

**Study of Healthcare Services for the Homeless**  
**Trinity University**  
**Healthcare Administration Department**

# Haven For Hope

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Class of 2016



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A report produced by Trinity University's Health Care Administration Class of 2016

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# Study of Healthcare Services for the Homeless

## Trinity University

### Healthcare Administration Department

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## **I. Introduction**

Trinity University's Health Care Administration Department's Class of 2016 undertook this assignment as part of the Capstone Course, a Practicum in Healthcare Management. The educational objectives included involving the graduate students in several "real world" projects, wherein they would exercise and demonstrate the competencies taught in the graduate curriculum. This "Study of Healthcare Services for the Homeless" project was made possible by the invitation of Mr. Mark Carmona, President and CEO of Haven for Hope (H4H). The Methodology section outlines the tasking and chronology of the Study.

We wish to thank the scores of people that gave of their valuable time to educate us, answer our questions, provide data and share their insights. They are too numerous to list here, but we would be remiss if we did not recognize Scott Ackerson. He was our "go to" person throughout the Study: identifying key people, making introductions, arranging appointments, responding to questions, interpreting issues, etc. Where our Study demonstrates insight, Scott's guidance was there. Where we missed the mark, well, that's on us. We are, however, solely responsible for the conclusions and recommendations in this Study.

## **II. Executive Summary**

This Study first describes the limitations found in our investigations of the health services provided for the homeless clients at Haven for Hope. We categorize the limitations into four functional "buckets":

- Lack of Care Coordination
- Lack of Accountability
- Lack of Primary and Urgent Care Services
- Lack of Continuum of Care

We then make short-term recommendations. We want to assert that we doubt that implementing these short-term Recommendations will enable us to reach the "tipping point" for materially lower EMS calls or ED use. Rather than substituting for the implementation the long-term recommendations of the "Desired Future State", we see their pursuit as early improvements for the homeless, low-hanging fruit that

provides experience and testing of components that must be fully integrated into the final model. These short-term recommendations include:

- Provide an On-Campus Class A Pharmacy
- Provide Specialty Care Consultations
- Expand or Shift Hours into Evening for CentroMed and ICC
- Provide On-Campus Transportation
- Realign Hospital Rotation

Shifting to the “Desired Future State”, we envision a single standard of care for all residents, in a shared space, under the supervision of a medical director, and with a stable and permanent funding mechanism.

Our recommended components of the H4H’s new Health Services entity are as follows:

1. Urgent Care Services

- 12 Hours per day and 365 days per year
- Onsite imaging and laboratory
- \$130K/Month operating expenses

2. PCMH Services Providing the Medical Home

- Staff Including: Physicians, Non Physician Providers (NPP), front office and back office
- Level 3 PCMH, including full time Physicians, in addition to the Emergency Medicine Physician performing Urgent Care

3. Full Class A Pharmacy

- 12 hours per day, seven days a week, same hours as Urgent Care
- Partner with provider (Example: HEB)

4. Specialty Care Coordinated by Referral Specialists

- Contracted specialists at Medicare rates
- Transportation provided, both to and from appointments
- Telemedicine visits, mobile health units, and time-share offices
- Importing high volume specialists to see patients at H4H timeshare clinics

5. Combination Crisis Care Center (CCC) and Integrated Care Center (ICC) Services

- Med-Surg and Primary Care fully integrated with behavioral health
- Encompassing all individuals on H4H campus and transitioning off the campus

#### 6. Ancillary services include Dental and Vision

- Move under the H4H health entity

#### 7. Medical Case Management and Outreach

- Outreach teams have caseloads of high utilizers of services
- Tailored to needs of individuals

#### 8. Single Electronic Health Record (EHR)

- Linked to H4H's HMIS for the homeless
- Access to HASA's Health Information Exchange
- To ensure the collection and optimization of data and facilitate case management

#### 9. Recommended Hospital Rotations

- **BMC, MMH and Nix**: Adult Rotation, every third day.
- **CSR's Children's Hospital of San Antonio**: Pediatrics, Labor and Delivery (Maternal and Child Health) and Gynecological patients, seven days a week.
- **UHS**: Full participation in CareLink for the homeless, continued Jail Health Services and Level I Trauma. (One possible UHS alternative would be to establish a Free Standing ED downtown at the Brady Green and enter the Adult Rotation.)

#### 10. Stable Funding

- Baseline Costs: Negotiate and establish Cost Benchmarks: Hospitals, EDs, EMS, City, County and Jail.
- "Pay it Forward": Negotiate contractual obligation to pay a portion of the cost savings to continue and advance the healthcare interventions

There are substantial costs to be avoided by hospitals and EMS, while the County and City are already avoiding huge costs as a result of even the presently disjointed system. Our adaptation of the ReThink Health Dynamics Model illustrates that the "missing link" in the traditional funding mechanism is the securing of contractual obligations from provider and governmental entities to supply permanent and stable funding to the Health Services entity that produces the cost avoidance.

### III. Methodology

The class of twenty-four students was tasked with analyzing the health care services received by the homeless population at Haven for Hope, and to a degree, throughout San Antonio. We began the process with an introductory meeting which included Haven for Hope Management, and stakeholders from the Center for Health Care Services, local health systems, STRAC, Methodist Healthcare Ministries, and other organizations. Upon completion of the initial meeting on September 15, 2015, the class then took two separate tours of the Haven for Hope campus. The first tour provided exposure to the Haven for Hope Transformational Center, Residential Center, and Intake processes. The second tour acclimated the class to the Courtyard setting on the Haven for Hope campus.

Once students were oriented to the organization, the class then devised a strategy to research the avenues of care available to San Antonio's homeless. The end goal is to provide potential solutions for providing appropriate medical care for Haven for Hope clients. The class organized small groups to focus on researching the stakeholders involved in the operations of Haven for Hope. The groups covered the following seven topics:

- Haven for Hope and the Center for Health Care Services
- City Government and HASA
- STRAC, EMS, and Bexar County's Sheriff Department
- The Health Systems in San Antonio
- Methodist Health Ministries and large 501c3 organizations
- The extensive list of Haven for Hope Partners and Collaborators
- CentroMed, Sarah E. Davidson Clinic

Investigations of these central players of the health care provided to Haven for Hope residents were performed in a qualitative manner. Class members completed interviews with employees and representatives of the respective groups. Requests were also submitted to H4H, CHCS, and local hospitals for quantitative data focusing on patient treatment. Though we were unable to obtain all necessary data for a complete view of the stakeholders' interactions with these organizations, the quantitative data that was obtained is presented in the following Study. The Study highlights a summary of recommendations for improving the healthcare services provided by Haven for Hope.

#### **IV. Overview of the Current State**

Overall, the interviews and other research indicate that all of the organizations working to provide services to the homeless community in San Antonio are doing excellent work. Everyone is giving their best efforts and the homeless population is much better off because of the efforts of the many workers and volunteers at Haven for Hope and its supporting organizations. In many ways, Haven for Hope has become a model that has drawn the attention and admiration of many communities studying how to improve their own care for the homeless. The analysis identified, however, a number of opportunities for improvement. These issues can be categorized into four broad areas: a lack of care coordination, a lack of overall accountability for client care, lack of primary care services, and a lack of continuum of care. These areas are expanded further in the paragraphs below.

##### **A. Lack of Care Coordination**

From our research, we find that there is inadequate care coordination for the health services offered at Haven for Hope. Of course, constrained resources are central to most deficits, but other issues are also evident. The main issues causing the inefficient use of health care services within Haven for Hope is lack of central command for health services, lack of communication, lack of patient tracking, and use of incomprehensive and multiple EMR systems.

Patients are currently accessing health care services through a multitude of Haven for Hope outlets including: the Restoration Center and Crisis Care Center (CCC), Zarzamora mental health clinic, the courtyard EMT, the CentroMed Sarah E. Davidson Clinic and others, including vision and dental. While it is clear there are a number of access points to health care within Haven for Hope's umbrella, there is no overall care coordination or set patient flow through the system as a whole. Patients get stuck in bottlenecks within the system. Some examples of these bottlenecks include lack of identification, lost paperwork and/or the inability to qualify for services (EG, the UHS' TAP program).

The central theme to every major problem found within the H4H system is due to a lack of communication from internal and external stakeholders. Patients fall between the cracks within the health care network because every major stakeholder does not communicate patient information and/or the previous services provided to the patient. There is no centralized protocol for patient information sharing between the



internal stakeholders, and the external stakeholders. Instead, HIPAA concerns are often cited as the reason why patient information cannot be shared. Patient information is taken via paperwork but there is no central HIE system that can be updated by all players. (HASA is destined to be this portal but progress has been slow.) Due to this lack of communication, patients are not being tracked throughout the continuum of care resulting in a failure to provide the right care at the right time for each patient.

