

Preventive, Wound, and Palliative Care for Homeless Patients

HEALING HANDS

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Preventive Care for People Experiencing Homelessness

PART I OF II IN A SERIES ON PREVENTIVE CARE

Homeless health care clinicians often interact with patients who have acute and urgent needs that take priority over general preventive measures. Particularly for clinics with limited resources, services, and time, implementing regular and comprehensive preventive care measures can be a challenge. While guidelines for preventive care measures exist, they are not usually tailored to a homeless population that experiences different key morbidities and causes of mortality than the general population. For example, individuals experiencing homelessness have high occurrences of infectious diseases, substance abuse, and mental health issues, all of which are related to and compounded by lack of access to housing, regular medical care, health insurance, nutritious foods, transportation, employment, and other factors.¹

This issue of *Healing Hands* will address some issues in preventive health care for people experiencing homelessness. Highlights include a list of key screenings that are relevant for populations of people experiencing homelessness and a discussion of the different kinds of programs—including medical respite programs, mobile medical units, and telehealth—that can help expand access to preventive health care services.

Disease Prevalence, Morbidity, and Mortality

People experiencing homelessness experience lower life expectancies and higher prevalence of many diseases. It is estimated that the average life expectancy for people experiencing homelessness is between 42 and 52 years of age, compared with 78 years in the general population in the United States. Though women generally have higher life expectancies than men, the difference is mitigated in the homeless population, where men and women have similar risks of dying early. Research has found that young women without homes have four to 31 times the risk of premature mortality as their housed cohorts.²

Despite these discrepancies in life expectancies, the evidence about leading causes of death for the population is limited. One recent key study tracked the causes of mortality among adults without homes in Boston over a 15-year period and found that of the 1,302 deaths recorded during the study period, drug overdose, cancer, and heart disease were the major causes of mortality. Amongst adults under the age of 45, drug overdose accounts for one-third of the deaths, and of the overdose deaths, opioids were implicated in 81 percent of them. The authors concluded

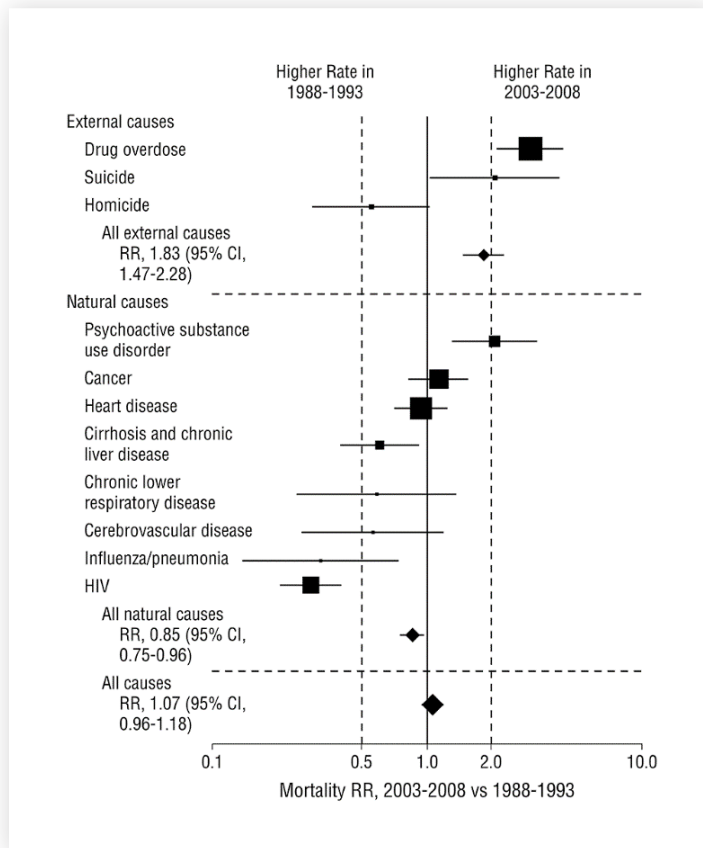


FIGURE FROM BAGGETT ET AL. (2003)

that “drug overdose has replaced HIV as the emerging epidemic” and that “interventions to reduce mortality in this population should include behavioral health integration into primary medical care, public health initiatives to prevent and reverse drug overdose, and social policy measures to end homelessness.”³ Though deaths from cancer, heart disease, and drug overdose can be reduced with appropriate preventive health care and behavioral supports, commonly-used preventive care guidelines may not reflect these specific mortality patterns.

“The burden of mental health and substance use issues amongst the homeless population is not adequately represented in traditional preventive care guidelines...”

Preventive Care Recommendations

Early screening is important because if diseases are caught earlier, treatment can begin, reducing the impact of the disease and potentially curing it or mitigating symptoms and complications. Moreover, lifestyle changes may be more effective in the earliest stages of disease progression, and nutritional and disease management counseling are a crucial part of early screening and treatment. In some cases, necessary specialty care can be accessed after early detection of diseases.

In general, there are three levels of preventive care. Primary preventive care aims to prevent the occurrence of disease; one example of this type of preventive care is vaccines. Secondary preventive care prevents complications from a disease that has developed or detects the disease before symptoms occur. For example, mammograms are a form of early screening that can detect the presence of breast cancer. Tertiary preventive care occurs when disease and conditions are already present but the clinician is focused on reducing the impact of the disease, thereby preventing further deterioration, morbidity, and mortality. An example of tertiary preventive care would be cardiac rehabilitation.⁴

The United States Preventive Services Task Force (USPSTF) issues a list of recommended measures for preventive care. These guidelines include information about demographics at higher risk of developing certain diseases, and suggest timelines for the implementation of certain screening procedures (e.g., “screening for colorectal cancer starting at age 50 years and continuing until age 75 years” and “screening for chlamydia in sexually active women age 24 years or younger and in older women who are at increased risk for infection.”)⁵

However, while comprehensive, these recommendations do not consider the unique health risks of people without homes. Focused preventive health guidelines might include the following considerations: homeless populations have a lower life expectancy, skewing the timeline for relevant screenings. People living in homelessness experience different disease prevalence than the general population, including high rates of often-untreated chronic conditions such as heart disease, certain cancers, and mental illnesses including depression. Other specific illnesses and injuries are significantly more common amongst people without homes. For example, one study that followed 1,181 homeless and marginally-housed adults in three Canadian cities for a year found that 61 percent of participants reported a history of traumatic brain injury (TBI). These rates are significantly higher than the general population. In follow-up, the study found that participants with a TBI history were significantly more likely to use the emergency department, be victims of assault, and get arrested or incarcerated.⁶

Research has also found that adults who are currently or recently homeless experience an earlier onset of certain geriatric conditions.⁷ Moreover, the burden of mental health and substance use issues amongst the homeless population is not adequately represented in traditional preventive care guidelines—considering that research has found that 50 percent of people experiencing homelessness have significant mental health issues.⁸ As

a result of these context-specific considerations, some traditional preventive care recommendations require adjustment when working with people experiencing homelessness. For example, the rate of Hepatitis C in adults who are homeless is between 17 and 45 percent, compared with 1.6 percent in the general population. Although USPSTF recommends against general screening for asymptomatic adults in the general population, due to the high prevalence amongst the homeless population this recommendation may need to be modified accordingly.⁹

Some of the USPSTF recommendations may also be difficult to implement in a resource-poor setting. Most health care providers working with homeless populations have insufficient time, limited staff, and limited resources. One study found that in a regular primary care office, it would take clinicians 7.4 hours per day (or 1,773 hours annually) to follow every guideline in the USPSTF guidelines for a patient panel of 2,500 with an age and sex distribution similar to that of the US population.¹⁰ These time constraints can be even more challenging in the context of preventive health care for people experiencing homelessness.

