# The Mary Howard Health Center: Meeting the Health Care Needs of the Chronically Homeless in Philadelphia

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## Summary

Since 1985, the Health Care for the Homeless Program has been bringing medical services directly to the homeless of Philadelphia in shelters, transitional housing day programs and even on the streets. The Mary Howard Health Center is the primary care component of a continuum of care that often begins with a street outreach worker, continues with health care delivered in shelters by nurses and culminates in full, primary care delivered in the Center. This model has proven successful in reaching and helping this vulnerable population. HCH is administered by the Public Health Management Corporation and is under the leadership of Elaine R. Fox. Mary Howard is the only primary health center in Philadelphia that solely serves the homeless population, and in particular, chronically homeless adults. The Center provides comprehensive primary care services, including family

planning, management of chronic diseases, behavioral health services, nutrition counseling and assistance with applying for benefits and obtaining housing. Mary Howard is a nurse-managed health center that addresses the complex health care needs of the patients it serves.

## The Causes of Homelessness

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Homelessness has its roots in structural issues — the shortage of decent, affordable and safe housing — combined with serious, long-standing personal problems, such as lack of educational or vocational skills, family violence and substance abuse and mental illness. These problems spiral out of control, resulting in the inability to provide for oneself or one's family. Rarely does a person have only one problem that causes homelessness. Problems are often compounded by undiagnosed or untreated substance abuse and mental health problems. Once people have exhausted their own resources and those offered by family and friends, they have no other option but to enter a homeless shelter.

Approximately 3.5 million people are likely to experience homelessness in any given year (National Law Center on Homelessness and Poverty 2007). Poor health status is closely associated with homelessness. In 2007, the Census Bureau estimated that 45.7 million Americans did not have health insurance (National Coalition for the

Homeless 2009a); income is a key determinant of the ability to obtain health insurance and pay for healthcare services. The lack of health insurance (National Coalition for the Homeless 2009a) goes hand-in-hand with the lack of employment, marginal jobs or jobs that pay “under the table.” Not only poor people are affected by the lack of health insurance: The National Health Care for the Homeless Council (2008) states that 50 percent of personal bankruptcies in the United States are related to healthcare problems.

## The Homeless and Lack of Health Care

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Homeless individuals rarely have access to comprehensive primary care. While the lack of insurance is one issue, it is not the only one. For homeless people, health care is not a priority as they engage in a daily search for a place to stay for the night, food and safety. Besides lack of insurance, barriers to their receiving needed care include inability to tolerate long waits in traditional healthcare facilities and their failure to keep appointments. Few providers are familiar with the culture of homelessness, nor do they have the time to address the many healthcare problems that are often intertwined with mental illness or substance abuse. As a result, homeless people frequently end up using costly hospital emergency rooms for problems that could have been

prevented with access to primary care. According to the Institute of Medicine (1988), poor health causes homelessness, homelessness causes poor health, and homelessness complicates efforts to treat health problems. The chronically homeless have an even greater intensity of problems and require even more services.

## The History of Health Care for the Homeless

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Health Care for the Homeless (HCH) has its roots in a national pilot project first funded by the Robert Wood Johnson Foundation and the Pew Charitable Trusts to find innovative ways to provide health care to homeless people. Because of the success of this project, federal start-up funding followed. In addition, financial assistance is obtained from grants from the Independence Foundation and Independence Blue Cross. Additional funding is provided via the Family Planning Council and Community Behavioral Health. For patients who have insurance and choose Mary Howard as their primary care provider, reimbursement from managed care is received. As a federally qualified health center, the project receives a higher rate of reimbursement per encounter. This helps to cover the close to 50 percent of clinic users who lack insurance.

