A. Strategies to Enhance Access

Several strategies are employed by HCH projects to overcome the obstacles to access discussed in Part I. Each section below reiterates these obstacles and offers the HCH response. Three strategic areas for enhancing access that can be applied to any HCH service relate to the questions:

- Where should services be provided?
- When should services be provided?
- How should services be provided?

RANDY – SPRINGFIELD, MASSACHUSETTS

It was a Friday afternoon when Randy showed up at my office in the Salvation Army complaining of a toothache. As I began to fill out the normal paperwork, my initial reaction was that this gentleman would probably not stay through the weekend. He looked not only uncomfortable, but acted totally disinterested and overly guarded. His lack of eye contact and reluctance to disclose any information was marked. He was started on an antibiotic, and he reluctantly agreed to meet me on Monday morning to schedule a dental appointment. I secretly questioned if I would see him again.

Monday morning he appeared with less swelling, but was still in considerable pain. He was terribly vague regarding his complaints, a pattern he was to follow for some time. He recalled that he had been in a fight and was hit in the jaw, but never went for treatment. I took him to the E.R. where an x-ray revealed a fractured maxillary sinus. He needed additional films and a referral to a specialist. His affect through it all remained flat and almost uninvolved. Again I questioned if he would follow through, or - more to the point - was he capable?

I decided to walk through the process with him. I began to learn more about this 35 year-old chronic alcoholic. After dropping out of school, he drank heavily for the better part of 17 years. He was single, unemployed, painfully shy, and had detoxed many times, yet he had no hope for a sober life. A normal life to him was drinking. Eight out of nine of his siblings were involved with alcohol and/or drugs. He had been hospitalized three or four times for pancreatitis. He went for health care only through the E.R. Although he continually complained of feeling sick, he rejected getting help from the clinic, until a blood sugar test indicated diabetes. Again, I knew I would walk him through this process or he would not follow through.

For the next several months we went on numerous appointments. Navigating through the system, I found myself advocating to help Randy receive the care to which he was entitled. When he was switched to insulin, I reassured him that I would help him learn to administer it himself, and to my surprise he accepted the challenge and demonstrated a desire and willingness to learn all he could about his disease. He attended diabetic classes, visited the nutritionist, tested his sugar daily, kept a journal of foods and feelings, checked in with me daily to go over his day, symptoms, and diet, and he kept follow-up medical appointments. Through it all his commitment to sobriety strengthened and he was accepted into a half-way house. Our encounters there every other week addressed his infamous vague complaints of just not feeling well. I gave him my constant encouragement to stay active in his 12-step group.

Graduation from the half-way house was pending and his destination was a rooming house where substance abuse was rampant. I felt uneasy with his complaints of boredom and desire to isolate. I told him I felt his health and sobriety were in serious jeopardy. I challenged him to do anything to get out of himself, as well as get into some counseling to deal with his depression. For the first time he was willing to respond to my observations and within a short time began weekly counseling, went on anti-depressants, and began volunteering at the local detox. He reported in a follow-up phone call he was feeling better than he ever remembered, and was considering moving from his present room to share an apartment with his sister.

Randy's commitment to recovery has continued to amaze me, as he has faced many challenges with numerous physical, emotional and economic set-backs. Having the opportunity to watch him grow in recovery is really a gift of our work.[1]

Maxine Kamlowski, RN, BSN, CARN
Health Care for the Homeless – Mercy Hospital

WHERE SHOULD SERVICES BE PROVIDED?

HCH projects are unique in their dedication to overcoming the following access barriers by taking services directly to people who are homeless.

- *Lack of awareness* – Homeless people may be unaware of what services are available and where they are located, especially if they are new to the area or newly homeless.

- *Lack of transportation* – Most people without homes do not have cars; the public transportation system in many cities may be expensive and inconvenient, and in rural areas perhaps non-existent.

- *Fear or distrust of large institutions* – Many people who are homeless, especially those with mental illness, have had negative experiences with large institutions. A large facility such as a hospital can be intimidating or confusing for anyone trying to maneuver through the system, and even more for people who are mentally ill or disoriented.

HCH response: Options for service delivery locations may be either fixed or mobile. Fixed-site locations include: shelter-based services; community health center or hospital-based clinics with special accommodations for homeless people; and free-standing HCH facilities such as clinics, respite units, drop-in centers or residential programs. Mobile options include use of mobile units and street outreach. Current federally-funded HCH projects tend to use more than one approach, frequently combining fixed-site and mobile services. Because shelter-based services, mobile units and street outreach could all be considered part of a larger outreach strategy, more detailed discussion on services and staffing is included in the chapter on "Outreach."

