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National Association of
Community Health Centers, Inc®

SPECIAL POPULATION SERIES

Obligations of Community Health Centers to Provide Outreach to Special Populations

Section 330 of the Public Health Service Act (Section 330) authorizes funding for health centers to support the provision of comprehensive primary and preventive care to medically underserved populations.[1] Section 330 grant funds may be awarded to health centers that serve all community residents (*i.e.,* Community Health Centers or CHCs)[2] and/or target one or more of these "special populations:"

Section 330(g): Migratory and seasonal agricultural workers
(Migrant Health Center or MHC programs).[3]

Section 330(h): Homeless populations
(Health Care for the Homeless or HCH programs).

Sections 330(i): Residents of public housing
(Public Housing Primary Care or PHPC programs).

Regardless of the type of funding a health center receives, to operate a successful program, residents of the community (in particular, the target population or populations) must be informed about:

- The existence of the health center;
- What services are available;
- How, when, and to whom they are available; and
- The appropriate manner by which patients can utilize the services.

For more information contact

Jacqueline C. Leifer, Esq. or
Marcie H. Zakheim, Esq.
Feldesman Tucker Leifer Fidell LLP
2001 L Street NW
Washington DC 20036
Telephone: (202) 466-8960
Fax: (202) 293-8103
Email: MZakheim@ftlf.com

or

Betsy Vieth
National Association of Community Health Centers, Inc.
7200 Wisconsin Avenue, Suite 210
Bethesda, Maryland 20814
Telephone: (301) 347-0400
Fax: (301) 347-0459
Email: BVieth@nachc.com

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1 Section 330 of the Public Health Service Act, as amended by the Health Centers Consolidation Act of 1996 and the Safety Net Amendments of 2002 (P.L. 104-299 and P.L. 107-251; 42 U.S.C. § 254b).

2 Grants awarded under Section 330(e).

3 While the Section 330 statute uses the term "migratory and seasonal agricultural workers," such populations are commonly referred to as migrant and seasonal farmworkers ("MSFWs"); as such, the term MSFW will be used throughout this Information Bulletin to refer to this population, as well as to their families.

A well designed, comprehensive community health program is meaningless if no one knows that the health center is there. Simply put – if you build it, they will not automatically come! Outreach activities designed to educate the public about the availability and appropriate use of services are a vital component of a successful health center program, providing valuable information that ultimately enables everyone to access necessary health care services.

In designing an outreach program, it is important to recognize that special populations, such as those indicted above, may demonstrate unique characteristics and experience unique access barriers that require health centers to use distinctive methods to effectively reach these populations. All health centers should be familiar with the challenges inherent in providing outreach activities to the special populations residing in their communities, as well as the activities designed to overcome such challenges, whether the health center specifically targets its services to such populations or serves the community at large whose residents may include: MSFW and their families; homeless adults, families and children (as well as children and/or youth at risk of homelessness); and/or residents of public housing.

This Information Bulletin is a guide for all health centers – both those that receive Section 330(e) funds to serve all community residents as well as centers that receive funds to target one or more of these special populations – in developing effective outreach programs that accommodate the unique needs and circumstances of special populations who are part of their communities. This Bulletin:

- Examines Section 330-related requirements for outreach activities;
- Highlights challenges faced by all types of health centers in providing outreach to special populations;
- Outlines different methods for solving these challenges; and
- Provides health centers with suggestions from experts in the field.

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REQUIREMENTS TO PROVIDE OUTREACH

Defining Outreach

Outreach can be defined in many different ways depending on, among other things, the specific activities performed and the intended target population(s). While there is not one universal definition of outreach, typically the purpose of outreach is to make contact with, locate and inform persons (and, in particular, underserved persons) of the availability of services, thus reducing barriers to care, increasing service utilization and, ultimately, improving the health status of the populations reached.

The requirements for a successful outreach program are as varied as its definition. A starting point for all health centers should be Section 330 of the Public Health Service Act (which authorizes the health center program), its implementing regulations and the various policy guidance issued by the Bureau of Primary Health Care (BPHC), each of which is explored below.

Section 330 of the Public Health Service Act and Implementing Regulations

Section 330 requires all health centers to provide, among other services, "services that enable individuals to use the services of the health cen-

ter (including outreach …)."[4] The implementing regulations also require health centers to provide:

> [S]ervices, including *the services of outreach workers,* which promote and facilitate optimal use of primary health services and [other services] …. and, if a substantial number of individuals in the population served by the health center are of limited English-speaking ability, the services of outreach workers … fluent in the language or languages spoken by such individuals.[5]

In requiring outreach activities, the statute and the regulations do not distinguish between different populations served by the health center. Rather, health centers have a broad obligation to provide outreach to all community residents and, in particular, all populations served by the health center, whether it is funded to support services that are targeted to one or more special populations or services offered to all residents of the community at large.

Further, neither the statute nor the regulations define the term "outreach" or offer advice regarding how health centers can design and implement outreach activities. To gain some insight into the specific requirements of outreach programs, health centers should review relevant guidance issued by BPHC, *e.g.,* the Health Center Program Expectations and funding applications, for additional information regarding the components of an effective outreach program.

