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HEALING HANDS

National Health Care for the Homeless Council

HCH|CN

Shelter-Based Care for Homeless Populations

Introduction

The Annual Homeless Assessment Report for 2016 found that on a single night in January 2016, 549,928 people experienced homelessness in the United States, and a majority of those people (68 percent) were staying in emergency shelters or transitional housing programs.[1] This point-in-time survey provides a glimpse at the number of people experiencing homelessness on any given day in the United States, as well as the fact that many of those people utilize emergency shelter services.

Many of the individuals staying in shelters have chronic and acute health conditions before arriving at the shelter, and the shelter environment can expose them to new risks. For example, crowded conditions may expose people to diseases such as tuberculosis and illnesses like the flu. Crowded, unsanitary, and unhygienic conditions may be linked to infestations like bedbugs and lice, or health conditions like asthma. Moreover, living in a shelter can be a traumatic life event that can create or exacerbate mental health conditions.[2]

Given the number of competing priorities in shelter environments, health care is not always treated as a top priority. This issue of *Healing Hands* will examine innovative shelter-based health care programs that provide low-barrier health care to people living in shelter settings, showing that reducing barriers to care not only leads to improvement in individuals' health, but also to population health. This issue will examine the types of health care that can be provided in a shelter-based setting, as well as best practices and lessons learned for collaborating effectively with shelter staff and providing person-centered, trauma-informed health care in a shelter.

Examples of Programs Providing Shelter-Based Services

The services that can be provided in shelter settings vary widely depending on the space and facilities that are available. Care providers working in shelter-based clinics or on a visitation basis must continuously ask themselves what services can be safely and efficiently provided in the shelter setting and which services must be provided elsewhere—and, for services that must be provided elsewhere, how clients' access to those offsite services can be facilitated. This section will highlight programs that are using diverse approaches, in different programmatic and geographic contexts, to provide health care to clients who are living in emergency shelters or who are utilizing drop-in shelter services.

Nancy Citarella is the RN Coordinator of the McKinney Homeless Program at Southwest Community Health Center in Bridgeport, Connecticut. The Southwest Community Health Center is a federally-qualified health center (FQHC) with sites all over Bridgeport, including school-based services. The McKinney program aims to "provide health care for the homeless that is comprehensive, including adult and pediatric care" by maintaining licensed exam rooms off-site; in all, they have two exam rooms in shelters, three in substance abuse recovery centers, and one in a transitional housing facility. Each room has a desk, chair, exam table, and scale, and care providers carry shelter bags with supplies. Nurse practitioners visit each site weekly on a regular schedule. At visits, providers conduct full health checks and schedule routine care and follow-up care in coordination with case managers. They are able to refer clients to other services, including integrated behavioral health, dental, OB/GYNs, lab services, podiatry, and nutritionists, through the community health center. "We try to make sure that the care is comprehensive and integrated, so that they're up to date with primary care and are getting care specific to their diagnosis and individual needs," explains Ms. Citarella. The McKinney Homeless Program is also involved with a community care team (CCT) working to establish broad community support for the goals of decreasing use of the emergency department by high utilizers, and increasing access to substance use treatment, specialty care, behavioral health services, legal support, housing resources, etc.

"We're not just looking at the physical or medical conditions, but also asking how can we, as a team, empower this patient or maximize their potential to live their life."

- Febi Mathew, Nurse Practitioner, Community Health Centers of Oklahoma, Oklahoma City, OK

In Oklahoma City, the Community Health Centers of Oklahoma have a homeless clinic branch that provides comprehensive primary health care, medical management, and behavioral health care for people experiencing homelessness and people in transitional housing. As the outreach provider, **Febi Mathew**, a Nurse Practitioner, travels with a nurse on Mondays to an inpatient women's rehabilitation center, then to a domestic violence shelter at a secure site. On Wednesdays, they visit the Salvation Army, and on Thursdays they visit a day center to which various agencies refer patients. In the shelter setting, they seek to provide as much primary care as they can.

At outreach sites there are limits to the care that can be provided based on the facilities. For example, explains Ms. Mathew, "On some sites we are in an office setting which may include a desk with chairs. In such a setting, it is difficult to perform certain procedures or exams, like gynecological exams or lab draws. We carry with us the supplies to do urinalysis tests, strep tests, and flu tests. If a patient requires further evaluation or work-up, we will then transport them to our clinic." Ms. Mathew also focuses on the importance of helping clients access mental health care as a component of managing physical conditions and chronic illnesses: "We work as a team to address the patient's needs in a comprehensive manner. We see the patient as a whole, which includes their medical needs, mental and behavioral health needs, and case management. We're not just looking at the physical or medical conditions, but also asking how can we, as a team, empower this patient or maximize their potential to live their life."

