NATIONAL HEALTH CARE for the HOMELESS COUNCIL

DEMONSTRATING VALUE:
MEASURING THE VALUE AND IMPACT OF THE HEALTH CARE FOR THE HOMELESS GRANTEES
August 2017

Value Statement

People experiencing homelessness have a unique set of challenges not well served by mainstream health providers. The National Health Care for the Homeless Council's National Cooperative Agreement (NCA) work helps to strengthen clinicians and programs that serve people experiencing homelessness by producing and disseminating best practices based on our HCH community's experiences, sound research, and policy analysis. Our NCA activities focus on providing training, technical assistance and essential information required to adapt clinical and operating practices in a changing health environment. Guided by the principles of cultural humility and sensitivity, we work to create a culture of inclusion to engage and incorporate consumers into all aspects of health center governance, and to prevent traumatization and the re-traumatization of patients who are homeless.

Purpose

Demonstrating the value of health centers is a necessary element to sustainability and measuring the importance of health delivery to underserved populations. How value is assessed can range from performance measures (i.e. care coordination and linkages), illustrating cost effectiveness, and access to reliable, high quality, and equitable care.[4] A framework for measuring the value in health care was published in the New England Journal of Medicine.

The Health Resources and Service Administration (HRSA) grants funding to health centers that meet federal program requirements through the Health Center Program Statute 330 of the Public Health Services (PHS) Act. Health Care for the Homeless (HCH) grantees provide specific and tailored care to individuals experiencing homelessness. Given the complex history and diversity in the development of HCH programs across the country and their varied infrastructures, there are many ways to evaluate the value of HCH grantees. HCH grantees aim to improve access and coordination of care to individuals that need specialized and adaptive care using innovative approaches. The purpose of this document is to provide a clear, digestible demonstration of the value HCH grantees and the impact of the HCH integrated care framework on health care delivery. This model of care is embedded in the principles of understanding trauma among this marginalized group. The grantees exemplified in this document highlight the value they provide to individuals experiencing homelessness and the impact their specialized services have on quality of care.

This document will provide clear examples of the uniqueness of this special population and the invaluable work HCH grantees providing direct services give to our communities. Additionally, first-hand accounts are provided in linked audio files, attesting the value of HCH grantees.

Who We Serve

It is widely known that individuals experiencing homelessness have greater morbidity and mortality rates than the general public and experience more

Our Voice[1]

Calvin Alston

Charlotte Garner

Carmon Ryals

chronic conditions and co-morbidities than their housed counterparts.[5] When compared to non-homeless populations, individuals experiencing homelessness face a multitude of complex health and social issues that are often integrated with past, present, and daily trauma that impact decision-making efforts and prioritization. Many individuals that are unhoused have concurrent chronic and acute physical health conditions that are often intertwined with other behavioral and mental health issues. Sixty-eight percent of homeless individuals reported that they had experienced psychological distress in the past month.[5] These conditions are exacerbated by exposure to the elements, heightened risk of violence through physical and sexual abuse, and a fragmented health system with restrictions on whom and how care is delivered, which can lead to hopelessness, distrust, misuse of emergency services, and self-treatment.[6]

Defining homelessness can be complex and challenging given varying definitions across sectors. Linkage to health outcomes can be an even more arduous task when there are no required criteria for using the Z.59 code, which is the International Classification of Disease, Tenth Revision (ICD 10) code for homelessness in electronic health records (EHRs).[7] Despite this challenge, HRSA's Uniform Data System (UDS) allows some linkages to be made across health center grantees. Nearly 1.2 million individuals experiencing homelessness were served by federally qualified health centers, with 70% of those individuals being served by HCH grantees. Of those served, 37.6% were uninsured, and 87.8% reported income at and below the national poverty level.[1] Our stakeholders, providers working at HCH programs, predominantly serve individuals who are uninsured and individuals or receive Medicaid (Figure 1).