Health Center Program Expectations

The Health Center Program Expectations issued by BPHC echo the statutory and regulatory requirements that health centers provide outreach and education, stating that:

> [A]ll health centers must also provide services which help ensure access to these basic health services as well as facilitate access to comprehensive health and social services. Specifically, health centers must provide: … services that enable patients to access health center services such as outreach … and education of patients and the community regarding the availability and appropriate use of health services.[6]

The Program Expectations also discuss the importance of each health center obtaining "a thorough knowledge of the community and population groups [it] intends to serve."[7] Recognizing that "all health centers serve diverse populations and must understand the differing needs of these populations," BPHC expects health centers that serve a large number of persons with a particular need to design programs that are responsive to that need.[8]

Given these broad expectations to serve the community in toto, each health center should design programs and services that are responsive to the needs of all populations served (regardless of the type of Section 330 funding it receives), taking into consideration any unique characteristics identified during the needs assessment process. Clearly, health centers that receive funds to target a special population (or populations) would consider the unique characteristics and challenges faced by those populations when designing all aspects of their programs (including outreach activities). Insofar as a community health center funded under Section 330(e) must respond to the needs of the community at large, Section 330(e)-funded health centers that serve special populations residing in their communities should include in their outreach efforts mechanisms specifically designed to reach such individuals and their families.

4 **Section 330(b)(1)(A)(iv); 42 U.S.C. § 254b(b)(1)(A)(iv) (emphasis added).**

5 **42 C.F.R. § 51c.102 (j)(14) and 42 C.F.R. § 56.104 (o)(14) (emphasis added). Please note that the implementing regulations apply solely to Section 330(e) and Section 330(g) grantees, respectively. However, insofar as outreach is a statutory requirement which applies to all programs funded under Section 330, HCH and PHPC programs maintain an outreach obligation.**

6 **BPHC Policy Information Notice (PIN) # 98-23: *Health Center Program Expectations* (August 17, 1998) at pp. 13-14.**

7 **PIN # 98-23 at p. 10.**

8 **PIN # 98-23 at p. 11.**

BPHC Application Guidance

As discussed above, Section 330, its implementing regulations, and the Program Expectations require health centers to conduct outreach, without defining the term or providing specific advice as to how to develop and implement outreach activities. Recent BPHC New Access Point (NAP) and Service Area Competition (SAC) funding applications provide some useful tips on how health centers can design effective service delivery models (which, by definition, include outreach activities) for all populations, including special populations.[9]

In particular, both the most recent NAP guidance and SAC guidance require special population applicants to describe, among other things, the manner in which the applicant will conduct comprehensive outreach that will inform its target population about the availability of services and will be integrated into the applicant's primary care delivery system. The guidances also suggest specific mechanisms by which special population applicants can provide services to their target populations, including:

- Arrangements to provide services at migrant camps and/or at farms;
- Transportation and other enabling services that will bring individuals to the health center site;
- Linkages with social, educational, and health care service organizations that provide services to special populations and participation with community-wide coalitions and advocacy groups that work on their behalf (as applicable).

Although these mechanisms are described in the context of providing clinical and related services, they offer valuable suggestions on unique approaches to reaching special populations in general (both directly and through arrangements with other organizations) which, in turn, can be applied to conducting outreach activities. These suggestions, as well as other methods by which health centers can provide outreach to special populations, are explored in greater detail below.

CHALLENGES IN DEVELOPING AND CONDUCTING OUTREACH ACTIVITIES FOR SPECIAL POPULATIONS

Patient-Related Challenges

Conducting community-wide outreach can be challenging in and of itself. Health centers trying to reach special populations may face additional outreach challenges based on the unique characteristics and needs of the MSFW, homeless and PHPC populations. While the three populations differ in numerous ways, they often experience similar outreach challenges (and, ultimately, barriers to care), including:

- Population mobility;
- Lack of transportation;
- Cultural and linguistic competency;
- Socio-economic issues.

Population Mobility and Lack of Transportation

The Program Expectations require health centers to provide programs and services "at locations and times that … are accessible to the community being served."[10] Whether due to their jobs, living situations or for other reasons, for some special populations, many of these locations may be temporary and subject to rapid change over short periods of time and/or obscure or remote. Complicating this further is the fact that special populations often lack transportation to go to locations at which outreach activities are conducted for the general community, such as health fairs and town hall meetings.

Recognizing both the mobility of certain populations, as well as their lack of transportation, health cen-

9 See generally PIN # 2007-06: New Access Points (October 6, 2006) and PIN # 2007-02: Service Area Competition (August 10, 2006). While the suggestions provided are discussed with respect to programs targeted to special populations, the examples provided are instructive to all health centers serving special populations (including Section 330(e) community health centers).

10 PIN # 98-23 at p. 15.

ters serving these populations may want to consider the following:

- Providing outreach activities at sites convenient to the special population that the center is trying to reach (*e.g.,* homeless shelters, MSFW camps, parks, abandoned buildings, central locations within public housing developments or within individual complexes located within larger developments).
- Developing approaches that reach out to the patients rather than expecting the patients to come to more routine community-wide outreach activities.

