

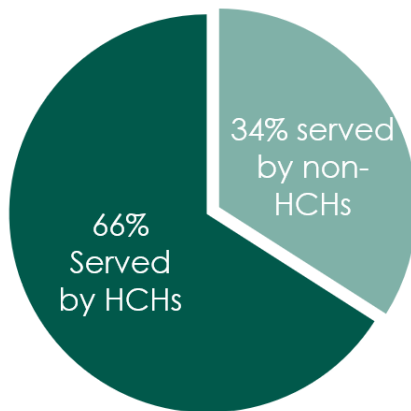
Filling the HCH Gap: Case Studies of Non-HCH Health Centers Serving People Experiencing Homelessness

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The HRSA Health Center (330(e)) program provides primary health services to medically underserved populations, including people experiencing homelessness, regardless of their ability to pay. While Health Care for the Homeless (HCH, 330(h)) health centers are required to serve people experiencing homelessness, all health centers can serve unstably housed patients. This is particularly important to consider in the 33% of US cities with populations of 100,000 or more that lack an HCH health center. But many “non-HCH” health centers report scarcely any unhoused patients: 39% reported 50 or fewer and 92 reported zero. This is partly due to a lack of screening for housing status and/or care that is not tailored to the specific challenges people experiencing homelessness may face.

1/3 of large cities lack an HCH health center

Patients Experiencing Homelessness in 2020



However, many non-HCH health centers are investing in shelter services, medical respite/recuperative care, and even housing. While Health Care for the Homeless (HCH) has a distinct history¹ from other health centers, lacking the designation does not preclude health centers from providing HCH-like care. All health care providers can provide care that addresses the structural impediments to health² including housing instability. In other words, health centers can do “HCH” without 330(h) funding.

This paper features case studies of health centers that lack HCH designation but provide proactive services to unhoused populations regardless. The intent is to promote practices for screening for housing insecurity at

non-HCH health centers, and to adapt services for unstably housed patients accordingly. It includes insights and recommendations on screening, non-HRSA funding, training staff, and providing non-medical services to people without homes and concludes with resources health centers can use to educate their staff on homelessness and how health center administrators might alter policies. It is the hope that health-center readers will use these resources to address the growing crisis of homelessness as a collective responsibility.

¹ <https://nhchc.org/pioneers>

² More commonly referred to as Social Determinants of Health.

Health Center Profiles

Leaning on trusted relationships: [Lamprey Health Care](#)

Principal Facility: Newmarket, NH

Total patients: 15,032

Patients experiencing homelessness: 1,392, 9.3%

Founded in 1971, Lamprey Health Care is New Hampshire's oldest health center with clinics in Newmarket, Nashua, and Raymond. While homelessness is largely hidden in these communities (a majority of unhoused health center patients are doubling up), the homeless population has increased over the last several years. Lamprey's foray into targeted services for unhoused clients was initiated by the director of a local soup kitchen who had prior experience on a health center Board and later joined Lamprey's Board after becoming close with their leadership. Increased attention to homelessness was also enhanced when they hired a new Chief of Clinical Services who had previously worked for an HCH health center. While their main site had long served people without homes incidentally, these new relationships drew attention to a more focused strategy.

In 2020, Lamprey received funding from the state of New Hampshire to open an intermittent clinical site at a Nashua shelter. At the time of the interview, uptake in these services was slow and affected by COVID-19 restrictions, but the groundwork of building a trustworthy reputation was progressing steadily. Staff who visit the clinic report a deeper sense of meaning and joy working with people experiencing homelessness. Lamprey then conducted an all-staff training on homelessness and housing insecurity to ensure everyone was equipped with the same competencies. This led to additional training on diversity, equity, and inclusion, which are issues fundamental to serving people living in homelessness and poverty.

COVID intensified these efforts both by contributing to an increase in housing insecurity and by providing new funding, such as through the CARES Act, that enabled Lamprey to help with short-term rental assistance for some patients. As seen across the country, the pandemic is accentuating that housing is health care.

Lamprey's reflections and advice:

- To be homeless often means to be ignored. Talking about homelessness among staff brings visibility to these marginalized people.
- Starting small is okay, if not ideal. Their shelter clinic is just four hours per week (at the time of the interview) but is changing lives. "We can make one little shift and make a big difference."
- Staff satisfaction in the workplace increases when staff can pursue their passions. It makes a difference to them when they feel they are a part of something that is important. In turn, increased job satisfaction improves clinical care.
- "We have a responsibility to take care of every member of our community."

