NATIONAL HEALTH CARE for the HOMELESS COUNCIL

Exploring Enabling Services as Bridges to Care

Introduction

This report examines the place of enabling services in the delivery of health care to people without homes. In the spring of 2013, the National Consumer Advisory Board (NCAB) conducted "Consumer Participation Outreach" activities in six U.S. cities, gathering from 321 currently homeless people their experiences with and perspectives on health care and enabling services. This participatory research is intended to help inform a rapidly developing health care system about what works and what is needed in homeless health care.

Background

Enabling Services Defined[1]

The term "enabling services" describes a group of services intended to increase access to health care and improve health outcomes.[2] Enabling services, including the following statutorily defined services[3], are required for federally-funded Health Centers, [4] including the Health Care for the Homeless projects throughout the country where this research was conducted.

The service descriptions and commentary in plain text below were used in the conduct of this research in the spring of 2013.

> *The Health Resources and Services Administration (HRSA) subsequently issued Program Assistance Letter (PAL) 2014-06, "Documenting Scope of Project in Updated Forms 5A and 5B." PAL 2014-06 provides current and official descriptors, which are provided in italics under each enabling service.*

Case management

Case managers are professionals who engage in needs assessment, care-coordination, monitoring, evaluation and advocacy for their clients.[5] Case managers develop and use knowledge of community resources and are involved in connecting clients to those resources based on client need. Case managers may communicate between the client and providers to help the client navigate systems.[6]

> *Case management services are the coordination of support and enabling services to meet the ongoing needs of a patient. At a minimum, these services include an assessment of factors affecting health (e.g., medical, social, housing, or educational), counseling and referrals to address identified needs and periodic follow-up of services.*

Benefits enrollment

Benefits enrollment specialists assess client need and potential eligibility for public benefits, including SNAP, Medicaid, Social Security and others. These professionals assist with application and enrollment into local, state and/or federal benefit programs.

> *Eligibility assistance services are support to health center patients to establish eligibility for and gain access to appropriate federal, state and local programs that provide or financially support the provision of medical, social, educational, housing, or other related services (e.g., Medicaid, Veteran's benefits, the Special Supplemental Nutrition Assistance Program, Legal Aid).*

Outreach

Outreach workers meet individuals experiencing homelessness where they reside or spend time. Successful outreach involves relationship development, communication about needs, sometimes bringing services to individuals and/or persuading individuals to visit service providers. Outreach workers may be the first and only contact or connection with health services that an individual experiencing homelessness has.[7]

> *Outreach services are a broad range of culturally and linguistically appropriate activities focused on recruiting and retaining patients from the target population/service area. At a minimum, these services must promote awareness of the health center's services and support entry into care. These services do not involve direct patient care where a provider is generating a face-to-face visit with a patient, documenting the care in a patient medical record, or exercising clinical judgment in the provision of services to a patient.*

Transportation[8]

Even if a health center is located within just a few miles, lack of transportation can prevent an individual experiencing homelessness from accessing health care in both urban and rural areas.[9] The use of transportation—whether through rides to and from appointments, bus passes, cab vouchers or other methods—in connecting homeless individuals to care is a particularly helpful enabling service.

> *Transportation services are services that enable patients to access health center services when transportation would otherwise be a barrier to care (e.g., providing transport vans, bus tokens or vouchers for public transportation, or linkages to other community transportation programs).*

Language interpretation

Misunderstanding the types of services provided or specific instructions for care (e.g. taking medication as prescribed) can result in grave medical complications or death.[10] Title VI of the Civil Rights Act, ensures that no provider can discriminate based on race, color or national origin,[11] which reinforces the provision of language interpretation as an essential enabling service.

> *Translation services are services to make care linguistically accessible and culturally responsive for individuals with limited English proficiency and/or a disability impacting communication. At a minimum, these services includes the timely availability of professional translation (written) and interpretation (oral) services (e.g., access to bilingual providers, onsite interpreters, language telephone line) based on the primary language(s) spoken by a substantial number of individuals in the health center's target population and service area. These services also include auxiliary aids to ensure effective communication with individuals who have disabilities.*

Health education

Homelessness seriously complicates the opportunity to learn about and capacity to adhere to a regimen of self-care that benefits long-term health. Offering health education among other enabling services can improve knowledge, attitudes and skills and can lead individuals to make different, healthier choices.[12]