If this is not practical due to resource or other constraints, health centers should consider:

- Providing transportation (*e.g.,* van service, vouchers and understandable directions for public transportation) to their special populations to ensure that they have access to outreach conducted for the general community.

Of note, if there is potential for danger to staff in conducting outreach in remote locations, health centers should consider the following:

- Training outreach workers in how to recognize and avoid (or minimize) dangers.
- Implementing organizational safety measures that address, among other things, outreach. For example, health centers may want to implement a policy requiring that outreach activities conducted in potentially dangerous locations be conducted during certain times of the day and/or in a group (rather than one outreach worker operating alone, or two outreach workers operating in concert).
- Exploring the potential liability involved in sending outreach workers to dangerous sites and addressing such liability through traditional risk management techniques (*e.g.,* avoiding the danger completely, purchasing insurance to mitigate liability).

Cultural and Linguistic Competence

The Program Expectations (as well the Section 330 statute and implementing regulations) require health centers to provide services and programs that (and hire staff who) are culturally and linguistically appropriate for the populations served.[11] The Program Expectations further require that "behaviors, practices, attitudes, and policies across all health center functions must respect and respond to the cultural diversity of communities and clients served,"[12] and suggest that health centers should embrace an expansive definition of "culture" that includes various factors (*i.e.,* language, gender, socio-economic status, sexual orientation, physical and mental capacity, age, religion, housing status, and regional differences), many of which impact special populations.

To develop and implement successful outreach programs for special populations, health centers should address pertinent cultural and linguistic barriers, ensuring that all outreach activities are designed and conducted in a manner that is easily understood by and is a cultural "fit" with the specific populations to be reached. Examples of linguistically and culturally appropriate outreach for special populations include the following:

- Health centers serving MSFW populations may want to consider conducting outreach activities through bilingual outreach workers, as well as focusing on offering services that are sensitive to the particular culture of the MSFWs.
- Health centers serving homeless individuals who have serious psychiatric disabilities may want to consider hiring outreach workers trained to address behavioral conditions.
- Health centers serving residents of large public housing developments comprised of several complexes, each of which houses members of different gangs, may want to consider conducting

11 PIN # 98-23 at p. 8; Section 330(k)(3)(K); 42 U.S.C. § 254b(k)(3)(K); 42 C.F.R. § 51c.303(l). Additionally, as recipients of Federal funds, health centers are subject to guidance issued by the Department of Health and Human Services (DHHS) on providing services to patients with limited English proficiency, as well as to the national standards for culturally and linguistically appropriate services published by DHHS' Office of Minority Health. For additional information about these guidelines (including their respective citations) and how to apply them to health centers, see the NACHC Information Bulletin, *Special Population Series # 4: Providing Services to Limited English Proficient (LEP) Patients.*

12 PIN # 98-23 at p. 8 (emphasis added).

outreach activities at each of the separate complexes or in "neutral" areas within the development.

Health centers should also recognize that overcoming cultural and linguistic barriers is not a static "one-time" deal. Rather, it is a dynamic process that changes over time as new populations (*i.e.,* new immigrant populations) move in and out of a heath center's community. Accordingly, health centers should periodically review outreach efforts to ensure that challenges associated with new populations are understood and addressed.

Socio-Economic Issues

Challenges related to the socio-economic circumstances of certain special populations also could arise. These challenges may include lack of education, extreme poverty, costs of health care and lack of insurance/payor source, suspicion or resistance to accepting services out of fear, *etc.* – any or all of which may deter special populations from responding to outreach and, thus, seeking out health care services. Yet these populations are considered by some estimates to suffer from the worst health conditions in the nation, often due to an individual's (or a family's) failure to seek preventive and primary health care, along with exposure to environmental hazards and injuries and the absence of safe food and drinking water.

To improve the health status of special populations, the cycle of deterrence must be broken. Health centers serving such populations should consider utilizing outreach methods that eliminate or reduce deterrence factors, thus supporting a greater response to outreach, which ultimately should result in special populations receiving appropriate health care services.

Organizational Challenges

In addition to challenges related to the unique characteristics and needs of special populations, there may be organizational challenges faced by the health center in conducting outreach activities for such populations, including:

- Lack of staffing and/or resources to conduct outreach activities targeted to individuals who, due to unique needs, may require extensive outreach beyond that provided to the general population;
- The need to train outreach workers to address not only the unique need of special populations, but also workers' feelings of frustration in trying to find or follow up with individuals who are mobile or difficult to reach, or with whom communication and other barriers may exist; and

The need to train outreach workers to recognize potential dangers and how to address them, given that certain outreach activities to special populations may involve remote locations.

OVERCOMING THE CHALLENGES

Taking into consideration the statutory, regulatory, and policy-related requirements and suggestions (as well as the lack thereof) regarding outreach activities, how do you design an outreach program that effectively overcomes the challenges and reaches the special populations residing in your community? Where should you begin?

