

ADAPTING YOUR PRACTICE

*General Recommendations
for the Care of Homeless Patients*



ADAPTING YOUR PRACTICE

General Recommendations for the Care of Homeless Patients

This project was supported by the
Bureau of Primary Health Care,
Health Resources and Services Administration,
U.S. Department of Health and Human Services.

Health Care for the Homeless
Clinicians' Network

2004

Adapting Your Practice: General Recommendations for the Care of Homeless Patients was developed with support from the Bureau of Primary Health Care, Health Resources and Services Administration, U.S. Department of Health and Human Services.

All material in this document is in the public domain and may be used and reprinted without special permission. Citation as to source, however, is appreciated. Suggested citation:

Bonin E, Brehove T, Kline S, Misgen M, Post P, Strehlow AJ, Yungman J. *Adapting Your Practice: General Recommendations for the Care of Homeless Patients*, 44 pages. Nashville: Health Care for the Homeless Clinicians' Network, National Health Care for the Homeless Council, Inc., 2004.

DISCLAIMER

The information and opinions expressed in this document are those of the Advisory Committee on Adapting Clinical Practices for Homeless Patients, not necessarily the views of the U.S. Department of Health and Human Services, the Health Resources and Services Administration, or the National Health Care for the Homeless Council, Inc.

PREFACE

Clinicians with extensive experience caring for individuals who are homeless routinely adapt their practice to foster better outcomes for these patients. This document is intended for health care professionals, students and ancillary personnel who have less experience working with this population and may not realize that some of their patients are homeless.

Standard clinical practice guidelines often fail to take into consideration the unique challenges faced by displaced people that may limit their ability to adhere to a plan of care. Recognizing this oversight, the Health Care for the Homeless (HCH) Clinicians' Network has made the development of recommended clinical practice adaptations for the care of persons experiencing homelessness one of its top priorities.

An advisory committee comprised of six health and social service providers devoted several months during 2004 to development of these general recommendations for the care of homeless patients, drawing from their own experience and from that of their colleagues in HCH projects across the United States. These recommended practice adaptations reflect their collective wisdom about the optimal care of individuals who are homeless or marginally housed. For the convenience of clinicians, we have included an overview of fundamental issues related to homelessness and health care and a summary of recommendations at the beginning of this document.

For more detailed guidance on the clinical management of specific health problems that are common among homeless people and particularly challenging for their caregivers, readers are referred to seven prior sets of adapted clinical guidelines — on diabetes mellitus, asthma, otitis media, reproductive health care, chlamydial and gonococcal infections, HIV/AIDS and cardiovascular diseases (hypertension, hyperlipidemia, and heart failure). A number of the recommendations contained in this more general guide were derived from these documents, which are available at: www.nhchc.org. The HCH Clinicians' Network anticipates developing adapted clinical guidelines on additional health problems in the future.

The general recommendations in this document specify what experienced clinicians know works best for patients who are homeless, with the realistic understanding that limited resources, fragmented health care delivery systems and loss to follow-up often compromise adherence to optimal clinical practices. We hope these recommendations provide helpful guidance to health care professionals who work with individuals who are homeless or at risk of homelessness and that they will contribute to improvements in both quality of care and quality of life for these patients.

Patricia A. Post, MPA
HCH Clinicians' Network

AUTHORS

Advisory Committee on Adapting Clinical Practice for Homeless Patients

Edward Bonin, MN, FNP-C, RN
Adolescent Drop-In Health Services
Tulane University Health Sciences Center
New Orleans, Louisiana

Theresa Brehove, MD
Venice Family Clinic
Venice, California

Susan Kline, MN, ARNP
Health Care for the Homeless Network
Dept. Public Health - Seattle and King County
Seattle, Washington

Mike Misgen, MA, LPC
Colorado Coalition for the Homeless
Stout Street Clinic
Denver, Colorado

Editor: Patricia A. Post, MPA

Aaron J. Strehlow, PhD, FNP-C, RN
UCLA School of Nursing Health Center
at the Union Rescue Mission
Los Angeles, California

Jeffrey Yungman, MSW, MPH
Crisis Ministries' Health Care for the
Homeless Project
Charleston, South Carolina

ACKNOWLEDGEMENTS

The clinicians listed above were primarily responsible for the development of recommendations contained in these supplemental guidelines. These dedicated caregivers from multiple clinical disciplines gave generously of their time to formulate guidance for practitioners less experienced in the care of patients whose comorbidities and limited resources, both financial and social, precipitate or exacerbate homelessness.

ACKNOWLEDGEMENTS, continued

In addition, we gratefully acknowledge the contributions of the following service providers who also shared their wisdom and experience in working with homeless patients:

- Judith Allen, DMD, McMicken Healthcare for the Homeless-Dental Program, Cincinnati, Ohio
- Bery Engebretson, MD, Executive Director, Primary Health Care, Inc., Des Moines, Iowa
- Laura Gillis, MS, RN, HCH Health Disparities Collaboratives Coordinator, National Health Care for the Homeless Council, Baltimore, Maryland
- Ken Kraybill, MSW, Clinician Specialist, National Health Care for the Homeless Council, Seattle, Washington
- Fred C. Osher, MD, Associate Professor, University of Maryland School of Medicine, and Director of the Center for Behavioral Health, Justice and Public Policy, Baltimore, Maryland

Finally, the Advisory Committee expresses its gratitude to the following individuals who reviewed and commented on the draft recommendations prior to publication:

- Jean L. Hochron, MPH, Acting Director, Office of Minority Health & Special Populations, Bureau of Primary Health Care (BPHC), Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services (HHS)
- Erin Knowles, MPH, Public Health Analyst and HRSA Scholar, Office of Minority Health & Special Populations, BPHC, HRSA, HHS
- John N. Lozier, MSSW, Executive Director, National Health Care for the Homeless Council
- Michele Lundy, MD, Director of Predoctoral Education, Department of Family and Community Medicine, Maricopa Medical Center, Phoenix, Arizona
- Lynn A. Martin, Second-year Medical Student, Vanderbilt University School of Medicine, Nashville, Tennessee
- Harriet McCombs, PhD, Senior Mental Health Advisor, Division of Clinical Quality, BPHC, HRSA, HHS
- Kathy McNamara and Tom Curtin, National Association of Community Health Centers
- Amy M. Taylor, MD, MHS, Principal Program Manager, Division of Clinical Quality, BPHC, HRSA, HHS
- Patricia C. Temple, MD, MPH, Professor of Pediatrics, Vanderbilt University, and Co-Director of Nurses for Newborns of Tennessee, Nashville, Tennessee

Table of Contents

Summary

Homelessness & health care: fundamental issuesvii–viii

Summary of recommendationsix–x

Introduction1–4

Diagnosis and Evaluation

History5–8

Physical examination8–9

Diagnostic tests10–11

Plan and Management

Plan of care12–13

Education, self-management13–14

Medications15–17

Associated problems, complications17–18

Follow-up19–20

Model of Care

Service delivery design21

Outreach and engagement21–22

Standard of Care22

Case Studies

Homeless Adult23

Homeless Adolescent24

Homeless Child25

Sources & Resources

Primary Sources26

Other References27–30

Suggested Resources30–31

Websites32

About the HCH Clinicians' Network32

Homelessness & Health Care: Fundamental Issues

- **Unstable housing** Residential instability increases risk for serious health problems, exacerbates existing illness, and complicates treatment. Lack of stable housing presents serious barriers to improving the health of people with acute or chronic illnesses. Meeting immediate needs for food and shelter leaves little time for medical appointments. Discomforts associated with illness and treatment side effects are compounded by lack of privacy, risk of abuse, theft of medications, and no place to lie down during the day. Access to housing and supportive services has been shown to increase adherence to treatment, decrease arrests and incarceration that disrupt treatment, and reduce costly visits to emergency rooms. Nevertheless, access to supportive housing is limited in many communities by lack of affordable housing for people with very low incomes, by long waiting lists for transitional housing, and by policies that exclude active substance users or ex-inmates.
- **Limited access to nutritious food & water** Homeless people have to eat whatever is available. Their meals are irregular, with limited or no dietary choice. Most food provided in shelters or soup kitchens is high in fat, starch, salt and sugar, which increases the risk for complications associated with diabetes and cardiovascular disease, health problems commonly seen in homeless individuals. People living in shelters or on the streets who lack easy access to potable water are at risk for dehydration, especially in warmer climates.
- **Higher risk for abuse** Physical and sexual abuse has been identified as both a cause and a consequence of homelessness. Living on the streets, in shelters, or doubled up with other families increases stress and risk for abuse. Over 80 percent of surveyed homeless women have been victims of severe physical or sexual assault. Homeless children are physically abused at twice the rate of other children and are three times as likely to be sexually abused. Homeless parents without access to childcare often leave their children with strangers. Formerly incarcerated perpetrators of sexual abuse who become homeless when released from jail may interact with families in shelters and at food distribution sites. In some shelters, single men, families and children all stay in the same room. Injury, exposure to sexually transmitted infections, psychological trauma and associated problems with engagement in a therapeutic relationship are among the negative sequelae of abuse.
- **Behavioral health problems** According to conservative estimates, about one-third of people who are homeless have serious mental disorders, and more than one-half of those with mental illness have co-occurring substance use disorders. The incidence of these disorders is considerably higher among people who have been homeless on a long-term basis. Substance use disorders, in particular, increase risk of exposure to infectious diseases and can cause or exacerbate diseases of the cardiovascular system and liver. Behavioral disorders and cognitive impairments associated with them can interfere with treatment adherence. Clinical practice adaptation and integration of medical regimens with the patient's regular activities can improve treatment effectiveness.
- **Physical/cognitive impairments** Physical and cognitive impairments are among factors that can precipitate and prolong homelessness. Exposure to the elements or to communicable diseases in shelters, victimization, nutritional deficiencies, co-morbidities and limited access to health care increase the likelihood that relatively minor impairments will become much more serious. Cognitive impairments seen in homeless patients are often associated with severe head injury, mental illness, chronic substance abuse, infection, strokes, tumors, poisoning or developmental disabilities. Cognitively impaired homeless persons with co-occurring substance use problems are frequently unable to access or benefit from traditional addiction treatment programs.
- **Developmental discrepancies** Homeless children, adolescents and young adults frequently exhibit developmental levels that do not match their chronological age. Many homeless children have speech delays secondary to chronic ear infections. Insufficient opportunities to practice gross and fine motor skills in constrained shelter environments may also retard normal development. Although survival skills are more sharply honed in homeless adolescents and youth than in their domiciled counterparts, chronic substance use and stress associated with homelessness can delay normal development. Developmental regression or neuropsychological dysfunction is commonly observed in homeless individuals regardless of age, gender, diagnosis or medical/psychiatric history; however, developmental discrepancies are especially pronounced in chronically homeless adults with cognitive impairments.
- **Higher risk for communicable disease** One out of every five Health Care for the Homeless clients has an infectious or other communicable disease. Respiratory infections, HIV and other sexually transmitted infections, skin diseases and infestations are disproportionately represented in homeless populations. The potential for rapid spread in crowded shelters or other congregate settings poses health risks for the general public as well, making communicable disease in itinerant populations of particular concern.
- **Serious & complex medical conditions** People without stable housing are at increased risk for acute and chronic diseases with multiple comorbidities. Because they may not seek or be able to obtain care until their illness is advanced, they often present with more acute, often life-threatening conditions (e.g., heart attack, stroke, organ damage secondary to uncontrolled cardiovascular disease and/or diabetes). Chronic health conditions, such as hyperglycemia and asthma, are exacerbated by stress and exposures associated with homelessness, as well as by delayed or interrupted treatment. Psychosocial and structural factors that impede homeless peoples' access to treatment and self-care increase their risk for medical complications.

