

# Reaching the Underserved

CONNECTING MOBILE & HOMELESS PEOPLE TO THE HEALTH DISPARITIES COLLABORATIVES

September 2005

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## WELCOME

**Health Care for the Homeless (HCH) Clinicians' Network** and **Migrant Clinicians Network (MCN)** are pleased to welcome you to the second edition of our joint e-newsletter, *Reaching the Underserved: Connecting Mobile & Homeless People to the Health Disparities Collaborative*. HCH Clinicians' Network and MCN serve as National Partners to Health Disparities Collaboratives. With this newsletter, we introduce two new editors, although neither clinician is new to the needs of mobile and homeless populations.

Jennie McLaurin, MD, MPH now serves as MCN's national coordinator for the HDC. Jennie replaces Amy Liebman, who has successfully gained a large environmental health grant for MCN! Amy will continue to serve on the Midwest Cluster steering committee and to offer her expert counsel. In addition to previous HDC work, Jennie has 20 years experience in migrant health as a past outreach worker, pediatrician, medical director, and program/policy consultant.

Sharon Morrison, RN, MAT now serves as the Health Disparities Collaboratives Coordinator for the HCH Clinicians Network. Sharon is stepping into the position previously filled by Susan Kline who has returned to clinical practice and has resumed her programmatic responsibilities with Health Care for the Homeless Network at Public Health, Seattle and King County. Sharon is a nurse with Boston's Health Care for the Homeless Program where she works with diabetic patients.

Please update your address books with our contact information found on the last page of this newsletter!

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## TOOLS AND RESOURCES

### :: Emergency Help For Displaced Persons

Hurricane Katrina has brought new focus to the idea of mobile, poor, and homeless populations. MCN and HCH have a long history of providing expertise in clinical care to such people in need. In addition to our regular resources, there are a number of new materials now available that specifically address the emergency needs resulting from a disaster such as Hurricane Katrina.

Go to the MCN’s Hurricane Katrina web page [http://www.migrantclinician.org/news/hurricane\\_updates.php](http://www.migrantclinician.org/news/hurricane_updates.php) for more information such as:

- Q&A on getting federal emergency assistance for undocumented citizens
- Immunization needs of displaced persons
- Providing patients with a portable medical record
- And much more!

For more resources on HDC topics, please visit our website at [www.migrantclinician.org](http://www.migrantclinician.org)

At the NHCHC link [www.nhchc.org](http://www.nhchc.org) you can find:

- Information on opportunities to volunteer
- How to donate much needed medical supplies
- Other topics of interest to health care providers involved in the response

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## SUCCESS STORIES

**:: Never doubt that a small group of thoughtful, committed citizens can change the world . Indeed, it is the only thing that ever has.**

**-Margaret Mead**

In Atlantic City, New Jersey, a small group of 13 clinicians are embracing the philosophy of Margaret Mead and making huge strides in changing the health of their patients.

In October of 2003, AtlantiCare began seeing homeless patients in their clinic. Two years later they average over 10,000 encounters annually and follow 125 patients in a diabetic collaborative.

From its inception, AtlantiCare has adopted the “Care Model” believing it would be beneficial to build their system using its standards of care.

AtlantiCare’s clinic is strategically located in the heart of a homeless shelter so from the beginning they have worked closely with shelter staff to partner in patient care. Using a system of intensive case management which includes both clinic and shelter staff, they have been able to track patients closely and monitor them in follow-up care. This method has proven successful.

Because AtlantiCare participates in the Federal 340B pharmacy assistance program, they are able to give each newly diagnosed diabetic patient a “starter kit” which includes a glucometers, all other

testing supplies and an insulin pen which they have found reduces the risk of syringe sharing in the shelter. Patients meet with a certified diabetic nurse educator to learn strategies for self care and then they are scheduled for their follow-up visit in three weeks: before their medication supply will need to be refilled. The clinic adopted a policy to not refill prescriptions via telephone which insures patients return to clinic to be seen. The diabetic nurse educator emphasizes the importance of medications to care but more importantly, patients can see how they “feel better” almost immediately. AtlantiCare has been able to lower HbA1c’s by 2.5 – 3 points in just eleven months using intensive care management.

Considering a future spread to depression, clinic staff have begun to administer the PHQ-9 assessment for depression to every patient. This year, AtlantiCare will get their first National Health Service Corps ANP in psychiatry who will work full time with patients to integrate behavioral health into each primary care visit.

Sandy Festa, LCSW of AtlantiCare shares “We see each meeting as an opportunity to reiterate patient education”.

To learn more about AtlantiCare and their innovative programs go to <http://www.atlanticare.org> or email the Project Director at [sandy.festa@atlanticare.org](mailto:sandy.festa@atlanticare.org)

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## **SIMPLE SOLUTIONS**

A core element in the Health Disparities Collaboratives is to assist patients to set Self Management Goals. For homeless patients who often have little control over their daily routine, this small act can be far-reaching.

