HIV/AIDS Care for Homeless Patients: Summary of Recommended Practice Adaptations

Health Care for the Homeless Clinicians' Network

MODEL OF CARE

Service Delivery Design

- **Flexible service system** – Allow walk-in appointments, provide outreach services; identify and resolve system barriers that impede access to care.
- **Integrated, interdisciplinary model of care** – Coordinate medical and psychosocial services across multiple disciplines and delivery systems, including provision of healthful food, clothing, hygiene items, housing, and transportation to service sites.
- **Access to mainstream health care system** – Network with community service providers to facilitate specialty referrals; assist with transportation; accompany patients to appointments.

Engagement

- **Outreach** – Use outreach workers, lay educators, and peer advocates to help locate hard-to-reach individuals and encourage them to obtain medical care. Offer diagnostic testing and treatment at outreach sites.
- **Clinical team** – Include professionals and paraprofessionals with strong engagement skills; listen to patients in nonjudgmental way; address psychosocial barriers to health as well as medical issues; employ intensive case management model.
- **Therapeutic relationship** – Build mutual trust with patient. Recognize that engagement of homeless patients often takes a long time. Promote provider retention and continuity of patient care.

DIAGNOSIS & EVALUATION

History

- **Review of systems** – Identify symptoms requiring immediate intervention; assess for chronic symptomatology.
- **Current living situation** – Ask where the patient sleeps and spends time during day; document patient contact information and specify how to contact clinical team. Ask about access to food, shelter, restrooms, place to store medications, options for stable housing.
- **History of homelessness** – Ask if this is first time without a home; determine whether lack of stable living situation is chronic or episodic. Explore circumstances that precipitated homelessness and available housing options acceptable to the patient.
- **Social history** – Ask about family, extended family, current social supports who might make decisions in the event of serious illness requiring hospitalization. Build trust before initiating discussions about advance directives, end-of-life care.
- **Regular activities** – Ask if the patient has a schedule or daily routine; assess whether a medical regimen can be integrated into regular activities. Explore ways to improve quality of life, motivation, and capacity for self-care.
- **Medical history** – Ask if ever hospitalized; if so, why. Ask if ever diagnosed with HIV; if so, when and how infected. Inquire about initial, lowest, most recent CD4 counts, last viral load, history of OIs. Ask if ever treated for HIV; if so, which medications were taken and for how long. Inquire about side effects, any medication changes/ discontinuations.
- **Previous providers** – Ask why the patient is changing services/ providers and what his/ her expectations are. Contact prior provider(s) to discuss transfer of care, specific issues.
- **Behavioral health history** – Ask if ever treated or hospitalized for a mental health or substance use problem, whether currently taking any medications. Evaluate mood, cognitive function, and general outlook. Ask about major stressors and coping mechanisms. Seek insight into the patient's emotional status and priorities.
- **History of abuse/ current risk** – Ask if ever physically hurt, afraid of being hurt, or forced to engage in sexual acts. Routinely assess for violence, abusive relationships, and patient safety.
- **Alcohol/ drug use** – Ask about current and previous use of alcohol and drugs, including nicotine and inhalants. Inquire about drug(s) of choice, frequency and pattern of use, IDU, injection practices, and access to clean needles. Ask how periods of sobriety were achieved.
- **Sexual history/ current practices** – Ask about specific sexual practices that may increase risk for HIV infection, and whether the patient has had sex with men and/or women. Ask about condom use and history of any sexually transmitted diseases.
- **Reproductive history** – Ask female patients about past/ current pregnancies, complications, whether any children were HIV-infected and if so, how treated.
- **Work history** – Ask what types of work the patient has done and longest time held a job. Ask about work-related illness, injuries, and toxic exposure (asbestos, silica, coal). Inquire about military service.
- **History of detention/ incarceration** – Ask if ever detained by police or incarcerated, about medical treatment during incarceration. Work with health care providers at local jails to promote continuity of care. Address risk of drug overdose after release with patients with history of detention/ incarceration who are using drugs (especially heroin).
- **Literacy** – Evaluate ability to read instructions in English or primary language in a non-threatening way.
- **Nutrition/ hydration** – Look for signs/ symptoms of malnutrition, dehydration. Ask about diet and eating habits; evaluate knowledge of proper diet, food resources, cooking skills, availability of cooking facilities. If the patient is not eating well, determine why. Inquire about access to water and other liquids.
- **Community** – Elicit information about cultural/ religious heritage and affiliations. Ask about attitudes of family, friends, community, cultural group toward HIV risk behaviors and persons who contract the virus.