General Tips on Developing a Successful Outreach Program

In general, each health center should:

- Assess the needs and circumstances of all populations, including special populations, who reside in the health center's community.
- Identify the specific challenges and barriers faced by each special population served by the health center, including population mobility (or lack thereof), cultural and linguistic barriers and socio-economic factors.
- Review various outreach activities and mechanisms discussed in BPHC guidance, as well as those developed, promoted and implemented by associations, advocacy groups and other providers and organizations working with and serving special populations (examples of which are described below).

- Bridge the gap between identified challenges and proven outreach methods by developing an outreach program that includes those activities and components that are appropriate to the particular special population(s) served by the health center, based on the identified needs, circumstances and challenges.
- Implement the outreach program, by (among other activities):
  - Establishing policies and procedures that reflect all components of the program as developed;
  - Hiring appropriate outreach staff and training them to understand not only the program components, but also how the components reflect the unique needs, circumstances and challenges of each special population served and how to properly interact with the individuals they are trying to reach;
  - Determining locations and hours of outreach activities (and specific tasks involved) that are appropriate for each special population served; and
  - If necessary, establishing safety procedures to protect the health center outreach staff.

In the next sections, we review examples of outreach models and programs that have been identified by other organizations and providers as overcoming the challenges in conducting outreach activities for special populations, and which, with some creativity, can be incorporated into a health center's outreach program.

Outreach for MSFW Populations

HRSA defines community outreach for MSFW populations as "community-based activities with migrant and seasonal farmworkers and their family members which improve both their utilization of health services and the effectiveness of those health services. *Community Outreach acts to increase the accessibility, acceptability, and appropriateness of available health services.*"[13]

A recent study conducted by the Kaiser Commission on Medicaid and the Uninsured reported that in 2002, 44% of all Section 330-funded health centers served MSFWs and their families and approximately 25% of all MSFWs received health care at a health center.[14] MSFW populations face numerous obstacles to receiving appropriate and timely health care services, including[15]:

- Poverty and lack of insurance;
- Distance from care and lack of transportation;
- Lack of knowledge about available services;
- Lack of understanding of health problems and risks;
- Lack of understanding of the US health care system;
- Cultural and linguistic differences with providers;
- Fear or mistrust of the health care system or governmental assistance.

Development of an outreach program tailored to address these barriers and to meet the overwhelming challenges faced by the MSFW population in accessing care provides a good starting point for (and plays a significant role in) overcoming or, at a minimum, reducing, many of these obstacles. To accomplish this, however, an outreach program designed for MSFWs and their families must play multiple roles. In general, the outreach program for such populations should[16]:

- Convey information regarding access to, eligibility for, and enrollment in, public programs, as well as vouchers for direct services.
- Provide services at locations where MSFW populations are found by utilizing mobile health vans and teams, as well as provide transportation to the health center's facilities through transportation vans, drivers, public transportation vouchers, and coordination services.

13 HRSA, *Community Outreach Guidance: A Strategy for Reaching Migrant and Seasonal Farmworkers* (1992) (emphasis added).

14 Rosenbaum, Sara and Peter Shin, *Migrant and Seasonal Farmworkers: Health Insurance Coverage and Access to Care,* Kaiser Commission on Medicaid and the Uninsured, p. 15 (April 2005).

15 Castanares, Tina, *Migrant Health Issues Monograph Series # 5: Outreach Services, National Center for Farmworker Health,* Inc. (NCFH), p. 28.

16 Castanares at p. 28.

- Provide information regarding the array of services available not only through the health center, but also through other community providers, health departments and others serving the MSFW population.
- Assist in obtaining referrals for services not provided directly by the health center and other providers.
- Provide culturally competent, peer-based education by utilizing lay health promoters (promotores and promotoras) and other community health workers, and offer trainings, presentations, screenings, and similar types of educational services.
- Bridge the cultural and linguistic gaps between MSFWs and providers by: assisting with interpretation, translation and advocacy on behalf of patients; by educating providers in cultural and linguistic competency; and by providing targeted case management.
- Convey accurate information and dispel myths and rumors within the community regarding the health care delivery system and governmental assistance.

Staff Characteristics: Use of Promotores/Promotoras – The use of *promotores* or *promotoras* as lay promoters, which originated in, among other places, North Carolina and Arizona, has become one of the most successful methods to reach MSFW populations. Typically, *promotores* and *promotoras* are current or former farmworkers who are trained to disseminate information about a host of health needs and issues, as well as accessible providers, tailored to meet the needs of the particular community in which they live. Because they speak Spanish and are part of the community, promotores and promotoras bridge the gaps between their communities, the health center and service providers in a culturally and linguistically competent fashion.

Location – As discussed above, it is important to provide outreach services at locations where MSFWs and their families may be found, including:

- Fixed sites where the health center has "set up shop," such as migrant camps and "social" centers where MSFWs gather; and/or
- Mobile locations that are subject to change, by utilizing mobile health vans and teams.

Further, health centers trying to reach MSFWs should be prepared to provide transportation to the health center's facilities through transportation vans, drivers, public transportation vouchers, and coordination services.

