

HEALING HANDS



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Working to Eliminate Barriers to Care for Homeless People

Across America, Health Care for the Homeless providers acknowledge the myriad and complex barriers to care that confront homeless families, youth, and single adults. During 25 years of service, these clinicians have learned the importance of first-hand knowledge, innovation, and relationship building in their efforts to secure pathways to rehabilitation and recovery for their clients. These following articles touch on self-imposed obstacles homeless individuals may create with hope that such discussion will enlighten informed and sensitive outreach techniques. The main thrust of this issue, however, is to illuminate the systemic barriers erected through governmental regulation and inflexible health care models that prevent homeless people from accessing the care they need and, in the end, waste social capital by denigrating human worth, decreasing productivity, and eroding economic stability.

Barriers to health care for homeless people include a generalized list of road blocks to access—money, insurance, transportation, time, and personal identification. Because such realities compete each day with the immediate needs for food and nightly shelter, a person who is homeless often puts off nagging and, hopefully, minor illnesses until it is no longer possible to ignore them. In addition, there are multifaceted issues related to specific homeless populations:¹⁻¹³

- *Families with children* often headed by single mothers become homeless for various reasons, but for those who are responding to domestic violence, safety dictates their need for protective shelter. Regardless of circumstances, insurance, birth certificates, proof of citizenship, credit cards, and cell phones may be inaccessible.

- *Young people* tend to leave home in a hurry, often with only a few dollars in their pocket, perhaps a driver's license, and a cell phone. Others may be aging out of the foster care system with no place to go.

- *Chronically homeless people* may have cognitive impairments related to mental illness, alcohol or drug dependency, stress from previous traumatic encounters, or traumatic brain injury (TBI). They may not currently or ever have been employed, lacking ongoing work records or Social Security numbers. Others have lost their identification papers along the way or fail to seek treatment because of shame, stigma, and discrimination.

- *People transitioning from prison and jail* may face civil consequences from their criminal convictions that make it difficult for them to find employment or housing (see Quick Tips Box, numbers 9–12).
- *Native Americans* experience greater health disparities than any other group within the United States and are at extremely high-risk of homelessness both in urban areas and on reservations where 40 percent of housing is considered inadequate.
- *Veterans* generally have higher median incomes, lower rates of unemployment, and better educations than their peers as well as

“We're an established system that provides a variety of programs to a continuum of low-income people, but a new provider of homeless health care services. Since assuming homeless care from the Metro Public Health Department in November 2008, we've found caring for homeless individuals presents particular challenges. We need to be sensitive to our homeless clients' unique needs associated with trauma, victimization, and a mobile lifestyle with unstable roots and social networks. Even newly homeless people have more pervasive diagnostic requirements with behavioral health needs almost equal to primary care. This necessitates staffing differences to insure program integrity. And then there's transportation—folks aren't all located in the center city and often don't want to come to the Downtown Clinic for care. While our mobile unit helps, it can only go to one site at a time and folks don't always get sick on schedule. Establishing the continuity of care we prefer will take time and innovative solutions.”

—Mary Bufwack, PhD, chief executive officer
United Neighborhood Health Services, Inc., Nashville, Tennessee

access to a broad range of special benefits through the Department of Veterans Affairs. Research shows, however, that instead of military service being the risk-factor, personal vulnerabilities related to isolation, addiction, mental and physical health, and lack of affordable housing are contributing factors exacerbated by a VA service delivery system often viewed as delaying access.

DOCUMENTING IDENTITY IS A HUGE PROBLEM Piecing the lives of homeless people back together takes time and since 9/11,

requirements for obtaining necessary documentation to establish a person's identity have become increasingly onerous.

Brian Colangelo, LCSW, is a mental health and substance abuse counselor for Project HOPE (Homeless Outreach Program Enrichment)—a health care for the homeless grantee—in Camden,

New Jersey. “My colleagues in the primary care association and I find a chain of barriers that homeless people in New Jersey encounter,” Colangelo says. “Lack of identification tops the list, and then there are visit copays, referrals to specialists, transportation challenges (all the specialists are located outside Camden), language barriers, scheduling problems, long wait times, insurance status, and immigration status. Even for clients who have insurance, the state of New Jersey requires them to show providers two forms of identification (one a photo ID), along with health insurance information or Families First card plus their copayment. If they don’t have insurance, they need two IDs, proof of income, proof of residency, and documentation that they are ineligible for insurance.