HCH is federally funded through the Bureau of Primary

Health Care (BPHC), a division of the Health Resources and Services Administration (HRSA), whose mission is to increase access to primary and preventative healthcare services among at-risk populations (National Health Care for the Homeless Council 2010). BPHC administers HCH as part of section 330 of the Public Health Service Act; HRSA gives grants to community-based organizations such as the Health Care for the Homeless Project. HRSA programs are mandated to provide primary health care, substance abuse services, emergency care, outreach and assistance in obtaining adequate housing. BPHC programs can also provide other services such as mental health and dental services. BPHC programs serve an estimated 740,000 homeless people annually (National Coalition for the Homeless 2009a)

### The Mary Howard Health Center

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Philadelphia's Health Care for the Homeless Program (HCH) is a continuum of services for homeless people ranging from street outreach, health care at shelters and non-traditional sites where homeless people congregate, to a comprehensive primary care health center in Center City Philadelphia. The primary care center, named The Mary Howard Health Center, opened its doors in 1997. The health center is named in honor of a chronically homeless Philadelphia woman, well known to service providers, who

died of health complications related to being homeless. The Center is within walking distance of many shelters; it serves more than 2,000 clients a year, mostly the chronically homeless, and has recently expanded through federal stimulus funding.

The Center's first location was in the basement of St. Luke's and the Epiphany Church at 13th and Pine Streets. Although it had only one exam room, it became an instant success with homeless people, referred by the project's outreach staff and by word of mouth. It was so successful, in fact, that the space was rapidly outgrown. The second center was in the first floor of an office building in Center City where the project now could contain four exam rooms and space for additional staff and services. Finally, thanks to the American Recovery and Reinvestment Act of 2009, Mary Howard was able to grow to ten exam rooms with space for behavioral health and social services.

### Medical Outreach

## Medical Outreach

Complementing services offered within Mary Howard Health Center, medical outreach plays a crucial role in providing integrated services and in addressing the healthcare needs of those without permanent housing. Health Care for the Homeless nurses such as Kate Gleason, RN, are assigned to homeless shelters where they provide nursing services such as medication

management, assessments, screening and referrals. One of Gleason's responsibilities, coordinated with a social worker, is to assess patients' medical and behavioral needs. During a recent visit to a large men's shelter that Gleason visits weekly, her kind but no-nonsense approach was demonstrated as she directed a resident of the shelter to the Center. She was able to discuss the client's needs, review his medical history and provide a nursing assessment prior to the referral. Her calm redirecting of the client's disjointed train of thought was emblematic of some of the challenges associated with building a healthcare relationship with those who are homeless and have a variety of medical and behavioral health needs. Health Care for the Homeless staff work with all service providers in the city. Homeless advocates and outreach workers are part of the network of providers that make it possible to successfully provide healthcare services along a continuum of care, from those living on the streets to those who are becoming self-sufficient. The chronically homeless are a particularly difficult population to access. These outreach efforts offer a haven of sensitive healthcare services to this generally marginalized community. Elaine Fox says she believes her staff "is effective in providing comprehensive health care to the homeless because they are sensitive to the needs of the homeless and provide care with a holistic approach that deals with the needs of the entire individual, and not just the medical needs of that person."

# Local Circumstances That Give Rise to Homelessness

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In the Southeastern Pennsylvania region, the median household income is $51,957; in Philadelphia, the median household income is $32,769 (Philadelphia Health Management Corporation Community Health Data Base 2004). The U.S. Bureau of Labor Statistics (2009) reports that Philadelphia has an unemployment rate of 10.6 percent, which exceeds the country's unemployment rate of 9.7 percent. In the Philadelphia area, 22.9 percent of people live below the poverty line (Philadelphia Health Management Corporation Community Health Data Base 2004). PHMC's service area has an estimated 25,000 homeless people (National Health Care for the Homeless Council 2009). Employment and income are closely related to access to healthcare services; when an individual lacks one or both of these, poor health outcomes often follow.

Fox describes some of the factors contributing to homelessness in Philadelphia:

- The erosion or elimination of many safety-net systems at the local, state and federal levels
- Inadequate substance abuse treatment services
- Inadequate outpatient mental health services
- Increased cost of housing in the private market

- Dwindling supply of vouchers for subsidized housing
- The increasing number of jobs that require technical skills and a higher level of literacy and the fewer people who are adequately educated and available to fill them

## Characteristics of the Chronically Homeless

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The U.S. Department of Housing and Urban Development defines chronic homelessness as the state of being an unaccompanied homeless individual with a disabling condition (e.g., substance abuse, serious mental illness, developmental disability or chronic physical illness), who has been continuously homeless for a year or more or has had at least four episodes of homelessness in the past three years. In order to be considered chronically homeless, a person must have been sleeping in a place not meant for human habitation and/or in an emergency homeless shelter.

