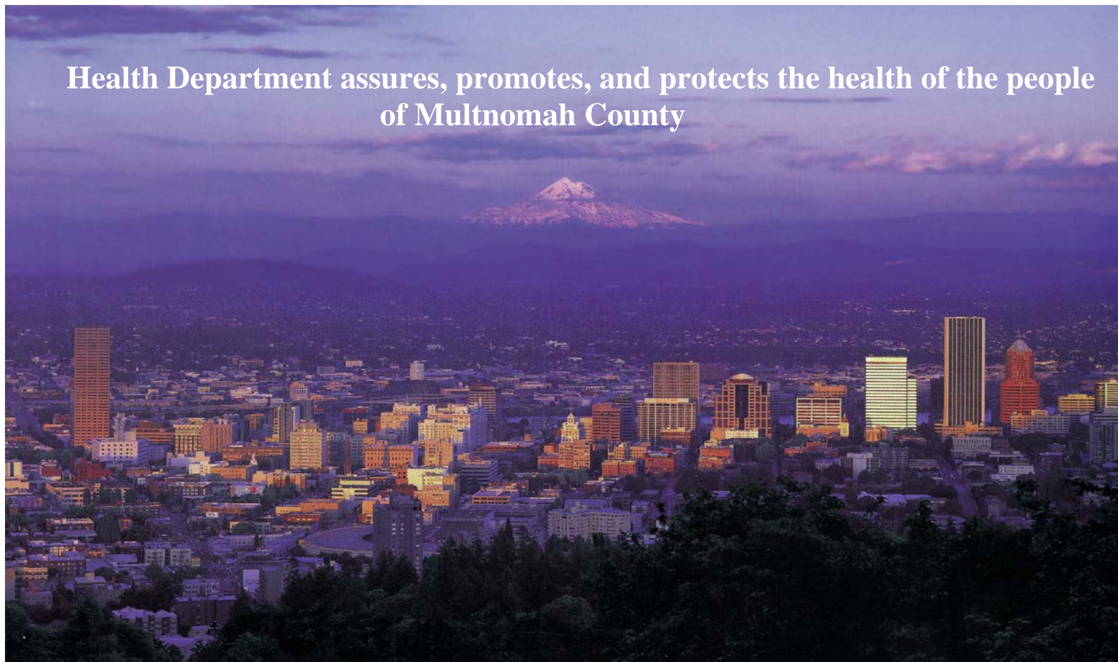
Health Care for the Homeless Inventory

Integration of Health Care Services with Portland's 10-Year Plan to End Homelessness

Written by Todd Guren, *Program Manager, Multnomah County Health Department*
March 2006



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Dear Colleagues,

Health care services are an important aspect of Portland's 10 Year Plan to End Homelessness. The Multnomah County Health Department developed a Health Care for the Homeless Inventory to show the role and contributions of all health care organizations and conduct a gap analysis to identify areas where additional resources will have the greatest impact.

Specifically, this inventory describes:

- Roles of health care organizations
- Population served
- Services provided
- Access to care
- Gaps
- Support of 5 of the 9 Actions to End Homelessness

The focus is medical care but also includes dental services, mental health, and addictions treatment. Five organizations, Multnomah County Health Department's La Clinica de Buena Salud and Westside Health Center (WHC), Central City Concern, Outside In, and Native American Rehabilitation Association (NARA), receive federal grant funding for health care for the homeless and serve an estimated 57-60% of the homeless population. These organizations form partnerships, coordinate services to prevent duplication, and have integrated health care into other programs for the homeless. The analysis in the inventory shows how Westside is a hub for medical care through its comprehensive range of services, outreach, and partnerships with other organizations.

This inventory also shows the gaps in health care services. They represent areas that are both in greatest need of additional resources and would provide the best outcomes in terms of improvements in the health care for the homeless delivery system.

- **Dental Services:** There is no downtown dental provider for the homeless and Northwest Medical Team's dental van mainly offers emergency services.
- **Medications:** NARA and WHC are the only organizations that have full-service pharmacies. Clients, especially those with chronic diseases, are given prescriptions but are often not able to fill them.
- **Respite Beds:** When clients are discharged from hospitals, they often have nowhere stable that they can go to recuperate and receive follow-up care so they won't have to be readmitted. Chronically homeless are more likely to be hospitalized and need respite beds after the hospitalization.
- **Mental Health for the Uninsured:** There is a high prevalence of mental illness in the homeless population and it is difficult to get services without insurance.

- **Specialty Care:** Doctors Offering Community Service (DOCS) is the only consistent option for specialty services and that is done on a volunteer basis by specialists. However it includes only 2.9% of the specialists in the Portland Metro Area (45 volunteers out of a total of 1,540[1] specialists).

Summary: Access is an important factor since there are a limited number of appointment slots. Case workers and clients need to contact multiple health care organizations until they find an open appointment. There can be barriers around transportation and extensive documentation is required for discounted or free specialty services at hospitals. The ability to centralize and coordinate available appointments and services could facilitate access and clients and case workers would spend less time searching for open appointments.

Despite the gaps and barriers, health care organizations have aligned their resources towards meeting objectives to prevent the discharge of people into homelessness, improve outreach to the homeless, increase the supply of permanent supportive housing, increase economic opportunity, and create innovative new partnerships to end homelessness. Some specific accomplishments include Central City Concern and WHC's Community Engagement Program which provides medical care, behavioral health treatment, and supportive housing for 100 chronically homeless and high utilizers. The dollar value of the supportive services is leveraged for Shelter Plus Care funds.