Physical examination

- **Comprehensive vs. serial, focused examinations** – Do focused physical exams in outreach settings; reserve comprehensive exams for clinic; defer genital exam until the patient feels comfortable.
  Homeless women – Offer option of being examined by provider of same sex. Assess for cervical dysplasia, HPV, vaginal candidiasis, pregnancy, evidence of physical/ sexual abuse.
  Sexual minorities – Provide appropriate exam/ screening for biological male taking estrogen, female taking testosterone, patient who has had sexual reassignment surgery or silicon or other implant. Listen nonjudgmentally to concerns; provide compassionate care.
- **Touch therapy** – Express empathy with appropriate physical contact (hand shake, shoulder touch); but recognize that some patients may find physical contact threatening (pay attention to nonverbal signals).
- **Signs & symptoms of HIV complications** – Realize higher risks associated with homelessness for TB, bartonellosis, weight loss, dehydration, and change in mental status due to comorbidities. Examine for oral candidiasis and voral leukoplakia (especially new patients with limited access to health care/ no history of HIV test).
- **Dermatological exam** – Look for skin growths, rashes, and fungal infections in mouth, groin, feet. Pay special attention to genital and rectal warts, skin problems associated with IDU, and foot care. Be aware of medications that precipitate sensitivity to sun exposure.
- **Neurological/ psychiatric evaluation** – Assess for mental illness including PTSD, substance abuse, and cognitive impairment; explore possibility of underlying psychiatric condition(s) in patients with substance dependence.
- **Dental/ retinal exams** – Include dentist and optometrist/ ophthalmologist on clinical team; use portable equipment in outreach sites.

Diagnostic tests

- **HIV testing/ screening** – Use rapid testing in outreach settings and for homeless/ runaway youth. Provide direct linkage to health care providers and assertive case management to assure access to HIV care. Offer testing to partners and children of HIV+ persons, if not already tested (provide incentives).
- **Pre-test counseling** – Give patient the option to decline HIV test; invite questions, offer information about what the test means.
- **Confirmatory test** – If initial screening test (oral mucosal, rapid test or standard blood test) is positive, do confirmatory test (Western blot/ immunofluroescence assay).
- **Post-test counseling** – Be sure the patient is engaged in care when a positive test result is communicated. Be personally available, listen, maintain contact. Use peer counselors (HIV-infected homeless/ formerly homeless individuals who have done well) to provide social support.
- **Laboratory tests** – ***Baseline labs:*** CBC, electrolytes, glucose, BUN, creatinine, liver function tests, lipid studies, urinalysis, toxoplasmosis gondii IgG antibody, RPR or VDRL, hepatitis A antibody total (Hep A, Total), hepatitis B surface antibody (HBsAb), hepatitis B surface antigen (HBsAg), and hepatitis C antibody (Hep C Ab). Pay more attention to liver function tests in homeless patients, whose risk for liver damage (secondary to hepatitis, alcoholic cirrhosis) is high. Regularly monitor liver function in patients on ART, hormones, HBV/ HCV treatment.
- **HIV Viral load** – Perform HIV viral load test (e.g., HIV-1 RNA quantitative assay or branched chain DNA assay (bDNA)) at baseline exam and every 3-4 months if the patient is stable on therapy. Also check HIV viral load when acute retroviral syndrome is suspected. Avoid HIV RNA assay following single positive rapid antibody test unless the patient reports prior positive HIV test.
- **HIV-1 Resistance testing** – Baseline genotypic resistance testing is recommended for all patients prior to initiation of ART and for treatment failure with HIV-1 RNA levels > 500-1000 copies/ml while taking failing regimen. Resistance testing is important even for treatment-naïve patients, 6-16% of whom have at least one major resistance mutation in their wildtype virus prior to starting ART.
- **HLA*B-5701 testing** – Test all patients for HLA*B-57 prior to initiating regimen containing abacavir (if assay available). Abacavir is contraindicated for any patient testing positive for HLA*B-57 (50% chance of severe hypersensitivity reaction).
- **Tuberculin test** – Test HIV+ patient for latent TB using TST/ PPD or blood assay test (QFT-g). Re-check homeless patients with negative result every 6 months; for those testing positive, do baseline chest X-ray and symptom screen every 6 months regardless of CD4 count. Collaborate with local health department for TB surveillance, screening and referrals to help decrease barriers to care. Provide written record of TB test results on wallet-sized card.
- **Hepatitis testing** – Test every HIV+ patient for HCV and screen annually. Test for immune response (anti-HBs) after HBV vaccination; consider double dose of vaccine if no immune titers; consider HBV DNA testing of patients with unexplained increased liver enzymes. Test for immunity (see Baseline labs) and vaccinate for hepatitis A accordingly.
- **Cancer/ STI screening** – Pap smear (for cancer, HPV) for all HIV+ women every 6 months until 2 normal PAPs, then once per year. GC/ clamydia and RPR or VDRL testing at baseline, then annually. Consider anal Pap smear and tests for rectal *N. gonorrhoeae* and *C. trachomatis* infection at baseline and annually in MSM and any patient with history of anogenital condylomata.
- **Pregnancy test** – Offer UCG urine test to sexually active female patients of childbearing age.