Racial and ethnic minorities are overrepresented among the chronically homeless, particularly African Americans (United States Conference of Mayors 2005):

- 39 percent are non-Hispanic whites (compared to 76 percent of the general population)
- 42 percent are African American (vs. 11 percent of

the general population)
- 13 percent are Hispanic (vs. 9 percent)
- 4 percent are Native American (vs. 1 percent)
- 2 percent are Asian (vs. 3 percent)

Military veterans are also overrepresented, with 40 percent of homeless men being veterans (National Coalition for the Homeless 2009b). The chronically homeless are typically male and middle-aged (Burt 2005), with women and families increasingly affected. In the United States an estimated 10,000 to 15,000 families deal with chronic homelessness (Culhane et al. 2007). The three most common causes of homelessness for families are poverty, lack of employment and lack of affordable housing. For single individuals the causes often reported are lack of affordable housing and substance abuse (United States Conference of Mayors 2008). Recently, as a result of the recession, there has been a major increase of homelessness in a majority of large cities in the United States, with a 12 percent average increase since 2007 and more families than individuals affected (United States Conference of Mayors 2009).

An estimated 20 percent of the homeless are chronically homeless, which equates to 124,000 individuals in the United States (U.S. Department of Housing and Urban Development 2008). These chronically homeless individuals use 50 percent of targeted services (National Alliance to End Homelessness 2010).
Diseases common to homeless people are heart disease,

cancer, liver disease, kidney disease, skin infections, HIV/AIDS, pneumonia and tuberculosis (O'Connell 2005). All of these conditions are exacerbated by life on the street, a lack of nutritious food, lack of a primary care provider and the lack of a stable living situation.

## Resources for Primary Care for the Homeless

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While all citizens, including the homeless, are able to use any of the City's public health clinics, these services do not accommodate homeless individuals' specific needs. The long waits for appointments, while unavoidable, are difficult for homeless people to manage. City health centers recently adopted a minimal co-pay for all its patients. Homeless people, however, do not have the funds for a co-pay, regardless of how minimal, that are required by traditional centers. As a result of not having a source of primary care, many homeless people instead use emergency services, resulting in expensive treatment and poor to nonexistent follow-up. Often homeless people are released from emergency rooms with prescriptions they cannot fill and instructions they cannot understand. The homeless have higher rates of emergency department use because of higher rates of untreated illness and lack of insurance. Even those with insurance,

may have been assigned to providers far from where they are, and may not even know who they are. Without the appropriate follow-up for needed medical care, problems are more acute when presented at the emergency room, and tend to cyclically reach an acute stage requiring emergent intervention. As a result, homeless people are three to four times more likely to die than the non-homeless population (O'Connell 2005).

The National Health Care for the Homeless Council (2008) estimates that 70 percent of homeless people do not have health insurance. This population is more apt to use emergency room services as a result of prolonged exposure to living without a permanent home, chronic health conditions and acute complications due to lack of medical and behavioral follow-up. In 2006, Pennsylvania spent a reported $790,754,728 on avoidable emergency care (National Association of Community Health Centers 2009). This type of health care is episodic and expensive, with poor health outcomes for the individual.

When an uninsured person goes to the emergency room, the mean expense per person is $1,038 (Kashihara and Carper 2009). Use of the ER for non-emergent services results in overcrowding and decreased access for those with truly emergent needs (Han and Wells 2003). Homeless individuals who use the ER are more likely to report a lack of primary care and social isolation (D'Amore, Chiang, and Goldfrank 2001).

Maggie Greco, director and a nurse practitioner at Mary Howard, reports an average of 40-50 people being seen at the center per day, a combination of walk-in visits and appointments; the majority of their clients, Greco reports, have serious mental health issues, and many have chronic conditions such as diabetes, hypertension, chronic obstructive pulmonary disease and hepatitis C. Many patients have never sought care before or have only received episodic care or costly ER visits.

## The Solution: Health Care Services That Target the Homeless

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HCH provides nurse-managed primary health care that is targeted to the homeless and easily accessible. At all levels, staff meet homeless people where they are. Strong outreach efforts and a primary care center with strong psychiatric supports have been crucial in establishing contact and maintaining relationships with the homeless, especially the chronically homeless.