Figure 1. Comparison of Patient Demographics between HCH grantees and all grantees reported in 2015 UDS

Patient Characteristics	All Grantees	HCH Grantees
Total Patients	24,295,946	890,283
Total Homeless	1,191,772 (4.9%)	840,130 (94.4%)
Age		
Children (<18 years old)	31.2%	12.3%
Adult (18-64)	60.9%	82.9%
Older Adults (65 and over)	7.9%	4.8%
Income Status		
Patients at or below 200% of poverty	92.2%	97.7%
Patients at or below 100% of poverty	70.9%	87.8%
Insurance Status		
Uninsured	24.4%	37.6%
Medicaid	48.9%	49.1%

Housing Type	
Shelter	258,100 (30.7%)
Doubling Up	242,562 (28.9%)
Transitional	101,639 (12.1%)
Street	72,744 (8.7%)
Other	100,700 (12%)
Unknown	64,385 (7.7%)

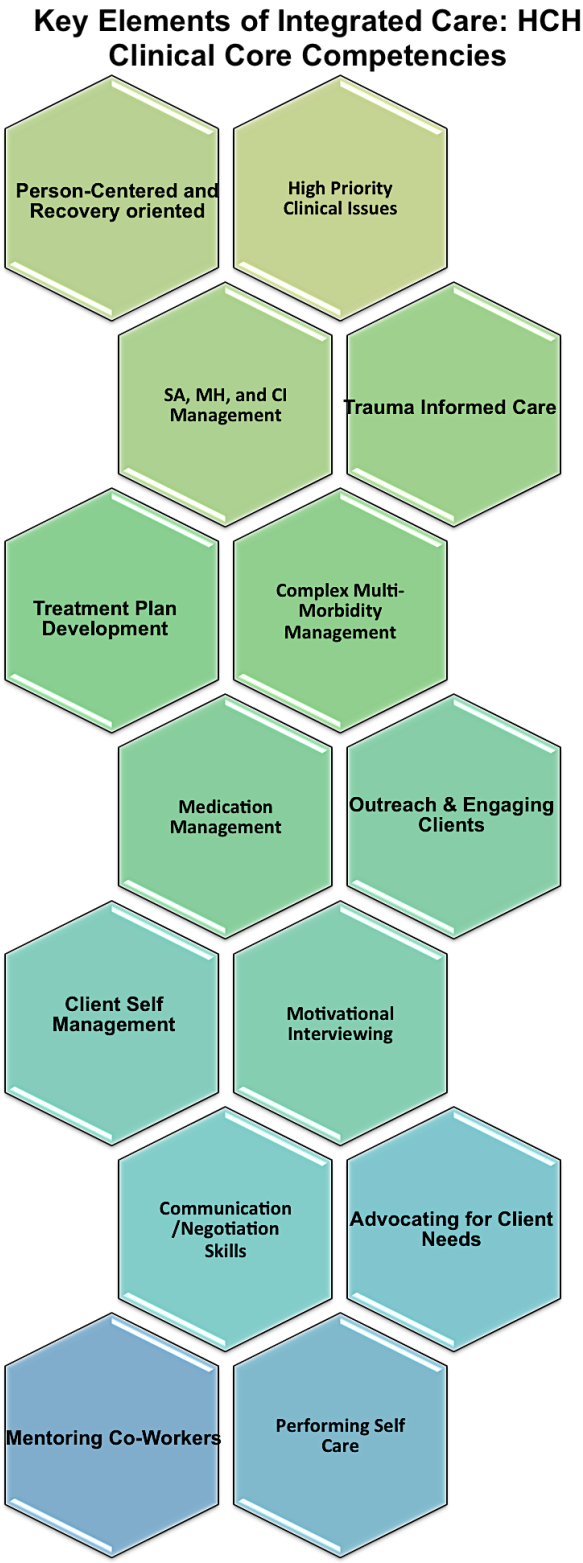
Given the non-discriminatory nature of where and whom homelessness strikes, where individuals seek care can itself be a significant barrier to accessing high quality health care. Homelessness is present in all communities and environments and happens to people of all backgrounds. According to recent UDS reports, HCH grantees provide care to a diverse group of individuals who are experiencing homelessness and/or co-identify as an agricultural worker or veteran. When HCH grantees were surveyed independently, 840,130 patients self-identified as experiencing homelessness, 20,142 were veterans, and 20,125 were agricultural workers. 53,176 patients had encounters with HCH grantees that are accessible to public housing settings and 8,380 received care in school-based HCH sites.

Who We Are

Health Care for the Homeless (HCH) began as a national demonstration program of the Robert Wood Johnson Foundation (RWJF) and the Pew Memorial Trust in 1985. It was replicated and expanded in the 1987

McKinney Act, and, as of the most recently available data (2015), now serves over 890,000 people experiencing homelessness each year through 295 federally funded health centers. Through the Health Center Consolidation Act of 1996, HCH became part of a larger set of programs addressing access to care through a network of safety net, community-directed care providers. According to STAT news, four medical trends that were developed and led by this movement include: 1) Electronic Health Records 2) Mixed providers in one setting 3) Transitional Care (with nearly 80 medical respite programs) and 4) Bringing care to the ones we serve through mobile unites and street teams (i.e. churches, shelters, food kitchens, and encampments).

