SERVICE ADAPTATIONS for SPECIAL POPULATIONS

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EXECUTIVE SUMMARY

Primary care projects that serve Special Populations adapt service delivery models, staffing patterns, and other aspects of clinical operations to meet the needs of their clients most effectively. These projects can therefore differ substantially from other, more traditional primary care delivery models.

For purposes of this paper, "Special Populations" include:
- Migrant and seasonal farm workers
- People experiencing homelessness
- Residents of public housing and surrounding areas
- Students in grades K-12 and their families

Each of these Special Populations faces barriers to accessing care in traditional delivery settings. Common barriers include lack of health insurance, lack of transportation, language and cultural barriers, suspicion of medical and other institutions, and complex medical and psycho-social needs that often make access to care difficult.

In response to these barriers, effective delivery models targeting Special Populations typically employ strategies such as:

- Mobile and temporary delivery locations
- Flexible hours and minimal use of appointment systems
- Comprehensive outreach
- An interdisciplinary approach
- Increased behavioral health and supportive services
- Use of mid-level providers and nurse-run clinics
- Decentralized, multi-site provision of care
- Culturally and linguistically appropriate staff
- Use of community outreach workers
- Linkage with other community support agencies

This paper will give readers a clearer picture of the realities facing Special Populations projects, as well as an explanation of why and how projects adapt clinical practices to address the complex needs of their clients. It is intended to cover only clinical adaptations and does not address other areas unique to Special Populations program design, such as administrative and fiscal issues, sliding fee schedules, and governance. Subsequent guidance materials will cover these issues.

HOW TO USE THIS PAPER

This paper is an educational document intended to provide insight and guidance to readers. It is especially targeted at those reviewers who are assessing New Access Point applications submitted to HRSA to serve the Special Populations noted above. **It is not a checklist** by which a project or proposal may be evaluated. Instead, it highlights the great variety of approaches that may be used to deliver care effectively to these individuals.

After a brief description of each special population, the second section of the paper examines Common Service Adaptations. Descriptions of adaptations are included for each of the 13 points in Criterion 2 of the Bureau of Primary Health Care Program Information Notice 2005-01, *Requirements of Fiscal Year 2005 Funding Opportunity for Health Center New Access Point Grant Applications.* The third section includes some population-specific program adaptations which are to be addressed by applicants. Finally, a list of "Additional Resources" is given for each special population. For readers seeking greater depth of knowledge than this paper is designed to provide, these resources are an excellent place to start.

TABLE OF CONENTS

I. CHARACTERISTICS OF SPECIAL POPULATIONS AND PROGRAMS THAT SERVE THEM

Migrant Health Centers

Migrant Health Centers (MHCs) serve migrant and seasonal farm workers (MSFWs) and their families through a variety of models. MSFWs have difficulty accessing primary care services due to rigorous work schedules, lack of transportation, and financial, linguistic, and cultural barriers.

Some geographic areas see an intensive influx of farm workers during a brief harvesting season. A migrant health center (MHC) may operate in these areas only during the harvest. Such an area may call for a health outreach project that operates in close proximity to work sites, primarily during the evenings and weekends for a few months each year.

Other MHCs serve clients who are involved in planting and pruning as well as harvesting. The number of such workers is increasing, and the population includes men living in groups, young families, and older adults coming to join their children and grandchildren. This population's broad health care issues include occupational and environmental risks, family planning, obstetrics, and chronic diseases such as asthma and diabetes.

The MSFW population is also at increased risk for depression, alcohol and drug abuse, HIV, and domestic violence. Treatment of these conditions is often limited by cultural barriers and taboos around discussing such issues. A large percentage of MSFWs and their families are racial and ethnic minorities and may speak little or no English. Therefore, cultural and linguistic appropriateness is of paramount concern to organizations serving these individuals.

Health Care for the Homeless

Health Care for the Homeless (HCH) projects recognize the many barriers to access faced by people experiencing homelessness. Homeless clients face complex medical and psycho-social issues, ranging from untreated diabetes and hypertension to tuberculosis, HIV, and co-occurring addiction and mental illness. The homeless population is complex and varied, including large numbers of children and adolescents, homeless veterans, victims of domestic violence, and undocumented immigrants. Some clients experience homelessness only sporadically, while others are homeless over a long period of time.

HCH projects work to approach clients in ways that eliminate common barriers to access, such as lack of health insurance, transportation, stable address, and telephones. Extensive outreach, both on the streets and at fixed sites (shelters, meal sites, and other programs) is a common way that projects approach potential clients. Treatment is also routinely provided in non-traditional settings, such as in shelters and soup kitchens, on the street, in mobile vans, and is conjunction with other social service and temporary housing providers. Additionally, projects often utilize an array of social services staff (outreach workers, case managers, addiction counselors, art

therapists, and others) to address the psycho-social issues faced by people experiencing homelessness.

Public Housing Primary Care

Public Housing Primary Care (PHPC) projects serve residents in and around public housing. According to the most recent data, 4.1 million households live in HUD's assisted rental units in the United States. Subsidized housing thus makes up one quarter of the 15.8 million US rental households. Of the total number of subsidized households, 28% live in public housing units, 30% utilize housing vouchers or certificates, and 42% live in units assisted by various private project-based HUD rental subsidy programs. More than half of public housing residents are African-American, and approximately 10% are Hispanic.