For a detailed exploration of how USPSTF recommendations can be tailored to a clientele also coping with homelessness, see the recommendations from [HCH's Preventive Medicine Task Force](#) (PMTF). This report provides commentary on the relevance of each USPSTF guideline to the homeless population and identifies 14 preventive health measures as high priority for this population: cardiovascular disease risk factors (blood pressure screening, hyperlipidemia screening, and diabetes screening), depression screening, intimate partner violence screening, infectious diseases (Hepatitis C, HIV, tuberculosis, chlamydia/gonorrhea), immunization delivery, substance abuse screening (alcohol misuse and illicit drug use screening, and tobacco counseling and intervention).¹¹ This report may help clinicians parse the ever-present question: Given all the recommended preventive services, how do clinicians prioritize in the face of limited time and resources?

Key Screenings

An assembled panel of clinicians and service providers generated the following list of screenings that clinicians should consider utilizing when seeing people experiencing homelessness. This list accounts for common conditions amongst adults without homes, including diseases and risk factors that are less commonly found in the general population. Some of the conditions require more detailed screening processes than others; for example, asking every client to slip off their shoes can be a form of foot care screening—which is not on any formal guidelines but is an important screening for people experiencing homelessness who are at high risk of both diabetes and environmental injuries to their extremities.

These recommended screenings are divided into the categories of (1.) disease screenings, (2.) mental and behavioral health screenings, (3.) safety screenings, and (4.) immunizations.

1) Screenings for health conditions and diseases common in people experiencing homelessness:

- HIV
- Hepatitis C
- Tuberculosis
- Cancer (especially cervical, breast, lung, prostate, and colorectal)
- Cardiovascular disease
- Tobacco use
- Traumatic Brain Injury
- Diabetes
- Hypertension
- Foot problems
- Low bone density
- Oral health problems
- Vision problems

(2) Mental and behavioral health screenings:

- Substance use (which may or may not qualify as substance use disorder)
- Alcohol use
- Depression
- Anxiety
- Suicide
- Adverse Childhood Experiences (ACES) (for adults and children)
- Trauma / PTSD
- Screening, Brief Intervention, and Referral to Treatment (SBIRT)

(3) Safety and living conditions:

- Housing
- Intimate partner violence
- Other forms of violence, including human trafficking
- Nutrition and food security
- Weather-related injuries
- Environmental illnesses

(4) Immunizations:

- Hepatitis A
- Hepatitis B
- Influenza
- TDAP
- Meningitis
- Zoster
- Pneumovax
- Prevnar
- HPV (for youth)
- All recommended pediatric vaccines (for children)

Greg Morris is the Program Director of the Homeless Clinic at Peak Vista Community Health Center in Colorado Springs, and the Executive Director of the newly founded Ascending to Health respite care program. He explains that even with the aid of generalized recommendations, the process of making decisions about preventive care is highly individual. When he sees patients, he evaluates a series of questions about their demographic and health condition: "What are their comorbidities? What age bracket? Male vs. female? Then I think about implementing preventive standard measures that fall into those demographics. A 55-year-old smoker will have a particular profile that is different from a 65-year-old who hasn't had a colonoscopy. Or...sometimes I get young adults in here who have been on the streets for much of their childhood and basic immunizations aren't up to date." These specificities influence the specific preventive healthcare measures that he chooses to assess and focus on.

Mr. Morris emphasizes that in a clinic that serves the homeless population, this assessment also factors in the material conditions in which the client is living: "A lot of what I see has to do with exposure—the chronic nature of being outside—versus shelter-based individuals who come in. Shelter-based patients might need TB testing. But if they're living on the street, then [I consider] environmental exposure—looking at their digits, making sure they have

wool socks, trying to do preventive measures to prevent frostbite." Other clinicians echo this concept, explaining that questions about safety and living conditions are crucial for assessing health risks and therefore an important part of preventive care. These questions might also include: How do you stay warm or get cool? How do you manage extreme temperatures? Do you have a backup plan if it gets too cold? Where do you sleep? Do you have a safe way to cook your food? Other questions might emphasize concern about interpersonal violence: Who do you hang out with? Is there anyone who you live with or near who poses a danger to you? How do you stay safe? For people experiencing homelessness, these questions should revolve around both intimate partner violence and other forms of violence that can occur on streets and in or near shelters.

Expanding Access to Preventive Care for People Experiencing Homelessness

Different kinds of clinical programs play a role in expanding the reach of preventive health care to people experiencing homelessness. For example, oral health care programs, medical respite programs, medical mobile units, and telehealth programs are all examples of creating access points through which people experiencing homelessness can access primary care services and preventive screenings.

Providing dental care can be an important aspect of a homeless health care provider's preventive care offerings.

Colleen Anderson is the Associate Dental Director at Boston Health Care for the Homeless Program (BHCHP). BHCHP provides dental care at two locations: a full-time clinic at the main location, and a part-time clinic co-located with a primary care clinic in a shelter. BHCHP dental clinics see many patients who present with acute dental issues, but as Dr. Anderson explains, "When folks do come to us for acute care initially, we make sure to screen for oral cancer and tobacco and substance use, as well as provide education about oral hygiene and how their oral health connects to their other medical conditions. Most importantly, we try to connect them with our clinic for comprehensive dental care." Understanding the linkages between preventive oral health care and more general preventive care is important. Dr. Anderson explains:

All dental care is preventive in some aspect. It's about trying to prevent disease in the first place, or diagnose and treat it early to reduce negative outcomes, or provide corrective treatment to restore the patient to good function, aesthetics, and comfort. Not having care puts patients at risk for infections, pain, tooth loss, etc. This can result in physical discomfort, but also affects their emotional well-being, their ability to eat and speak, and has a real social cost related

ADDITIONAL SCREENING RESOURCES

- » [Ask & Code: Documenting Homelessness Throughout the Health Care System](#) offers examples of ways Health Care for the Homeless sites ask about housing status
- » [The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences \(PRAPARE\) Assessment Tool](#) provides sample questions for discussing social determinants of health, including housing status, housing stability and safety
- » The [SAMHSA-HRSA Center for Integrated Solutions](#) shares resources for implementing Screening, Brief Intervention, and Referral to Treatment (SBIRT), an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs; Patient Health Questionnaire (PHQ-9), a tool to identify depression; as well as other screenings
- » [Tools and Tips from Futures Without Violence](#) includes questions to help providers raise the issues of family and intimate partner violence

to work and relationships. Poor oral health also contributes to complications for many medical conditions (diabetes, cardiovascular disease, immune compromised conditions, etc.). Preventing oral infections, pain, and tooth loss with routine dental care, and so avoiding the related functional, emotional, and social costs, is clearly part of providing preventive care to patients.