A recent accomplishment is that WHC received a federal grant to fund a medical van. This medical van will bring a range of health care services to the sites of community organizations that provide services and housing for homeless families and individuals. These community organizations will also be able to leverage the health care services for Shelter Plus Care funds. Additionally, they can apply for additional grants because with the medical van they can show potential funders that they can provide a continuum of care for clients.

We hope this inventory and review will help our community plan and coordinate service as well as spark ideas and solutions that may result in better and appropriate care for the most vulnerable in our community.

Sincerely,

Lillian M. Shirley, RN, MPH, MPA
Director

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[1] Source: 2003 MGMA data

Health Care for the Homeless Inventory

Introduction: In November 2005, two articles were published in the Los Angeles Times about health care services for the homeless. The first article titled, *"Health Officials Puzzled at Rise in Hepatitis A"* described how an outbreak of hepatitis A that started in the homeless population had spread. Reported hepatitis cases in LA have increased fourfold in the last month. The second article, *"Hospitals Acknowledge Taking Homeless Patients to Downtown Los Angeles,"* describes how Los Angeles officials are addressing the potential suburban hospital practice of "dumping" homeless patients in the downtown area after treatment.

These articles show the potential public health issues that can develop when there are not health care services in place for homeless clients. It also shows what can happen when there is not a continuum of care in place, such as discharge options for hospitals. Homeless clients that are discharged after treatment will likely become ill again; continuing a cycle where plans are only developed after the situation has developed into a crisis.

In December 2004, a 10-year plan was developed to end homelessness in Portland and Multnomah County. The plan is built on the principles of focusing on the most chronically homeless populations, streamlining access to existing services to prevent and reduce other homelessness, and concentrate resources on programs that offer measurable results. As demonstrated by the articles above, health care services are a key component of the plan to end homelessness.

Five community health centers in Portland, which include Multnomah County Health Department's Westside Health Center and La Clinica de Buena Salud, Outside In, Central City Concern's Old Town Clinic, and Native American Rehabilitation Association, receive health care for the homeless grant funding and other safety net clinics provide health care services. These clinics form a continuum of care that is integrated with 5 of the 9 actions to end homelessness. Specifically, they prevent the discharge of people into homelessness, improve outreach to the homeless, increase the supply of permanent supportive housing, increase economic opportunity, and have created innovative new partnerships to end homelessness.

Number of Homeless in Multnomah County: Accurately determining the number of homeless is difficult with potential underreporting and different definitions of homelessness. The methodologies used for counting the numbers of homeless are detailed below:

One Night Count: According to the latest One Night Street and Shelter counts that Portland's Bureau of Housing and Community Development (BHCD) and JOIN coordinate, there were 4,879 homeless individuals in shelters or on the street in Multnomah County. There might be some overlap between the Shelter and Street counts, but it would be slight. The Street count and Shelter count are used to express the total number of persons who experience homelessness on any given night, which is the source

of 4,000 persons who experience homelessness on any given night in Portland.[1] However, the latest Street and Shelter counts included all of Multnomah County so the current number is higher.

The numbers from these counts use the federal Housing and Urban Development (HUD) definition for homelessness which is also used by recipients of McKinney grant funds. Specifically, this definition is *an individual who lacks a fixed, regular, and adequate nighttime residence or who has a primary nighttime residence that is a temporary shelter, is an institution, is not designed or intended to be used for regular sleeping accommodations.* This federal definition does not include individuals who are "doubling up" or are being housed by friends and family members.

Methodology for Counting Homeless Families using the School Count:[2] The School Count is another method that is used to include homeless families who do not usually access shelters. They are more likely to be doubled up with other families or living in motels. The School Count uses the Health Resources and Services Administration (HRSA) definitions for homelessness which defines individuals who are "doubled up" or being housed by friends and family members as homeless. Homeless families are possibly underreported by organizations that use the HUD definition.

The Multnomah County Educational Service District began collecting data on homeless students for the 2003-04 school year from seven school districts in the county. The total count was 2,684 homeless students but this was understood to be an underreport since there were some problems in implementing the survey.

The methodology for using the School Count to determine the number of homeless family members is as follows: According to the public policy report issued by the National Center on Family Homelessness in 2003, *Homeless Children: America's New Outcasts*, 20% of school-aged homeless children are not enrolled in school.[3] Therefore, since 2,684 students represent 80% of the total homeless, school-aged youth, it is calculated that the total is 3,355.

According to the One Night Shelter Count, 40% of all children in shelters are less than 5 years old. The previous number of 3,355 homeless school aged children represents 60% of total homeless children. Therefore, the total number of homeless children in Multnomah County is 5,592.

Assuming there is an average of 2 children per family, than there are at least 2,796 adults living with the homeless children. Therefore, the total number of people living in homeless families that include children less than 18 years old in Multnomah County is at least **8,388** (2,796 adults + 5,592 children).

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[1] *10-Year Plan to End Homelessness - Action Plan,* Citizens Commission on Homelessness
[2] Developed by the Coalition for Homeless Families
[3] www.familyhomelessness.org

Annualized Count: This is based on the Multnomah County and Portland databases that track clients who access services. BHCD compiles the annualized counts, which have been typically been between 16,000-18,000. However, the last annualized count was 18,000-19,000. In 2004, BHCD estimated that there were 1,600[4] chronically homeless individuals. This count uses the HUD definition.