Asking better questions: [Peninsula Community Health Services](#)

Principal Facility: Bremerton, WA

Total patients: 34,977

Patients experiencing homelessness: 7,395, 21.1%

Peninsula Community Health Services (PCHS) was founded in 1987 and became a HRSA-funded health center in 1995. PCHS serves the Kitsap and Mason County areas west of Seattle and have rapidly expanded with ten primary care clinics, seven dental clinics, seven school-based clinics, five mobile medical units, a substance use disorder (SUD) Quick Response Team, and a supported behavioral health clinic. Given the rate of housing insecurity in the region, it may seem unsurprising that more than a fifth of their patients were identified as homeless, but it was not always the case. PCHS used to only screen for housing insecurity for patients who lacked an address when registering or the front desk otherwise suspected they might be struggling with homelessness. After learning from a colleague at a conference that many unhoused clients may put the address of the shelter or transitional housing program or that of the friend or relative, they changed their housing question from “are you homeless?” to align with the Uniform Data System (UDS) shelter categories. Without changing any services, this alteration in screening alone drastically increased their UDS number for patients experiencing homelessness, proving definitively that it matters how you ask.

But this fact should not be misunderstood. Asking about housing insecurity, as with other traumatic histories, can be especially painful. PCHS's CEO said, for example, that they do not use PRAPARE³ due to its rigidity and incompatibility with the electronic medical record (EMR) workflow. They also do not universally screen for Adverse Childhood Experiences because doing so has been retraumatizing for their patients. It is critical, in their experience, that housing questions are asked in a trauma-informed, sensitive manner: “You can be totally insensitive in asking the questions... *and* you can be totally uplifting in asking the questions.”

PCHS responded aggressively to the data revealed in changing the housing question. With no mobile medical units in 2018, they now have five, which they estimate serve about 90% of their unhoused patients. They have also taken a robust role in COVID-19 response, operating isolation and quarantine facilities and organizing testing and vaccinations. They have also assumed operation of Kitsap Connect, a successful program initiated by the county health department to reduce inappropriate use of emergency services for people experiencing homelessness.

PCHS's reflections and advice:

- The mobile medical and school-based health center programs are not moneymakers; they are PCHS's “feel-good programs.” Their Board is not driven by profit but by mission. “We look to break even and that's enough.”

³ PRAPARE stands for Protocol for Responding to and Addressing Patients' Assets, Risks, and Experiences, a common tool for measuring social determinants of health data. Learn more:

<https://www.nachc.org/research-and-data/prapare/>

- PCHS does not attempt to be everything to everyone. They focus on primary care services for unhoused patients, referring to partners for more complex behavioral health or medical issues. If clients are already connected to the Continuum of Care⁴, there is little else to be done in a region with scarce affordable housing.
- PCHS is fiercely patient-centered, including on housing: if patients are content living on couches for now, for example, staff will not pry. The client determines their own needs and priorities.
- Services for people struggling with homelessness are considered essential to the mission of the organization. “We feel ethically obligated that these are our patients.”

Integrating health with social services: [VIP Community Services](#)

Principal Facility: Bronx, NY

Total patients: 2,173

Patients experiencing homelessness: 316, 14.5%

Vocational Instruction Project, dba VIP Community Services, was founded by a priest in 1974 as a faith-based ministry providing job training to people in poverty and struggling with addiction in the Bronx, the nation's poorest urban county.⁵ Over time, VIP added behavioral health and street outreach services, later becoming a Certified Community Behavioral Health Clinic. In the 1990s, they began operating shelters through contracts with the New York City Department of Homeless Services. VIP owns and operates 198 units of permanent supportive housing. It was only in 2017 that VIP became a health center. VIP, therefore, is an example of a longstanding human services nonprofit serving numerous people experiencing homelessness, addiction, and poverty that only added primary care in recent years – without HCH designation.