Family incomes of PHPC patients are well below the poverty level. A third of PHPC clients do not speak English as their primary language. Many of those accessing services at PHPC sites have no health insurance or receive Medicaid. Often, people living in public housing are not officially on the lease, and may be reluctant to seek out health care and other types of assistance.

While this population may face similar medical conditions as the general population (hypertension, asthma, diabetes, ear infections, and mental illness), acuity is often more severe due to environmental concerns, especially in the case of respiratory disease. Residents face increased psycho-social problems associated with poverty and associated with the isolation of many public housing communities, and their medical conditions are often under-diagnosed and under-treated. Incidents of violence have a great impact on these communities.

School-Based Health Centers

School Based Health Centers (SBHC) are comprehensive primary care health centers serving children and adolescents in grades K-12 within the confines of the school building. Family and community members are also served by SBHCs. SBHCs are located in schools or on school grounds and provide on-site comprehensive, preventive, and primary medical services using a multi-disciplinary staff and a family-centered approach to care. Mental health and oral health services may be provided on-site or by referral linkages to community providers. SBHC services are provided with parental consent, with the exception of minor consent services mandated by individual states. Other services may include ancillary, enabling, and pharmacy services. Services must be culturally sensitive, linguistically appropriate, confidential, family-oriented, and tailored to meet specific needs of the community and youth served. Targeted health education programs are an integral part of each project, with many different approaches being implemented by school-based health centers, including violence prevention activities, fitness programs, wellness promotion, parenting groups, and self-esteem enhancement activities.

II. COMMON SERVICE ADAPTATIONS

(NOTE: The format below follows Section V.1 Criterion 2 of *PIN 2005-01*)

1. Applicant describes the <u>scope of the proposed project</u> (see Attachment 5, Definitions), including the proposed service delivery model (e.g., freestanding, single or multi-site, migrant voucher, mobile site, school-based location, or combination), and locations/settings where services are provided.

Migrant, homeless, public housing, and school-based health care projects vary greatly in size and scope, from small interdisciplinary teams conducting rural outreach or shelter-based services, to seasonal clinics and voucher programs, to mobile teams serving a number of schools or shelter sites, to large, free-standing health centers providing a wide array of medical and supportive services. Grantees often exhibit a hybrid of several service delivery models, providing service to clients at fixed-site clinics, at migrant work sites, at shelters and meal sites, on the streets, and in mobile outreach vehicles. Strategies for increased accessibility vary from community to community, depending on client needs and available resources.

MSFWs experience transportation and communication barriers to mainstream services, often amplified by linguistic and cultural barriers. Work opportunities typically take precedence over medical and other concerns. In response to seasonal changes in need and limited resources in rural areas, some **MHC projects** make extensive use of voucher programs, providing vouchers for clients to purchase services from health centers and other local service providers. MHCs use a variety of sites, including those located at or near work sites, as well as employing mobile outreach teams.

People experiencing homelessness also face barriers to accessing health care and other essential services. Therefore, **HCH** providers locate services in sites such as shelters, meal sites, and drop-in centers. Providing services at these locations, as well as utilizing mobile outreach teams that go to streets and camps, eliminates many of the transportation and communication barriers confronted daily by homeless clients.

PHPC and **SBHC** clinics are deliberately located in settings that create ready access to concentrated populations with particular health care needs. Characteristics of the projects will vary according to the needs of their clients. The use of community health educators and outreach workers are used extensively to link patients to primary health care. These community health workers serve as advocates to help patients negotiate barriers they encounter while attempting to access primary health care.

2. Applicant demonstrates that the <u>proposed model</u> is most appropriate and responsive to the identified community health care needs (i.e., the service delivery plan addresses the priority access to care, health and social problems of the target population(s) for all the major life cycles and for each special population to be served (i.e., migrant, homeless, children in schools, residents of public housing)).

Projects that serve Special Populations recognize the complex medical and psycho-social situations faced by their clients and adapt service delivery models to meet their particular needs. Each of the Special Populations being served has its own acute and chronic medical and psycho-social needs. Delivery models for these populations are designed to best meet these needs. In order to meet the needs of Special Populations, effective service delivery models are broad in scope, providing medical care, behavioral health services, and case management that address the medical and social complexities of the special population being served.

In some cases, certain delivery sites may focus on a particular age group, as is the case with school-based projects or program serving homeless and runaway adolescents. In projects that do not serve all life cycles, provisions are made for appropriate referrals to ensure care for patients who the projects are not adequately equipped to serve.

The **MSFW** population faces increased risk of domestic violence, mental illness, addiction, childhood trauma, lack of education, chronic physical illnesses, and other personal vulnerabilities. This population is also more likely than the general population to experience occupational illness and injury as a result of difficult working and living conditions. MSFWs routinely experience musculo-skeletal injury, upper respiratory infection, and periodontal disease. As the population of farm workers shifts towards young, single men, **MHCs** may focus their limited resources on that population and may not address all life cycles. In this case, provisions are made to ensure referrals and coordination of care for those life cycles not served at the primary site.

