Mark Masselli: This is Conversations on Health Care, and I am Mark Masselli.

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: Margaret, the Royal Wedding, hope you caught a glimpse of that the other day with William and Kate to the death of Osama Bin Laden, the news has dominated by stories of epic proportions recently.

Margaret Flinter: Well, there is certainly a lot more anticipation about the Royal Wedding than there was the attack on the compound where Bin Laden was staying. That was a well kept secret. And certainly, both stories captured public attention for very different reasons and in different ways. But meanwhile, we go about our daily lives. Politicians continue to fight over the budgets. Students prepare for graduation. And the homeless, well, they continue to struggle to find food, shelter, and health care.

Mark Masselli: A tip for graduating college students, you need to stay on top of your health care coverage. I am not telling you something you already don't know. But under the Affordable Care Act, young adults can remain on their parents' plan until age 26. Recently, I read that at least 600,000 young adults have already taken advantage of this provision. The Obama Administration estimated that about 1.2 million young adults would sign up for coverage in 2011 but these early numbers from insurance companies show that it still has a little room to grow there.

Margaret Flinter: It does. And we noted in all of our work on Health Reform that that was one of the highest risk populations to be uninsured, so certainly a very practical intervention. And it's also welcome news for the Obama Administration. It shows that measures in the Affordable Care Act are working. But those political battles over Planned Parenthood and Medicare, Medicaid and the budget are far from over. Indiana Republican Governor and the potential 2012 presidential candidate Mitch Daniels announced last week that he plans to sign a legislation that would prevent Planned Parenthood in Indiana from receiving Medicaid funds, and that one is bound to generate some new lawsuits.

Mark Masselli: Meanwhile, back in Washington this week, the senate is gearing up for another heated battle to talk about the budget for 2012. But you know last night, the President brought the leadership together and hopefully, they can maybe reestablish a cooperative tone with Democrats and Republicans working together. At the same time, bipartisan effort in the House Energy and Commerce Committee to find a permanent sustainable solution to the Medicare physician payment problem is progressing in response to the committee's request. The American Medical Association is proposing a complete overhaul of the **formula** use to determine reimbursement to provide ______ 2:21 see Medicare patients. we will keep an eye on that.

Margaret Flinter: Well, if they can do that, that would be the one of the longest running challenges that they will have solved. So wish them luck. And Congress will have a period of time from 2012 to 2016 to work on that legislation creating a new payment formula. And I think that both the AMA and the American Academy of Family Physicians really want to use that time to test new payment models as a way of improving coordination and quality of care, certainly strengthening primary care as well as lowering cost.

Mark Masselli: Turning to today's show, we are going to discuss homeless health care and what's necessary to care for the unique health needs of this population. We are happy Barbara DiPietro is here with us today. Barbara is the Policy Director for the National Health Care for the Homeless Council.

Margaret Flinter: And we are happy that she will shed some light on this important topic. You know we always say along with our colleagues that our # goal is ending homelessness. But wherever you are, why a program here in Connecticut has been providing health care to the homeless population around Connecticut from shelters to soup kitchens to down by the river and with the ______3:25 on Health Care for the Homeless on a national level. And no matter what the story, hear all of our shows on our website at Chcradio.com. Subscribe to iTunes to get our show regularly downloaded. Or if you want to hang onto our every word and read a transcript of our show, visit us at Chcradio.com. And don't forget, if you are a social media aficionado, become a fan of Conservations on Health Care on Facebook and follow us on Twitter.

Mark Masselli: And as always, if you have feedback, email us at Chcradio.com, we would love to hear from you. Before we speak with Barbara DiPietro, let's check in with our producer Loren Bonner with Headline News.

Loren Bonner: I am Loren Bonner with this week's Headline News. The Centers for Medicare and Medicaid has announced a new initiative for quality. Under new regulations in the Affordable Care Act, Medicare will begin to reward hospitals for the quality rather than the quantity of care they provide. Hospitals that do better than average in a variety of measurements or show the greatest improvement from the previous year would earn bonus payments. More than 3,000 acute care hospitals will have their payments adjusted starting in October of 2012. The initiative marks the transition away from the fee-for-service system which many experts believe has contributed to a necessary care and high costs. A new five-minute questionnaire is helping pediatricians detect the early signs of autism in very young children. Researchers at the University of California San Diego's Autism Center of Excellence found that a brief screening in a he pediatrician's office can detect autism-like symptoms in children as young as 12 months old, giving them an important head start on treatment. Normally, children aren't diagnosed with autism until age 2 or 3 when symptoms like lack of eye contact and engagement become more apparent. Although such a questionnaire could present a misdiagnosis for some families, experts say the benefits of early

intervention outweigh the downsides. Soon, new federal rules will target the way junk food is marketed to children. With childhood obesity on the rise, regulators want to restrict the way unhealthy food is advertised to kids. The guidelines which are meant to be voluntary tackle a broad range of marketing not only in TV and print but also in online video games, social media, and websites. The effort is being called one of the government's strongest efforts so far to address the extension of children's advertising in the online world.