PLAN & MANAGEMENT

Plan of Care

- **Next steps** – Develop plan of care with the patient's active involvement. Specify next steps to expect; reassure the patient they need not be done right away.
- **Interdisciplinary team** – Include addiction/ mental health counselors, medical care manager, and treatment advocate on the clinical team. Every member of the team should engage in care planning/ coordination and patient education.
- **Basic needs** – Develop strategies with the patient to meet basic needs (food, clothing, housing, mental health issues) as part of individualized plan of care.
- **Patient priorities & goals** – Assess the patient's priorities in meeting immediate and long-term needs. Address immediate medical needs first (patient's reason for the visit) rather than underlying causes.
- **Governmental assistance** – Assist with applications for programs that facilitate access to health and social services (Ryan White, HOPWA, SSI/ SSDI, Medicaid, Food Stamps).
- **Communication** – Do not criticize the patient; speak in a straightforward, nonjudgmental manner. Elicit feedback regarding the patient's

understanding of the plan of care. Use an interpreter or lay educator to facilitate communication and assure culturally competent care for patients with limited English proficiency.

Education, Self-Management

- **Basic education about HIV** – Teach HIV-infected patients how to know if they are sick, how to tell if illness is serious, how to care for self when sick, when to seek urgent/ emergent care. Specify where to get medicine and where to go to recuperate when ill.
- **HIV transmission** – Review safer sexual practices; facilitate access to condoms. Teach IV drug users risk reduction strategies: self-administered injections, avoid sharing drug paraphernalia, use of needle exchange program. Stress antiretroviral prophylaxis to reduce perinatal transmission of infection. Help HIV-infected mothers who are homeless determine most appropriate infant feeding option, depending on individual circumstances (exclusively formula feed or breastfeed; don't alternate between the two).
- **Prevention** – Discuss ways to reduce HIV risks for the patient and others. Promote behavioral change through individual, small group, and community interventions based on investigation of actual patient behaviors and structural barriers to desired change. Use motivational interviewing, risk reduction techniques, and social skills training. Reinforce information with interactive activities involving repetition, positive feedback, and acting out new skills.
- **Addiction management** – Realize that a history of drug abuse does not preclude successful treatment for HIV. Tailor HIV care to needs of the patient; look for evidence of a stable routine to evaluate readiness for ART. Use outreach and intensive case management to facilitate engagement in care. For patients able to integrate medical regimen into daily routine, use peer educators and counselors to facilitate adherence. For those not ready for ART, promote harm reduction, treat comorbidities, and prescribe OI prophylaxis. Educate the patient about potential interactions between drugs of abuse and antiretroviral medications.
- **HIV therapy** – Assure HIV-infected homeless patients that they can manage treatment successfully. Explore their understanding of HIV therapy. Explain what CD4 counts and viral loads are and how these measurements are used.
- **Written instructions/ reminders** – Specify when to take medications each day; confirm understanding of medical regimen. If trouble reading, refer to member of clinical team who can spend more time explaining instructions; offer referral to literacy/ ESL program. Specify any dietary restrictions associated with medications. Ask shelter staff to remind the patient to take medications.
- **Drug resistance** – Explain risk of developing resistance to HIV medications if not taken consistently or appropriately, but stress importance of ART.
- **Treatment advocates** – Use social workers, nurses, or case managers as liaisons between the patient and providers to promote successful treatment adherence.
- **Directly observed therapy** – Use DOT for patients with co-occurring TB, substance use disorders, and/or mental illness; provide transportation assistance to bring them to the clinic once daily to take medications.
- **Side effects management** – Be candid about possible side effects of ART (e.g., diarrhea). Ask what side effects the patient has noticed; if no medical alternative with fewer/ less severe side effects is available, explore strategies to minimize/ accommodate them. Provide snacks.
- **Urgent medical problems** – Explain symptoms of hypersensitivity to all prescribed medications. Stress need for prompt evaluation of: fever, new rash, difficulty breathing, abdominal/ back pain, vomiting, headache, vision changes. Tell the patient to go to a drop-in clinic or ER if feeling ill.
- **Supportive relationships** – Encourage supportive relationship with a provider, social worker, or friend. Link the patient with a sponsor in a community-based program. Offer social support groups in addition to groups for therapy or counseling. Help patients adapt to living in transitional housing.
- **Nutrition counseling** – Educate the patient about nutrition, diet, dietary supplements. Include a nutritionist/ dietician on the clinical team. Prescribe multivitamins, nutritional supplements with less familiar brand names/ lower resale value to reduce risk of theft.
- **Medical home** – Explain what primary care is, how to use a regular source of care, and how a relationship with provider(s) can help the patient avoid becoming acutely ill.
- **Education of service providers** – Educate all service providers about HIV and the need for nonjudgmental, compassionate care. Explain to medical providers how treatment adherence and successful outcomes are possible even for homeless individuals with behavioral health problems. Educate primary care providers about management of chronic pain and addictions. Understand your own feelings about substance use, sex work, mental illness, homelessness; seek insight from more experienced providers.

