Medical Care & Treatment of Homeless Populations

Outreach Services

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A number of specific health conditions occur more frequently among homeless people and are often more poorly controlled than the general population.

Studies have consistently documented mortality rates are higher among homeless people as the relationship between homelessness and poor health is bidirectional.

We can work towards eliminating disparities in health care by providing learning and skill building opportunities through screening for exposure to violence, poor nutrition, and substandard housing; focusing on building an integrative outreach approach to reducing mortality rates.

All staff working with homeless populations should have an understanding of specific challenges in health promotion and strategies to implement and advocate for better health outcomes.
Introduction

- Definition of Homelessness
- Epidemiology Of Health Conditions
- Mortality
- Healthcare Utilization
- Health Conditions
- Psychosocial Issues
- Mental Health
- Strategies For Engagement
- Integrated Behavioral Health Services
- El Rio Stories
Definition:
In 1987, the Stewart B. McKinney Homeless Assistance Act defined a homeless person as someone who lacks a fixed, regular, and adequate nighttime residence who lives in a shelter or a place not designed for human habitation. In 2009, the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act expanded the definition to include those at imminent risk of housing loss within 2 weeks and people fleeing from domestic violence without adequate resources to obtain housing.
HUD defines a chronically homeless person as someone with a disabling condition who has been continuously homeless for at least one year or homeless four times in the previous 3 years.

Homelessness conveys a certain sameness of all people that does not correctly define the complexities of the groups or individuals. For example, data from 2011 in Arizona categorizes people as black, white, other, and Native American. No specific subset for Hispanic. Homelessness contains a certain homogeneity that belies the complexity of the population.
Epidemiology

There are several challenges to quantifying the number of homeless people in the United States including state variables. Most recent data from HUD (2014) identify 578,000 people as homeless on a single night in January of that year. Of this population 100,000 were estimated to be chronically homeless.

Arizona ranks 29th state in poverty ranking in …., and in health care services. From this rough data we can extrapolate to challenges specific to health care delivery in AZ. Nationally, 69% homeless people reside in emergency or transitional shelters and the rest live in unsheltered space. There is variation between cities, in warmer climates fewer homeless people reside in shelters.
The median age of homeless people is approximately 50 years old, almost one-fourth of homeless people are children. About 37% of sheltered homeless people are female. Homeless families represent 37% of the United States homeless population. Minority racial groups are disproportionately represented among homeless people in the United States.
Elements of the homeless life that boost early death;

Lack of adequate shelter and proper facilities for maintaining personal hygiene can exacerbate illness.

Exposure to extremities of weather and temperature, crowded shelter living increases the spread of communicable disease such as TB and pneumonia.

Homeless people may lack the ability to access some of the fundamental rituals of self-care, bed rest, good nutrition & personal hygiene.

Homelessness exacts a heavy toll, the daily struggle for food and shelter may take priority over physical and mental health care.
Mortality

Studies have consistently documented mortality rates among homeless people that are higher than in the general population. A 1985-1988 study in Philadelphia documented a mortality rate 3.5 fold higher than in the general population of the city. Other studies have demonstrated homelessness may confer health risks beyond those associated with poverty alone.

Mortality disparities are particularly higher among homeless youth and young adults, whose mortality rates are 8 to 11 times higher than in age comparable non-homeless cohort.
Overall, more than one-half of all deaths among homeless people are attributable to tobacco, alcohol, or drug use and drug attributable mortality rates exceed those in the general population 8-17 fold. While drug overdose is the leading cause of the death overall and accounts for one in three deaths among those under the age of 45 years, cancer and heart disease remain the predominant cause of death among older homeless individuals.

The most common cause of death among homeless adults has shifted over time but continue to reflect a heavy burden of addiction related illness. A 1988-1993 study of homeless adults in Boston found that HIV/ AIDS was the leading cause of death among those aged 25-44 years. Since then, there has been considerable decline in HIV related deaths and significant increases in deaths related to substance use disorders and drug overdose.
Homeless persons have higher rates of medical and psychiatric hospitalization and emergency department use compared with the general population. The pattern of acute care use among homeless people may be related to the high prevalence of substance use disorders and mental illness in addition to poor access to primary care and preventative care services.