- **Discontinuous/inaccessible health care** Frequently interrupted and uncoordinated care is a consequence of homelessness. Mobility, lack of health insurance, fragmented health services, and a mainstream health care system that is often not prepared to deal with the complex psychosocial problems presented by homeless patients partially explain their discontinuity of care. Transience makes comprehensive medical care, referrals and follow-up difficult. Aggressive outreach and case management, together with efforts to provide a “medical home” and access to integrated medical, behavioral health and social services can promote continuity of care and better health outcomes.
- **Lack of health insurance/resources** Over half of surveyed homeless service users nationwide and three-fourths of Health Care for the Homeless clients have no health insurance, primarily because they do not qualify for public health coverage and cannot afford private health insurance. Lack of insurance limits access to specialty care and prescription drugs. Poor adults who are not pregnant, not disabled, not elderly or do not have dependent children are ineligible for Medicaid in most States. Even those who are eligible frequently have trouble completing the complex enrollment process and obtaining covered services, especially under managed care. Lack of required documentation to verify eligibility is the most frequently cited obstacle to Medicaid enrollment for homeless people. Proof of identity, residence and income is difficult to provide without a home, a car or continuous employment. Even when they are able to obtain required documentation, people who are homeless may not have a safe place to keep it. Personal papers are often lost or stolen when moving from place to place.
- **Barriers to disability assistance** For many chronically homeless people, Supplemental Security Income (SSI) is the only door to Medicaid and supportive housing. But getting SSI is extremely difficult for this population, particularly for persons with severe mental illness. Homeless disability claimants have higher denial rates than other claimants. Insufficient documentation of functional impairments by medical providers partially explains this discrepancy. Persons with asymptomatic HIV infection and those with disabling addictions without evidence of underlying mental illness are excluded by federal law from eligibility for SSI. This restricts their access to housing, health care and opportunity for recovery.
- **Cultural/linguistic barriers** Minority racial and ethnic groups — particularly black/African Americans, Native Americans and Hispanic/Latinos — are overrepresented among homeless people in the United States. Serious health discrepancies between cultural and ethnic minorities and the general population are starkly apparent in the higher prevalence of asthma, HIV, diabetes, cardiovascular disease and depression among the unstably housed. Fifteen percent of Health Care for the Homeless clients are identified as best served by languages other than English. Insensitivity to cultural heritage, native language, patient beliefs and values and to the special needs of people experiencing homelessness often present serious obstacles to health care.
- **Limited education/literacy** Homeless adults, especially those in families, are more likely to have dropped out of high school and less likely to have completed education beyond high school, compared to all U.S. adults. Mobility, chronic illness, stress and anxiety associated with homelessness cause sleep loss and fatigue that can interfere with learning, often resulting in missed school days and educational setbacks for homeless children. A number of homeless people do not read English well or are unable to read at all. Erroneously assuming that a patient can read directions on medicine bottles or an appointment card can lead to serious complications and loss to follow-up.
- **Lack of transportation** Limited or no access to transportation makes healthcare inaccessible for many homeless people and is a primary obstacle to employment, particularly in rural areas. Severe geographic barriers, such as mountainous terrain or vast distances from available services, exacerbate this problem. Even if a health center is only several miles away from those needing medical services, lack of transportation can be a serious barrier to care in urban as well as rural areas.
- **Lack of social supports** People who are homeless often lack the social supports on which most people depend in hard times. Many have traveled far from their place of origin, seeking jobs, services or respite from abuse. Alienation of family and friends often precipitates homelessness for those with intractable chemical dependencies and/or untreated mental illness. Stigmatization of homeless people — particularly those with disabilities, chronic substance use disorders, HIV or nontraditional sexual orientations — further isolates them and even limits their access to appropriate health care. Having burned their bridges with the community, some retreat to camps or makeshift shelters, far from developed areas. Permanent housing with supportive services is often prerequisite to their reestablishing or developing connections with family or community.
- **Chronic stress** Many homeless people live in a constant state of stress that can have negative effects on their health. Adaptations made while homeless can be maladaptive in other situations (e.g., distrust that protects street dwellers may prevent them from seeking needed health care; denying bodily sensations while sleeping on the ground may desensitize them to signs and symptoms of disease). Homeless patients have even more difficulty than others focusing on medical providers’ instructions or remembering them, due to preoccupation with meeting basic needs. Stress and anxiety may distract homeless parents from giving their children the attention they require for normal development.
- **Criminalization of homelessness** Homeless people are frequently arrested for loitering, sleeping, urinating or drinking in public places — activities that are permissible in the privacy of a home. This results in a criminal record for non-criminal behavior, which prevents them from getting jobs, housing and needed services. In many communities, when homeless people are arrested, even if for a public nuisance offense such as loitering or public urination, any medications they have with them may be confiscated and not returned. This punitive approach to homelessness detracts attention from the health care needs of homeless individuals.

Health Care for Homeless Patients: Summary of Recommendations

DIAGNOSIS & EVALUATION

History

- **Living conditions** – Ask where patient is staying. Explore access to food, water, restrooms, place to store medications; exposure to toxins, allergens, infection; threats to health/safety. Be alert to possible homelessness.
- **Prior homelessness** – what precipitated it; whether first time, episodic, chronic; history of foster care
- **Acute/chronic illness** – Ask about individual/familial history of asthma, chronic otitis media, anemia, diabetes, CVD, TB, HIV/STIs, hospitalizations, medications.
- **Prior providers** – what worked well, does patient have regular source of primary care
- **Mental illness/cognitive deficit** – problems with stress, anxiety, appetite, sleep, concentration, mood, speech, memory, thought process and content, suicidal/homicidal ideation, judgment, impulse control, social interactions
- **Developmental/behavioral problems** – adaptive/maladaptive, underlying pathology
- **Alcohol/nicotine/other drug use** – Ask about use (amount, frequency, duration); look for signs of substance abuse/dependence.
- **Health insurance/prescription drug coverage** – entitlement assistance (Medicaid/SCHIP, SSI/SSDI)
- **Sexual** – gender identity, sexual orientation, behaviors, partners, pregnancies, hepatitis/HIV/other STIs
- **History & current risk of abuse** – emotional, physical, sexual abuse; knowledge of crisis resources, patient safety
- **Legal/violence history** – legal problems, violence against persons or property, domestic/interpersonal violence, history of arrest/incarceration, treatment while incarcerated
- **Regular/strenuous activities** – consistent routines (treatment feasibility); level of strenuous activity
- **Work history** – longest time held a job, occupational injuries; vocational skills and interests
- **Literacy** – If “trouble reading,” offer help with intake form; assess ability to read English.
- **Nutrition/hydration** – diet, food resources, preparation skills, liquid intake
- **Cultural heritage/affiliations/supports** – involvement with family, friends, faith community, other sources of support
- **Strengths** – coping skills, resourcefulness, abilities, interests

Physical examination

- **Comprehensive exam** – at 1st encounter if possible, following standard clinical guidelines
- **Serial, focused exams** – for patients uncomfortable with full-body, unclothed exam at 1st visit
- **Dental assessment** – age appropriate teeth, obvious caries, dental/referred pain, diabetes patients
- **Special populations** – Victims of abuse, sexual minorities

Diagnostic tests

- **Interpersonal violence** – Posttraumatic Diagnostic Scale for Use with Extremely Low-income Women
- **Mental health screenings** – Patient Health Questionnaire (PHQ-9, PHQ-2), MHS-III
- **Substance abuse screening** – SSI-AOD
- **Cognitive assessment** – Mini-Mental Status Examination (MMSE)
- **STI screening** – for chlamydia, gonorrhea, syphilis, HIV, HBV, trichomonas, bacterial vaginosis, monilia
- **Baseline labs** – including liver function tests
- **PPD** – for patients living in shelters and others at risk for tuberculosis
- **Health care maintenance** – cancer screening for adults, EPSDT for children
- **Developmental assessment** – Denver II or other standard screening tool
- **Forensic evaluation** – if strong evidence of child abuse

PLAN & MANAGEMENT

Plan of care

- **Basic needs** – Food, clothing, housing may be higher priorities than health care.
- **Patient goals & priorities** – immediate/long-term health needs, what patient wants to address first
- **Action plan** – simple language, portable pocket card
- **After hours** – extended clinic hours, how to contact medical provider when clinic is closed
- **Safety plan** – if interpersonal violence/sexual abuse suspected; mandatory reporting requirements
- **Emergency plan** – contacting PCP before going to ER, location of emergency facilities
- **Adherence plan** – clarification of care plan/patient feedback; use of interpreter, lay educator if LEP

Education, self-management

- **Patient/parent instruction** – simple language/illustrations, confirm comprehension; pocket card listing immunizations, chronic illnesses, medications
- **Prevention/risk reduction** – protection from communicable diseases
- **Behavioral change** – individual/small group/community interventions, motivational interviewing
- **Nutrition counseling** – diet, dietary supplements, food choices, powdered formula for infants
- **Peer support** – support groups, consumer advocates
- **Education of service providers (shelter/clinical staff)** – re: special problems/needs of homeless people

Medications

- **Simple regimen** – low pill count, once-daily dosing where possible; capsules/tablets for child > 5 yrs
- **Dispensing** – on site; small amounts at a time to promote follow-up, decrease risk of loss/theft/misuse; avoid written prescriptions when possible.
- **Storage/access** – in clinic/shelters; if no access to refrigeration, don't prescribe meds that require it.
- **Patient assistance** – entitlement assistance, free/low-cost drugs if readily available for continued use
- **Aids to adherence** – harm reduction, outreach/case management, directly observed therapy
- **Potential for misuse** – inhalants, bronchodilators/spacers, pain medications, clonidine, needles
- **Side effects** – primary reason for nonadherence (diarrhea, frequent urination, nausea, disorientation)
- **Analgesia/symptomatic treatment** – patient contract, single provider for refills of pain medications
- **Immunizations** – per standard clinical guidelines; influenza, pneumococcus, HAV, HBV, Td for adults
- **Antibiotics** – standard liquid measurements, importance of completing regimen, RSV prophylaxis
- **Dietary supplements** – multivitamins with minerals, nutritional supplements with lower resale value
- **Managed care** – Prescribe medications that don't require pre-authorization, assistance getting Rx filled

Associated problems, complications

- **No place to heal** – efficacy of medical respite/recuperative care, supportive housing,
- **Masked symptoms/misdiagnosis** – e.g., weight loss, dementia, edema, lactic acidosis
- **Developmental discrepancies** – focus on immediate concerns, not possible future consequences
- **Functional impairments** – documentation of disabilities, assistance with SSI applications
- **Dual diagnoses** – integrated treatment for concurrent mental illness/substance use disorders
- **Loss of child custody** – support for parent of child abused by others, and for abused parent

Follow-up

- **Contact information** – phone numbers, e-mail addresses for patient/friend/family/case manager
- **Medical home** – to coordinate/promote continuity of health care
- **Frequency** – more frequent follow-up, incentives, nonjudgmental care regardless of adherence
- **Drop-in system** – anticipate/accommodate unscheduled clinic visits
- **Transportation assistance** – provide carfare/tokens, help with Medicaid transportation services

- **Outreach, case management** – Connect with community outreach programs, HCH providers
- **Monitor school attendance** – Address health/developmental problems with family/school.
- **Peer support** – client advocate to accompany patient to clinical appointments/ambulatory surgery
- **Referrals** – linkage with specialists, pro bono care, providers sensitive to underserved populations

MODEL OF CARE

Service delivery design

- **Multiple points of service** – clinics, drop-in centers, outreach sites; electronic medical records, if feasible
- **Integrated, interdisciplinary** – coordinated medical and psychosocial services
- **Flexible service system** – walk-ins permitted, help with resolving systems barriers
- **Access to mainstream health system** – ready access to secondary/tertiary care

Outreach and engagement

- **Outreach sites** – streets, soup kitchens, shelters, other homeless service sites
- **Clinical team** – use of outreach workers/case managers and medical providers to promote engagement
- **Therapeutic relationship** – based on trust, nonjudgmental care, frequent encounters
- **Incentives** – to promote engagement: food, drink, vouchers, hygiene products, subway/bus fare (tokens)

Standard of care

- **Evidence-based medicine** – Make elimination of health disparities a clinical goal.

INTRODUCTION

Poverty, coupled with the lack of affordable housing, is the primary cause of homelessness (Baumohl, et al, 1996). Poor health and inadequate access to health care are among the factors that precipitate homelessness among impoverished people (Institute of Medicine, 1988). For those who are struggling to pay for housing and other basic needs, the onset of a serious illness or disability can easily result in homelessness following the depletion of financial resources.