“Our clients are mostly single adults, many of whom are men. Every time they come to the clinic, the waits are long because of paperwork,” Colangelo continues. “Those who have been convicted must get a letter from the Camden County Board of Social Services or welfare office to insure that Project HOPE gets reimbursed for their care. Moreover, without a photo ID, there is no access to hospital care.

“Outreach through walking teams and mobile health vans is important for the care of homeless adults,” Colangelo adds. “Many clients have limited mobility making even a half-mile trip to a clinic too much for them. Others do not have identification or may fear registration procedures, signing forms, or giving personal information. Indeed, those who suffer from anxiety or paranoia find it difficult to build trusting relationships. Last year, Project HOPE was able to purchase a van through a grant from Catholic Health East and we are finding that some clients are much more comfortable there.

“Using case management effectively allows us to sit down, assess problems, and determine how to get from point A to point B,” Colangelo explains. “We consider the van a first step in clients’ medical care. Once they establish a relationship with a doctor, nurse, or outreach worker, they eventually come to the health center for more intensive treatment.”

According to **James Herbert**, a Social Security Administration (SSA) representative in Camden, New Jersey, “Since 9/11, photo IDs have become extremely important because government agencies want to know who you are now. Even a birth certificate doesn’t explain a person’s present identity. So without that photo ID, the amount of paperwork necessary is huge and includes doctors’ records, work records, education records. It’s best to start at the SSA website—www.SSA.gov—for accurate information.”

When someone has never worked, they will need to apply for an original identification card and must provide at least two documents to prove age, identity, and U.S. citizenship or current lawful, work-authorized immigration status. Those who are not U.S. citizens and do not have Department of Homeland Security work authorization must prove a valid non-work reason for requesting a card. Those age 12 or older who have never received a Social Security number, must apply in person (see Quick Tips Box, number 1).

The next step for those without insurance may be application for Social Security benefits through supplemental security income (SSI) for people with low incomes and few resources who are age 65 and above, blind, or disabled. People who are disabled may apply to receive Social

Security Disability Insurance (SSDI) if they have worked in jobs covered by Social Security and have a medical condition that meets Social Security’s definition of disability (see Quick Tips Box, numbers 1, 4–7). Disability is strictly defined under Social Security based on an individual’s inability to work:¹⁴

- Unable to do work that he or she did before
- Cannot adjust to other work because of his or her medical condition(s)
- Disability has lasted or is expected to last for at least one year or to result in death

Disabled adults who have never worked may be entitled to benefits, if one of their parents receives Social Security retirement or disability benefits, or if the parent has died and had worked long enough under Social Security.^{14,15}

OVERCOMING BARRIERS TO BENEFITS At HCH, Inc., in Baltimore, Public Benefits Manager **Pete Iacovelli** is the go-to person for insurance and public benefits. Iacovelli does not talk in terms of barriers—he talks about challenges to be overcome. “I start with a knowledge base,” he says, “and then apply personal, face-to-face interaction, helping our clients get the care they need by being straight with everyone. Folks are all overworked and so my job is to go the extra mile.

“I go online to see how the legislation—Maryland’s actual code of law—is written because it’s first essential to understand how the benefits are supposed to work,” Iacovelli continues. “I’ve built strong relationships with the people in state offices who administer public benefits, and I meet with them for benefits clarification and to advocate for particular individuals. In addition, I educate our staff members and clients, all of whom have come to trust me.

“In Maryland, the Primary Adult Care Program (PAC)—the state’s part of Medicaid—requires an official Maryland ID and client benefits can often be available within 45 days of application. PAC covers prescription drugs, primary care, limited dental and vision care with a pair of glasses annually, and outpatient addiction treatment. When public benefit processors reject applications, again it helps to have the regulations handy. We always remain positive, but if needed, we’re ready to call an administrator to help resolve a problem.”