J. Douglas Van Ramshort is the Outreach Case Manager at Regional Health Clinic in Hammond, Indiana. This FQHC operates four locations (two standalone clinics and two within mental health centers) around Hammond, a city with a population of 80,000 located between Chicago and Gary, Indiana. Down the street from the original clinic is a shelter where Regional Health Clinic has built an exam room and provides onsite care every day. In addition to providing health care, intensive case management assists patients with insurance, prescriptions, follow-up appointments, disability services, and housing. One important part of this case management process is assisting clients in accessing specialty care and other crucial community resources. Mr. Van Ramshort explains,

> The infrastructure here makes it more difficult because we don't have the public transportation and accessibility that larger cities have... At one point [Hammond] was a big steel town with an affluent downtown area, and lots of public services and transport. As steel jobs have left, there's been a toll on public services... One

> big success I've seen is being able to provide transportation for patients to go to specialty appointments, lawyers' offices, Social Security, and other visits that they need to do to get healthier or more stable. We have one van that is specifically used to pick people up who are homeless and in public housing and bring them to primary care appointments or specialists.

Julie Bauch is the Nursing Supervisor at Hennepin County Health Care for the Homeless in Minneapolis, Minnesota, and **Dawn Petroskas** is the Clinic Manager. **Charis Folkerts**, **Joel Gray**, **Molly Hoff**, and **Rebecca Bohr** are the Clinic Supervisors who manage nine clinics in shelters and drop-in centers, including a 24-hour shelter that serves men and women and provides access to medical respite, a drop-in center, a pay-for-stay and transitional housing facility, a large family shelter, a youth site with drop-in services and transitional housing for youth between the ages of 16 and 24, a site inside a domestic violence shelter that has short-term shelter and transitional housing units, an evening shelter in a church basement, overnight shelters, and more.

Ms. Petroskas notes the importance of having "a really interdisciplinary team" in this model: "medical assistant, medical provider, social worker, pharmacist, nurse, case manager, community health worker (CHW)—all of these people on the team are equally important, and their roles often overlap, so everybody has to help each other out in order to be successful for the patients' care." The team

notes that this sort of interdisciplinary outreach model does create certain logistical challenges; from an administrative perspective, notes Ms. Bauch, "it's extremely challenging to support, supervise, coach, train, and orient satellite clinics" when staff are not often in the same space. And Ms. Hoff notes that the space resources and limitations are different at different sites: "We use the space that shelters have available and let us use... and we often outgrow the space we are given." Nonetheless, says Ms. Bauch,

> One challenge is also one of our greatest strengths: by being a clinic in the shelter, we build strong, long-lasting relationships with our clients and they learn to trust us and like us. Our goal is to bridge them to ongoing primary care, so while they're accessing our clinic we're separately trying to get them connected to a health care home.

In Springfield, Massachusetts, Mercy Medical runs a Health Care for the Homeless program; **Holle Garvey** and **Geraldine Kennedy** are Clinical Managers. Mercy staff provides care at their main shelter site that is fully staffed and open every weekday, as well as several satellite sites in a three-county area, including shelters, rehabilitation programs, and a drop-in center. These satellite sites generally have one care provider present at a time. Some of these sites have offices, while some have space without an exam room. The main shelter site has what Ms. Garvey and Ms. Kennedy call the "deluxe model" of office space with three exam rooms. Some of the satellite sites have space set aside for mental health services. However, because most of the satellite sites are not open every day, care providers often share multi-purpose space with other programs. Ms. Kennedy and Ms. Garvey explain that working in multiple sites requires flexibility regarding restrictions and resources:

> Each shelter has its own flavor, so you have to be willing to figure out how best you can serve the clients within that system. The staff is always different, there are different rules at different sites, and you must be very flexible... For example, we work with a few Christian rehabilitation programs that have restrictions on allowed medications. We know we're guests so we practice within those parameters. We've been working on making this an open and welcoming environment where people want to come and engage with us... and we try to create that environment from the very beginning of when they walk into our offices.

They note that working with other clinical providers, such as the behavioral health clinic down the hall, to develop a system of warm hand-offs, is key to creating connections between the different elements of care onsite.