Mark Masselli: This is Conversations on Health Care, and today, we are speaking with Barbara DiPietro, Policy Director for the National Health Care for the Homeless Council. Welcome, Barbara.

Barbara DiPietro: Thank you.

Mark Masselli: The National Health Care for the Homeless Council has been working to break the cycle of homelessness for over a quarter of a century. Give us your perspective on the complicated health care needs of the homeless population and talk to us a little bit about what the relationship is between poor health and homelessness.

Barbara DiPietro: Sure. Well, for 25 years, Healthcare for the Homeless Health Center has been delivering patient-centered coordinated care to people experiencing homelessness that's really trying to take into consideration the unique needs of people who are living on the street and in shelters. And I think what most people don't appreciate is the interrelated role between health care and homelessness. And one of the typical patterns, spirals, if you will, that we see, people can be stable and working and paying taxes and living their lives. But if you have an unexpected illness or an accident, an injury, something like that, if your health insurance only pays part of it or you are not insured, pretty soon these medical bills will pile up. And particularly, if you can't work, if you are working in construction or labor or something that's physically intensive or you can't sit because of the spinal compression or anything that could happen to anyone, pretty soon it takes a toll on your ability to work. And so what you will see is spiral starting to occur where you can no longer work. And then if you lose your job, not only do you lose your income but you lose your connection to employer-sponsored insurance if it was available to begin with. And so what you will see then is people starting to rely on their savings, friends and family. But after a while, without being able to address those health care issues, those get worse, your ability to pay for them becomes fewer, your resources become fewer. And pretty soon you end up losing the house that you are living in with a rent or mortgage. And then you start either staying with friends or family, and then pretty soon those relationships get tapped out. And then you will find yourself living in a shelter, and this slide is more common than we would know. So that's one scenario. Another scenario is for people who have had chronic lifelong conditions who have always had a hard time finding work. And so we are relying either on public safety net programs or depending on whether they qualify for

them what's likely being uninsured. 70% of the patients that we see at Healthcare for the Homeless Health Centers are uninsured, and that's out of a million patients that we saw in 2009. And so when we look at the same chronic disease that all Americans have – high blood pressure, diabetes, obesity, heart disease – but particularly so, and people are experiencing homelessness. Being homeless is stressful. You don't have easy access to meds. There is really a hard way of maintaining your health once you are on the street. And so then that becomes harder to end your homelessness once you are homeless because the more sick you become, the less able you are to navigate a social services system that requires you to ______ 9:25 all over the town to fill out paperwork.

Margaret Flinter: So Barbara, you have done an amazing job, I think in that opening of describing the slide into homelessness that can hit people, and I think you pointed out why it's so critical that there would be really close collaboration among all the services and the service providers that are trying to address homelessness, things like integrating affordable primary care and behavioral health care with housing and employment assistance programs. Talk to us about the policy changes that you are after, that you believe can address some of these systemic root causes of homelessness, certainly poverty, lack of housing, poor health. But what are the policy changes that you think can reverse that?

Barbara DiPietro: Well, you certainly hit on it in terms of the partnerships and linking housing and health care. That's absolutely key. Broader than simply housing and health care, which are two key pieces, income, so we need sustainable incomes and benefit levels for people who are low income. This isn't just about people experiencing homelessness, this is about preventing homelessness. And so the best way out of poverty is to give someone a good paying job and absent that. If they are disabled or unable to work, they need benefit levels that are actually meaningful and don't mire people in poverty. Our Social Security payment is about $680 a month. There is nowhere in this country you are going to be able to live in a decent standard of living at $680 a month but that's what we pay for people who can't work. And then also really looking at reforms to education systems, not just for K-12 but higher education, adult literacy, the supports that people need to keep them independent. And then of course this brings me back to the health and the homelessness and the housing that we need in order to have those combinations present. Just having one piece alone is not going to prevent or end homelessness, and it's certainly not going to do the prevention work globally we need in terms of preventing poor health, which we don't do a very good job in our current health care system at preventing.

Mark Masselli: You know Barbara, the Healthcare for the Homeless projects now exist in virtually every state across the country because of the Stewart B. McKinney Homeless Assistance Act of 1987. I should note that we are in Connecticut and Stewart was a congressman who served Connecticut quite well, a national leader in this area. And as you mentioned, health centers across the

country sponsor many of these projects. What research are you doing on homeless health here and what are the challenges of incorporating what you are learning into this program across the country?