Internally, patient information is shared and tracked via paper trail. Externally, patient information is being shared via paper trail, phone call, and electronically via separate EMRs but largely outside HASA's HIE. Patients who access health services outside of the H4H campus rarely have adequate treatment information to continue their care plans via H4H services. Access to Specialty care is especially fragmented or not completed at all. This revolving door and lack of tracking provides a significant burden on H4H services. Additionally, the revolving door and poor tracking multiply the potential care costs because patients turn to EMS and EDs for services that should be provided at H4H.

The many external partners make this coordination particularly difficult:

- There appears to be little communication between CentroMed and the on-site ICC.
- The Center for Health Care Services (CHCS) receives no patient information from external players. CHCS has no way to currently track patients, thus resulting in failed care plans, loss of financial resources and duplication of services.
- The Zarzamora Behavioral Health Clinic utilizes paper documentation to verify services rendered. These documents must be presented to CHCS and CentroMed before treatment or referrals can be made to external providers.
- San Antonio Metropolitan Health currently serves the Courtyard through an 1115 waiver grant to conduct TB screenings and treatment, but has no coordination to their CHCS counterparts to identify which patients have received care.
- I Care San Antonio & San Antonio Christian Dental Clinics have onsite clinics where only 25% of those served are directly from H4H. Operations are siloed and health services rendered are not tracked within H4H.
- Care coordination fails between hospitals and H4H health services due to lack of centralized EMR for patient information to flow properly.

## **B. Lack of Accountability**

An issue related to lack of coordination is that there is no one entity that is accountable for the complete health needs of the homeless. Individual organizations exercise accountability and authority for their part but there is no Conductor of the entire symphony. This lack of accountability constitutes a major issue found within our assessment. Haven for Hope has recognized this deficit and has jointly funded and appointed (along with CHCS) Mr. Scott Ackerson to direct all activities in the Courtyard and newly reorganized Integrated Care Clinic (ICC). While that is a positive step forward, it is well short of the singular command and control of the entire health services enterprise that is necessary for *Full Integration*. Everyone responds to their own hierarchy, operates in their own model, looks at their own metrics, and has little visibility of what others do either upstream or downstream from their organization. How could they know?

Haven for Hope clients access care through the intake office, the Courtyard dispensary, sick bay, and ICC. However, due to uncoordinated methods of gathering data and lack of communication among these access points, little accountability is visible to us. As a result, it is not clear how often patients receive care at the right place and the right time. Staff report that a “wait and see” approach is sometimes the only option available. Instead of seeking early or preventative care measures, notably through the sick bay, patients are left to enervate until emergency care is actually required. Due to minimal data integration among clinics, patients often fall off the clinic’s radar once they seek care outside of the ICC. Improving data and communication to *all* Haven for Hope caregivers, in addition to clearly defining who is in charge (along with what time periods), will promote accountability in providing proper care for Haven patients.

The city government leases the property on which Haven for Hope is located. In funding and supporting H4H, the San Antonio government is achieving its objective of getting the homeless off the street and into a safer environment. Moreover, considerable costs have been avoided from the government’s perspective (\$13,968,441 in 2013-14 year).<sup>1</sup> The jail diversion program – a joint endeavor between the San Antonio Police Department and Haven for Hope – has so far proved successful: Officers involved in Crisis Intervention Training (CIT) take detained homeless individuals to H4H where they are assisted and helped to become productive citizens of San Antonio. The majority of those apprehended and detained tend to suffer from mental health and substance abuse issues. Unfortunately, without appropriate treatment,

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<sup>1</sup> Extracted from Report from Gilbert Gonzales, MH Director of Bexar County

these individuals become trapped within the criminal justice system, experiencing multiple incarcerations and undergoing the associated legal proceedings. However, by redirecting these individuals to H4H, they are receiving both care and shelter at a fraction of the cost of incarceration or hospitalization. Treatment at H4H costs approximately \$20 to \$30 per day whereas incarceration in the general population costs \$65 per day; incarceration in a designated mental health unit is even more expensive, ranging from \$200 to \$300 per day. Hence, the government of San Antonio, especially the jail, courts, and law enforcement, has benefited greatly from the success of H4H. Nevertheless, there remains much to be accomplished. Presently, the 30-bed allotment at H4H for the jail diversion program has reached its capacity.

Methodist Healthcare Ministries (MHM) is a major funder of Haven for Hope and many of the partners located on the campus, including CentroMed and Center for Health Care Services (CHCS), the main providers of primary medical care and behavioral healthcare, respectively. Currently, the data collected by MHM from its funded partners is rudimentary; only basic patient demographics and insurance data are obtained. In the future, MHM is considering requiring more robust performance metrics from its partners. The collection of such data is integral to improving the overall assessment and accountability of Haven for Hope and its partners. By connecting metrics to funding agreements, MHM can ensure that the appropriate data is being obtained and analyzed and that certain quality indicators are being achieved. Additionally, MHM also funds Health Access San Antonio (HASA), the regional health information exchange. Presently, CentroMed and CHCS are under-utilizing HASA. Moving forward, MHM is exploring the possibility of mandating that these organizations connect their EHRs to the HASA portal. Tracking patients via HASA would result in greater accountability, better coordination of care, and, ultimately, better patient outcomes.

### **C. Lack of Primary and Urgent Care Services**

From our research, we find that the primary care services offered to the Haven for Hope patients are inadequate. Though some services exist on campus, the demand and type of services required is beyond their scope (bearing in mind the organizations are doing what they have been asked to do). Some of the major care deficits include limited hours of operation, understaffing on campus, lack of proper and available pharmaceuticals, and appropriate providers to meet the medical demands on campus. Because of these deficits, external players including hospitals and emergency services are seeing low-acuity patients that should be seen in primary care settings. If the appropriate services were to be provided, overall costs could be reduced and resources could be better utilized for higher acuity patients.

CHCS currently operates an Integrated Care Clinic (ICC) that provides both mental health and medical care services for eligible individuals (individuals with mental illness AND chronic health conditions) as well as a medical dispensary accessible from the Courtyard. Though there is a primary care physician available on a part-time basis, this person has a caseload of more than 250 patients, many of whom are from the surrounding community. Scheduling appointments and ensuring that patients show up for them becomes difficult. This clinic is limited to the services they provide and disconnects exist among the types of services needed and the types of services provided. In addition, many patients require medications for mental illnesses, which are unavailable in the Dispensary.

One of the key players providing healthcare services to the Haven for Hope population is the Sarah E. Davidson CentroMed Clinic. CentroMed is located on Haven for Hope's campus and provides medical services, family practice, healthcare for the homeless, lab services and triage. The clinic operates Mondays through Fridays from 8am to 5pm, and they schedule same-day appointments only, in order for patients to receive care. CentroMed also manages a class D pharmacy on site. They are unable, however, to supply or prescribe Haven patients with antidepressant or sleeping medications. Usually there are four to five intake workers on staff to manage the 20-30 people waiting outside. This waiting queue of patients is very unstructured and often patients may wait all day expecting to be seen and still have to come back the following day. While CentroMed provides many services on the campus, there is still a lack of primary care for the complex needs of the H4H patients.

The scope of available services at the CentroMed Clinic also limits the ability of patients to receive the right care at the right time. Some of the issues most prominent within the Haven for Hope population, include mental health issues, sprains/fractures and alcohol-related issues are left untreated. Additionally, patients, who already have difficulty having their most basic needs met, are experiencing issues receiving follow-up care. Patients deemed as needing immediate care that is not within the scope of the clinic are sent to an emergency department.

Haven for Hope currently relies on the assistance of various agencies to remain functional. Though helpful, maintaining the balance among all of the organizations becomes difficult. Some of the various healthcare providers on the Courtyard include:

- University of Incarnate Word School of Nursing. Nursing students frequent the Courtyard each semester to provide foot care clinics, health screenings and health promotion education.
- Texas Liver Institute provides free testing and vaccination for Hepatitis. If members are found to be positive for Hepatitis, they can be linked to the Institute for treatment through research study participation.
- San Antonio Aids Foundation provides free condoms to the Courtyard and regularly occurring HIV/AIDS testing clinics.
- Veterans Affairs Social Workers frequently conduct outreach on the Courtyard to link veterans to healthcare services available to them through the VA. The VA provides a shuttle service, leaving H4H at 8:18 AM and returning at 3 PM, Monday-Friday.
- San Antonio Metropolitan Health currently serves the Courtyard through an 1115 waiver grant to conduct TB screenings and treatment.
- I Care San Antonio & San Antonio Christian Dental Clinics have onsite clinics where 25% of those served are directly from H4H.

#### **D. Lack of a Continuum of Care**

Related to the lack of adequate primary care services is the more general issue that Haven for Hope clients do not get the right care at the right time leading to ineffective and inefficient care. Continuum of Care is a concept involving a system that guides and tracks patients over time through a comprehensive array of health services spanning all levels and intensity of care. Abbreviated hours for many health care providers lead to long wait times when the providers are open to provide care. Residency requirements of many services offered are a barrier to many H4H patients getting care at the right time. The transient nature of many members leads to missed appointments, which prevents the members from seeking care for an indefinite period of time. The lack of a “medical home” leads patients to delay seeking care until the problem has escalated to the point where they need emergency care.