At Boston’s Health Care for the Homeless Program, one diabetic nurse is utilizing the principles of a Japanese therapy known as Morita Therapy to help patients to set goals...and to act on them. Developed by a Japanese Psychiatrist, Shoma Morita (1874 – 1938), Morita therapy is oriented toward “action”. It recognizes that while we may often feel overwhelmed or distressed by feelings such as depression, anxiety and fear, making the small step of acceptance of these feelings can help us to move forward. While we may not be able to control our feelings, we can still control our behavior.

The nurse’s role can be to help the patient to clarify steps of what needs to be done.

We often think of self management goals as being specific to a diagnosis such as diabetes or CVD and not in conflict with meeting the needs of daily living. But for disenfranchised patients who live with competing priorities, a self management goal might start with something basic such as a promise to follow through with a housing appointment or to come to a shelter clinic for a change of socks every day.

While making a plan can be easy, one’s desire is usually not enough to maintain change. The stress of street/shelter life can easily take precedence over a set goal. Morita offers strategies for patients to co-exist with their feelings while continuing to move forward. They begin by making small steps and these steps often give them the confidence they need to continue.

To find out more about Morita and other forms of Japanese therapies visit [www.todoinstitute.com](http://www.todoinstitute.com)

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## FEEDBACK FROM THE FIELD

### What's In A Name? Addressing Patient Use of Multiple Names

Do you ever have a hard time keeping up with medical records because your patients go by different names at different times? A lot of you have spoken up about this one! There are a number of ways that clinics handle this, but first let's go over why it happens:

- **Culture**—This is probably the biggest factor. The *majority* of people around the world practice a different naming custom than our American record-keeping style accommodates. For instance, what we call a first name is listed as a last name in many Asian populations—thus we call the famous baseball star “Ichiro” even though that is his first name. Some cultures have more than one name that is a “called” name, depending on social and familial relationship. And most of us have experience with Hispanic clients who seem to have several last names, reflecting a tradition of incorporating both maternal and paternal names into the surname. Often what we consider the last name or surname is the middle name. Take the name Anna Maria Rodriguez Duran. Rodriguez is the surname we are accustomed to using, but it is typically placed in the middle of her name. If our records don't allow for a patient to identify herself in the way she is accustomed, there is a good chance that records will differ from place to place, or that the patient will be confused about which name you want.
- **Fear**—This is big a factor for undocumented workers and their family members who are not legally authorized to be in the US and fear deportation. Many times, workers are using an alias that is tied to a Social Security number and fear losing their ability to work by offering their legal name. Fear is also a common issue for those who have names reflecting Middle Eastern ethnicity. There are also fears related to domestic violence. A name is of course, very personal. Even if it appears simplistic, it is wise to explain the purpose of getting a full legal name(s) that will be consistent from place to place—and ensure the privacy and confidentiality related to the use of their legal name.
- **Simple confusion, Multiple requests, and various record-keeping practices**—Do you ever forget your password to a webpage? When we are asked multiple times to list something in an unfamiliar format, there is a good chance that we will forget it from one time to the next. And when requests are not standardized from place to place, the problem is compounded. For example, some places simply combine the double Hispanic surname of its patients into one long name. Other sites list the two names but separate them. The same person is listed in different alphabetical format as a result. (For instance, as Rodhamclinton in the first instance and as middle name Rodham, last name Clinton in the second.) And, the patient may *sign* her name a third way! Confusion is reduced when the questions are asked consistently and with explicit directions.

#### So how do you handle this?

Here are all the ways that you told us you try to avoid name confusion:

- **Require one name only**—Many clinics require a patient to “pick” a name that will be used for all medical records at all possible sites. This is a good idea, but it depends on patient cooperation rather than on a better system.
- **Request all names used by patient**—Other centers allow multiple names, and then code that combination with a number/name combination. There are many ways of doing this and it allows birthdate information and patients with identical names to be accounted for as well.
- **Pick one name but list all names**—This is probably the most common response. It still requires a search at times, but it increases the possibility of matching outside record information to the right chart. Centers typically photocopy some sort of ID and then list alternate names as an alias in the chart.

**In Sum:** Ask the patient for their legal name; for all other names used at work, school, medical office, or home; for the proper sequence of the names; and for how to best address them respectfully as a patient in your center. Let them know why you need this information and how you will ensure their privacy and confidentiality in using it. Photocopy any “ID cards” or documents with names as available. When requesting records, list all known names of the patient, as well as birth date and other identifiers. Make every effort NOT to ask for a Social Security

number or card. GIVE the patient a center ID card with his/her primary name listed as well as other names, if possible. This will help distant sites accurately communicate with you.

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