The experience of homelessness both causes and exacerbates poor health (Institute of Medicine, 1988; Wright, 1990). “As a consequence of poor nutrition, lack of adequate hygiene, exposure to violence and to the elements, increased contact with communicable diseases, and fatigue accompanying the constant stress of residential instability, people without homes suffer from ill health at much higher rates than do people living in stable housing” (McMurray-Avila et al, 1998). Although they are chronologically younger, the health and functional problems of middle-aged, homeless adults resemble those of geriatric persons in the general population (Gelberg, et al, 1990).

Homeless people are at higher risk for chronic, uncontrolled medical conditions such as asthma, chronic obstructive pulmonary disease, diabetes, hypertension, peripheral vascular disease, chronic liver and renal disease than are domiciled people (Fleischman, et al., 1992; Wright, 1990). Transience and congregate living increase their risk for contracting and transmitting communicable diseases. Tuberculosis infection rates among people who are homeless remain high in many cities, and shelters are major sites of transmission (Nardell and Brickner, 1996; Brickner, 1998; CDC, 2002).

As many as half the people living with acquired immune deficiency syndrome (AIDS) in the United States are estimated to be either homeless or at imminent risk of homelessness (Song, 1999). Average prevalence rates of the human immunodeficiency virus (HIV) that causes AIDS are at least three times higher in surveyed homeless populations than in the general population (Song, 1999; Lopez-Zetina, 2001). High rates of viral hepatitis (HBV, HCV) are also reported among homeless adults and youth, particularly those involved in intravenous drug use and unprotected sex (Garfein et al., 1998). Parasitic skin infestations (scabies and lice) and dermatological conditions (psoriasis, impetigo, seborrhea, nonspecific dermatitis, cellulitis) are frequently seen in hospital emergency rooms where homeless people seek care (Scanlon and Brickner, 1990; O’Connell, 1999).

A middle-aged man lives in his wheelchair. He ambulates with it and sleeps in it. The man is a double amputee and incontinent. He can't control his bladder. He never wears pants; the lower half of his body is covered only by rumpled, stained sheets. Although he habitually stays at a local shelter, he is barely tolerated, since he publicly relieves himself in jars or cans he carries, whenever and wherever. Thieves routinely steal his medications, assault him, and tip over his wheelchair. A health care worker insists that he belongs in a nursing home, but he has no documented mental disability. He has been unable to qualify for SSA benefits.

Kenneth Townsend, MDiv, Nashville, Tennessee
Healing Hands, October 2002

Poor diet, chemical dependencies, and exposure to the elements increase displaced people's risk for complications of chronic illness and premature mortality. Food selection in most shelters and soup kitchens is limited (Wright, 1990). One in five Americans has a substance use (alcohol or drug) problem, compared to an estimated two out of three homeless persons (Burt, 1999). About 70 percent of surveyed homeless people smoke nicotine, compared to 25 percent of the general U.S. population (Sachs-Ericsson, 1999; Szerlip, 2002; Connor, 2002). Hypothermia and frostbite are risk factors for early death among street dwellers (Hwang, et al., 1998, as cited in O'Connell, 1999).

Limited access to health services and fragmented health care delivery systems present significant obstacles to appropriate medical care for homeless people (Scanlon and Brickner, 1990; McMurray-Avila, 2001; Zerger, 2002). Lack of health insurance, limited resources, and preoccupation with meeting basic survival needs partially explain why persons experiencing homelessness tend to seek health care only in emergencies (O'Connell, 1999). When care is delayed, health problems often become more complicated. Homelessness also complicates the delivery of health care (Institute of Medicine, 1988; Bricker et al. 1990). Health conditions requiring regular, uninterrupted treatment — such as tuberculosis, HIV, addiction, and mental illness — are extremely difficult to manage without a stable residence.

Homeless people may resist treatment or have extreme difficulty adhering to a medical regimen — particularly if they suffer from psychiatric illnesses, mental retardation, and/or substance use disorders. Storage space is limited, requiring displaced people to carry medications on their person. As a result, pills are often lost, stolen, or crumble in pockets from the movement of walking. Multi-dose regimens are especially challenging. Medication that must be taken with food may be problematic if meals are irregular and limited to once or twice a day. Poor water intake and lack of access to bathroom facilities complicate the use of diuretics and medications with gastrointestinal side effects (Brickner PW, et al., 1990). Despite these impediments, experienced homeless service providers and their clients have demonstrated that emergencies can be prevented and health outcomes improved with a comprehensive, client-centered approach to care and self-management (McMurray-Avila, 2001).

Physical and sexual abuse in family and other relationships has been identified as both a cause and a consequence of homelessness (Stein, 2002; U.S. Conference of Mayors, 2003). Living on the streets or in shelters increases risk for abuse. Those who are mentally ill or under the influence of alcohol or drugs are even more vulnerable to victimization, and less likely or able to seek help (Wenzel, 2001; Burroughs, 1990). Homeless children are physically abused at twice the rate of other children and are three times as likely to have been sexually abused (National Center on Family Homelessness, 1999). Homeless youth are often victims of abuse, before and after becoming homeless (Robertson and Toto, 1998). Homeless women are at especially high risk for severe physical and/or sexual abuse (Browne and Bassuk, 1997). In one study, almost 90 percent reported having been violently victimized at some point in their lives (Bassuk et al., 1998); in another, nearly one-third said they had been raped within the past month (Kushel, et al., 2003).

Severe mental illnesses with chemical dependencies are more common among solitary homeless women, many of whom have lost their children because of these disorders (Bassuk et al., 1998).

Homelessness is well documented as an independent predictor of emotional and behavioral problems. Residential instability amplifies mental health risks engendered by family fragmentation, abuse, neglect and abandonment. Homeless youth in their teens and early 20's demonstrate high rates of conduct disorders, substance abuse, posttraumatic stress disorder, depression and attempted suicide (Robertson and Toto, 1998). Homeless women have higher

rates of behavioral health problems (substance use disorders, major depression, posttraumatic stress disorder) than do other women, but are less likely to receive mental health care (Zima et al., 1996). Over 20 percent of homeless children 3-to-6 years old have emotional problems serious enough to require professional care (Institute for Children and Poverty, 1999). Homeless children under age 12 are at significant risk for developmental delays, depression, anxiety, behavior disorders and learning disabilities (National Center on Family Homelessness, 1999). The strongest predictor of behavioral health problems in homeless children is their mother's level of emotional distress (Zima et al., 1996; National Center on Family Homelessness, 1999).

Children born to homeless women have low birth weight (< 2500 grams) at higher rates than the national average (Institute for Children and Poverty, 1999; National Center on Family Homelessness, 1999). From infancy through childhood, they are significantly more likely than other children to have acute and chronic illnesses, primarily due to their families' higher psychosocial risks, residential instability, and limited access to appropriate health care (National Center on Family Homelessness, 1999). Gaps in health coverage, difficulty accessing health care, and variable quality of care are common barriers experienced by homeless families (Ibid.).

Health Care for the Homeless providers at the New York Children's Health Project report that nearly one in four of their pediatric patients requires a specialist consultation, often for chronic conditions that have not previously been identified or treated (Grant, et al., 2000, 2002). Sheltered homeless children have twice as many middle ear infections, 5 times more gastrointestinal problems, and 6 times as many speech and stuttering problems (National Center on Family Homelessness, 1999). These children are less likely than other children to have been breastfed, more likely to be exposed to second-hand smoke, and more likely to live in overcrowded conditions (three main risk factors

The woman huddled in a corner of your clinic waiting room may be young or middle-aged, unaccompanied or with small children. She is probably unexpected or late for her appointment, a little breathless and distracted, somewhat disheveled. If you look closely, you can read anxiety and fatigue in her face. Listen carefully, and you may hear embarrassment or a trace of fear in her voice. She may be homeless or on the verge of homelessness, seeking help for a minor health problem that masks a history of abuse and addiction. Afraid of shocking or repelling you, she hesitates to reveal this information but secretly hopes that you will discover her secret, because she desperately needs your help.

Patricia Post, Herstory of Homelessness,
Opening Doors, Fall, 2000

Sonya is a slight, inquisitive seven-year-old girl living with her mother and younger brother in a shelter, homeless for the second time. Sonya is very protective of her little brother, and people sometimes call her "little mommy." Between stays, she lived with her paternal grandmother and her aunt, as well as in a car with her mother. She switched schools four times in the last two years, and skipped nursery school and kindergarten. Sonya struggles to keep up in second grade, but is clearly bright and shows great effort. Some mornings she is hungry and can't concentrate. She has missed many school days because of asthma. Sonya's natural curiosity sometimes results in scolding by adults. Her mother is often busy at her welfare-to-work program or in search of housing, and is not always available to help Sonya with her daily needs. Yet Sonya's mother is affectionate with her children, and her father visits the children weekly.

Rachel Kirzner, MSW, Philadelphia, Pennsylvania
Healing Hands, May 2003

for otitis media). Multiple ear infections, inappropriately treated, may result in hearing loss that can delay speech and language development, and eventually affect school performance.

Children living in shelters are twice as likely to have asthma as low-income housed children, and 4 to 6 times more likely than the average American child (National Center on Family Homelessness, 1999; McLean, 2004). Higher exposure to environmental allergens and lack of a regular source of care increase their risk for uncontrolled asthma. Sleep loss and exhaustion, common side effects of asthma, can reduce a child's capacity to learn and a mother's ability to cope with the stress of being homeless.

Homeless adults unaccompanied by children comprise approximately 60 percent of surveyed homeless people in the United States (Burt,

1999; U.S. Conference of Mayors, 2003). Lack of affordable housing, insufficient education to meet increasing job skills requirements, residual effects of child abuse or neglect, and functional disabilities or uncontrolled chronic illness are among the structural and individual variables that often give rise to residential instability, regardless of gender or family status. Health problems associated with substance use, lack of shelter, and limited access to needed health and social services impede resiliency and increase risk for chronic homelessness.

Clinical practice guidelines for people who are homeless are fundamentally the same as for those who are housed. Nevertheless, primary care providers who routinely serve homeless patients recognize an increased need to take living situations and co-occurring disorders into consideration when working with these patients to develop a plan of care. The recommendations in this guide were developed to assist clinicians that provide health care to individuals who are homeless or at risk of becoming homeless. It is our expectation that these simple clinical practice adaptations will increase opportunities for homeless patients to receive the optimum standard of care and ultimately reduce their higher morbidity and mortality risks.

The primary sources for these recommendations are seven sets of adapted clinical practice guidelines developed by the Health Care for the Homeless Clinicians' Network, available at: www.nhchc.org. (For full citations, see page 26.)

General Recommendations for the Care of Homeless Patients

Diagnosis and Evaluation

HISTORY

- **Living conditions** Ask every patient about his or her living situation to assess residential stability and the possibility that s/he may be marginally housed or homeless.¹ (“Where do you live? Who lives there with you? How long have you lived there?”) Ask where the patient sleeps, where s/he spends time during the day, and how s/he can be contacted. Ask explicitly about access to food, water, shelter, restrooms and a place to store medications. Assess environmental factors that may expose the patient to toxic substances, allergens or infection or otherwise threaten health and safety.
- **History of homelessness** If the patient is staying in a shelter, a vehicle, on the street or in any other unstable living situation, ask if this is the first time s/he has been without a home. Be aware that some people are too embarrassed to admit that they are homeless or don’t consider themselves homeless if staying with a relative or friend. Gently ask a parent with an unstable living situation if his/her child has ever been in foster care (“Has your child ever had to live away from you? Have you and your child ever been separated?”) Living in foster care increases risk for future homelessness. If there were prior episodes of homelessness, try to determine whether residential instability is chronic or episodic. If currently homeless, try to understand the circumstances that precipitated homelessness and explore available housing options that might be acceptable to the patient.
- **Medical history** Ask about medical conditions for which homeless people are known to be at increased risk — e.g., asthma, chronic ear infections, anemia, diabetes, cardiovascular diseases, tuberculosis, HIV and other sexually transmitted infections (STIs). If the patient is school age, inquire about missed days due to illness. Ask whether s/he has ever stayed in a hospital; if so, where and for what reason(s). Request available medical records from hospitals and other clinicians to gather information about prior diagnoses and treatments, but do not withhold care if

¹ A homeless person, as defined by the Bureau of Primary Health Care, is “... an individual without permanent housing who may live on the streets; stay in a shelter, mission, single room occupancy facility, abandoned building or vehicle; or in any other unstable or non-permanent situation. An individual may be considered to be homeless if that person is ‘doubled up,’ a term that refers to a situation where individuals are unable to maintain their housing situation and are forced to stay with a series of friends and/or extended family members. In addition, previously homeless individuals who are to be released from a prison or a hospital may be considered homeless if they do not have a stable housing situation to which they can return. A recognition of the instability of an individual’s living arrangement is critical to the definition of homelessness.” (Principles of Practice: A Clinical Resource Guide for Health Care for the Homeless Programs, Bureau of Primary Health Care/HRSA/HHS, March 1, 1999; PAL 99–12.)

records are unavailable. If medical records and patient recollection are insufficient to identify specific medications taken, ask if the patient can show you old prescriptions or medicine bottles.

