MEDICAL

Examination of the Costs of Homelessness and Issues Related to Determining the Cost-Effectiveness of Supportive Services and Housing in Washoe County, NV

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Executive Summary

Homelessness has been an ever-increasing problem in cities all across the nation. Chronic health problems and high medical costs associated with homelessness have led to frequently high, unpaid medical bills incurred by homeless patients. The lack of proper mental health care treatment, government-sponsored housing, and social-service programs for the poor has accumulated in costs and public frustration over the past three decades. In more recent years, questions have been raised about whether the many public resources used by homeless individuals are ultimately more costly than housing and other services that could prevent homelessness. Data on the social costs associated with the homeless has been difficult to obtain, making it hard for policy makers to evaluate the issues completely.

St. Mary's Regional Medical Center

Many of the homeless patients that visit the Emergency Room at St. Mary's are known as "frequent flyers;" meaning the same individuals repeatedly come to the hospital for treatment. The number of ER visits by this population greatly increases in the winter months, as the cold weather prompts them to find warm shelter. Many persistently homeless patients will come in related to suicidal acts and/or thoughts during the winter to get a bed.

Some of the most common diagnoses for homeless patients are alcohol withdrawal, abuse, and detox. Some of the other prominent diagnoses are: ETOH/alcohol, seizures, chest pain, confusion/mental illnesses, suicidal

ideations, and abdominal pain. They may also be brought in because they have been in an altercation or beaten up, pneumonia, and failing kidney and livers. These diagnoses all relate to symptoms that go untreated due to lack of services.

The proportion of homeless patients is much higher in the Emergency Department than Inpatient Care; however, the costs incurred are much greater treating a homeless patient admitted to Inpatient Care compared to the Emergency Department. Generally, when a homeless patient is taken into Inpatient care, the diagnosis is more serious and therefore requires a greater amount of medical care.

Renown Medical Center

Similar to St. Mary's Regional Medical Center, Renown receives a great deal of frequent flyers that populate their Emergency Department each year. The more common ailments for homeless patients include: alcohol abuse, pain in limb, alcohol withdrawal, chest pain, depressive disorder, head injury, and psychosis. Many of these symptoms are very common amongst all chronically homeless individuals.

HAWC Outreach Clinic

HAWC Outreach Medical Clinic's goal is to provide health and dental care to homeless individuals and families in Northern Nevada. They provide patients with the highest quality of comprehensive primary and preventive care. In 1998 HAWC secured a "Healthcare for the Homeless" grant to operate a homeless healthcare clinic. Since its inception, the HAWC Outreach Clinic has provided approximately 19,000 medical visits for homeless individuals. The HAWC Outreach Clinic provides primary care, mental health counseling, medical screening, drug/alcohol screening and counseling, and referrals. Various medical professionals donate their time to provide free services, and the Clinic is also supported by the main facility's team of physicians and dentists.

Northern Nevada Medical Center

A very small proportion of homeless individuals go to Northern Nevada Medical Center. As an estimate, about six to eight homeless patients are admitted into inpatient care per month. In the winter months the number increases due to the cold weather which causes more sicknesses in the homeless population. When there are special events going on the number of homeless entering the Medical Center increases as well. However, its location on the east side of Sparks, away from downtown Reno and the more heavily homeless populated 4th Street makes it a relatively small medical service provider for homeless individuals. Generally, homeless

patients come in for alcohol detox treatment, substance abuse, and upper respiratory chest pain.

VA Sierra Nevada Health Care System

The VA Sierra Nevada Health Care System (VASNHCS), Reno, Nev., provides primary and secondary care to a large geographical area that includes 20 counties in northern Nevada and northeastern California. The VA's specialized homeless veterans treatment programs have grown and developed since they were first authorized in 1987. The programs strive to offer a continuum of services that include:

- Aggressive outreach to those veterans living on streets and in shelters who otherwise would not seek assistance
- Clinical assessment and referral to needed medical treatment for physical and psychiatric disorders, including substance abuse
- Long-term sheltered transitional assistance, case management, and rehabilitation
- Employment assistance and linkage with available income supports
- Supportive permanent housing

The Department of Veteran Affairs has a program offering Health Care of Homeless Veterans (HCHV). This program provides housing information, substance abuse treatment, mental health treatment, assistance with residential issues, eligibility and enrollment, and access to medical care.

Washoe County Department of Social Services

Washoe County Adult Services encompasses the General Assistance and Health Care Assistance program. In a few months a new system will be put in place that will capture whether incoming patients are homeless. Currently, only the chronically homeless are identified in records, the more transitional homeless population living with friends, or jumping from place to place are not designated as homeless. The projected proportion of chronic homeless individuals receiving some sort of assistance from Washoe County Adult Services is 4%. Therefore, the chronic homeless clientele make up 4% of the total population served by Washoe County Adult Services. Also, the transitional homeless population makes up approximately 15% of the total population served.

Recommendations

The use of medical care by individuals who are homeless leads to costs on the system and strains on the medical personnel involved. Some of the underlying patterns and observations made by the data lead to two conclusions: (1) current laws related to the use and access of emergency medical treatment has led to an inefficient use of Emergency Department

services; (2) the underlying nature of homelessness makes the use of medical services unavoidable.

Passed in 1986, the Federal Emergency Medical Treatment and Active Labor Act (EMTALA) is a statute which governs when and how a patient may be refused treatment and/or transferred from one hospital to another when he/she is in an unstable medical condition.

In essence, then, the statute:

- Imposes an affirmative obligation on the part of the hospital to provide a medical screening examination to determine whether an "emergency medical condition" exists
- Imposes restrictions on transfers of persons who exhibit an "emergency medical condition" or are in active labor, which restrictions may or may not be limited to transfers made for economic reasons
- Imposes an affirmative duty to institute treatment if an "emergency medical condition" does exist

The EMTALA law has essentially created a situation where the mainstream medical service providers have become the primary care, clinical care, emergency care, and trauma care service providers for the homeless as well as short-term shelter in a pinch. There are no disincentives for homeless individuals relative to the use of the Emergency Room as a source of a full spectrum of medical care. In many cases, because this population has no other easy access point to receive basic medical care, and because the EMTALA has created a system in which no individual may be turned away, Emergency Rooms are frequented by homeless patients.

The second conclusion is that the underlying lifestyle characteristics of homelessness generate the demand for these individuals to frequent the Emergency Rooms and occasionally extended inpatient care. Most homeless patients admitted to an ER have symptoms related to the following diagnosis: consumption of alcohol, bodily pain, and mental health related issues. Therefore, efficient mitigation of the high use of medical facilities and the corresponding cost by homeless individuals requires solutions for homelessness overall.

- The pending Community Triage Center will serve to mitigate a part of the medical costs. They will be primarily focusing on mental health and drug/alcohol treatment. They will not provide acute trauma and for those with more serious conditions, individuals will be sent via ambulance to one of the major medical service providers.

- Another cost mitigating strategy would be to increase funding to agencies such as HAWC Outreach Clinic, where primary and clinical medical, mental health, and drug/alcohol care is provided.

- It is important to understand that if the homeless population were moved to transitional and/or permanent supportive housing, there would still be a need for health care services. Therefore, it would be inaccurate to assume that resources could be moved from providing health care to providing housing. Housing does not preclude the need for medical and mental health care. The inappropriate use of certain medical treatment services might be mitigated through the provision of other “easy access” sub-acute treatment options.

1 – Medical Service Providers

Medical Sections & Data Providers

1 - St. Mary's Regional Medical Center
2 - Renown Health
3 - HAWC Outreach Medical Clinic
4 - Northern Nevada Medical Center
5 - VA Sierra Nevada Health Care System
6 - Washoe County Department of Social Services
- The Healthcare Center (formerly Washoe Medical Center)

Type of data from these providers:

- Annual financial costs/revenues
- Client demographics
- Number of homeless patients served per year

What will be done with the data provided?

- Number of homeless patients served
- Costs associated with serving homeless population
- Type of medical services used by homeless patients

Introduction

Since the early 1980s, homelessness has been an intractable problem in cities all across the nation. Some observers trace the growth of homelessness largely to the social policies of the 1970s, including the deinstitutionalization of the mentally ill. In more recent years, questions have been raised about whether the many public resources used by homeless individuals are ultimately more costly than housing and other services that could be used to prevent homelessness or to mitigate some of the costs incurred by interceding. Precise data on the social costs and financial costs associated with the homeless has been difficult to obtain, making it difficult

for policy makers to evaluate the issues completely. However, there does seem to be linkage between chronic health problems and high medical costs associated with homelessness.

Most individuals who become designated as homeless in the Reno/Sparks area can be found in or near the downtown Reno area. This location provides the closest emergency room access to St. Mary's Regional Medical Center and Renown Medical Center, which are both located in close proximity of downtown Reno.

The process in which data was provided related to the number of homeless patients served by each medical service provider varied somewhat from each provider, but the methodologies included very similar approaches. For both St. Mary's Regional Medical Center and Renown Health, the challenge was that they had no designation in their database of patients as "homeless." Therefore, in order to respond to our data request, they had to derive a surrogate designation of "homelessness" in order to have a method of extracting data from their database. Their operational definitions for homeless are presented below, along with some discussion of the limitations of these operational definitions and an explanation as to why these definitions are useful and acceptable for the purposes of our research.

If a patient was admitted to St. Mary's or Renown Health with a "general delivery" address and with no insurance, then for the purposes of our request, this became an operational definition of "homeless." Additionally, St. Mary's referenced ICD 9 codes, which represent International Classification of Diseases. The homeless data pulled by St. Mary's is therefore additionally screened by ICD 9 codes which they believe are typically associated with the homeless population, such as ETOH (intoxication), psychiatric disorders, volume depletion, anxiety, and hypertension. Accordingly, St. Mary's looked at its uninsured patient population and compared such figures to the stats pulled based on ICD 9 codes and general delivery address to configure their estimated homeless patient count and related costs.

Both medical centers and the research team agreed that this operational definition, including no insurance or uninsured and address by general delivery, was the best available operational definition to extract the data. We also agreed that this approach has limitations in its precision in estimating the true homeless population, as described below.

There may be homeless patients who are admitted to the hospital and provide an address of a friend, a weekly motel, or simply an old or fictitious place of residency. Consequently, these homeless patients will not be picked up by screening the address field in the database for "general delivery," which constitutes no address given. There may be individuals who provided an address of general delivery when in fact they are not homeless and may have an address; this may occur when an individual may not be cooperating

with staff because of a language barrier, severe mental illness, intoxication level, and/or inability to pay for services, or other various situations. This may cause an individual who may not be homeless to be included as homeless.

The second factor, no insurance, may also cause under or over inclusion because some individuals who are homeless may have insurance; therefore, they are not picked up in the homeless patient data collection process described above, and some with insurance may not provide that information leading to inclusion in the count when they should not have been.

Estimates derived using the medical providers' operational definitions provide gross estimations of the homeless population within the region that is accessing medical services through these two providers. Because essentially the same operational definition was used for both Renown Health and St. Mary's Regional Medical Center, and was used to extract data over a five-year time period, the order of magnitude and the trend analyses generated using this definition provides good insight into the usage of medical services through these providers by homeless population, capacity and load considerations, general cost analyses, and other aspects of this research project.