VIP screens for housing insecurity with questions adapted from PRAPARE at every clinical encounter – it is a required field in the electronic health record (EHR) and cannot be skipped. There are dozens of ways clients interact with VIP, only some of which reside in the health center scope of project. “What we report to HRSA is not even close to the number of homeless people we serve,” their CEO explained. Uniquely among the health centers interviewed for these case studies, VIP was already accustomed to providing housing and support services to people struggling with homelessness, training all staff in the structural impediments to health as part of the regular onboarding process. Their challenge was adapting to HRSA Health Center Program compliance.

VIP actually applied for Health Care for the Homeless funding through the New Access Point opportunity in 2018, but was not awarded. This has not deterred them. At the time

⁴ Learn more about homelessness funding and Continuums of Care in this explainer for health care providers: <https://www.chcf.org/wp-content/uploads/2021/07/HomelessnessResponse101ProvidersStakeholders.pdf>

⁵ <https://www.vipservices.org/about-us/>

of the interview, VIP was on schedule to open a 136-bed men's facility with mental health and substance use treatment, among many other initiatives.

VIP's reflections and advice:

- VIP's CEO challenges the term *Social Determinants of Health* because "nothing social determines your health." The point is structures such as lack of access to affordable housing resulting from conscious policy decisions determine one's wellbeing. Social factors impede health; they do not determine health.
- If one does not address these impediments, it affects health outcomes, which in turn affects health centers' bottom line. Screening is the first step.
- In the absence of HCH funding, VIP has leveraged numerous other funding sources to provide comprehensive care, especially through the Substance Abuse and Mental Health Services Administration (SAMHSA), the Department of Housing and Urban Development (HUD), and local government. Options are available.

Taking training seriously: [Penobscot Community Health Care](#)

Principal Facility: Bangor, ME

Total patients: 57,333

Patients experiencing homelessness: 1,142, 2%

Maine has just two HCH health centers, which together served 72% of the state's 5,734 unhoused health center patients reported in 2020. Nearly three quarters of the remaining patients are served by Penobscot Community Health Care (PCHC), incorporated in 1997 in Bangor, about 130 miles northeast of Portland. PCHC's twenty sites include primary care, dental clinics, pediatrics, geriatrics, and school-based health. Most notably, they have a clinic embedded in a homeless shelter that shares a campus with a 48-unit transitional housing facility, both of which PCHC owns. At the time of the interview, PCHC had dedicated some beds in their shelter to medical respite/recuperative care⁶ and is looking to expand the program already.

PCHC experienced exponential growth since its inception in the late 1990s now with nearly 900 employees. The homeless shelter was acquired about ten years ago, which also brought on their now Homeless Services Director who has championed the program ever since. These services are funded through a combination of the health center base grant, state contracts, and Medicaid reimbursement, but is ultimately a mission-driven program. While they hope for a New Access Point in the future, they are getting creative in funding services in the meantime, including hospital contracting for their new recuperative care beds.

PCHC's reflections and advice:

- With an institutional commitment to equity and belonging, PCHC rigorously trains staff on issues like trauma-informed care, harm reduction, cultural competency,

⁶ <http://www.nimrc.org/>

homeless services 101, and racial equity. This costs money and time but is nonnegotiable. "It should rise to the level of requiring certification," said their Director of Homeless Services.

- This training "gets less and less important the farther you get through the door," which is to say, the first people whom patients encounter are the most crucial to train in the skills necessary to provide a welcoming environment. "We target a population that is already distrustful of systems. Building trust starts at the front door." Put plainly, the front office risks ruining the first impression without comprehensive training. "If you don't know what you're doing you shouldn't be doing it."
- Commitment from the top is essential. Much of the innovation in the last few years for this work arrived along with a new CEO.

Stepping up during a crisis: [Alliance Community Healthcare](#)

Principal Facility: Jersey City, NJ

Total patients: 10,488

Patients experiencing homelessness: 732, 7%

Horizon Health Center, dba Alliance Community Healthcare, was founded in 1963 as a volunteer-run family planning clinic working out of a local church; while it has grown substantially, it remains the smallest health center in Hudson County. Jersey City is the seat of Hudson County, situated just across the Hudson River from lower Manhattan, making it functionally an extension of New York City with a high rate of homelessness. Before COVID-19, services for people without homes occurred incidentally, rather than through targeted programs; in part this was in deference to the local HCH health center. But the pandemic drew attention to the profound needs of residents experiencing homelessness, specifically the need for isolation/quarantine for unhoused people. Alliance stepped up to meet that need.