According to a survey filled out by BHCD for the 2005 U.S. Conference of Mayors Conference, there are 19,102 homeless individuals. However, the annualized count is typically expressed as a range because of difficulties with determining the exact number of homeless. BHCD's methodology for the annualized count is a summation of the persons served by the four homeless systems. There may be some duplication across systems until a regional Homeless Management Information System (HMIS) is implemented. It is likely to be an undercount due to the number of persons who seek but are unable to access services.

Number of Homeless Served by Health Care Providers: Federally Qualified Health Centers (FQHC) use the HRSA definition, which defines individuals who are "doubled up" or being housed by friends and family members as homeless. Therefore, it is important to note that a different definition for homeless is used for HUD-funded organizations and HRSA-funded organizations.

Homeless clients are served by the Multnomah County Health Department's Westside Health Center (WHC) and La Clinica de Buena Salud, Outside In, Central City Concern (CCC), and Native American Rehabilitation Association (NARA), who receive health care for the homeless grant funding. This funding is from the Bureau of Primary Health Care. While WHC provides comprehensive medical services to clients of all ages, each of the other clinics have their own niche for services and clients.

- **MCHD La Clinica**: Focuses on homeless children and families, Latinos, and the Cully neighborhood where it is located. Through MCHD's other sites, it has access to medications, lab, diagnostic services, WIC, and dental services.
- **Outside In**: Focuses on homeless youth but does see adults. The bulk of their services are naturopathic, acupuncture, and National College of Naturopathic Medicine provides services at Outside In. It provides extensive outreach and also has a medical van.
- **CCC**: Focuses on supportive housing, behavioral health, and addictions treatment for adults. It provides comprehensive primary care services through Old Town Clinic and acupuncture, behavioral health, and other related services through Portland Alternative Health Clinic.
- **NARA**: Focuses on Native Americans, those who identify themselves as Native Americans, or family members of established clients. NARA provides a comprehensive range of primary care services, a pharmacy, behavioral health, and residential alcohol and drug treatment.

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[4] *10-Year Plan to End Homelessness- Action Plan,* Citizens Commission on Homelessness

- **MCHD WHC**: Provides comprehensive primary care and behavioral health services for children, youth, adults, and families. In addition to the downtown location, WHC has satellite clinics at St. Francis Dining Hall, New Avenues for Youth, and provides outreach nursing staff at shelters and other outreach locations. WHC has diagnostic services, mental health, addictions treatment through contracts, a pharmacy, and access to MCHD dental services and WIC. Finally, a medical van will start in June that will provide outreach and medical services to families at homeless service sites.

These clinics work together to ensure that health care is integrated with other organizations and there is not a duplication of services. Below is a table that shows the number and characteristics of clients who access health care services from the 5 health centers listed above. The source of this data is the Uniform Data System (UDS) which is used by HRSA to collect data from FQHCs.

Setting of Homeless Clients Served at MCHD La Clinica, MCHD WHC, CCC, Outside In, and NARA (2004)[5]	
Clients who are in shelters	2,532
Clients who are in transitional housing	1,727
Clients who are doubling up	3,760
Clients who are on the street	2,032
Other	1,604
Unknown	2,900
Total homeless clients served	***14,555***

The 3,760 clients who are "doubling up" represent 25.8% of total homeless clients served who are not counted in the street or shelter counts. If the HUD definition was used for health care services for the homeless, 10,795 homeless clients would have received care in 2004. Comparing the 10,795 clients to the last annualized count of 18,000-19,000, it can be estimated that between 57-60% of homeless people in Multnomah County received health care services from these main providers. This is an estimate due to potential underreporting and the number of homeless clients in the "unknown" category.

The table below shows the type of health care services accessed in 2004 at the same 5 clinics.[6] Other professional services include a visit with provider that doesn't fit into the other categories, such as an acupuncturist, chiropractor, physical therapist, herbalist, etc. Enabling services includes case managers, educational specialists, etc.

[5] UDS: Uniform Data System used by HRSA to collect data from FQHCs
[6] ibid

Percent of Total Homeless Encounters that were	Total
Medical	26.7%
Dental	0.1%
Mental Health	8.6%
Substance Abuse	23.6%
Other Professional Services	31.9%
Enabling Services	9.1%
Total	100.0%

Only 0.1% of encounters were dental visits which does underscore the lack of dental services for homeless persons. However, only 1 of the 5 clinics had recorded any dental encounters in their UDS reports so this might be reflective of how data is captured.

The following table shows the age and gender of homeless clients served in 2004 at the same 5 clinics.[7] A little more than half are males age 20-64.

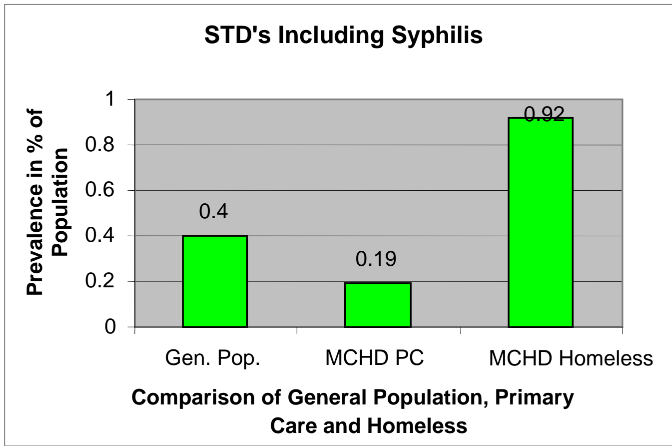
Age and Gender	Male	Female	Total
Age 0 - 19	3.9%	5.0%	8.9%
Age 20 - 64	51.1%	38.1%	89.2%
Age 65+	1.1%	0.8%	1.9%
Total	56.1%	43.9%	100.0%