Over one-half of homeless adults lack a usual source of healthcare. Homeless people report a substantial burden of unmet need for basic health services, including medical care, prescription medications, mental health care, eyeglasses, and dental care.
Health insurance is a critical determinant of healthcare access for homeless people. Those with health insurance coverage are more likely to use ambulatory and non-hospital care services. Compared with homeless people who have health insurance, uninsured homeless adults are more likely to report an unmet need for healthcare or prescription medications and are less likely to have a usual source of care.

Evidence from Canada, the United States Veterans Affairs system and Massachusetts suggests that universal health insurance alone is unlikely to resolve the access problems or adverse utilization patterns of homeless people.

Additionally, homeless people who sometimes or often do not get enough food to eat are more likely to be medically or psychiatrically hospitalized, and are more likely to be high users of emergency department services. Individuals with high levels of difficulty in meeting their needs for food, shelter, clothing, and safety are less likely to have a usual care source and more likely to go without needed healthcare.
Covariance Predictors with Primary Care & Mental Illness Among The Homeless

- Characteristics of Patient
- Social Support
- Choice of Providers
- Primary Care Services Targeting the Homeless

Patients Expectations

Patients Perception of the Experience

Patient Experience Seeking & Using Services
Socioeconomic conditions that contribute to the prevalence of illness and early death among the homeless population:

- Poor Diet
- Obesity/Malnutrition
- Inadequate Sleeping Conditions
- Overcrowded Shelters
- Limited Facilities For Adequate Hygiene
- Exposure To The Harsh Elements
- Exposure To Violence
- Social Isolation
- Lack Of Health Insurance
Skin and foot problems - these are among the most frequently cited reasons for homeless people to seek medical care.

Dermatophytes' - Infrequent opportunities to remove or change socks and shoes combined with reliance on shared shower facilities place homeless people at high risk for fungal infections involving the feet. These include tinea Pedi's and onychomycosis. (we can show pictures)

Arthropod infestations – Scabies, lice, and bed bug infestations often accompany the adverse living conditions associated with homelessness.
Health Conditions

**Bacterial infections** – Cellulitis occurs commonly among homeless individuals (54) and the congregate nature of shelter life increases the risk for methicillin-resistant Staphylococcus aureus.

**Mechanical problems** – Painful corns and calluses, often the result of ill-fitting shoes and an ambulatory lifestyle are common foot conditions. Homeless people who sleep upright on chairs are at risk for venous stasis disease and associated dermatitis.

**Exposure-related conditions** – Homeless people are at high risk for exposure-related skin conditions such as frostbite and immersion (“trench”) foot (58, 61, 62) and of course dehydration and heat related illness locally.

**Hypertension**, peripheral vascular disease, chronic liver or renal disease.
Health Conditions

Respiratory infections-
Respiratory Infections with Homelessness is a risk factor for tuberculosis (TB) infection, the rates of infection are disproportionately high among homeless people, other bacterial and viral infections of the respiratory tract are far more common overall and account for a substantial number of healthcare visits. Homeless persons have higher rates of death due to pneumonia and influenza in comparison to non-homeless persons. Additionally, the high rate of smoking among homeless persons contributes to a disproportionately high burden of obstructive lung disease. (e.g., asthma, COPD)

Sexually-transmitted and blood borne infections.
HIV infection – An estimated 3 to 11 percent of homeless people are infected with HIV. Despite concerns about medication non-compliance and viral resistance, evidence suggests that the majority of homeless individuals treated for HIV have good adherence. Once-daily medication regimens for HIV have further decreases concerns about adherence and have likely contributed to the substantial reduction in HIV deaths among homeless people.
**Traumatic brain injury** – A history of traumatic brain injury (TBI) is more common among homeless people than in the general population. Several studies estimate a prevalence of about 50%. TBI and subsequent cognitive impairment may be a risk factor for homelessness, additional research is needed to clarify the link.

**Cardio metabolic disorders** – Although coronary artery disease, hypertension, dyslipidemia, and diabetes are not more prevalent among homeless individuals, they are often more advanced or more poorly controlled.

**Limited dietary choices at shelters**, difficulty coordinating medication usage with meals, and logistical challenges with storing and administering insulin are just a few of the barriers that homeless diabetics face in self managing their illness.

**Dental problems** – Dental care is another one of the most frequently cited health needs of homeless people. In a national survey of homeless veterans, 60% rated their oral health as fair or poor. Among patients of a shelter-based dental program in Boston, 91% of those examined had untreated dental caries. Missing teeth are common.
Psychosocial Issues

Substance use disorders – Available evidence has consistently suggested a higher burden of substance use disorders among homeless people than in the general population. Prevalence estimates vary depending upon the subset of the population being sampled and the instrument used.