According to EMS officials, the 911 calls made from 1 Haven for Hope Way (and the Courtyard) account for 1% of all calls met by EMS. This totals 1600 calls of the approximately 160,000 received by EMS per year, a considerable amount for a single location. Many of these calls are non-emergent, but still result in the costly transport of the patient to the emergency department. On average, these calls take 55 minutes and because of this overutilization, the emergency services provided to these non-emergent patients take

away from their ability to meet the calls of patients with more emergent needs elsewhere. STRAC officials estimate that almost 50% of the calls from Haven for Hope could be reduced if the appropriate services were to be provided on campus in a different setting, especially preventive care.

Another suggestion from STRAC/EMS officials is that H4H could benefit from a reliable dispatcher on campus at all times who could act as a first responder to 911 calls in order to distinguish what calls actually require full emergency services. Another suggestion is to have a Paramedic or Advanced Care Practitioner available in the Courtyard (rather than an EMT) to assess and triage prospective 911 calls.

According to hospital officials, most of the patients that seek care in the emergency department of the participating hospitals could receive care in a different care setting. These patients have a much lower acuity than others presenting in the emergency department and typically need some type of primary care intervention. The table below summarizes data from Baptist Medical Center's visits from known homelessness addresses for 2014. Note that courtyard clients are much less likely to be admitted and have a lower acuity level compared to other homeless patients. Using an Emergency Severity Index (ESI) score of 4 or 5 as an indicator of those patients who could have been treated in an urgent care center, over 40% of ED visits from the courtyard and about a third of all visits could have been avoided. According to data from Methodist Metropolitan, the top three diagnoses for Haven patients include: mental health, fractures, and alcohol-related issues. The lack of coordination creates big problems for the hospital as they are utilizing resources that could be allocated for higher acuity patients.

Table 1  
BMC Homeless Hospital Visits

Category	Total Visits	%Admit	%Discharge	%Transfer	%ESI 4 or 5
Haven for Hope	471	24.0%	66.9%	1.1%	26.8%
H4H Courtyard	695	12.2%	76.0%	0.9%	41.0%
Other Homeless	587	19.4%	68.1%	2.2%	30.3%

The Courtyard is staffed from 6am-2pm, 2pm- 10pm, and 10pm to 6am with 8 community guest specialists. During weekdays there is 1 clinic supervisor, 1 lead, 1 medication technician, and 1 EMT (all variable upon availability). Within the Courtyard, ICC staff tries to track down patients scheduled for care. The transient nature of the clients in the courtyard generate challenges for recurrent care appointments. The ICC staff will make 3 attempts to reach out to the patient for their appointment. However, if the patient cannot be found within the grounds of the courtyard or contacted in another fashion, then the patient is considered a 'no show' and is dropped from the schedule as non-compliant. The patient then has to start the whole process all over again.

Additionally, the primary care physician, as part of the Integrated Care Clinic, works part-time and also sees patients from the community outside of Haven for Hope and the Courtyard. To see a psychiatrist, patients can wait up to six months until their scheduled appointment, their conditions worsening in the interim. All the while, their ability to receive care often hinges on whether or not they can provide proper identification. Many of the H4H patients have to wait months until they receive the necessary papers that can qualify them for medical services. Additionally, many stakeholders are unable to track patient movement throughout the system, and there is limited access to patients' medical history. Essentially, when patients show up in the ED, they are starting from square one.

CommuniCare will (via a grant from MHM) assist patients who present in Emergency Departments in Downtown San Antonio hospitals for follow-up care. Often uninsured or low-income patients do not have a medical home, have neglected their health, and utilize emergency rooms for issues that could be prevented through routine preventative health care. Many patients are not aware of available health services through a community health center. Therefore, they do not take the preventative or necessary steps to improve their health which necessitates a greater degree of care than would be required if they had accessed care earlier. This CommuniCare intervention is methodologically sound but it is being applied so far downstream (in the EDs) that its effectiveness is limited, especially for the homeless.

HASA is funded by MHM and the Health Systems and its mission is to enable organizations to record and share patient data. Many patient encounters, however, are not recorded (specifically primary care). The lack of meaningful utilization of HASA indirectly impacts members receiving the right care at the right time. Increasing communication within the HIE would enable all parties to better serve patients and recognize individual patterns while individuals could still benefit from preventative or early care. It would also allow providers and Haven for Hope employees to better determine eligibility for certain benefits. If all the members were enrolled in all benefits they were eligible for, many would no longer need to delay care.

## **V. Short-Term Recommendations**

Before we transition to the Desired Future State, we want to provide some short-term recommendations. But we first want to assert that we doubt that implementing these Short Term Recommendations will enable us to reach the “tipping point” for materially lower EMS calls or ED use. Applied in a piecemeal fashion, some interventions might initially make ED use and EMS calls higher rather than lower. Going to the ED will still be the “Easy Button”. Our real goal is to develop and tailor the on-campus services so well that going to or staying at H4H becomes the new “Easy Button”. You have to give your clients “adequate reason” to do what you want them to do. And it has to constitute adequate reason **in their world** (voice of the customer), not ours.

The Short Term Recommendations are:

- Provide an on-campus Class A Pharmacy
  - See MHM ‘s Wesley Model in Section VI of this Study



- Provide Specialty Care Consultations through the purchase of CareLink Memberships from UHS
  - See MHM’s SRS Model in Section VI of this Study
- Realign Hospital Rotation as shown in Section VI
- Expand or Shift CentroMed and ICC Hours into evening
- Provide on-campus Transportation (see Section VI)

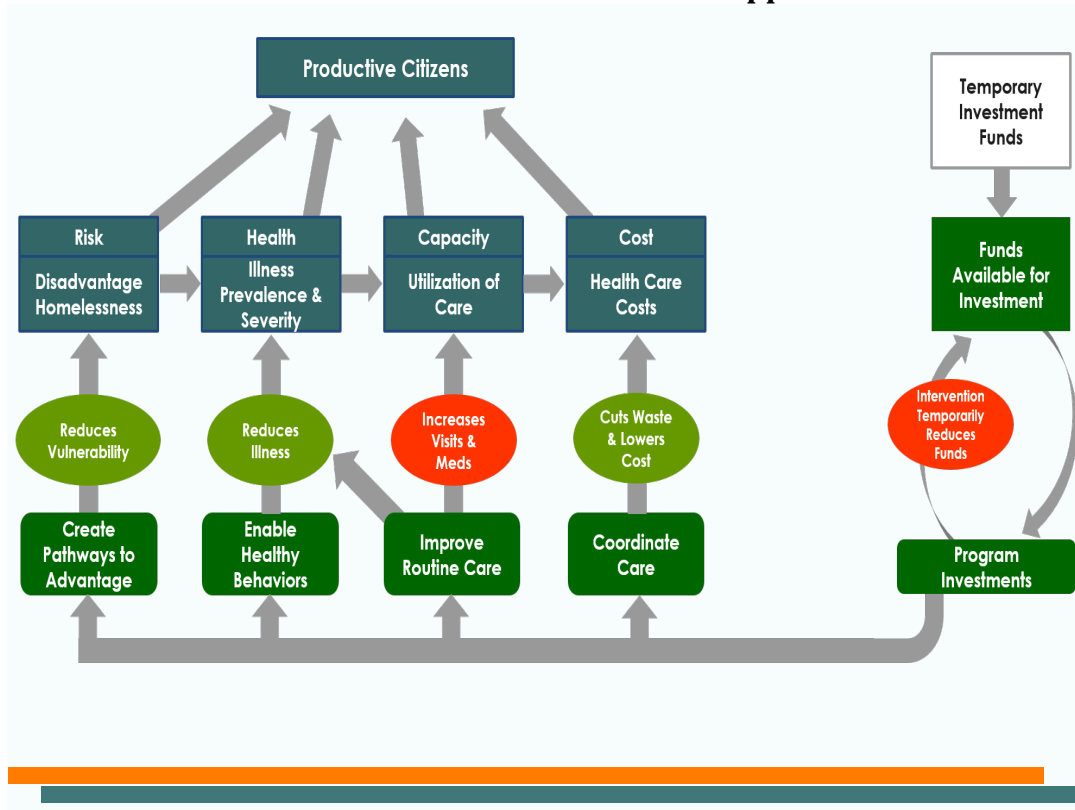
We see these short term solutions as early improvements for the homeless, low hanging fruit that provides experience and testing of components that will be fully integrated into the final Model as the desired future state is implemented.