- **Prior providers/medical home** Inquire about other health care providers the patient has seen and what the patient/family liked or disliked about prior health care. Ask if the patient has a “medical home” (regular source of primary care) and whether access to the primary care provider is limited in any way (e.g., by a change in health insurance or lack of transportation).
- **History of mental illness/cognitive deficit** Ask if the patient has ever been told s/he had a mental illness or cognitive impairment and if ever hospitalized for an emotional, nerve, or psychiatric condition. Ask about and observe for problems with stress, anxiety, appetite, sleep, concentration, mood, speech, memory, thought process and content, suicidal/homicidal ideation, judgment, impulse control and social interactions. Normalize discussion of mental health issues by asking whether the individual has been experiencing “stress, low energy, difficulty focusing or mood swings” rather than “mental illness.” Ask if the patient has ever been treated for depression, anxiety or other concerns and if s/he is currently experiencing any of these problems. Assess the patient’s ability to take pills daily and return for follow-up care. If mental health problems are suspected, ask if the patient would like an appointment with someone (preferably a mental health professional on the clinical team) to discuss his/her concerns further. If the patient is reluctant to discuss a mental health problem with another clinician, ask what s/he would like you to do to address it and re-visit the issue of referral at a later point.
- **Development/behavior** Evaluate the special needs of every patient, including possible developmental delays. If the patient is a child, inquire about interaction with family members and behavior at daycare or school. If problems are reported, assess for possible hearing loss and/or speech delays secondary to chronic ear infections, commonly seen in homeless children. Recognize that behavior problems frequently occur in response to the stress of being homeless and are not necessarily indicative of underlying pathology. Behaviors that are adaptive while homeless may be maladaptive in other settings.
- **Alcohol/drug use** Ask about current and previous use (amount, frequency, duration) of alcohol and drugs, including nicotine, recognizing that smoking is more common among homeless than domiciled people and often begins at a younger age. To engage the patient in conversation about this topic, ask, “What are the good things about using?” followed by “What are the not so good things?” Assess the individual’s level of readiness for behavioral change. Provide relevant information about health risks related to substance use. Look for substance use disorders that may complicate treatment adherence for other health and mental health issues.
- **Health insurance, other resources** Ask whether the patient has health insurance that covers prescription drugs, and how s/he obtains medicine. If uninsured or without prescription drug coverage, provide assistance in applying for entitlements, including Medicaid, the State

Children's Health Insurance Program (SCHIP), Supplemental Security Income (SSI), or other assistance for which the patient may be eligible.

- **Sexual history** Ask about gender identity, sexual orientation, sexual behaviors, partners, pregnancies and sexually transmitted infections, including hepatitis. Obtain a detailed history of sexual practices, including number/gender of sex partners and their risk for HIV, use of condoms or other barrier methods, and types of sexual intercourse. Ask if the patient has ever exchanged sex for money or other needs. Use written questions so the patient knows it is standard procedure to ask them. Ask the same questions of both males and females in a nonjudgmental way.
- **History/risk of abuse** Assess for a history of emotional, physical or sexual abuse and exploitation; ask all patients if they have ever been physically hurt, afraid of being hurt, or made to do things sexually they didn't want to do. Ask about family stress and relationship problems, recognizing that chronic illness in a child can increase the child's risk for abuse. Discuss medical confidentiality and its limits (e.g., in cases of child abuse, threat to self or others). If abuse is suspected, evaluate patient safety and follow mandatory reporting requirements in your state. (See page 12 for resources where this information can be obtained.)
- **Legal/violence history** Ask about the patient's current/past legal problems and if there is any history of violence against persons or property. Be alert for indications of domestic violence. If a history of violence is indicated, assess the patient's potential for current/future violence. Ask about arrests and incarceration and whether the person ever received medical or mental health treatment while incarcerated. A history of incarceration is associated with increased risk for infectious diseases, interrupted treatment, and barriers to housing following discharge.
- **Regular/strenuous activities** Ask if the patient has any sort of schedule or daily routine. Explore evidence of consistency in the patient's life to assess whether a medical regimen can be integrated into his/her regular schedule of activities. Ask the patient to describe strenuous activities (e.g., walking — how far in blocks?). Knowledge of activity level can be useful in designing an exercise program to prevent or reduce complications of cardiovascular disease or diabetes.
- **Work history** Ask what types of work the patient has done and the longest time s/he held a job to identify abilities and interests, assess stability, and determine risk for comorbidities associated with toxic exposures (e.g., to asbestos, silica, coal). Ask about any work-related illnesses or injuries and whether they have interfered with gainful activity (i.e., made it difficult to do work, resulted in job loss, presented obstacles to hiring). If so, consult the Association of Occupational and Environmental Clinics for referrals and assistance (www.aoec.org).
- **Literacy** Ask if the patient has trouble reading or wants help filling out the intake form. This can serve as a non-threatening way to evaluate ability to read English while allowing the patient to save face, since "trouble reading" can indicate vision, literacy, or language problems.

- **Nutrition/ hydration** Look for signs and symptoms of malnutrition and dehydration. Ask where the patient has meals and what kinds of food s/he eats. Inquire about access to water and other liquids, especially in summer months. Understand that homeless people are at risk for malnutrition and obesity because of limited dietary choices. Evaluate the patient's knowledge of proper diet and food resources (pantries, soup kitchens, delivered meals, nutritional supplements), as well as cooking skills and availability of cooking facilities. If the patient is not eating well, determine why (e.g., limited access to nourishing food, poor dentition, use of resources for other needs).
- **Cultural heritage/affiliations** Ask about the patient's cultural background, faith community and/or other affiliations, to identify potential social supports. Be aware of health disparities between cultural/ethnic minorities and the general population (higher risk for cardiovascular disease, asthma, cancer, depression, etc. among ethnic minorities and other medically underserved populations).
- **Strengths** Ask about the patient's perceived strengths and abilities as well as present and past interests. Recognize that it takes a great deal of resourcefulness, patience and tenacity to meet survival needs while one is homeless. Seeking health care, keeping appointments and adhering to treatment are all examples of basic strengths that should be acknowledged. Homeless people also have vocational and artistic skills or other talents that may go unnoticed. Comment on strengths you see in the person.

PHYSICAL EXAMINATION

- **Comprehensive exam** A full-body, unclothed examination of a homeless adult is rarely possible before engagement is achieved. The patient may be too fearful to be examined, indicating the need to build a therapeutic relationship first. Be sensitive to the patient's comfort level. Explain at the first visit what a comprehensive physical examination entails, and ask permission to perform one. If the patient prefers not to disrobe at the first visit, defer the genital exam until the second visit or whenever his/her comfort level allows, especially for young adolescents or if a history of sexual abuse is suspected. Once engaged, a more complete examination can be performed. For children, use every patient visit as an opportunity for a general physical examination, including height, weight, head circumference and other screenings recommended by standard clinical guidelines (American Academy of Pediatrics: www.aap.org/policy/paramtoc.html).
- **Serial, focused exams** If the patient is not ready for a comprehensive physical examination, conduct serial, focused examinations until a therapeutic relationship has been established (e.g., examine the patient's feet, listen to his/her chest). Ask permission to perform each physical exam. Be attentive to the patient's comfort level and pay attention to nonverbal cues; do whatever s/he can tolerate at the time. Schedule a return visit within a short period of time and plan frequent follow-up encounters to complete the examination.

- **Dental assessment** Screen infants and children for age appropriate teeth and obvious tooth decay. In a child 6 months – 2 years of age, chalky white or brown areas on upper anterior teeth are signs of Early Childhood Caries and require referral to a dentist experienced in the care of pediatric patients. If the patient complains of ear ache, sore throat or sinus pain with no evidence of infection, check for decayed molars or other dental disease and refer for an oral health assessment, recognizing that referred pain to the ears and throat can be a symptom of dental problems. Ask adult patients whether they are experiencing any dental pain, bleeding gums or foul mouth odor and when their last dental examination was. Be aware that dental disease is common among homeless people, especially those with diabetes mellitus. A dental assessment is particularly important for diabetes patients with poor blood sugar control.
- **Abused patients** Recognize that a high percentage of homeless people have experienced physical and/or sexual abuse. Whenever possible, offer patients the option of being examined by a health care provider of the same sex. To decrease anxiety, explain at the outset the purpose of each visit and what the patient can expect to happen. Always explain what you are going to do before you do it.
- **Sexual minorities** Recognize that homeless people with a non-traditional sexual orientation or gender identity experience even greater obstacles to health care than do other homeless people, and may not have seen a primary care provider for years. Cancer, sexually transmitted infections and depression are among the health conditions that are less likely to have been detected or treated in gay, lesbian, bisexual or transgender (GLBT) individuals (Gay and Lesbian Medical Association, 2001). Be aware that GLBT individuals who are homeless are more often victims of sexual or physical assault, use highly addictive substances more frequently, and have higher rates of psychopathology (including depression and suicidal ideation) than their heterosexual counterparts (Noell and Ochs, 2001; Cochran et al., 2002; Kushel et al., 2003). A male taking estrogen needs to have mammograms; a female taking testosterone still requires Pap smears and breast exams/mammograms according to standard schedules. Any patient who has had a silicon or other implant should receive both physical and radiological examinations and be carefully monitored. Patients who have had sexual reassignment surgery require genital examination as part of regular health care maintenance.

DIAGNOSTIC TESTS

- **Screening for interpersonal violence** Routinely assess for domestic/interpersonal violence. A screening tool recommended for this purpose is the Posttraumatic Diagnostic Scale Modified for Use with Extremely Low Income Women. (To obtain this questionnaire, contact The National Center on Family Homelessness, formerly The Better Homes Fund: 181 Wells Ave, Newton Centre, MA 02459; Tel: 617-964-3834; Fax: 617-244-1758. See also: Melnick and Bassuk, 2000).
- **Mental health screens** Screen every patient for depression. National measures recommended by the Health Disparities Collaborative on Depression are based on the 9-item Patient Health Questionnaire (PHQ-9), a depression scale developed for primary care, available at:
English: www.healthdisparities.net/HDCToolsandManuals/Depression-Decision%20Support/PHQ-9_Patient_Questionnaire.doc
Spanish: www.healthdisparities.net/HDCToolsandManuals/Depression-Decision%20Support/PHQ-9_Patient_Questionnaire-Spanish.doc
A 2-item pre-screen (PHQ-2), using the first 2 questions in the PHQ-9, has also been validated for use in primary care (Staab and Evans, 2000).

To screen for a range of psychiatric conditions, consider using the Mental Health Screening Form III, a public domain instrument that takes about 5 minutes to administer (available at: www.asapnys.org/Resources/mhscreen.pdf).

- **Substance abuse screening** Screen homeless adults and adolescents to determine risk for substance use problems. Consider using the Simple Screening Instrument for Alcohol and Other Drug Use (SSI-AOD), also in the public domain, which is validated for use in general populations and short to administer. The SSI-AOD screening tool may be administered as an interview or as a self-administered test. Both versions are available at: www.health.org/govpubs/bkd143/11m.aspx#TIP11.EXB2-2
- **Cognitive assessment** Assess for cognitive impairment related to mental illness, chronic substance use, AIDS-related dementia, opportunistic infection or medication side effects, which may affect adherence to treatment regimens. Test for specific competencies: Can the patient understand directions, make competent decisions, organize time well? The Mini-Mental Status Examination (MMSE), an 11– item questionnaire that can be answered in 10 minutes, is a widely used assessment tool for adults. The MMSE tests orientation, attention, immediate and short-term recall, language, and the ability to follow simple verbal and written commands. For information about how to obtain it, see: www.minimental.com/.
- **STI screening** For sexually active patients, concurrently assess for and treat sexually transmitted infections, recognizing higher incidence and need for more frequent STI screening of patients engaging in risky sexual behaviors. Test for gonorrhea, chlamydia, syphilis, HIV (following local regulations regarding patient consent), hepatitis B antigen, trichomonas, bacterial vaginosis and

monilia. If a pelvic examination is refused by a female patient, urine gonorrhea and chlamydia screening combined with self-administered vaginal swab for saline and KOH preparations may be useful screening tools.