Figure 2. Key Elements of Integrated Care: HCH Clinical Core Competencies



HCH works to overcome common barriers to care, which requires innovative approaches to address complex health and social needs. These approaches have proven to become widespread strategies to care and guidelines for best practices.[8-10] A few commonly reported barriers impacting access to care include transportation, stigma, lack of personal identification, and insurance. However, individuals experiencing homelessness face other immediate needs as well, such as safety, food, and shelter. Prioritizing these needs can be extremely challenging as an individual or a family experiencing homelessness or an unaccompanied youth in similar situations. Overcoming these challenges and barriers is a primary directive of HCH grantees, which leads to holistic services and better care for this special population.

How We Deliver Care: Going Beyond Traditional Medical Care

Key elements of the HCH model are: 1) outreach and engagement, including the development of patient tracking methods; 2) community collaborations to provide HCH patients with a variety of social and health benefits and services; 3) case-management; 4) medical respite care; and 5) consumer involvement and patient-driven care.[8]

HCH patients are distinct from the general community health center population and often require integrated and well-coordinated care that is deeply embedded in trauma-informed principles and harm-reduction approaches. Individuals experiencing homelessness often have complex health issues with co-morbidities and co-occurring conditions in which it is imperative to provide comprehensive care.[11] Frequently, many of

the health conditions experienced by those who are homeless are unique, chronic and require ongoing care. Given these needs, the structures of mainstream primary care service delivery often fall short, and research has repeatedly described procedural obstacles to care and a reality that homeless patients often feel stigmatized and unwelcome in care settings.[12]

The integrated model of care and wrap-around services pioneered through HCH grantees, demonstrated through the co-location of medical, behavioral, and social services for individuals with complex physiological and sociological factors, is key to reducing some barriers related to disjointedness of care. The integrated and interdisciplinary care that is delivered through the model provides continuity of care in what is often described as a fragmented system.[13]

Delivering care to this special population goes beyond traditional frameworks and requires sensitivity, innovation, and passion. This holistic approach to care delivery requires our providers to meet the patients where they are, which could often mean providing care outside of the clinic (i.e. streets, under bridges/overpasses, and other shelters). It is imperative that HCH providers are trained on a core set of learned competencies (Figure 2).

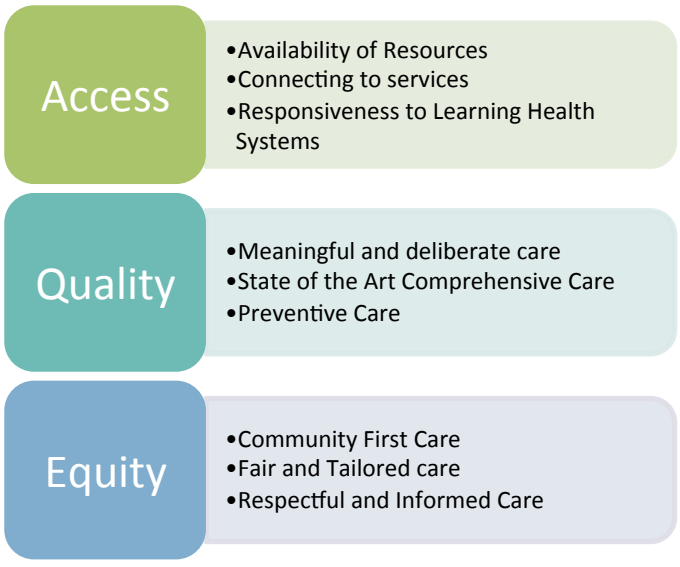
Our Voice

Bobby Watts[2]

The Value We Provide: Assessing the value of HCH grantees across three domains

This paper focuses on three domains considered to be pivotal components that effectively demonstrate the value of targeted approaches of care to individuals experiencing homelessness delivered by HCH grantees. HRSA has highlighted these domains as key measurable areas of interest, providing funding to grantees that demonstrate training and technical assistance to health centers to increase access to care, achieve operational excellence and quality improvement strategies, and enhance health outcomes and health equity within state and regional contexts. How these domains are defined is outlined below (Figure 3):