People experiencing homelessness have many similar complex medical and psycho-social issues as MSFWs. Additionally, while immediate medical problems are addressed in all service delivery plans, effective plans are also sensitive to the psycho-social issues that can cause or be exacerbated by homelessness. **HCH projects** often focus on specific subpopulations and may not fully serve all major life cycles, in part because other community resources may be in place. Some projects may instead collaborate with community partners with referral plans for particular life cycle needs such as pediatric, prenatal, and geriatric care. HCH programs are required by statute to offer substance abuse services to those clients that are in need for such services.

SBHC projects are generally focused on the student population and may not include all major life cycles. Many of the medical, mental health, substance abuse, and oral health needs of students can be addressed in programs housed within the schools. For those services that cannot be provided within the school building due to space limitations or by agreement with the host school, many projects have developed cooperative agreements with community service providers to ensure access to appropriate care for the student population. If they cannot provide all

services directly on site, referral and coordination of services between the SBHC and community providers can address the need to serve family members of SBHC students.

3. *Applicant discusses how the required <u>primary, preventive and supplemental health services</u> (e.g., enabling services, eligibility assistance, outreach, and transportation) will be provided to all lifecycles of the target population and for each special population to be served (i.e., migrant, homeless, children in schools, residents of public housing) at each proposed service site (e.g. via contract, referral system, etc.).*

The unique circumstances of Special Populations often require special attention to enabling services, eligibility assistance, transportation, and outreach. Special Populations programs often emphasize these and other supplemental services. How these services are provided will also vary depending on the particular situation of the proposed sites (e.g. shelters, meal-sites, work-sites, various schools and housing projects, street outreach).

Projects often develop transportation programs such as service vans, public transportation vouchers, and taxi vouchers. In addition, some projects utilize on-site eligibility assistance for food stamps, housing programs, health insurance programs including Medicaid and SCHIP, disability, and other public benefits.

MHCs often establish outreach programs utilizing Promotores, "lay workers" who engage in outreach and health promotion. Outreach teams visit growers and farm worker housing to enlist the cooperation of the employer and landlord and inform farm workers of available health services. Patients in need of care may be transported to the health center at scheduled times by the agency driver. Some migrant projects provide outreach workers with laptop computers to facilitate farm worker enrollment and eligibility determination for medical and social services. Although some projects have outreach workers, drivers, eligibility workers, Promotores, and interpreters, others may have one person performing multiple functions, such as: driver/outreach worker, health promoter/eligibility worker, etc.

Outreach is often the most effective way to break down barriers to health care access, particularly for homeless patients. **HCH projects** send teams out on the streets, to the shelters and to meal-sites, to encampments and to childcare programs for homeless children. These outreach teams provide medical care and social support, and are often the most important link in engaging homeless clients. Case management to coordinate care and assist with housing, entitlements and other services is a critical component of the interdisciplinary team approach that characterizes HCH.

In much the same way, **PHPC** and **SBHC** teams take health care to their clients by conducting outreach in a variety of schools and housing sites to provide access to primary care services.

4. Applicant demonstrates that the required primary, preventive and supplemental health services will be available and accessible to the target population <u>without regard to ability to pay</u> (i.e., applicant demonstrates is has established a schedule of charges for services and corresponding schedule of discounts based on a person's ability to pay for all persons below 200 percent of poverty).

Each project sets an established, board-approved schedule of services and a sliding fee scale. Requirements of payment are particularly difficult for **homeless people and MSFWs**, the vast majority of whom are uninsured and live at or below 100% of poverty. Sliding fee schedules recognize this difficulty and programs waive fees altogether for patients at or below 100% of poverty.

SBHCs often use estimates from the school's free/reduced lunch program and/or the district's estimate of poverty among children in the schools as an indicator of which students may require services provided on a discounted basis.

5. Applicant demonstrates a clear and defined plan for providing <u>oral health care services</u> that assures availability and accessibility to the target population either directly on-site or through established arrangements (e.g., contract, referral, etc.) without regard to ability to pay.

Acute and chronic oral health needs are common in each of the Special Populations.

Virtually all **MSFWs** have deferred oral health needs that become acute, and it is particularly important for **Migrant Health programs** to have arrangements for oral health emergencies and preventive care. Some organizations establish their own dental services, creating freestanding dental clinics, incorporating dental services into an existing medical clinic, or acquiring portable equipment to provide dental care at various sites. Other programs collaborate or contract with community providers of oral health care, such as sliding fee-clinics or dental schools, to ensure access to oral health care for patients.

Homeless persons have similar oral health needs, and **HCH projects** use similar service delivery strategies. Often dental care for adults is limited to dental hygiene instruction and managing dental emergencies, and referrals are made for more extensive oral health care. Integration of primary care and oral health is important, and may take the form of shared medical records or other methods of communication. Volunteer dentists are often used, either on-site or by referral.

Most **PHPC** projects are housed within public housing complexes and experience severe space limitations, making it difficult for direct provision of oral health services. Therefore, oral health service delivery strategies often include oral health screening and referral.

Many **SBHCs** are limited in their ability to provide oral health care services on-site due to physical space or construction limitations within the school building. School-based medical providers provide general oral health screenings on-site, and may use portable dental equipment to provide service in the school in some cases. Agreements with community dental providers

can create linkages to appropriate oral health care for the student population, including sliding-fee scale community dental clinics or agreements with local dental schools.

6. Applicant demonstrates a clear and defined plan for providing <u>mental health care and substance abuse services</u> that assures availability and accessibility to the target population either directly on-site or through established arrangements (e.g., contract, referral, etc.) without regard to ability to pay.