## **VI. Desired Future State**

### **A. Overview**

In this Overview, we first detail the ReThink Health Dynamics Model as the prism through which the Desired Future State is to be viewed. Our adaptation of the ReThink Model, as applied to the Homeless population, is shown in the following two figures. In Figure 1, we begin with the overarching goal of persons being Productive Citizens. In terms of Health Status, we then identify four negative forces that inhibit achieving the goal of being “Productive Citizens”. They are: 1) RISK - the enormous Disadvantage of being Homeless, 2) HEALTH - the resulting exacerbation in Illness Prevalence and Severity, which then inundates 3) CAPACITY - Utilization of CARE, which – in turn - produces 4) COST - high Health Care Costs. *(Health, Care and Cost are, of course, the three components to the “Triple Aim”)*. To intervene in this viscous cycle, communities traditionally raise Funds and entrust those temporary Funds in an Organizational vehicle (such as H4H) that makes Program Investments to effect Interventions aimed at disrupting the vicious cycle.

**Figure1:  
The ReThink Health Model Applied to the Homeless**



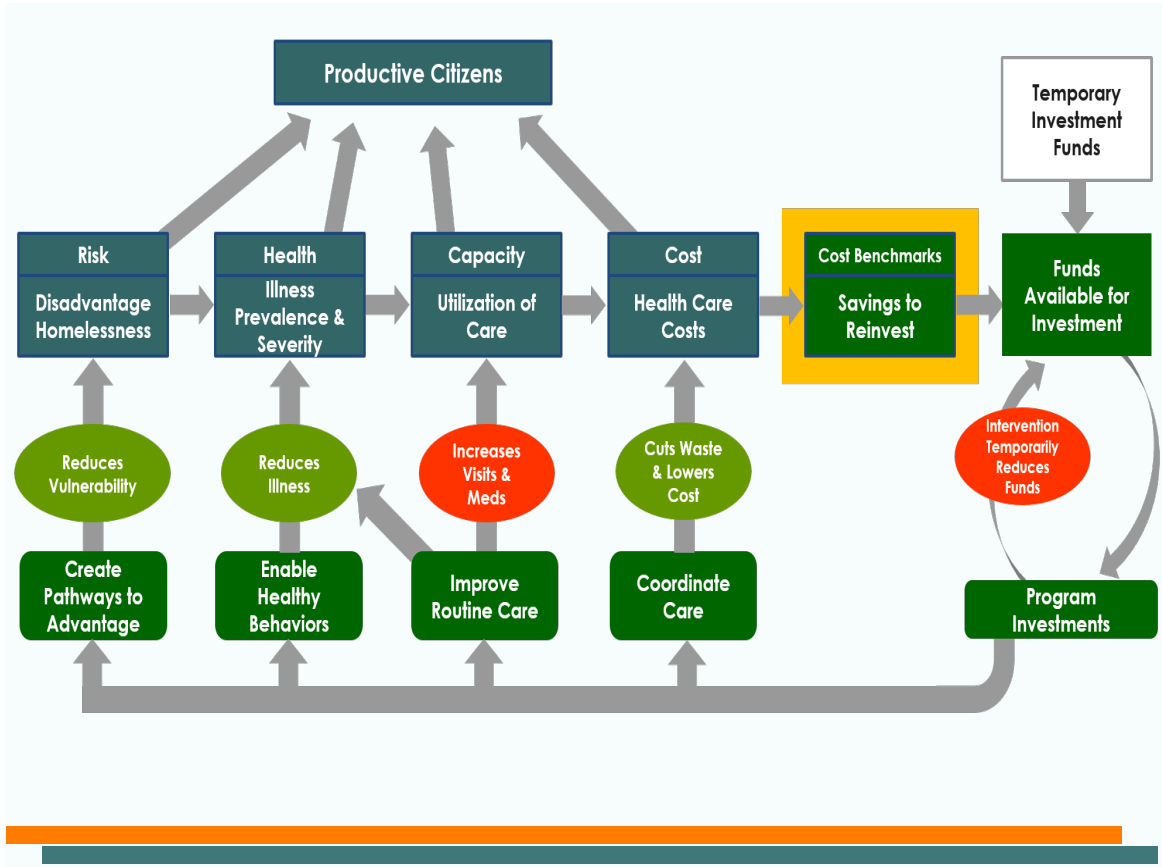
The Interventions can be categorized under four strategies:

1. The Creating Pathways to Advantage strategy is aimed at countering Disadvantage and employs tactics designed to Reduce Vulnerability. Providing housing of various kinds (shelters, temporary, transitional and permanent housing) heads the list. “Housing First” is widely touted as the Best Demonstrated Practice (BDP). Tactics that are even more effective are preventive in nature and examples include providing affordable housing, repairing leaky roofs, refinancing home loans, debt relief in foreclosures, providing gainful employment, providing support to discharged veterans and foster children that turn 18 years old, etc. Being furthest “upstream”, Creating Pathways to Advantage has the most leverage to improve the lot of the homeless (or the “about to be homeless”) but also lies outside the scope of providing health care services and this Study.
2. The Enable Healthy Behaviors strategy employs tactics designed to Reduce Illness. Many of these tactics are prophylactic in nature and include providing condoms, needle/syringe exchanges, a safe place to store medications, socks and foot ware to keep feet dry, sleep aids, protection from the sun, a safe place to exercise, oral hygiene items, nutritional food low in added sugars, a sanitary place to go the bathroom, soap and showers, etc.

3. The Improving Routine Care strategy employs tactics designed that both Increase Visits and Medications and Reduce Illness. The connection to Reducing Illness consists of the administering vaccinations, foot care, STD testing and treatment, allergy medications, asthma controller drugs, screenings of various kinds, including drug screening. Regarding Visits and Meds, these tactics center around providing the right care delivered timely and in the right setting. The next best thing to preventing an illness is to diagnose it early in the disease process, thus enabling us to apply the most effective and elegant forms of therapy. Most of the homeless health care deficits we identified require the tailoring and redesign of Routine Care. This will cost money to do but enables an even larger payoff further downstream in the Cost strategy.
4. The Care Coordination strategy employs tactics designed to cut waste and lower total costs for this population. We have already detailed the Care Coordination deficits and gestured toward the cost effectiveness promises to come. Here, we want to emphasize that, in addition to “cost effectiveness” benefits there are “care effectiveness” benefits for the patients themselves. Unnecessary care, delivered in the wrong setting actually does harm to patients, and not just trivial harm. The sequelae of iatrogenic complications are well documented in the literature: wrong medication, double dosing, radiation exposure, shock, pulmonary arrest, and death, to name a few.

So the picture of these interventions looks appealing enough until you note that as the temporary funds are depleted, the Organization must turn more and more of its attention to fund raising, applying for grants, etc., another vicious cycle. The “missing link” in this “traditional model” is that the organizations that have benefitted from the cost reductions are not obligated to share any of their windfalls with the Health Services organization that produced the interventions that lowered their costs. In Figure 2, the Model provides for a permanent source of stable funding from the benefited organizations in the form of “Savings to Reinvest”, as calculated via agreed-on “Cost Benchmarks”.

**Figure 2**  
**The "Missing Link" for Stable Funding**



The ReThink Health Model provides context for understanding the account below detailing the “Desired Future State”.

## B. Components

When asked why he was drawn to research, write, produce and star in the Broadway musical “Hamilton”, [Lin-Manuel Miranda](#) said that he asked himself: “What’s the thing that’s **not** in the world that **should be** in the world?” In terms of their health needs, that is the question that the Homeless are asking. The complete model is in C, below but we first list and describe the Components of the desired future state. The Font turns green when we specifically describe the Model.

As graduate students, we have a limited view. So we asked others, steeped in decades of experience and researched the literature.<sup>2</sup> The following is a composite or mosaic representation of what we heard and

<sup>2</sup> Key Elements of Integrated Care for Persons Experiencing Homelessness

A Guide for Health Care for the Homeless Providers, Claire F. Goyer, M.Ed. National Health Care for the Homeless Council June 2011, <http://www.nhchc.org/wp-content/uploads/2011/10/Key-Elements-of-Integrated-Care.pdf>

were able to understand. We know our limitations leave it flawed. We offer it, not as complete or 100% accurate, but as a starting point for dialogue within the community.

One further caveat: the listing below is easily misconstrued as separated parts. That is not our intent. We cannot avoid enumerating via a list but intend that all of the component parts achieve *Full Integration*. The status quo is a combination of “Independent Coordination” and “Collaboration” models.<sup>3</sup> “*Full Integration*” is the **STANDARD OF CARE**: merged practices in a shared space, a single treatment plan, one treatment team, managing complex multi-morbidities, managing substance abuse, mental health disorders and cognitive impairments. In scope, the outpatient services begin with enabling self-care and end with hospice care.

We acknowledge that much of the exposition that follows is already present in the “Current Reality”. We have elsewhere explained how the status quo lacks scale, adequate funding, cohesion, free flow of information and singular command, control and accountability. Our adaptation of the ReThink Health Dynamics Model suggests how these deficits might be addressed conceptually. But where the Model refers to “Initiatives” and “Program Investments”, here we flesh them out in terms of their forms, functions, services, capabilities, entities, and facilities, etc.