Collaborating Effectively with Shelter Staff

A key component of operating a health care clinic or outreach health care services in a homeless shelter or drop-in center is working collaboratively with the shelter and other entities in the community. Questions that may arise for clinical staff include:

- How do shelter policies on substance use affect people with addictions?
- How do shelter policies affect people experiencing mental health challenges and behavioral issues?
- What does the shelter do when there are health issues that arise for clients overnight, when clinic staff is not available?
- What policies does the shelter have around documentation that may affect access to health care for undocumented immigrants, victims of domestic violence, and other people without access to documentation?
- How can shelter staff and the health care team work together to prevent people with health issues, including mental and behavioral health issues, from being evicted from the shelter?
- How can shelter staff facilitate follow-up care for clients?
- Are there other ways in which shelter management may affect health programs?

Cindy Manginelli is the TennCare Shelter Enrollment Project Coordinator for the National Health Care for the Homeless Council. She emphasizes the importance of building relationships in developing systems for low-barrier health care for people living in shelters. "In our project," she explains, "we try to form relationships between shelters and clinics. The biggest barrier is that both groups are serving the same people but have different priorities." Most shelters are trying to find housing for clients, and may be on a deadline to meet that goal, so health care may only be a priority for case managers and other shelter staff to the degree that it helps reach that goal.

Ms. Manginelli explains:

> When I go to shelters and talk about health care, shelters typically want to talk about bed bugs, lice, scabies, etc.—things that pass through the shelter. There is less interest in managing chronic disease, pain management, and other issues that would probably be high on the priority list for clinic staff... Shelter staff is thinking, 'We can deal with those things when we get them into housing.' Clinics that try to have mandatory physicals or exams often take the opposite stance and say, 'Now that you're here in shelter let's try to implement a good pain management system or get those chronic diseases under control,' but the shelter staff may want to push that off. This results in conflicting interests between shelter and clinic staff.

"A lot of clinics try to build strong relationships with people in leadership... when those are not the ones who will facilitate or prevent patients from coming in. Building relationships with case managers and crisis counselors... makes a big difference with our projects."

- Cindy Manginelli, TennCare Shelter Project Coordinator, National Health Care for the Homeless Council, Nashville, TN

To bridge this gap of priorities, Ms. Manginelli suggests facilitating conversations about the shelter's needs and priorities. For example, she says, "if you have a shelter that really wants you to come in and treat everyone for lice, or check everyone for scabies and provide treatment, then start there. Start with what is a priority for the shelter, because meeting their felt need is a way of building relationships." She recommends asking: What is the shelter's perceived primary health problem? It may differ from clinic staff but being accessible in ways that matter to the shelter is a way of building the foundation of a relationship and developing rapport with the shelter.

Ms. Manginelli also recommends that clinic staff take the time to understand shelter-level processes for intake and case management, in order to understand which staff members will be referring clients to the clinic. She states:

> A lot of clinics try to build strong relationships with people in leadership, such as executive staff, when those are not the ones who will facilitate or prevent patients from coming in. More than likely it will be case managers who are either helping clients into health care or are not.... Building relationships with case managers and crisis counselors—focusing on that level of staff—makes a big difference with our projects. [This means] making sure case managers have phone numbers,

> know our faces, know they will get through to the clinic, and are able to help clients safely plan around diagnoses after a visit. So nurses and doctors should connect with case managers on both ends, and develop a level of intentionality in networking with staff at that level.

Ms. Folkerts agrees that it is important for health care providers to become acquainted with all levels of shelter staff, explaining that when she started working in shelter-based care,

> I was encouraged to spend a significant amount of time with advocates and security staff, learning their jobs and shelter policies and procedures. I do rounds: Every morning before overnight guests leave, I check in with advocates to see if they have any referrals or know where people I'm looking for can be found. I also go to the floors as often as possible to have open communication with the staff. Usually when I'm on the floors, clients will stop me and ask questions about appointments, medications, health issues—care coordination things. So spending time in the shelter has been important for me in developing these relationships.

Tips for Working Effectively with Shelter Staff

1. Develop systems for bi-directional information sharing between clinic staff and shelter staff. Establish protocols for obtaining consent for information sharing from clients, so that care plans can be monitored and follow-up can be obtained. For example, if a person has diabetes and needs dietary modifications, or a person requires a medication that must be refrigerated, it is crucial to get the client's permission to engage shelter staff in meeting these needs on a daily basis.