- **Baseline labs** Perform laboratory tests as specified in standard clinical guidelines. Pay more attention to liver function tests in a homeless patient whose risk for liver damage (secondary to hepatitis, history of IV drug use, or heavy alcohol use) is high. Patients on hormones or statins should also have regular monitoring of liver functions.
- **PPD** A number of practitioners recommend purified protein derivative (PPD) tuberculin skin testing for homeless patients every six months because of their higher risk for contact with active tuberculosis and unpredictable follow-up. Various agencies (including shelters) require proof of TB testing. It is not unusual for a homeless person to have been tested multiple times for TB by different providers. Provide a written record of test results on a wallet-sized card that patients can carry with them.
- **Health care maintenance** At every visit, follow standard clinical guidelines for routine health maintenance screenings, including mammograms and other cancer screening, recognizing that the patient may not have seen a health care provider in a long time. When possible, do standard screenings when the patient is seen for an acute problem, rather than rescheduling (e.g., offer to perform a Pap smear at the same visit when a woman comes in for a URI). Offer pregnancy testing (UCG urine test) to all heterosexually active female patients of childbearing age.
- **EPSDT screening** For children, follow standard procedures for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services as a routine part of primary care. These are mandatory covered services under Medicaid, for which most homeless children qualify. (A description of these services is available at: www.mchlibrary.info/KnowledgePaths/kp_EPSDT.html. Other resources are Bright Futures and the AAP Guide to Health Supervision.)
- **Developmental assessment** If developmental delay is suspected, assess the patient's developmental level using a standard evaluation tool (e.g., Denver Developmental Screening Tests: www.denverii.com/DenverII.html). For a child, use an assessment tool that does not rely solely on parental report. Conduct the assessment with the parent present, to demonstrate that a delay does or does not exist. Partner with the parent to address any delay identified. An annotated list of developmental and behavioral screening tools can be found at: www.dbpeds.org/articles/detail.cfm?id=5.
- **Forensic evaluation, if warranted** If sexual abuse of a child is suspected, facilitate the patient's referral through Child Protective Services or the police to a center experienced in forensic interviewing and evaluation.

Plan and Management

PLAN OF CARE

- **Basic needs** Understand that health care usually is not the most urgent problem for individuals or families who are homeless unless they are acutely ill; food, clothing and housing may be perceived as more important. Developing an individualized plan of care with the patient that incorporates strategies to meet these basic needs will strengthen the therapeutic relationship, increase patient stability, and promote successful treatment.
- **Patient goals & priorities** Carefully assess the patient's immediate and long-term health care needs and what s/he identifies as priorities. Ask what the patient or family would like you to do. Address immediate medical needs first (the patient's reason for the visit) rather than underlying causes (e.g., provide cough medicine or pain relief, where indicated, even if you don't think they are medical priorities). Be sensitive to the patient's beliefs and values; encourage adults to select their own goals, even if they differ from the providers' or are prioritized differently. When a goal is chosen, work in every way possible to help the patient overcome barriers to achieving it.
- **Action plan** A written action plan can give the patient and/or parent a sense of control. Most important is to clarify the plan of care in language they can understand. For those who are comfortable with written information, summarize key points on a pocket card that can be carried with them. Ask if there is another person who can help the patient or family cope with illness.
- **After hours** Extend clinic hours to accommodate working patients who cannot take time off for clinic appointments without risking their jobs. Inform the patient about after-hours clinic schedules and how to contact a medical provider by telephone when the clinic is closed.
- **Safety plan** If interpersonal violence or sexual abuse is suspected, help the patient develop a safety plan; explain and follow your state's mandatory reporting requirements. (A summary of state reporting requirements for domestic violence/adult abuse is available at: <http://endabuse.org/statereport/list.php3>. For information about reporting requirements for child abuse or neglect in all 50 states, see: <http://nccanch.acf.hhs.gov/general/statespecific/index.cfm> and the National Clearinghouse for Child Abuse and Neglect Information: www.calib.com/nccanch/statutes/index.cfm. Hot line phone numbers for reporting suspected abuse and neglect are available at: www.acf.dhhs.gov/programs/cb/publications/rpt_abu.htm) If suspected child abuse is reported, let the parent know you are doing this to help the child. Offer support to a parent whose child has been abused by someone else. An abused parent may also need protection. Part of treating the child is helping the parent avoid future abuse.

- **Emergency plan** Help the patient/family make a plan for emergencies. Be sure they know the location of emergency facilities. Instruct them to contact a primary care provider, if possible, before going to the emergency department. Provide a phone number where a medical provider can be reached after hours. Inquire about telephone access; if they do not have ready access to a telephone, ask if there is a friend or case manager who can call on their behalf.
- **Adherence plan** Recognize that adherence problems often result from unrealistic expectations of the provider. Explain the plan of care in simple language and elicit patient feedback to confirm understanding. Avoid medical jargon and euphemisms that can be confusing and perceived as “talking down” to the patient (e.g., with an adolescent, talk about “having sex” not “intercourse”). Use an interpreter and/or lay educator (*promotoras*) to facilitate communication and ensure culturally competent care for patients who do not speak English or have limited English proficiency. At the end of every clinic visit, ask the patient or parent, “Is there anything we talked about today that is unclear? Is there anything in the plan of care that will be difficult for you?” Work with the patient/family to find ways to reduce potential barriers to adherence or modify the plan of care.

EDUCATION, SELF-MANAGEMENT

- **Patient/parent instruction** Explain health problems and proposed treatment in language the patient/parent can understand, and confirm understanding. Use illustrations to facilitate comprehension. If giving written instructions, provide educational materials in the patient’s first language, using simple terminology and large print to compensate for any visual limitations. Develop your own patient education materials or use existing resources. (For examples, see materials prepared by the National Center for Farmworker Health for low-literacy patients who speak English or Spanish: www.ncfh.org/00_ns_rc_pateduc.shtml and Healthfinder for Kids, Office of Disease Prevention and Health Promotion: www.healthfinder.gov/kids/.) Provide a pocket card listing immunizations, any chronic illnesses, test results and current medications, to document medical history for the next caregiver or school authorities.
- **Prevention/risk reduction** Explain risks associated with any health problems for which the patient is being treated and discuss ways in which s/he can reduce them for him/herself and others, in the case of communicable disease. Make parents aware of risks to their child from exposure to people who are sick. Explain what they can do to reduce the child’s susceptibility to future infections (e.g., smoke-free environment, frequent hand washing, coughing into the crook of one’s elbow to prevent spread of viral infections, covering a small infant’s face with a blanket in crowded areas). Don’t recommend use of anti-bacterial soaps, which are thought to increase the risk of bacterial resistance.

- **Behavioral change** To encourage behavioral change, use individual, small group and community interventions based on careful investigation of actual patient behaviors. Motivational interviewing, risk reduction and social skills training can facilitate engagement and help to resolve ambivalence about behavioral change (Miller and Rollnick, 2002; HCH Clinicians' Network, 2000.) Help homeless parents learn effective parenting skills. Recognize that plans to shape new behaviors in children or extinguish old ones are difficult to carry out in congregate living situations, where parent-child interactions may be subject to public scrutiny, criticism and interference from others.
- **Nutrition counseling** Educate patients about nutritional health, diet and dietary supplements. If possible, include a nutritionist on the clinical team who is knowledgeable about the limited food choices that homeless people typically have. Give examples of how to make the best dietary choices possible in settings where food is obtained. Educate parents of infants about the nutritional, immunologic and developmental benefits of breastfeeding as well as contraindications for doing so — i.e., potential for maternal transmission of drugs or infection (such as HIV) in breast milk. For infants who are bottle feeding, recommend use of powdered formula that can be prepared as needed. (Keeping liquid preparations safe from spoilage can be difficult for homeless families.) Ask about access to clean water and refrigeration and assess the parent's capacity to manage formula feeding with appropriate hygiene. Explain the importance of using clean water to prepare formula milk and cleanse bottles and nipples. Review how long prepared formula or milk is safe to use without refrigeration.
- **Peer support** For patients experiencing extreme stigmatization or isolation, create support groups where they can share concerns and learn how others are coping with similar health problems. Consider using consumer advocates (formerly homeless persons) to accompany homeless patients to appointments with specialists and attend clinic sessions with the patient and primary caregivers.
- **Education of service providers** Educate yourself and other service providers about the special needs of homeless patients. Recognize that treatment adherence and successful outcomes are possible, even for homeless individuals with mental health/substance use problems. Take time in a safe setting to explore your own feelings about people who are homeless. Talk about your experiences, biases and stereotypes with other providers who are more experienced in caring for homeless patients. (For information about providers who work with homeless patients, contact the Health Care for the Homeless (HCH) Clinicians' Network: network@nhchc.org, 615/226-2292; or consult the Directory of HCH grantees and subcontractors, available online at: (www.bphc.hrsa.gov/hchirc/directory/.) Educate shelter staff, food workers and volunteers and about the health needs of your homeless patients.

MEDICATIONS

- **Simple regimen** Use the simplest medical regimen warranted by standard clinical guidelines, to facilitate treatment adherence. Consider expense, frequency, storage requirements and duration of treatment in selecting medications for homeless patients. If clinically indicated, once daily, directly observed therapy is preferable, especially for patients who may be unable to adhere to a more complex regimen. Make sure the patient/parent understands how to take/administer prescribed medications appropriately. For children over 5 years of age, use pills, tablets or capsules instead of liquid formulations to avoid the need for measurement or refrigeration. Some capsules can be opened and sprinkled in food, if necessary.
- **Dispensing** Negotiate the amount of medications to dispense at a given time with the patient, based on clinical indications, the patient's wishes and ability to hold onto the medications, transportation issues, etc. Dispensing small amounts of medications at a time can provide an incentive to return for follow-up if transportation to and from the clinic is available and affordable for the patient. (Some homeless patients frequently lose medications if larger quantities are provided.) Dispensing medications on site is more advantageous than sending homeless patients to a pharmacy with a prescription.
- **Misuse** Recognize the potential for medications/delivery devices to be misused. Inhalants, bronchodilators and spacers, pain medications, syringe needles and some anti-hypertensives may be lost, stolen, and/or sold to persons with chemical dependencies. Albuterol is used to enhance the effects of crack cocaine. Clonidine extends the effects of heroin and reduces withdrawal symptoms for persons addicted to opioids. Insulin syringes may be misused to inject IV drugs. These factors may provide an incentive for some individuals to report having a condition not actually diagnosed. Dispense smaller amounts of medications to patients known to "lose" them; this allows for closer follow-up and prompt identification/elimination of barriers to adherence and can limit opportunities for misuse afforded by multiple authorized refills.
- **Storage/access** Educate the patient about safe storage of prescribed medications. If the patient is staying in a shelter, ask if medicine can be stored there. Explain to shelter staff that the medications are necessary for the patient's health, costly to replace, and should be made easily available to him/her when needed. Or allow homeless patients to store medications at the clinic and come there daily for treatment. If medications are not stored in the clinic and the patient does not have access to refrigeration, avoid prescribing medications that require it.
- **Patient assistance** Recognize that even a small co-payment for prescription drugs can be excessive for homeless people; for those without health insurance or access to programs that provide free medications, the cost of medical treatment may be prohibitive. Help uninsured patients obtain all entitlements (Medicaid/SCHIP, SSI) or other assistance for which they may be eligible, including reduced-cost drugs available through the U.S. Public Health Service 340B Pharmaceutical Discount program (<http://bhpc.hrsa.gov/opa/>) or pharmaceutical companies' programs for low-income

individuals (www.rxassist.org; www.needymeds.com). If co-payments required by the health plan present a financial barrier to treatment, or if reduced-cost drugs are not readily available and immediate treatment is required, consider providing free medication samples when available; but recognize the potential for difficulty in obtaining medications for continued use. Assure continued access to medications before initiating treatment.