1. Medical-Surgical Services and Primary Care: We first survey existing models. While the capabilities of a freestanding Emergency Department would be optimal from many standpoints, it is culturally distinct from the integrated Primary Care required, lacks several capabilities (E.G., medical home, pharmacy) and would consume far too much of any budget. An Urgent Care model would provide services 12 hours a day (10 AM to 10 PM), seven days a week, with core staffing of an Emergency Medicine trained physician, with onsite imaging and laboratory. Urgent Care’s abilities to suture, apply splints or casts, prescribe any class of medication, remove foreign objects, etc., are but a few of the key additions to the current FQHC model. A listing of Urgent Care services is shown in Appendix Table 1 and operating cost estimates are in Appendix Table 2.

The Med-Surg model in our “Desired Future State” is one containing the Emergency Medicine Physician, services and hours of operation of an Urgent Care center, augmented by PCPs and Non-Physician Practitioners (NPPs).

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<sup>3</sup> Developing an Integrated Health Care Model for Homeless and Other Vulnerable Populations in Colorado, A Study from the Colorado Coalition for the Homeless  
OCTOBER 2013, page 23, <http://www.coloradocoalition.org/userfiles/Library/CCH.SIM.2013.pdf>

We want to be clear that the addition of Urgent Care suite of services does not supplant the Primary Services that form the *raison d'être* of all Health Care Services delivered by the new H4H entity. One cohort of the Homeless population only want immediate needs attended to and will not submit to services beyond that. We will have to gain their confidence over time. As the old Chinese proverb intones: “When the student is ready, the teacher will appear”. But the overwhelming number of homeless clients will embrace Integrated Care. We will not detail that model here, as it is replete in the literature. The 2013 Health Affairs article by Michael Porter, et al., is foundational to the radical **idea of basing primary care on the specific needs of patients and integrating delivery models by subgroups (that share conditions, pathologies and location).**<sup>4</sup>

2. Behavioral Health Services: Our first model here is the Crisis Care Center (CCC) operated by CHCS. The current (and only) CCC is a vitally important asset but has but a fraction of the capacity needed, as evidenced by being on “diversion” one third to one half of the time. The CCC’s first priority is to serve the patients delivered by law enforcement agencies. CHCS patients from its other routine clinics internally consume most of its remaining capacity. Access is nil for patients originating at other providers such as the Hospitals/EDs and Haven for Hope.

Our second behavioral health model is the Integrated Care Center (ICC) recently opened by CHCS in the Courtyard of Haven for Hope. There is much to recommend this expanded set of behavioral health and primary care services for the Courtyard population but providing different health services (Courtyard versus Transformational) is counterproductive.

The Behavioral Health Model in our “Desired Future State” is one containing a combined CCC and ICC. Haven for Hope needs a single, dedicated, fully integrated set of healthcare services (Med-Surg integrated with Behavioral Health) on campus that maintains no barriers among Courtyard (700), Transformational Campus (800) and homeless clients from off-campus transitional housing provided by others such as the SAMM (350) and a myriad of recognized and vetted shelter providers.<sup>5</sup> By containing a second CCC, law enforcement can access the H4H Health facility for the homeless, while continuing to take domiciled patients to the current CCC. See the Vera Institute of Justice Report “First Do No Harm: Advancing Public

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<sup>4</sup> (<http://vbhcprize.com/wp-content/uploads/2014/03/Porter-Redesigning-primary-care.-A-strategic-vision-to-improve-value-by-organizing-around-patients-needs.pdf>)

<sup>5</sup> <http://www.homelessshelterdirectory.org/cgibin/id/city.cgi?city=San%20Antonio&state=TX>

Health in Policing Practices”: <http://www.vera.org/pubs/public-health-and-policing> for an excellent survey of Best Demonstrated Practices.

3. Pharmacy/DME: Second only to specialty care, the inaccessibility of pharmacy services pervades the quixotic quest by the homeless to adhere to most treatment plans. The prescribing deficits in the status quo are addressed by the Medical-Surgical, Primary Care and Behavioral Health services outlined above. (That is physician prescribers on duty 12 hours a day.) The real “Catch 22” lies in getting the prescription filled.

Our model here is the Class A Pharmacy at MHM’s Wesley Community Health Center ([WCHC](#)). Although MHM contracts with a local pharmacy provider, MHM retains management, budgetary and operational responsibility for the services delivered to MHM-registered patients. Serving a registered patient population of 22,500, the MHM pharmacy fills 84,000 scripts annually. Purchased stock supplies 53,500, while subscription to the Dispensary of Hope service provides 19,000 and the Medication Assistance Program, the remaining 11,500. MHM’s Medication Assistance Program (MAP) is robust, having saved \$5.4 million in the first ten months of 2015.

The Pharmacy Model in our “Desired Future State” is one containing a fully functioning Class A pharmacy, open during the same 12 hours per day as the other healthcare facilities. HEB would be the ideal partner to provide and operate the pharmacy, under contract with the new H4H Health Service entity. (MHM already has arrangements with HEB for their School Based Clinics.) The Pharmacy operation is also the best locus for a limited set of Durable Medical Equipment needs. Of all the services in our model, the provision of Pharmacy/DME services would probably reduce unnecessary ED visits and 911 calls the most.

4. Specialty Care: Specialty care services are the most complicated, fragmented and difficult to provide. We draw from two models: CareLink and Temporary Assistance Program (TAP) from the tax-supported Bexar County Hospital District, doing business as the University Health System (UHS) and MHM’s Specialty Referral Services (SRS).

The mission of the SRS:

*“...is to challenge the status quo of unfunded patient access to specialty healthcare and provide each patient access to the absolute best healthcare available; healthcare that is state of the art and world-class regardless of the ability to pay.”*

In terms of scope:

*“Specialty Referral Services (SRS) is available to assist qualified patients/clients obtain access to specialty care, hospitalization, diagnostics and other services based on need; focusing on secondary and tertiary care. SRS synchronizes specialty referral activities and access to care within the current boundaries of the Southwest Texas Conference of the United Methodist Church which coincides with those of Methodist Healthcare Ministries of South Texas, Incorporated.”*

In 2015 through October, SRS made 4,123 referrals via its primary and school based clinics and from 80 Wesley Nurses (an enhanced parish nursing model) based throughout San Antonio and South Texas. The YTD cost was \$1,479,506 (\$358.84 per referral) and that included \$73.96 per referral in pharmacy costs.

SRS has a staff of three referral specialists, which recruit and maintain relationships with the specialists that agree to see their referrals. SRS pays the specialists Medicare rates. SRS refers patients requiring hospital services to the Methodist Healthcare System, which provides those services at no charge. Most of the physician participation comes from independent private physicians and dentists recruited from the Professional Staff of the Methodist Healthcare System (MHS). In some cases, the physicians do not bill and provide their services on a “pro bono” basis. MHM has agreements with some independent groups as well as groups owned by MHS. MHM’s SRS service is not a CareLink provider but MHM has contracted directly with certain UTHSC clinics, with mixed results.

Eligibility is set at >200% of the Federal Poverty Level (verified by tax return, receipt of government benefits such as Food Stamps, unemployment insurance, disability via SSI, foreign ID for the undocumented immigrant, etc.), residency within the 72 county area of the Southwest Texas Conference of the United Methodist Church (phone bill, utility bill, confirmation by Haven for Hope, etc.).

The University Health System operates CareLink for Bexar County residents who have homes and a Temporary Assistance Program (TAP) for homeless Bexar County residents. According to the CareLink Handbook:

*CareLink provides an affordable monthly payment plan based on family size and income. Members receive quality healthcare through University Health System with services provided by CareLink network doctors or other pre-approved providers. In order to stay enrolled in CareLink, you must make your monthly payments and keep your medical appointments.*

Income eligibility has recently been tightened:

*Members must be residents of Bexar County at or below 100 percent of the federal poverty level (FPL). However, the program allows enrollment over 100 percent FPL for those individuals who have either an exemption or denial letter from the Marketplace (income calculated differently- Modest Adjustment Growth Income vs. Adjusted Growth Income.) CareLink average membership for 2014*



*was 40,685, which is a decrease from 52,404, or 23percent in 2013. Membership has been decreasing since 2010 due to the Affordable Care Act (ACA).<sup>6</sup>*

Eligibility for CareLink used to begin at 200% of the FPL. Due to the lack of Medicaid Expansion in Texas, anyone with income between 100% and 138% cannot qualify for ACA health plans via the Federal Marketplace. The 2015 policy quoted above is evidently designed to require those in the “gap” to go through the Marketplace’s application process and produce an “exemption or a denial letter”. This is an example of a “defensive routine” that transfers the expense of determining eligibility to another entity and serves as an additional hurdle for the indigent Bexar County resident. For the homeless, it’s another hoop to jump through to access the TAP. Eligibility also differs in length of membership, with CareLink offering 11-month memberships and all 68 listed services. Homeless Bexar County residents ***are not eligible for CareLink*** but are, instead, limited to 90-day memberships in the TAP, which covers only 34 of those same services.<sup>7</sup> The UHS Benefit Matrix offers no explanation for why homeless Bexar County residents should qualify for half the services and remain eligible a quarter of the time enjoyed by their domiciled peers.

