Louisville -Yay! Welcome!

Addressing Key Preventative Health Measures in Homeless Health Care Settings
WELCOME

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Overview

- The Current Office Visit Challenges (Non-Specialty) “Yes we are Specialists”

- Why Preventative Medicine Task Force (PMTF) – The Original Report

- Approach to Implementing Preventative Health Measures During the Patient Encounter “and Otherwise”
Overview

- Methodology: Developing the clinical guidance.

- Select Key Preventive Measures common to HCH clinical setting: How to Implement Screenings.

- Q & A
Colleen Conry, MD, Professor and Senior Vice-Chair, CU Dept. Family Medicine

John Smith

- 62 yo with Diabetes, Hypertension and Obesity
- Fee for Service Insurance Plan
My Visit with John Smith in 1987

- 15 minute visit to check on diabetes
- Weight 210, Height 5’11”, BP 142/92
- Normal physical exam
- No sugar in urine
- Refilled Diabeta and Diazide
- Asked to eat healthy and come back in 6 months to a year
My Visit with John Smith in 2014

- 15 minute visit to check on diabetes
- Weight 230, Height 5’11”, BMI 32.1, BP 142/92, Pulse Ox 93%, Pulse 88
- Monofilament exam normal
- HgA1C = 7.8
- PHQ 2 = 3
- Former smoker, quit 5 years ago
- Drinks 2 drinks/night, no illicit drugs
- Speaks English, reads at a 8th grade level
- Prefers to learn by listening
- Likes to be called “Jack”
And I Haven’t Even Walked in the Room yet!
My Visit with John Smith in 2014

- Things I need to do:
  - Adjust dose of diabetes meds
  - Assess for medication compliance
  - Check lipids
  - Check creatinine
  - Check microalbumin
  - Document last ophthalmology and dental visit
  - Assess need for diabetes education
But Wait There’s More

- Check on colonoscopy status and if necessary order colonoscopy
- Update immunizations and make sure he has had pneumovax
- Discuss why PSA is not indicated
- Review diet and exercise
- Set BMI goal
- Set behavioral goals and document in the chart
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And More...

- Complete a PHQ9 because the PHQ 2 was positive
- Adjust dose of anti-hypertensives
- Check BMP
- Ask about aspirin
- Calculate cardiac risk – decide if he should be on high dose or moderate dose statin
- Update 5 Wishes and document Power of Medical Authority
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This isn’t Sustainable

- It will take more than 18 hours per day just to complete the prevention needed by our patients
- The Fee for Service Model only rewards us for doing things to patients, not for preventing future problems
- The (non) reimbursement system focuses on diseases and not on patients
## The Physician Foundation 2014 Survey (n=20,088)

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<th>Your professional morale &amp; feelings for current state of medicine</th>
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<td>Very Negative</td>
<td>23%</td>
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<tr>
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<td>35%</td>
<td>37%</td>
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<td>Somewhat Positive</td>
<td>34%</td>
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<tr>
<td>Very Positive</td>
<td>8%</td>
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<th>Would you recommend medicine to your children?</th>
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<td>41%</td>
<td>50%</td>
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<tr>
<td>No</td>
<td>59%</td>
<td>50%</td>
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In 2008, you the clinician wanted help with implementing preventive health measures in the homeless healthcare setting.

The Clinicians Network, prioritized in 2010, the development of a guidance for clinicians to follow in the HCH setting.

The product was “Health Care Delivery Strategies”- Addressing Key Preventative Health Measures in Homeless Health care Settings.

Key- One size does not fit all!
What's known Going In

- Health disparities exist in the homeless population.
- Low socioeconomic status and living conditions have a direct influence on health.
- Inadequate housing contributes to infectious and chronic disease, injury, and can affect child development adversely.
- Much of the research documents the health needs of the homeless, but few directives on prioritizing preventive care services.
The Real Issue

- Manageable health conditions are equally prevalent in general and homeless populations.
  - Hypertension
  - Diabetes
  - High Cholesterol

- Barriers to care have a tremendous impact on poor health outcomes for the homeless!
  - Cardiovascular disease is the leading cause of death among older men experiencing homelessness!
Barriers to Preventive Care (Patient)