Figure 3. Defined Hallmarks of Value among HCH Grantees

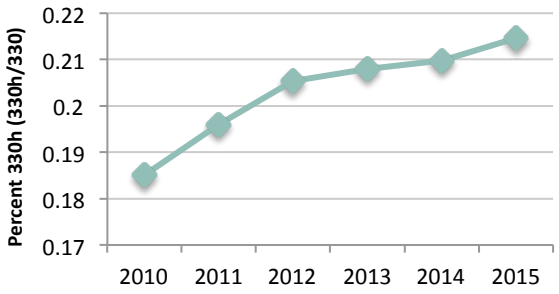


1. Access – illustrating the diversity and breadth of care and the utility of services provided to individuals experiencing homelessness. It is critical to understand the equality of access to resources, care and the equity in which it is delivered.
2. Quality – demonstrating the high integrity and way in which care is delivered and the type of services that are required to provide meaningful, deliberate and valuable care.
3. Equity – delivering evidence-based, community first approaches with tailored and fair care to individuals experiencing homelessness. Delivering pragmatic preventive and state-of-the-art practices in learning and evolving health systems to support a culture of health to communities.

Access

With a shift in economic structures leading to increased costs of living, yet no increase in income, the need to provide a safety net of care and access to services and quality care is growing more critical. The need for increased access to health care for individuals on the precipice of unstable housing becomes more pressing.

Figure 4. Increase in HCH Grantees 2010-2015



330h-funded grantees make up 21% of all 330 grantees and have been steadily increasing since 2010 (Figure 4). Since 2013, the HCH population has consistently made up nearly 4% of the total patients seen by grantees as reported by UDS. Of the 24 million patients reported by all 330 funded grantees in 2015, 890,283 patients were seen by HCH grantees.

An assessment conducted by the National HCH Council (NHCHC) of the types of services provided by the HCH grantees (n=80), is demonstrated in Table 1. Ninety-one percent of HCH grantees provide case management, followed by HIV Screening (71%), and Substance Abuse Services (68%, others provide referrals). A specific hallmark of HCH clinics is the practice of meeting the patients where they are. Table 1 describes these services across a varied range of care.

HCH programs and similar programs that have emerged tailor the design and delivery of primary care services to be responsive to individuals whose residential situation often results in difficulty accessing mainstream care. The nature of those tailored services is multifaceted, and has been described in position papers and manuals of best practice from NHCHC itself and in research. Some key elements include selection of staff, adjustments to service hours, emphasis on closer degrees of coordination with other care providers, and equipping the clinic to respond to tangible needs including water, storage, transportation, and shelter or addiction treatment assistance.[3]

Table 1

Type of Service	Percent of Clinics
Care/Case Management	91%
HIV Screening/Education	71%
Substance Abuse Services	68%
Street Outreach	66%
Support/Education Services	65%
Dental Services	64%
Pediatrics	61%
Pharmacy/Dispensary Services	41%
Geriatrics	41%
Perinatal Care	35%
Services in Supportive Housing	31%
Mobile Clinical Services	30%
Vision Services	26%
Medical Respite	18%

Accessibility and co-location of services is a hallmark of HCH grantees. The physical location of our grantees in urban and rural environments and in settings such as schools and public housing greatly increases accessibility for our widespread and diverse population. Capital Link has outlined the importance of co-location and collaboration of health centers in non-traditional settings to address housing and food insecurity and the alignment of these initiatives with those of HRSA priorities (Capital Plans and Needs of Health Centers). Many of the HCH grantees have already worked and continue to work to specifically address these significant social determinants of health.