Cultural and Linguistic Competence – As previously discussed, an effective outreach program targeted to MSFW populations must address cultural and linguistic competency issues (including literacy, countries and cultures of origins, demographic trends). In particular, language is often a significant barrier to care. Migrant farm-workers are predominantly from Mexico; approximately 9 out of 10 say they read and speak little or no English.[17] Thus, outreach requires more than designing a program that goes to where the MSFW population is located; it also requires a staff that is bilingual.

The health of a MSFW or his or her family may be jeopardized if the health center attempts to provide services without an interpreter or by using family members or friends who volunteer to interpret for the health care provider. Without an interpreter, signs and symptoms can be misunderstood, leading to misdiagnosis. Friends and family providing translation may edit or change the message so that the interaction is controlled by the family member. Thus, support staff and outreach workers should be formally trained so that language skills can be tested and medical terminology, ethics, and the role of the interpreter can be taught.[18]

17 **Rosenbaum and Shin at p. 1.**

18 **A sampling of websites that provide information on cultural competency and interpreter training as well as educational materials are: http://www.diversityrx.org/; http://www.xculture.org/; http://gucchd.georgetown.edu/; http://www.nmci.org/; http://erc.msh.org/.**

Outreach for Homeless Populations

Among the resources available to assist health centers in developing their outreach programs for homeless populations, two may be particularly helpful. In 1999, BPHC issued a Program Assistance Letter (PAL), which focused specifically on the delivery of services (including, but not limited to, outreach services) to homeless populations.[19] In 2002, the National Health Care for the Homeless Council (NHCHC) developed a detailed curriculum to teach those who work with homeless populations how to conduct outreach.[20] The curriculum is quite extensive and, whether it is followed in whole or in part, provides useful information on how to develop outreach programs tailored to the needs and experiences of the homeless populations.[21]

According to the NHCHC curriculum, the underlying principles that guide successful health center outreach to homeless individuals are[22]:

- Contact should be friendly, not threatening.
- Outreach services should be offered where the homeless "live."
- Repeated contact over time is more likely to engage the individual.
- The staff should attempt to engage individuals who are reluctant or suspicious to receive assistance.
- The staff should assess the needs, services and strategies should be tailored to meet those needs, and the menu of services should be flexible.
- The staff should provide a prompt response to an individual's basic survival needs.
- The staff should exhibit patience in motivating individuals to accept services.
- Contacts should be initiated at various times of the day, including unscheduled contacts.
- A team approach by professionals, paraprofessionals, and or consumers should be implemented.

Given the unique circumstances and needs of homeless populations, in general, the health center's outreach program for such populations should:[23]

- Convey information that promotes awareness of not only the health center's services, but also the availability of services (*e.g.,* health care, substance abuse, mental health, social service, etc.) in the community at large.
- Address the individual's immediate need, whether that need is medical care, intervention for a crisis situation, a cup of coffee, or a place to sleep.
- Assess the individual's medical, psychiatric and social needs and development of (or assisting in developing) a treatment plan.

19 BPHC PAL # 99-12: *Principles of Practice – A Clinical Resource Guide for Health Care for the Homeless Programs* (March 1, 1999).

20 The National Health Care for the Homeless Council, *Outreach to People Experiencing Homelessness: A Curriculum for Training Health Care for the Homeless Outreach Workers* (June 2002, as amended in November 2003) (the Curriculum). This publication was supported by a grant through the Health Resources and Services Administration and can be accessed in its entirety at http://www.nhchc.org/Curriculum/.

The curriculum is broken into six modules, which discuss different phases of the outreach process and provide both "hands-on" exercises and tips for each phase: (1) "Understanding the Basics of Outreach and Homelessness," includes the role and main characteristics of outreach (the "where," "what," and "why" of outreach); (2) "Preparation – Starting on Solid Footing (Part I)," includes ensuring worker safety while performing street outreach and the promotion of cultural competence in outreach; (3) "Preparation – Starting on Solid Footing (Part II)," includes making initial observations and introductions, building trusting relationships, and enhancing listening skills; (4) "Companionship – Sharing the Journey," includes an overview of the prevalent health, mental health, substance abuse and social issues that may be encountered by outreach workers, and assessing clients' needs and concerns; (5) "Expanding the Circle of Care," includes using community resources and services, making successful referrals and linkages, and understanding and promoting advocacy and its role in outreach; and (6) "Mutuality – Coming Home," includes preparing for the transition and closure phase of the outreach worker-client relationship.

21 Due to space limitations, this section briefly summarizes a small portion of the information contained in both PAL # 99-12 and the Curriculum. The authors encourage readers who are considering developing outreach programs for homeless populations to review both documents in their entirety.