Medications

- **Medical priorities** – Weigh benefits and risks of ART; if ART is not of clear benefit (i.e. if CD4 cell count >350 cells/ml). Address other medical priorities first: psychotropic therapy, management of substance abuse and uncontrolled chronic diseases such as hypertension, diabetes, seizures (which can interfere with HIV treatment).
- **OI Prophylaxis** – Explain importance of prophylaxis for opportunistic infections (OIs) at every visit if the patient is not initially interested in preventive treatment. Recognize that taking medications for OI prophylaxis regularly can be an indication of readiness for ART.
- **Immunizations** – Homeless patients should receive: influenza vaccine (annually), hepatitis A & B vaccine, Tdap (if no prior vaccination and 11-64 years of age; 1 booster dose if last immunization >10 years ago), and pneumococcal polysaccharide vaccine (PPV) every 5 years.
- **HIV treatment readiness** – Build therapeutic relationship and assure regular source of care before initiating ART. Encourage more frequent visits to prepare for treatment. Evaluate readiness for treatment and ability to adhere to plan of care: understand lifestyle, how basic needs are met; look for evidence of a daily routine. Address issues that may complicate adherence (e.g., mental illness, substance use). Involve the patient in making decision to begin ART.
- **"Practice" medications** – Consider use of placebos or vitamins as "practice medications" to demonstrate readiness/ lack of readiness for ART. (The patient must be aware that these tablets are not ART.) Not recommended for patients with CD4 <200 for whom ART is urgent.
- **Antiretroviral medications** – Be knowledgeable about HIV treatment alternatives. Individualize initiation of ART and continually reassess treatment adherence and effectiveness. Ensure access to medications that can be taken once or twice daily.
- **HIV specialist** – Partner with an HIV specialist through consultation or referral; if > 5 patients are HIV+, consider developing expertise in treatment of HIV/AIDS yourself. Optimally, HIV specialist should be part of the clinical team.
- **Simple regimen** – Prescribe the simplest, most effective ART regimen possible; once daily dosing is optimal, if clinically indicated. If prescribing TMP-SMX DS for PCP, one dose per day is preferable, but 3 times per week is acceptable. Don't undertreat HIV or OI just because the patient is

homeless.