Another medical service provider included in the project is Northern Nevada Medical Center, located on the east side of Sparks, which also receives a small proportion of homeless in their emergency rooms and inpatient care; however, the number of homeless is quite small in comparison to the other two medical centers. The HAWC Outreach Clinic located near downtown Reno offers free medical care for individuals who are homeless and serves as one of the key medical service providers for the regional at-risk homeless population. Due to lack of any "screening mechanism" for data collection and designation purposes, every individual who is served at the HAWC Outreach Clinic is considered to be experiencing some degree of homelessness.

For those homeless individuals who qualify for assistance, Washoe County Department of Social Services provides payment for medical-related services to the local hospitals, clinics, and other medical providers. They do not directly designate "homeless" clients served, instead two homeless subgroup populations are identified and estimations are made to the overall proportion of clientele served. The persistently homeless are believed to make 4% of the overall population served by Washoe County Department of Social Services, while the transitional homeless sub-population make up approximately 15% of the total clientele served.

The Veterans Affairs Hospital has many programs aimed at homeless veterans. Currently it is estimated by the VA that more than one-third of the U.S. homeless population are veterans and may qualify for free or low-cost mental and medical treatment. The Department of Veteran Affairs has a

program offering Health Care for Homeless Veterans (HCHV). This program provides housing information, substance abuse treatment, mental health treatment, assistance with residential issues, eligibility and enrollment, and access to medical care. Some of the general housing conditions that qualify a veteran for the Health Care of Homeless Veterans Program are living in someone else's home, in a car, on the street, in a shelter, or if a veteran is about to become homeless.

1 - St. Mary's Regional Medical Center

Description of facility and staff

Saint Mary's Regional Medical Center is a privately owned and operated facility with 312 inpatient beds and 27 emergency room beds. The paid staff is made up of RN's, CNA's, MD's, LPN's, and EMT's and other ancillary staff.

How do the homeless patients come to St. Mary's RMC and who refers them?

Generally, homeless patients are brought in by law enforcement, REMSA, and especially in the winter, they come in themselves. Homeless individuals are brought in by law enforcement following altercation, ETOH (alcohol) issues, psych problems, and other such similar instances. More often than not, homeless patients are not referred to St. Mary's; they are brought in for medical needs and services not elective admission.

What is the process in which patients are identified as homeless?

St. Mary's does not use designation of homeless; instead, on admission to the medical center they have referral criteria sent to case management. If a patient answers 'yes' to the following question, 'Do you or your family have concerns regarding your home situation while hospitalized (housing, spouse, children, pets, finance, etc.),' then a case management consult is requested.

Case Managers and Social Workers see patients that they receive referrals on or if they know the patient, usually many of the same homeless patients frequent the medical center. To help determine whether an individual is homeless, Case Managers and Social Workers will look at the patient's address. Generally, patients who cannot pay or who do not provide an address, are recorded in the system under the following type of examples: general delivery, private pays, county pending, etc.

Any staff member of St. Mary's may send a patient referral to Case Management. Unfortunately, at this time, there is no means to pull data by 'referrals sent to case management for this population.'

Case Management Referral Criteria

1. **Purpose**

   To identify potential situations that may require case management services.

2. **Group Affected**

   Case Management Department, Physicians, Interdisciplinary Staff, Nursing Staff, Patients/Families

3. **Policy**

   The Case Management Department, through the discharge planning process, provides individualized continuity of care. Development of the plan of care is a coordinated, confidential, interdisciplinary process when recognized patient preferences, needs and self-care potential. Discharge planning is individualized; patient oriented, and ensures patient access and choices of services during hospitalization, post-discharge and in the emergency department. Collaboration between the community, facility and professional disciplines facilitates the process of informed decision making by patients and families.

4. **Procedure**

   A. Within 24 hours of admission, the Case Management Department will assess high-risk patients for case management, discharge planning and/or appropriate interdisciplinary referrals.

   B. The high-risk categories are related to patient diagnosis, psychosocial or economical factors, which place the patient at risk for barriers to effective discharge management or increase re-admission. The following categories are used as a guide in identifying patients who may be in need of clinical case management.

Identification Triggers – related to homeless individuals

General

- Transferred from other facilities- acute care, ECF (Extended Care Facility or Nursing Home), rehabilitation facility, etc.
- New ostomies and wound care
- Currently receiving home health or hospice services
- Metabolic, cerebrovascular or neurological conditions with implications for probable impairment or life style adaptations
- Classified as disabled by Medicaid or Medicare under 65 years
- No known support system
- Impaired skills of daily living (i.e. paraplegics)
- Homeless or unable to return to previous living situation
- Patients who are primary caregivers for significant other or dependent
- Diagnosis/conditions requiring supervision or instructions
- Cognitive or impaired communication skills
- New diagnosis of chronic diseases (i.e. diabetes, Chronic Obstructive Pulmonary Disease, cancer, Congestive Heart Failure)

- Patients from out of state or country
- Requiring parenteral therapy at home
- Patients with no health insurance
- Chronically/terminally ill (i.e. Multiple Sclerosis, ulcerative colitis, Crohn's disease, diabetes mellitus, asthma, cancer)

Psychiatric/Chemical Dependence

- Admissions for Psychiatric/Substance Abuse
- Attempted Suicide

Multiple Admissions

- Re-hospitalization
- Frequent service encounters ---6 times in 6 months (Observation Short Stay, inpatient, Emergency Department)
- Repeat ER visits

A. After intervention, they document according to policy in the Interdisciplinary Care Plan and MIDAS (computer program)

B. The documentation includes:

- Reason for the assessment
- Psychological/social evaluation
- Financial resources
- Current living environment
- Potential for self-care
- Post-hospital plan
- Action taken/plan

C. Documentation will be concurrent and will include:

- Contacts with the patient, family, and significant others
- All contacts for placement or referral to community/government resources
- All resource materials provided to the patient/family or significant others
- Patient instruction/education provided regarding resources and post-discharge arrangements

D. Re-assessment of patient will be provided based on the appropriateness of the situation

Social Work Referral Criteria

1. **Purpose**

   To define the referral criteria for social workers in the inpatient setting

2. **Group Affected**

   Patients, Physicians, Case Management Department, and Nursing Staff

3. **Policy**

   Saint Mary's Regional Medical Center (SMRMC) will provide social work services to optimize patient care outcomes. Social workers will utilize

referral criteria to prioritize and identify patients/families/significant others requiring social work intervention.

4. **Procedure**
   A. Social Workers will be available for assessments upon request. To be completed within 24 business hours or sooner dependent on the nature of the situation.
   B. Collaboration with the interdisciplinary team will take place before and after patient interventions.
   C. Emergency Room will be dealt with on a case-by-case basis after ED (Emergency Department) Case Manager does assessment.
   D. The following identification triggers will be used as guidelines for potential referrals:

Identification Triggers – related to homeless individuals

General

- Patients/Families in crisis
- Financial difficulties requiring assistance with community resources
- Respond to all codes
- Complex discharge planning concerns with psychosocial issues
- Resource to Interdisciplinary Team (i.e. after fetal demise, adoptions)

Catastrophic Illness/Injury

- Cancer diagnosis
- Newly diagnosed catastrophic illness (patients/neonates/infants)
- Terminal diagnosis /code status/ end-of-life issues
- Newly diagnosed AIDS patients
- Patients/Families requesting advance directives
- Families experiencing grief reactions and bereavement

Psychiatric Issues

- Assist with psychiatric patients
- Attempted suicides
- Victims of violent crimes
- Suspected Abuse/Neglect Situations
- Referral of patients with history of substance abuse to rehabilitation programs

After intervention document according to policy in the Interdisciplinary Care Plan and MIDAS

The documentation will include:

- Reason for the assessment
- Psychological/social evaluation
- Financial resources
- Current living environment
- Potential for self-care

- Post-hospital plan
- Action taken/plan

Documentation will be concurrent and will include:

- Contacts with the patient, family, and significant others
- All contacts for placement or referral to community/government resources
- All resource materials provided to the patient/family or significant others
- Patient instruction/education provided regarding resources and post-discharge arrangements

Reassessment of patient needs will be provided based on the appropriateness of the situation.

Are homeless patients sub-grouped (i.e. substance abuse, mental illness, etc.)

St. Mary's does not distinguish homeless patients into subgroups. They code their patients after discharge; therefore, sub-grouping individuals can be done retrospectively.

Description of each service provided to homeless patients

The hospital does not directly provide services for homeless individuals. They refer to other agencies, such as state, county, or non-profit organizations/services.

St. Mary's Community Take-Care-a-Vans and free clinics provide medical care for low income, needy families. While most patients served through St. Mary's Community Take-Care-a-Vans are not homeless, one of the four mobile vans is used by the Kids to Seniors Korner Program. The program focuses on many at-risk groups including the persistently homeless population living out on the streets and moving in and out of temporary establishments.

The Kids to Seniors Korner Program is a synergistic private/public collaborative which involves seven local partners: the Reno and Sparks Police Departments; Saint Mary's Mission Outreach; Washoe County Sheriff's Office, District Health Department, Social Services and Senior Services. This alliance presents opportunities to provide a combination of services to at-risk populations such as low-income children, as well as families where English is not the primary language. Utilizing a large mobile clinic, the partnership utilizes a two-tiered service delivery system which includes a multi-disciplinary team that follows a "Knock 'n' Talk" philosophy – bringing a team of professionals into a targeted low-income neighborhood (and areas highly populated with homeless families, such as

shelters, hotels, etc.), knocking on doors and talking to children, their families and seniors regarding their needs.

Once needs are identified, registered nurses, social workers, HSSS workers, law enforcement officers, and interpreters coordinate and case manage to provide medical/social service assessments, health, safety and nutrition education, referrals, follow-up services and home visits to under-served children, their families, and seniors living in targeted low-income areas. Over 9,950 children, families, and seniors were served in Washoe County neighborhoods in 2005.

Approximate number of homeless patients receiving each service

Many hospitals use an indexing system known as ICD 9 codes, which represent International Classification of Diseases. The homeless data generated by St. Mary's is sorted by those ICD 9 codes which are typically associated with the homeless population, such as ETOH (intoxication), psychiatric disorders, volume depletion, anxiety, and hypertension, and cross-sorted by address of "general delivery," which implies the individual does not have a permanent address. Method of payment was not used in the process of collecting homeless data. However, St. Mary's did look at the "uninsured" population and compared such figures to the stats pulled based on ICD 9 codes and general delivery address.

The totals shown in Tables1-1 and 1-2 below incorporate all six years of data and represent the total number of homeless and approximate costs ("normalized" costs) incurred by St. Mary's in the Emergency Department and Inpatient/OSS care. The average number of homeless patients and total normalized costs incurred in St. Mary's Emergency Department and Inpatient/OSS care was calculated using complete yearly data available from 2001 to 2005.

St. Mary's Regional Medical Center does breakdown its total costs into variable and fixed components. Variable costs include those costs or expenses which vary directly and proportionately with volume of patient services provided. These expenses fluctuate on a day-to-day basis and would "go away" if that patient population was not present. Fixed costs include those costs or expenses which do not vary with volume, in the short term. The same expenses would be incurred whether the volume increased, decreased, or stayed the same.