Dr. Anderson notes that due to underdiagnosis and lack of access to dental care, individuals experiencing homelessness are “more likely to experience the emotional, social, and functional costs related to severe oral disease.” Barriers to preventive dental care include the presence of other medical or behavioral health conditions, side effects from medication, limited mobility, fear or anxiety, or other psychological barriers. “Many people have difficulty with basic self-care, like brushing twice a day, because of lack of access to bathrooms or supplies,” explains Dr. Anderson. They may also lack access to proper nutrition, and as a result might be eating foods that contribute to cavity formation and exacerbation of dental conditions. Additionally, because many people experiencing homelessness are facing a number of health challenges simultaneously, these competing priorities may lead to oral health care, and particularly preventive oral health care, taking a back burner.

BHCHP has a number of protocols that coordinate medical and dental team efforts to help patients overcome these barriers to dental care access. For example, Dr. Anderson explains, medical clinicians routinely provide oral health screenings, education, and dental referrals to patients, paying close attention to medical conditions that put the patients at higher risk for oral disease. Case managers help coordinate care, including assistance with transportation and scheduling, and all patients staying in the medical respite facility are offered appointments at the dental clinic. Moreover, BHCHP does dental outreach at medical sites, and has begun coordinating between behavioral health providers and dental care providers to provide better care for patients who experience anxiety around dental treatment. All of these efforts to improve coordination between medical, dental and behavioral teams result in improved access to comprehensive and multi-faceted preventive health care.

Medical respite facilities can also play an important role in expanding access to preventive care. The average length of stay in medical respite programs nationally is 42 days.¹² The time in medical respite care is a unique occasion in which patients are not only focused on their health and wellness

but also easily accessible to their providers. Providers can use this time to engage patients in preventive screenings and follow up with education and self-management goal setting as needed.

In addition to targeting patients for primary and secondary prevention, medical respite programs deliver tertiary preventive care, providing patients with recovery assistance to reduce complications of existing diseases and conditions. According to Mr. Morris, research has found that patients without homes who are discharged from emergency departments will usually return to the emergency department within 90 days “due to complications or not having a place to recuperate;” in fact, he says, “50 percent of patients without access to medical respite care end up in the hospital within a week, and 75

percent return within two weeks. Thus, medical respite care is a way to provide direct medical services that prevent recidivism back to the hospital and complications from the initial hospital visit. It provides a bridge as [patients] transition to a primary care setting.”

Mobile Medical Units offer another way to increase access to preventive health

care. In Greenville, South Carolina, **Brandon Cook** is the Health Care for the Homeless Program Manager at New Horizon Family Health Services, Inc. A major component of the Homeless Program is a Mobile Medical Unit that serves patients without homes in a 13-county service area. By partnering with homeless shelters and soup kitchens, the Mobile Unit is able to create opportunities for follow-up with clients who regularly utilize those services. However, because of the high volume of patients seen and the large geographic area covered, full screenings for preventive care can be a challenge “because we are trying to see as many people as possible,” explains Mr. Cook. In order to ensure providers remember to address preventive health during a busy visit, the program has reminders set on the electronic medical records: “If you’re an established patient,” says Mr. Cook, “if it’s that time of year to ask about your cancer screening, that will pop up.” The program also offers a full range of preventive screenings and primary care services, as well as in-house and community referrals for specialty care. The availability of these services—administered by a care team that includes a rotating cast of a medical provider, a Registered Nurse who serves as the Patient Care Coordinator/Educator, an LPN, medical assistants, a clinical support specialist who helps with patient registration and does referrals, and an outreach specialist—expands the reach of preventive services into regions where it would otherwise be a challenge to access.

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- GREG MORRIS, HOMELESS CLINIC PROGRAM DIRECTOR, PEAK VISTA COMMUNITY HEALTH CENTER; EXECUTIVE DIRECTOR, ASCENDING TO HEALTH

Another vehicle for improving the spread of preventive health services is telehealth. Mr. Cook explains that the mobile unit currently travels to five counties in South Carolina but the program's catchment area is technically 13 counties, and they are preparing to launch a telehealth program to reach uninsured patients in more distant areas: "Telehealth for primary care is a great opportunity for us to pilot a program in our area that will allow us to spread across those 13 rural counties," he says. "It's not cost effective for us to take the medical unit an hour away for one or two patients. If I could use a smaller team with a provider who is still in the office and we could link back to the provider, I feel like we could touch more people, be more productive, and expand the program." Telehealth will allow New Horizon to expand the same types of services that its Medical Mobile Unit provides, including acute care, preventive screenings, chronic disease management, and health education, to population-sparse areas.

Extending telehealth services to vulnerable populations can be a challenge, since homeless populations may often lack "home-based" access to technology necessary for telehealth interactions. However, some care providers have begun to explore the relevance of telehealth for homeless populations. For example, one study evaluating the telehealth experience of recently-homeless veterans found that peer support at enrollment, facilitated access to equipment, and peer support for technical difficulties may be helpful in bridging the "digital divide" and expanding the relevance of telehealth initiatives to populations experiencing homelessness.¹³

Conclusion

Clinicians who work with clientele experiencing homelessness agree that realistic and effective care plans should account for the patient's personal context, looking at factors like living conditions, level of motivation, and material constraints. A patient's top health priority might be different from the provider's, and compliance may depend upon the provider's willingness to conceptualize preventive care in a way that accounts for the patient's lived realities. The next issue of *Healing Hands*, designed as a companion to this issue, will present expanded perspectives on preventive care, re-conceptualizing effective preventive care as more than a set of screenings, but as a coordinated array of supports that treat the patient as a whole person.

"Clinicians who work with clientele experiencing homelessness agree that realistic and effective care plans should account for the patient's personal context, looking at factors like living conditions, level of motivation, and material constraints."