Rhonda Carter, one of two psychiatric nurse practitioners at Mary Howard Health Center, believes that the Center's management by nurses, "who are nurturing by nature, providing the attention and thorough care that the clients most appreciate," is a central factor in the center's success. As Carter describes the services offered at Mary

Howard, “The integrated services for medical, behavioral health, social services, lab accessibility, eye care, nutrition education, and education for diabetes and hypertension are effective for this population.” Carter is among the staff that pride themselves on being flexible, non-judgmental and sensitive to clients’ needs. Success is measured in small steps.

Carter relates a success story. “Cookie” is a 51-year-old well-educated African-American woman; after being injured on the job and without finances to maintain her apartment, she became homeless. She lived in the shelter system over a year. She had a history of recurrent depressive episodes, which were exacerbated by her homelessness, to the point of suicidal ideations. She was started on psychotropic medication, received supportive counseling and was able to address her medical needs at Mary Howard. This helped reestablish some stability in her mood and maintain her physical health. She is now working and living in her own apartment, and she plans to return to school for a nursing career. Finances are limited, but she is determined and motivated.

According to Fox, several elements of HCH make it unique and successful:

1. *HCH understands the culture of homelessness.* Clinicians and staff need to be good, patient listeners, and always treat the individual as a person and not as a medical problem. As a nurse-run

facility, HCH emphasizes treatment of the entire person. This is contrary to the traditional model of diagnosing and treating illness, often without understanding the context of the patient's life.

2. *HCH focuses on chronic conditions.* The treatment of chronic diseases is multi-faceted. Messages are reinforced at each visit by each clinician who sees the patient. A diabetes support and education group has proven to be very successful, and a nutritionist provides one-on-one nutritional counseling, all of which support the patient. Patients are actively involved in their own care. The goal is incremental and positive change over time.

3. *HCH integrates primary and behavioral health.* This integration allows for a smoother and more likely transition to and acceptance of psychiatric evaluation and assistance. In the traditional model, the primary care physician may make a referral to a mental health professional, but follow-through is often unlikely for anyone, let alone a homeless person. At Mary Howard, two psychiatric nurse practitioners provide assessment, counseling and medication to those in need. A licensed clinical social worker provides "brief intervention counseling" to primary care patients right in the exam room. In all cases the intent is to provide mental health services within the safe confines of the primary care setting.

4. *Outreach is essential to reaching homeless people and bringing them into a system of care.* Services at shelters build trust and make it easier for clients to come in to the Center. Collaborative efforts among stakeholders help to ensure that patients receive the right mix of care and do not fall through the cracks.

5. *HCH collaborates and forms strategic partnerships with city departments, outreach teams, communities and housing coalitions.* This enables all participating groups to work collectively in order to find solutions to complicated structural problems that are not easily solved.

6. *Awareness of Mary Howard Health Center comes from outreach efforts, shelter referrals, hospital referrals and word of mouth.* The Center has walk-in and scheduled appointments, and when appointments are not kept, the approach is collaborative, not punitive. Walk-in hours are well utilized. Team work both within the Center and within the broader provider community is essential.
According to Jenny Villegas, MSW, who is responsible for handling social services at the center, “networking and keeping strong connections to other social service agencies in the city is essential. This collaborative attitude is one that requires constant nurturing, and cannot be taken for granted.” Philadelphia is unique in its culture of organizations committed to ending homelessness. As a result of Mary Howard’s networking with other social service agencies, outcomes tend to be more comprehensive, and much less fragmented. As for the

center itself, Villegas states that the entire staff works well together, employing a common approach of respect for the dignity of the individual. Villegas is able to assist with much of the paperwork necessary to obtain identification, medical assistance, welfare and Social Security benefits. “Changing habits can be slow with this population, and so much patience and a reining in of our own expectations for change is essential,” says Villegas.

