenges identified, both administrators and clinicians indicated that working with high risk and vulnerable populations (e.g. medically complex, behaviorally challenging, injection drug users, sex workers, transgender people, etc.) was a professional development area that would require specialized training. Administrators and clinicians also agreed that integrating primary care and behavioral health and developing more advanced policy advocacy skills were other areas which required specialized training for clinical staff.

The majority of administrators and clinicians involved in this needs assessment have worked with patients experiencing homelessness for 10 years or more and are looking for advanced level learning opportunities. It is unclear how respondents may have perceived the term "advanced" as a definition was not clearly stated within the survey. It may be assumed that respondents are seeking learning opportunities that go beyond an introductory level and aim to address the more complex clinical and administrative issues that arise in providing services to those experiencing homelessness. Another possibility may be that these respondents are looking for learning opportunities that reflect new evidenced-based strategies.

Other similarities found were the preferred methods for learning indicated by administrators and clinicians. Both groups reported preferences for conference workshops and seminars; clinicians specifically stated face-to-face-learning opportunities as a preference. On-line training and webinars were also reported as preferred learning methods but much less frequently than the face-to-face options. Continuing education credits were more influential for clinicians than administrators when selecting learning opportunities.

An additional subgroup identified by both administrators and clinicians as needing more attention and training, were those individuals who serve as front-line staff (front desk attendees, clerks, intake workers, etc). Front-line staff typically has the first encounter with clients and their interaction with a client can make a significant impact on whether or not someone will continue to receive care. Training suggested for front-line staff included: communication skills, client engagement strategies, customer service skills, and how to work with individuals with mental health issues.

The consumer portion of the needs assessment focused primarily on accessibility to certain services, their experiences with HCH project staff, and challenges they have experienced. It should be noted that while several consumers reported having mostly positive experiences with HCH clinicians and staff, several of them reported they felt that they were being judged as though they had nothing to offer. Consumers also indicated that not knowing where to find help was one of their biggest challenges. This slightly contrasts the earlier statements made about generally feeling that services were available in their area. However, their comments in reference to their "biggest challenges" may reflect services needed by people who are homeless not listed on this survey.

Learning opportunity interests reported by consumers were primarily focused on: how to assist individuals who were newly experiencing homelessness and how to engage in advocacy for themselves and others experiencing homelessness. Based on comments made about speaking and social anxieties, learning opportunities that would help consumers overcome these fears may be beneficial.

Conclusion

The main purpose of the knowledge and skills needs assessment was to help target the Council's education, training, and TA activities to meet the stated needs of HCH grantees in the field. Three methods were used to gather information from staff and consumer representatives from HCH projects and other agencies assisting individuals who are homeless throughout the United States. Results from the key informant interviews, focus groups, and surveys will assist Council members, board, and staff to identify and prioritize needs, create learning strategies, and develop curricula and services to meet these needs.

This needs assessment is funded through HRSA funding and is therefore focused on finding knowledge, skills, and attitude gaps **for 330h grantees**. This document reflects the knowledge, skills, and attitude needs of the 330h grantees who participated in the three stages of this project. This document may not reflect the overall needs of Council members, which include organizations and individuals not associated with 330h programs. The Council understands those needs to be important to the overall environment of care and healing for people experiencing homelessness which is why that understanding is reflected in the Council's mission and three-year goals. This needs assessment for 330h grantees, is part of the Council's larger mission.

HCH professionals live in a rich learning environment that is constantly evolving with opportunities for learning that include: professional interaction, conversation, educational events, information and feedback. Council staff recognizes that this needs assessment is only the first step of trying to identify learning needs for HCH professionals and consumers. We will use this document for future needs assessments, planning, action, and evaluation. The HCH field will constantly face new challenges. We must ensure that the Council provides optimal training and TA that adequately equips HCH professionals to respond to emerging trends in health care, the health services delivery system, and most importantly the health care needs of medically complex individuals who are experiencing homelessness.

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Appendix A

Strategic Plan of HRSA

Overall Strategic Plan Released 5-10-10 as funder their philosophy and strategic plan should have a bearing on our training and technical assistance opportunities. The National HCH Council should mirror our parent organization making appropriate adjustments for our special population and provide technical assistance and training to HCH projects to assist them in meeting these goals and requirements.

Goal I: Improve Access to Quality Health Care and Services

Sub-goals

a. Assure a medical home for populations served.
b. Expand oral health and behavioral health services and integrate into primary care settings.
c. Integrate primary care and public health.
d. Strengthen health systems to support the delivery of quality health services.
e. Increase outreach and enrollment into quality care.
f. Strengthen the financial soundness and viability of HRSA-funded health organizations.
g. Promote innovative and cost-efficient approaches to improve health.

Goal II: Strengthen the Health Workforce

Sub-goals

a. Assure the health workforce is trained to provide high quality, culturally and linguistically appropriate care.
b. Increase the number of practicing health care providers to address shortages, and develop ongoing strategies to monitor, forecast and meet long-term health workforce needs.
c. Align the composition and distribution of health care providers to best meet the needs of individuals, families and communities.
d. Assure a diverse health workforce.
e. Support the development of interdisciplinary health teams to improve the efficiency and effectiveness of care.