For the purpose of the research project, the estimated costs shown in Table 1-1, 1-2, and 1-4 are "normalized" using a 36% cost-to-charge ratio. Similarly, in the Renown Regional section costs were derived in the same manner for the purpose of consistency. However, Renown Regional reported their average cost-to-charge ratio to vary from 22% to 26% and decided upon a 26% "normalization" rate.

The hospital "normalized" costs listed in the tables below have some limitations that need to be understood. The charges from which the costs were calculated are not all inclusive. For example, these charges do not include the fees of physicians; whose charges are billed separately by the physicians' offices, and so their figures are not included in the hospital figures. Also, when patients are seen, many charges and services are bundled and, with subsequent allocation on both the charges and costs calculations, which reduces "precision" in calculating and/or applying cost-to-charge ratios. The cost-to-charge ratios of 36% and 26% were rates suggested by each entity for use across multiple years. Each entity computes a cost-to-charge ratio on an annual basis but the conversion rates utilized for this study are not those specific annual rates, but rather "ballpark" rates suggested by each entity. Because each entity may calculate their cost-to-charges ratio differently and may allocate costs differently, no inferences should be made from the different ratios.

St. Mary's indicated the amount of reimbursement, if any, is relatively low; therefore creating situations where the costs of providing medical services to the homeless is not reimbursed, which results in higher costs to all those who can and do pay for medical services. Costs that are not reimbursed become part of the calculation the medical service providers use in determining and negotiating rates with the local governmental entities (i.e. Washoe County), state entities (Medicaid), self-funded insurance programs and insurance carriers. In other words, local residents and taxpayers eventually pay the un-reimbursed costs incurred by the homeless population.

Table 1-1
St. Mary's Emergency Department
2001 – 8/2006

Year	Homeless Patients	Estimated Cost-to Charge Ratio Rate	Cost per Patient Based on Cost-to-Charge Ratio
2001	183	$74,385	$406
2002	242	$111,353	$460
2003	176	$89,030	$506
2004	209	$128,402	$614
2005	235	$199,437	$849
ytd 8/2006	173	$124,431	$719
TOTAL	**1218**	**$727,038**	**--**
***AVERAGE**	***209**	***$120,521**	***$567**

Source: Saint Mary's Regional Medical Center
* Average based on 2001-2005 data

The Emergency Department data shown in Table 1-1 shows a fluctuating trend in the number of homeless patients served. The five-year average from 2001 to 2005 in the number of homeless patients served per year was 209.

An average of 209 homeless patients cost roughly $120,521 per year , and an average cost per patient (based on cost-to-charge ratio) of $567. The total cumulative Emergency Department normalized costs derived from 2001 through August 2006 was approximately $727,038. Therefore, the average Emergency Room cost per patient (based on cost-to-charge ratio) for the total 1,218 homeless patients admitted over the almost six-year period was $567.

The Inpatient and OSS data shown in Table 1-2 also shows a fluctuating trend in the number of homeless patients served. The five-year average from 2001 to 2005 of homeless patients served per year was 167. An average of 167 homeless patients treated through Inpatient or OSS, amounted to average yearly charges totaling $2,214,453, which averages to a $13,481 cost per patient over the five-year time period. The total cumulative Inpatient and OSS cost derived from 2001 through August 2006 was approximately $11,713,237. Therefore, the average Inpatient and OSS cost per patient (based on cost-to-charge ratio) for the total 888 homeless patients admitted over the almost six-year period was $13,481.

Table 1-2
St. Mary's Inpatient & (OSS) Observation Short Stay
2001 – 8/2006

Year	Homeless Patients	Cost-to-Charge Ratio Rate	Cost per Patient Based on Cost-to-Charge Ratio
2001	165	$1,884,171	$11,419
2002	217	$2,395,463	$11,039
2003	222	$3,344,499	$15,065
2004	132	$2,017,375	$15,283
2005	98	$1,430,758	$14,600
ytd 8/2006	54	$640,971	$11,870
TOTAL	**888**	**$11,713,237**	**--**
***AVERAGE**	***167**	***$2,214,453**	***$13,481**

Source: Saint Mary's Regional Medical Center
* Average based on 2001-2005 data

In Table 1-3, the percent of homeless patients that make up the total inpatient and emergency room population are listed. The average number of patients admitted to inpatient care from 2001 to 2005 was approximately 48,140. Homeless patients made up about 0.44% of this average per year. From the average 83,614 number of patients admitted in the Emergency Department from 2001 to 2005, homeless patients represented 1.14% of the total average yearly patient population. Clearly, the proportion of homeless patients is much higher in the Emergency Department than Inpatient Care; however, as shown in Table 1-1 and 1-2, the costs incurred are much greater treating a homeless patient admitted to Inpatient Care compared to the Emergency Department.

Table 1-3
St. Mary's Percent Homeless of Total Patients
2001 – 8/2006

Year	Total IP Patients	IP Homeless Percentage	Total ED Patients	ED Homeless Percentage
2001	45,280	0.36%	16,392	1.12%
2002	47,761	0.45%	14,687	1.65%
2003	50,779	0.44%	13,803	1.28%
2004	47,694	0.28%	13,827	1.51%
2005	49,188	0.20%	14,767	1.59%
ytd 8/2006	33,127	0.16%	10,138	1.70%
TOTAL	**273,829**	**--**	**83,614**	**--**
***AVERAGE**	***48,140**	***0.44%**	***14,695**	***1.14%**

Source: Saint Mary's Regional Medical Center
* Average based on 2001-2005 data

Table 1-4 simply aggregates the total homeless costs incurred in both the Emergency Department and Inpatient/OSS Care. Therefore, the total number of homeless patients admitted to St. Mary's from 2001 to ytd 8/2006 totaled to 2,106, with a total normalized cost-to-charge ratio of $10,424,953 and an average cost per homeless patient over the almost six-year period of $4,950. The average number of homeless patients seen per year from 2001 to 2005 totaled to 376, the yearly average cost-to-charge rate from 2001 to 2005 was $1,956,709, with an average yearly total cost per homeless patient (based on cost-to-charge ratio) of $5,179.

Table 1-4
St. Mary's Total Homeless Patient Costs
2001 – 8/2006

Year	Homeless Patients	Cost-to-Charge Ratio Rate	Cost per Patient Based on Cost-to-Charge Ratio
2001	348	$1,641,271	$4,716
2002	459	$2,100,713	$4,577
2003	398	$2,877,297	$7,229
2004	341	$1,798,161	$5,273
2005	333	$1,366,104	$4,102
ytd 8/2006	227	$641,407	$2,826
TOTAL	**2,106**	**$10,424,953**	**--**
***AVERAGE**	***376**	***$1,956,709**	***$5,179**

Source: Saint Mary's Regional Medical Center
* Average based on 2001-2005 data

Table 1-5 presents the top nine ICD 9 codes diagnosed by St. Mary's to their homeless patients. The ICD 9 code ETOH, signifies alcohol, Volume Depletion is dehydration, and Anxiety corresponds to a patient if they are scared, nervous or have psychiatric disorders, Hypertension represents high blood pressure, and Chest Pain is related to possible heart issues, bronchial, or upper respiratory problems. Some of the ICD 9 codes are repeated in the list of St. Mary's top ICD 9 codes

Table 1-5
Top ICD 9 Codes Incurred by St. Mary's Homeless Patients
2005-2006

1	ETOH
2	Volume Depletion
3	Anxiety
4	Psychiatric Disorders
5	ETOH
6	General Symptoms
7	General Symptoms
8	Hypertension
9	Chest Pain

Source: Saint Mary's Regional Medical Center

What other service-providers and services are St. Mary's Regional Medical Center patients referred to?

St. Mary's refers homeless patients to a variety of service providers depending on need. Referrals are made for the following services/needs: shelters, medications, medical care, food, mental health, financial issues, alcohol/ETOH abuse, and drug abuse.

Below are examples of resources provided to the homeless population if needed:

Alcohol/Drug Treatment

- Alcoholics Anonymous: Alcoholic treatment and counseling
- Northstar Detox and Treatment Center: Alcoholic treatment and counseling
- Westhills Hospital: Free assessment, 24 hours a day, insurance, Medicare, adults/teens

Domestic Violence

- CAAW: Twenty-four hour crisis line; women and children's shelter, food, clothing
- Safe Embrace: Twenty-four hour crisis line; women and children's shelter, food, clothing

Food Resources

- St. Vincent's Dining Room: Lunch served Monday-Saturday 11:30-12:30pm; breakfast served Sunday 8:30-9:30am

Homeless Services

- H.E.L.P.: Seven days a week, 9-3pm; provide Greyhound bus ticket and work program
- Project ReStart: Monday-Friday, 8-4:30pm, general homeless services, Rep Payee Program
- Catholic Community Service of Northern Nevada: Medications/food/rent assistance

Homeless Shelters

- Reno-Sparks Gospel Mission: Men, women, and children; 3 nights free, then a charge
- Men's Drop-in Center: Maximum of 30 days per year, for men only

Medical Clinics

- HAWC Medical Clinic: Must have income, Medicare or Medicaid, sliding fee scale, all ages
- HAWC Outreach Clinic: Monday-Friday 8-4:30pm, helps homeless, those living in motel, Medicaid, Medicare- no charge
- Washoe Medical Center Clinic: Indigent medical care only; 8-12pm and 1-4pm, must meet eligibility

Mental Health

- Twenty-Four hour Crisis Call Line
- NNAMHS: Adult inpatient/outpatient services, no insurance required

Prescriptions

- Care Chest of Sierra Nevada: Medical equipment/medications, fill out application/income guideline
- Salvation Army: antibiotics only, need ID

State/County Assistance

- Nevada State Welfare: Food Stamps, Medicaid, TANF
- Washoe County Social Services: General Assistance, Adult Services Medical, Children's Protective Services, Health Department

Are there employees who work directly with patients that I may interview?

Missy Shuman, Manager of Case Management, from St. Mary's Regional Medical Center, provided descriptive information on the process and everyday interactions with homeless patients.

On October 11, 2006, Lisa Jones, a social worker for St. Mary's, gave her insight on the hospital care and interaction with the persistently homeless population. For the past three years she has been a social worker in the Emergency Department and the Intensive Care Unit and deals with homeless patients on a regular basis. Below are the aggregated responses from St. Mary's employees Missy Shuman and Lisa Jones.

1. **How many estimated homeless patients have you seen over the years? Are there seasonal, regional, or type of injury trends related patients who may be homeless?**

    - Because of its downtown location, most homeless patients brought to St. Mary's by police or REMSA are usually picked up West of Virginia Street. Those individuals picked up East of Virginia Street are generally sent to Renown Medical Center.

    - Many of the homeless individuals that visit the Emergency Room are known as "frequent flyers;" meaning the same individuals repeatedly come to the hospital for treatment. The number of ER visits by this population greatly increases in the winter months, as the cold weather prompts them to find warm shelter. Many persistently homeless patients will come in related to suicidal acts and/or thoughts during the winter to get a bed. They know how the system works and when a patient is brought in for suicidal ideations, they must be evaluated and if warranted sent to NNAMHS and a Legal 2000 must be filed.