For **MSFWs**, substance abuse, domestic violence, and mental health problems are present, but often are not obvious due to the remote nature of living arrangements for most farm workers. Most farm workers exist "on the edge" and must constantly react to challenges they face. As a result, behavioral health issues such as domestic violence, substance abuse and mental illness are not at all uncommon. In many MSFW communities, taboos and cultural values keep these problems hidden from view.

Primary care providers are often the sole source of health care for farm worker patients. As such, providers must be trained to address mental health and substance abuse issues, screening for substance abuse, depression, and anxiety, as well as incorporating appropriate treatment. Clinical treatment often goes hand in hand with community resources such as Promotores and folk or traditional healers.

Severe mental illness and substance use, often co-occurring, are extremely prevalent within the **homeless population**, especially among individuals experiencing long-term, or "chronic," homelessness. Community-based programs are often ill-equipped to deal with, or not sensitive to, the needs of mentally-ill, addicted, and dually-diagnosed people who are living on the streets or in shelters. In addition, many behavioral health programs have long waiting lists or are not accessible to people without health insurance. Due to this problem of great need and limited resources, **HCH projects** must decide upon the balance between providing primary medical care and providing behavioral health services. This balance often differs from traditional medical models. It will also vary from project to project, depending upon a number of factors including the presence and effectiveness of existing community resources.

Due to the difficulty of effectively treating mental illness and addiction while a patient is experiencing homelessness, inpatient treatment can often be the most effective approach. Day treatment, drop-in centers, and harm reduction programs are also used with great effectiveness. Some HCH projects have entered into formal agreements with behavioral health providers, jointly funding and staffing outreach teams, psychiatric services, and counseling for addictions. Others have established residential treatment programs and supportive housing programs for mentally ill clients and those recovering from addictions. Harm reduction programs that offer education, support, and other services are appropriate tools in the continuum of behavioral health services offered to homeless people. However, it should be noted that, as by statute, all HCH programs must provide substance abuse services to those clients who require such services. These services may be provided directly or through referral.

Because residents of public housing often live in violent, high-stress environments, **PHPCs** recognize the need to provide behavioral health services to their clients. Some projects may provide these services directly, while others develop relationships with community mental health and substance abuse providers, ensuring that these services are available through referral.

Many **SBHC projects** have established the provision of integrated medical and mental health care on-site in the schools. These programs are coordinated with existing school services (school psychologists, counselors, and social workers) to avoid duplication of services and to maximize the number of children receiving care. Behavioral health services are appropriate to the age and needs of the student population to be served. On-site programs may be provided by SBHC staff, or by formal arrangements with community behavioral health service providers. Students may have the need for mental health services that are best provided off-site from the school, such as medication evaluations, psychiatric services, or partial hospitalization programs. These services may be coordinated with community providers through formal or informal agreements.

7. Applicant demonstrates that the service delivery plan includes participation in a <u>disease/care management and system improvement program</u>, such as the BPHC-supported or sponsored Health Disparities Collaborative, to address the major chronic disease incidences within the target population.

Numerous **MHC, HCH, PHPC,** and **SBHC projects** have participated successfully in BPHC Health Disparities Collaboratives, despite the fact that it is difficult for small projects to participate due to the level of staff commitment required. Short of participation in a BPHC-sponsored Collaborative, projects in their start-up phase frequently utilize other approaches to formal ongoing quality improvement while committing to eventual participation in a Collaborative.

Projects may be involved in a variety of quality improvement efforts, including:
- Participation as part of a nearby community health center program
- Development of internal system of quality improvement
- Participation in quality improvement efforts of sponsoring organization

8. Applicant demonstrates that the services will be <u>culturally and linguistically appropriate</u>.

Cultural appropriateness in dealing with Special Populations not only addresses the specific linguistic and cultural needs of minorities, but also includes sensitivity to the vulnerabilities of farm workers, homeless persons, poor people living in subsidized housing, and students. Cultural sensitivity recognizes the distrust of providers and institutions often felt by people in these situations.

Projects consider many key components when designing a culturally and linguistically appropriate care model, including:

- Translation of health education materials
- Improved access to interpreter services
- Community participation in development of services
- Development of cultural competence training programs for all staff
- Increased use of community health workers
- Greater inclusion of minority physicians and traditional providers

Clearly with **MSFWs**, which include a high percentage of Spanish-speaking and other non-English speakers, linguistic and cultural barriers often exist, and **MHCs** make strong efforts to understand and address these barriers, through the extensive use of minority providers and staff, mutli-lingual staff and documents, and lay outreach workers (Promotores) who have a deep understanding of the culture and language of the people being served.

One basic way that **HCH projects** provide culturally appropriate services is through outreach and effective engagement—literally meeting people where they are. Additionally, racial and ethnic minorities and undocumented immigrants experience homelessness at a rate far disproportionate to that of the general population. Organizations serving homeless individuals may employ formerly homeless persons and others who have utilized program resources in the past.

With an influx of many different cultural groups, particularly Southeast Asian refugees and those from many African and Eastern European countries, projects that serve **residents of public housing** face many cultural and linguistic challenges. One way that **PHPC** projects address these issues is by hiring staff who live in public housing and are connected to these various cultural/ethnic groups.