22 The Curriculum, Module 1C: *Purpose and Principles of HCH Outreach.*

23 PAL # 99-12 (pp. 8, 10-11); The Curriculum, Module 1C: *Services Provided Through HCH Outreach.*

- Provide "direct" services, such as:
  - Medical care, dental care and/or mental health and chemical dependency services.
  - Screening services for diseases or disorders.
  - Case management.
  - Referrals to specialty care services not available from the health center.
  - Access to support groups or life skills training.
  - Access to housing assistance, financial support programs, legal assistance.
  - Advocacy services.
- Distribute basic necessities and supplies to support health promotion, such as hygiene items, and providing health education.
- Provide on-going emotional support and follow-up.
- Intervene in crisis situations by offering links to emergency care.

Staff Characteristics – Often, homeless individuals feel estranged or alienated from the community, as well as suspicious or resistant to accepting services out of fear, depression, or lack of trust. Outreach workers may be able to break down these barriers, bridging the gap by acknowledging and addressing the psychological, informational, or systemic barriers to accepting services. The professional characteristics of the outreach staff may vary significantly, based upon the specific services provided. However, it is suggested that, among other characteristics, outreach workers should: be flexible, non-judgmental, respectful, relaxed, tactful, patient, resourceful, calm in an emergency, cautious and alert to potential danger, resourceful, and assertive.[24] Above all else, outreach workers should consistently treat people with respect and provide competent and compassionate care.[25]

Location – As discussed above, it is important to provide outreach services at locations where homeless individuals are found, including[26]:

- Fixed sites where the health center has "set up shop," such as shelters, missions, soup kitchens, drop-in centers, transitional housing, respite programs, and hygiene facilities; and/or
- Mobile locations that are subject to change, such as streets, alleys, bridges, overpasses, parks, vacant lots, abandoned buildings and cars, camps, public facilities (*e.g.,* libraries, bus/train stations), and institutions (*e.g.,* hospitals, jails, detox and treatment facilities).

Trust – Once the outreach locations have been determined, the outreach worker can begin the process of building trust between him or herself and the homeless individual he or she is engaging.[27] Pal # 99-12 defines outreach as "an effort to approach and engage homeless persons with the *objective of developing a relationship of trust.*"[28] While developing and fostering trust is a key factor in any patient relationship, it is critical in providing services to homeless populations, from the initial contact by the health center's outreach workers, to the intake process and the delivery of health care services, to ensuring necessary follow-up activities are undertaken. Treating persons with dignity and respect is critical to building trust and establishing the rapport that must develop in order for outreach to be successful. Other engagement strategies include creating a safe "presence"; initiating non-threatening conversation; and offering sandwiches, coffee, blankets, clothing, hygiene products, *etc.*[29]

Cultural and Linguistic Competence – Another critical factor in developing a successful outreach program is cultural and linguistic competence, which, as discussed above, is defined broadly to encompass race, ethnicity, language, gender, socio-economic status, sexual orientation, physical and mental capacity, age, religion, housing status, and regional differences. In the homeless population, for example, it is common for individuals to be concerned about privacy,

24 **The Curriculum, Module 1C:** ***Professional and Personal Characteristics of HCH Outreach Workers.***

25 **The Curriculum, Module 2A:** ***Professional and Ethical Guidelines for HCH Outreach Workers.***

26 **The Curriculum, Module 1C:** ***Where HCH Outreach Happens.***

27 **PAL # 99-12 at pp. 8, 10-11.**

28 **PAL # 99-12 at p. 7 (emphasis added).**

29 **The Curriculum, Module 1C:** ***Services Provided Through HCH Outreach.***

suspicious of larger institutions and the people who work for them; they also may be unaware of the services available, and embarrassed about the difficulty of maintaining personal hygiene.[30] Exacerbating these problems is the rejection by, or the negative interactions they have experienced from, family, friends, health care providers, police, and the community at large. Further, some homeless individuals may have limited English proficiency.[31]

Other Examples of Outreach for Homeless Populations

Homeless populations vary significantly in terms of their composition and characteristics. Accordingly, each health center should build upon the general principles described above by tailoring its outreach program to fit the particular needs of the homeless population it intends to serve. Further, health centers should identify and accommodate sub-groups or individuals within the homeless population who may respond to outreach activities differently, depending on their orientation or background.[32] Below are just a few of the examples of outreach services tailored to meet the specific needs of the population served by the program.

North of Market Senior Services is focused on the health and social services needs of adults over 55 who live in San Francisco's Tenderloin district. Recognizing that older homeless individuals often have poor nutrition, less stamina, and may need longer hospitalization, the outreach workers and case managers work with building managers in the area and with the sheriff's eviction unit to locate older people who may be at risk. They provide direct outreach at residential hotels and apartment buildings that house low-income older residents who may, for example, be isolated, have health, social and/or financial problems, or face eviction from a conversion to condominiums.

The Night Ministry in Chicago travels by mobile health bus to nine Chicago neighborhoods six nights a week from 7 pm until 1:30 a.m. Nurses provide basic health care, assessment and referral, along with HIV counseling. A minister and outreach workers also travel on the bus and offer counseling, information, and companionship. In the summer, outreach includes curbside barbecues and soup suppers along the bus route.

Art Street – In Albuquerque, New Mexico, homeless children and families are brought into a program called Art Street, which is an open art studio that also offers art therapy groups and introduces participants to medical and social services.