Tobacco- An estimated 68-81% of homeless adults are current cigarette smokers. Homelessness is independently associated with 2 fold higher odds of being a current smoker, and homeless people have 3-5 fold higher rates of attributable mortality. Despite interest in quitting, quit rates among homeless smokers are about one-fifth the national average.
Alcohol- An estimated 29 to 63% of homeless individuals have a lifetime history of alcohol use disorder, contributing to 6 to 10 fold higher rates of alcohol- attributable mortality that in the general population.

Other drugs- An estimated 20 to 60% of homeless individuals have a lifetime history of a drug use disorder. Marijuana, cocaine, and opioids appear to be the most commonly used substances in the population. Although drug use may be regional. Certainly in Arizona and more rural areas we see Methamphetamine abuse.
There is a high prevalence of substance use disorders and mental illness among homeless persons.

Before the 1960’s people with chronic mental illness were often committed involuntarily to state psychiatric hospitals.

…Because the community based treatment centers that were supposed to take place of state hospitals were either inadequate or nonexistent, many of these people end up living on the streets.

Today the importance of tailored healthcare delivery designed for homeless persons’ needs, with such services potentially holding special relevance for persons with mental health conditions. To improve patient experience among the homeless, organizations may want to deliver services that are tailored to homelessness and offer a choice of providers.
Mental illness
As with other statistics specific to homeless population, estimates of mental illness homeless adults has varied widely with prevalence range from 15-90%.

In a community-based probability sample of homeless adults in Los Angeles, the lifetime prevalence of severe and persistent mental illness was 28%, including a 14 % lifetime prevalence of psychotic disorders and a 30% lifetime prevalence of major affective disorders.

More common, milder forms of mental illness with studies reporting significant psychological stressors in the past month.
Violence and traumatic victimization are frequent contributors to homelessness and common experiences of homeless populations.

In a Massachusetts study of homeless women, 63% had experienced severe violence by an adult partner; 43% had been sexually molested as a child, 67% had experienced severe physical abuse as a child, and 88% had experienced at least one form of violence in their lifetime.

These violent experiences do not affect women only. Two California studies found that over 20% of homeless men have been physically or sexually assaulted in recent past. This estimate approached 40% among transgendered individuals.

Hate crimes against homeless people are always a concern. Between 1999 and 2008, the National Coalition for the Homeless estimated that 880 hate crimes perpetrated against homeless people, including 244 resulting in death.
Overall approach – Homeless healthcare is an extension of Patient-centered care. Surely it has its unique challenges, but the biology of illnesses and their treatment are fundamentally the same as in any other population.

For chronic illnesses, empirical guidelines should be implemented. However, the approach to providing care for homeless people may need to be modified. It can be extremely challenging for diabetics to achieve glycemic control and for patients with high risk of stroke or blood clots to take anticoagulation therapy.
Engagement: The process of building trusting relationships. Engagement involves creativity, as well as flexibility.

When clinicians use a comprehensive approach with patients, they will benefit and view their providers as someone who is concerned for them and explains how to work towards positive change.
Engagement is crucial: It is described as the process by which a trusting relationship between worker and client is established.

Engagement provides context for assessing needs, defining service goals, and agreeing on a plan for delivering these services. The main goals of outreach are to care for immediate needs, develop trusting relationships, and connect clients to mainstream services.

Some homeless individuals will engage quite readily, while some of the seriously mentally ill may be more difficult to reach for formal healthcare services.

We suggest an egalitarian (equal) approach to care based not on a power dynamic but service-oriented approach to care.
Trauma-informed approach – In a primary care setting, a trauma informed approach recommends universal screening for history of trauma educating staff to be sensitive to physical and emotional boundaries.

History gathering – Allow patients to guide the pace and direction of initial health conversations. It is critical to update and document contact information as this often changes.

Special considerations; should also be given to addressing current and past substance use as well as symptoms of mental illness. Specific screening tools may be helpful.

Laboratory testing – Given the high prevalence of HCV among homeless people, it is encouraged to screen for Hepatitis. Also as in any population, HIV testing should be routine.