- **Aids to adherence** To facilitate treatment adherence, use motivational enhancement skills; negotiate with the patient; adopt a harm reduction approach;² provide outreach, intensive case management, directly observed therapy and medication monitoring. Explore obstacles to taking medications appropriately and problem-solve with the patient. Ask, “What concerns do you have about being able to take your medicine regularly?” “Is there someone who might help you take your medicine and keep track of it?” If clinical symptoms or test results indicate nonadherence, find out why the patient is not taking medication(s) as prescribed and address the reasons. The use of pillboxes may help patients keep track of medications and discourage resale. Give parents a cross-off chart to keep track of medication administered to their child; explore other methods they might use to increase adherence.
- **Side effects** Prescribe medications with fewer/less severe negative side effects, which are a primary reason for nonadherence. Avoid prescribing medications with significant sedative or gastrointestinal side effects. Medications that make homeless people feel sicker or diminish alertness may compromise their safety on the streets or in shelters. (Homeless individuals are often victims of gratuitous violence while sleeping out-of-doors. Those experiencing prolonged homelessness are at especially high risk for severe head injury from assault or being hit by cars.) If prescribing diuretics, be sure the patient has easy access to a restroom and bathing facilities and will be able to return for laboratory tests required to monitor them. If medications can be taken with food, provide nutritious snacks to prevent nausea, which often results from taking medicine on an empty stomach. Be more aggressive in changing medications for homeless patients to minimize negative side effects; or treat side effects symptomatically if alternative medications are contraindicated.
- **Immunizations** Update immunizations at every clinical encounter, recognizing that many homeless people tend to seek care only when sick, often miss scheduled appointments for well-child care or health care maintenance and may lose track of records. Given their high risk of exposure to respiratory infections in congregate living situations, all homeless patients should receive the influenza vaccine annually and be immunized against pneumococcus according to standard clinical guidelines. For homeless adults, provide hepatitis A and B vaccines and update tetanus (Td) if the last immunization was more than 10 years ago. (See recommended immunization schedules for children, adolescents and infants at: www.cdc.gov/nip/menu/groups.htm#child; for adults: www.cdc.gov/nip/vaccine/vac-chart-hcp.htm.)

² Harm or risk reduction refers to activities that are designed to reduce or minimize the damage caused by high-risk behaviors, with the ultimate goal of eliminating them. Examples include needle exchange, methadone maintenance, and outreach programs that distribute educational materials, syringes, condoms and bleach kits, and facilitate contact with other services. (HCH Clinicians' Network, 2000)

- **Antibiotics** Emphasize that all prescribed antibiotic regimens must be completed. (“Don’t stop when symptoms cease or use for the next infection.”) Urge patients to use standard measurements for liquid preparations (not just “a swig”) and provide a measuring device. If the patient is an infant, determine whether s/he is a candidate for respiratory syncytial virus (RSV) prophylaxis.
- **Analgesia/symptomatic treatment** Recognize that a number of morbidities commonly seen in homeless patients, including untreated dental problems, hepatitis and traumatic injuries, can result in chronic pain. It is important to remember that some drugs, such as methadone and other narcotics, can increase or decrease the effects of pain medications. Work with the patient to understand the underlying cause of pain. Prescribe appropriate pain medication and document why you prescribed it. To avoid overmedicating or contributing to drug-seeking behavior, specify the plan of care in a written contract with the patient, designating a single provider for pain prescription refills. Consider providing a cough suppressant or analgesia for a child’s acute ear infection, if not detrimental, to allow the child to sleep. A crying child will disrupt other shelter residents, which could place the family at risk for eviction.
- **Dietary supplements** Prescribe multivitamins with minerals. Assure that pregnant patients receive appropriate vitamin supplements (with folic acid). Consider prescribing nutritional supplements with less familiar brand names that have lower resale value to reduce the likelihood of theft.
- **Managed care** Know what medications are on your state’s Medicaid/SCHIP drug formularies and which ones require pre-authorization by a managed care plan. If possible, prescribe medications that do not require prior authorization to avoid delaying treatment. Help homeless patients fill their prescriptions, especially if they are required to use an approved pharmacy within a managed care network that is far from where they are staying.

ASSOCIATED PROBLEMS, COMPLICATIONS

- **No place to heal** Provide recuperative care/medical respite facilities where homeless patients can convalesce when ill, recuperate following hospitalization, or receive end of life care. Medical respite services are cost effective because they prevent future hospitalizations (Buchanan et al, 2003). (For information about medical respite/recuperative care alternatives, see *Medical Respite Services for Homeless People: Practical Models* by Marsha McMurray-Avila, 1999: www.nhchc.org/.) Facilitate entry into permanent housing to alleviate many of the associated problems and complications listed below.
- **Masked symptoms/misdiagnosis** Realize that disease symptoms may be difficult to differentiate from comorbidities in patients with multiple disorders. For example, weight loss in an individual who is homeless may be due to primary malnutrition rather than HIV wasting syndrome. Dementia may be secondary to chronic mental illness/chemical dependency, opportunistic infection, neu-

rological changes associated with AIDS or normal aging. Dependent edema may result from excessive ambulation for long periods or sleeping in chairs, and is not necessarily related to heart failure. Lactic acidosis symptoms (abdominal pain, shortness of breath) may be secondary to diabetes or COPD. Chronic bronchitis, emphysema and/or tuberculosis may mimic asthma symptoms.

- **Developmental discrepancies** Recognize that homeless adolescents and youth may be developmentally less advanced than peers of the same chronological age in some respects and more precocious in others (e.g., survival skills). Concrete thinking predominates over abstract reasoning skills. Homeless adults with mental illness or chronic substance use may have impaired reasoning and delayed social development that cause them to act like young adolescents. When discussing behavioral change with these patients, focus on immediate concerns rather than possible future consequences.
- **Functional impairments** Functional deficits secondary to chronic illness or injury can limit a patient's capacity to follow a plan of care. Musculoskeletal impairments, lack of facilities, or the area where a patient lives may limit exercise alternatives. Impaired cognitive functioning can interfere with follow-up care and treatment adherence. Tailor the plan of care to the patient's needs and capacities. Document the patient's medical conditions and functional status with cognizance of disability determination procedures required for Federal assistance under SSI/SSDI (Quick, Zevin and O'Connell, 2004). Facilitate applications for disability assistance and SSI-related Medicaid.
- **Dual diagnoses** Recognize that individuals with either a non-addictive mental health disorder or a psychoactive substance use disorder are at increased risk for developing co-occurring disorders. In clinical samples, the lifetime prevalence of co-occurring mental health and substance use disorders exceeds 50 percent (Winarsky, 1998). The presence of one condition should prompt screening for and assessment of co-occurring conditions. In dually diagnosed patients, both conditions should be viewed as primary; outcomes improve when care is provided in a comprehensive and integrated fashion (Drake et al., 2001). Motivational interviewing can be used to promote readiness for behavioral change in persons with co-occurring disorders (Miller and Rollnick, 2002). When the severity of the illnesses creates significant disability, consider referral to a mental health program while maintaining coordination between behavioral health care and primary care.
- **Loss of child custody** Patients with substance use disorders and/or mental illness may fear legal separation from their children. Realize that a parent who loses child custody may also lose access to shelter and benefits, and may not be able to get the child back until housing is obtained. Specify shelter options and other resources for parents whose children are placed in foster care. Refer the parent for addiction treatment/mental health care, to promote recovery and family reunification.

FOLLOW-UP

- **Contact information** Verify contact information at every visit. Ask where the patient is staying (shelter, street, doubled up with other families), where s/he usually sleeps or obtains meals and how s/he can be contacted (e.g., phone/cell numbers, e-mail address). Request emergency contact information — address and/or phone number of a family member, friend or case manager with a stable address.
- **Medical home** Encourage every patient to find one primary care provider (PCP) to coordinate health care. Be active in following up with the patient's regular PCP (if you are not that person) to communicate what has been done and facilitate continuity of care. Let the PCP know that the patient is living in a shelter; tell the patient/family you will contact their regular provider to share this information.
- **Frequency** Encourage more frequent follow-up visits for patients known to be homeless. Positive incentives can be used to encourage follow-up (e.g., snacks, clean socks, hygiene items or meal vouchers for every kept appointment or group meeting attended). Keep lines of communication open, even if the patient does not adhere to the plan of care.
- **Drop-in system** Anticipate, understand and accommodate unscheduled clinic visits. Create a drop-in time in primary care clinics with no appointment required, particularly for new patients. Encourage routine follow-up for established patients, supplemented by an open-door policy for drop-ins.
- **Transportation assistance** Help homeless patients arrange for transportation to and from clinic visits and specialty referrals. Help them connect with your state Medicaid program's non-emergency transportation system, if eligible, or provide transportation/carfare (e.g. bus tokens, taxi vouchers) to facilitate follow-up. Become familiar with transportation resources in your community. (For a list of Medicaid transportation contacts in each state, see: www.ctaa.org/ntrc/medical/contacts.asp.)
- **Outreach, case management** Collaborate with outreach workers and case managers to facilitate treatment adherence and follow-up care, including referrals to other facilities. A premature infant born to a homeless mother should be reconnected to an established Premie Follow-up Clinic and early intervention program, where available. Connect with homeless outreach programs, homeless health care providers, homeless coalitions or other advocates for underserved populations in your community. (For information about Health Care for the Homeless projects in your area, see: www.hchirc.bphc.hrsa.gov/directory.)

- **School attendance** For a patient of school age, monitor missed school days due to illness. Work with the patient, family, and school to address health and developmental problems of homeless children that interfere with learning and emotional stability, and to help homeless adolescents remain in school or obtain a graduate equivalency diploma (GED). Develop a relationship with the School District Homeless Liaison.
- **Peer support** Provide a client advocate to accompany the patient to appointments for diagnostic tests or ambulatory surgery.
- **Referrals** More aggressive referrals are needed for homeless patients who require access to professionals in multiple clinical disciplines. To facilitate access to specialists, develop referral relationships with providers willing to accept patients with Medicaid/Medicare or provide *pro bono* care for those ineligible for public health insurance. Refer the patient or family to community resources/social services if there are psychosocial problems that may interfere with adherence. Provide a client advocate to accompany homeless patients to appointments for diagnostic tests or ambulatory surgery.

Model of Care

SERVICE DELIVERY DESIGN

- **Multiple sites** Provide care where homeless people congregate, at multiple points of service (e.g., clinics, drop-in centers and outreach sites), as feasible. Consider using electronic medical records to promote continuity of care among multiple service sites.
- **Integrated, interdisciplinary services** Coordinate medical and psychosocial services across multiple disciplines and delivery systems, including the provision of food, housing, bathing facilities and transportation to service sites. Optimally, medical and psychosocial services should be easily accessible at the same location; fragmented service systems do not work well for homeless people. Resolution of the patient's homelessness is prerequisite to resolution of numerous health problems and should be a central goal of the health care team.
- **Flexible service system** Access to care for initial evaluation or ongoing treatment depends on the existence of a flexible service system that homeless individuals can use on a walk-in basis or through outreach workers. Provide drop-in centers or designated slots for walk-in clients in every primary care clinic so that appointments aren't necessary. Help to identify and resolve system barriers that impede access to care, recognizing that some barriers are not within the patient's capacity to control. Enlist the patient's assistance, and with his/her permission, utilize everyone in the community with whom s/he has contact to facilitate delivery of care.
- **Access to mainstream health system** Ensure that all homeless patients requiring referrals for secondary or tertiary care have access to the mainstream health care delivery system. Full collaboration between primary care providers and specialists is the only effective treatment and management strategy. Network with other community service providers who are sensitive to the needs of homeless patients to facilitate specialty referrals; assist with transportation and accompany patients to appointments. Frequently, the main problems for homeless clients are systems and access barriers rather than differences in intent or desire to adhere to a plan of care.