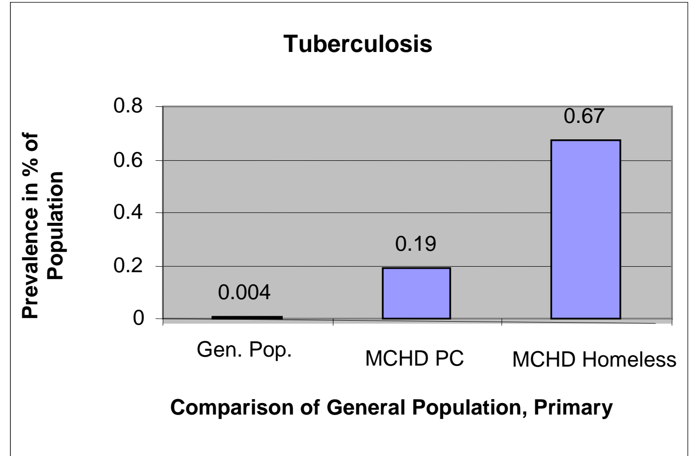
Health Disparities: When compared to the general population, Multnomah County's homeless population faces numerous health issues and substantial barriers to health services. Homeless residents in Multnomah County are disproportionately affected by infectious disease, mental health and behavior problems, lack of proper nutrition, oral health disease, lack of immunizations, substance abuse, unintentional injury, complications related to HIV/AIDS/STDs, asthma, and respiratory infection.

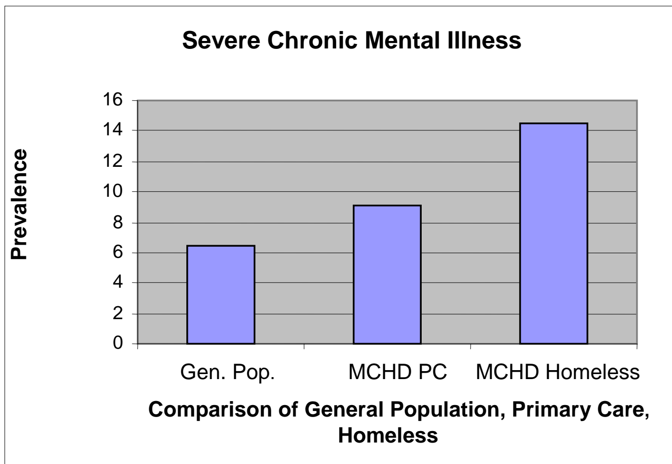
The data presented in the graphs below from the Health Department's Westside Health Center for homeless clients as compared to the Health Department's general client population indicates that there is a greater need for chronic disease management, mental health care, substance abuse treatment, and certain types of acute care services for homeless persons (as compared to the overall client population).[8]

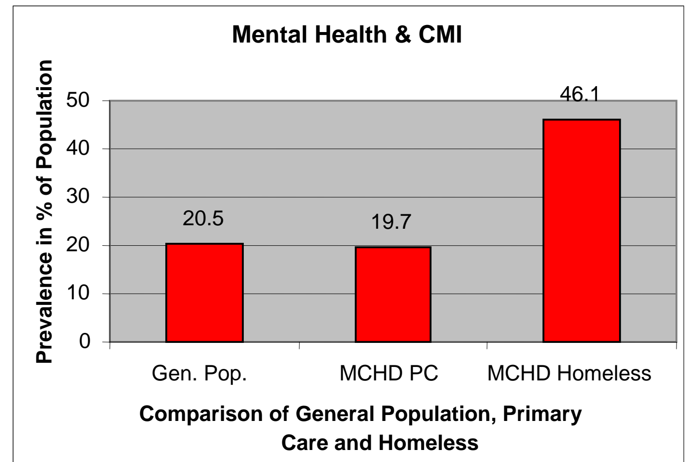
[7] ibid
[8] Compiled by Kim Tierney, Program Manager of MCHD Westside Health Center

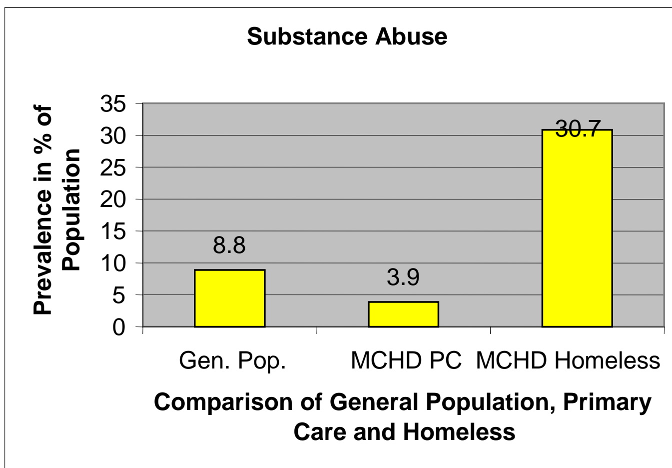
Health Disparities:

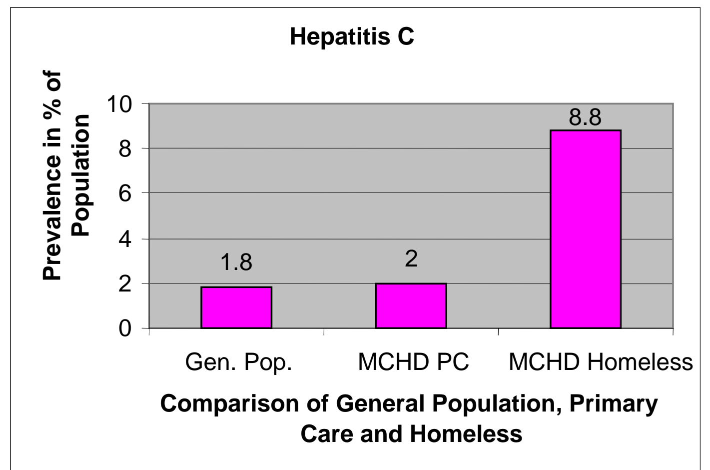












The following table shows the rate of chronic diseases among the clients at the same clinics mentioned above in 2004.[9]

Chronic Disease: Percent of Homeless clients	Total
Hypertension	7.2%
Asthma	3.0%
Diabetes	4.2%
HIV	1.9%

The rate of diabetes in Oregon in 2005 was 6%. Since studies show that diabetes is higher in the homeless populations, the fact that only 4.2% of homeless clients with diabetes were treated should indicate that clients with diabetes are not able to access care.

Continuum of Care: In addition to the clinics that receive federal funding for providing health care to the homeless, Coalition of Community Health Clinics provides a range of services at different clinics. The Coalition can also refer clients to specialty care through Doctors Offering Community Service (DOCS) network of 45-55 specialists who will provide specialty care for low-income clients. OHSU provides pediatric care and refers high-risk pregnancies to its network of OBGYNs.

The table in the back that is titled, "Health Care for the Homeless: Continuum of Care" describes the services and clinics in detail for both children and adults. Blue text indicates a service that is provided by MCHD.

Access to Care: Access to care for homeless clients at clinics is impacted by how many appointments slots are available for new patients. Since new patient appointments take more time and providers can only care for so many clients in their patient panels, these slots are limited. Additionally, clinics balance out those new patient slots for uninsured and those with insurance (usually OHP) in order to remain financially viable. The table below shows the appointment slots for new patients and gives an idea of the amount of access at different clinics.

Clinic	New patient slots
MCHD La Clinica	20 new patient slots/week
MCHD WHC*	40 new patient slots/week for uninsured and those with OHP
CCC*	10 OHP new patient slots/week and 3-4 new uninsured/week through Drug and Alcohol treatment program
NARA	20 new patient slots/week
Outside In	Walk-in clinic that sees clients on a first-come, first-served basis. Priority is given to homeless, youth under 21, injection drug users from our syringe exchange, and follow-up referrals from medical outreach.

*MCHD WHC contracts with CCC to see 400 uninsured patients through a federal expanded medical capacity grant.

[9] UDS: Uniform Data System used by HRSA to collect data from FQHCs

Wallace Medical Concern and other clinics in the Continuum of Care and Road Map are walk-in clinics.

Road Map for Treatment: The map in the back that is titled, "Road Map for Health Care for the Homeless," shows where children, families, and adults go for treatment and where clinics and case managers refer clients. The road map also shows where the jails and hospital emergency rooms refer clients. Blue arrows and text indicate a service that is provided by MCHD. Takeaways from the road map include:

- The large numbers of arrows pointing to and from the case manager show how case managers are needed to facilitate access for clients. There are less arrows from the homeless clients to clinics because it is more difficult for them to access services directly.
- Case managers need to contact multiple organizations to try and find access to care for clients. Therefore, there are arrows pointing to almost every clinic.
- MCHD WHC sees the highest volume of patients and provides services at multiple sites.
- The client groups are broken out into Children, Families, and Adults because they often have to go to different clinics for care. The map shows that not all clinics are able to serve all family members. As a result, clients have to go to additional clinics in order receives services for everyone in their families. MCHD WHC can serve all members of a family. Youth receive services at Outside In and New Avenues for Youth.

Gaps - Services That are Most Difficult to Access: There are some services where there are few options, resources, and/or need greatly exceeds capacity. The greatest gaps in providing health care for the homeless include medications, respite beds, dental care, mental health for uninsured, and specialty care.

Medications: Affordable medications are a systematic problem in the health care system but it represents a larger gap for providing health care for the homeless. Access to medications for those with chronic diseases is especially difficult. NARA and MCHD are the only organizations that have full-service pharmacies that can provide medications through donations, discounts, or by signing up clients for medicine assistance programs. Federal regulations restrict these clinics to providing pharmacy services to their own patients. CCC and Outside In have physician-dispensed pharmacies that have a stock of some medications, samples, or can sign clients up for medicine assistance programs. Other clinics or emergency rooms will give a client a prescription but they will often not be able to fill it.

Respite Beds: When clients are discharged from hospitals, they often have nowhere stable that they can go to recuperate and receive follow-up care. Chronically homeless people are more likely to become hospitalized and need respite beds after discharge. Different organizations do have some respite beds, but there is not enough and no coordinated process for placing clients at those beds after discharge. As a result, clients will often relapse, become ill, or decompensate and will have to be admitted to the

hospital again. This cycle is not a good use of resources. Respite beds are very cost-effective. The dissolution of General Assistance has made this situation even worse and resulted in challenges to move seriously ill people out of respite into skilled nursing facilities. The community needs a larger program dedicated to respite that provides a continuum of respite from acute short-term recovery to longer-term care.