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Expanding Our Vision of Possibilities for Preventive Care PART II OF II IN A SERIES ON PREVENTIVE CARE

In the previous issue of *Healing Hands*, we discussed the importance of preventive care for people experiencing homelessness. Though a series of preventive care guidelines exist, clinicians and care providers working with the homeless population often have to make decisions about how to best apply these guidelines to a population that has lower life expectancy, earlier onset of geriatric conditions, unique lifestyle challenges, and different disease prevalence than the general population. The most effective preventive care plans are more than just a series of screenings; they evaluate the material conditions of clients' lives and engage clients in care plan implementation.

In this issue, we will highlight the work that providers across the country are doing to transform care systems into networks of holistic preventive health care that is trauma-informed, patient-centered, and relevant to multiple dimensions of consumers' lives. After first discussing patient-level barriers to accessing preventive care, we will consider some practices that care providers utilize to help patients overcome the barriers, including trauma-informed care practices, building trusting relationships, creating a patient-centered clinic culture, holistic health care, inventive interventions, and community partnerships.

Patient-Level Barriers to Accessing Preventive Care

Despite the crucial importance of preventive care to health and wellbeing, people experiencing homelessness face a variety of barriers to accessing preventive care. Some clients are deterred from seeking preventive care due to lack of insurance or uncertainty about the availability of free services. Even where free services exist, physical barriers (such as lack of transportation, long distances, disability or decreased mobility, or transience) may complicate access to those services. People experiencing homelessness may also have psychological or emotional barriers to accessing care; for example, a history of trauma can affect a patient's ability and/or willingness to access services in a variety of ways, and past negative experiences with the medical community may cause patients to avoid interactions with the health care system. On top of these reasons, insufficient trusting relationships with service providers can also serve as a deterrent.

Some people experiencing homelessness have never received regular medical care, or they have only accessed care for acute problems. They may not understand the

value of primary care and prevention or the consequences of untreated chronic disease. As **Alvin E. Colbert, Jr.**, a Peer Specialist at Healthcare Center for the Homeless in Orlando, Florida, explains: "If you've been on the street for five, ten, fifteen years, you fall into the habit of taking care of yourself in certain ways that may or may not line up with societal norms. The quickest way to feel better or get a meal may be to go to the emergency room. That's a way to handle medical care." In many cases, the local emergency department (ED) seems more accessible to patients without homes in need of medical help than a primary care clinic. It makes sense that preventive health care, or screenings for diseases that one does not know one might have, could take a back burner to more urgent concerns, such as accessing treatment for acute health problems, staying safe, or finding housing and food.

Dana Basara is the Dean of Nursing at Grantham University in Lenexa, Kansas, and previously worked for 25 years as the director of an ED Trauma Center in three locations. She notes, "Routinely [people without homes] will utilize the emergency department as access for medical care. ... The majority of cases seen are non-acute and not even emergent. People use the ED because they can't get access to any form of health care because they don't have any money or insurance." Patients are treated for a chief complaint in EDs, Dr. Basara explains, "but EDs don't do major preventive care, due to the lack of follow-up treatment." She notes that EDs do some preventive care, such as giving some vaccinations, but that EDs are designed to focus on emergencies and need to continue improving methods for continuity of care:

Diseases are killing people younger than they should when they are homeless and can't access primary care and follow-up. Continuity of health care is saving people's lives. [People without homes] die younger than any other population as they don't get access to preventive care. For example, if I have diabetes, I could lose a leg because I don't have access to needles or nutritional counseling, and all that goes under preventive health care.

People experiencing homelessness have a disproportionate burden of chronic disease and increased difficulty accessing care. This leads to complications that can result in increased ED utilization, further reinforcing the use of the ED for medical care. As care providers implement practices designed specifically to help patients overcome these barriers to access to care—both material and attitudinal—the result is improved continuity of care and improved access to necessary preventive health care. Patients who are well

connected with a primary care provider are also less likely to utilize the ED inappropriately.

Trauma-Informed Care

Because a high proportion of individuals experiencing homelessness have lived and continue to live through trauma, an awareness of trauma-informed care is critical for overcoming psychological and attitudinal barriers to preventive care. Care that is trauma-informed recognizes trauma symptoms, acknowledges the role trauma has played in an individual's life, and seeks to understand and address the needs of those with trauma

histories. This is particularly important for screenings, such as pap exams and other gynecological exams, prostate exams, mammograms, and HPV screenings, which can be uncomfortable and invasive for all people, and can trigger trauma for individuals who were affected by sexual abuse or violence. Trauma-informed care also requires that providers be

well apprised of the needs of transgender clients when implementing measures such as gynecological exams and sexually transmitted infections (STI) tests. For further information on delivering trauma-informed services, view [Healing Hands: Delivering Trauma-Informed Services](#).

Linda Nguyen is the Population Health Coordinator at the Old Town Clinic for Central City Concern in Portland, Oregon. She notes that past trauma is a significant barrier for some of the clinic's patients, especially around pap screenings:

Certain layers of trauma prevent people from being comfortable with seeking preventive screenings that may potentially save their life. We work hard to provide trauma-informed care at our clinic. We coordinate care across various treatment teams and carefully review diagnoses for information on previous trauma. If previous trauma is noted in their chart, I would reach out to their case manager to see whether trauma might be affecting their access and ask, what is the best way of messaging to this specific person about their health needs? All of our providers go through trauma-informed training, and we work collaboratively to ensure compassionate care for our patients. As a comprehensive clinic, we offer access to services like behavioral health or mental health. We have health educators and care coordinators who also act as additional

touching points for the patient. If providers can't get patients to engage in a preventive screening or a behavioral health change, the safety network can step in and support them to create a safe space for clients, some of whom are coming in with previous trauma and bad experiences with other health care providers, in order to help them feel more safe and included in our clinic.

Creating these layers of trauma-informed care does not happen automatically; it requires a commitment on the part of clinic staff to create both common language and concrete structures that support the provision of trauma-informed care. Intentionally supplying trauma-informed care can be the basis for building trusting clinical relationships; as Ms. Nguyen says, "I know that time is valuable and limited, but getting to know the client, knowing what is happening in her life at the moment, really speaks to what sort of care the patient might be willing to receive."

Building Trusting Relationships

As mentioned above, a lack of trust in the medical system is a significant barrier to accessing preventive care for many people experiencing homelessness. Mr. Colbert explains that "a big barrier is getting [clients] to trust me, because in some cases [the medical community] hasn't followed through on promises in the past. Building rapport and trust means saying I'm going to do something, then doing it." Peer support is one tool for building supportive and trusting relationships that can help clients become engaged in accessing preventive care. People who have experienced homelessness may be able to help their peers feel comfortable with the process more effectively than a provider can; as Mr. Colbert notes, "I've been in situations where I've dealt with substance abuse or not having a stable place to live, so I'm not looking down on anyone. I was able to find my way out so I can show somebody else the path." Peer support can also create networks of care, as folks with pre-existing relationships begin to have important conversations about health and encourage one another to seek out care.