> *Health education services are a variety of learning experiences designed to help individuals improve their health. At a minimum, these services include education regarding the availability and appropriate use of health services. Services may include primary prevention and/or targeted education on self-managed care and other health promoting behaviors for patients with identified risk factors or conditions (e.g., tobacco cessation). These services may also include education on injury prevention and unique needs and risks of special populations (e.g., education to prevent common exposures experienced by migratory and/or seasonal agricultural workers).*

Supportive counseling

Mental health is a common concern among individuals experiencing homelessness. Serious conditions like schizophrenia, bipolar disorder, and major depression, are a common experience for individuals who experience homelessness.[13] Homelessness includes a high likelihood of experiencing traumatic events like assault and robbery, which makes homelessness itself a "chronic stressor."[14] Problems associated with substance abuse, whether independently or as a co-occurring disorder, are also prevalent among individuals surviving homelessness.[15] The attention and care provided through counseling can link individuals to health care and recovery.

> *Mental health services are the prevention, assessment, diagnosis, treatment/intervention, and follow-up of mental health conditions and disorders (e.g., depression, anxiety, attention deficit and disruptive behavior disorders) including care of patients with severe mental illness who have been stabilized. These services may include treatment and counseling for health center patients such as individual or group counseling/psychotherapy, cognitive-behavioral therapy or problem solving therapy, 24-hour crisis services, and case management services.* ***Psychiatry is considered a specialty service.***

Non-statutory Enabling Services

For the purposes of this project, NCAB included as additional enabling services several other commonly used services, the availability of which may help people experiencing homelessness connect to or utilize health care. These services are food, clothing, housing, laundry and shower services, mailbox, voicemail and telephone services, GED or education assistance, employment services, assistance managing money, medical respite services[16] and daycare or childcare. Each of these services addresses important determinants of health. But as with the statutorily defined services, access to these supportive services may help individuals who experience homelessness develop greater knowledge and awareness of health needs, and improved ability to address those needs, however indirectly.

The Role of Enabling Services

Enabling services play a central role in many of the evidence-based and emerging services in health care, including for individuals experiencing homelessness.

With the arrival of the Affordable Care Act and especially implementation of the Medicaid expansion in over half of the states and the District of Columbia in 2014, millions of previously uninsured Americans can now access health care. Enabling services can play a vital role in connecting the uninsured to insurance and the newly insured to care. The central aim of this CPO

report is to test the ability of enabling services in joining individuals experiencing homelessness to health care. The survey also considers which enabling services are most effective in that effort.

Enabling services can lead to more appropriate and cost-efficient health service utilization. A report by Hegner asserts that nearly 75% of expensive emergency room visits nationwide concern non-emergency conditions that could be more appropriately treated in a non-emergency setting.[17] For individuals experiencing homelessness, emergency department usage is 3 times higher than the general population.[18] One explanation of this disparity is that the need for primary care is overtaken by other basic needs, including shelter, food and safety,[19] and that individuals without established primary care relationships turn to emergency rooms when in distress. By design, emergency departments are not equipped to meet these or all of the psychosocial needs of individuals who are homeless. A health system that provides enabling services at the primary care level will theoretically manage care so that individuals make less use of emergency departments.

Chronic health conditions play a significant role in the lives of individuals experiencing homelessness: a Canadian study, for example, found that eight out of ten individuals experiencing homelessness also had at least one chronic health condition.[20] An analysis of health centers in HRSA's 2009 Health Center Patient Survey, including homeless and non-homeless patient data, demonstrated that individuals experiencing homelessness had a significantly higher likelihood of having two or more chronic health conditions (these included hypertension, diabetes, obstructive lung disease, heart problems or stroke, liver conditions of any kind, weak or failing kidneys, cancer and HIV/AIDS) than non-homeless patients.[21] As part of a coordinated effort to address chronic health conditions, enabling services—especially health education and case management—support the Chronic Care model's concepts of self-management and community resources.[22] One study revealed, for example, that diabetes self-management education improved psychosocial and clinical outcomes for patients with diabetes.[23] As part of its system design, Chronic Care management advocates for access to services that improve outcomes through case management for patients with complex needs.[24]

Provision of comprehensive care is a core component of the Patient Centered Medical Home (PCMH) model that assures care for clients with complex needs. This includes integration of physical and mental health care and social services. [25] The PCMH model involves several enabling services, including supportive counseling, health education and case management. Case managers are often integral to the care coordination and integration component of PCMH, especially as the complexity of patient needs increases.[26] Case managers assess social needs and family circumstances and incorporate services to meet these needs into the variety of services patients receive.[27]