    - The most frequent diagnoses for homeless patients is alcohol withdrawal, alcohol abuse, and detox. Some of the other prominent diagnoses are: ETOH/alcohol, seizures, chest pain, confusion/mental illnesses, suicidal ideations, and abdominal pain. They may also be brought in because they have been in an altercation or beaten up, pneumonia, and failing kidney and livers. These diagnoses all relate to symptoms that go untreated due to lack of services.

2. **Who determines that a patient is homeless? How does that process or determination happen?**

    - Most persistently homeless patients are not brought in on their own.

    - When patients are admitted for care, (no patient is ever turned away for lack of ability to pay), patients are asked for identification, address, and other such similar information. It is never assumed a patient is homeless; however, most of the homeless patients served at St. Mary's are single males, with a smaller proportion of homeless families. If they are homeless, they will either say they are homeless, or it will be implied by the information provided at admittance.

- If it is perceived the patient may be homeless by a nurse, doctor, or receptionist, a referral is made to case management or social work.

3. **When you determine your patient is homeless, does that change the process in which you have to administer them and their services? If so, how?**

    - The process of service care is unchanged whether a patient is homeless or not. As mentioned above, no patient is denied care; however, referrals are made to case management and social work for potential additional services they may need upon discharge.

    - Also, because of the frequency of persistently homeless patients, most nurses and staff recognize many of the homeless patients they serve on a regular basis. Many of the persistently homeless patients return to the hospital within 2 to 4 weeks.

4. **Do you find other patients feeling uncomfortable around homeless patients who come to the hospital?**

    - Most homeless patients are brought in by law enforcement or REMSA, therefore they do not go through the normal lobby triage waiting area.

    - For all patients' safety, including the homeless patient, various diagnoses are grouped in rooms together to allow for proper visualization and treatment.

5. **Have you ever had any serious disturbances while working with homeless patients? (Such as a lack of cooperation, not staying in room/bed assigned, becoming violent, cursing, etc).**

    - It is not uncommon for these patients to attempt to get up, as they are unfamiliar with the surroundings or disoriented due to diagnosis. These disturbances are easily handled and do not in general pose to be a safety risk.

6. **How long is the average persistently homeless individual admitted (Emergency Room, Inpatient, OSS, etc)?**

    - It depends on the diagnosis for which they are being brought to the hospital. For serious illnesses, they can spend days, which incur higher costs.

    - The routine homeless patient coming through the ER will most likely spend anywhere from 12 to 24 hours in the hospital before released.

7. **What other services/service-providers do you or your co-workers refer/send clients/patients?**

- St. Mary's refers patients for the following needs and/or service providers related to the homeless:
  - Depression/Mental illness: walk-in clinic at NNAMHS
  - Housing: shelters throughout local area
  - Food banks: St. Vincent's Dining Room and food services
  - ID services: St. Vincent's ID program
  - Work or transportation needs: H.E.L.P.
  - Follow-up medical care: HAWC, Washoe Clinic, Care Chest

- Almost always, persistently homeless patients never ask for job assistance. Generally, this population isn't looking for a job. However, St. Mary's does provide job source provider information.

2 - Renown Regional Medical Center

Description of facility and staff

Renown Health is a not-for-profit Nevada health care provider and a nationally recognized leader in improving the quality of health care. Renown Health is northern Nevada's largest health network that includes four hospitals, eight family care facilities, eight locations for diagnostic imaging and much more. Renown Regional Medical Center currently has 529 beds and in addition to being the region's only Level II trauma center, Renown Regional provides inpatient and outpatient services in a wide variety of specialties including cancer, heart, neurosciences, orthopedics, surgery, intensive care, women's and children's health and renal dialysis.

How do the homeless patients come to Renown Regional Medical Center and who refers them?

Generally, homeless patients are brought in by law enforcement, REMSA, buses, taxis, and they also come in on foot.

What is the process in which patients are identified as homeless?

If a patient is admitted to Renown Regional as a "general delivery" and "no insurance," the patient is designated as homeless for the purpose of this study.

Case management and social services assesses each inpatient and facilitates applications for coverage. In addition to the nurses and doctors who care for patients who are homeless; Emergency Department (ED) case managers, social workers, ALERT team members and floor case managers experience first hand encounters with homeless individuals in the hospital everyday.

Are homeless patients sub-grouped (i.e. substance abuse, mental illness, etc.)

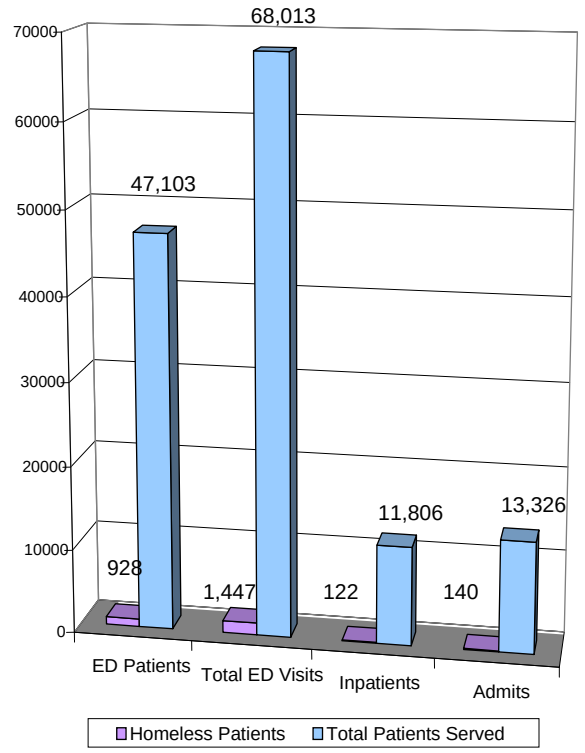
The Renown ALERT team assesses every mental health and substance abuse patient to determine appropriate level of care. Then an appropriate referral is made to case management or social services within the Regional Medical Center or to other facilities and programs.

Approximate number of homeless patients receiving each service

The number of homeless patients and total visits are selected using filters for "general delivery" and "no insurance" for the purpose of this study. In Figure 2-1, nine hundred twenty-eight people who are homeless generated 1,447 Emergency Department visits and 806 of them were discharged from the ED. One hundred twenty-two of the 928 Emergency Department homeless patients went on to generate 140 inpatient admissions.

In 2006, homeless ED patients made up approximately 1.97% of the total number of patients and 2.13% of total visits to Renown Regional's ED. OF the total number of people admitted to Renown Regional through the ED, homeless individuals comprised 1.05% and generated 1.03% of the total admits.

Figure 2-1
Renown Regional Medical Center Homeless Patients Served in FY 2006



Source: Renown Regional Medical Center

Table 2-1 represents the top diagnosis entered for homeless patients entering the Renown Medical Center Emergency Department. Most of the diagnoses are related to the consumption of alcohol, bodily pain, and mental health related issues.

Table 2-1
Renown Medical Center – Top 10 ED Diagnosis
2006

ALCOHOL ABUSE-UNSPEC	24
PAIN IN LIMB	24
ALCOHOL WITHDRAWAL	23
CHEST PAIN NOS	23
DEPRESSIVE DISORDER NEC	21
HEAD INJURY NOS	21
PSYCHOSIS NOS	19
ABDOMINAL PAIN-SITE NOS	19
ALCOHOL ABUSE-CONTINUOUS	19
OTH CONVULSIONS	18
BACKACHE NOS	18

Source: Renown Regional Medical Center

Table 2-2 represents the top diagnosis entered for homeless patients entering the Renown Medical Center Inpatient care. Three of the most frequent diagnosis stems from alcohol consumption and the remaining are traumas, heart maladies and infections.

Table 2-2
Renown Medical Center – Top 7 In-Patient Diagnosis
2006

ALCOHOL WITHDRAWAL	9
DELIRIUM TREMENS	8
CELLULITIS OF ARM	6
ACUTE PANCREATITIS	4
PNEUMONIA ORGANISM NOS	3
OPEN WOUND-CHEST/S COMP	3
CHEST PAIN NOS	3

Source: Renown Regional Medical Center

Approximate costs associated with homeless patients

For internal projects; direct variable, direct fixed, indirect variable and indirect fixed costs are assigned and calculated in Renown's cost accounting database. For external comparison projects, Renown uses the same criteria that all hospitals use to calculate their cost-to-charge ratios after filing annual Medicare cost reports. As seen in Table 2-3 below and based on the most recent cost report, Renown's cost-to-charge ratio of 26% is used to estimate costs incurred by homeless people.

Table 2-3 represents normalized costs associated with homeless patient encounters in the Emergency Department and Inpatient care. The 1,307 Emergency Department visits cost an estimated $111,079 in 2006 with an average cost per visit of $85. The 140 people who progressed from the ED to inpatient cost $417,290 in 2006 with an average of $2,981 per admission.

Although homeless people seek care in the ED more frequently than they are admitted to the acute care hospital, (as seen in Table 2-4,) costs for a few hours of diagnosing and treating in the ED are a fraction of those needed during a multiple-day inpatient stay.

Table 2-3
Renown Health Inpatient Admit & Emergency Department Costs 2006

	Homeless Patients	Normalized Cost-to-Charge Ratio Estimated	Average Normalized Cost per Visit
Emergency Department Visits	1,307	$111,079	$85
Inpatient Admit	140	$417,290	$2,981
Total Homeless Patients	**1,447**	**$528,368**	**--**

Source: Renown Regional Medical Center

What other service-providers and services are Renown RMC patients referred to?

Renown has a social services referral list it distributes to all patients who may be in need of assistance.

3- HAWC Outreach

Mission Statement:
"Provide primary health and dental care to homeless families and individuals in Washoe County. We will strive to provide our patients with the highest quality, comprehensive primary and preventive care."

HAWC Outreach definition of homelessness:
Homelessness is defined as "an individual or family that lack housing." This includes people living on the street and in drop-in shelters but is more encompassing. The homeless may be staying in transitional housing, rehabilitation programs, or may be "doubled up." Doubling up refers to people who are forced to stay with others in a temporary and unstable environment.

Description of facility, staff, and general services provided

HAWC Outreach Medical Clinic's goal is to provide health and dental care to homeless individuals and families in Northern Nevada. They provide patients with the highest quality of comprehensive primary and preventive care. The HAWC Outreach Medical Clinic is a program of the HAWC Community Health Centers. In 1987, the Stewart B. McKinney Homeless Assistance Act was enacted to provide relief to the nation's rapidly increasing homeless population. The addition of section 340 established the Health Care for Homeless Program to provide primary health care.

In 1998 HAWC secured a "Healthcare for the Homeless" grant to operate a homeless healthcare clinic. Since its inception, the HAWC Outreach Clinic has provided approximately 19,000 medical visits for homeless individuals. The HAWC Outreach Clinic provides primary care, mental health counseling, medical screening, drug/alcohol screening and counseling, and referrals. Various medical professionals donate their time to provide free services and the Clinic is also supported by the main HAWC Clinic facility's team of physicians and dentists.