Another important tool for building relationships of trust is outreach. Outreach workers form a key part of care teams and are able to share information with clients that will increase their motivation to seek out health care. **Thommie Mungo** is a Community Health Worker in the Choose

HEALTH Program in Atlanta, Georgia. She describes the following lessons from her outreach work:

I've seen more engagement once the basic needs have been met. Once the barriers of housing, food, and other social resources are either eliminated or put on course to being addressed, then people are more open to talking about and dealing with whatever health issues they may have. That's the biggest part of our collaboration's success: getting in, building a rapport, being relatable, and understanding that people do care about being well and about being educated, but if I don't have any groceries, I'm not even thinking about my health. A lot of times providers don't get a chance to see this, because clients have a fear of exposing that and expressing that... But I go in and feel comfortable in a house, and I'm talking to her about her mental health and why it's important, and sharing as much information I can to change her thought process. This takes a lot of time, and it's very individual and different, so we make adjustments as needed. We also meet regularly as a staff to talk about our caseloads and figure out innovative ways to reach people, teach them about their health, and inform them of resources in the community. We become another layer of support and in some cases the only layer of support that individuals have.

Because providers may not have time or space to fully understand the realities of a client's life, outreach workers

and community health workers can use this multifaceted understanding to develop stronger rapport and trust. A team-based approach to health care provision enables different members of the team to share their knowledge about a client's health needs and life circumstances, leading to more comprehensive and realistic care plans.

"Once the barriers of housing, food, and other social resources are either eliminated or put on course to being addressed, then people are more open to talking about and dealing with whatever health issues they may have."

- THOMMIE MUNGO, COMMUNITY HEALTH WORKER
CHOOSE HEALTH PROGRAM

Building a Patient-Centered Culture

It can be helpful for care teams to work together on developing the appropriate language for patients. Messages such as "Your future is important to me" and "I want you to live a long and healthy life" can help clients recognize the ways in which clinicians and other care providers are trying to invest in their future and can also contribute

to developing a trusting relationship. These kinds of conversations may feel, to patients, more like expressions of caring and less like clinical insistence. When entire care teams—medical providers, peer specialists, social workers, administrative employees, outreach workers, etc.—have the same messages about prioritizing health, it may help patients see the relevance of recommended preventive care measures to their lives and well-being. This is partly a process of working to help patients understand why clinics emphasize certain measures. As Ms. Mungo explains, for many patients “housing takes priority over diabetes; it’s hard to think of chronic diseases when [a patient] has so many other things on their plate.” Educating patients about the long-term implications of accessing or not accessing preventive care is part of empowering them to make choices that are conducive to long-term health.

It takes training to drive these clinical culture shifts and develop a common language that is trauma-informed and patient-centered. One strategy that can be useful for communicating compassionate health messages to people experiencing homelessness is motivational interviewing. Motivational interviewing is an interaction style that is collaborative (honors a patient’s expertise and perspective), evocative (presumes that the resources to change reside within the patient), and empowering (affirms the patient’s right and capacity for self-direction while facilitating informed choice).¹ Clinics may want to consider offering training in motivational interviewing or other patient-centered communication techniques, as part of the process of developing a common language that can be used to empower patients to take accountability for their part in preventive health care.

Mindfully creating systems of compassionate language is an important part of developing supportive environments where clients feel safe to ask questions, listen to advice, and reach out for help. As Mr. Colbert explains: “[If clients] feel comfortable where they are and feel like they have someone in their corner, they are more likely to lean on you and trust you to take care of them. You need trust, connection, and personal rapport in order to help people break harmful habits. Every behavior is an attempt to meet a need.” For Mr. Colbert, one of the keys to developing this kind of relationship is being reliable—“doing what you say you will do and being consistently supportive.”

Holistic Health Care

Supportive clinical environments also consider the multifaceted needs of clients. People without homes experience health problems in the context of other stresses and traumas, such as unemployment, violence, stigma, trauma, and chronic forms of deprivation. In acknowledgment of this fact, some care providers with available resources work to offer holistic health care to clients. This form of preventive health care seeks to understand and address not only the physical needs of clients, but also their emotional, social, mental, and spiritual health. For example, Ms. Nguyen describes the following offerings that are available at the Old Town Clinic in Portland:

Our offerings include acupuncture, art therapy, positive thinking, healthy cooking, and a wellness calendar. Every day of the week there are several activities available that provide comprehensive spirituality, healing, qi gong, yoga, and clay and ceramics. We also have a new collaboration with Oregon Food Bank: Cooking Matters, a 6-week cooking program for clients who may not know how to cook or know what is in season; they get... a better understanding of nutrition and cooking on a budget... I would consider these programs preventive care. Most people just think of medical visits and checkups and things like that, but primary care is also about engaging people



A “COOKING MATTERS” CLASS AT CENTRAL CITY CONCERN’S
OLD TOWN CLINIC IN PORTLAND, OREGON

in their care...[and] creating a relationship with the patient to improve their overall quality of their life, which might mean stretches or healing, or letting out stress through ceramics, or maybe they learn to cook—all of those things add up.

In other words, engaging clients in their own health care in any dimension may lead clients to feel more empowered to tackle other areas of their health. Creating access to holistic health care resources can improve physical aspects of health as well as the overall quality of life for clients experiencing homelessness.

Mr. Colbert explains that the creation of supportive networks of care is also a form of preventive care—"because if you're bored and you don't have anything to do," he says, "you look to what you're used to, and it's really easy to fall into old habits." His program hosts regular community meetings to bring their clients that live in the same neighborhood together to discuss their concerns and needs. This way, Mr. Colbert says, "I can get in front of a problem before it becomes a hospital problem. If someone has been coughing for a week, I can make her an appointment at our clinic and pick her up and take her. That helps her avoid having to go to the emergency room, and she doesn't have to worry because she knows [she has] an appointment and [she'll] have a way to get there." Creating social contingencies around health care is one way to encourage patients to engage more fully with preventive care resources.