2. Understand shelter policies and create care plans for clients that work within the parameters of these policies. If possible, work with shelter staff to develop policies and procedures that serve the health needs of clients; these could include developing shelter-level public health initiatives, engaging care for people who have critical illnesses, maintaining contact with people who are ill and get kicked out of shelters, preventing people from being evicted from shelter in the first place, developing interventions for behavioral issues, assisting clients with transportation for specialty appointments, and engaging case management to assist with medical follow-up and facilitation.

3. Understand shelter-level processes for intake, case management, and referrals, and help staff refine these processes if they are open to feedback. Develop a culture of communication with shelter staff.

4. Account for gaps in priorities. For example, a client may be scheduled for a medical follow-up during the day but also be required to leave the shelter for a certain number of hours per day to look for work. Be prepared to work around priority gaps like these in order to facilitate access to care.

5. Offer trainings for shelter staff. Trainings could cover a variety of topics, depending on what is needed, ranging from the referral process for new clients with health issues, to implementing care plans, to infectious disease prevention, to establishing continuity of care for patients with chronic illnesses.

6. Work with shelter staff and clients alike in making small changes to improve the general health conditions of the shelter. For example, widely-available hand sanitizers and tissues can help manage the spread of potentially contagious illnesses in crowded situations, and improvements in general cleanliness can prevent the spread of MRSA, strep infections, pneumonia, and other illnesses.

7. Bring a person-centered, trauma-informed perspective to the shelter and its services. This can be done both through prioritizing these values in clinical care and providing support to shelter staff through consultation and training. For example, a clinic could encourage offering a training series for front-line shelter staff that focuses on issues like trauma-informed care, conflict resolution, motivational interviewing, and related topics.

8. Collaborate with shelter staff, through learning and teaching components, to address social determinants of health. Look at opportunities that come out of collaboration with case managers to work together on these challenges and support clients as they deal with health issues and move toward becoming housed.

9. Require clinical staff to tour shelters and understand what it is like for clients to live in that particular shelter. "Often clinicians have a view of what life is like in a shelter that is inaccurate," explains Ms. Manginelli, and spending time on the floor and with clients inside the shelter is one way to develop stronger connections with clients in the service of providing the best medical care possible.

"Shelter staff want their clients to be healthy and take medical advice," explains Ms. Manginelli. "Very often shelters will say they've just never taken time to sit down and think about this. So we ask ourselves: 'What do our patients do when they come back from the clinic? And how can we help the shelter continue facilitating their health care after they have left us?'"

Best Practices for Shelter-Based Care

Based on many years of experience working in shelters and other outreach sites to provide health care to people experiencing homelessness, here are some lessons that care providers have learned about best practices for providing shelter-based care.

1) Highlight the importance of follow-up. Nancy Citarella explains that follow-up efforts can be particularly difficult with clients experiencing homelessness, due to transience. Clients may stop attending appointments or leave shelters suddenly for a variety of reasons. To press back against this, Ms. Citarella suggests,

> Just try to maintain a rapport with the clients. I feel like we need to at least talk with them by phone if we can, at least every few months, to see how they're doing. Health care is not always their first priority. They want to know where they're going to sleep, [or] where their next meal is coming from, so we just like to remind them that we're here and offer to schedule something. Keeping in touch. We use a tickler system so that we are constantly calling people or getting in touch at least every three months. We see patients for re-assessment at least every six months. Having a room in the shelter makes follow-up a bit easier with certain populations.

2) Integrate trauma-informed care. Febi Mathew notes that many people experiencing homelessness have experienced trauma, and that living in a shelter environment can exacerbate that trauma or be traumatic in its own right. Continuous attention to the role that trauma plays in clients' mental and physical health is essential. Ms. Mathew describes her work with women who have been victims of domestic violence like this:

> We encounter people experiencing some form of trauma daily. We have found people who are severely ill and abusers have not allowed them to access care. Our initial visit may not even be a medical visit, but just letting them talk about their traumatic events. Sometimes, they may just sit and cry for few minutes before even speaking. Our visits at the domestic violence shelters can be long as we just sit and listen. The medical aspect might not be long, on the other hand; we may spend most our time comforting, counseling, encouraging, and telling them they made the right decision to leave the abusive relationship. Many of these patients have had their independence sucked out of them. They feel they cannot survive on their own. That is when we work to instill in them a belief in their resiliency and empower them. We work to get them connected with educational needs, access to employment, housing, resources, and even vehicles in a few instances. Sometimes our patients will come back to tell us their success story. We're on the front lines of helping them heal from their trauma and build enduring and resilient relationships with other trauma survivors. Often they don't trust anyone at first and the visit may be formal. But being available, accessible, and accepting of them and their trauma is all that is needed.