OUTREACH THAT DOES WHAT IT TAKES Part of an interdisciplinary outreach team, **Kathleen Jackson, NP**, provides transitional care management to vulnerable groups including people who are homeless, impoverished, and medically uninsured. Launched by the Camden Coalition of Healthcare Providers in 2007, Jackson and her colleagues, Jessica Cordero, a bilingual community health worker, and social worker candidate Nicole Spiegel, hit the streets to closely follow the highest hospital and emergency department (ED) users—and their innovative outreach model is proving to be effective.

Using a planning grant from the Robert Wood Johnson Foundation’s New Jersey Health Initiatives program, Jeffrey C. Brenner, MD, designed what he refers to as a health care home without walls. Aiming to tackle the ED “super users,” the team helps clients become insured, gets them on necessary medications and back into primary care, and, when needed, into nursing homes or day programs. Outcomes show that before the program, 34 of 92 clients visited local hospitals 62 times each month at a cost of \$1.2 million. After enrollment, patient utilization of hospitals and EDs dropped 40 percent (see Quick Tips Box, number 14).

Jackson explains: “We go to our clients—many very fragile with comorbid physical and mental health as well as substance-related care needs—and do whatever it takes in coalition with other Camden agencies to solve the problems that have created barriers to their health care. It may be identification, benefits, transportation, or medications. Our goal is to use an innovative approach to redirect ED-seeking behaviors and the need for hospitalization while helping clients achieve improved health. Along the way, we’ve garnered the support of the Centene Foundation for Quality Healthcare, Cooper Health System, Lourdes Health System, Merck Company Foundation, and Virtua Health System.”

AN ADMINISTRATOR’S POINT OF VIEW In Atlanta, Tom Andrews, president of Saint Joseph’s Mercy Care Services, Inc., understands. “It’s always a matter of using Peter to pay Paul while constantly seeking ways to offer service to new groups in need. Our 11 clinics (four fixed-site and the others served one to two days a week from a mobile coach) provide health care where it’s needed most through primary medical and dental care; social services, case management, and mental health assessments; and outreach programs,” Andrews says. “Homeless individuals comprise the majority of our clientele and most others are at-risk for homelessness. Almost 90 percent of our clients are at or below 100 percent of the federal poverty level, which makes it a tremendous challenge for them to access medical services. Georgia’s Medicaid program only serves children, pregnant women, elderly, and the disabled. And with continuing state deficits, projections for 2011 and 2012 don’t look any better than the current fiscal picture.”

Andrews continues: “MARTA [Atlanta’s mass transportation system] is available in the central city but it has never expanded to the suburbs making transportation a real problem. We use vans and cars to help get clients where they need to go. Grants will pay for transportation as part of direct services, which also include primary care, dental care, social services, outreach, and even some addiction care, but don’t cover overhead—the money for salaries, upkeep, and new facilities. The unexpected keeps me awake at night—this year we lost a grant for TB screening, which is required before people can access housing, drug treatment, and mental health care. Now as folks try to get the test through public agencies, the resulting bottleneck has women and children sleeping on shelter floors for eight to ten days as they wait for testing.”

ACCESSING PSYCHIATRIC AND ADDICTION CARE “In Atlanta, identification is a huge issue,” according to Amanda Wagner, LMSW, a mental health professional at Saint Joseph’s Mercy Care Services. “In order to access psychiatric and specialty care at Grady Health System, people need to have a state of Georgia-issued photo ID, which requires a mailing address and proof of birth. While Crossroads Community Ministries and several local social service agencies will provide secure mailing addresses and the Georgia Law Center for the Homeless helps clients with pro bono affidavits for states that require identity verification, the process takes time and the ability to navigate such a complex system is difficult for most clients. For people who are consistently focused on basic needs of eating and sleeping, health care loses importance. In addition, homeless individuals must obtain a letter of verification on shelter letterhead attesting that they live in Fulton-DeKalb Counties and are homeless without income in order to obtain the zero-pay Grady card that allows outpatient treatment and pharmaceuticals.”