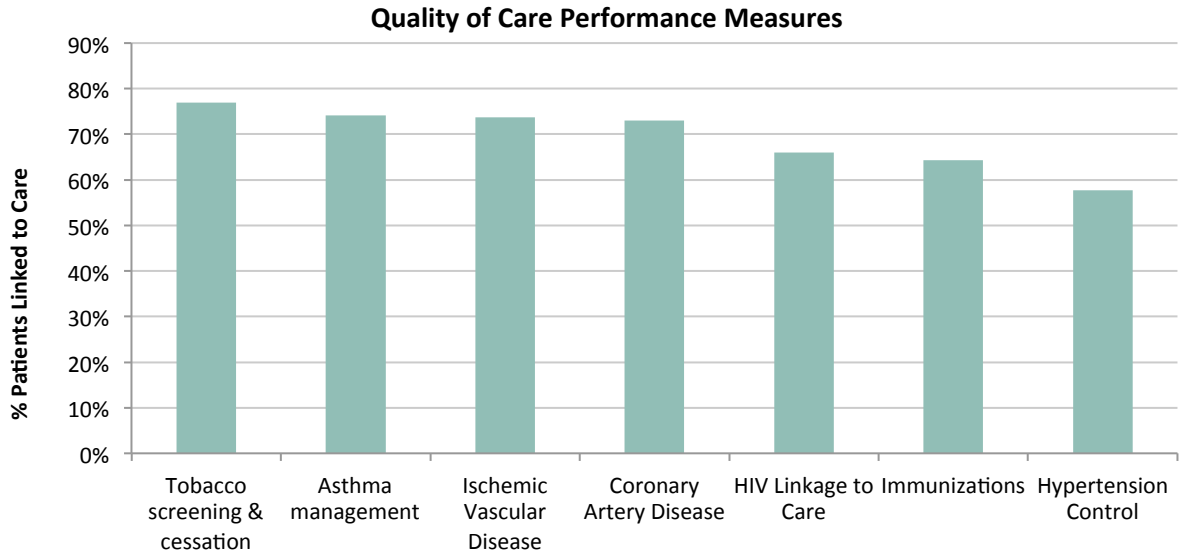
Quality

HRSA provides Quality Improvement awards across eight categories to community health centers that receive 330 funding to measure quality assurances and promote successful improvement among programs. In 2016, HCH grantees were awarded in all categories with the greatest achievement in Clinical Quality Improvers (demonstrating notable improvement in one or more Clinical Quality Measures) followed by Patient Centered Medical Home (PCMH) recognition, and employing EHRs as a reporting method.

Analysis of service growth rates and performance measures for 60 HCH standalone grantees was conducted from the 2015 UDS to serve as an autonomous sample of HCH programs (i.e. those that exist independently,

and not within larger community health centers). Analysis of growth in full-time equivalent (FTE) staff over the 2014-2015 timeframe showed a large increase in vision services staff and modest increases in mental health, dental, overall medical, and substance abuse services staff. HCH funding used to invest in workforce capacity allows otherwise overstretched staff members to focus on key roles and responsibilities. This results in efficient workflows and improved care through increased time with patients, synced coordination of care, and appropriate patient follow-up. These improvements in workflow lead to better linkage to care, improved maintenance of self-care, fewer clinic visits, and—more importantly—improved community health. Linkages to care among the standalone HCH grantees are presented in Figure 5.

Figure 5. Performance measures among the 60 standalone HCH grantees demonstrated 50% or more of patients successfully linked to care by condition.

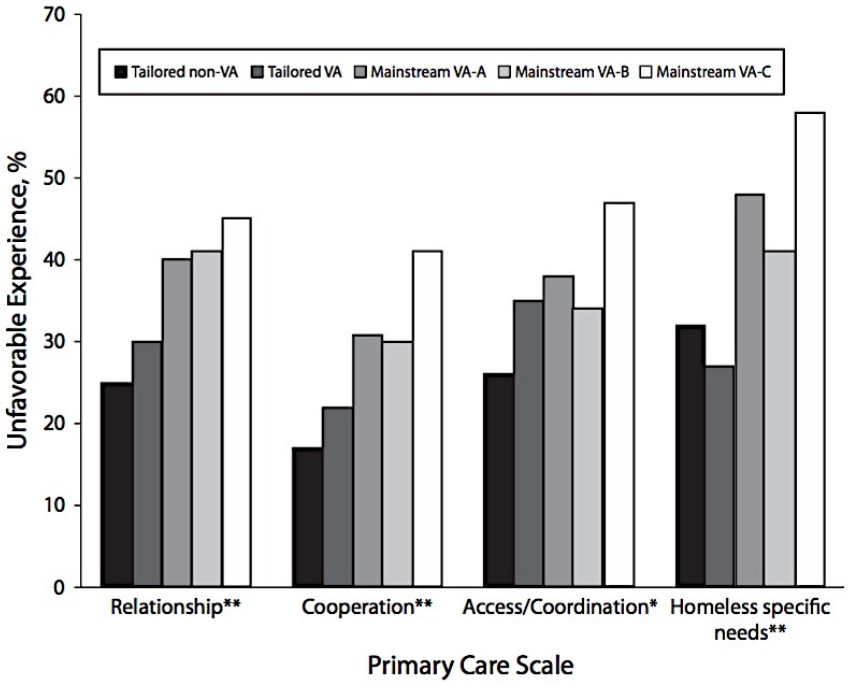


Equity

The cultural humility of providers in HCH settings is critical to building trust and creating a safe, patient-driven environment for patients to seek care. Each patient has unique experiences with homelessness, and adjusting the health needs to the patient is an invaluable characteristic driving this specialized care. How patients are treated greatly impacts the patient experience and utilization of services. Often, these services are not accurately captured in health center surveillance; however, HCH grantees have chosen to write in services they do provide on a daily basis to meet clients where they are (Figure 6).