Funded by the county government in collaboration with a local hospital system, Alliance established a "step-down" facility for COVID-positive patients experiencing homelessness to recuperate from hospitalization and connect to benefits. Working with these marginalized patients quickly revealed clients' many other needs. Thus, Alliance expanded to provide services like hygiene stations, laundry facilities, clothing closets, food/nutrition, and are even working on obtaining their own housing and shelter services. Tapping into the medical respite model, they intend to continue their step-down unit as recuperative care beyond the pandemic.

Alliance's reflections and advice:

- COVID made the peripheral central. No one wanted to talk about homelessness other than on moving them out of sight, but the pandemic forced the crisis into the mainstream. With a solid reputation for quality health care in the community, Alliance was positioned to take on the challenge.

- Alliance developed their own Social Determinants of Health screening tool, which their EHR vendor customized into their system. Integrating into the EHR makes screening for housing inextricable from the intake process.
- The enthusiasm necessary to accelerate these services was driven by the COO with full support of the CEO, underscoring the case for supporting staff passions and gaining buy-in from the top.

Themes and Insights from the Interviews

- The point of highlighting these non-HCH health centers is not to suggest that HCH designation is meaningless but rather to show that health centers are making progress regardless of their funding designation.
- While Community Health Centers are mandated to serve anyone presenting for care in their services area, they may not create targeted programs for people without homes. Creating such services may require a champion. For some interviewed health centers, that champion had prior HCH experience to build upon, which may constitute a helpful tip for others: hire for HCH background.
- For many interviewees, targeted services for unhoused patients are an obvious expression of their mission as a health center. The health center 330(e) designation is distinct from the three others (330(h), 330(i), and 330(g)) in that it focuses on a geographic community rather than a population. But residents experiencing homelessness are a part of each community even if they lack a permanent address, so serving this population ought to be considered integral to any health center's mission.
- Simply changing how one asks the housing question can drastically affect one's numbers. Asking "are you homeless?" leaves out many who fit the Health and Human Services (HHS) definition of homelessness⁷ but either do not identify as homeless or would not disclose it even if they do. For example, those who are couch-surfing may not consider themselves homeless, but this "doubling up" is considered homelessness for HRSA. Having better data, in turn, can fuel new funding and partnerships.
- If health centers want to address the Social Determinants of Health (SDOH), they must prioritize housing because it is arguably the most profound influence on well-being. Housing is both foundational to Maslow's hierarchy of needs⁸ on its own and affects access to other human needs like food, water, rest, and safety.
- Health centers that do not currently provide tailored services for people experiencing homelessness presumably point to the absence of funding for it. Indeed, the health center base funds may not cover many who lack insurance. But the interviewed health centers used other sources, particularly local government grants and contracts. Systems that are strained by overutilization and uncompensated care are the natural funders and partners for homeless health services (see the Resources section below).

⁷ <https://nhchc.org/where-does-homelessness-happen/>

⁸ <https://www.simplypsychology.org/maslow.html>

- The majority of interviewed health centers were in states with Medicaid expansion, so their clients were more likely to be insured. However, the UDS data suggest that the proportion of homeless clients to the overall patient population is comparable between non-HCH health centers in expansion versus non-expansion states. More research is needed to explore this comparison.
- A premise of this paper is that many of the largest US cities lack an HCH-funded health center, so health centers in those communities are the default primary care providers for this population. Ironically, however, most interviewed health centers are in service areas that do have an HCH health center. This suggests that the extent of homelessness is significant enough that all health centers can provide services to people experiencing homelessness without infringing on others' work.

Nine Strategies for Health Centers to Improve Services for Unhoused Patients

- 1 Screen everyone for housing insecurity in a destigmatizing, trauma-informed manner.** Health centers cannot know the extent of housing insecurity among their patients unless they gather the data and cannot provide patient-centered care without knowing their clients' living conditions. However, it is crucial to screen inclusively.
- 2 Waive fees for clients experiencing homelessness.** It is a misconception that non-HCH health centers are required to charge a co-pay. With approval from its Board, the Health Center has discretion to design its Sliding Fee Scale and policy for waiving fees to ensure cost is never a barrier for people living in homelessness. People with no income should not be charged for services.
- 3 Train all staff on homelessness and poverty.** The majority of the health center patient population lives under the poverty line. Staff should understand the mission of the Health Center Program as rooted in the Civil Rights movement⁹ and comprising a key component of the health care safety net. When staff understand the structures that perpetuate poverty and make health centers necessary, they are more likely to be mission-driven, which may mitigate burnout.¹⁰
- 4 Get involved with the Continuum of Care (CoC).** Homelessness touches many if not all sectors but is primarily a housing issue. HUD organizes homeless services funding through local CoCs.¹¹ In order to help resolve housing crises facing patients,