Goal III: Build healthy communities

Sub-goals

a. Lead and collaborate with others to help communities strengthen resources that improve health for the population
b. Link people to services and supports from other sectors that contribute to good health and wellbeing.
c. Strengthen the focus on illness prevention and health promotion across populations and communities.

Goal IV: Improve health equity

Sub-goals

a. Reduce disparities in quality of care across populations and communities
b. Monitor, identify and advance evidence-based and promising practices to achieve health equity.
c. Leverage our programs and policies to further integrate services and address the social determinants of health.

d. Partner with diverse communities to create, develop and disseminate innovative community-based health equity solutions, with a particular focus on populations with the greatest health disparities.

Requirements of HRSA

Health centers that serve the special medically underserved population must meet certain program requirements as prescribed by HRSA

Knowledge and Skills Needs Assessment
Required and Additional Services
Staffing Requirement
Accessible Hours of Operation/Locations
After Hours Coverage
Hospital Admitting Privileges and Continuum of Care
Sliding Fee Discounts
Quality Improvement/Assurance Plan
Key Management Staff
Contractual/Affiliation Agreements
Collaborative Relationships
Financial Management and control Policies
Billing and Collections
Budget
Program Data Reporting Systems
Scope of Project
Board Authority
Board Composition
Conflict of Interest Policy

Required Health Center Performance Measures

Percentage of pregnant women beginning prenatal care in the first trimester

1. Percentage of children with 2nd birthday during the measurement year with appropriate immunizations
2. Percentage of women 21-64 years of age who received one or more Pap tests during the measurement year or during the two years prior to the measurement year.
3. Percentage diabetic patients whose HBA1c levels are less than or equal to 9 percent
4. Percentage of adult patients with diagnosed hypertension who most recent blood pressure was less than 140/90
5. Percentage of births less than 2,500 grams to health center patients
6. Must include one Behavioral Health (mental or substance abuse) and one oral health performance measure

Federal Strategic Plan to Prevent and End Homelessness

http://www.usich.gov/PDF/OpeningDoors_2010_FSPPreventEndHomeless.pdf

Appendix B

Key informant questions

(General questions presented to all interviewees)

1. What is your position?
2. How long have you been in your position?
3. How long have you been involved with the HCH Council?
4. Are you a member of any Network or Committee?
5. If yes, why did you choose to join or become involved?
6. What is your interpretation of what the Council does? (To see how people view the role of the Council, is congruent with the role that we see for ourselves)
7. In the last year, have you attended or participated in or been the recipient of any learning, training or technical assistance activities sponsored by the Council?
8. If so, which one(s)?
9. Have you participated in any other educational or learning activity sponsored by another organization? If so, please specify _____

Key Informant questions specific to area of expertise

Administrators/ Clinicians

1. Does your organization have a CAB?
2. Does your organization have a dedicated staff person for policy/advocacy work?
3. How much does your organization spend on birth certificates and other identification materials related to meeting federal benefits requirements?
4. In the last year, have you sought technical assistance from an organization?
5. Is yes, who and what did the technical assistance consists of?
6. If you are looking for new information about the care for homeless individuals, where do you go to get new information?
7. Is there any additional information or training that can assist you in doing your job better?

8. What do you see is the greatest education or training need among those who work in the health care for the homeless field?

9. In what areas do you feel Training or Technical Assistance is needed?
    a. HCH Model of Care
    b. Principles of Respite Care
    c. Outreach
    d. Governance
    e. Relating to parent organizations
    f. Consumer Participation
    g. Advocacy
    h. Policy development and implementation
    i. Other

10. How can the Council do better in meeting this greatest need?
    a. Increase awareness (printed material, educational seminars)
    b. Increase educational opportunities (webinars, regional trainings, online instruction)
    c. Increase training (hands on training, conferences, workshops)
    d. Increase capacity building (site visits, technical assistance instructions)
    e. Increase technical assistance
    f. Offer more training online

11. Who are your main partners or collaborators that assist your organization in accomplishing its mission?

12. Final question- Is there anything important you think I missed?

Consumers

1. In working with NCAB and other consumers, what do you see as the greatest learning or educational need?

2. As we begin to survey other consumers, what type of questions pertaining to their learning and education needs should we be asking them?

3. We are planning to do an overall survey, what questions regarding consumer involvement or anything related to the consumer should we include in this survey?

4. Do you know how many organizations have a CAB?

5. Does your organization have a dedicated staff person for policy/advocacy work?

6. Final question- Is there anything important you think I missed?

Appendix C

Focus Group Questions

1. If you were a genie in a bottle with 3 clinical outcomes wishes to grant to your clients/patients what would they be?
2. We know there is no genie, but as we look at health outcomes we wish for our clients and/or patients, please tell me what you think the main skills and knowledge are needed by you and others to assist your clients/patients to meet these outcomes?
3. If you wrote a book, on Homeless Health Care for Dummies- What topics would be included in Chapter 1?
4. After writing your book, on Homeless Health Care for Dummies, who would you share the book with to ensure that they learned every topic in Chapter 1?
5. If the HRSA representative came for a site visit and asked you, what training or technical assistance is needed to address these issues and improve clinical outcomes, what would you tell him/her?
6. What can your organization do to have an impact on clinical outcomes?