Figure 6. Tailored services offered by HCH Grantees. The more times a service was mentioned the larger the font.

Figure 7. Patients report less unfavorable experiences at HCH tailored primary care sites. Tailored = homeless specific sites, mainstream = non-homeless tailored sites. Tailored non-VA is a 26-year HCH grantee.[3]



Research has typically supported the value of these efforts to tailor primary care service design in the way that HCH programs do. A large study comparing tailored and mainstream primary care programs among 605 patient respondents found that patients assigned a superior rating to the primary care experiences in tailored clinics, using a validated homeless patient experience survey that has been accepted by the Agency for Healthcare Research and Quality to its Quality Metrics Clearinghouse.[3, 14] A frankly unfavorable care experience was 1.5 to 3 times more common in mainstream non-HCH care settings compared to a well-regarded model HCH program (see graphic), and these analyses fully addressed potential differences between the patients of the 5 sites compared. Similarly, in Veterans Health Administration efforts to adopt the HCH model since 2012, reductions in emergency department and inpatient hospital use were larger in those Veteran Affairs (VA) clinics that adopted more service-tailored care elements.[15]

Chronicles: The Community Health Center Stories

Health Care for the Homeless

Finally, HCH staff members are very collaborative through the NHCHC, contributing to quality programs specialized to improve care to individuals experiencing homelessness. Over the past three decades, the NHCHC has successfully gathered the interests of health care professionals, researchers, advocates, and people without homes into a respected, coherent and principled movement that insists upon quality care and the human right to housing and health care.[16] The Council publishes a bank of resources that document the value of targeted and tailored health care to this population, effectively demonstrates guidelines for best practices, and features consumers who can attest to the impact that HCH grantees have on their personal narratives.[1, 8]

In the absence of HCH Grantees

Community Impact. In the absence of the valued quality care and targeted services uniquely provided by HCH grantees, there would likely be even higher rates of mortality in individuals without homes due to reduced access to primary care, behavioral health services and tailored treatment. These include outreach efforts, street medicine, and medical respite programs, to name a few. A loss of specialized clinical and housing case managers could lead to a potential for individuals to be lost in a health care system with poor follow-up on the true needs of this special population.

Individual Impact. Consumer-driven interactions and informed care tailored by those experiencing homelessness would be endangered, as our unique population may be less likely or have less opportunity to serve on governance boards. Community-driven Learning Health Systems are informed by these invaluable interactions in spaces where voices are heard and individuals feel safe.

Cost Impact. A loss of these safety-net services leads to increased emergency room visits, chronic hospitalizations, and higher readmission rates, which research has shown increases the costs to an already overburdened health system. In a recent study among individuals experiencing homelessness with six or more emergency room visits accounted for 73% of all emergency room visits in a cohort of nearly 6500 total homeless patients. This trend was also reflected in high rates of hospitalizations.[6] Two or more visits to HCH sites by patients have shown to reduce inappropriate emergency room visits.[17]

These gaps in provision and engagement in care could lead to a collapse of a specialized trauma-informed safety net that was built on the experiences of providers, nurses and other staff that care for individuals without homes. By acting as one of the few providers in the community that are willing, trained and have the diverse capacity to engage this special population that historically do not have favorable health outcomes—and often feel unwelcome—in traditional health care settings, HCH providers reduce the burden on other community outpatient providers while realizing positive outcomes for an often marginalized and overlooked population.

Recommendations for How to Better Demonstrate Value among HCH Grantees:

- Collectively and collaboratively share metrics and trends with local level and publish findings
- Identify benchmarks that define value using this Capital Link toolkit (Performance Benchmarking Toolkit for Health Centers: Tracking Data to Improve Financial Performance) and maintain data dashboards with local safety net providers
- Increase capacity for linking health data and housing outcomes
- Share Value through Storytelling
    - Health Care for the Homeless, Orlando FL
    - HCH Stories
- Celebrate Health Care for the Homeless (HCH) Day – Find ways to demonstrate value and celebrate the uniqueness of HCH. https://www.nhchc.org/hch-day/

Disclaimer

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