UHS arranges and pays the UTHSA’s University Physicians Group (UPG) to see the CareLink and TAP patients. In some specialties, UHS contracts with non-UT groups. UHS’s own employed primary care physician group, the Community Medicine Associates (CMA) also serves CareLink and TAP patients.

For UHS’ TAP, access for the homeless is difficult because many can’t produce proof of residency, document their income or produce the required forms of identification. For those who satisfy all the requirements, the 90-day eligibility period proves to be brief, which fragments continuity of care. Transportation is yet another hurdle.

The Specialty Care Model in our “Desired Future State” is one containing dedicated staff of Referral Specialists that coordinate appointments with contracted specialists who accept Medicare rates. For Bexar county residents, the new H4H Health Service entity should become an approved provider for CareLink and (in lieu of paying Medicare rates) have the option to pay the sliding scale amount that the patient would pay if he/she were domiciled. The TAP distinctions would be eliminated. The H4H Healthcare Service entity would contract with MHM for its SRS service, which would ride herd on the CareLink appointments as well as handling the non-Bexar residents, including undocumented immigrants.

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<sup>6</sup> REGULAR MEETING OF THE BEXAR COUNTY HOSPITAL DISTRICT BOARD OF MANAGERS Tuesday, June 30, 2015, page 17.

<sup>7</sup> see <http://www.universityhealthsystem.com/files/frontEnd/carelink/CareLink-Benefit-Matrix-2015.pdf>

None of this works without dedicated transportation (see 5 below) but sometimes the specialists can physically and virtually come to H4H. With Haven for Hope's central location, connections and proximity to other homeless domiciles, some specialty consultations could be facilitated by mobile vans and telemedicine visits.

In addition to sending registered H4H clients to the offices/clinics of contracted physicians, much specialty care can be provided in the new H4H health facility (on a "time-share" basis for high volume specialties). The operations of the indigenous H4H health services and the specialty clinics would provide excellent clinical experience for Fellows, Residents and Students from the local Medical Schools (UTHSC and Baylor), the Dental School and other health professional programs at the UT Health Science Center (Nursing, Non-Physician Providers (NPP)s, Physical Therapy, Respiratory Therapy, etc.), as well as the University of the Incarnate Word (Nursing, Pharmacy and Optometry) and allied health programs at the Alamo Community College District.

5. Transportation: Our transportation model is the MHM shuttle vans, operating from the Wesley and Dixon Clinics and the MHS Health Bus.<sup>8</sup> Health Bus is a service that offers free rides to patients who have difficulty with transportation. Service is provided to any Methodist Hospital, any of its facilities, and to doctors (offices locations) on the medical staff at any Methodist Hospital. Health Bus is equipped with seat belts and is wheelchair accessible. Health Bus serves anyone inside Loop 1604. To schedule a ride on Health Bus, clients call MHS-RIDE at least 48 hours in advance of their appointment or scheduled admission, Monday through Friday from 8 a.m. to 5 p.m.

The Transportation Model in our "Desired Future State" is one containing dedicated vans and centralized scheduling by the Referral Specialists and Case Managers. Drivers could be recruited from the H4H clients themselves as paying jobs. With Haven for Hope's central location, connections and proximity to other homeless domiciles, a dedicated transportation service would bridge this gap. Transportation needs to be two ways. Many homeless reside in shelters all over the community and the transportation service needs to bring them to the H4H Health Services and return them "home". If you don't want them to go by EMS ambulance, provide on-demand transportation.

6. Ancillary: The services of the current H4H providers for such services as vision and dental can be continued but need to come under the direct aegis of the new H4H Health Services entity.

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<sup>8</sup> <http://sahealth.com/util/forms/HealthBusMetro.pdf>

7. Case Management and Outreach: The integrated model will need to contain robust Case Management and active Outreach teams.<sup>9</sup> The ability to target high utilizers for services tailored to their morbidities and circumstances is vital to reducing the unnecessary ED visits and avoiding the resulting hospitalizations. Outreach Teams carry caseloads of homeless “high utilizers” and provide assessment, services and communications to avoid the unnecessary use of EDs and 911 calls to EMS. As capacity and skills are developed, domiciled (IE, not homeless) high utilizers could also be serviced at the paid request of Hospitals and EMS providers that identify them.

8. DATA: Table 4 lists the current health information systems of San Antonio providers serving the homeless.

**Table 2**  
**San Antonio's Tower of Babel**

ORGANIZATION	EMR or Homeless Information System
CommuniCare	NextGen
CentroMed	NextGen
MHM (Methodist Ministries clinics)	NextGen
CHCS	Anasazi (from Cerner)
UT Medicine	Epic
Community Medicine Associates (UHS)	Allscripts Sunrise
Humana Physicians	Transcend Insight
Southwest Alamo Group	eMD
MHS	Meditech
CHRISTUS	Meditech
BHS	McKesson
UHS	Allscripts Sunrise

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<sup>9</sup> Outreach is defined as “...contact with any individual who would otherwise be ignored (or underserved)...in non- traditional settings for the purpose of improving their mental health, health, or social functioning or increasing their human service and resource utilization.” (Morse, 1987), quoted in Key Elements of Integrated Care for Persons Experiencing Homelessness, op. cit.

Nix	Siemens
Haven for Hope	HMIS (via HUD)

With so many different systems operating without any sort of interoperability there are always going to be problems. HASA is the region's HIE and has the mission of connecting all of these systems via its portal. Progress has been painstakingly slow and several interviewees complained that HASA was "not up to the task". These impressions are not well informed. HASA cannot force these healthcare organizations to connect. The organizations themselves must do so. All are well intentioned but have higher priorities for enhancing their EHRs than connecting to HASA. This is a particularly acute deficit for the homeless. In addition to the healthcare organizations, law enforcement, EMS and Haven's own HUD-sponsored system, Homeless Management Information System (HMIS), need to be connected if H4H are to coordinate healthcare as well as housing.

In our Desired Future State, organizations that fund these health care entities will require time-bounded progress toward full connectivity and then confirm completion (accountability). There are two additional accountability elements to this full EHR/HIE connectivity. First, to be registered as H4H Clients (and be eligible for all the health services), persons will have to explicitly "opt-in" to permitting access to their PHI among all providers and H4H's HMIS itself. Second, to both establish the cost benchmarks, document performance going forward and calculate cost savings, it is vital that all H4H registered clients be identified and that their service-level data be automatically collected and aggregated *in real time*. The completeness and integrity of the data must stand up to a rigorous independent audit. The data provided by Baptist Medical Center (BMC) and Metropolitan Methodist Hospital (MMH) were dependent on the knowledge of individuals in those hospitals who recognized the addresses of shelters, etc. (CentroMed actually produced the most extensive list of homeless shelter providers.)

In the current state, some data has to be manually double entered from one system to another. In many instances, a user must log in to multiple systems to piece together information. HIPPA is often cited as the barrier to sharing information but connecting to HASA can ameliorate this problem. Concerns about client confidentiality also require a high-level negotiation among collaborating clinicians, program managers, and across agencies. Additionally HUD recognizes the need and ability to share homeless data among organizations caring for the homeless.

*“PHAs and grantees, and their partners should work together to create and update processes that protect beneficiary confidentiality and conform to federal Health Insurance Portability and Accountability Act (HIPAA) regulations. However, it is possible to construct strong data-sharing agreements that still respect residents’ right to privacy. As long as data is aggregated **or there has been an Authorization to Release Information signed**, health clinics, schools, and other service providers can share information with housing agencies. This data sharing results in stronger service networks and more streamlined service provision for residents.”<sup>10</sup>.*

Additionally, there are specific exceptions to HIPPA for law enforcement agencies when public safety concerns are evident. Finally, in our Desired Future State, many of these problems are obviated by bringing most all the health care functions under a single organization and requiring contracted providers to be connected.

9. Hospital Rotation: The current rotation consists of BMC, MMH, Nix and, recently, CHRISTUS Santa Rosa (CSR) in the Medical Center. (CSR no longer has an adult ED or hospital downtown.) Transport to the Medical Center is inefficient. Downtown EMS crews experience longer run times and, once they get into the Medical Center, they get “caught in the spin cycle” of those calls and can’t get back downtown. Further, if transport to the Medical Center is to be required of CSR then UHS, which also has no ED or hospital downtown, should also be added to the rotation. Rather than have CSR and UHS enter the rotation, we recommend other assignments. Yet, all the health systems need to play some role in providing ED and hospital services for the homeless. Here is what we recommend for the Homeless population:

1. **BMC, MMH and Nix:** Adult Rotation, every third day.