- Lack of Transportation
- Mental Health issues
- Different set of Priorities
- Competing appointments
- SA/EtOH
- Labor Services
Barriers to Preventive Care (Clinician)

- Insufficient Time
- Lacking Staff
- Insufficient Time
- Lack of Resources
- Insufficient Time
MULTIPLE COMPLEX Co-MORBIDITIES

DIFFERENT PRIORITIES

MENTAL HEALTH ISSUES

LACK OF HOUSING

I DIDN’T EAT LUNCH

NO TIME!
Importance of Prevention

- Many manageable health conditions are less controlled in the homeless population.
- Lead to development of complex co-morbidities.
- Resulting in frequent hospitalizations.
- Ending in a life expectancy roughly half that of the general population.

Ridiculous Statistic and must change!
Homelessness is evil and must be destroyed!
Levels of Preventive Care

- **Primary**: Preventing the disease.
- **Secondary**: Disease develops, but prevent complications.
- **Tertiary**: Disease and Complications develop, prevent progression.

- Many times clinicians encounter homeless patients for the first time at the secondary or tertiary level.
American Journal of Public Health states it would take a clinician 7.5 hours to follow every guideline in the USPSTF recommendations.

Need to “trim the fat” and screen for conditions that would truly impact morbidity and mortality of the homeless patient.

Task force set sail into the abyss of how to best address the lack of adequate preventative healthcare screening measures for the homeless patient specifically.
These recommendations by the Task Force in no way obviate the clinician from performing any screening available.
Methodology

- Literature review conducted against The United States Preventative Services Task Force recommendations (relationship between homelessness and health)
- Cross reference guidelines to known specialty recommendations (ADA, Framingham, etc).
- Goal to use the literature review to identify and prioritize preventive practices in HCH setting.
Results of the Review

- Isolated 5 screening and delivery recommendations as contributing to the highest impact of care within the homeless healthcare setting.
  - Cardiovascular Disease Risk
  - Depression Screening
  - Infectious Disease
  - Substance Abuse
  - Intimate Partner Violence

- Will have the greatest impact on decreasing morbidity and mortality, while “increasing” life expectancy.
Developing the Recommendations

- PMTF conducted an evaluation of the USPSTF recommendation (2010) for general and special needs populations.

- Each recommendation scrutinized and ranked via the following criteria:
  
  * Impact of care.
  * Resources available
  * Potential Barriers
The HCH PMTF also identified preventive measures not present in the USPSTF recommendations. Based on high prevalence and health outcomes in homeless persons. Funding stream requirements also a factor.
RESULTS

• A detailed description of each recommendation: “The Guidance” - Addressing Key Preventative Health Measures....

• Provides a side-by-side compare and contrast of the HCH PMTF and USPSTF recommendations are listed in reference to clinical topic.

• We will now touch on prevalent clinic topics most common to HCH clinicians.
Case Scenarios

- Depression
- Cardiovascular Disease
- Hepatitis C
Wave of the Future!
The Team!
Depression

- 2003 HCH User Survey reported 42% of respondents (>13) experienced at least one symptom of depression in the previous month.
- 20% had unmet mental health needs.
- Only 7% of CHC’s patients have depression as a primary diagnosis.
- Likely due to inability to perform consistent screenings.
Depression Cont’d

- Homelessness is a significant stressor on physical and emotional health.
- The HCH PMTF agrees that depression screening should be part of preventive care.
- Barriers are usually related to lack of resources, cultural beliefs, lacking integration of care.
- Peak Vista Homeless Health Center intake survey:
  * 1250 patients in 2009
  * 426 checked mental illness
  * 302 checked substance abuse
  * 226 checked both
Depression transcends all HCH projects.
Proper screening and control of depression can have a profound effect on early diagnosis and control of other chronic illness.
Therefore, staff assisted depression care supports should be prioritized to enhance accurate diagnosis, treatment, and follow-up care.
Depression Screening

- USPSTF suggests screening when staff assisted depression care supporters are in place to assure accurate diagnosis, effective treatment, and follow-up.

