

Organizing Health Services for Homeless People

A PRACTICAL GUIDE

Second Edition

Marsha McMurray-Avila

PREFACE TO THE SECOND EDITION

This book recounts important lessons from the work of a remarkable group of people over more than a decade. Marsha McMurray-Avila, the author, provides a few of the names in her acknowledgments, listing those who have provided direct help in the writing and compiling of this material. There are many whose names do not appear, unheralded heroes of a monumental effort to ease pain, save lives and change the world. I trust that this book represents them well, and will nurture them and their successors.

Marsha is herself one of the stalwarts of the Health Care for the Homeless movement, having served as a front-line provider and eventually as Executive Director of the effort in Albuquerque. She has also chaired the National Health Care for the Homeless Council, and has served on various national-level advisory committees and task forces. Marsha is now the Program Coordinator of the National Council, where her knowledge and commitment continue to strengthen the HCH community. For Marsha, this is a labor of love for the people who suffer the most in our political economy, and of profound respect for those who are called to respond to that suffering. She is one of our best.

This book was made possible with support from the Bureau of Primary Health Care, the federal agency whose grants are the financial backbone of many Health Care for the Homeless projects. The leadership of the Bureau and its Division of Programs for Special Populations is committed to improving the health status of poor and homeless people. It is our good fortune that officials there share our understandings of what must be done to assure health care for homeless people, and to overcome homelessness itself. However, the views expressed herein are the author's, and do not necessarily represent the views of the Bureau of Primary Health Care or of the National Health Care for the Homeless Council.

Someday, this book will be hopelessly obsolete, because homelessness in America will be just a bad memory and adequate health care will be a well-established right for everyone. May this publication hasten that day.

John N. Lozier
Executive Director
National Health Care for the Homeless Council

August 1, 2001

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Most of all, I thank my loving family for their patience and support.

NOTES ON THE SECOND EDITION

It is amazing how much can change in four years, and tragic how much stays the same. Although I am always pleased to hear how much this book has helped people create, improve and expand health services for people who are homeless, I desperately wish that it were not necessary to publish a second edition. Statistics have changed, organizations have changed, website addresses have changed; I have tried to correct as much of that as possible. But homelessness is still with us and it will take all of us working together to correct that.

I would like to thank several people who helped review sections and/or gather information to update this second edition: Allan Ainsworth, Heather Barr, Barbara Conanan, Marianne Feliciano, Jean Hochron, Jen Holzwarth, Ken Kraybill, Kevin Lindamood, John Lozier, Jenny Metzler, Heidi Nelson, Eve Rubell, Beth Sharber, Jeff Singer, Amy Taylor, David Vincent, Suzanne Zerger and others to whom I apologize for not naming. I am also appreciative of our designer, Linsey Sieger, and thank her for her patience in this process.

Marsha McMurray-Avila
July 2001

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Introduction

Homelessness – the social and economic phenomenon characterized by the condition of being without a home – graphically reveals the relationship between socioeconomic factors and health. It is not uncommon for health problems to be major or contributing factors leading to homelessness. At the same time, the condition of homelessness causes and exacerbates health problems, leading to rates of illness and injury from two to six times higher than for people who are housed.² Homelessness also severely complicates the delivery of health services.³ Without access to appropriate health care, acute and chronic health problems may go untreated, creating medical complications and impeding the individual's ability to overcome homelessness.

“Bill” suffered near-fatal head injuries when he was beaten and robbed in Albuquerque, New Mexico. He spent two and a half months in a local hospital recovering. As a result of his injuries, Bill, 33, lost some of his hearing, began to have seizures, and is in constant pain. In describing his situation to a clinic staff person, he said, “I never had just a 40-hour job. I either worked 60 hours or worked two jobs.”

Unable to work after the accident, he, his wife, and his son received AFDC and Medicaid, which paid for his hospitalization. But after his wife and son left him, he was cut off Medicaid. Although he did begin receiving \$184 a month in temporary disability benefits, without Medicaid he was told the hospital could no longer treat him.

“My head is still held together with staples,” Bill said. He needs the staples removed as well as ongoing therapy, but no hospital will care for him because he has no insurance. “I don’t understand how this works. I’ve paid taxes for 20 years before this. I don’t know why it works this way.”

The only way Bill could regain Medicaid was to qualify for Supplemental Security Income (SSI) on the basis of his disability, but the process could take months, even years, to complete. In the meantime, Bill [lived on the streets and stayed in shelters... Still] he asked for nothing more than the appropriate medical treatment so he could return to work, earn a living and regain his independence. Bill said, “There’s nobody on this man’s earth that’s going to tell me I’m not going to be able to take care of myself.”¹

“Hoskie Jake [age 58] died on March 12, 1991, in Phoenix, Arizona. He was born on the Navajo Reservation near Canyon de Chelly, Arizona. Like many Indian men of his generation, Hoskie enlisted in the army at the age of 16 and served for four years in the Pacific. Upon returning home, Hoskie married and had five children, but found it difficult to re-assimilate to a rural reservation life of shepherding and farming. After separating from his wife, he migrated to Phoenix, where he worked in construction doing high steel work.

With the demolition of 36 of the city's original stock of 42 Single Room Occupancy (SRO) hotels, Hoskie became homeless, sleeping in shelters and on the streets. Ironically, he laid the girders on many of the downtown office buildings that replaced the hotel where he once lived.