OUTREACH AND ENGAGEMENT

- **Outreach sites** Conduct outreach on the streets, in soup kitchens, in shelters and other places where homeless people receive services.
- **Clinical team** Use outreach workers and case managers to promote initial engagement with the patient. Hire staff proficient in languages used by the populations served. Involvement of all members of the clinical team (outreach workers, case managers, medical providers, mental health professionals, substance abuse counselors and a nutritionist) in care planning and coordination is important to facilitate engagement, diagnosis, treatment and follow-up of persons experiencing homelessness.
- **Therapeutic relationship** Nonjudgmental and supportive patient interactions with members of the clinical team are essential for successful engagement in a therapeutic relationship. Recognize that caring for homeless patients is as much about building relationships as about clinical expertise.
- **Incentives** Offer incentives to promote engagement – e.g., food and drink (or meal vouchers), hygiene products (toothpaste, brushes, socks), subway/bus cards or tokens.

STANDARD OF CARE

- **Evidence-based medicine** Provide the same, evidence-based standard of care to patients who are homeless as to patients who have more resources. Elimination of health disparities between these patients and the general population should be a clinical goal.

CASE STUDY: HOMELESS ADULT

The patient is a 49-year-old African American male who complains of wheezing and breathing difficulty for the past two weeks. He has difficulty conversing. He has a cough, shortness of breath, and dyspnea on exertion. He says he wheezes constantly, especially at night. His symptoms are aggravated with activity and at night when the temperature drops and he sleeps in the shelter under a fan. The patient states that he has had asthma "for years" but not as a child, and usually uses Primatene Mist if he can't get inhalers. He was seen at the county hospital three days ago where he got three inhalers, but had them stolen while taking a shower at the mission. He denies fever or chills. He reports occasional chest pain but none now, a cough of green "flame," cold symptoms, and a history of bronchitis and pneumonia.

Medical history: The patient reports that he is allergic to penicillin and has seasonal allergies. He uses two or three inhalers — an Albuterol ("Arbitrol") inhaler 10-12 times daily, plus a green inhaler (2-3 times a day) and a white one. He used the Albuterol inhaler incorrectly during the interview (sprayed three times in mouth, then inhaled; shook inhaler again and repeated). He has been a tobacco smoker for over 30 years (one pack per day). He also smokes crack cocaine daily. He reports no intravenous drug use, but admits to consuming alcohol daily for "several" years. He uses Primatene Mist as needed, two unspecified antihypertensive drugs, one "water" pill (diuretic), and another (unidentified) pill. The patient has not had a flu shot or pneumococcal vaccine. He had a positive tuberculin (PPD) test and a chest X-ray months ago that was negative for tuberculosis. He has had hypertension for 10 years and was diagnosed with congestive heart failure three years ago. Prior to this diagnosis, he was using multiple inhalers and was sent to the hospital in congestive heart failure. He was hospitalized in 1999 for a myocardial infarction and pneumonia. He reports no other hospitalizations, but has had multiple asthma exacerbations and treatments. He has used steroids in the past. He denies any gastroesophageal reflux disease (GERD). He denies having psychiatric or emotional problems, acknowledging that he was hospitalized one time "for his nerves," but is unsure of the details. He says he never took psychotropic drugs and denies a depressed mood. His psychiatric evaluation does not indicate hallucinations or delusions; score of 52 on the Global Assessment Scale.

Physical examination: On examination, his respiratory rate is non-labored but rapid, with audible anterior and posterior wheezing. Peak Flows: 200, 210, 175. Blood pressure 157/100; pulse: 92; respiration rate: 24. Flat affect, teeth in poor repair; caries identified.

Social history/environment: Homeless for the past ten years, the patient lives in shelters and on the streets, and eats at missions or shelters. He works occasionally as a day laborer and says he was on welfare but is now on "penalty" (disenrolled for noncompliance with program requirements). Currently he has no income because of his chronic asthma. The patient completed the tenth grade. He is single and not in a relationship. He has no children or record of military service.

Assessment: Acute asthma/respiratory distress, poorly controlled; homeless; Stage I hypertension, uncontrolled, on unknown medications; history of cardiovascular disease; cognitive deficit related to medications and improper inhaler use; medication (inhaler) over-use; nicotine dependence; other substance abuse, possible dependence; mental illness/neurocognitive deficits; dental caries.

Plan: Clinic nebulized Albuterol treatments, steroid MDIs, spacers, diuretics, referral to case manager for housing and drug abuse treatment, biweekly clinic appointments for follow-up.

Outcome: Patient was completely compliant with medical treatment and entered a drug and alcohol program. Blood pressure, blood sugar, cholesterol and lipids all back to normal; diabetes and cardiovascular disease well controlled.

Aaron Strehlow, PhD, FNP-C, RN, Los Angeles, California, 2004

CASE STUDY: HOMELESS ADOLESCENT

The patient, a 19-year-old white female with mental illness, presents at the clinic with a complaint of side effects from Depo Provera (bleeding and undesired weight gain).

Social History: Her mother died in a car accident shortly after she was born. She was raised by her father and did not attend school. (Compulsory education was not enforced in the rural area of Alabama where she grew up.) At age 15, she was brought to a shelter in Birmingham following the death of her father, as an alternative to juvenile detention. There were no social services in her hometown. She has lived on the streets for the past three years, often feeding from dumpsters. Limited social skills and low literacy present serious barriers to employment. Currently she has no income and engages in sex work to support herself, which she describes as “taking up with somebody” so she has a place to stay. Initially engaged by the Mobile County Mental Health Outreach team, the patient was almost 19 when she was first seen by mental health services.

Medical history: The first time she was brought to the clinic, the patient was diagnosed as low functioning with schizophrenia and multiple sexually transmitted infections (trichomonas, gonorrhea and syphilis). No significant health problems were identified other than mental illness and her developmental disability. She had no disability benefits and no other health insurance, but did qualify for family planning services under the State's Medicaid program.

Contraceptive history: Acknowledging her life style, the provider talked to the patient about birth control, and she agreed to try Depo Provera. She returned to the clinic because of concern about bleeding, a known side effect that is usually temporary. Despite attempts to reassure the patient, she was unable to understand that the bleeding probably would not persist longer than three months. She was immensely frightened by the bleeding and worried also about weight gain following her first Depo injection. Birth control pills combined with condom use were offered as an alternative, to protect against pregnancy and sexually transmitted infections.

Physical examination: Routine, including complete breast, thyroid, heart, abdomen, and pelvic exam.

Labs: hematocrit, hemoglobin, STD screening (HIV, VDRL, culture for gonorrhea, chlamydia, wet prep), Pap smear, urinalysis, blood sugar.

Medications: Prolixin, IM; Cogentin; Orthonovum 7-7-7.

Follow-up: The patient frequently encounters HCH staff on the street to report lost pills. When given 3-4 months' supply of birth control pills at a time, she would constantly lose them. When the prescription was limited to one pill pack per month, she seemed to appreciate coming by the clinic more frequently for the social interaction, sometimes to talk, other times just to get the pills, which are kept in a special place for her.

Current assessment: family planning, history of mental illness

Plan: Continue on Orthonovum 7-7-7; dispense only one pill pack per month. Follow up with mental health services to assure that the patient is addressing her mental health problems. Work with case manager to help patient apply for disability assistance and find permanent housing.

Outcome: With assistance from homeless mental health outreach staff, the patient was admitted to transitional housing and is currently residing in a group home.

Sharon Brammer, FNP, Mobile, Alabama, 2002

CASE STUDY: HOMELESS CHILD

Presentation: D.H. is a 2 1/2-year-old African American male who presented with the complaint of wheezing. He and his mother are residing in an overnight shelter and were seen in the day shelter for women and children. The child goes to a local clinic and has lived his whole life in Baltimore.

Medical history: The patient's last well-child check-up was six months ago, when his diagnosis was asthma, speech delay, and chronic otitis media. A hearing test was not ordered. His immunizations are up to date, according to his mother. Prescribed medications: Albuterol in a nebulizer for asthma. The nebulizer was last used one month ago.

D.H.'s mother stated that he does not listen to her, especially when she calls to him from a distance. He has never been seen by an ear, nose and throat (ENT) specialist, although his mother stated that his primary care provider (PCP) had mentioned that this referral may be made.

Physical exam: The tympanic membranes were noted to be retracted on examination, with decreased light reflex and mobility. On further questioning, the patient's mother stated that he had an "ear infection" for a "whole year" last year. He was last treated six months ago. His mother stated that she often did not complete the entire course of medication, but would stop when the child felt better or when she moved from one relative to another and left the medication at the previous house.

Treatment & follow-up: Amoxicillin was ordered, the prescription was filled, and the patient's regular PCP was notified of the treatment given and the family's current living situation. The PCP was encouraged to order an ENT referral as soon as possible so that follow-up can occur while the family is still in shelter.

Outcome: Patient was referred for ENT assessment by the primary care provider. PE tubes were inserted and the child's chronic infection resolved. Because the family was homeless, the PCP referred them to a case manager for assistance with follow-up and transportation.

Betty Schulz, CPNP, RN, Baltimore, Maryland, 2002

PRIMARY SOURCES

HCH Clinicians' Network. *Adapting Your Practice: Treatment and Recommendations for Homeless Patients with Cardiovascular Diseases: Hypertension, Hyperlipidemia, and Heart Failure.*

Nashville, Tennessee: National Health Care for the Homeless Council, 2004:

www.nhchc.org/clinical/2.28.04CVDguide.pdf

HCH Clinicians' Network. *Adapting Your Practice: Treatment and Recommendations for Homeless Patients with HIV/AIDS.* Nashville, Tennessee: National Health Care for the Homeless Council,

2003: www.nhchc.org/Publications/HIVguide52703.pdf

HCH Clinicians' Network. *Adapting Your Practice: Treatment and Recommendations for Homeless Patients with Asthma.* Nashville, Tennessee: National Health Care for the Homeless Council,

2003: www.nhchc.org/Publications/asthma.pdf

HCH Clinicians' Network. *Adapting Your Practice: Treatment and Recommendations for Homeless Children with Otitis Media.* Nashville, Tennessee: National Health Care for the Homeless

Council, 2003: www.nhchc.org/Publications/otitis.pdf

HCH Clinicians' Network. *Adapting Your Practice: Treatment and Recommendations on Reproductive Health Care for Homeless Patients.* Nashville, Tennessee: National Health Care for

the Homeless Council, 2003: www.nhchc.org/Publications/reproductive.pdf

HCH Clinicians' Network. *Adapting Your Practice: Treatment and Recommendations for Homeless Patients with Chlamydial or Gonococcal Infections.* Nashville, Tennessee: National Health Care

for the Homeless Council, 2003: www.nhchc.org/Publications/STDs.pdf

HCH Clinicians' Network. *Adapting Your Practice: Treatment and Recommendations for Homeless Patients with Diabetes Mellitus.* Nashville, Tennessee: National Health Care for the Homeless

Council, 2002: www.nhchc.org/Publications/clinical_guidelines_dm.pdf

OTHER REFERENCES

- Baumohl J (Editor). *Homelessness in America*. National Coalition for the Homeless. Phoenix: The Oryx Press, 1996. ISBN 0-89774-869-7: www.nationalhomeless.org/oryx.html
- Bassuk EL, Buckner JC, Perloff JN, Bassuk SS. Prevalence of mental health and substance use disorders among homeless and low-income housed mothers; *Am J Psychiatry* 155: 1561–1564, 1998.
- Brickner, PW (PI). Stopping the Spread of Tuberculosis Using Ultra-violet Germicidal Irradiation (UVGI) in Homeless Shelters, The National TB Project. October 1998, 1–3.
- Browne A and Bassuk SS. Intimate violence in the lives of homeless and poor housed women; *Am J Orthopsychiatry*; 67(2): 261–278, 1997.
- Buchanan D, Doblin B, and Garcia P. Respite Care for Homeless People Reduces Future Hospitalizations. *Journal of General Internal Medicine*. 18(s1):203, April 2003.
- Buckner JC, et al., Homelessness and its relation to the mental health and behavior of low-income school-age children, [Worcester, Massachusetts], *Dev Psychol*, 35(1): 246–57, January 1999: www.tbhf.org/public.html.
- Burroughs J et al. Health concerns of homeless women. In Brickner, P.W. et al. (Eds.) *Under the Safety Net: The Health and Social Welfare of the Homeless in the United States*. New York: W.W. Norton & Co., 1990: 139–150.
- Burt MR, et al. *Homelessness: Programs and the People They Serve – Findings of the National Survey of Homeless Assistance Providers and Clients*. The Urban Institute, December 7, 1999 [technical report]: www.urban.org/housing/homeless/homeless-tech.html
- CDC. Reported Tuberculosis in the United States, 2002: Table 26. Tuberculosis cases by homeless status: www.cdc.gov/nchstp/tb/surv/surv2002/PDF/T26.pdf
- Cochran BN, Stewart AJ, et.al. Challenges faced by homeless sexual minorities: Comparison of gay, lesbian, bisexual, and transgender homeless adolescents with their heterosexual counterparts; *American Journal of Public Health*, 92(5):773–7, May 2002.
- Connor SE, Cook RL, Herbert M, Neal SM, Williams JT. Smoking cessation in a homeless population: There is a will, but is there a way? *Journal of General Internal Medicine*, 17(5): 369–372, 2002.
- Drake RE, Essock SM, Shaner A, et al. Implementing dual diagnosis services for clients with severe mental illness. *Psychiatric Services*, 52: 469–476, 2001.