QUICK TIPS ON BENEFITS FOR PROVIDERS AND HOMELESS CLIENTS

1. Your Social Security Number & Card, 2009 | Social Security Administration | www.ssa.gov/pubs/10002.html and www.ssa.gov/online/ss-5.pdf
2. Where to Write for Vital Records, 2010 | Centers for Disease Control & Prevention | www.cdc.gov/nchs/w2w.htm
3. 2010 Policy Statements: Disability Benefits & Homelessness; Incarceration, Homelessness, & Health; and Medicaid & Homelessness. National Health Care for the Homeless Council | www.nhchc.org/Advocacy/PolicyPapers/policystatements.html
4. Documenting Disability Training for Medical Providers: An Interactive Online Course, 2010 | National Health Care for the Homeless Council | www.nhchc.org/DocDisability/DocDisOnline.html
5. FirstStep: On the Path to Benefits for People Who Are Homeless. An interactive program for case managers & outreach workers, 2009 | Centers for Medicare & Medicaid Services | www.cms.gov/apps/firststep/index.html
6. Expediting Access to SSA Disability Benefits: Promising Practices for People Who Are Homeless, 2007 | Policy Research Associates, Inc | www.prainc.com/SOAR/soar101/PromisingPractices.pdf
7. Spotlight on PATH Practices & Programs: PATH Programs Providing SOAR, 2008 | PATH Technical Assistance Center | www.pathprogram.samhsa.gov/ResourceFiles/hixdx54a.pdf
8. Reducing Barriers to Health Care: Covering Kids & Families Access Initiative Toolkit, 2007 | Center for Health Care Strategies | www.chcs.org/publications3960/publications_show.htm?doc_id=443981
9. Employment & Housing Facts for People with Criminal Records, 2010 | Seattle Office for Civil Rights | www.seattle.gov/civilrights/documents/Criminal_Records3sided_01-10.pdf
10. Did Social Security Stop Your Benefits Because You Had an Arrest Warrant? (Martinez v. Astrue), 2010 | Urban Justice Center | www.urbanjustice.org/pdf/publications/Consumer_Handout_long.pdf
11. The Smart Book: A Resource Guide for Going Home. County-specific resources for social services staff & offenders | New Jersey Department of Corrections, Office of Transitional Services | www.state.nj.us/corrections/OTS/OTS_Inmate_and_Family_Resources.html
12. Second Chance Act: Programs Funded in 2010 | National Reentry Resource Center | www.nationalreentryresourcecenter.org/announcements/second-chance-act-programs-funded-in-2010
13. Collaborative Process: The Care Model | Health Resources & Services Administration Knowledge Gateway (multimedia resources) | www.healthdisparities.net/hdc/hdcsearch/isysconcept/Collaborative%20Process/The%20Care%20Model/?IW_BATCHSIZE=25
14. Camden Coalition for Healthcare Providers: Multidisciplinary Outreach Team, 2008 | Agency for Healthcare Research & Quality | www.innovations.ahrq.gov/content.aspx?id=2265
15. Policy Brief: Health Reform & Health Care for the Homeless, 2010 | National Health Care for the Homeless Council | www.nhchc.org/KeyHealthReformProvisions.pdf
16. National Health Service Corps | Health Resources & Services Administration | www.nhsc.hrsa.gov

Wagner continues: “If someone is a danger to themselves or others, they can get care through emergency services, which will send a crisis team to assess them, but even with benefits it may take a month before the client sees a psychiatrist for a follow-up appointment. Grady’s intake clinic for mental health assessments is faster but still may take a week following contact.

“Other barriers to access include lack of transportation and long wait times. Some clients are too sick to take public transportation on their own, let alone sit and wait for appointments, and need a case manager to accompany them, in which case we use company vehicles,” Wagner adds. “Accessing inpatient detoxification is even more difficult and requires an extremely tenacious client. The Georgia Crisis and Access Line is a mental health and substance abuse clearinghouse, which screens clients over the phone for residential detoxification program beds. In order to secure space in the program, case managers and clients begin calling the crisis line at 8:00 a.m., but often the limited detoxification beds are taken by 10:00 a.m. That means someone who is ready to enter substance abuse treatment will have to wait another day. Unfortunately, many clients leave feeling defeated and do not return the next day to try again.”