Barbara DiPietro: Well, one thing we are looking at very closely is how do the homeless patients that are at health centers differ from other low income but still **stably housed** health center clients. We know that disproportionately they are uninsured, disproportionately they are under 100% of poverty. We are looking at how enabling services and the support services that Healthcare for the Homeless Centers provide, and what the value is there, and how that increases the quality of care that we are able to provide and the health outcomes that our patients experience as a result of those interventions. So we are trying to isolate how that works with homeless clients. We are also checking to look at some research around pain management. Chronic pain is something that a lot of Americans live with. But people experiencing homelessness, when you live on the street, chronic pain ends up being much more of a debilitating factor. And for a variety of reasons, addiction issues or just other co-occurring complications, prescription pain killers are not always the best remedy or the most constructive solution for someone. So how is it that we can be more mindful about people's pain levels and how we treat those. So we are really taking a very close look at some of these pieces so that we can figure out how does homeless health care fit into this rubric of a larger health care system and where might we need to make some fine-tuned control in terms of just meeting individual patient needs.

Margaret Flinter: Barbara, on that federal level, President Obama's agenda certainly could be seen as a step in the right direction for Healthcare for the Homeless. Certainly, Health Reform is going to expand, Medicaid to cover more of the poor and uninsured Americans, and you noted I think 70% of people who are homeless or uninsured today, hopefully that will address some of that. But in addition to that, I would like to hear a little more about the national initiative called Opening Doors which has a goal of ending homelessness within 10 years. What's your assessment of the path that that is on towards its great goal and where does Healthcare for the Homeless fit into the Opening Doors program?

Barbara DiPietro: The Opening Doors is really a fine road map to where this country needs to go in terms of systemic macro-level solutions. Return back to health care and housing and education and incomes in those supports, those are really the underpinnings of that document in terms of again the larger picture, not just focusing on ending homelessness but focusing on preventing it. But what we are seeing right now is there is a limit to what the **present** administration can be doing because that's also absolutely tied with the resource allocation we need in terms of investing in housing, investing in health care, investing in people. And we are seeing a Congress that is unfortunately not as interested in making those investments. And so while the plan is absolutely on point, the present administration is absolutely going full steam ahead in implementing both federal initiatives, the Opening Doors initiative as well as Health Reform. We see those

working in concert together. We see Healthcare for the Homeless squarely for both of those, both in terms of Health Reform and the Medicaid expansion, the investments in community health centers, all those pieces that allow us to work better, and then also in Opening Doors and saying how we can be linking our health services to housing so that we can be getting people off the street not only bettering our communities but also bettering individual outcomes.

Mark Masselli: This is Conversations in Health Care. Today we are speaking with Barbara DiPietro, Policy Director for the National Healthcare for the Homeless Council. Barbara, you mentioned earlier that coordinated team based primary care is the most effective in treating health care needs of the homeless. This is really what the patient-centered medical home is all about. But we are interested in hearing about the implications of this medical home model and caring for homeless populations. How do you think this model fits into the community health centers that serve homeless populations?

Barbara DiPietro: They absolutely do. I think one of the hallmarks of health centers in general but Healthcare for the Homeless Centers in particular has been our team-based approach over the decades we have been in operation. So working together as teams, working to integrate both primary care and behavioral health and case management which is also a key piece of that. So how those teams work together and how we have integrated those disciplines I think is a hallmark that we are used to. Now, one of the things that we are looking at now is with the accreditation levels and formalizing of patient-centered medical home, what does that really mean, what do health homes mean for people without homes really. And so when we were looking at achieving some of this recognition, so there is no reason why Healthcare for the Homeless Centers wouldn’t be on par with others in meeting these criteria. However, there are a few pieces that do bear special recognition. And the patient population that we work with will make some aspects of meeting patient-centered medical home more of a challenge. For example, how you communicate and get in touch with your clients is more difficult when your clients don’t have stable housing, they don’t have a home phone. They may have a cell phone but maybe not. They may have a message center or someone you can get a note to. But those sort of complications, how do you use those informal communication structures with confidential health information. So that’s one piece. How do you track your patients over time and be able to record health outcomes if your patients disproportionately leave? Sometimes we won't know where our patients are for six months, a year, they get arrested, they go to jail, they visit their Aunt Martha three states away. Sometimes we don’t know where they are. And so some of those pieces are important. And then when we look at the ability to do effective patient engagement in bringing the patient into the decision making, it's part of that team, I think that’s a little harder when you have people who are so vulnerable that their literacy is compromised, their ability to communicate sometimes is compromised. And so how is it as health care providers, we work within these criteria to be able to do the best we can. Certainly, we do have a

number of our members who are going forward and getting and trying to get a patient-centered medical home recognition. But this is a challenge for people who disproportionately have high risk chronically ill patients as they are based patient center, and not for instance in some practices where you have only 10% or 15% of your patients will be (inaudible 19:01).