Veterans Administration – Veterans are one of the largest sub-populations of homeless adults. The VA conducts outreach programs (including aggressive outreach to veterans living on the street and in shelters who otherwise would not seek assistance) to connect homeless veterans to both mainstream and homeless-specific VA programs and benefits. In particular, outreach is conducted through several homeless programs, including the VA's Health Care for the Homeless Veteran's Program (provides ambulatory care services for homeless veterans with behavioral health issues), the VA's Domiciliary Care for Homeless Veterans Program (provides medical care and rehabilitation in residential settings on the grounds of VA medical centers), and Veterans Benefits Assistance at VA Regional Offices (provides homeless services coordinators at VA regional centers who furnish outreach and help expedite claims).

30 *See generally* NHCHC, *Addressing Cultural and Linguistic Competency in the HCH Setting: A Brief Guide,* which can be accessed at www.nhchc.org/competency.html.

31 NHCHC reports from the 2001 Uniform Data System (UDS) that the largest identified racial ethnic groups in the homeless population are Black/African American (37.4%) and Hispanic/Latino (20.2%). Fifteen percent are identified as speaking a language other than English.

32 See Outreach Calls for Creative Approach, Opening Doors, Newsletter published by HRSA/BPHC, Spring 2002, http://bphc.hrsa.gov/hchirc/pdfs/newsletter/spring_02.pdf.

Outreach for Residents of Public Housing

Similar to other special populations, residents of public housing tend to be in poor health relative to other populations, yet often do not have access to needed preventive and primary care. Although individuals and families living in public housing suffer from many medical conditions common to low-income populations generally (*e.g.,* hypertension, asthma, diabetes, ear infections, and mental illness), they also have certain special health care needs. In 2005, the National Health Care for the Homeless Council published a report indicating that "acuity is often more severe [among public housing residents] due to environmental concerns, especially in the case of respiratory disease."[33] That same report also stated that "[r]esidents face increased psycho-social problems associated with poverty and associated with the isolation of many public housing communities, and their medical conditions are often under-diagnosed and under-treated."

The first step in eliminating or reducing these disparities and improving health status is developing and conducting an outreach program that ensures that the residents of public housing are informed about the availability of services, as well as the manner in which they can be accessed. In general, a successful outreach program for residents of public housing should include many of the same elements as those designed for other populations. In this respect, the outreach program should do the following:

- Provide information regarding the array of services available not only through the health center, but also through other community providers and health departments serving the same population.
- Convey accurate information and dispel myths and rumors within the community regarding the health care delivery system and governmental assistance programs.
- Convey information regarding access to, eligibility for, and enrollment in, public programs.
- Assist in obtaining referrals for services not provided directly by the health center and other providers.
- Provide culturally competent, peer-based education by utilizing community health workers, and offer trainings, presentations, screenings, and similar types of educational services.
- Bridge the cultural and linguistic gaps between residents of public housing and providers by: assisting with interpretation, translation and advocacy on behalf of patients; by educating providers in cultural and linguistic competency; and by providing targeted case management.

Staff Characteristics – Similar to outreach programs for other special populations, outreach activities for residents of public housing should be conducted in a friendly, non-threatening manner. Often, residents of public housing may feel alienated from the community at large, as well as suspicious or mistrusting of the established delivery system. To counter these feelings, outreach workers should: be flexible, non-judgmental, respectful, relaxed, tactful, patient, resourceful, calm in an emergency, cautious and alert to potential danger, resourceful, and assertive. The outreach staff should attempt to engage individuals who are reluctant or suspicious to receive assistance. Above all else, outreach workers should consistently treat people with respect and provide competent and compassionate care.

Participation of Residents – Unique to the PHPC program is the statutory requirement that all PHPC programs provide for ongoing consultation and input from the residents of the public housing development. In particular, PHPC programs must consult with the residents in preparing an application for funds, a well as provide for ongoing consultation regarding the planning and administration of the health center program.[34] One way to demonstrate such participation is by including "community health workers" as part of the outreach staff. Similar to *promotores* and *promotoras,* community health

33 National Health Care for the Homeless Council, *Service Adaptations for Special Populations,* at p. 5 (Feb. 2005), available at http://www.nhchc.org/ServiceAdaptations0205.pdf Section 330(i)(3); 42 U.S.C. § 254b(i)(3)

34 Section 330(i)(3); 42 U.S.C. § 254b(i)(3)

workers are lay persons from the community who are trained to disseminate information about a host of health needs and issues, tailored to meet the needs of the particular community in which they live. In this regard, community health workers help to bridge the gaps between their communities, the health center and service providers in a culturally and linguistically competent fashion.

Location – If possible, outreach activities should be conducted in a central location of the public housing development. However, under certain circumstances, it may not be possible to do so. Often, public housing developments are comprised of several buildings or complexes. For several reasons (in particular, the presence of different gangs at each building/complex and the level of violence between the different gangs), the residents from one building or complex may not want to pass through the other buildings complexes to access outreach activities. Under these circumstances, activities could be conducted at a central location within each complex or at a "neutral" location outside of the public housing development.