- **Dietary restrictions** – Inquire about access to regular meals. If possible, prescribe medications without dietary restrictions.
- **Side effects** – Be more aggressive with homeless patients in treating side effects or changing medication, if an equally effective alternative is available.
- **Drug toxicities** – Be aware of serious toxicities associated with ART. Screen for HLA-B5701 before prescribing abacavir. Review symptoms of hypersensitivity with the patient.
- **Drug interactions/ contraindications** – Monitor all patients on ART for development of glucose intolerance, diabetes, lipid abnormalities, lipodystrophy.
  Methadone – Be aware that NNRTIs and certain protease inhibitors can reduce methadone efficacy by as much as 50%. If protease inhibitor is indicated, use ritonavir boosting or work directly with methadone maintenance treatment program to adjust dosage upward. Recognize that successful adherence to methadone therapy for persons addicted to heroin can increase adherence to ART.
  Other analgesics – Be aware that some HIV medications can decrease/ increase efficacy of pain medications, including narcotics. Work with the patient to understand underlying cause of pain; prescribe appropriate pain medication and document why you prescribed it. To avoid contributing to drug-seeking behavior, make a contract with the patient specifying the plan of care and designating a single provider for pain prescription refills.
- **HIV treatment & substance use** – Prescribe medications compatible with substances used. If ART is desired and there is evidence the patient can adhere to the medical regimen despite substance use, suggest taking HIV medications before using other drugs.
- **Drug resistance** – Use genotype or phenotype testing to inform choice of therapy. Individualize therapy; balance possible side effects with simplicity and low resistance barrier with tolerability. Select initial treatment regimen to which the patient can adhere, preferring medications with a low pill burden where possible.
- **Adherence monitoring** – At every visit, ask how many doses of each medication were missed over the last week/ month. Explore and address barriers to adherence. Problem solve with the patient; if forgetting doses is a problem, use pill boxes/ watch alarms/ other methods to help patient remember medications. Address adherence routinely so problems are identified before the patient develops resistance and fails regimen. (N.B.: CD4 decrease or viral load rebound is sign of treatment failure, very late stage marker of adherence.)
- **Medication storage** – Allow homeless patients to store medications at clinic and come there daily for treatment. If the patient does not have access to refrigeration, avoid prescribing medications that require it (e.g., ritonavir). Urge shelter staff to make stored medications easily available to residents.
- **Access to medications** – Assure continuous access to medications before initiating treatment. Provide transportation to pick up medications or arrange for delivery to a reliable location acceptable to the patient.

Associated problems, complications

- **Medication side effects** – Recognize that medications which interfere with survival on the streets by making people feel sicker or more fatigued will not be acceptable to homeless patients. Be more aggressive in treating side effects or changing medication for homeless patients if an equally effective alternative is available.
- **Severe drug toxicities** – Be aware of life-threatening complications of ART and how to manage adverse effects (e.g., medication hypersensitivity reaction, hepatic necrosis, Stevens Johnson Syndrome, pancreatitis, lactic acidosis).
- **More acute illness** – Homeless people with HIV/AIDS often present with more advanced disease, exacerbated by OIs and other comorbidities. Provide/ refer to medical respite facility where homeless patients can convalesce following hospitalization or when ill, or receive end-of-life care.
- **Co-occurring mental illness & substance dependence** – Treat co-occurring disorders simultaneously within the same program. Involve a psychiatrist knowledgeable about cumulative side effects of polypharmacy who is interested in assessment and management of HIV-infected homeless patients with behavioral health disorders.
- **Cognitive impairment** – If the patient has difficulty remembering appointments, don't assume nonadherence; assess cognition. Explore etiology of cognitive problems (e.g., mental illness, chronic substance abuse, AIDS-related dementia, OIs); seek accurate diagnosis with specialty consult if necessary.
- **Hepatitis** – Treat HCV/ HBV in patients with co-occurring HIV. Consult a specialist. Be aware of association between antiretroviral drugs and hepatotoxicity; carefully monitor liver enzymes during ART. Seek psychiatric consult prior to initiating HCV therapy. For co-occurring alcoholism, use behavioral contract or other strategies concurrently with HCV treatment to promote sobriety and reduce risk of liver damage. When initiating ART in patient with HIV/ HBV coinfection, consider including lamivudine and tenofovir as part of a fully suppressive antiretroviral regimen. Immunize against HBV (especially IDUs). Immunize seronegative patients against HAV. For better treatment outcomes, facilitate access to supportive housing and behavioral health care.
- **Tuberculosis** – Do more frequent TB screening of HIV-infected homeless persons. If tuberculin test is positive, initiate isoniazid prophylaxis. Use directly observed TB/ HIV therapy to promote treatment adherence and reduce risk of drug resistant organisms.
- **Abuse** – Work with all service providers in clinics and shelters to protect homeless patients from physical assault and verbal abuse.
- **Pregnancy** – Ensure access to contraception to prevent unwanted pregnancies: medroxyprogesterone acetate q3 mo/ patch/ pill as well as male condoms or alternative barrier methods (female condom, diaphragm if desired). Develop good consulting relationships with obstetricians to help pregnant homeless patients with HIV. Facilitate Medicaid enrollment of infants born to HIV-infected mothers to expedite zidovudine therapy postnatally.
- **Lack of transportation** – Provide transportation assistance/ carfare to facilitate appropriate follow-up care.
- **Lack of stable housing** – Strongly advocate for low-barrier subsidized housing in your community for people living on the streets or in shelters, with no pre-requisite to achieve sobriety or attain a level of stability before housing is offered.
- **Financial barriers to HIV care** – Facilitate applications for SSI/ Medicaid or SSDI/ Medicare. Seed Ryan White services for patients with no/ limited health insurance coverage. Keep detailed records of functional impairments; secure representative to help patients apply for SSI/SSDI; develop working relationship with Disability Determination Services; ensure that consultative examinations are conducted by physicians with significant experience treating homeless patients. Advocate for all patients to obtain needed health care, regardless of insurance status.
- **Stigmatization** – Provide nonjudgmental, compassionate care and offer social support to homeless individuals, especially those with HIV/AIDS. Educate shelter staff about HIV/AIDS.
- **Incarceration** – Develop collaborative relationships with correctional facilities to assure appropriate discharge planning and continuity of care following release.