The following description of different approaches to HCH service delivery relies heavily on information gathered and documented by Cousineau et al for a 1995 study of the HCH program commissioned by the Bureau of Primary Health Care.[2]

Shelter-based services

The most common strategy for reaching and engaging homeless people in services is to establish a service delivery site in a shelter, soup kitchen or other location where people who are homeless gather. Some shelters may be amenable to renovating an area specifically for the clinic. When enough space is available, this could even include a separate waiting room, examining rooms, dispensaries, laboratories and counseling rooms. Depending on particular state regulations, clinics such as these may need to be licensed.

Other shelters may only set aside a special area for clinical services on the days the HCH team is there, such as part of the waiting room, a conference room, office or bathroom. Clinicians are usually limited to triage and simple procedures in these situations, especially given the difficulties in maintaining privacy and protecting patient confidentiality. Problems that cannot be treated in that environment would then need to be referred back to an HCH clinic or HCH contractor.

Special accommodations in existing clinics

Other strategies HCH projects use to accommodate homeless people include making operational or structural changes in existing clinics. This is particularly true of projects sponsored by community health centers, where the base clinic may be renovated to include showers, additional exam rooms or expanded waiting rooms. Changes may also be made in operations, such as special clinic hours designed to better meet the needs of people who are homeless, or adding walk-in clinics so that appointments are not mandatory. Projects sponsored by hospitals may also schedule times for special clinics within their facility for people who are homeless.

Free-standing HCH facilities

Some HCH projects have found that the optimal way to reach and treat people who are homeless in their community is through the establishment of a free-standing clinic specifically for that population. These clinics may be placed in storefronts, office buildings or separate facilities, but are always located close to shelters, single-room-occupancy (SRO) hotels or other services for homeless people. Sites such as these may be designed to offer all HCH services under one roof, or may use more than one building in close proximity with different services in each. HCH projects may also develop free-standing facilities devoted to special programs such as respite units, drop-in centers or residential programs.

Mobile units

Mobile units are an innovative approach to bringing health care teams, equipment and services to places where homeless people are found. Trailers, trucks, step vans or specially-constructed mobile homes may be used, with many variations in size. Most have one or more exam rooms and small office areas for practitioners, while some have small labs, dispensaries and even x-ray units. The more well-equipped units offer the advantage of providing more care directly, rather than having to refer clients elsewhere.

Mobile units offer HCH teams the flexibility of being able to travel to several sites without having to deal with inadequate facilities, scheduling limitations or policy constraints in shelters. They can be kept stocked from the base clinic, avoiding the inconvenience of staff having to transport supplies to outreach clinics in their personal vehicles.

Compared with providing care on the streets or in inadequate shelter facilities, mobile units definitely offer an advantage. However, they still cannot provide the kind of comprehensive care that would be available in a well-equipped fixed-site clinic. In addition, they are expensive to purchase and operate, and require considerable maintenance. One rural program that used a mobile unit to take services to isolated parts of the state discovered that the unit required one day of maintenance for every four days of operation.[3]

Programs considering the use of a mobile unit should carefully weigh the advantages and disadvantages, with particular attention to the needs of the people they hope to reach, where they are located and if a mobile unit is the best and/or only way to provide access to care. The mobile unit might best be viewed as one piece of an overall strategy that also includes fixed-site locations to which clients can be referred when necessary, not only for medical care, but also for mental health and substance abuse services, and case management.

Street outreach

Street outreach is primarily directed toward finding homeless people who might not use HCH services due to either lack of awareness of those services or active avoidance. Those who actively avoid services are often mentally ill, paranoid, or angry due to previous negative experiences. Much of street outreach is focused on establishing rapport, either through sharing of food, information or simply conversation. The goal is to eventually engage people in the services they need, either from HCH or another agency.

HCH outreach teams visit anywhere people who are homeless might be found. Common street locations for outreach are under bridges and freeway overpasses, alleys, parks and vacant lots. In rural areas or on the fringes of urban areas, outreach workers may go to the riverbanks, foothills, wooded areas or desert. Outreach teams can also frequent public facilities where homeless people may take shelter during the day, such as libraries or transportation terminals. Many outreach teams go to welfare hotels, cheap motels or SRO's where people live on the edge of homelessness. Some teams have special arrangements with jails, detox/treatment programs or other institutions to enter and make contact with ongoing HCH clients or potential clients regarding available services when they are released. And, of course, teams will often visit shelters, soup kitchens and other service locations.