Dental Care: The only options for dental care are MCHD dental clinics and Northwest Medical Team's dental van which primarily provides only pain relief and emergency dental care. OHSU's Dental School offers discounts but the cost is out of range of homeless clients. There is no downtown dental site. With regards to dental services, there are very few options and a great need. The previous table that showed 0.1% of encounters at FQHC clinics for dental services demonstrates the lack of access.

Mental Health for the Uninsured: Organizations who are part of the Coordinating Committee to End Homelessness (CCEH) were surveyed about the biggest gaps in health care services for their clients. Most responded that the biggest gap was lack of mental health options for uninsured clients. Given the high rate of mental illness and lack of insurance, there is a great need.

Specialty Care: Doctors Offering Community Service (DOCS), a network of 45-55 specialists who volunteer, is the only consistent option for specialty services and that is done on a volunteer basis by specialists. There is no access for some specialty care, such as orthopedics, for homeless clients. Before an appointment can be made with a specialist, the specialist will request that certain imaging, lab work, or diagnostic scans are done. This represents an additional step in the process as the provider or organizations will have to coordinate access for those services and a funding source. Making a complex referral requires access to lab work and diagnostic services. The MCHD clinics are the only clinics that can access this type of service for its clients through on-site services or County Health Source funds.

Barriers to Care: There are often one or two options for health care and there is not sufficient capacity for the clinics that provide comprehensives services to meet all of the demand. As shown by the Access table, clinics can only accept a limited number of new uninsured clients. There are also long waits for appointments at some other clinics. In response to the CCEH survey, one of Human Solution's family advocates wrote, "Continuity of care is difficult. The demand for sliding scale health care is intense, so if a client misses an appointment (and it could take a month or more to GET an appointment), the clinic can not be flexible with this person."

As shown by the Road Map for Treatment, accessing care requires multiple phone calls or "shopping" around until appointments can be made at a clinic. While clinics do coordinate services with each other, case managers and clients will contact each clinic multiple times because they can only accept a limited number of clients each day. Some clinics have $20-$25 co-pays that can be a barrier since the clients will not have that much money.

Getting discounted or donated services at hospitals or private clinics requires extensive documentation and advocacy. Case managers will both coach clients and advocate for them on how to approach the front desk and business offices for donated or discounted services. Applications for donated or discounted services can be quite extensive, thick, and include a lot of red tape. For example, some hospitals have asked for one full year of pay stubs and tax returns in charity care applications. Finally, for an operation in a hospital to be discounted or donated, the hospital would have to donate operating room time, a surgeon would donate their time, and an anesthesiologist would also donate their time. Since this requires extensive advocacy and applications, an organization needs a social worker or dedicated staff to facilitate an operation for their clients.

Transportation can be the final barrier. While families will have or be able to get insurance for their children, it is difficult to bring their children to all of the appointments through multiple buses.

Alignment with the 10-Year Plan to End Homelessness:

Preventing discharge into homelessness: One of the nine actions of the 10 Year Plan is preventing institutions, such as jails or hospitals, from having to discharge homeless people into the streets because there aren't linkages to services. Health care providers have set up programs, linkages, and discharge options with institutions to prevent discharges into homelessness.

- **Respite Care for Clients Leaving the Hospitals**
  - Multnomah County Health Department's WHC provides 0.2 FTE nurse and social worker for a 4-bed respite program at Taft Hotel; an 80-unit licensed residential care facility.
  - Central City Concern has a 6-bed respite care program that contracts with Providence and OHSU.
  - Outside In has 2 recuperation beds for clients and also provides vouchers for motel rooms through Clearinghouse.
  - Cascadia Behavioral Health's 70th Street Respite provides respite bed for clients that are already involved with mental health.
  - Homeless Infirmary Project (HIP) includes 15 emergency beds at Harbor Light shelter for clients who are ambulatory but need some minor medical support. The beds fit very specific needs and conditions so they have been underutilized.
- **Other Discharge Options for Emergency Rooms**
  - Cascadia's Project Respond is a 24/7 mobile crisis unit of multiple teams of mental health professionals. From 1:00-10:00 pm, two teams are assigned to hospital emergency rooms to help link clients with services after discharge.
  - Clients that are already established with MCHD's WHC and La Clinica, Central City Concern, Outside In, or NARA can be discharged to their provider at their respective clinic.
- **Discharge Options for Clients Leaving the Jails**
  - Westside Health Center coordinates discharge planning with Multnomah County's Corrections Health. Other WHC programs include:

        - Unfunded 20 Program which provides mental health services for 20 uninsured clients per month when they are discharged.
        - Facilitated access to care for clients at River Rock, a residential substance abuse treatment center for criminal justice clients, but this center has closed.
        - WHC sees referrals from the Department of Community Justice's Transitions Service Unit.
    - Central City Concern's Parole Transition Program provides transitional housing, case management, mental health, and health care services for clients who were recently paroled.