Many schools are challenged by the presence of **students** from many countries and cultures that speak many languages. **SBHCs** have addressed the need for cultural and linguistic competence by hiring bilingual and/or bicultural staff who are familiar with the needs of the predominant populations within the school. Most school students have some level of competence in English, but communication with parents/guardians regarding medical or mental health issues may be challenging for SBHC providers. SBHCs have addressed the need for competence through the utilization of interpretation services such as the AT&T Language Line, or have trained SBHC staff in medical interpretation in languages other than English. Referrals to bilingual community providers may serve the needs of both students and their families.

9. Applicant demonstrate <u>comprehensiveness and continuity of care</u> for the new access point(s), including a discussion of the following:
(a) Hours of operation that assure services are available and accessible at times meeting the needs of the population including evenings and weekends as appropriate;
(b) Mechanism to assure professional coverage during the hours when the health center is closed; and
(c) Case management system that demonstrates coordination at all levels of health care, including arrangements for referrals, hospital admissions discharge planning and patient tracking.

a. Hours of Operation

Migrant and seasonal farm workers are frequently in a location to do time-sensitive, intensive labor. During peak periods of activity, the workers may be required to work from dawn until dusk. **MHCs** carefully match hours of operation with the time available to farm workers to seek care. The ability to adjust hours of operation and provider availability is especially important when inclement weather may result in a large demand for services, as families take advantage of unanticipated time off to seek medical care.

Homeless clients are often in the position of having to choose between a meal and a job for the day, a shelter bed or a medical visit. The most effective delivery models recognize these difficult choices and provide service during hours and at places that best meet the needs of the patients. This can mean extending clinic hours to include evenings and weekends. It can mean sending a team to a shelter in the evening when the most people are there. Or it can mean conducting street outreach at times when clients are just waking up, setting up camp for the evening, or working in the afternoon and evening.

As a result of welfare reform and more stringent HUD guidelines, an increasing number of **public housing residents** are working or in school/training programs during the day, resulting in the need to provide services during the evenings and weekends.

The hours of operation for **SBHCs** should approximate the school hours. Services may not be available in the school building during evenings or weekend hours due to security needs and staffing limitations within school facilities.

b. Coverage Plan

After-hours coverage is frequently a challenge for **MHCs**, particularly those located in rural or frontier areas. Access to any after hours care may involve travel over significant distances to a hospital that may not be equipped to address the cultural and linguistic needs of the population. Projects need to address this issue and design realistic coverage systems given the limitations of their communities.

HCH projects ensure after-hours coverage for patients often through arrangements with other community providers, such as urgent care clinics and hospital emergency departments. It should be noted that a telephone referral service is not always the most effective and efficient way of providing coverage, due to limited access to telephones by homeless patients.

For **SBHCs** that do not serve as the primary care provider, it is essential to establish referral linkages to community service providers to ensure that family members of students have an established "medical home" within the community that is appropriate for the adult and pre-school population. Many schools prohibit 'non-students' from entering school facilities during or after school hours.

Coverage on the weekends and during school vacations is most often coordinated with other community providers.

c. Case Management

In addition to ensuring access through appropriate hours and a solid coverage plan, case management is a critical tool in coordinating care for all Special Populations. Within the **MSFW** population, case management services for mobile populations improve care delivery and follow-up. Case management ameliorates challenges such as high rates of "no-shows," rates of persons who do not return for follow up care, and limited availability of a patient's complete medical history. **MHCs** often enter into formal relationships with other 330(e) grantees that serve the same populations to ensure coordination of services. For example, projects may collaborate on tuberculosis treatment and prevention.

Because **people experiencing homelessness** often do not have the basic tools necessary to accomplish daily tasks such as making telephone calls, getting to appointments, reading and writing, the role of case managers is increasingly important to the effectiveness of **HCH projects**. Case managers are often the link between mainstream healthcare systems, homeless service providers, housing programs, homeless health clinics, and the clients themselves. A case manager is often the key person to assist a homeless person in navigating systems that may otherwise be impenetrable, and is a key participant in the interdisciplinary team approach of HCH.

Public housing residents who have been displaced through HUD's HOPE VI public housing redevelopment program have also been displaced from their health care home. Case management and follow-up are required to ensure that they continue to have access to their existing primary care provider or are referred to and linked with another more accessible provider site.

10.   *Applicant demonstrates that the development of the new access point is the result of a <u>strategic planning process</u> that examined the needs of the community and included community input and Board involvement. Applicant discusses the extent to which the proposed health center will address the priority health care needs, improve access to primary health care services and reduce health disparities for the medically underserved in the community/target population(s*

Special Populations programs often involve a wide variety of community stakeholders in program planning and governance.

Stakeholders for the **farm worker** population include farm workers, farm worker representatives, board members, employers, and migrant services providers such as migrant education, migrant Head Start program officials, migrant housing providers, churches, WIC programs, and other social service providers. These types of individuals may be involved in the development of a new migrant health access point as well as in the governance of an on-going program.

For **HCH projects** often involve community organizations providing housing, shelter, and other services, as well as homeless individuals and community supporters, in the development of a new HCH access point and in program governance.