Enabling services play a significant role in the success of Permanent Supportive Housing (PSH). The PSH model, an approach which has broad support as a solution to chronic homelessness,[28] starts with effective outreach and engagement services. The PSH model succeeds when tenants or potential tenants have formed partnerships with outreach workers and other providers who provide case management and other services once individuals are housed.[29] The CPO survey examined housing assistance itself as an enabling service that connects individuals experiencing homelessness to health care services. Permanent Supportive Housing provides housing stability and supportive services, which is associated with decreases in emergency room visits, inpatient hospital stays and use of residential mental health facilities for PSH residents.[30]

Methodology

Too often, individuals who experience homelessness have been excluded from decision-making processes, including decisions that directly impact their lives. Consistent with the human rights principles of the National Health Care for the Homeless Council (NHCHC), this research project was designed and conducted by people who have experienced homelessness.

The CPO survey is an annual project conducted by NCAB and NHCHC staff. NCAB members selected and committed to pursuing this particular topic. NCAB leaders and other currently and formerly homeless healthcare consumers participated in other stages of the survey process, including developing the survey instrument, piloting the survey, and survey implementation. Consumers from HCH grantees in six cities – Atlanta, Baltimore, Chicago, Cincinnati, Ft. Lauderdale and Houston – conducted this CPO survey. The NHCHC Research Team provided technical support throughout the survey process.

NHCHC staff and NCAB Steering Committee members comprised the team that carried out the CPO process as a whole. Once the topic was chosen, the team met to develop survey questions to examine the impact of enabling services, and to learn which services would make it more likely for individuals experiencing homelessness to access primary health care services. After initial survey questions were written, the instrument was tested with consumers at one HCH project, and a final survey instrument was adopted.

Consumers were recruited to administer the surveys and were trained through a webinar. The training began with a description of materials needed to conduct the survey and the importance of communicating with HCH staff to ensure project support of the survey process. Trainers recommended that surveyors carry lists of local resources (e.g. medical care, food pantries, housing,

etc.) to offer survey participants. The training asked each surveyor to collect at least 75 surveys and recommended locations where surveys could be conducted (e.g. HCH waiting rooms, soup kitchens, libraries). The training explained eligibility criteria – that participants be at least 18 years of age, able to understand survey instructions and currently homeless. Survey research basics were covered: confidentiality, a trauma-informed approach and informed consent.

The online training instructed surveyors to complete a Survey Monkey survey after watching the training to indicate completion of the training and knowledge of and familiarity with the training material. NHCHC staff reviewed the Survey Monkey responses and followed up with anyone who provided an incorrect answer. The training also encouraged surveyors to contact NHCHC staff for any trouble-shooting needs.

Initially, volunteers from nine cities were slated to participate in conducting the CPO survey – Atlanta, Baltimore, Cincinnati, Chicago, Ft. Lauderdale, Houston, Nashville, Salt Lake City and Worcester. Leaders from each of these cities viewed the training, either alone or with members of their respective Consumer Advisory Boards (CABs). In cases in which they viewed the training alone, leaders were instructed to share the information with fellow CAB members who would assist with conducting the survey. Having completed the training and with copies of surveys in their hands, the consumer volunteers began conducting surveys.

For various reasons, surveyors in three cities - Nashville, Salt Lake City and Worcester – were unable to conduct or complete the survey process. The remaining cities participated and contributed completed surveys for the CPO project. Surveyors reported the time it took to administer surveys ranged from ten to thirty minutes. In most cities, three or four volunteers conducted surveys, though Atlanta used nine. Volunteers visited individuals in soup kitchens, shelters, camp-sites, parks, street corners, clinic waiting rooms and under bridges, to conduct the surveys. According to surveyors, individuals who participated in the survey expressed happiness that the survey would support better access and that "someone was trying to break the barriers down"[31] to health care access. The final count of surveys received was 326; five were excluded because two were completed by respondents who were not homeless and three lacked the minimal number of answers required. This left 321 surveys for data analysis. Data were entered into SPSS, then cleaned to make sure information was coded consistently and accurately. National HCH Council research staff then analyzed both quantitative and qualitative data.

Results

A total of 321 individuals located in six cities completed the Enabling Services CPO survey. Consumer surveyors forwarded all completed surveys to the NHCHC office for data entry and analysis. Surveyors from Atlanta provided the largest share of surveys (73 or 23%).