How do homeless patients come to HAWC Outreach and who refers them?

The HAWC Outreach Clinic is strategically located in the "Homeless Corridor," an area within Reno consisting of shelters and motels where homeless families and individuals are concentrated.

What is the process in which patients are identified as homeless?

Individuals who come to HAWC Outreach Clinic for services are asked basic questions regarding where they live, and if they live in a stable environment. Receiving medical care at HAWC is not based on the ability to pay. The Clinic serves to represent medical care given to those living in an unstable environment, and not on the ability to pay; however, the "unstable" environment is assumed to characterize a state of homelessness, and not any other sort of living situation.

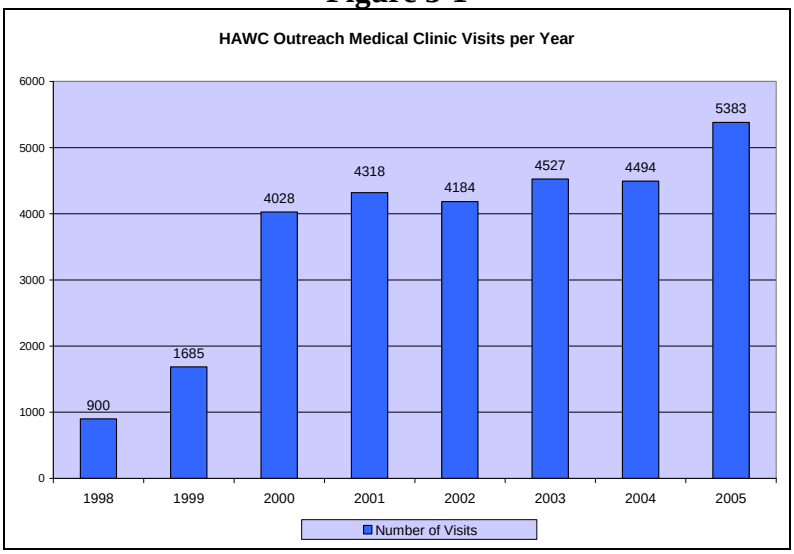
Approximate number of homeless patients receiving care

On average twenty patients are seen per day at the HAWC Outreach Clinic. In the winter months, the number of patients served jumps to thirty per day. The cold winter weather causes more homeless individuals to get sick and require medical attention.

Dental and diabetic services are the most widely used services; however, the Clinic is limited in their ability to provide unlimited needs of service. HAWC Outreach receives federal funding for a set amount of money to be used over a one-year period, and therefore is limited in this nature.

Figure 3-1 shows the annual number of visits per year. From 2000 to 2005, the Clinic saw over 4,000 visits per year. The average visit load per year may serve as a rough estimate as to the total number of homeless individuals within the Reno-Sparks-Washoe County area; however, we do not know from this graph how many individual homeless patients made up the total number of visits per year. A relatively small number of homeless patients may make up a large proportion of the total visits.

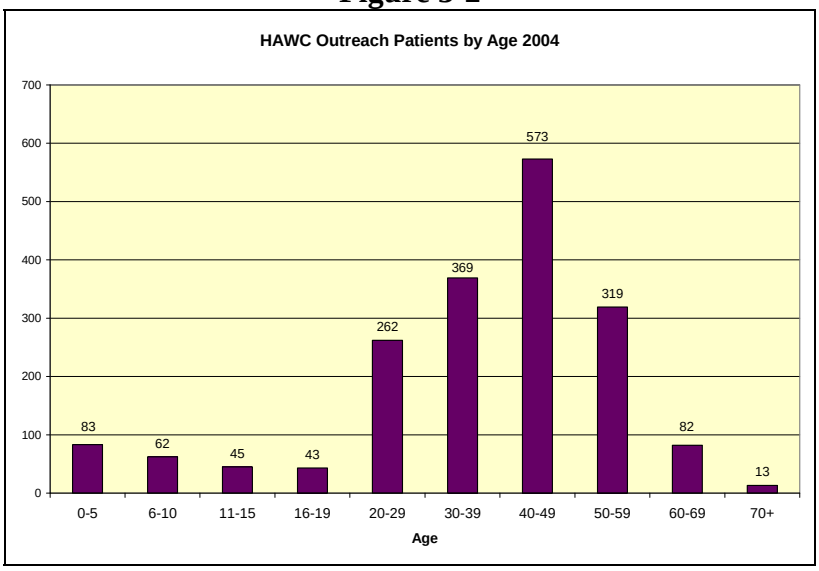
Figure 3-1



Source: HAWC Outreach Medical Clinic

The data collected in Figure 3-2 through 3-5 are based on survey questions asked by the staff of HAWC Outreach Clinic, and therefore, the total numbers represented per year, do not aggregate to the total number of visits shown in Figure 3-1.

Figure 3-2

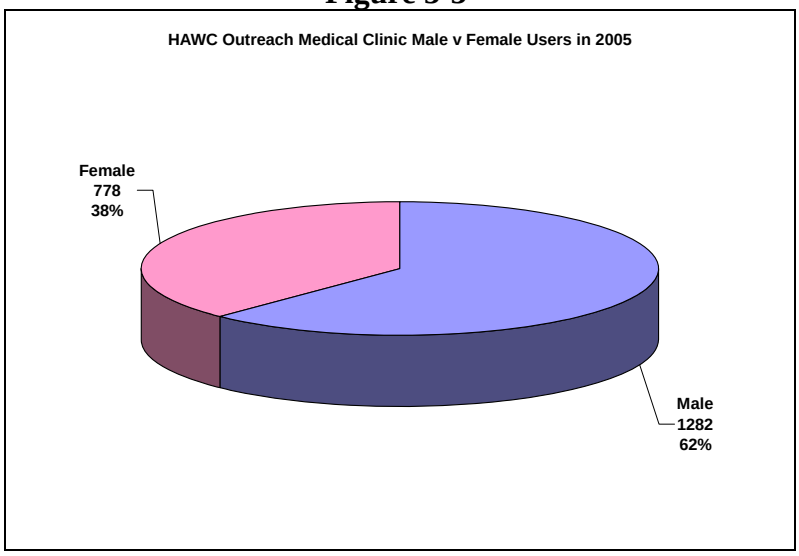


Source: HAWC Outreach Medical Clinic

In Figure 3-2 the 2004 age distribution of HAWC Outreach patients is shown. A large majority, approximately 30%, of patients surveyed are between the ages of 40 to 49-years-old. The overall general age distribution is from 20 to 59-years-old and makes up over 80% of the age distribution served.

Figure 3-3 gives a gender breakdown of HAWC Outreach Medical Clinic patients surveyed in 2005. Male patients make up approximately 62%, while the proportion of females is 38%.

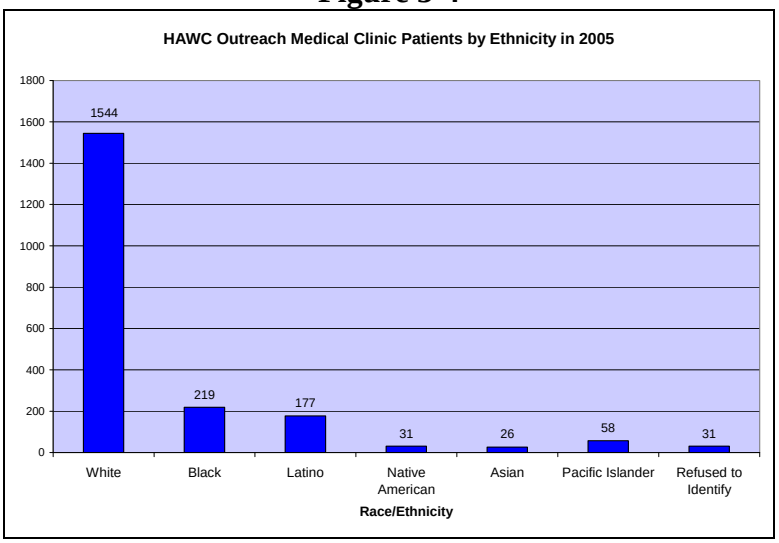
Figure 3-3



Source: HAWC Outreach Medical Clinic

Figure 3-4 represents the ethnic breakdown of patients surveyed by HAWC Outreach Clinic in 2005. A vast majority of patients served are White, approximately 75%; the next largest ethnic group is Blacks, making up 10% of the overall ethnic distribution, followed by Latinos with 8.6%.

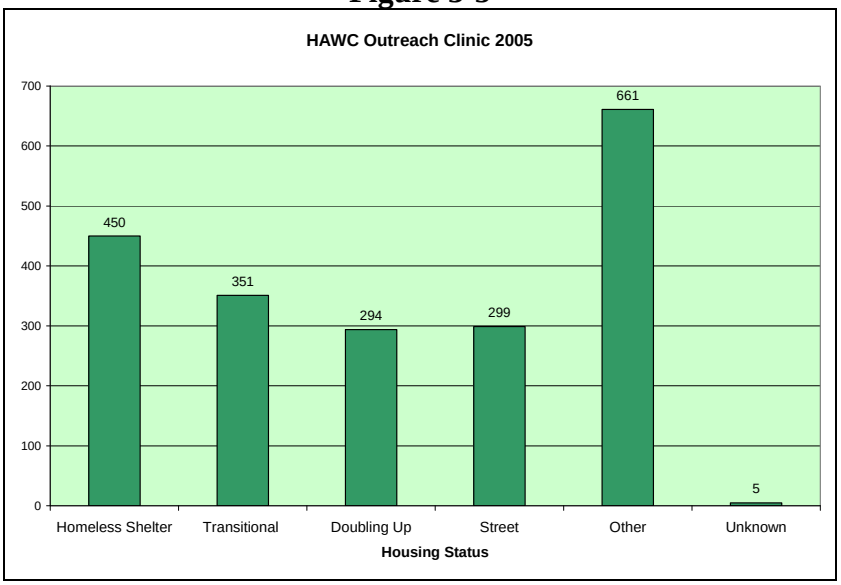
Figure 3-4



Source: HAWC Outreach Medical Clinic

In Figure 3-5, HAWC Outreach Clinic patients were asked to designate their housing status. The most prominent response was “other,” as shown in the graph, however, 21.8% responded they were living in a homeless shelter, 17% listed transitional housing, 14.3% replied doubling up, and 14.5% answered living on the street. The “other” category may include motels, vehicles, or other forms of make-shift housing.

Figure 3-5



Source: HAWC Outreach Medical Clinic

In Table 3-1 and 3-2, a list of selected diagnoses and services rendered at HAWC Outreach Clinic for 2005 is shown. Some of the more notable and highly used services from the HAWC Outreach Clinic include: asthma, chronic bronchitis and emphysema, diabetes mellitus, hypertension, alcohol related disorders, other substance related disorders, and depression and other mood disorders. In both tables, the number of encounters and number of users/patients are identified for 2005. The number of encounters represents visits, while the number of users/patients is the actual number of individuals who make up the overall number of visits per year.