WHEN ARE THE BEST TIMES TO PROVIDE SERVICES?

Another significant obstacle to access is:

- *Scheduling difficulties* – Mainstream services depend on scheduled appointments, which are often hard for homeless people to keep, due to competing priorities for survival, such as finding day labor, a free meal or a shelter bed for the night. People who are homeless also lack access to telephones to make appointments or change them if necessary.

HCH response: Scheduling of services should coincide with the most convenient times for the population being targeted, and should not conflict with those times when homeless people are normally searching for a meal or shelter. Shelter-based clinics would obviously need to be held during times when shelter guests are present. Unless the shelter allows guests to be in the facility during the day, this could mean setting up an evening clinic. Outreach needs to be scheduled for times when people are most likely to be found. People staying in camps may leave early to find breakfast, in which case outreach workers would need to start even earlier. Outreach to people involved in prostitution (including runaways and throwaways) may be more effective in the evening hours. Twenty-four hour HCH programs, such as respite units or residential programs, have more latitude in scheduling particular activities or service availability, but still need to assure that the schedule is based on client needs, rather than staff needs.

An important guideline regarding scheduling is to be consistent and structured regarding times when providers are available, while flexible regarding who receives care during those times. In other words, sites need fixed schedules whether they are located in free-standing clinics, shelters, hospitals or mobile units. Homeless people depend a great deal on word-of-mouth and on getting to know when they can expect certain services or people to be available. If the schedule is continually changing for when the medical providers will be at the shelter, or when the hospital clinic will be open, or when the community health center has their special homeless clinic, or when the mobile clinic might show up under that bridge, confusion may turn to frustration for those who most need care.

However, within those set hours it is often impossible to have scheduled appointments with specific individuals. Many HCH projects set aside certain times as walk-in clinics, while other times are designated for scheduled follow-up appointments with clients who have an established history of care. Federally-funded HCH projects are required to make arrangements for

24-hour access to care. Given budget limitations in most projects, different approaches are employed for providing that access. Some projects actually have contracts for emergency after-hours services. However, most tend to rely on either a 24-hour answering service or a recorded message explaining where to go or whom to call for urgently needed services. Projects that are based in hospitals clearly have an advantage in this regard, with 24-hour emergency services already available.[4]

HOW SHOULD SERVICES BE PROVIDED?

Many other aspects of how care should be provided relate to overcoming the obstacles to access listed below.

- *Lack of financial resources or health insurance* – Only a small percentage of people who are homeless have health insurance, primarily in the form of Medicaid. The vast majority have no insurance and no money to pay for care.

HCH response: No person who is homeless is ever denied care due to inability to pay. Some HCH projects have set up sliding fee schedules (as required for federally-funded projects), but homeless people almost invariably fall into the zero-pay category. Reimbursement through Medicaid is arranged for those who have that coverage.

- *Lack of documentation* – Even for organizations with a sliding fee scale, the financial eligibility process (proving income or lack of income) to qualify for free or reduced services presents a barrier to homeless people who rarely have the kind of paperwork, identification or other documentation necessary to prove their indigent status. In the case of immigrants without documentation, this becomes even more problematic.

HCH response: HCH projects require minimal written documentation from clients. Name and birthdate are needed to establish an individual identity in the client database, however even that may be difficult when working with people who are severely mentally ill, people who use multiple aliases, or people who are encountered on street outreach and are only receiving sandwiches or information, but are not involved in a formal referral. Immigrants who are homeless are served without need for documentation of residency status. (Documentation that is necessary for tracking demographic characteristics of clients or information necessary for ongoing care is based on observation or what the client is willing to share. See chapter on "Information Systems" for more discussion.)

- *Language and cultural barriers* – Homeless people who speak a language other than English, or whose cultural background is different from the mainstream culture found in many health care or social service institutions, may have difficulty using those services.

HCH response: HCH staff are expected to be culturally competent. (See chapter on "Cultural Competence" for more discussion.)

- *Attitudes of providers* – Homeless people are not necessarily treated with dignity and respect by mainstream providers of service who may be especially reluctant to treat individuals with poor personal hygiene, bizarre behavior or confused mental states.