⁹ <https://www.npr.org/sections/health-shots/2021/06/03/998566213/with-roots-in-civil-rights-community-health-centers-push-for-equity-in-the-pande>

¹⁰ See

https://js.sagamorepub.com/jpra/article/view/1472#:~:text=Organizations%20rely%20on%20their%20mission_disseminated%20both%20internally%20and%20externally and https://journals.lww.com/academicmedicine/Fulltext/2015/09000/Developing_a_Pipeline_for_the_Community_Based.31.aspx

¹¹ https://www.hud.gov/program_offices/comm_planning/coc

health centers should familiarize themselves with these programs. CoCs, moreover, are incentivized by HUD to partner with health care organizations.¹²

5 Provide comprehensive, harm-reduction, low-barrier substance use services.

While most people struggling with addiction have stable housing, substance use disorders disproportionately affect people experiencing homelessness. As the opioid epidemic surges, it should be considered customary to provide medication for opioid use disorder (MOUD) and other therapies for preventing overdose and recovering from substance use disorders.

6 Pursue becoming a Trauma-Informed Organization. Homelessness is a form of trauma, and a majority of people experiencing homelessness have experienced additional traumatic events (some of which precipitated their homelessness). Health center staff may also have experienced some level of trauma, such as racism and sexual violence. Beyond just trauma-informed patient care, then, health centers should aspire to be trauma-informed organizations.

7 Explicitly welcome marginalized populations. Black or African American people constitute just 13% of the US general population but are 40% of the unhoused population. Some 40% of youth without homes are LGBTQIA+. This means that serving unstably housed patients necessitates creating welcoming, safe environments¹³ for oppressed people and institutionalizing racial equity.¹⁴

8 Include patients experiencing homelessness in governance. The health center program is unique in its mandate to be governed by the population served through the patient-majority Board. However, patients experiencing homelessness are often left out of these efforts, occasionally even among HCH health centers. Consider including the lived expertise of homelessness on health center Boards and/or forming a Consumer Advisory Board.

9 Outreach to those who may not come to the health center. People without homes have numerous, valid reasons to avoid a brick-and-mortar health center. If they leave their campsite, among many examples, they risk losing all their possessions. Therefore, services must be brought to where people reside.

Conclusion: Targeted Universalism

Coined by Dr. John A. Powell (who chooses not to capitalize his name) of University of California, Berkeley, *Targeted Universalism*¹⁵ argues that focusing on the most marginalized populations – tailoring policies and services to their unique needs – both attends to the suffering of the most vulnerable and also benefits the whole system. In the movement to end homelessness, for example, as A Way Home America believes,¹⁶

¹² See the FY21 CoC Program Competition notice: <https://hudexchange.us5.list-manage.com/track/click?u=87d7c8afc03ba69ee70d865b9&id=5db2c493c7&e=1947ab6712>

¹³ See <https://www.lgbtqihealtheducation.org/publication/ten-strategies-for-creating-inclusive-health-care-environments-for-lgbtqia-people-2021/>

¹⁴ See <https://www.dismantlingracism.org/> and <https://www.racialequitytools.org/>

¹⁵ <https://belonging.berkeley.edu/targeteduniversalism>

¹⁶ <https://www.awayhomeamerica.info/>

policies that focus on LGBTQIA+ youth and youth who are Black, Indigenous, or other People of Color (BIPOC) who are experiencing homelessness sets the stage to end homelessness for all youth. Everyone benefits from an equitable society.

In this framework, improving services specifically for people experiencing homelessness benefits all health center patients because it creates more equitable practices and institutions. All patients deserve trauma-informed, patient-centered, wrap-around services that are tailored to their unique experiences and informed by their own feedback. The characteristics of the "HCH model" are neither exclusive to HCH health centers nor exclusively beneficial to people experiencing homelessness. The hope is that this paper encourages readers to proactively serve people without homes not just because the crisis of homelessness is worsening but because everyone stands to gain from more inclusive practices.