The development of an **SBHC** as a single new access point, or in combination with a community primary care access point, commonly results from a planning process that involves parents, students, the community-at-large, and key school personnel. With a relatively stable target population, it is possible to conduct a thorough assessment of the medical, mental health, substance abuse, and oral health needs of the students in the schools to be served. Frequently, the establishment of a school-based health center is identified by the community as a high priority, creating a site that will increase access to care for the child and/or adolescent population. The development or expansion of SBHCs may be identified as part of the strategic plan for local, regional, or state organizations.

11. Applicant demonstrates <u>collaboration and coordination of services with other providers</u> including other existing FQHCs and section 330 grantees in the area. This should include a description of both formal and informal collaborative and partner arrangements, which assure a seamless continuum of care and access to appropriate specialty care for the target population(s). Applicant provides copies of relevant contracts, MOUs, letters of commitment or investment (e.g., from the school board, local hospital, public health department, etc.), as part of the application attachments.

Because the majority of **farm workers** live below the federal poverty level and are uninsured, migrant health projects should collaborate closely with existing programs in the community, the county, and the state in order to maximize resources and provide the most comprehensive services possible. The scope of the project and the demographic characteristics of the patients (single men or families) will determine which partnerships and/or MOAs need to be established (i.e. migrant education, migrant Head Start) and which other local and state resources or programs need to be pursued (i.e. Healthy Start, Ryan White, homeless programs).

Similarly, due to the level of uninsured persons among **homeless patients** and the complexity of their needs, a broad level of collaboration can be extremely effective in providing safety net services. HCH providers often coordinate and collaborate with other providers in the community—public hospitals, other FQHCs, mental health centers, shelters and housing programs, meal sites, schools, HIV services, other HCH projects, law enforcement, networking groups and coalitions. Some of these relationships are formalized in MOUs and other written agreements, while others are formed through the relationships between staff working on a daily basis to coordinate care. HCH projects routinely engage in contracts and agreements for use of sites, purchase of health care services, social services, and out-stationed entitlement workers. Other partners include homeless coalitions and Continuum of Care planning bodies.

PHPCs should demonstrate community collaboration through close coordination with local housing authorities, as well as by establishing PHPC advisory committees, composed of residents of public housing, representatives of housing authorities, welfare-to-work programs, and other people from the broader community.

School-based projects, by virtue of their location within or on school grounds, must work closely with host school(s) to establish positive working relationships and to sustain these relationships throughout the life of the project. SBHCs often demonstrate these collaborative partnerships through letters and agreements with appropriate community partners and school leaders at local and administrative levels. In addition, SBHCs should develop plans to coordinate services with community medical, mental health, and oral health providers to avoid duplication of services.

12. Applicant demonstrates that <u>the proposed clinical staffing pattern</u> for the new access point(s) (e.g. number and mix of primary care physicians and other providers and clinical support staff, language and cultural appropriateness, etc.) is appropriate for the level and mix of services provided.

Staffing patterns generally reflect the needs of the clientele, as well as addressing the issue of cultural competency. In response to limited resources and increasing demand for services, many projects have established nurse-run or nurse practitioner-run clinics. Some projects use physicians primarily to provide clinical leadership and oversight to mid-level providers, who comprise a large part of the clinical staff.

With **MHC projects**, the proposed staffing mix can vary, depending on the array of services required in a specific setting (e.g. nurse practitioners for prenatal, pediatrics, or family planning care). A logical system for maximum coverage with linguistically and culturally appropriate clinical staff is the goal.

In addition to family practice physicians, internists, and specialists, **HCH projects** tend to rely heavily on mid-level providers (nurse practitioners and physician assistants). RNs, LPNs, and medical assistants are used in various settings, depending on the level of nursing skill needed. It is also important to remember, based on the psycho-social complexities of homelessness, that supportive services staff such as social workers, case managers, drug and alcohol counselors, and outreach workers often play as central a role in homeless health care as the physicians and nursing staff.

Staffing patterns of **PHPCs** are similar, utilizing midlevel providers, community health workers and advocates, and other supportive services staff.

SBHC projects are unique in their ability to provide services in locations within the students' school environment. Students are able to develop rapport with the school-based providers based on the development of an atmosphere of safety and confidentiality. Effective school based providers have expertise in child or adolescent care; SBHC programs utilize the services of nurse practitioners, clinical social workers, RNs, and other staff who are competent in pediatric and adolescent healthcare. To ensure that the SBHC staff operates in conjunction with a larger system of care, SBHCs develop support for clinical supervision, consultation, and medical/mental health back-up services.

13. Applicant describes a detailed plan for <u>recruiting and retaining appropriate health care providers</u> as appropriate for achieving the proposed staffing pattern.

As with all other programs that target vulnerable populations, all projects that serve Special Populations seek staff that is mission-driven, competent, compassionate, non-judgmental, and willing to work in situations that are not always ideal—such as providing services on the street, in a school, at a work site, or in the back room of a shelter. Additionally, the emotional strain of working so closely with patients who are under constant stress and danger can take its toll on staff, causing burnout and staff turnover. Professional isolation and drastic seasonal changes in workload also complicate staff recruitment and retention.

Projects that deal effectively with these staffing issues rely on a number of recruitment and retention techniques. To recruit appropriate providers, they may post jobs not only in local publications, but also on national websites, such as those provided by the National Healthcare for the Homeless Council, the National Association of Community Health Centers, and other professional organizations. Strong job candidates are often identified through word-of-mouth or informal networking groups, or through on-going relationships with health professions schools.