2. **CSR’s Children’s Hospital of San Antonio:** Pediatrics, Labor and Delivery (Maternal and Child Health) and Gynecological patients, seven days a week. Medicaid and CHIP do provide coverage for most of the homeless children and mothers.

3. **UHS:** Full participation in CareLink for the homeless (see Specialty Care, above), continued Jail Health Services and Level I Trauma. (One possible UHS alternative would be to establish a Free Standing ED downtown at the Brady Green and enter the Adult Rotation.)

### C. **The Finished Model**

After an extensive literature search, we settled on the Stout Street Health Center in Denver, owned and operated by the Colorado Coalition for the Homeless as being the best example of what our envisioned

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<sup>10</sup> <https://www.hudexchange.info/resources/documents/Notice-CPD-11-09-Pih-11-51-Promoting-Partnerships.pdf>

future state should look like. We highly recommend reading their 2013 Study.<sup>11</sup> The \$35 million development contains the Health Center on the Ground Floor and Second Floors (approximately 11,000 S.F. per floor) and three floors containing 78 housing units. See Appendix Figure 1 for a layout of the facility.

Serving a homeless population base of 18,000 in the metro Denver area, the property features

*“larger interior waiting areas to eliminate the physical and emotional discomfort of standing in long lines on the street and a sheltered exterior courtyard for patients to utilize prior to opening hours. A new off street access bay for ambulances and emergency vehicles will prevent traffic obstructions that are common at the current site.”*

The health services organization for the Colorado Coalition features the following leadership positions:

- Director of Integrated Health Services
- Medical Director of Integrated Care
- Directors of Medical and Psychiatric Services

Assuming that the homeless population of San Antonio is a fraction of Denver’s 18,000, the size of the facilities would be adjusted accordingly. We recommend that contacts and site visits to Denver occur to both see the facilities and, more importantly, experience the fully integrated model and its organizational design.

## **VII. Recommendations for Further Study and Conclusion:**

### **A. Recommendations for Further Study**

1. Determining the detailed mix of services that are necessary to make the H4H Health Services Model the “Easy Button”. Extensive clinical determinations to be made.
2. Determining the best way to establish a unique patient identifier for the homeless, shared by all providers. Required for care coordination, access to services and tracking use and associated costs.
3. Working with the Hospitals, EMS and Government beneficiaries of the proposed intervention, conduct a financial study to establish an agreed on rationale for setting the cost benchmarks, measuring progress made and calculating payments owed.
4. Working with HASA and the health care organizations to develop binding commitments for connecting

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<sup>11</sup> “Developing an Integrated Health Care Model for Homeless and Other Vulnerable Populations in Colorado”, <http://www.coloradocoalition.org/userfiles/Library/CCH.SIM.2013.pdf>

all EHRs to the HIE by dates certain.

5. Meadows Mental Health Policy Institute study, commissioned by MHM, is nearing completion and will soon be available for further study and implementation of behavioral health recommendations, as they apply to the homeless.

## **B. Conclusion**

As an educational experience, this project has been enormously rewarding. We have learned a lot about who the homeless are and the substantial challenges they face. Many of the common misconceptions that we held about the homeless were dispelled in the process. We also gained an appreciation for the dedication and passion of those working and volunteering at Haven for Hope and its affiliated agencies and organizations. The accomplishments of Haven for Hope are amazing and few communities can come close to the accomplishments that the San Antonio community has achieved regarding its homeless population. We also experienced the frustrations of not being able to go deeper and produce a better Study. Only the limitations of time and space (and four other courses) prevented us from doing so. We hope that the next HCAD class is invited to take this up where we left off.

Our Study is in no way definitive or dispositive. Many flaws exist, some known and others unknown to us. We apologize in advance for our errors of commission and omission. We are sure they are many in number. We do ask that the Study be viewed in a holistic fashion. We tried to paint a picture of the Current State, as seen by relatively novice outsiders. Few insiders have had the opportunity to do that so we hope that the Study sheds some light on the whole. We also adopted a theoretical framework to help categorize, interpret and explain the Current State as well as the Desired Future State. It got a little wonky but some will relate to that.

Most importantly, we wanted to take all that we learned and design a Model for the future that coheres. It's the "vision thing" but it's important to have one. As Proverbs 29:18 extols: "Where there is no vision, the people perish." Haven for Hope itself is the product of just such a vision. But a legion of practical concerns will impinge on this Health Services vision. There will be skeptics and there will be cynics. You can work with the skeptics because their skepticism is borne out of frustration. And they are only frustrated because they care. Use that.

The cynics are another matter. For them, no answers are possible. All is lost. Marginalize and ignore them, as best you can. Above all, don't become infected yourself. Avoid the evasion of cynicism, which –

paraphrasing the philosopher Michael Sandel – goes like this: These questions (in this case, regarding homelessness) have been with civilization since the beginning of time and if they couldn't be solved by the most experienced and capable leaders on the planet, what makes us think that we here in San Antonio (much less graduate students over a 14 week semester) could provide answers to these questions? That is true enough. But what makes this pursuit worthwhile, fascinating and inescapable is that **your community is living out answers to these questions every day**. It's not that we don't have answers. It's that our current answers are not good enough. And we want to make a difference.

Our fondest hope is that the Health Services Model is at least compelling enough to catalyze a dialogue among the stakeholders and larger community. We would be comfortable with whatever results from that.



**Appendix Table 1:  
Urgent Care Services**

<p><b>1. General Illness Diagnosis &amp; Treatment</b></p> <ul style="list-style-type: none"> <li>• Abscess incision and drainage</li> <li>• Allergic reactions</li> <li>• Allergies</li> <li>• Asthma</li> <li>• Athlete's foot/fungus infection</li> <li>• Bronchitis</li> <li>• Burns from heat or chemical exposure</li> <li>• Congestion</li> <li>• Cough</li> <li>• Diaper rash</li> <li>• Ear infection</li> <li>• Earache</li> <li>• Eye infection</li> <li>• Fever</li> <li>• Flu symptoms</li> <li>• Cerumen Impaction</li> <li>• Gastrointestinal disorders</li> <li>• Insect bites</li> <li>• Itchy skin</li> <li>• Migraine</li> <li>• Nausea</li> <li>• Rashes</li> <li>• Runny nose</li> <li>• Sinus infection</li> <li>• Skin allergy</li> <li>• Skin infections</li> <li>• Sore throat</li> <li>• STD testing and treatment</li> <li>• Stomachaches and stomach pains</li> <li>• Urinary tract infections</li> <li>• Wound infection, cellulitis</li> </ul> <p><b>2. Injuries</b></p> <ul style="list-style-type: none"> <li>• Burns from heat or chemical exposure</li> <li>• Fractures</li> </ul>	<ul style="list-style-type: none"> <li>• Splints</li> <li>• Sprains</li> <li>• Stitches/Suturing/Stapling</li> <li>• Strains</li> <li>• Wound infection</li> </ul> <p><b>3. X-rays Available</b></p> <ul style="list-style-type: none"> <li>• Upper extremities</li> <li>• Lower extremities</li> <li>• Chest (lungs)</li> <li>• Spine / Lumbar</li> <li>• Skull (face)</li> <li>• Abdominal</li> <li>• Pelvis / Hip</li> </ul> <p><b>4. Lab Services Available</b></p> <ul style="list-style-type: none"> <li>• Basic Metabolic Panel</li> <li>• Blood Glucose</li> <li>• Complete Blood Count</li> <li>• Comprehensive Metabolic Panel</li> <li>• Electrolytes</li> <li>• Fecal Blood Occult</li> <li>• Flu</li> <li>• Mono</li> <li>• Pregnancy</li> <li>• Strep A (sent out)</li> <li>• Trichomonas</li> <li>• Urinalysis</li> </ul> <p><b>5. Pediatric Services</b></p> <ul style="list-style-type: none"> <li>• Influenza</li> <li>• Bronchitis</li> <li>• Asthma</li> <li>• Infections (ear/ eye/ urinary tract/skin)</li> <li>• Rashes</li> <li>• Sore throats</li> <li>• Headaches and colds</li> <li>• Treatment for minor pediatric injury</li> </ul>	<p><b>6. Occupational Medicine Services</b></p> <ul style="list-style-type: none"> <li>• Workers' compensation injury and illness management</li> <li>• Physical exams</li> <li>• Drug screens</li> <li>• Laboratory and screening tests</li> <li>• Spirometry/pulmonary function</li> <li>• EKG</li> <li>• Respiratory fit</li> <li>• Hearing</li> <li>• Blood</li> <li>• Urine</li> <li>• BAT</li> <li>• Digital x-ray services</li> <li>• Vision screening</li> <li>• Immunizations</li> </ul> <p><b>7. IMMUNIZATIONS AND VACCINATIONS</b></p> <ul style="list-style-type: none"> <li>• Flu Shots</li> <li>• Hepatitis A</li> <li>• Hepatitis B</li> <li>• Measles/Mumps/Rubella</li> <li>• Meningitis</li> <li>• Rabies</li> <li>• Shingles</li> <li>• Tetanus/Diphtheria/Pertussis (TDAP)</li> <li>• Tuberculosis (TB), TB skin test</li> <li>• HPV</li> <li>• Pneumococcus</li> </ul>
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**Appendix Table 2:  
Urgent Care Cost Estimates**