Demographics

Table 1 presents the demographic data for the respondents of this survey. Males represented nearly 72% of the respondents and the median age was 47 years. Over half (58%) identified themselves as African American. Fifty percent were considered "chronically homeless", having experienced homelessness for more than one year.

TABLE 1 – Respondent Demographics

Characteristic	n	%
Gender		
Male	225	72
Female	87	28
Race/ethnicity		
African American	183	58
Caucasian/White	93	30
Hispanic/Latino	20	6
Multiracial	15	5
Asian/Asian American/Pacific Islander	3	1
Length of Homelessness		
Greater than 1 year	152	50
More than 6 months – less than 1 year	75	24
More than 1 month – less than 6 months	66	22
1 month or less	14	5

Current Health Status

Respondents described their general health status, the types of health problems they experienced, and areas in which they had recently received treatment. They then explained the barriers that prevented them from meeting their health care needs and the kinds of services they would like to receive.

The most common reported health status was "fair" health (36%). A third (32%) indicated being in "good" health and nearly a fifth (18%) reported a status of "poor" health. A much lower percentage (8% and 7%, respectively) indicated "very good" or "excellent" health status.

To describe health problems, survey participants were asked to select all types of conditions that applied to them (see Table 2). Among five different areas of health problems and the option of "none of the above," over half of respondents reported having medical problems (52%). Nearly half selected dental (49%) and over forty percent (43%) identified vision as a health issue. Many responses (39%) represented comorbidity, including more than one of the following conditions: medical, mental/emotional, substance abuse/addiction.

Table 2 also represents the areas in which respondents had received treatment. (Some respondents indicated having received treatment for health conditions for which they had not mentioned problems. Only responses that corresponded with answers to the question about health problems were included.) Most individuals who reported health problems indicated they had received care for medical needs over the past year. Almost as many had received treatment for mental health concerns and over half had obtained treatment for substance use/addiction problems. Notably, a fifth of respondents reportedly had not received treatment for any health conditions. Less than a third of individuals reporting dental problems had received dental care and though a large percentage reported problems with vision, only 38% of those reported having received treatment.

TABLE 2 – Reported Health Problems

Health Problem Type	Health Problems		Received Treatment	
	n	%	n	%*
Medical	167	52	132	79
Dental	156	49	47	30

Vision	139	43	53	38
Mental	136	43	96	71
Substance Use/Addiction	105	33	55	52
None of the above	34	11	n/a	n/a
Not currently receiving treatment for any	n/a	n/a	57	20
More than one of the above**	124		39	

* represents percentage of individuals who received treatment for reported health problems

**39% of respondents reported experiencing comorbidity of two or more of the following types of health problems: medical, mental/emotional, substance abuse/addiction.

Using a qualitative, open-ended question format, individuals provided reasons for not having received treatment in the past year. Of the 155 responses to this question, half cited financial limitations as the main reason for not receiving treatment, (49% indicated that they did not have the money to pay for services or their co-pay and 51% indicated lack of insurance). Eighteen percent of responses were related to "self" as a perceived barrier ("too stubborn," "not making care a priority," or that a drug addiction did not allow them to get to a provider). Seventeen percent of respondents indicated they were in the process of seeking care, but that they were having difficulty with appointments (statements related to long waits, being currently on a wait list for care, being unable to make appointments or "going through the system"). There were several other mentions (11%) related to lack of access to transportation or money to ride the bus as a reason for not receiving care in the past year.

Respondents described types of health services they would like to receive, but which they are not receiving currently. This was also an open-ended question. Of the 194 responses, the majority (57%) mentioned dental care as a priority. Almost half (48%) indicated a desire for medical care. Sixty-nine individuals (44%) included vision as a type of service they would like to receive. Mental health (18%) and substance use/addiction (11.6%) followed the other types of services. Notably, a few respondents mentioned housing (8%) as a desired "health service."

Table 3 shows the facilities respondents most often used to obtain health care services or treatment. Of the 274 individuals who responded, the largest proportion indicated they visit a clinic that specifically serves people experiencing homelessness. Some individuals visited a public health clinic/health department facility (16%), several indicated "emergency room" (15%), and a similar number (15%) lack a usual source of health care.