Dispersion of Public Housing Residents – The advent of the Hope VI program has resulted in the destruction of many high-rise public housing complexes, as well as the dispersion of public housing residents. Further, the transition of traditional public housing developments to, and the placement of Section 8 housing units in the middle of, mixed housing developments has resulted in a sense of isolation among the residents. Now more than ever, outreach combined with services provided at a variety of locations and through a variety of means is critical for residents of public housing.

Health centers who are experiencing this shift may want to consider using mobile vans as part of their outreach efforts. For example, the health center could consider parking a van in a location near to the old development (or in a central location visited by the public housing residents) to ensure that patients were aware of the new location of the PHPC program. Further, once the PHPC program is relocated, the health center could utilize mobile vans to continue its outreach efforts in the original location, thus ensuring that dispersed residents do not fall through the gaps.

ADDITIONAL GUIDANCE AND RESOURCES

The following is a sampling of the numerous resources available to assist health centers in developing and conducting outreach for special populations:

- **HRSA Bureau of Primary Health Care –** key program areas include: Health Care for the Homeless Information Resource Center, the Migrant Health Program, and the Public Housing Primary Care Program: http://bphc.hrsa.gov/; http://bphc.hrsa.gov/Hchirc/; http://bphc.hrsa.gov/migrant/; http://bphc.hrsa.gov/phpc/
- **DHHS Office on Minority Health –** DHHS office with resources on cultural and linguistic competence: http://www.omhrc.gov
- **National Resource Center on Homelessness and Mental Illness (SAMHSA)** – office within SAMHSA (DHHS agency) that focuses on the effective organization and delivery of services for people who are homeless and have serious mental illnesses: www.nrchmi.samhsa.gov.
- **Department of Veteran Affairs (VA)** – the VA provides substantial hands-on assistance directly to homeless veterans. The VA conducts outreach programs to connect homeless veterans to both mainstream and homeless-specific VA programs and benefits. (For additional information on outreach conducted under VA homeless programs, see the section above on "Outreach for Homeless Populations."): www.va.gov
- **National Health Care for the Homeless Council** is an organization that advocates for reform of the health care system to best serve the needs of people who are homeless. As discussed above, among numerous training and education materials, NHCHC developed a detailed curriculum to teach those who work with homeless populations how to conduct outreach: http://www.nhchc.org

- **National Coalition for the Homeless** is an organization that works to meet the immediate needs of people who are currently experiencing homelessness or who are at risk of doing so. In addition to health care needs, NCH advocates for and provides information on housing justice, economic justice, and civil rights. www.nationalhomeless.org

- **Farmworker Health Services Inc.** is an organization that works with local communities to improve the quality of life of farmworker families, with a focus on increasing accessibility and availability of health services for farmworkers. To that end, FHSI provides training and program assessment and evaluation services to help migrant farmworker programs determine if they are effectively reaching the farmworker population, and offers numerous training materials to make farmworker outreach easier and more effective (including the Outreach Resource manual and annual reports on innovative outreach approaches and outreach needs assessments): www.farmworkerhealth.org

- **National Center for Farmworker Health, Inc.** is an organization that is dedicated to improving the health status of farmworker families by providing information services and products and by removing the regulatory barriers faced by workers and their families as they move between States and by enrolling more farmworkers and families in Medicaid and State Child Health Insurance (SCHIP). In addition, it conducts workshops and distributes fact sheets about how to enroll in child health programs: www.ncfh.org

- **Migrant Health Promotion** is an organization that is committed to strengthening the capacity of farmworker families and their communities by improving health status through peer education and advocacy. Among other things, MHP provides technical assistance and capacity to health centers in teaching them how to set up a promotores / promotoras program: http://www.migranthealth.org

CONCLUSION

All health centers are required to provide access to comprehensive, affordable primary and preventive health care and enabling services (including outreach) to special populations, whether such individuals comprise the center's target population or are residents of the general community in which the health center is located. Reaching these populations, however, may present unique challenges. For example, while outreach staff typically travel to locations where patients live, work or gather, with respect to special populations, some of these locations may be temporary, obscure or remote (or, at worst, may present a danger to the outreach workers). Further, due to the unique characteristics and needs of special populations, outreach staff may need to be educated in how to engage them in non-threatening and creative ways and to present health care and related information and options in a culturally and linguistically appropriate manner.

Whether serving only one of these populations or all residents of the community, including such populations, every health center should review and, as appropriate, consider utilizing activities and methods identified by associations, advocacy groups and other organizations working with and serving special populations (as well as successful models currently in place at other providers serving these populations). Consider working collaboratively with other social, educational and health care organizations and community groups that focus on these populations so as to enable your health center not only to implement effective outreach programs, but also to grow and enhance programs that fully fit the particular needs of your community.

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National Association of Community Health Centers, Inc.®
7200 Wisconsin Avenue, Suite 210
Bethesda, MD 20814
Telephone: 301-347-0400
Fax: 301/347-0459
Website: www.nachc.com