Table 3-1
HAWC Outreach Medical Clinic
Selected Diagnoses & Services Rendered I
2005

	Number of Encounters	Number of Users/Patients
Selected Infectious & Parasitic Diseases		
Symptomatic HIV	5	5
Asymptomatic HIV	0	0
Tuberculosis	0	0
Syphilis & other STDs	**67**	**61**
Selected Diseases of the Respiratory System		
Asthma	**188**	**128**
Chronic bronchitis & emphysema	**298**	**224**
Selected Other Medical Conditions		
Abnormal breast findings, female	0	0
Abnormal cervical findings	1	1
Diabetes mellitus	**331**	**130**
Heart disease (selected)	**59**	**40**
Hypertension	**623**	**293**
Contact dermatitis & other eczema	**44**	**44**
Dehydration	2	2
Exposure to heat or cold	1	1
Selected Childhood Conditions		
Otitis media eustachian tube disorders	**48**	**45**
Selected perinatal medical conditions	2	2
Lack of expected normal physiological developments	1	1
Selected Mental Health & Substance Abuse Conditions		
Alcohol related disorders	**147**	**112**
Other substance related disorders (excluding tobacco use disorders)	**123**	**110**
Depression and other mood disorders	**157**	**87**
Anxiety disorders including PTSD	**43**	**33**
Attention deficit and distruptive behavior disorders	2	2
Other mental disorders, excluding drug or alcohol dependence (includes mental retardation)	**74**	**64**

Source: HAWC Outreach Medical Clinic

Table 3-2
HAWC Outreach Medical Clinic
Selected Diagnoses & Services Rendered II
2005

	Number of Encounters	Number of Users/Patients
Selected Diagnostic Tests/Screening/Preventive Services		
HIV Test	0	0
Mammogram	1	1
Pap Smear	**113**	**109**
Selected immunizations	**55**	**51**
Contraceptive management	**46**	**37**
Health supervision of infant or child (ages 0 to 11)	**13**	**12**
Selected Dental Services		
Emergency Services	0	0
Oral Exams	8	7
Prophylaxis only - adult or child	7	7
Sealants	0	0
Fluoride Treatment only - adult or child	7	7
Restorative Services	4	4
Oral Surgery (extractions and other surgical procedures)	**65**	**62**
Rehabilitative Services	1	1

Source: HAWC Outreach Medical Clinic

What other service-providers and services are HAWC Outreach patients referred to?

Renown Health System referrals may be made for patients with catastrophic illnesses; they maintain an eligibility standard of less than $619 monthly gross income and they also accept Medicaid. Pregnant individuals are sent to Washoe Pregnancy Center for more intensive care. Generally, HAWC will refer homeless patients to other homeless service providers such as St. Vincent's, Salvation Army, ReStart, H.E.L.P, etc.

How is HAWC Outreach's budget organized and what is the allotted amount of funding for particular medical services?

The projected yearly budget for HAWC Outreach Clinic is $450,000, the yearly dental salary is approximately $130,000 and money spent on salary, medications, and labs is almost $295,000 per year.

Table 3-3 shows the Principal Third Party Insurance Source in 2005 at HAWC Outreach. Most patients who receive medical care from HAWC Outreach are not insured. Approximately 0.5% of all patients have private insurance, while 93% are uninsured.

Table 3-3
HAWC Outreach Medical Clinic 2005

Principal Third Party Insurance Source 2005		
	0-19 years-old	**20 & Older**
None/Uninsured	98	1,815
Medicaid	32	68
Medicare	0	36
Private Insurance	1	10
Total	**131**	**1,929**

Source: HAWC Outreach Medical Clinic

Table 3-4 represents costs for the HAWC Outreach Clinic in 2005. Some of the notable costs listed are: medical cost per medical user/patient ($217), dental cost per dental user/patient ($324), and total cost per total user/patient ($281).

Table 3-4
HAWC Outreach Medical Clinic
Costs 2005

Percent of Total Costs by Costs Center after	
Medical	**43%**
Dental	**43%**
Pharmacy	6%
Lab/X-ray as	4%
Mental/Addictive Srvc	2%
Costs per User/Patient	
Medical Cost per Medical User/Patient	**$217**
Dental Cost per Dental User/Patient	$324
Total Cost per Total User/Patient	**$281**
Costs per Encounter	
Medical cost per medical encounter	**$82**
Dental cost per dental encounter	**$156**
Pharmacy cost per medical encounter	$11
Lab & X-ray cost per medical encounter	$8

Source: HAWC Outreach Medical Clinic

4 - Northern Nevada Medical Center

Description of facility and staff

Northern Nevada Medical Center provides physicians and patients with the latest in technological innovations for diagnosis and treatment of the most acute clinical conditions. The emergency department is a certified Level-III emergency department and serves more than 24,000 patients annually.

Northern Nevada's highly regarded 15-minute ER guarantee has garnered high patient satisfaction ratings. The hospital expanded the emergency department in 2003, more than doubling its size, from eight to 18 beds, and increasing capacity of the diagnostic imaging department, as well.

Since it opened in January, 1983, Northern Nevada Medical Center has been jointly owned and operated by a partnership with Universal Health Services, Inc., of King of Prussia, Pennsylvania, the nation's third largest hospital management company. The hospital is accredited by the Joint Commission on the Accreditation of Health Care Organizations and licensed by the state of Nevada.

How do the homeless patients come to Northern Nevada Medical Center and who refers them?

Homeless patients that come to Northern Nevada Medical Center generally are brought in by law enforcement, REMSA, or they come in on foot.

What is the process in which patients are identified as homeless?

A patient is recognized as homeless if they acknowledge they are homeless or if the patient does not have an address listed upon intake. If they are homeless a note is made in their medical file, therefore, to pull the number of homeless patients annually visiting Northern Nevada Medical Center would require a labor intensive search through each individual file to seek the number of designated homeless patients.

Approximate number of homeless patients receiving each service

As an estimate, about six to eight homeless patients are admitted into inpatient care per month. In the winter months the number increases due to the cold weather which causes more sicknesses in the homeless population. When there are special events going on the number of homeless entering the Medical Center increases as well. Generally, homeless patients come in for alcohol detox treatment, substance abuse, and upper respiratory chest pain.

A very small proportion of homeless individuals go to Northern Nevada Medical Center. Its location on the east side of Sparks, away from downtown Reno and the more heavily homeless populated 4th Street makes it a relatively small medical service provider for homeless individuals.

What other service-providers and services are Northern Nevada Medical Center patients referred to?

Northern Nevada Medical Center will provide taxi cab vouchers if they were brought into the Medical Center from the east, such as Fernley or Fallon. Also medication vouchers are provided for those who cannot afford medication.

Information on local homeless service providers such as St. Vincent’s, RSGM, Men’s Drop-In Center, H.E.L.P., ReStart, and HAWC Outreach are provided to homeless patients as well as job resources.

5 - VA Sierra Nevada Health Care System - HCHV Program

Description of facility, staff, and general services provided

The VA Sierra Nevada Health Care System (VASNHCS), Reno, Nev., provides primary and secondary care to a large geographical area that includes 20 counties in northern Nevada and northeastern California. Approximately 120,000 veterans reside in this region, with Reno representing the largest urban area. The Reno campus is the site of the Ioannis A. Lougaris VA Medical Center, which operates 56 hospital beds and 60 Transitional Care Unit beds. During the 2004 fiscal year, VASNHCS provided care to over 24,000 unique patients, which accounted for approximately 229,000 outpatient visits, while treating more than 2,900 inpatients.

VASNHCS has an operating budget of more than $114 million and employs approximately 750 employees. VASNHCS provides a broad array of inpatient care and outpatient services in medicine, surgery, neurology, mental health, pharmacy, interventional radiology, alcohol/drug treatment, ophthalmology, audiology/speech pathology, dental care, and home care. The hospital offers a wide range of diagnostic services, including MRI, CT, ultrasound, nuclear medicine, as well as diagnostic cardiac catheterization services.

VA offers a wide array of special programs and initiatives specifically designed to help homeless veterans live as self-sufficiently and independently as possible. In fact, VA is the only Federal agency that provides substantial hands-on assistance directly to homeless persons. Although limited to veterans and their dependents, VA's major homeless-specific programs constitute the largest integrated network of homeless treatment and assistance services in the country.

VA's specialized homeless veterans treatment programs have grown and developed since they were first authorized in 1987. The programs strive to offer a continuum of services that include:

- Aggressive outreach to those veterans living on streets and in shelters who otherwise would not seek assistance
- Clinical assessment and referral to needed medical treatment for physical and psychiatric disorders, including substance abuse
- Long-term sheltered transitional assistance, case management, and rehabilitation
- Employment assistance and linkage with available income supports
- Supportive permanent housing

The Department of Veteran Affairs has a program offering Health Care of Homeless Veterans (HCHV). This program provides housing information, substance abuse treatment, mental health treatment, assistance with

residential issues, eligibility and enrollment, and access to medical care. The VASNHCS started its Health Care for Homeless Veterans Program in 2000, and currently employs two full-time HCHV social workers and a half-time HCHV clinician in Minden. The HCHV Program offered at VASNHCS specifically looks to conduct as much as outreach as possible.

How do the homeless patients come to the VA's HCHV and who refers them?

Homeless individuals coming to the VA are generally referred by other service providers or find out about the HCHV program by word of mouth. Patients are also contacted through aggressive VA HCHV outreach. The VA HCHV outreach staff participates directly with the Crisis Intervention Team (CIT). The CIT are specially trained police officers who are certified to recognize individuals with a mental health disorder and who may be homeless on the streets and within the community.

What is the process in which patients are identified as homeless?

The veteran's VA eligibility (i.e. veteran status) is determined by the Eligibility Department upon registration. Individuals who come to the VA Sierra Hospital to receive Health Care for Homeless Veterans care fill out a contact form. The form asks the following question categories: veteran description, military history, living situation, medical, substance abuse, psychiatric status, employment status, and interviewer observations. For the purpose of this program, Health Care for Homeless Veterans, the definition of homelessness is adopted from the Interagency Council on the Homeless. According to this definition, a homeless person is:

1. An individual who lacks a fixed, regular, and adequate nighttime residence.

2. An individual who has a primary nighttime residence that is: (a) a supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill); (b) an institution that provides a temporary residence for individuals intended to be institutionalized; or (c) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings. For the purposes of the HCHV, the term "homeless" or "homeless individual does not include any individual imprisoned or otherwise detained pursuant to an Act of Congress or a State law. (Stewart B. McKinney Homeless Assistance Act; Public Law 100-77, July 22, 1987).

Therefore, some of the general housing conditions that will qualify a veteran for the Health Care of Homeless Veterans Program: living in someone else's home, in a car, on the street, in a shelter, or if a veteran is about to become homeless.

What are the demographics of homeless veterans nationally and locally?

About one-third of the U.S. adult homeless population has served their country in the Armed Services. On any given day, as many as 200,000 veterans (male and female) are living on the streets or in shelters and perhaps twice as many experience homelessness at some point during the course of a year. Many other veterans are considered near homeless or at risk because of their poverty, lack of support from family and friends, and dismal living conditions in cheap hotels or in overcrowded or substandard housing.