"Often [clients who have experienced trauma] don't trust anyone at first and the visit may be formal. But being available, accessible, and accepting of them and their trauma is all that is needed."

- Febi Matthew, Nurse Practitioner, Community Health Centers of Oklahoma, Oklahoma City, Oklahoma

3) Recognize the necessity of community collaborations. J. Douglas Van Ramshort explains that in his work, community collaborations are essential:

> My best advice is be very flexible. The more planning I do, and the more rigid programming I try to implement, the less that works. Being flexible and letting the day come to you and going from there has been one of the better things I've learned to do. I've also learned about getting people on your side before you implement programs, and making sure that people around you are for it, and it's not a duplicated service. Don't reinvent the wheel; ask around to discover if people have already tried an idea or if they're already doing it. See pitfalls ahead of time, and be open to retooling ideas so you don't make the same mistakes. Really depend on your network... Be creative. See who in the community provides services that might be more effective for the patient. So much of service providing is networking, knowing who is around.

4) Mitigate fear and shame. According to Cindy Manginelli, two of the biggest issues for clients seeking medical health are fear and shame. Clients may have fears around going to the doctor; for example, women who have been victims of domestic violence or are experiencing homelessness for other reasons may be afraid of losing custody of their kids or being institutionalized. On top of this, many people who are

experiencing homelessness feel shame and a sense of worthlessness; some people do not go to the doctor because they do not feel they are worth it, and social attitudes toward people who are homeless can reinforce this belief. Ms. Maniginelli implores

> clinic staff and shelter staff to understand that barrier is huge. Everything either reinforces or challenges that belief when someone walks into a clinic. This can be reinforced with shelter staff, too, [so clinics can work with shelter staff to get] on the same page about creating hand-offs that are affirming and reassuring and allay fears. The shelter staff also has to trust clinicians, that they will be able to be understanding of clients' needs. If the shelter staff has a bad experience with the clinic, they won't call them anymore. There is a high importance of being trustworthy for both clients and shelter staff.

5) Focus on stories. Geraldine Kennedy and Holle Garvey explain the importance of allowing clients time and space to tell their stories. Not only is this a key element of building trust between the client and the provider, but clients' personal narratives also often hold the key to understanding their mental and physical health:

> We know our patients extremely well. We allow them to become comfortable with us, and we listen to their stories. We bear witness to their stories. All their stories affect their mental and physical health, and it's so important to listen to them because if you don't, you miss so much. And a lot of times, patients want to be heard and they want the providers to know who they are and where they've been because it informs where they're going.

When asked what strategies they use to help clients open up and share their stories, Ms. Garvey and Ms. Kennedy suggest:

- Utilize motivational interviewing techniques.
- Let clients lead the conversation.
- Listen carefully to pick up on nuances of the client's words and affect.
- Be open to the fact that clients might not be ready to have certain conversations yet: "it takes time for people to open up."
- Enlist all staff members, including providers, in the task of creating a welcoming environment.
- Face clients, make eye contact with them, and allow them sufficient time to tell their stories.
- Be flexible. "If they came in for foot pain and then started talking about trauma, then the function of the visit becomes a discussion of their trauma."

6) Meet clients where they are. Julie Bauch says, "With all the challenges aside, I think that literally and physically meeting the clients where they're at is the best way to deliver care to this population in particular." Shelter-based care is a way of physically meeting clients in the space where they live, which therefore reduces a number of barriers to accessing care for a population that is already stretched very thin. Joel Gray adds,

> The way in which we operate is really the most humane and kind and generous sort of care that I think is really possible. Some people that have been utterly failed by the system and distrust the system come to us and we're able to support them and get them back into proper care for cancer, substance use, any number of things. We do actually get to spend the time with people, and it just is about the humanity of forming those relationships, the creative solutions and seeing people as they are and getting to the heart of what's going on with them, recognizing the trauma rather than being the trauma in terms of contributing to dehumanizing processes for people who are already totally stressed out with myriad things.

Conclusion

Programs that provide health care services on-site at shelters and other temporary and transitional housing facilities are a way of providing low-barrier health care to people experiencing homelessness. As Ms. Garvey and Ms. Kennedy explain,

> You're bringing the service to the patient. For this population, they have to make a lot of decisions about their time and resources, and bringing the services to them is a way to more effectively facilitate their well-being. It's good for continuity of care and trust... People who have received primary care from us and moved away continue to come back here for their care. It speaks to the power of the relationship-building. We have really good relationships with our patients and we work hard to get clients to where they want to be.

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