HCH response: HCH staff are specifically trained to work with homeless people and are committed to that end. In their discussion of a patient-oriented approach to care,[5] Koegel and Gelberg commented that

> *"Experienced providers of care to the homeless have learned that regardless of their physical or psychological appearance, homeless individuals, like all of us, respond positively when they are treated with respect and dignity. Those with experience with this population have also learned that behavior, which at first seemed bizarre, made sense once viewed in the context of the*

TO WHOM IT MAY CONCERN,

I met Jan over three years ago at her office. At that time, my life was totally unmanageable and hopelessly unstable. I was homeless, very ill both physically and mentally and hopeless. I was living in a tent out on the streets. Jan invited me into her office and immediately I saw something so special about her; besides being very skilled and professional, she seemed to really understand my needs. She kept monitoring my progress and a few months later I was well on my way to recovery. I got a temporary place to stay and Jan referred me into medical and psychiatric care. Her gentle kindness and love gave me the strength and courage I had lost within myself so long ago. Jan was not only a case manager to me, but also a friend and mentor.

Through Jan's guidance and care I discovered a part of me that wanted to give to others as she had given to me. I began attending a two year college seeking an A.S. in Human Services and a certificate of completion in Drug & Alcohol Studies. I am currently doing my internship with an agency that serves the homeless. My life today is very rewarding and fulfilling. I am well on my way to achieving my goal of being a case manager, like Jan. Without the wonderful people that commit themselves to provide for people like myself, all hope for recovery would be lost. Thank you so much Jan! I love you!

everyday lives of their patients. Understanding the etiology of behaviors is not always sufficient to allow problems in service provision to be solved, but it does foster a tolerance and appreciation that goes a long way toward creating a more satisfying relationship between patient and provider."

Wright elaborates on the importance of attitude in promoting continuity of care, especially having patience and discretion in asking sensitive questions:[6]

"The ability of care providers to engage homeless clients in a system of continuous health care depends crucially on establishing rapport and trust, this in a population that by nature tends to be suspicious and disaffiliated. To the extent that extensive, detailed probing about health issues would interfere with the building of an appropriate relationship with a client, it is naturally and understandably avoided."

Accessibility – from a homeless person's perspective – is greatly influenced by the attitude of the care provider. Many HCH projects have received verbal or written testimony over the years from clients expressing their appreciation not only for the care they received but the respect that was shown them during their visit. The attitude of HCH staff and the rapport they are able to establish with their clients are well-reflected in this letter from an HCH client regarding her case manager.

- *Lack of comprehensive services* – Most mainstream health care organizations are primarily medical and not organized to deal with the complex issues that are part of being homeless. When people are treated only for the "presenting problem," the underlying cause of that problem may not be addressed. The person is then discharged back to the same environment that contributed to creating the situation in the first place.

- *Fragmented services* – Even in communities with numerous services available, they are often buried in indecipherable bureaucratic systems with inflexible rules. Trying to maneuver through these "non-systems" only adds to the desperation and frustration a homeless person already feels.

HCH response: The following chapters each offer an elaboration of a particular HCH service component. Together these services demonstrate the comprehensiveness of the HCH approach, the philosophy of treating the "whole person," and how the fragmentation of services may be overcome.

NOTES

1 Case study submitted by M. Kamlowski. HCH, Mercy Hospital, Springfield, Massachusetts, 1997.

2 M. Cousineau, E. Wittenberg and J. Pollatsek. *A Study of the Health Care for the Homeless Program: Final Report*. Washington, DC: Bureau of Primary Health Care, 1995, pp. 26-28.

3 M. Cousineau, et al. 1995, p. 27.

4 M. Cousineau, et al. 1995, p. 33.

5 P. Koegel and L. Gelberg. Health Care to Homeless Persons: A Patient-Oriented Approach. In D. Wood (Ed.), *Delivering Health Care to Homeless Persons: The Diagnosis and Management of Medical and Mental Health Conditions*. New York: Springer, 1992, 29.

6 J.D. Wright. The Health of Homeless People: Evidence from the National Health Care for the Homeless Program. In P.W. Brickner (Ed.), et al., *Under the Safety Net: The Health and Social Welfare of the Homeless in the United States*. New York: W.W. Norton, 1990, p. 18.

7 Letter nominating Janet Stone for HCH Clinicians' Network award. HCH/Nipomo Community Medical Center, San Luis Obispo, California, 1997.