Across the board, clinicians find that barriers to care begin within a bureaucratic maze so difficult to untangle that many eligible people, particularly those who are homeless with mental health or co-occurring substance-related disorders never apply.^{12,14,16} Research has found that permanently housing chronically homeless people with access to SSA benefits can reduce the cost of care by as much as 30 percent.¹⁶ Indeed, income is essential to access housing and for those disabled by serious mental illness, disability income is the primary source of stable income. Realizing these associations as a step toward eliminating homelessness, the SSA's Homeless Outreach Projects and Evaluation (HOPE) initiative launched from 2003 to 2005 is structured to help providers and SSA representatives work in tandem to improve homeless individuals' access to SSI and SSDI benefits.¹⁷ ■

Anticipating the Promise of Health Care Reform with Innovative Program Solutions

When talking about the provisions in the 2010 Patient Protection and Affordable Care Act, NHCHC Policy Director **Barbara DiPietro, PhD**, points out opportunities that will benefit homeless people and their HCH providers. “While Medicaid expansion to everyone with incomes up to 133 percent of the federal poverty level (FPL) won't be fully implemented until January 2014, some states have calculated that they will save money by expanding Medicaid coverage for low-income adults earlier. Both Connecticut and the District of Columbia have submitted state plan amendments to the Centers for Medicare and Medicaid Services; D.C. expects to save \$56 million over four years (2010–2014).”

The Kaiser Commission reports that “under the enhanced outreach scenario applied uniformly across states, Medicaid enrollment could increase by 22.8 million by 2019 resulting in a 70 percent reduction in uninsured adults under 133 percent of poverty.”¹⁸

“The new law invests \$11 billion over five years in HRSA-supported health centers,” DiPietro continues, “with most of the funding (\$9.5 billion) dedicated to new access points and expanded services capacity to prepare for nearly 20 million new health center clients. The rest is directed to capital improvement of facilities and construction of new sites.” In addition, the law speaks to workforce development by (see Quick Tips Box, number 15):

- Investing \$1.5 billion over five years in the National Health Service Corps to place an estimated 15,000 primary care providers in underserved communities

(see Quick Tips Box, number 16)

- *Developing incentives* to address the shortage of nurses through loan repayment and retention grants, and increased capacity for education
- *Creating scholarships* to increase the number of primary care providers, establishing a public health workforce loan repayment program, providing training for medical residents in preventive medicine and public health, and promoting training in cultural competence
- *Supporting development* of primary care models such as medical homes, team management of chronic disease, and programs that integrate physical and mental health services

DiPietro adds: “As HCH providers, we need to plan for increased capacity and new programming to meet the growing demand for services. We need to ensure that our clients are enrolled in Medicaid as soon as possible and are receiving comprehensive health care in order to live healthy, productive lives.” (See Quick Tips Box, numbers 4–8.)

HITTING THE GROUND RUNNING In Nashville, Tennessee, many neighbors do not have secure or regular housing. As many as 6,000 people may live in shelters, on streets, in cars, in motels, or in one of 85 encampments throughout Davidson County. Others move constantly between homes of families and friends. At United Neighborhood Health Services (UNHS), doctors, nurse practitioners, physician assistants, behavioral health specialists, and dentists provide comprehensive, quality, affordable care at both the Downtown Clinic (DTC) and through a

mobile clinic, which provides comprehensive medical care to those unable to come to a regular clinic location. With two exam rooms, the mobile unit regularly visits lunch programs, local tent cities, and community fellowships. Retinal eye exams, drug and alcohol programs, teen programs, prenatal services, and diabetes programs are also available.

Bill Friskics-Warren, MDiv, director of homeless services for UNHS, understands that meeting people where they are, whether that means going to a tent city or tailoring treatment to their readiness to accept it, is absolutely crucial to providing effective, culturally sensitive care.^{19–21}

“That's why we are setting up mini-clinics at Mercury Courts, a Single Room Occupancy development, and at Park Center East, a provider of wraparound services to people living with mental illness,” Friskics-Warren says. “In each case, we will have a provider and a medical assistant working a set number of hours, several days each week. Our partner agencies will do outreach among their clients or residents, as well as provide transportation to folks from nearby sites, such as transitional housing or other associated apartment complexes. At Park Center East, we will be working from the psychiatric clinic that's already there. Our clinician will be on-site on days when their psychiatric nurse practitioner is scheduled, thus maximizing our chances of providing integrated health care to patients.