TABLE 3 – Usual Source of Care

Health Care Facility	Frequency	Percentage
Clinic specifically for people experiencing homelessness	97	35
Public Health Clinic/Health Department	44	16
Emergency Room	42	15
Hospital Outpatient Clinic	10	4
VA Hospital	9	3
Other Community Health Center or Clinic	8	3
Private Doctor's Office	7	3
Other	16	6
Don't have a usual place to go	41	15

Type of Insurance

Respondents identified which type of insurance they had. Over half reported not having insurance of any kind (53% - see table 4 below). 17% reported they were enrolled in Medicaid. 14% reported enrollment in other state or local health programs. Responses in the "Other" category (31) were allocated to two main areas: Clinic Financial Assistance (20) and Managed Care Organizations (5). Clinic Financial Assistance insurance benefits mentioned were "w-72," "w-80," "w-20" or "MOPED" (Medical Options for Patient Eligibility Department). Managed Care Organizations mentioned included BCBS and Molina Medicaid Solutions, United Health Care and Coventry. Six other comments could not be categorized, such as AARP, and "medical card".

TABLE 4 – Insurance Type

Insurance Type	Frequency	Percentage
None	168	53
Medicaid	54	17
HFS Medicaid – Illinois (1)		
Ohio Medicaid Program- ODJFS (1)		
Amerigroup Community Care (3)		
United Health Community Plan (1)		
Jai Medical System (1)		

Maryland Physicians Care (2)		
Priority Partners (1)		
Bravo Health (1)		
Other (3)		
Other state/local health program	45	14
Texas Gold Card (26)		
PAC (6)		
County Care Medicaid Program (1)		
Buckeye Community Health Plan (1)		
Other	31	10
Medicare	19	6
Veterans benefits	12	4
Don't know	4	1
Private	3	1

Enabling Services Received

Out of a list of nineteen (see Table 5) services, survey participants were asked to indicate which ones they had received while experiencing homelessness. More than any other, respondents listed food assistance as a service they accessed. Next, individuals selected clothing assistance and laundry and shower services. Nearly as many individuals indicated case-management was a service they accessed while experiencing homelessness.

TABLE 5 – Enabling Services and other Supportive Services

Service Type	Frequency	Percentage
Food assistance	230	72
Clothing assistance	167	52
Laundry and shower services	139	43
Case management	135	42
Outreach	105	33
Housing assistance	95	30
Mailbox services	95	30
Voicemail services/telephone	91	28
Assistance applying for benefits	87	27
Transportation	87	27
Supportive counseling	79	25
Health education	76	24
Employment services/job training	42	13
GED or education assistance	27	8
Assistance managing money	20	6
Respite services	10	3
Language interpretation	4	1
Daycare/childcare	3	1
Other	5	2

Note: Only (n=1) valid "other" response mentioned: "legal assistance"

The survey asked individuals if the enabling services they received allowed them to access care they had previously been unable to receive. For 177 (65%) out of 274 respondents, enabling services did help with access to care, 82 (30%) indicated enabling services were not helpful and 15 (6%) did not know.

Next, in an open-ended question format, survey participants reported one example of a health related problem that improved because they used enabling services. The responses are categorized under the following five headings.

General health improvement: Of 115 answers, 76 (66%) were related to general health improvements, a term used here to describe different areas of health (disease control: diabetes and hypertension; pain control: arthritis and other pain being controlled by medication or other treatment; medicine for a health condition, including mental health; improved nutritional choices).

Assistance with services: Twenty-five respondents (22%) mentioned their health improved due to an increased knowledge of services that would improve their health– food services were mentioned most often and the majority of these individuals indicated that they learned about the services through a local church. Assistance with benefits most often related to receiving needed benefits such as Medicaid/Medicare and Food stamps.

Mental Health/Substance Abuse Treatment: twenty-three (20%) individuals included comments related to the ability to go see/talk to a counselor, receive medication to control mood/disorders, attending sobriety meetings and being able to remain clean.

Housing: eleven (10%) individuals mentioned housing, indicating that housing was needed "in order for health to get better."

Dental/Vision: ten (9%) respondents indicated an ability to receive needed dental treatment or obtain "new teeth." In the area of vision, nine respondents reported receiving an eye exam and/ or obtaining glasses, which improved their vision.

Most Important Enabling Services

Survey participants were asked which enabling services (as listed in Table 5) were most important to accessing needed health services. Of the 203 individuals that responded to this question, almost half (49%) designated food assistance as useful in obtaining health services. Nearly the same amount of respondents (48%) listed case management as an important enabling service. Housing assistance was the third most frequently listed most important enabling service (31%).