Margaret Flinter: Well, certainly, one element of the patient-centered medical home that's obviously important to this group is the Electronic Health Record and the ability of health information exchanges to move people's information around certainly as people move around within communities and between communities. But Barbara, I want to ask you just about one special group within the homeless population that I am not sure Americans are always aware, so represented in the homeless population, and that's children, children who are living in shelter. Certainly, children are living on the streets in some cases, particularly teens in runaways. But children living in shelter, children who are homeless, what are the special initiatives that you work on related to children and maybe some of the policy initiatives, specifically around ending homelessness for children?

Barbara DiPietro: I think the most recent study I have seen has been that one in 50 children in this country is experiencing homelessness. That's 2% of all children under 17. The public school system has identified a million kids in the school system K-12 that they have identified as homeless. And when we look the millionaire or so folks that Healthcare for the Homeless has served, about 17% are under the age of 17. So we do absolutely see a segment of children. One of the things that is particular is that in order to engage the kids, you have to engage their parents. And for many homeless families, this means being with mom. And so how is it that we work with both moms and kids in shelters, we are working with them to enroll them in CHIPs or Medicaid, most often Medicaid at those income levels, how is it that we are making sure that the family is able to access food stamps, access any rental assistance or energy assistance that they might be eligible for, how is it that by engaging the children – because typically children are eligible for a broader array of safety net assistance. But kids can enroll themselves, and so we need the partnership of parents to be present there with kids. Now, as you can imagine, particularly as kids get older and we see adolescent youth, you start seeing more of the separation from family, and this may be because the family is unstable, there may be behavioral health issues or violence or other things that are driving the family apart. And so sometimes we will encounter on unaccompanied youths, those youths who are under the age of majority but are disconnected from parents. And it is very difficult to provide medical care to children absent a parent's consent. And so even if we are able to provide emergency services, we can't treat diabetes, we can't treat asthma, we can't prescribe an asthma inhaler to a 15-year-old who presents to us for care, unless we can find a parent to consent to that care. And I think that's one of the loopholes that's in most state laws that prevents us from being as effective with unaccompanied youths in treating their health particularly because they are at such high risk of street violence, STDs, unplanned pregnancies and all of these

pieces that go with youth health in general but especially if you were on the street.

Mark masselli: Barbara, we would like to ask all of our guests this question, when you look around the country in the world, what do you see in terms of innovations and who should our listeners at Conversations on Health Care be keeping an eye on?

Barbara DiPietro: I would like to see us be paying more attention to what's going on in Europe and in other industrialized countries where they have been able to achieve universal access and where medical bankruptcies are unheard of. 62% of the bankruptcies in this country are caused by medical debt. And even when this incredible law goes into effective Health Reform here, we still have 20 million people that remain uninsured in this country.

Margaret Flinter: Today, we have been speaking with the Barbara DiPietro, Policy Director for the National Healthcare for the Homeless Council. Barbara, thank you so much for joining us on Conversations and Health Care.

Barbara DiPietro: Thank you.

Mark Masselli: Each week, Conversations highlights a bright idea about how to make wellness a part of our communities into everyday lives.

Margaret Flinter: This week's bright idea focuses on an experiment in giving, thus having a direct impact on the health and wealth being of communities. Ron Shaich, Co-Founder of Panera Bread, one of the most successful restaurant chains in America, decided it was time to make a difference by addressing the food and security issues that affect millions of Americans. A year ago, he opened the first nonprofit Panera community café in Clayton, Missouri, and he based it on the idea that customers can take what they need and give what they can. Panera Cares, it's called, and it offers the full Panera menu of wholesome soup, salads, sandwiches and breads to anybody who needs a meal. People are encouraged to take what they need and donate their fair share. No prices, no cash registers, only suggested donation levels and donation bins. The Panera Cares Café business model is designed to be self-sustaining with support from the community. Shaich says, "Finding communities where there is a mixed population of people who can sustain it and people that can benefit from it is key to staying afloat." So far, 20% of customers leave more than what's suggested; 60% leave the suggested price; 20% leave less. Based on this success, two more Panera Cares community cafés have opened around the country, one in Dearborn, Michigan and another in Portland, Oregon. A café built on the concept of shared responsibility, dignity, good food and strong communities, now that's a bright idea.

Margaret Flinter: This is Conversations on Health Care. I am Margaret Flinter.

Mark Masselli: And I am Mark Masselli. Peace and health.

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