<b>1. Getting to Opening Day</b>	
Finish out for 4000-4500 square foot building	\$350,000.00
Medical equipment and supplies	\$150,000.00
One month of salaries to get staff/providers trained	\$40,000.00
<b>Total *</b>	\$540,000.00
<b>2. Basic Staffing</b>	
Physician FTE's	1.50
Mid Level FTE's	1.00
Front Office FTE's	2.50
Back Office FTE's	4.50
<b>Total</b> (LMRTs can function as MAs)	9.50
<b>3. Staffing Salaries and Wages per Month</b>	
Physician Staffing	\$36,000.00
Physician Medical Director Fee (25-35K/clinic/year)	\$2,500.00
Mid level provider (\$65-\$75/hr)	\$12,600.00
Front Office Staff (\$13-\$15/hr)	\$4,939.20
Back Office Staff (LMRT's/MA) (\$17-\$19/hr)	\$6,350.40
<b>Total</b>	\$62,389.60
<b>4. Total Monthly Expenses</b>	\$130,000.00

Christopher Cheney, "The New Urgent Care Wave", HealthLeaders, Nov 2015, pp 38-40.

# Appendix Figure 1: Ground and Second Floors, Stout Street Health Center

## 08 SSHC Floor Plan: Ground Floor

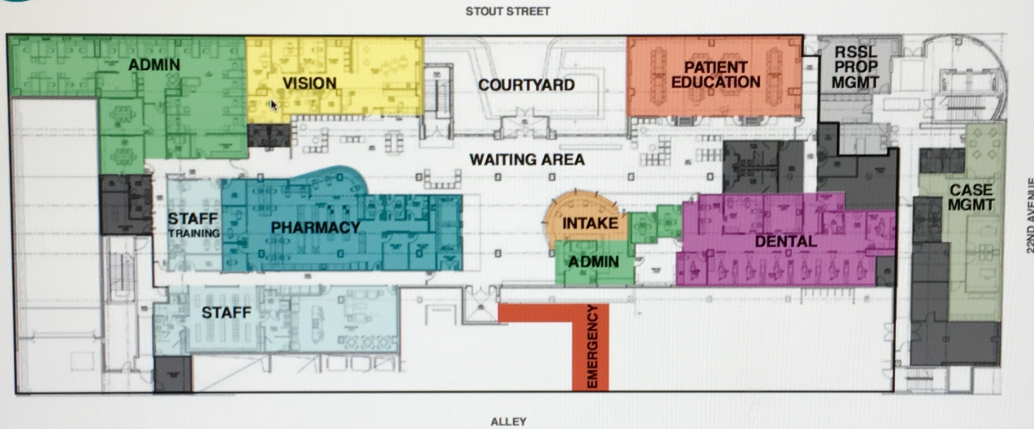


Figure 7: Stout Street Health Center Floor Plan: Ground Floor

## SSHCH Floor Plan: Second Floor

08

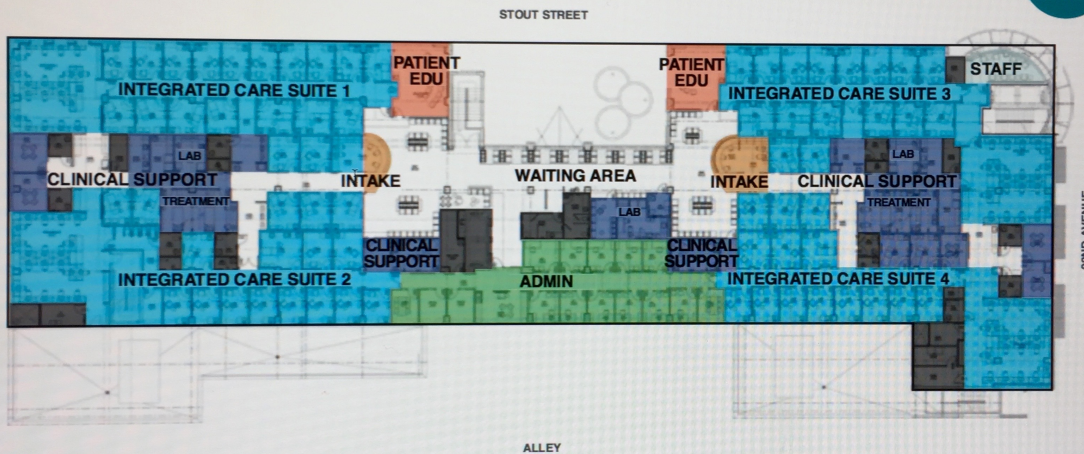


Figure 8: Stout Street Health Center Floor Plan: Second Floor

**Appendix Figure 2:  
CentroMed Response Letter**



MEMORANDUM

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**TO: Mr. John Hornbeak**

**DATE: December 10, 2015**

**FROM: Ernesto Gomez, Ph.D.**

**RE: *Study of Healthcare Services  
for the Homeless Report***

A handwritten signature in blue ink, appearing to read "Ernesto", with a horizontal line underneath it.

**CC: File**

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CentroMed appreciates the opportunity to comment on the draft *Study of Healthcare Services for the Homeless* report. We appreciate the time and effort put forth by Trinity University students in conducting the study inasmuch as their report elucidates the many gaps in the delivery of healthcare services to persons experiencing homelessness. We are in general agreement with the report's findings and endorse its core recommendation to expand the scope of healthcare services at Haven for Hope (Haven). In endorsing the proposed approach, it is important to underscore a few key points listed below.

- O Glaring shortcomings noted in the report in the form of 'silos' in operation are due to the way services were structured at inception and are not to be attributed to the wishes of any of the organizations currently providing services at Haven.
- O Urgent care services will certainly address a number of emergent conditions that patients present but will fall short of continuity care (ongoing, not episodic) that a patient-centered medical home requires to address ongoing health care needs and foster optimal health outcomes. A clinic site that incorporates continuity care and urgent care services offers the optimal scope of healthcare services for the population of interest at Haven.
- O The primary care model utilized to serve vulnerable populations must incorporate behavioral health as an integral part of primary care. The report clearly notes the prevalence of mental health and substance abuse conditions of persons experiencing homelessness and emphasizes the interrelatedness to physical health and mental health. It is unfortunate that the report did not incorporate the collaborative work CentroMed and the Center for Health Care Services (CHCS) did in integrating primary care into one of CHCS' mental health clinics. Much was learned from this endeavor, particularly the significant challenges of implementing an Integrated Behavioral Health (IBH) model of care with severely mentally ill populations with multiple undiagnosed and/or untreated health conditions, most of whom had unstable home environments and limited familial or

social support. The lessons learned from that pilot clinic are applicable and transferable to an IBH model of care at Haven.

- D It is important to underscore that persons experiencing homelessness most often do not have the social or emotional stability required to follow treatment regimens prescribed by medical personnel. The use of a model of care that incorporates behavioral health services requires a complement of support services, inclusive of: (1) Patient-based Case Management to monitor patient compliance with treatments and daily dispensing of pharmaceuticals therapies; (2) Care Coordination Services to ensure patients obtain requisite referral services and appropriate follow-up (continuity care); (3) Specialty Care and Diagnostic Testing to address health concerns that fall beyond the scope of care at an outpatient ambulatory setting; (4) Transportation Services to enable patients to access required services; and (5) Enabling Services to enroll patients in social and support programs that can assist patients in their transition to a higher level of stability and self- sufficiency.
- D A common medical record is paramount to achieving integrated care. The use of a common Electronic Medical Record (E.H.R.) facilitates integration and fosters greater level of consultation and collaboration among clinical providers.

As the only HRSA-funded Healthcare for the Homeless provider in Bexar County, CentroMed is acutely aware of the significant challenges in providing coordinated healthcare services to persons experiencing homelessness. With 28 years of experience in the delivery of health care services to persons who are homeless, CentroMed has amassed extensive knowledge in the subtleties of a healthcare delivery system adapted to care for vulnerable populations. Moreover, as a HRSA-designated healthcare provider to serve homeless populations, CentroMed has access to 340B drug pricing and FTCA liability coverage, and has ongoing opportunities to draw additional HRSA funding to expand the scope. of healthcare services for patients served by Haven. CentroMed is well-positioned to implement the Integrated Behavioral Health model proposed in this study and is prepared to staff up our Davidson Clinic to accommodate the higher level of care indicated inclusive of after-hours care, introduction of a Class A Pharmacy on campus, and the addition of Psychiatry-level Integrated Behavioral Health (IBH).

We look forward to working with the group designated to develop plans for expanding and enhancing the scope of healthcare services provided to patients at Haven for Hope and other persons experiencing homelessness.

Thank you again for the opportunity to comment on the report.