- PMTF suggests the same.
  - Refer to an appropriate provider if necessary and applicable.
Depression Screening (The How)

- Use of a BHC in clinic is invaluable.
  1. Assesses all new patients. (PHQ 9)
  2. Maintains follow-ups (Repeat PHQ 9)
  3. Assist in outreach. (Mobile Van)
  4. Position is a collaboration with local Mental Health agency (Grant)

- MA performs PHQ 9
- Nurse Coordinator may assist
- Front desk staff to submit PHQ 9 for patient to complete
Behavior Health
Cardiovascular Disease

- Major Risk Factors in Homeless Population
  1. Cigarette Smoking
  2. Elevated Blood Pressure
  3. Elevated Serum total and LDL Cholesterol
  4. Diabetes

- Ironically incidence the same across housed and homeless population
Cardiovascular Disease (Screening)

- USPSTF clinical risk assessment recommendations based on:
  1. Age
  2. Diabetes
  3. Total Cholesterol Levels and HDL Levels (Total panel in conjunction with HDL-C on fasting/non-fasting samples)
  4. Blood Pressure
  5. Tobacco Use

- Recommends Men 45-79 and Women 55-79 use ASA to reduce MI and Stroke risk
Cardiovascular Disease (Screening)

- USPSTF
  1. High Blood Pressure, routine screening for adult men and women.
  2. Hyperlipidemia, Men age 20-35 and women over 20 who are at increased risk for CAD; all men aged 35 and older.
Cardiovascular Disease (Screening)

- MPTF identified the following specific to the homeless population after extensive review:
  1. Blood Pressure screening, Same as USPMTF (All visits)
  2. Hyperlipidemia screening, Same as USPMTF (But special attention to increased prevalence for those on anti-psychotics)
  3. Diabetes, Combination of USPMTF and American Diabetes Association.
Cardiovascular Disease (The How)

- Blood Pressure
  1. MA/RN routine screenings for BP at office intake.
  2. Out of office serial BP readings (Fire Station)
  3. Mobile Van and Outreach to camps/drop in centers (BP checks and quick follow-up)
Cardiovascular Disease (The How)

- Hyperlipidemia
  1. Check PMH and age.
  2. Routine check on all first visits and if taking Anti-psychotics.
  3. Follow-up every 6 months. (Two Months if Initiating Medications)
  4. Provide transportation to lab, if needed. May check non-fasting Total Cholesterol.
Cardiovascular Disease (The How)

- Diabetes
  1. Team Approach!
  2. First visit profile for risk, FH, Age, Race, Weight, Co-morbidities, etc.
  3. UA/Finger Stick (Prior to visit)
  4. MA/RN standing orders to obtain labs based on risk
  5. Provide Transportation
  6. BHC Collaboration (Disease Centered Counseling)
  7. Quick follow-up/outreach/Mobile Van (Tickler List)
Shelter Outreach
Street Outreach
Hepatitis C

- **USPSTF**
  1. Recommends against routine screening for hepatitis C infection in asymptomatic adults who are not at risk for infection.

- **PMTF**
  1. Recommends adults and unaccompanied youth treated in HCH settings are offered testing; Frequency of repeat testing based on epidemiologic data.
Hepatitis C

The quandary

1. Assess for risk factors (During visit/prescreening based on intake questions-MA/RN).
2. Visit with Nurse Coordinator.
3. If you screen, what are treatment options?
4. Medicaid pay for treatment?
5. Non-Medicaid State (Restrict testing, per USPSTF?)
6. Set screening days (Soup Kitchens, Mobile Vans, Drop-In Centers)
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My Visit with John Smith in 2017

- Receive per member per month fee to pay for team to provide care in addition to physician
- Visit planned in advance
- Care team plans visit, labs completed ahead of time and organized for easy understanding
- Care team identifies needed chronic and preventive care needs
- Team members provide counseling/education prior to visit such as diabetes education
My Visit with John Smith in 2017

- 15 minute visit to check on diabetes, prevention and mental health
- Weight 230, Height 5’11”, BMI 32.1, BP 142/92, Pulse Ox 93%, Pulse 88
- Scribe documents history and physical, enters orders into the record
- Adjust medications, reinforce recommendations of other team members, discuss his personal health goals
- Warm hand-off to behavioral health to address elevated PHQ
- Electronic consult request to endocrine for recommendations for starting insulin
- Finished with visit and ready to go home at 5:00.
Movie Credits:

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Questions?

Thank You!