Improved Outreach for the Homeless: Another of the nine actions in the 10-Year Plan is to improve outreach in order be able to offer homeless clients immediate access to care. The following are outreach services of different health care providers:

- **Westside Health Center** has satellite clinics at St Francis Dining Hall and New Avenue for Youth, and provides full medical services, social work and nursing outreach for homeless adults, youth, and families. Westside also offers the following outreach services:
    - WHC sends nurses to Clark Center, shelters, TPI, Harbor Light, JOIN, SRO hotels, the streets, Transition School, and SUN System Regional Service Centers for Homeless Families.
    - WHC nurses also screen for TB at shelters and provide services at flu clinics.
    - WHC will start delivering primary health care and behavioral health to homeless families in June with their medical van.
- **Multnomah County Health Department's La Clinica** has a community health specialist that conducts outreach in the Cully neighborhood and is part of the neighborhood's Community Provider network and Latino network.
- **Outside In** coordinates outreach work with WHC to prevent overlap and sends providers to Goose Hollow Family Shelter, Dignity Village, Rose Haven Women's Day Shelter, medical street outreach to Latino Day laborers on Burnside and sex workers on SE 82nd.
    - Outside In received funding for a medical van with two exam rooms which they will begin bringing to those locations.

Increase supply of permanent supportive housing: The 10-Year Plan describes how permanent supportive housing is one of most effective tools for ending long-term homelessness. Health care providers have been integrating services with supportive housing units and offering a comprehensive range of services for clients.

- **Westside Health Center** has agreed to provide supportive services for clients at Cascadia's Prescott Terrace which helps leverage supportive housing funds. WHC is looking at similar arrangements with some other organization.
- **Central City Concern** provides primary care and behavioral health services for approximately half of their clients in the 1,301 units of housing that it owns or operates.

- **NARA** provides health care for clients in their 62 beds for residential drug and alcohol treatment and has a transitional housing unit for five women and their children.
- **Cascadia Behavioral Health Care** has on-site psychiatrist 1 day/week and psychiatric nurses for clients at Royal Palm and Bridgeview transitional housing programs.
- **Community Engagement Program (CEP)** Westside and Central City Concern collaborate on CEP for 100 chronically homeless and high utilizers.
    - Utilizes intensive case management and a multi-disciplinary team approach with primary care and psychiatric care on site.[10]

Increase economic opportunities for homeless people: Health care providers have been part of the city and county's efforts to improve access to workforce assistance and receipt of disability benefits for those who are eligible.

- **MCHD** has been training social workers and medical providers at WHC and La Clinica to assist clients with SSI/SSDI eligibility.
- **Joint Access to Benefits (JAB)** is a program run by Multnomah County's Department of Community Justice that collaborates with other county departments including the Health Department. Its goal is to initiate the application for Social Security benefits for those incarcerated individuals from Multnomah County prior to release so they can receive benefits as early as possible after release in order for stable housing and medical assistance to be provided.
- **Central City Concern** operates the following employment assistant programs:
    - The West Portland One Stop provides comprehensive employment services for those facing employment barriers due to homelessness and addiction. It features a job resource center, employment support classes, career training and advancement services, and 19 on- and off-site community partners.[11]
    - CCC operates multiple business entities and offers employment training.
- **Outside In** operates an Employment Resource Center that works with youth to increase work readiness, obtain and retain employment and build a positive work history. An education component helps youth obtain their GED and enter college.[12]

Create innovative new partnerships to end homelessness: Health care providers have been working to improve relationships and partnerships among other agencies to leverage funding available for permanent supportive housing.

- **WHC's** agreement to provide supportive services for Prescott Terrace allowed Cascadia to further leverage federal Shelter Plus Care Program funds.
    - Shelter Plus Care is a program designed to provide housing and supportive services on a long-term basis for homeless persons with disabilities and their families.

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[10] Retrieved from www.centralcityconcern.org on December 6, 2005
[11] ibid
[12] Retrieved from www.outsidein.org on December 6, 2005

- Organizations that can quantify the dollar value of the supportive services that they receive from health care providers can receive matching funds from this program.

Other Models: Health care providers in other cities have developed their own models for health care for the homeless.

Seattle: Seattle's King County Health Care for the Homeless services focus more on outreach and provides health care services through contracts with 12 community health centers. Outreach teams that include nurses, nurse practitioners, and mental health and chemical dependency counselors, go to selected homeless sites throughout King County. They provide screenings, referrals, and link clients to services. Some of the teams also work at contracted clinics while some have on-site space. Other aspects of King County's program include a needle exchange, medical respite beds, intensive case management, and homeless youth clinics.

San Francisco: Recently, Mayor Gavin Newsome announced that a 106-bed facility for disabled homeless will open in late December 2005 and a 75-100-bed medical respite center will open next year. Newsome has introduced a Care Not Cash program that eliminates cash assistance while providing permanent housing and supportive services. Newsom said 1,101 chronically homeless people have been housed to date under the Care Not Cash program — now called Housing First — and all of the 2,400 homeless people drawing city welfare checks when he began the program in May 2004 will have been offered permanent housing in the next five months, given bus tickets home, or left the welfare rolls.[13]

San Francisco's Department of Public Health started a Direct Access to Housing Program in 1998. The Health Department has 360 units of permanent supportive housing in five SRO hotels and a 33-bed licensed facility. There are on-site case managers and mobile behavioral health teams that provide services. Additionally, they operate clinics, use medical vans, outreach teams, and their model is similar to Portland's with the exception of operating permanent supportive housing.

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[13] "Newsom: City doing 'very good job' on homelessness," retrieved from http://www.sfexaminer.com/articles/2005/12/21/news/20051221_ne04_newsom.txt.