“If things go as seamlessly as we hope they will,” Friskics-Warren continues, “Park Center's members [clients] will view the UNHS provider as Park Center's physician—someone

who is an integral part of an agency in which they've already placed their trust—rather than yet another professional who's 'all in their business.' In addition to removing the transportation barrier, we will remove other barriers that Park Center's clients might otherwise face, such as uncertainty or fear, if they had to seek care at another UNHS site.

"We're also working with Operation Stand Down Nashville (OSDN) to send our mobile unit to their Edgehill office one day a week, where they typically have 70 to 80 veterans on-site who come for an array of services from help with job searches to checking their mail boxes—hundreds of veterans use OSDN as a mailing address. We hope to provide provisional assessment and treatment to those with chronic conditions that otherwise might not get treatment, for reasons ranging from lack of transportation to mistrust of larger institutions."

A major tent city in Nashville washed away in the May 2010 flood. Initially, a Red Cross emergency shelter at Lipscomb University housed the 170 residents. Some have moved to temporary housing and others have relocated to a temporary site in Antioch. While permanent housing is what is needed, many individuals who were living in the tent city are ineligible for housing that might be provided by the government or a private property owner due to things like felony convictions.²²

Pam S. Brillhart, MSW, is director of special projects for UNHS. "Part of my role is to work with our Consumer Advisory Board (CAB). Several of our members are especially articulate when expressing the group's ideas for change and are not afraid to speak up. They realize many in our community are deeply concerned about homeless individuals but there are a lot of meetings with undirected results, which sometimes seems like a lack of coordination; the right hand not knowing what the left is doing. A new CAB member summarized the feeling: 'People are happiest when they are



Jason White is working hard to establish his new life and wants to enable others to do the same.

actually doing something—I'm tired of being in groups where nothing changes."

Another CAB representative, **Jason White**, bluntly describes how he sees homelessness in his birth city. Determined, White uses his life-long knowledge of the city and is able to get what he needs. He sees many other homeless people as conflict adverse and lacking the strength to confront challenges in their life situation without ongoing support. "I truly feel that it's a war out there much of the time," White says. "Many folks want to help, but others in the community just want to throw the homeless people away.

"I made some bad choices and ended up with an addiction problem. I lost my wife and home," White continues. "Over the last several years, I've had to start from scratch and rebuild my life, get my IDs and paperwork back together, learn where I could sleep at night, where I could find food. Public transportation doesn't go to construction or factory jobs. Sources for food are plentiful but not always consistent, so homeless folks get discouraged and feel they're on a wild goose chase.

"I ran a halfway house for folks in recovery for six months or so," White adds, "and was responsible for a group of truly fragile people;

I still go over every Saturday to check on them. I've been working as a professional marketer for ten months now, have some money saved and my own place to live, but I still don't feel entirely secure. I just keep working on it."

Keith Junior, MD, is the chief medical officer for UNHS. He views barriers to care within a framework of education. He wants to deliver the best possible care internal medicine can provide and knows that a medical home style of practice, electronic medical records, bundled services, and patient-centered sensitivity are all important to his clients' ongoing recovery and good health.^{23,24} He also wants patients to understand the premises of good medicine so that they will want to take better care of themselves.

"You know, no person is less important than I am—we're all in this together," Junior says. "Sometimes people aren't trained to do a specific job but they may know more about something else; it's just like my mechanic and cars—he keeps me on the road and I want to keep him going, too! When patients come in with sore throats, I want them to leave knowing their throat will feel better soon, but the more important item was checking and catching their high blood pressure early and treating it before it causes complications that aren't so easy to take care of such as heart or kidney disease. I want them in for those preventative checks in between major milestones. I want them to think like their pancreas so we can watch blood sugar and act before they have diabetes. I want them to know we will always look after the ABCs—airways open, breathing robust, and circulation top notch. I especially want them to know that we care about them as individual human beings." ■

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