- **Special populations:**

  Homeless women – Offer social support and counseling to HIV-infected homeless women, many of whom have a history of abuse, can be harder to reach than men, and may require more intensive services.

  Homeless youth – When discussing behavioral change with runaway/ homeless youth, focus on immediate concerns rather than possible future consequences.

  Sexual minorities – Create a safe and nondiscriminatory clinical environment for HIV-infected GLBT patients; build trust and rapport; facilitate access to comprehensive health care and housing. Educate patients using injected hormones about clean needle exchange.

  Immigrants – Assure access to health care for individuals with infectious diseases, regardless of immigration status. Provide linguistically appropriate and culturally competent health services.

Follow-up

- **Contact information** – At every visit, seek contact information (telephone/ cell phone numbers, mailing/ email addresses) for the patient, a family member/ friend with a stable address, shelter where the patient is currently staying, or other location where s/he might be found.
- **More frequent follow-up** – Try to see homeless patients every 1-2 weeks, especially early in the course of treatment. Reinforce the patient's understanding of the plan of care repeatedly. Be mindful that relationship-building is as important as primary care interventions.
- **Drop-in system** – Encourage routine follow-up for established patients supplemented by an open-door policy for drop-ins (more effective than appointments for people whose lives are chaotic).
- **Help with appointments** – Help patients make and keep clinical appointments and routinely remind them of appointments. Find out what their regular commitments are and at what time of day they can come to the clinic.
- **Incentives** – Provide a client advocate to accompany the patient to appointments for MRI, colposcopy, or ambulatory surgery. Provide incentives for every kept appointment or group meeting attended (e.g., carfare plus meal voucher).
- **Transportation** – Provide transportation to and from specialty referrals. Arrange to pick up new patients and those unable to come to the primary care clinic on their own.
- **Outreach & intensive case management** – Provide medical outreach to unstably housed HIV-infected individuals on the streets, in shelters, drop-in centers or transitional/ long-term housing for homeless people living with AIDS. Visit inpatients daily to reinforce engagement, facilitate discharge planning, and promote better follow-up care.
- **Peer support** – Offer group activities to create positive peer support for patients having difficulty with ART. Create opportunities for group leisure or quality of life activities to develop or deepen support networks and promote a sense of self-worth

What Is Homelessness?

A ***homeless person*** 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. 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, March1999; PAL 99–12.

Excerpts from *Adapting Your Practice: Treatment & Recommendations for Homeless Patients with HIV/AIDS (2008)*
Health Care for the Homeless Clinicians' Network

These and other recommended clinical practice adaptations are available at *http://www.nhchc.org/practiceadaptations.html*