Currently, the number of homeless male and female Vietnam era veterans is greater than the number of service persons who died during that war -- and a small number of Desert Storm veterans are also appearing in the homeless population. Although many homeless veterans served in combat in Vietnam and suffer from Post-Traumatic Stress Disorder (PTSD), at this time, epidemiologic studies do not suggest that there is a causal connection between military service, service in Vietnam, or exposure to combat and homelessness among veterans. Family background, access to support from family and friends, and various personal characteristics (rather than military service) seems to be the stronger indicators of risk of homelessness.

Almost all homeless veterans are male (about three percent are women); the vast majority are single, and most come from poor, disadvantaged backgrounds. Homeless veterans tend to be older and more educated than homeless non-veterans. But similar to the general population of homeless adult males, about 45% of homeless veterans suffer from mental illness and (with considerable overlap) slightly more than 70% suffer from alcohol or other drug abuse problems. Roughly 53% are African American or Hispanic. Table 5-1 shows the VASNHCS has very similar trends to the national average in the categories of Age, Gender, and the Hispanic and Other category under Race/Ethnicity. The percent of Afro-American and White at the VASNHCS site are drastically different from the average taken from all national VA Health Care Sytems.

Table 5-1
VA Sierra Nevada Health Care System
Demographic Characteristics at Intake
Fiscal Year 2000-04

	Age	Gender		Race/Ethnicity			
	Mean At Intake	Male	Female	Afro-Amer	White	Hispanic	Other
VA Sierra Nev HCS	51.7	96.20%	3.80%	7.60%	84.80%	4.20%	3.50%
All National Sites	49.1	96.60%	3.40%	47.40%	44.90%	5.40%	2.40%

Source: Northeast Program Evaluation Center

Description of services provided and approximate number of homeless receiving service

VA's Homeless Providers Grant and Per Diem Program

The Grant and Per Diem program is offered annually (as funding permits) by the VA to fund community-based agencies providing transitional housing or service centers for homeless veterans. Under the Capital Grant Component VA may fund up to 65% of the project for the construction, acquisition, or renovation of facilities or to purchase van(s) to provide outreach and services to homeless veterans. Per Diem is available to grantees to help off-set operational expenses. Non-Grant programs may apply for Per Diem under a separate announcement, when published in the Federal Register, announcing the funding for "Per Diem Only."

Loan Guarantee Program for Multifamily Transitional Housing

This new initiative authorizes VA to guarantee no more than 15 loans with an aggregate value of $100 million within 5 years for construction, renovation of existing property, and refinancing of existing loans, facility furnishing or working capital. No more than 5 loans may be guaranteed under this program prior to November 11, 2001. The amount financed is a maximum of 90% of project costs. Legislation allows the Secretary to issue a loan guarantee for large-scale self-sustaining multifamily loans. Eligible transitional project are those that:

1) Provide supportive services including job counseling
2) Require veteran to seek and maintain employment
3) Require veteran to pay reasonable rent
4) Require sobriety as a condition of occupancy
5) Serves other veterans in need of housing on a space available basis.

VA Assistance to Stand Downs

VA programs and staff have actively participated in each of the Stand Downs for Homeless Veterans run by local coalitions in various cities each year. In wartime Stand Downs, front line troops are removed to a place of relative safety for rest and needed assistance before returning to combat. Similarly, peacetime Stand Downs give homeless veterans 1-3 days of safety and security where they can obtain food, shelter, clothing, and a range of other types of assistance, including VA provided health care, benefits certification, and linkages with other programs.

Veterans Industries

In VA's Compensated Work Therapy/Transitional Residence (CWT/TR) Program, disadvantaged, at-risk, and homeless veterans live in CWT/TR

community-based supervised group homes while working for pay in VA's Compensated Work Therapy Program (also known as Veterans Industries). Veterans in the CWT/TR program work about 33 hours per week, with approximate earnings of $732 per month, and pay an average of $186 per month toward maintenance and up-keep of the residence. The average length of stay is about 174 days. VA contracts with private industry and the public sector for work done by these veterans, who learn new job skills, relearn successful work habits, and regain a sense of self-esteem and self-worth.

CHALENG

The Community Homelessness Assessment, Local Education, and Networking Groups (CHALENG) for veterans is a nationwide initiative in which VA medical center and regional office directors work with other federal, state, and local agencies and nonprofit organizations to assess the needs of homeless veterans, develop action plans to meet identified needs, and develop directories that contain local community resources to be used by homeless veterans.

More than 10,000 representatives from non-VA organizations have participated in Project CHALENG initiatives, which include holding conferences at VA medical centers to raise awareness of the needs of homeless veterans, creating new partnerships in the fight against homelessness, and developing new strategies for future action.

DCHV

The Domiciliary Care for Homeless Veterans (DCHV) Program provides biopsychosocial treatment and rehabilitation to homeless veterans. The program provides residential treatment to approximately 5,000 homeless veterans with health problems each year and the average length of stay in the program is 4 months. The domiciliaries conduct outreach and referral; vocational counseling and rehabilitation; and post-discharge community support.

HUD-VASH

This joint Supported Housing Program with the Department of Housing and Urban Development provides permanent housing and ongoing treatment services to the harder-to-serve homeless mentally ill veterans and those suffering from substance abuse disorders. HUD's Section 8 Voucher Program has designated 1,780 vouchers worth $44.5 million for homeless chronically mentally ill veterans. VA staff at 35 sites provide outreach, clinical care and ongoing case management services. Rigorous evaluation of this program indicates that this approach significantly reduces days of homelessness for veterans plagued by serious mental illness and substance abuse disorders.

Supported Housing

Like the HUD-VASH program identified above, staff in VA's Supported Housing Program provides ongoing case management services to homeless veterans. Emphasis is placed on helping veterans find permanent housing and providing clinical support needed to keep veterans in permanent housing. Staffs in these programs operate without benefit of the specially dedicated Section 8 housing vouchers available in the HUD-VASH program but are often successful in locating transitional or permanent housing through local means, especially by collaborating with Veterans Service Organizations.

Drop-In Centers

These programs provide a daytime sanctuary where homeless veterans can clean up, wash their clothes, and participate in a variety of therapeutic and rehabilitative activities. Linkages with longer-term assistance are also available.

VBA-VHA Special Outreach and Benefits Assistance

VHA has provided specialized funding to support twelve Veterans Benefits Counselors as members of HCMI and Homeless Domiciliary Programs as authorized by Public Law 102-590. This specially funded staffs provide dedicated outreach, benefits counseling, referral, and additional assistance to eligible veterans applying for VA benefits. This specially funded initiative complements VBA's ongoing efforts to target homeless veterans for special attention. To reach more homeless veterans, designated homeless veterans coordinators at VBA's 58 regional offices annually make over 4,700 visits to homeless facilities and over 9,000 contacts with non-VA agencies working with the homeless and provide over 24,000 homeless veterans with benefits counseling and referrals to other VA programs. These special outreach efforts are assumed as part of ongoing duties and responsibilities. VBA has also instituted new procedures to reduce the processing times for homeless veterans' benefits claims.

Program Monitoring and Evaluation

VA has built program monitoring and evaluation into all of its homeless veterans' treatment initiatives and it serves as an integral component of each program. Designed, implemented, and maintained by the Northeast Program Evaluation Center (NEPEC) at VAMC West Haven, CT, these evaluation efforts provide important information about the veterans served and the therapeutic value and cost effectiveness of the specialized programs. Information from these evaluations also helps program managers determine new directions to pursue in order to expand and improve services to homeless veterans.

The VA Northeast Program Evaluation Center (NEPEC) is responsible for conducting the national outcomes performance assessment. NEPEC is based at the VA Connecticut Healthcare System in West Haven, CT. Directed by Robert Rosenheck, MD, Professor of Public Health and Psychiatry in the School of Medicine at Yale University, NEPEC has extensive experience evaluating outcomes of homeless people.

Table 5-2 and 5-3 represent data collected from the VA Northeast Program Evaluation Center. Table 5-2 shows trends in veterans treated by the HCHV Program in 2003 and 2004, while Table 5-3 represent trends in intake volume for veteran treated by the HCHV program. Both tables compare data specifically from the VA Sierra Nevada Health Care System and all national sites.

Table 5-2
VA Sierra Nevada Health Care System
Fiscal Years 2003-04

Trends in Veterans Treated by HCHV Program					
	Number of Visits	Number of Individuals	Visits per Individual	Clinicians Visited	Visits per Clinician
VA Sierra Nev HCS					
FY 2003	287	253	1	2	143.5
FY 2004	420	316	1.3	2	210
All National Sites					
FY 2003	243,456	60,970	4	375.5	648.4
FY 2004	249,010	63,283	3.9	376	662.3

Source: Northeast Program Evaluation Center

Table 5-3
VA Sierra Nevada Health Care System
Fiscal Year 2000-04

Trends in Intake Volume for Veterans Treated by HCHV Program		
	VA Sierra Nev HCS	All National Sites
Number of Intakes		
FY 2000	129	34,206
FY 2001	302	46,862
FY 2002	360	44,296
FY 2003	230	42,380
FY 2004	289	42,485
Number of Clinicians		
FY 2000	2	245.4
FY 2001	2	334.1
FY 2002	2	335.9
FY 2003	2	335.5
FY 2004	2	334.7
Intakes per Clinician		
FY 2000	64.5	139.4
FY 2001	151	140.3
FY 2002	180	131.9
FY 2003	115	126.3
FY 2004	144.5	126.9

Source: Northeast Program Evaluation Center

It is estimated by the Coordinator of the Health Care for Homeless Veterans that of the current (2006) estimated 300 clients served through the HCHV Program, approximately 85% to 90% suffer from co-occurring mental health and substance abuse disorders. It was also observed by the Coordinator of HCHV that about 50% to 60% of those who receive assistance through HCHV recognizably benefit, 10% to 15% are believed to really shine and successfully improve for the better, and lastly, 15% to 25% of the truly chronically homeless veterans who come through the HCHV Program do not improve and continue their way of life.

VA Sierra Nevada Health Care budget information related to homeless services provided

Table 5-4 looks at the amount of funding provided in 2004 for personal services, looking particularly at the VA Sierra Nevada Health Care. In the 2004 data, the VASNHCS did not receive any funding for supported housing or HUD-VASH, however, they did receive approximately $103,197 for the Health Care for Homeless Veterans program.

Table 5-4
VA Sierra Nevada Health Care System
Fiscal Year 2004

Personal Services				
	HCHV	Supported Housing	HUD-VASH	Total
VA Sierra Nev HCS	$103,197	--	--	$103,197
All National Sites	$25,817,134	$1,918,201	$2,940,999	$30,676,334

Source: Northeast Program Evaluation Center

What other service-providers and services are patients referred to?

The VA has a referral list it provides clients. Some of the services referred in the Reno/Sparks area include: ReStart, HAWC Outreach, Reno Sparks Gospel Mission, Men's Drop-In Center, North Start Treatment & Recovery Center, Catholic Community Services, St. Vincent's Dining & Housing, Social Security, CAAW, Crisis Call Center, RHA, Washoe County Social Services – General Assistance, Disabilities Action Advocates, Job Connect-Veteran's Representatives, Reno-Sparks Indian Colony, Nevada Urban Indian, and Salvation Army.

