General Recommendations for the Care of Homeless Patients: Summary of Recommended Practice Adaptations

Health Care for the Homeless Clinicians' Network

ASSESSMENT

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** – Ask about current medications, including psychiatric l contraceptive l OTC meds, dietary supplements, any "borrowed" medicine prescribed for others.
- **Prior providers** – including oral health providers; what worked/ didn't work, 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, insight, judgment, impulse control, social interactions; symptoms of brain injury (head aches, seizures, memory loss, lability, irritability, dizziness, insomnia, poor organizational/ decision making skills).
- **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, entitlements (Medicaid/ SCHIP, SSI/ SSDI), other assistance
- **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 problems/ violence** - against persons or property, 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, veteran status, occupational injuries/ toxic exposures; vocational skills and interests
- **Education level, literacy** – Ever in special ed.? 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: height, weight, BMI, % body fat, abdominal girth, heart, BP, lungs, thyroid, liver, dermatological, oral, fundoscopic, genital, lower extremities
- **Serial, focused exams** - for patients uncomfortable with full-body, unclothed exam at 1st visit
- **Special populations** - Victims of abuse, sexual minorities
- **Dental assessment -** age appropriate teeth, obvious caries, dental/referred pain, diabetes patients

Diagnostic tests

- **Baseline labs** - including, EKG, lipid panel, potassium & creatinine levels, HbA1c, liver function tests
- **Asthma** – spirometry or peak flow monitoring
- **TB** – PPD for patients living in shelters and others at risk for tuberculosis; QuantiFERON®-TB Gold test (QFT-G) if available
- **STI screening** - for chlamydia, gonorrhea, syphilis, HIV, HBV, HCV, trichomonas, bacterial vaginosis, monilia
- **Mental health** - Patient Health Questionnaire (PHQ-9, PHQ-2), MHS-III, MDQ
- **Substance abuse** - SSI-AOD
- **Cognitive assessment** - Mini-Mental Status Examination (MMSE), Traumatic Brain Injury Questionnaire (TBIQ), Repeatable Battery for the Assessment of Neuro-Psychological Status (RBANS)
- **Developmental assessment** - Ages & Stages Questionnaires, Parents' Evaluation of Developmental Status (PEDS), Denver II or other standard screening tool
- **Interpersonal violence** - Posttraumatic Diagnostic Scale for Use with Extremely Low-income Women
- **Forensic evaluation** - if strong evidence of child abuse
- **Health care maintenance** - cancer screening for adults, EPSDT for children

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, preparation for evacuation
- **Adherence plan** - clarification of care plan/patient feedback; use of interpreter, lay educator if LEP; identification of potential barriers

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, risk of delayed/ interrupted treatment
- **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** 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 pain medication refills
- **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 meds that don't require pre-authorization, assistance getting Rx filled
- **Lab monitoring** – Monitor patients on antipsychotic medications for metabolic disorders.

Associated problems, complications

- **No place to heal** - efficacy of medical respite/recuperative care, supportive housing,
- **Fragmented care** – multiple providers. Use EMR; list prescribed meds on wallet-sized card.
- **Masked symptoms/ misdiagnosis** - e.g., weight loss, dementia, edema, lactic acidosis
- **Developmental discrepancies** - focus on immediate concerns, not possible future consequences
- **Functional impairments** - Document medical and functional impairments;, assist with SSI/SSDI applications; tailor plan of care to patient needs and capacities.
- **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, e-mail 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 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

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

Outreach and engagement

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

Standard of care

- **Clinical standards** – scientific evidence, expert opinion, recommendations of experienced homeless services providers. Make elimination of health disparities a clinical goal.
- **Consumer Involvement** – in peer support, program governance, advocacy, research
- **Integrated service & advocacy** – to improve service access for homeless people, address structural causes of homelessness, prevent staff burnout, and facilitate client recovery

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: General Recommendations for the Care of Homeless Patients (2010)*
Health Care for the Homeless Clinicians' Network

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