Health Care for the Homeless: Adults and Youth- Continnum of Care

MCHD Services are in blue

Outside In primarily serves youth but services are also open to adults on a walk-in basis

NARA (Native American Rehabilitation Association is open to self-identified Native Americans, family of those who receive treatment at NARA, and those who have previously received treatment

DOCS- Doctors Offering Community Service- volunteer services and are contacted through central referral process

PACS- Portland Adventist Community Services Family Health Center

NCNM- National College of Naturopathic Medicine

Clinic	Screening/ Check-ups	Prenatal Care	Naturo-pathic/ Chiro-practic	Medical Care	Dental Care	Addictions	Mental Health	Medications	Chronic Disease Mgmt	Diagnostic Services	Specialty Referrals	Specialty Services
MCHD La Clinica	X	X		X	Refer to MCHD Dental Services			Access through MCHD pharmacies	X	Access to X-ray, lab & funds for diagnostics	X	
MCHD Westside	X	X		X	Refer to MCHD Dental Services	Through contract w/CCC	On-site & contract w/Cascadia	On-site pharmacy	X	X-ray, lab & funds for diagnostics	X	
NARA	X	Through 1st trimester	X	X	Refer to MCHD, NW Dental Van 4/yr	60 Bed Residential Treatment, Outpatient Services & Counseling	X	On-site pharmacy	X	Limited Lab	X	
Outside In (mostly youth)	X		X	X	Refer to MCHD, NW Dental Van 1/wk	X	X	Samples and stock of medications, physician-dispensed		Limited Lab	X	
New Avenues for Youth (youth)	X	X		X	Refer to MCHD	Contract w/CCC through MCHD		Access through MCHD pharmacies	Refer to MCHD	Access to MCHD diagnostics	Refer to MCHD	
Central City Concern (CCC)	X	X	X	X	Refer to MCHD, NW Dental Van	X	X	Samples and stock of medications, physician-dispensed	X	Lab and contract for diagnostic services	X	

Cascadia				on-site nursing		X	Psychiatric nursing care and psychiatrist 1/week at Royal Palm, Bridgeview					
CODA, Inc.						Residential Addiction treatment	X					
Wallace Medical Concern	X			X				Antibiotics & some OTC meds			X	
NCNM			X					Natural Medicine pharmacy	Diabetes, Hypertension	Some lab work at reduced cost		
PACS	Breast & Cervical Screening			X							X	
West Burnside Chiropractic			X							X-Ray services		
DOCS												Network of 45-55 specialists

Health Care for the Homeless: Children- Continnum of Care

MCHD Services are in blue

PACS- Portland Adventist Community Services Family Health Center

NPNPCHC- North Portland Nurse Practitioners Community Health Center

DOCS- Doctors Offering Community Service- volunteer services and are contacted through central referral process

NARA (Native American Rehabilitation Association is open to self-identified Native Americans, family of those who receive treatment at NARA, and those who have previously received treatment

Clinic	Screening/ Check-ups	Prenatal Care	Immunizations	Naturo-pathic/ Chiro-practic	Medical Care	Dental Care	Mental Health	Medications	Chronic Disease Mgmt	Diagnostic Services	Specialty Referrals	Specialty Services
MCHD La Clinica	X	X	X		Well-Child Visits	Refer to MCHD Dental Services		Access through MCHD pharmacies	X	Access to X-ray, lab & funds for diagnostics	X	
MCHD Westside	X	X	X		Well-Child Visits	Refer to MCHD Dental Services	On-site & contract w/Cascadia	On-site pharmacy	X	X-ray, lab & funds for diagnostics	X	
NARA	X	Through 1st trimester	X	X	Well-Child Visits	Refer to MCHD, NW Dental Van 4/yr	X	On-site pharmacy	X	Limited Lab	X	
NPNP-CHC	X		X		Well-Child Visits						X	
PACS	X				X						X	
OHSU												High-Risk OBGYN Clinic
Old Town Clinic-Letty Owens (CCC)	X	X	X	X	X	Refer to MCHD, NW Dental Van	X	Samples and stock of medications, physician-dispensed	X	Lab and contract for diagnostic services		
DOCS												Network of 45-55 specialists

Road Map for Healthcare for the Homeless ***(for children, families, adults, and organizations that serve homeless clients)***

Children
Families
Adults

NPNPCHC
PACS
NCNM
Wallace Medical Concern
West Burnside
Chiropractic

Dental
MCHD Dental

Dental- NW
Medical Van

Medical Van
(Outside In)

Case Manager

La Clinica
(Latino children & families)

New Avenue for Youths (youth)

Outside In (youth)

NARA (Native Americans)

Behavioral Health & Residential Addiction Treatment- Cascadia, CODA

Westside
Unfunded 20

St Francis Dining Hall

Central City Concern
CEP

Jails/Prisons

S u p p o r t i v e H o u s i n g

Legacy Good Sam Clinic, PACE, Richmond (OHSU), Rosewood

Homeless Families Medical Van

Transition School

JOIN

Shelters/Transitional Housing: Clark Center, Transitions Project, Inc. Harbor Light

CCC Respite

Emergency Rooms

Specialty care- DOCS

Respite Care: Taft

HIP: Harbor Light

Providence Mission Clinics (Gateway, North Portland)

Key

PACS	Portland Adventist
NPNPCHC	N. Portland Nurse Pract.
HIP	Homless Infirmary Proj.
NCNM	Nat. College Naturopathic Med.
DOCS	Doctors Offering Comm. Service
PACE	Providence Resident Clinic
CEP	Community Engagement Program