Inventive Interventions

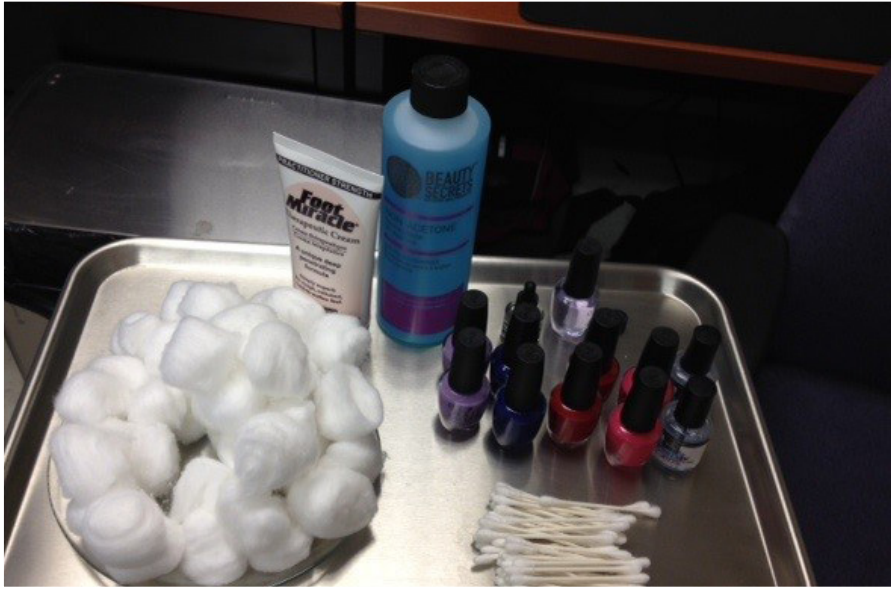
Service providers face a lot of pressure to meet reporting measures in order to maintain organizational stability and regular funding. In some cases, clinics may be measured and evaluated based on the implementation of indicators that are not actually the most relevant for the populations they serve and may not account for the complicated circumstances in which patients without homes live. Some care providers have come up with novel ways to meet requirements by combining screenings or developing creative ways to weave together interventions,



PARTICIPANTS IN A "COOKING MATTERS" CLASS PREPARE
HEALTHY VEGETABLES

preventive measures, and practices that account for social determinants of health.

One example of an innovative approach to preventive screenings is described by **Mollie Sullivan**, a Clinical Mental Health Counselor at Mercy Medical Center's Health Care for the Homeless Program in Springfield, Massachusetts. Every year the program hosts a foot clinic at one of their largest clinic sites. They attract patients by incorporating giveaways and inviting patients to a "spa session" hosted by doctors and nurse practitioners. After soaking the participants' feet, the provider performs foot care, including toe nail clipping, callous removal, and a diabetic foot exam. As Ms. Sullivan explains,



SUPPLIES ARRANGED IN PREPARATION
FOR A FOOT CLINIC "SPA DAY"

This is a tool we use to engage our patient in foot care, but eventually it leads to engagement involving other medical conditions. Often these patients are unfamiliar with our services and this welcomes them and introduces them to our clinic. Any further follow-up appointments that are needed or any diabetic education that is needed can be scheduled that day as well. After their foot care is completed they can then go to see the staff for a pedicure, [and] they will walk away with new socks, flip flops, and a goodie bag. In the past we have used med students, nursing students, and podiatry providers to volunteer this day at our clinic. We offer fruit, water, and snacks to those waiting on their "spa treatment." We have used this day as an engagement tool for those who may not otherwise seek care from us. We also use the event as an educational tool as well as an "all hands on deck approach" to provide our patients with not only the foot care they need but a little extra TLC.

Not only does this approach extend crucial preventive care to participants, but it also provides them with human contact, stress relief, and holistic care. In this way, the clinic is able to work toward meeting requirements for preventive care while engaging with the multifaceted needs of clients.

Annie Nicol implements similar inventive initiatives as the Director of Homeless Services at Petaluma Health Center in Petaluma, California. Ms. Nicol notes that when developing

strategies for expanding preventive care measures, "most can be sweetened with an incentive, an 'I really care about you' message, and education." For example, Ms. Nicol recommends that after screening people for tobacco use, "smokers can be referred to cessation groups and offered nicotine patches, gum, or lozenges. There are also medications that can be prescribed. Encouraging clients to have a buddy who is interested in quitting helps as friends often smoke together. [Another approach is assisting the patient in] planning a reward for quitting (e.g., a nice dinner, a massage, or shopping) to be paid for with the savings from not buying tobacco." As another example, Ms. Nicol notes that while colon cancer screenings can be particularly challenging for

people experiencing homelessness, their organization can offer a three-day respite care bed in advance of colonoscopies to facilitate the preparation. They also offer incentives for the return of a fecal occult blood card, such as a gift card or other reward.

Petaluma Health Center also hosts Women's Health Nights (which they sometimes call pap parties). While maintaining standards of trauma-sensitive care, providers develop a celebratory environment to honor women's health, facilitate educational conversations about health, and provide attendees with access to screenings and education. The Health Center selects a large and suitable venue for the event, and engages other health providers in the community to assist with the exams. A pre-printed invitation is created that mentions there will be snacks and a goody bag, and transportation to the event is provided. Patients are given information about the importance of pap tests in catching abnormalities early, and other information about women's health is shared. At the end of the night, after exams have been conducted and incentives shared, providers make follow-up appointments for the attendees to receive their results, and another incentive is named for keeping the follow-up appointment.

These general principles of providing incentives and creating a nurturing, educational environment can also be utilized for other varieties of preventive care. For example, Ms. Nicol notes the importance of warm handoffs to

mental health providers in conjunction with depression screenings. For mammograms, clients can be transported to local radiology departments as a group, after patients are given the opportunity to invite friends and community members to join them. After diabetes screenings, navigators or outreach providers can walk through the food lines and assist patients in making healthy choices. All of these examples could be replicated by other care providers working to meet standard requirements for preventive care measures while also maintaining a patient-centered environment at the clinic.

Community Partnerships to Create Networks of Care

Ebony Johnson is the Program Manager of the United Way's Choose HEALTH program in Atlanta, Georgia. Ms. Johnson explains that the Choose HEALTH program was founded in 2013 as a response to "concern from the medical community and the philanthropic community about the number of avoidable emergency room visits; there were over 300,000 individuals who overused the emergency room in 2012... and we wanted to bring together the public and private health centers to discuss the issues and look for ways to manage the problem." The program started by selecting a public hospital in metropolitan Atlanta and putting patient navigators in the ED to redirect people to neighborhood clinics, but found that the patients "needed much more intensive social service wraparounds, due to issues with housing, transportation, and other challenges," explains Ms. Johnson.

After realizing this, the Choose HEALTH Program hired community health workers (CHWs), including Thommie Mungo, who were tasked with conducting home visits, case management, accompanying patients to medical visits, and providing services such as reminders to take medications and health education. CHWs are also able to refer clients to community resources for housing, employment, mental health and substance abuse programs, and other crucial services. Program enrollment targeted individuals who were frequently utilizing the ED including those who had a high number of ED admissions due to chronic health conditions. As Ms. Mungo describes it,

My basic role is to teach the populations that I serve how to properly use the ECC [Emergency Care Center] to reduce the rates. A lot of homeless clients

use the ECC just for a means to sleep, [thinking] "If I have to go through the process, I'll go through it just knowing I'll be able to lay down in a bed." A lot of clients have health issues like hypertension and diabetes, and all of my clients use the ECC as a primary care instead of the other way around. One of the things we have done was to implement getting clients connected to a primary care home—like our center, or to follow them wherever they go for 6 months in the community. We try to follow them, teach them about chronic diseases they have, and talk to them about medications and best practices.