On the street, Hoskie contracted tuberculosis (TB), for which he received medication through the Maricopa County TB outreach team. But [when] the County discontinued its outreach program, [it became] necessary for patients to go to a clinic to receive medication. Hoskie felt unwelcome at the clinic because of the hostile way in which homeless people were often treated there.

As his TB became more serious, Hoskie found himself no longer able to work. By early 1990 he was eating very little, his six foot frame wasting away to 98 pounds. His days and nights were spent lying on a piece of cardboard near the downtown soup kitchen, waiting for a friend to bring him food that he rarely was able to eat.

When his condition was reported to County TB program staff, they said they were unable to see him on the street and that he needed to come in to the clinic. When local homeless outreach workers offered Hoskie transportation to the clinic, he refused, citing the shabby manner in which he had been treated previously. Finally, in September 1990, a local social service provider arranged for Hoskie to be arrested for trespassing and given the option of being taken to the emergency room of the County Hospital, or to the County jail. Hoskie chose the former, and was immediately hospitalized. He stayed in the hospital until he was placed in a nursing home in January 1991. Two months later he died.⁴

Any attempt to end homelessness, either in the life of one individual or by changing the policies and circumstances that cause people to become homeless, must necessarily address the issue of health in its broadest sense. In 1978, the International Conference on Primary Health Care held in Alma-Ata declared that health is “a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity... (it) is a fundamental human right and... the attainment of the highest possible level of health... requires the action of many other social and economic sectors in addition to the health sector.”⁵

Since the mid-1980s, an approach has been evolving that integrates the provision of health care with other services to meet social and economic needs of people without homes. Embodied in the national Health Care for the Homeless (HCH) program, this approach is based on the belief that health, as a state of total well-being, cannot be achieved without ending homelessness in the lives of individuals and families. In order to address both the causes and consequences of homelessness related to health, the HCH program reflects a “social orientation” to primary care. This orientation incorporates the medical model of care – which focuses primarily on physical health – into a broader public health model, with significant emphasis on the social conditions of homelessness and the provision of services necessary to address those conditions.

The HCH approach to integrating services evolved as a direct response to the complex and multiple needs of people who are homeless. As this response took shape in numerous locations throughout the country, it reflected the particular needs, environment and resources in each community. A theme that will recur throughout the following pages is that, although essential elements must be included in the design of HCH programs, there are many ways to go about accomplishing the mission. Those essential elements are the focus of this guidebook, the purpose of which is three-fold:

1. To provide an easy reference for communities or groups interested in starting a health care project to serve people who are homeless, by outlining some basic but necessary steps in the process.
2. To assist current HCH projects that want to improve or expand their services, by offering ideas, resources and contacts.
3. To describe the rationale for the continuing existence of the HCH program.

This guidebook may be read in its entirety or used selectively by referring only to certain sections. Those who are just starting out may want to read from beginning to end, to better understand the relationships of the many parts and how they connect to form a comprehensive whole. Those already involved in HCH projects may need only to consult specific sections in areas where they are seeking to improve or expand their services.

The guidebook is intended to complement the many other books and documents that address the development and operation of HCH pro-

jects, most of which are cited throughout and listed in the Notes at the end of each chapter or in the appendices.

Although it has been our intent to be consistent with the published guidelines for federally-funded HCH projects, it should not be assumed that this guidebook replaces the need to refer specifically to “Program Expectations” and other grant-related documents for clear program guidance.

Frequent references will be made in the following pages to the experience of the 137 federally-funded HCH projects (as of July 2001). However, this is not meant to imply that the work can only be undertaken with federal funding. Hopefully the ideas and information offered here will be useful for communities interested in establishing an HCH project with or without federal funding.

Part I of the guidebook begins with an overview describing the interaction of homelessness and health — how people become homeless and who is most vulnerable to it. That section will describe what we know at this point in time about the characteristics of those who become homeless. This leads into a general discussion of health problems related to homelessness, followed by a description of the obstacles people who are homeless face in getting help for those health problems.

Part II describes how the HCH program developed in response to the health problems and access barriers faced by people who are homeless.

Part III covers basic recommendations related to planning, organizational structure and governance for those starting up a new HCH project.

Part IV discusses service delivery strategies based on the experience of existing HCH projects. This section describes specific elements necessary for provision of services in the following areas: medical care, substance abuse services, mental health services, case management, outreach, dental care, respite services and housing links.

Part V offers ideas about tools that organizations need to operate effectively, including: strategic planning; resource development/fundraising; financial systems; information systems; staffing issues; cultural competence; quality improvement/quality assurance; and program evaluation.

Part VI focuses on education and advocacy — two vital tools for maintaining the gains we’ve already made. As long as there are people without

homes, we need to keep the national HCH program viable and effective. Education and advocacy will also increase our impact in working with others to ultimately end homelessness.

NOTES

- 1 S. O’Sullivan. Beating Triggers Man’s Slide Into Homelessness. *Salud*. Albuquerque Health Care for the Homeless, Inc. Summer 1991, p. 3.
- 2 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.
- 3 Institute of Medicine/Committee on Health Care for Homeless People. *Homelessness, Health and Human Needs*. Washington, DC: National Academy Press, 1988.
- 4 From L. Stark. Phoenix Consortium to End Homelessness, as reported in L. Williams, *Mourning in America: Health Problems, Mortality, and Homelessness*. Washington, DC: National Coalition for the Homeless, 1991, p. 8.
- 5 Declaration of Alma Ata: Report of the International Conference on Primary Health Care, Alma-Ata, USSR, 6-12, September 1978. Geneva: World Health Organization, 1978.