To promote staff retention, some organizations provide staff support through regular staff retreats, ongoing trainings, clinical supervision and other methods. Projects also support membership in professional organizations such as Migrant Clinicians' Network and the HCH Clinicians' Network.

III. OTHER SPECIAL POPULATIONS ISSUES AND STRATEGIES

In addition to the above criteria, applicants requesting funding for a new access point(s) for the following types(s) of health center must also respond to the following criteria:
        (NOTE: This is found in Section V.1 of PIN 2005-01, at the end of Criterion 2)

MIGRANT HEALTH

(a)   Environmental and/or occupational hazards

Due to difficult working and housing conditions, there is a high incidence of occupational health-related illness and injury within the farm worker population. Hazards include dust and other particles in the air; use of ladders and knives; stoop labor and heavy lifting; pesticides; inclement weather conditions; lack of sanitation; overcrowded living facilities; and social isolation. These hazards contribute to the high rates of infectious disease; conditions of the skin and musculo-skeletal system; unintentional injury; diminished mental health, including depression and the use of alcohol and other substances; and non-specific symptoms.

Among the strategies used by successful Migrant Health projects are to:
- Establish peer education programs to reach and teach farm workers about health promotion and illness or injury prevention, body mechanics, and general hygiene.
- Screen farm workers for environmental & occupational illnesses by including in the health care history questions related to working & living conditions and hazards.
- Conduct screenings and education for specific illness, such as tuberculosis or asthma.
- Include in health care plan specific goals and objectives to reduce environmental public health hazards, such as control of mosquitoes, flies and/or rodents within the migrant camps to limit exposure to West Nile virus, dengue and other vector-borne illnesses.
- Provide training of other health center staff in occupational hazards of MSFWs.

(b) Outreach programs

Outreach is an essential component of a migrant health delivery system, whether in a traditional or hybrid model. Unfortunately, in times of economic stress, non-reimbursable services such as outreach are sometimes eliminated and MHCs must balance among competing needs. Without the critical outreach component, there is no assurance that this hard to reach population will be brought to care.

Among the strategies used by successful Migrant Health projects are:
   a. Hire farm workers and train them as outreach workers and/or health promoters.
   b. Collaborate with other area farm worker programs (Migrant Education, Head Start, Labor Migrant Ministries and Day Care) to pool outreach teams.
   c. Develop migrant service coalitions and uniform intake/referral mechanisms.

d. Develop contractual relationships with Migrant Education, Head Start and Day Care to provide medical and dental services, such as physical exams, transportation, on-site nursing care, immunization clinics, etc.

e. Host multi-agency health fairs and in which local area health system providers become involved in providing free or low cost services such as TB tests, immunizations, mammograms, cholesterol tests, health education etc.

f. Contract with the existing Central Office Grantees such as Migrant Health Promotion or farm worker Health Services to secure guidance and advice in the creation of a health promoter or outreach program.

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HEALTH CARE FOR THE HOMELESS

(a) *Substance abuse services including detoxification, risk reduction, outpatient treatment, residential treatment and rehabilitation for substance abuse.*

Limited resources for substance abuse treatment typically prevent HCH projects from becoming comprehensive substance abuse treatment programs. However, all HCH projects must ensure access to substance abuse services as required by statute. Some projects provide addiction services directly, while others collaborate with existing substance abuse services in their communities. "In-house" services may take the form of drop-in centers that provide food, education, formal support or 12-step groups, and individual counseling. Projects may also establish supportive housing programs for people wrestling with addiction, or conduct street outreach through which clients are connected with services. As components of substance abuse treatment, medical providers in HCH projects may employ, where appropriate, Buphenorphrine, Antabuse, Methadone, or acupuncture. Harm reduction approaches are common.

Community collaborations may include joining a formal network of substance abuse providers to increase the efficacy of referrals or formalizing organizational relationships through Memoranda of Understanding.

Many HCH projects recognize the problems that addiction creates for homeless clients, and have developed clear pathways of identifying and responding to substance abuse problems along a continuum that includes intake, detoxification, treatment and rehabilitation. The integration of behavioral health, primary care, and case management services is a crucial aspect of providing care for homeless people.

(b) *Outreach programs*

One of the barriers to access that many homeless people face is their own suspicion of institutions. They may have been, or felt that they were, treated badly in the past. They may have mental illnesses that make institutions seem intimidating or overwhelming. They may be closed off to anyone who tries to approach them. Effective outreach is focused on building rapport and offering options. This may appear to be slow or not cost-effective, but the reality is that over time, through the careful process of relationship-building, outreach staff can assist clients in entering into many

different services that will play a part in addressing their healthcare needs and ending their homelessness.

The integration of outreach into the primary care delivery system may be exemplified by shared paper or electronic medical records, joint staffings on shared patients, special clinic arrangements for providing services to clients identified by outreach, and provision of transportation. Outreach efforts often involve the provision of primary care at an outreach site or on a mobile medical van.

(c)   Coordination of services with providers of housing, job training, and other essential supports for persons who are homeless.