At the end of the three-year pilot program, data showed that 84 percent of patients had reduced ED visits during the course of the program, and that 77 percent of patients had in fact maintained a zero re-admission rate while in the program. Additionally, about 86 percent of the enrolled patient population was linked to primary care services in health centers or within satellite clinics. For more information on how clinics can utilize and fund Community Health Workers, view [Integrating Community Health Workers into Primary Care Practice: A Resource Guide for HCH Programs](#).

"People are very interested in the data itself, in those numbers," says Ms. Johnson, who emphasizes that some of the key interventions leading to the impressive outcomes are home visitation and assessment of living conditions, facilitated transition of care, establishing contact with primary care, assisting with medication and health education, and generally bridging the gaps between

patients and providers.

"Education is key," she says: "[When] we're able to educate our patient population on how to manage their chronic conditions, and really look more holistically at a person, we're more successful in preventing avoidable hospital visits and helping people manage their chronic conditions." She goes on to explain that collaborations throughout the community have been essential to the program's success:

Collaborations work well. Providers are so busy with their caseload, and their patients have a lot of variant needs, but establishing connections in communities and establishing community partnerships can go a long way. [Create] connections between health systems, with [health centers], and community services; even though

"At the end of the three-year pilot program, data showed that 84 percent of patients had reduced ED visits during the course of the program, and that 77 percent of patients had in fact maintained a zero re-admission rate while in the program."

different clinics specialize in different areas of scope, we all see the same problems and clients hop between systems. Collect data on where people go and help them access a place where they can be seen regularly. I can't advocate enough for building partnerships and not re-inventing the wheel with others in the community.

Suggested citation: National Health Care for the Homeless Council. (October 2017). Expanding Our Vision of the Possibilities for Preventive Care. *Healing Hands*, 21:3. (Author: Melissa Jean, Writer). Nashville, TN. Available at: www.nhchc.org.

For communities where the resources are available, these kinds of collaborations can prove an effective way to marshal resources and build upon the various forms of expertise present in a community.

Conclusion

People living in homelessness are often in crisis. With some creativity and collaboration, care providers can move beyond methods of meeting that crisis and into methods of incorporating forward-looking, preventive care into all interactions. This can involve ensuring that the benefits of preventive care are not an abstraction to patients, while simultaneously honoring the patient's priorities and agency. As Ms. Johnson explains, "Those who want the help are more successful than those who aren't yet in a place where they're ready to move past their current situation. For providers to meet people where they are is very critical." By understanding the specific challenges faced by people experiencing homelessness, and the way these challenges can create barriers to accessing preventive care, providers can create trauma-informed, patient-centered environments that support patients as they overcome material and attitudinal barriers to care.

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Disclaimer

This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U30CS09746, a National Training and Technical Assistance Cooperative Agreement for \$1,625,741, with 0% match from nongovernmental sources. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

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HEALING HANDS

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Best Practices and Considerations for Wound Care

Robert King had an abscess that just wouldn't heal. The abscess developed while Mr. King was experiencing homelessness, but even after he found housing, the wound persisted. After two years with the abscess, Mr. King was referred to a specialized wound care clinic through Central City Concern in Portland, Oregon. For six months, he went to the wound care clinic once a week, where **Pat Buckley**, a Physician Assistant and Naturopathic Doctor at the Old Town Clinic, taught him how to do dressings himself and provided him with all the supplies he needed to change his own dressings daily. Clinic staff also explained to Mr. King that he was malnourished and helped him access a nutrition program that provided him with high-protein foods free of cost. "I started getting my health back up," he says, "and put on a couple of pounds and started to heal a little better." After six months of treatment, the wound was fully healed. Mr. King says that it was a challenge to treat the wound while also dealing with homelessness, but that the specialized care and treatment at Central City Concern helped him through it. "People were willing to help me out in areas where I didn't think I'd get any proper help," he says, "and eventually the abscess was healed."

Research has shown that people experiencing homelessness often experience acute wounds as a result of lacerations, injuries, fractures, stabbing or gunshot wounds, burns, frostbite, and chronic medical conditions such as diabetes. When these acute wounds are not adequately treated, they can evolve into chronic

wounds—such as venous stasis ulcers, diabetic foot ulcers, or intravenous (IV) drug use site infections. These types of wounds, left untreated, can cause serious health problems and be life-threatening; however, they can also be very difficult to treat, particularly when the patient has inadequate access to consistent health care, appropriate housing, and other necessary, critical resources.

Non-healing wounds present considerable difficulties for people experiencing homelessness and their care providers. "When we're dealing with our homeless and marginally housed folks," explains Ms. Buckley, "there are a lot of barriers to good healing. For example, warmth is important for good wound healing. If it's the middle of the winter and someone is sleeping outside, it will take longer for a wound to heal." She notes that "access to food is another issue because you have to have the right combination of protein and nutrients" for optimal healing, and transportation and finances are other considerable barriers. Hygiene, including the regular cleaning of wounds, can be difficult to maintain with consistency for people experiencing homelessness; many providers recount stories of clients trying to reuse dirty dressings or being unable to access showers and clean supplies. Healing can also be inhibited by insufficient rest, continued exposure to trauma, not having a place to store medications and supplies, smoking or drinking, other forms of substance abuse, and absence of family support during times of illness.

Clinical practices can also, in some cases, inhibit optimal healing of wounds. Some care providers recommend using outdated medical methods for wound care, either due to a lack of resources or a lack of knowledge. Ms. Buckley explains:

Without having a basic understanding of wound care, a lot of people default to old style management. A lot of people get discharged with wet-to-dry dressing changes several times a day, which doesn't promote wound healing because it dries out the wound and rips off tissue, then the constant wound-packing irritates the wound. Studies have shown that moist wounds heal faster than dry wounds. So there needs to be an understanding of how to find the right balance between enough moisture for the wound to heal but not so much moisture that the tissue will macerate ... A lot of providers don't do best practices and as a result don't have the right supplies. At our clinic it took us over six months to get the right balance of supplies in-house that enables us to adapt as wounds evolve.

Current best practices emphasize the necessarily holistic nature of adequate wound care. This issue of *Healing Hands* provides perspectives on the role of clinics, respite facilities, outreach teams, and community partnerships in facilitating improved wound care for people experiencing homelessness.