Finally, respondents had the opportunity describe other kinds of enabling services that could improve their health and access to health services. The 200 answers to this open-ended question are categorized as follows:

Case Management: There were 64 responses that were related to help in accessing different areas of health, including dental, vision, or medical assistance. Also noteworthy was the need for help in

making appointments or obtaining "easier" or "faster" access to care. Access to physical fitness was mentioned to address health issues, as well as a need to obtain health education related to nutrition.

- Housing: 58 respondents expressed an interest in a stable place to reside.

- Transportation assistance: 46 respondents reported the need for transportation to get around, particularly with bus passes, or transit cards to get to appointments.

- Employment services or job training: 27 respondents identified an interest in receiving support for job preparation or finding a job.

- Benefits assistance: 22 respondents mentioned the need for assistance in obtaining health insurance and disability benefits. Food-related assistance was also mentioned.

- Assistance Center: 10 respondents were interested in learning about all enabling services and finding one central location to access all of them.

- Counseling services: 5 respondents expressed an interest in counseling or therapy to manage depression/mood disorders.

- Education assistance: 4 respondents were interested in learning how to speak English, use computers and other topics.

- Outreach: 2 respondents were interested in outreach, but provided limited descriptive information.

- Other: 13 respondents commented on additional enabling services ideas. These included time-management, stress management, money management and obtaining identification.

Discussion

This survey sought to illuminate enabling services utilization, health status, unmet health care needs, self-reported barriers to care and the perceived benefits and importance of enabling and other supportive services. This perspective is vital as the perceptions and attitudes of consumers will impact the effectiveness of services and should guide the delivery of those services.

Poor health, access and barriers to care

The results of this survey confirm what has been known through previous studies for some time: individuals experiencing homelessness are in poorer health compared to their housed counterparts.[32,33,34] Over half of respondents reported poor or fair health (54%) and very few reported very good or excellent health (14%). Additionally, substantial portions reported various types of health problems, likely with a significant amount of comorbidity. This is no surprise, as the experience of homelessness causes poor health and poor health is often a cause of homelessness in the first place. Illness or injury can often lead to job loss, loss of health insurance, significant financial burdens, and ultimately homelessness. Moreover, once homeless, individuals often face exposure to the elements, threats of violence, inadequate nutrition, and tremendous stress, all of which can lead to physical and mental health conditions.

In terms of access, respondents reported less than universal access for medical and mental health problems, with over one-fifth of those with such problems not accessing treatment. Access was even less for those with substance abuse problems, with only half accessing needed substance abuse treatment. The disparity between medical/mental health and substance abuse treatment may be due to low motivation to seek substance abuse treatment, as personal readiness to seek treatment was reported as a barrier a number of times.

Vision and dental services are still less accessible, with only 38% and 30% respectively receiving treatment for needed vision or dental problems. Respondents frequently reported a desire to obtain dental care (57%) and vision care (45%) as well.

In assessing why respondents did not always obtain needed treatment, many barriers are evident. Over 50% reported that they were uninsured, a measurement that nears 60% when including those who reported 'financial assistance from a clinic' as their source of insurance. This is consistent with the 62% homeless uninsured rate shown in Uniform Data System that tracks HCH and other health center data.[35] This lack of insurance and the financial security it can provide coincides with the respondents' most common reason for not seeking care: financial difficulties. Expanding insurance coverage as well as ensuring that safety net policies and insurance policies limit or eliminate cost-sharing requirements could address this barrier to care. Increased provision of benefits enrollment, in jurisdictions where appropriate benefits exist, is advisable.

Difficulties accessing care due to problems making appointments, long wait lists or lack of transportation made up another significant portion of responses. These responses coincide with

research done on barriers to care that individuals experiencing homelessness face.[36,37] These responses seem to indicate an expansion of enabling services, to assist with system navigation and transportation, as well as an expansion of safety net providers to reduce wait times would be helpful. These responses may also indicate that for many who are experiencing homelessness, health care is not their top priority and competing needs such as food and shelter make finding the time and resources needed to attend appointments difficult.