Because of the extreme poverty of homeless clients, they are often eligible for benefits and programs, but there are often barriers to access as well. Many HCH projects focus on coordinating housing, job training and other important services, recognizing that access to these services impacts the overall health of patients. Eligibility workers from other organizations, such as the Social Security Administration, the Federal Food Stamp program, and housing programs routinely are out-stationed to HCH clinics. Likewise, effective collaboration is exemplified by the presence of HCH workers at those organizations' sites.

Another way that applicants demonstrate collaboration is through transportation arrangements, such as van schedules that provide access to other service agencies, such as Social Security offices, other entitlement offices, and job training sites.

Homeless healthcare providers often take the lead in establishing networks and coalitions of providers, and they routinely work on an individual staff level to improve relationships with providers of other homeless services, such as housing, employment services, and other support. Strong coordination within this continuum of services is essential to the effective provision of any services.

(d)   Case management services

Case management for people experiencing homelessness is not limited to a narrow definition of coordinating medical care, as it might be in some mainstream healthcare settings. The case manager is often the person a homeless client has come to trust the most, and who can assist that client in navigating many systems, from healthcare to education, to obtaining public benefits, to accessing housing. Case management also provides a level of emotional support and psycho-social treatment.

(e)   *Participation in community-wide planning*

The development of additional resources is crucial to resolving the homelessness that underlies their health problems. Advocacy to affect the distribution of resources and functioning of community systems, therefore, is crucial to the effectiveness of HCH projects. Some projects rely primarily on Executive Directors and Board Members to conduct advocacy, while others involve staff at all levels, as well as consumers, in advocacy work, and include advocacy updates at staff and board meetings. In many communities, Health Care for the Homeless projects take the lead in community-wide coordination of services, local implementation of HUD's Homeless

Management Information System, Continuum of Care planning processes, and long-term strategic planning to end homelessness.

PUBLIC HOUSING PRIMARY CARE

(a) Location of the proposed new access point service site(s)
PHPC projects are generally located in public housing units and/or in free-standing clinics directly adjacent to public housing. For projects located adjacent to public housing, community health workers and advocates are used extensively to notify residents of services and bring them to the clinical site. Close coordination with housing authorities is crucial, particularly due to the need to relocate health centers as a result of HUD's HOPE IV redevelopment program.

(b) Agreement with the local public housing authority

Longstanding formal agreements sometimes exist between housing authorities and PHPC projects located directly in public housing, but when services are located off-site, letters of support or informal agreements are enough to demonstrate collaboration.

(c) Resident involvement in the administration of the new access point.

PHPCs involve resident in various ways: resident input in planning processes; hiring preferences given to residents; and resident participation on boards and advisory committees.

SCHOOL BASED HEALTH CENTERS

a) *Arrangements with the school staff and providers (e.g., school nurse, school psychologist, etc.) when applicable.*

Most SBHC programs have established the provision of integrated medical and mental health care on-site in the school. These programs are coordinated with existing school pupil personnel services (school psychologists, school social workers, etc.) to avoid duplication of services and to maximize the number of children receiving care. The memorandum of agreement with the host school may define the specific services to be provided by the School Based Health Center staff.

b) *Access to health care during the summer and other times when the school is closed (e.g. vacations, weekends).*

The schedule of services must be defined in agreement with the host school. Some schools do not permit access to the buildings on weekends, evenings, or vacations due to security issues and staff limitations. School based health centers may establish off-site locations to provide health services to students during the summer months when school is not in session. When appropriate, the School Based Health Center may provide services to students in the school during the

summer months, or may establish formal or informal referral mechanisms with the parent organization and/or appropriate primary care facilities.

(c) Agreement *with the school system to permit access to the school facility for the SBHC.*

The memorandum with the host school may define the hours of operation and any limitations in access to the building during times when the school is not in session.
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IV. ADDITIONAL RESOURCES

Migrant Health Centers

Migrant Clinicians' Network. http://www.migrantclinician.org

National Center for Farmworker Health. http://www.ncfh.org

Health Care for the Homeless

Principles of Practice: A CLINICAL RESOURCE GUIDE FOR HEALTH CARE FOR THE HOMELESS PROGRAMS. BPHC Program Assistance Letter 99-12.
ftp://ftp.hrsa.gov/bphc/docs/1999PALS/PAL99-12.PDF

Balancing Act: Clinical Practices that Respond to the Needs of Homeless People by Marsha McMurray-Avila, Lillian Gelberg and William R. Breakey
http://aspe.hhs.gov/progsys/homeless/symposium/8-Clinical.htm

National Health Care for the Homeless Council and *HCH Clinicians' Network*
www.nhchc.org

Health Care for the Homeless (HCH) Information Resource Center
http://www.bphc.hrsa.gov/hchirc

Public Housing Primary Care

Public Housing Primary Care Program
http://www.bphc.hrsa.gov/phpc/

Public Housing Primary Care Information Bulletins
http://www.bphc.hrsa.gov/phpc/infobulletins/index.htm

National Association of Housing and Redevelopment Officials
 http://www.nahro.org

School-Based Health Centers

National Assembly on School-Based Health Care www.nasbhc.org

The Center for Health and Health Care in Schools
http://www.healthinschools.org

Fact Sheet for Congress on School-Based Health Centers
http://www.nasbhc.org/APP/2002_data_fact_sheet.pdf

"School-Based Health Centers: A Child-Focused Safety Net Strategy"
http://www.nasbhc.org/APP/SBHC%20Fact%20Sheet.pdf