Mary Howard’s incorporation of primary care with behavioral health within one visit has been instrumental in the Center’s success. The process of obtaining a psychiatric referral illustrates the difference. Typically, it is essential to have a primary health provider and determine what insurance (for those who have it) is accepted. Those who lack identification or a permanent mailing address cannot obtain health benefits. Those who have found a primary care provider and obtained an appointment may lack transportation funds and may be focused on daily survival versus the need for delayed care. Then there is the humiliation associated with sitting in a waiting room for those who may be wearing soiled clothes and be soiled themselves, and encounter a judgmental attitude from the staff at providers’ offices. Only having gotten this far can the homeless generally obtain a psychiatric referral. And then the cycle continues. Those with behavioral health problems are disadvantaged in their capacity to follow through with such a lengthy and often degrading experience.

## Social Impact and Funding

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As a primary healthcare center with collaborative outreach connections, Mary Howard offers targeted provision of care to the chronic homeless population. This in turn impacts the health of the individual by addressing problems as they occur, and not at the point of emergent care. The culture of the Center is non-judgmental, which is of vital importance for a population that tends to feel acutely that they have failed in their personal lives, and may come to expect judgment as a standard response. Staff encourage and praise any incremental improvement as the keystone to building a more trusting relationship. Building trust and conveying the sense that professionals at the health center care about their clients are essential elements of maintaining a consistent relationship. Having medical, behavioral and social services under one roof increases the likelihood that the homeless will obtain necessary care before a situation becomes a crisis. Providers and staff who are sensitive to the needs of this population are paramount, and the good rate of return of patients at Mary Howard speaks volumes about the comfort level of those who obtain services there.

## Social Return on Investment

# Social Return on Investment

The average cost of providing care to a homeless person at Mary Howard is $214.74 per nurse practitioner visit. In comparison, the average per-person cost of treating a homeless person in an ER is $1,038. (Though the homeless who are admitted to the hospital tend to require longer stays than their non-homeless counterparts, for simplicity's sake the following analysis does not include the cost of hospitalization, which would add to the expenses greatly.)

To ascertain the social return on investment for Mary Howard's primary care services, taking into account the average 40-50 patients the Center sees each day, we can calculate the projected cost of those patients going to the ER instead and the difference in cost between the two scenarios. According to this calculation, the estimated return on investment of utilizing the services of Mary Howard is $8,561,904 on a yearly basis (see Figure 1).

## Figure 1. Annual estimated social return on investment for Mary Howard Health Center's primary care services


## Conclusion and Policy Implications

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Philadelphia has been a leader in the movement to end homelessness. With the recent enactment of the Patient Protection and Affordable Care Act, the promise of the expansion of Medicaid will enable many more people to be eligible for this entitlement. Though this no doubt will benefit many living in poverty, the homeless population, and especially the chronically homeless, will remain one of the most challenging segments of the population to reach. That is why it is crucial that the federal government continue to support Health Care for the Homeless and other safety net programs. This program has been proven cost-effective in treating the special needs of the homeless. Targeted, primary and integrative care provided by nurse-led health centers has worked, and worked well, and continued federal support is imperative.

HCH provides targeted health care to a vulnerable population that has few resources for primary care. Jenny Villegas of Mary Howard Health Center related the success story of Valerie, a 60-year-old woman who was living under one of the major highways in Philadelphia. With repeated outreach efforts, Valerie finally agreed to go to a shelter, where she remained for nine months. From there, she was able to have access to the integrated care provided by Mary Howard, including services for behavioral health. Prior to her homelessness, she had been employed in television production, and reported

self-medicating for her increasingly worsening mental health symptoms with alcohol and medications. Because of her increasingly erratic behavior, she lost her job and eventually her home. With proper care of her psychiatric illness, she eventually moved from the shelter to transitional housing, and after one year there, she now has her own apartment. Her mental illness is well managed, and she was able to obtain Social Security benefits. Valerie continues to use the Center for her health care. The integration of medical and behavioral health care appears to be a common thread in the success of clients served by Mary Howard and HCH.

Mary Howard Health Center and all of HCH's outreach programs and efforts have made a difference in the lives of homeless people. Staff members understand the culture of homelessness and the special needs of those who are chronically homeless. With a strong emphasis on collaboration and utilizing a nurse-run model of integrative care, the program has been very successful, and has been replicated nationally. Under the capable direction of Elaine Fox, the program continues to expand and meet the complex needs of the homeless. Appropriate political and financial support is imperative to allow for this effective and innovative model of care to continue.

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