Medication prescribing – The pharmacological approach to acute and chronic illnesses should be evidenced based. A simple medication regimen is best. Staff working with homeless should familiarize themselves with local resources that provide medications at low cost or on a charity basis. One useful resource is needymeds.org.
Diabetic patients and insulin – This can pose special challenges in our extreme climate as insulin can be stored at “room temperature” and extremes of temperature should be avoided. Also long acting insulins are preferable to short acting insulins that are meal based.

Concerns for medication abuse – Consideration should be given to the street value of certain medications. For multiple reasons, opioids should be prescribed cautiously. However, homelessness should not be viewed as a contraindication alone to opioid prescribing.

Psychiatric and addiction care – The high burden of mental illness and substance abuse use disorders among homeless people makes screening for and treating these conditions and essential aspect of care. There are many screening tools available for mental health and addiction concerns, however we would suggest only performing such screenings if appropriate interventions can be performed.

Approach to preventive care – When possible, patients should receive age appropriate preventive care. Immunizations and vaccines are important given the preponderance of communicable diseases.
Housing Interventions

**Linear models** – Early housing models made housing contingent upon abstinence from drug and alcohol use and participation in treatment programs. There is argument about how successful these programs are. They can help patients achieve higher sobriety and abstinence rates than those attending day treatment programs only, however, critics question the basis or requiring abstinence as housing entry.

**Housing first** – In contrast to linear models, “housing first” does not mandate participation in treatment programs. Instead, comprehensive support services are provided by an interdisciplinary team of health and social professionals. Studies of housing first demonstrate improvements in housing stability over usual care.
Healthcare for the homeless program
In 1985, the Robert Wood Johnson Foundation and the Pew Charitable Trusts allocated funding for the original Health Care for the Homeless (HCH) Program in 19 cities across the country. With funding from the Health Resources and Services Administration (HRSA) this program was expanded in 1987. Since then, the HCH program has grown to include more than 220 federal grantees that provide care to over 800,000 people annually.
Centpatico Behavioral Health Of Arizona holds a contract with ADHS/DBHS to manage the behavioral health care services for the following counties Santa Cruz, Cochise, Graham, Greenlee, Yuma, La Paz, Gila, Pinal, & Pima. They provide behavioral health services to members of AHCCCS eligible with Title XIX and Title XX! Benefits and adults with serious mental illness (SMI). They also provide state funded crisis services to all who live in our service area. There are also some block grant services that they provide to people who qualify. Their goal is to manage funds provided by Arizona Federal programs to help members reach their wellness and recovery goals. They work with their members and communities providers and families to create a team approach to treatment and support each member in recovery.
Integrated health care services: Cenpatico Integrated Care will be offering whole person health care, providing both medical and behavioral services to people who have been designated as having a serious mental illness. Integrated Care is inclusive to medical Care.

Behavioral Specialist will not only focus on your mental health problems but also the impact these issues can have on your physical health. We care about making you better both in body and mind.

Cenpatico Integrated Care firmly believes in recovery and that by treating the whole person we empower members to improve their lives and be engaged in their community.
Outreach-based approach – Sometimes based on hierarchy of needs: food, shelter, clothing, safety often take priority over routine healthcare for most homeless individuals.

Subsequently, the traditional clinical models that rely on patients presenting to care for scheduled appointments may be suboptimal. An outreach program embeds clinical services in the places that homeless people frequent by necessity: shelters, soup kitchens, and drop-in centers.

A team based street outreach model may be needed to reach the homeless.
The lack of affordable housing and the limited scale of housing assistance programs have contributed to the current housing crisis and to homelessness.

“The loss of affordable housing puts even greater numbers of people at risk of homelessness.”

Resources For affordable housing;

Tucson Affordable Housing
http://housingtucson.com/about-us/
PimaCountyHousingSearch.org
http://www.pimacountyhousingsearch.org/Resources.html
Summary & Recommendations

Mortality rates among homeless people are higher than in the general population. Drug overdose is the leading cause of death under the age of 45, while cancer and heart disease are the leading cause of death in adults older than 45.

Homeless people have higher rates of hospitalization and emergency department use but poor access to primary medical care and a high burden of unmet need for basic health services.

A simple medication regimen is best.

Patients should receive age-appropriate preventative care and screening, including vaccinations.

The high burden of mental illness and substance use disorders among homeless people makes screening for these conditions an essential aspect of care. Where available, case management services and multidisciplinary community treatment models may be effective in treating mental health and substance use.

Selected housing programs have been associated with improved health and social outcomes.

Health Care for the Homeless program clinics provide tailored services in a multidisciplinary environment.
References


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