Opportunities and limitations of the ACA

States choosing to participate in Medicaid expansion are expecting to see significant increases in insurance coverage.[38] This should expand access by addressing some, though not all, of the financial barriers faced by individuals experiencing homelessness. [39] Medicaid coverage often still requires different forms of cost-sharing and a substantial body of research shows copays and premiums can act as a barrier to accessing care for low-income people. [40] States using Section 1115 waivers to expand Medicaid have also sought and in some cases obtained approval to charge copays and premiums even to those below the poverty line.[41,42,43]

Furthermore, states' decisions to participate in the expansion do not guarantee access. Those currently uninsured have considerable difficulty navigating the health care and health insurance enrollment systems.[44] In-person assistance has been shown to be most effective for many, so continuing enrollment assistance, itself an enabling service, is critical.[45]

Medicaid also is not required to provide all needed benefits. Adult dental and case management are two benefits respondents needed most and Medicaid coverage will not necessarily improve access to these services. For adult dental in particular, benefits have been limited and further reduced in recent years. A recent survey showed 23 states offer no adult dental benefits or only emergency benefits.[46] Since the economic downturn, several states have moved to limit adult benefits even more or eliminate them completely.[47] This is especially problematic considering the prevalence of dental problems among individuals experiencing homelessness.[48]

The ACA will have little impact on the barriers to care respondents reported if they reside in states not participating in Medicaid expansion. This is unfortunate as many of the states currently not participating in Medicaid expansion have higher rates of uninsurance and greater physician shortages than states choosing to participate.[49,50] They also have some of the lowest mental health spending per capita, with states like Texas, Louisiana, and Florida spending less than $75 per resident on state-funded mental health treatment.[51] Moreover, many of these same states have drastically cut mental health funding in recent years, with South Carolina, Alabama, and Alaska all

cutting mental health funding over 30% from 2009-2012.[52] In states that have not expanded Medicaid, health centers will be even more critical venues of care for those remaining uninsured.

Enabling services and improved health care access

Enabling services appear to be generally helpful in obtaining care respondents were previously unable to access. Two-thirds (65%) reported as much and qualitative responses about how enabling services improved access to health and other services included improved management of chronic conditions, improved nutrition, improved access to medications, improved access to referrals, and an increased awareness of available community services. These qualitative responses show improved access, education, and coordination that are likely to improve health outcomes.

The three most common services received were food assistance (72%), clothing assistance (52%), and laundry/shower services (43%). The prevalence of food assistance is encouraging, but it is unclear to what degree it contributes to good nutrition as many food pantries and soup kitchens serve foods high in sugars, fats, and carbohydrates. Clothing assistance, laundry, and shower services are helpful in improving hygiene and sanitation for those experiencing homelessness. These services are critical to provide basic material needs, but they do not necessarily facilitate access to other health care services.

Statutory enabling services including case management, benefits enrollment, outreach, transportation, language interpretation, health education and supportive counselling were all accessed by respondents with less frequency, with case management (42%) and outreach (33%) being most frequently identified. Transportation, health education, and assistance applying for benefits were in the 20% to 30% range. Few respondents indicated receiving language interpretation. Because the survey was offered in English only, responses are not reflective of a broader, linguistically diverse homeless population. The fact that one third of respondents received outreach, assistance with applying for benefits, transportation assistance, or health education and less than half received case management is a concern, in that these are essential services for all Health Centers. Not all respondents received services at HCH projects though, so perhaps these services would be more widely accessed if more participants were connected to HCH grantees.

The total number of enabling services received by respondents was rather low: approximately one quarter received less than three of the 18 listed, half received less than four, and three quarters received less than six. It is possible that many people primarily receive services providing basic material needs and few services facilitating their access to health services. This is concerning considering the barriers to accessing health care services which many people experiencing homelessness face.

Critical enabling services need to be more widely available

One noteworthy enabling service is outreach, which is critical to reaching harder to engage individuals who have often spent more time homeless and likely have more serious health conditions.[53] Individuals experiencing homelessness have often endured negative experiences with the human service system and service providers, as well as numerous other traumatic experiences that damage one's capacity to trust others. Having professionals spend the time and effort to engage those on the street is an essential component of homeless services. Expanding outreach services would be beneficial, especially given the importance of outreach in enrolling homeless individuals in the ACA Medicaid expansion.

The relative lack of outreach services is also problematic when considering reported usual sources of care. A high rate of respondents reported their usual source of care was either the ER (15%) or that they had no usual source of care (15%). Outreach services could assist these individuals in identifying a reliable source of primary care, which would allow better care coordination and the development of a relationship with a provider. Using the ER as a regular source of care is also very expensive for the health system generally. It is also noteworthy that these findings differ with findings from the previous National HCH Council CPO, Within Reach, which found that about half of respondents had been approached by an outreach worker.[54] This may be because the Within Reach study was conducted in the community at sites that outreach workers are likely to frequent.