- Garfein RS, Doherty MC, et al. Prevalence and incidence of hepatitis C virus infection among young adult injection drug users; *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology*; 18(Supp1): S11-S19, 1998.
- Gay and Lesbian Medical Association. *A Healthy People 2010 Companion Document for Lesbian, Gay, Bisexual, and Transgender (LGBT) Health*, April 2001:
www.glma.org/policy/hp2010/index.html
- Gelberg L, Linn LS, Mayer-Oakes SA. Differences in health status between older and younger homeless adults. *Journal of the American Geriatric Society*, 38(11): 1220–9, Nov 1990.
- Goldfinger SM et al. HIV, homelessness, and serious mental illness: Implications for policy and practice. Delmar, NY: National Resource Center on Homelessness & Mental Health, March 1998.
- Gonzalez EA et al. Neuropsychological evaluation of higher functioning homeless persons: A comparison of an abbreviated test battery to the mini-mental state exam. *Journal of Nervous and Mental Disease*; 189(3): 176–181, 2001.
- Grant R, Sherman P, Kory WP, Lambert M, Redlener I (The New York Children's Health Project). The clinical benefits of facilitated specialist referral in a high risk pediatric population, presented at the Academy for Health Services Research annual scientific conference, 2000; 2002 data accepted for presentation at the Academy for Health Services Research, June 2004.
- HCH Clinicians' Network. Eliciting Behavioral Change; *Healing Hands* 4(3): June 2000:
www.nhchc.org/Network/HealingHands/2000/hh.06_00.pdf
- Hwang SW, Lebow JM, Bierer MF, O'Connell JJ, Orav EJ, Brennan TA. Risk factors for death in homeless adults in Boston. *Arch Intern Med* 1998; 158: 1454–1460.
- Institute for Children and Poverty. *Homeless in America: A Children's Story*, Part One, p. 15, 1999: www.homesforthehomeless.com/facts.html.
- Institute of Medicine. *Homelessness, Health, and Human Needs*. Washington, DC: National Academy Press, 1988: <http://books.nap.edu/books/0309038324/html/index.html>
- Kushel MB, Evans JL, Perry S, Robertson MJ, Moss AR. No door to lock: Victimization among homeless and marginally housed persons; *Arch Intern Med*; 163(20): 2492–9, 2003.
- McMurray-Avila M, Gelberg L, Breakey WR. Balancing act: Clinical practices that respond to the needs of homeless people. HUD/HHS Symposium on Homelessness Research, 1998:
<http://aspe.hhs.gov/progsys/homeless/symposium/8-Clinical.htm>

- McLean DE, Bowen S, Drezner K, Rowe A, Sherman P, Schroeder S, Redlener K, Redlener I. Asthma among homeless children: Undercounting and undertreating the underserved; *Arch Pediatr Adolesc Med.*;158: 244–249, 2004:
- Nardell EA and Brickner PW. Tuberculosis in New York City: Focal transmission of an often fatal disease; *JAMA*, October 16, 1996; 276(15):1259–1260.
- National Center on Family Homelessness (formerly the Better Homes Fund). *Homeless Children: America's New Outcasts*, June 1999.
- Noell J et al. Childhood sexual abuse, adolescent sexual coercion and sexually transmitted infection acquisition among homeless female adolescents; *Child Abuse and Neglect*; 25(1): 137-48, Jan 2001.
- Noell JW and Ochs LM. Relationship of sexual orientation to substance use, suicidal ideation, suicide attempts, and other factors in a population of homeless adolescents; *Journal of Adolescent Health*, 29(1):31–6, Jul 2001.
- O'Connell JJ. *Utilization & Costs of Medical Services by Homeless Persons: A Review of the Literature & Implications for the Future*. National Health Care for the Homeless Council: April 1999: www.nhchc.org/Publications/utilization.htm
- Rew L et al. Sexual abuse, alcohol and other drug use, and suicidal behaviors in homeless adolescents; *Issues in Comprehensive Pediatric Nursing*; 24(4): 225–40, Oct-Dec, 2001.
- Robertson MJ and Toto PA, Homeless youth: Research, intervention, and policy, National Symposium on Homelessness and Research, 1998: <http://aspe.hhs.gov/progsys/homeless/symposium/3-Youth.htm>
- Sachs-Ericsson N, et al. Health problems and service utilization in the homeless. *J Health Care Poor and Underserved*, 10(4): 443–452, 1999.
- Song JY. *HIV/AIDS & Homelessness: Recommendations for Clinical Practice & Public Policy*. National Health Care for the Homeless Council, November 1999: www.nhchc.org/HIV.pdf
- Scanlon BC and Brickner PW. Clinical concerns in the care of homeless persons. In: Brickner PW, Scharer LK, Conanan BA, Savarese M, Scanlan BC. *Under the Safety Net: The Health and Social Welfare of the Homeless in the United States*. New York: WW Norton & Co., 1990: 69–81.
- Staab JP and Evans DL. A streamlined method for diagnosing common psychiatric disorders in primary care; *Clin Cornerstone* 3(3):1–9, 2000. © 2000 Excerpta Medica, Inc.: www.medscape.com/viewarticle/407396_1 (Posted 01/01/2001).

Tyler KA et al. Predictors of self-reported sexually transmitted diseases among homeless and run-away adolescents; *Journal of Sex Research*; 37(4): 369–77, 2000.

U.S. Conference of Mayors. 2003 Hunger and Homelessness Survey: www.usmayors.org/

Winarski JT. *Implementing Interventions for Homeless Individuals with Co-occurring Mental Health and Substance Use Disorders: A PATH Technical Assistance Package*. Rockville, MD: Center for Mental Health Services/Substance Abuse and Mental Health Services Administration/ U.S. Department of Health and Human Services, 1998: http://pathprogram.samhsa.gov/pdf/implementing_interventions.pdf

Wright JD. Poor People, Poor Health: The health status of the homeless. In: Brickner PW, Scharer LK, Conanan BA, Savarese M, Scanlan BC. *Under the Safety Net: The Health and Social Welfare of the Homeless in the United States*. New York: WW Norton & Co., 1990: 15–31.

Zima BT, Wells KB, Benjamin B, Duan N. Mental health problems among homeless mothers: Relationship to service use and child mental health problems. *Arch Gen Psychiatry* 53: 332–338, 1996.

SUGGESTED RESOURCES

HCH Clinicians' Network. *Healing Hands*, a bimonthly publication for clinicians serving homeless individuals. 1998–2004 issues available at: www.nhchc.org/healinghands.htm

Holzwarth J. *Addressing Cultural and Linguistic Competence in the HCH Setting: A Brief Guide*. National Health Care for the Homeless Council, 2002: www.nhchc.org/Cultural/index.htm

Kraybill K. *Outreach to People Experiencing Homelessness: A Curriculum for Training Health Care for the Homeless Outreach Workers*. National Health Care for the Homeless Council, June 2002: <http://www.nhchc.org/Curriculum/curriculum.htm>

Kraybill K and Zerger S. *Providing Treatment for Homeless People with Substance Use Disorders: Case Studies of Six Programs*. National Health Care for the Homeless Council, August 2003: www.nhchc.org/Advocacy/FactSheets/CA05RCasestudies-FINAL5.pdf

McMurray-Avila M. *Homeless Veterans: A Resource Guide for Providers*. National Health Care for the Homeless Council, April 2001: www.nhchc.org/Publications/HomelessVetsHealthCare.pdf

McMurray-Avila M. *Organizing Health Services for Homeless People*, 2nd Edition. ISBN: 0971165092. Nashville: National Health Care for the Homeless Council, Inc., 2001. Table of contents, ordering information at: www.nhchc.org/Publications.

McMurray-Avila M. *Medical Respite Services for Homeless People: Practical Models*. National Health Care for the Homeless Council, December 1999:

www.nhchc.org/Publications/MedicalRespiteServices.pdf

Melnick SM and Bassuk EL. *Identifying and Responding to Domestic Violence Among Poor & Homeless Women*. The Better Homes Fund, February 2000: www.nhchc.org/Publications/domesticviolence.htm

Miller WR and Rollnick S. *Motivational Interviewing: Preparing People to Change Addictive Behavior*, 2nd Edition. ISBN: 1572305630. New York: Guilford Press, 2002.

Morse G. A review of case management for people who are homeless: Implications for practice, policy, and research. Presented at the HUD/HHS Conference on Homelessness Research, October 1998: <http://aspe.hhs.gov/progsys/homeless/symposium/7-Casemgmt.htm>

National Center on Family Homelessness, Health Care for the Homeless Clinician's Network. *Social Supports for Homeless Mothers*, 2004: <http://www.familyhomelessness.org/SupportsForHomelessMothers.pdf>

National Health Care for the Homeless Council. *Health Care for the Homeless: An Introduction*. 22 minute video and user's guide, June 2001. To order: www.nhchc.org/Publications/

National Health Care for the Homeless Council. *Health Care for the Homeless: Outreach*. 21 minute video, June 2001. To order: www.nhchc.org/Publications/

O'Connell JJ (Editor). *The Health Care of Homeless Persons: A Manual of Communicable Diseases and Common Problems in Shelters and on the Streets*. Boston Health Care for the Homeless Program, June 2004.

Post P. *Casualties of Complexity: Why Eligible Homeless People Are Not Enrolled in Medicaid*. National Health Care for the Homeless Council, May 2001: www.nhchc.org/Publications/CasualtiesofComplexity.pdf

Post P. *Hard to Reach: Rural Homelessness & Health Care*. National Health Care for the Homeless Council, February 2002: www.nhchc.org/Publications/RuralHomeless.pdf

Quick PD, Zevin BD, O'Connell JJ. *Documenting Disability: Simple Strategies for Medical Providers*. National Health Care for the Homeless Council, 2004: www.nhchc.org/Publications/

Zerger S. *Chronic Medical Illness and Homeless Individuals: A Preliminary Review of Literature*. National Health Care for the Homeless Council, April 2002: www.nhchc.org/Publications/literaturereview_chronicillness.pdf

Zerger S. *Health Care for Homeless Native Americans*. National Health Care for the Homeless Council, February 2004. www.nhchc.org/Publications/FINALHnNativeHealth.pdf

WEBSITES

Association of Clinicians for the Underserved	www.clinicians.org/
Health Care for the Homeless Information Resource Center	www.bphc.hrsa.gov/hchirc/
Health Disparities Collaboratives	www.healthdisparities.net/
Institute for Children and Poverty	www.homesforthehomeless.com/
Migrant Clinicians' Network	www.migrantclinician.org/
National Center on Family Homelessness (previously The Better Homes Fund)	www.familyhomelessness.org/
National Coalition for the Homeless	www.nationalhomeless.org/
National Health Care for the Homeless Council/ HCH Clinicians' Network	www.nhchc.org
National Resource Center on Homelessness & Mental Illness	www.nrchmi.com/

ABOUT THE HCH CLINICIANS' NETWORK

Founded in 1994, the Health Care for the Homeless Clinicians' Network is a national membership association that unites care providers from many disciplines who are committed to improving the health and quality of life of homeless people. The Network is engaged in a broad range of activities including publications, training, research and peer support. The Network is operated by the National Health Care for the Homeless Council, and our efforts are supported by the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, and member dues. The Network is governed by a Steering Committee representing diverse community and professional interests.

To become a member or order Network materials, call 615 226-2292 or write to network@nhchc.org. Please visit our Web site at www.nhchc.org.