Resources

- [Where Does Homelessness Happen?](#)
 - This web-based infographic by the National Health Care for the Homeless Council (NHCHC) depicts the shelter arrangements that qualify as homeless under HRSA's UDS categories, noting those that are distinct from HUD's and other definitions.
- [So You Want to Start a Health Care for the Homeless Program](#)
 - This NHCHC two-page brief explains to both existing and potential health centers how HCH designation is achieved with suggestions for non-HRSA funding in the meantime.
- [Ask & Code: Documenting Homelessness Throughout the Health Care System](#)
 - This brief makes the case for screening for and documenting homelessness, as this paper does, but addresses all health care providers and argues for the use of the ICD code for homelessness. Its appendix of housing questions is longer than the one that follows below.
- [A Vision of Health Care for All](#)
 - Published in 2016, this report summarizes the history of the Health Care for the Homeless program from its roots at St. Vincent's Hospital in New York to its home in the health center program, highlighting core characteristics of the model of care and lessons learned along the way.
- [General Recommendations for the Care of Homeless Patients](#)
 - A membership group of the NHCHC, the HCH Clinicians' Network has adapted dozens of traditional clinical guidelines to the context of homelessness. This seminal edition takes a broad overview of clinical adaptations for unhoused patients.
- [Without Housing: Decades of Federal Housing Cutbacks, Massive Homelessness, and Policy Failures](#)
 - Composed by Western Regional Advocacy Project, this documents the key historical events that contributed to the spike in American homelessness that endures today.

- [Principles of Practice: A Clinical Resource Guide for HCH Programs](#) (archived)
 - This HRSA Program Assistance Letter has been retired but includes insight into how HCH programs gained more structure from HRSA's perspective as it was published just three years after HCH became a Health Center Program designation.
- [Trauma-Informed Care Webinar Series](#)
 - The majority of people without homes have experienced traumatizing incidents, and homelessness itself is traumatic. Understanding trauma is crucial to serving unhoused clients. This four-part training features trauma-informed care trainer and author Matt Bennett and is prime material for staff onboarding.
- [Trauma-Informed Organizations Toolkit](#)
 - Developed as a culmination of a three-year, HRSA-funded learning collaborative, this toolkit provides resources in support of each characteristic of a trauma-informed organization, moving from trauma-informed care on a client level to institutional transformation.
- [Resource Page](#) on Engaging Consumers in Governance
 - Consumer leadership is a central characteristic of all health centers but engaging clients who are currently experiencing or have experienced homelessness in governance (Board or CAB) often requires tailored approaches. The NHCHC specializes in this issue and has collected many supporting resources on this webpage.

Appendix: Three housing questions from interviewed health centers

Living Arrangements	
<input type="checkbox"/> Rent	<input type="checkbox"/> Live with relative or friend
<input type="checkbox"/> Own Home	<input type="checkbox"/> Transitional Housing
<input type="checkbox"/> Shelter	<input type="checkbox"/> Street
<input type="checkbox"/> Other	
Housing Information	
<input type="checkbox"/> Own/rent your home without help (NOT HOMELESS)	
<input type="checkbox"/> Staying with friends/relatives (DOUBLING UP)	
<input type="checkbox"/> Have concerns about your housing and want help (OTHER)	
<input type="checkbox"/> Living on the street, outdoor, in a car/travel trailer (STREET)	
<input type="checkbox"/> Staying in a treatment facility (TRANSITIONAL)	
<input type="checkbox"/> Living in public housing where all tenants get discount rent (PUBLIC HOUSING)	
<input type="checkbox"/> Staying in a shelter-short term housing like the mission, YMCA, etc. (SHELTER)	
<input type="checkbox"/> Living somewhere not meant to be a home-no running water/heat (OTHE)	
<input type="checkbox"/> Having been homeless in the last year and have housing now (TRANSITIONAL)	
Do you rent or own?	
DOUBLING UP: if the patient reports living arrangements in which they share a household with another family	
SHELTER: if the patient reports staying at a shelter	
STREET: if the patient reports living on the street or in a car	
TRANSITIONAL: if the patient reports having living arrangements that are temporary and do not have their own housing	
NOT HOMELESS: if the patient reports having their own apartment or a home	

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