Other helpful services include those that provide educational and other life skills training such as job training, GED attainment, and assistance managing money. These services were rare, with 13%, 8%, and 6% of respondents reporting receiving these respectively. This is disconcerting since these are the types of services that can help individuals experiencing homelessness ultimately achieve stability and economic independence.

Housing and case management services among most requested

Responses outlining the importance of different services demonstrate that meeting basic needs is a priority for consumers. When ranking the three most important enabling and supportive services, food assistance was identified by about half of respondents, followed closely by case management. Assistance with housing, clothing, and benefits were all identified by over 20% of respondents. This emphasis on basic needs shows basic survival is a challenge for those experiencing homelessness and also illuminates the potential difficulty some may have in focusing on health care needs.

Assistance with housing was consistently identified as important throughout the survey; it was even written in for certain questions where the option was not offered. Homelessness is fundamentally a housing problem, and few services will be fully effective if stable housing is not obtained. Housing was reported as one of the most important enabling services 31% of the time and was the second most commonly requested enabling or support service. Homeless health care providers are well aware of the importance of housing, but unfortunately affordable housing stock has been declining for decades. New investment in affordable housing is required to better provide housing assistance for those in need.

Case management was also frequently requested and highlighted as important. For individuals with multiple health problems and complex social needs, it is critical to have professional assistance in coordinating various treatments and navigating different human service systems. It is not surprising, therefore, that respondents placed a priority on case management. Case management is infrequently reimbursed by third-party payers and despite the need, case management is not a mandated service under Medicaid.

Expanding enabling and support services that reduce homelessness

Case management and housing assistance are essential for certain treatment models such as Assertive Community Treatment (ACT) and Permanent Supportive Housing (PSH) that serve especially vulnerable individuals experiencing homeless.[55] The fact that case management and housing, the two basic services of PSH, were the two most commonly requested services is interesting and demonstrates considerable unmet need for these services.

The general disparity between the most common and most important enabling and support services is one of the most substantive takeaways from the survey. Food, clothing, shower, and laundry services were the most common but food, housing, and case management were seen as the most important. Additionally, case management, housing, and transportation were the most requested. This information should guide funders and program managers to offer or expand these types of services that generally support stable housing.

Survey limitations

One significant limitation of the survey was the number of respondents. Several locations who initially indicated they would participate were ultimately unable to conduct the survey. The results are therefore not statistically significant and not generalizable. The survey locations were also all located in major metropolitan areas and the respondents were mostly men who had been homeless over one year. This subset of individuals experiencing homelessness may value different services than others. For instance, those homeless for a shorter time may value job training or

educational services more because they may have been more recently connected to the job market.

Definitions of types of health insurance and sources of care also proved a limitation. Each community employs different names for various clinics and those accessing these clinics are often unfamiliar with whether a particular clinic is an HCH project, a community health center, or some other type of public clinic. Similarly, Medicaid and other types of insurance frequently have different names and the exact public program funding the coverage may not be known by recipients.

A similar issue with defining enabling and support services themselves limits these results to some degree. It was challenging to define case management, respite services, or outreach succinctly yet accurately. Surveyors provided short descriptions upon request, but some confusion may have occurred. The similarity of case management and assistance applying for benefits may also explain the rather low priority respondents placed on assistance with benefits, as this is a central service provided through case management.

Conclusion

Individuals experiencing homelessness and the medically disenfranchised generally face significant barriers to accessing appropriate health care services. The Health Center model, however, provides significant opportunity – through enabling services – to overcome these barriers and open a door to improved health, social stability and housing. As the Health Center program expands with direct support from the Affordable Care Act, and as states adopt Medicaid expansions that will improve both Health Center funding and consumers' access to care, the prospects for reducing homelessness are increased. It is important in this context that Health Centers recognize the disparity between services accessed and services requested that this research reveals. As new resources are secured, program administrators should consider:

- Designing appointment systems that minimize difficulties, wait times, and system navigation challenges.
- Improving access to permanent supportive housing and the housing support and case management on which the model relies.
- Continuing food, shower, and other services that provide immediate needs but also promoting services that can improve future financial independence such as job training, GED services, and access to benefits.

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