6 - Washoe County Department of Social Services – Adult Services Division

Description of facility, staff, and general services provided

Washoe County Adult Services encompasses the General Assistance and Health Care Assistance program. Approximately thirty-three employees work for the Division.

To apply for the General Assistance Program or the Health Care Assistance Program, an application of assistance must be filled out. The following information is evaluated and verified from thorough interviews and the application process: identification, employment, income, resources, insurance, and medical information. This information is then used to qualify applicants for General Assistance and the Health Care Assistance Program.

Health Care Assistance Program (HCAP)

The Health Care Assistance Program provides for reimbursement of medical and institutional care costs as is reasonable and necessary for the diagnosis and treatment of an eligible applicant's injury or illness.

Social Services are provided to HCAP clients with medical, social, and/or emotional difficulties. Services include assessment of the client's needs, evaluation of the client's ability to meet his/her needs, crisis intervention, home evaluation, follow-up services, and referrals to other programs and community resources. The Department provides help to those clients who require assistance to complete applications for Supplemental Security Income (SSI), Social Security Disability (SSD), and/or State Medicaid.

The HCAP program includes the following:

- Adult Protective Services
- Burial and Cremation
- Adult Group Care and Long Term Care
- Medical Assistance
- Medical Assistance
    - Inpatient
    - Outpatient
    - Emergency Room
    - Diagnostic Testing
    - Clinic Services

General Assistance

General Assistance (GA) provides cash grants to help low-income families or individuals. Generally, applicants for GA fall into one of three categories: employable applicants, applicants pending assistance from Nevada State Welfare, and disabled applicants. Applicants must apply for assistance form State, Federal, and other community programs before requesting assistance form the County.

Employable Applicants

Employable applicants are those individuals who are currently unemployed but able to work. Able-body, employable applicants may be eligible for GA if they have not been terminated from employment due to their own faults of

habits or voluntarily resigned form a job within 30 days from the date of application. With some exceptions, employable applicants must actively look for work. Employable applicants are assisted in GA for a maximum of 30 days in a 12-month period.

Applicants Pending Assistance from Nevada State Welfare

Applicants for Temporary Aid for Needy Families (TANF) are assisted while their applications are being processed by the State. Assistance is granted for up to 30 days in a 12-month period based on the condition that the applicant cooperate fully with the State and follow through with the application process.

Disabled Applicants

Applicants who are permanently disabled must provide medical verification of their disability and apply for Supplemental Security Income (SSI), Social Security Disability (SSD), Medicaid, and/or Vocational Rehabilitation services. These clients are eligible for assistance while pending the above programs.

Who refers homeless individuals to Washoe County Adult Social Services?

Most clients who come for assistance are referred from medial entities, local service providers, or through others who receive assistance.

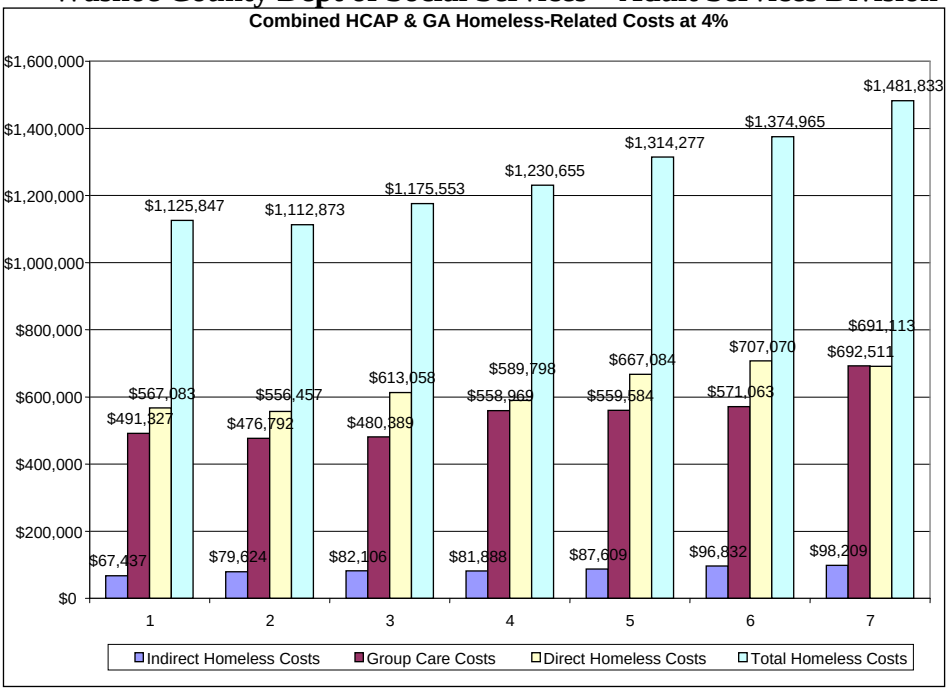
What is the process in which patients are identified as homeless?

In a few months a new system will be put in place that will capture whether incoming patients are homeless. Currently, only the persistently homeless are identified in records, the more transitional homeless population living with friends, or jump from place to place are not designated as homeless.

Approximate number of homeless patients receiving each service

In Figure 6-1, the 4% number represents the street homeless population served through General Assistance and HCAP. This is based off the number of clients served in both programs who are identified as homeless. Therefore, the chronic homeless clientele make up 4% of the total population served by Washoe County Adult Services.

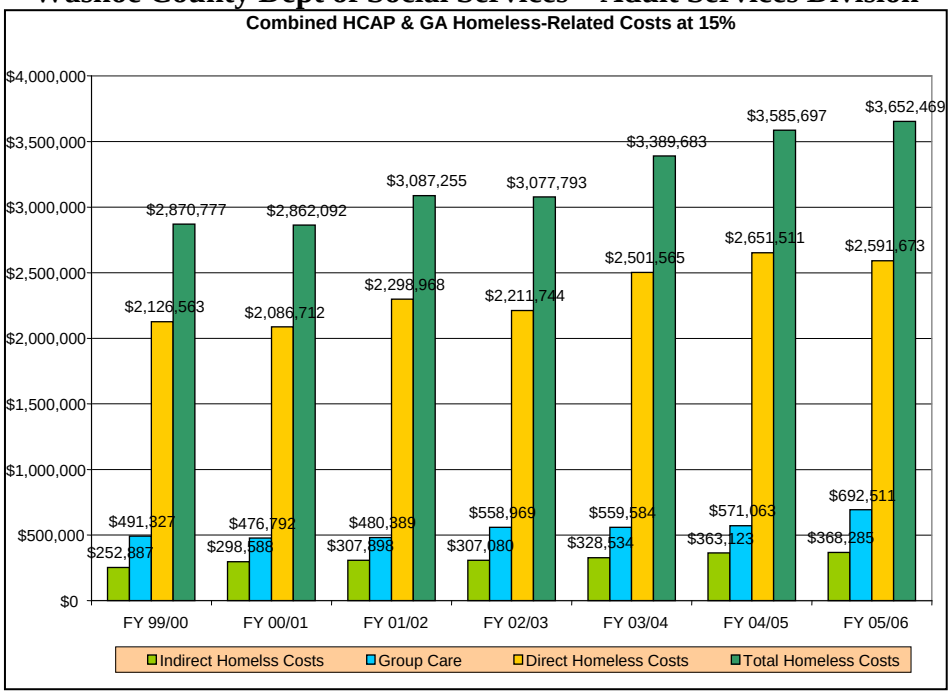
Figure 6-1
Washoe County Dept of Social Services – Adult Services Division



Source: Washoe County Department of Social Services

In Figure 6-2, the 15% homeless proportion of total clients served is based on information gathered from Washoe County Social Service workers and is subjective, as this information is not directly tracked. The 15% population represents those individuals who live with friends or bounce around from place to place.

Figure 6-2
Washoe County Dept of Social Services – Adult Services Division



Source: Washoe County Department of Social Services

How is funding allocated to Washoe County Department of Social Services?

Funding for the Health Care Assistance Program is mandated by NRS 428.295 and requires a 4 1/2 % annual increase in this funding from the previous year and NRS 428.050, which requires the County to levy an *ad valorem* tax of not less than 6 cents but not more than 10 cents of each $100 of assessed value. These two funding sources supply funding for HCAP.

What other service-providers and services are clients or patients referred?

Washoe County Department of Social Services refer clients to Nevada State Welfare for Food Stamps and Temporary Aid for Needy Families (TANF); State of Nevada, Division of Health Care and Finance Policy, Medicaid; and also Social Security Administration. Clients are also referred to any of the many community partners and programs for which they may be eligible.

Summary Observations and Conclusions

The use of medical care by individuals who are homeless leads to costs on the system and strains on the medical personnel involved. Some of the underlying patterns and observations made by the data lead to two conclusions: (1) current laws related to the use and access of emergency medical treatment has led to an inefficient use of Emergency Department services; (2) the underlying nature of homelessness makes the use of medical services unavoidable.

Passed in 1986, the Federal Emergency Medical Treatment and Active Labor Act (EMTALA) is a statute which governs when and how a patient may be refused treatment and/or transferred from one hospital to another when he/she is in an unstable medical condition.

In essence, then, the statute:

- Imposes an affirmative obligation on the part of the hospital to provide a medical screening examination to determine whether an "emergency medical condition" exists
- Imposes restrictions on transfers of persons who exhibit an "emergency medical condition" or are in active labor, which restrictions may or may not be limited to transfers made for economic reasons
- Imposes an affirmative duty to institute treatment if an "emergency medical condition" does exist

The EMTALA law has essentially created a situation where the mainstream medical service providers have become the primary care, clinical care, emergency care, and trauma care service providers for the homeless as well as short-term shelter in a pinch. There are no disincentives for homeless individuals relative to the use of the Emergency Room as a source of a full spectrum of medical care. In many cases, because this population has no other easy access point to receive basic medical care, and because the EMTALA has created a system in which no individual may be turned away, Emergency Rooms are frequented by homeless patients.

The second conclusion is that the underlying lifestyle characteristics of homelessness generate the demand for these individuals to frequent the Emergency Rooms and occasionally extended inpatient care. Most homeless patients admitted to an ER have symptoms related to the following diagnosis: consumption of alcohol, bodily pain, and mental health related issues. Therefore, efficient mitigation of the high use of medical facilities and the corresponding cost by homeless individuals requires solutions for homelessness overall.

- The pending Community Triage Center will serve to mitigate a part of the medical costs. They will be primarily focusing on mental health and drug/alcohol treatment. They will not provide acute trauma and for those with more serious conditions, individuals will be sent via ambulance to one of the major medical service providers.

- Another cost mitigating strategy would be to increase funding to agencies such as HAWC Outreach Clinic, where primary and clinical medical, mental health, and drug/alcohol care is provided.

- It is important to understand that if the homeless population were moved to transitional and/or permanent supportive housing, there would still be a need for health care services. Therefore, it would be inaccurate to assume that resources could be moved from providing health care to providing housing. Housing does not preclude the need for medical and mental health care. The inappropriate use of certain medical treatment services might be mitigated through the provision of other “easy access” sub-acute treatment options.

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