The Role of Clinics

Central City Concern opened their specialized wound care clinic at the Old Town Clinic in September 2014. Pat Buckley and other staff had noticed that their patients with wounds seemed to have difficulty accessing standard wound care clinics, and that primary care clinics often had difficulty creating adequate wound care plans, relying instead on standard dressing changes. "I started taking some classes on wound care," she says, "and our nurse manager had the idea to use the extra space downstairs to create a wound care team with a provider so that people could have direct access. Within weeks, we had a full schedule every day and were having a hard time finding space for new patients." The clinic,

Dominic Lupica was a client at Old Town's wound care clinic when skin grafts on his legs burst open. The grafts, which had been placed on his legs in 2001 as a result of necrotitis fasciitis, had previously burst open and taken 18 months to heal. This time, says Mr. Lupica, Ms. Buckley and her co-workers helped him heal the wounds in about three months. The difference, he explains, is that the wound care clinic "went for care aggressively." They gave him protein bars and protein shakes and helped him access other nutrition services. He started out going in for dressing changes three times a week, then tapered down to once a week; he notes that the dressing changes were waterproof so that he could shower. "I feel that they gave me the best treatment," he says. "I've seen a lot of doctors, and here they've really done it for me."

located in the inner city, was accessible and familiar to clients, including clients with mental health issues. As a result of this specialization and accessibility, Ms. Buckley reports that follow-up with wound care patients has improved, as have treatment outcomes.



EXAMPLE OF CHRONIC ABSCESS
(PHOTO COURTESY OF DR. SUSAN PARTOVI)

The clinic's mission is to create knowledge and conditions to facilitate healing for people with chronic wounds. "If somebody comes in with a wound, for example a stasis ulcer of the ankle or an abscess from IV drug use," explains Ms. Buckley, "we create a plan that will fit the patient's current situation as best as possible." Some people are able to come to the clinic three or four times per week for follow-up. But if a patient can't get into the clinic three times a week for dressing changes, clinic staff develop a dressing that will stay on for a whole week or provide the patient with materials and training to change their own dressings. Plans also involve provisions for access to nutritious food and other needed resources. "In our clinic, we tailor the wound care to the patient's capability," says Ms. Buckley. "When we get the right combination of supplies together, we find that wounds start healing very quickly."

Not many primary clinics are able to offer specialized wound care; in many cases it requires a referral to specialty care. Treating wounds in primary care clinics can be challenging. As Ms. Buckley explains, "When you have a lot of wound care patients, they tend to use up primary care time, and other patients may have difficulty accessing care because so many spots are filled by wound care patients." Moreover, wound care protocols may rely upon medical assistants' work, but they are not able to assess alone, change the care plan, or make any decisions about the direction of care. As a result, "medical assistants may find themselves doing the same thing over and over, just changing the dressings, which can cause wounds to dry out and healing to stall," warns Ms. Buckley. She explains that since opening the specialized wound care clinic, the Old Town Clinic has been able to overcome many of these challenges and improve outcomes for their patients.

Wound Care Resources

- » PESI Health Care: www.pesihealthcare.com
- » Columbia Wound Care Consortium: www.columbiawound.org
- » Association for the Advancement of Wound Care (AAWC): www.aawconline.org

Wound Care Certification Resources

- » Wound Care Education Institute (WCEI): www.wcei.net
- » Wound Ostomy and Continence Nurses Society (WOCN): www.wocn.org
- » National Alliance of Wound Care and Ostomy (NAWCO): www.nawccb.org

One group of patients who often experience difficulties with non-healing wounds is IV drug users. The Center for Harm Reduction is a satellite site of Homeless Health Care Los Angeles; **Susan Partovi** is the Medical Director and a physician at the Center, which is well known throughout the community in Skid Row where it is located in Los Angeles, California. She estimates that 80 to 90 percent of their clients are experiencing homelessness at any given time, and explains that they see many clients with non-healing wounds: "It's very common when you're injecting in the same place over and over, and getting repeated infections in the same area ... The tissue breaks down and dies, and you end up with ulcers and chronic wounds ... In my experience, a lot of times people like to use in the ulcers because usually the ulcers have a lake underneath—they think they're accessing a vein, but really they're not, which causes repeated injury."

The Center for Harm Reduction runs an urgent-care clinic, where clinicians provide care for clients with acute and chronic wounds

and abscesses. Dr. Partovi explains that they often see very large abscesses in the clinic and are able to treat them on-site. One highly successful aspect of their abscess care services has been to keep people out of the emergency room. The Center also utilizes harm reduction educational techniques to prevent the occurrence of these types of wounds, by educating clients about injecting different sites, using clean needles, practicing safe and sterile techniques, and accessing proper wound care services when necessary. The Center is open every day including weekends, so although the medical staff aren't always available, access to clean needles and other materials is always available to clients. The Center also runs a needle exchange, which provides a sense of community and the opportunity for care providers to provide other resources such as community referrals. The exchange facility, Dr. Partovi explains, "becomes like a second home to them. Because their drug use is a priority, exchanges are very successful. People who engage in needle exchanges are healthier, and they're also more apt to use less and/or quit, because they have that resource ... A lot has to do with [care providers employing] a non-judgmental, meeting-them-where-they're-at philosophy, and seeing them as human beings."

Central to the harm reduction practice is this stance of non-judgment; as Dr. Partovi explains, "from the person up front to the janitors to the doctors, everyone who works [at the Center] ... shares our 'meet them where they're at' philosophy. Once people get to know our medical group, they become open to [receiving] care." According to Dr. Partovi, some clients come in with stories of having been "treated poorly in the emergency rooms: often belittled, told that they deserve their plight, not offered anesthesia—pretty egregious ethical issues." As a result, "people often have an internalized sense of deserving their suffering. We're changing conversations about addiction. We want to make sure our clients are as healthy and happy as possible."

Advice for New Wound Care Clinics

With Pat Buckley, Physician Assistant and Naturopathic Doctor at Central City Concern's Old Town Clinic

- » Seek out specialized training. "Send at least one person in the clinic for specific training in wound care so that there is someone who is knowledgeable and/or certified—a go-to person who can consult for whoever needs help."
- » Check the supply closets. "Get a broad stock of supplies so that you can address a wide variety of wounds. Wounds evolve, so just because something is wet this week doesn't mean it will be wet next week ... Care providers need to be able to adapt to the ever-changing environment of the wound."
- » Spread the word to other staff. "Do a general training for all the providers on wound care basics ... [For example], we put together resources and reference sheets that provide information about different colors in the wound bed, what to look for, how to respond to wound presentation, etc.—a cheat sheet that starts providers on figuring out how wounds work and how to treat them."
- » Consider the role of technology. "Our electronic medical records system has a template that populates when assistants do a dressing change ... It helps ensure that they hit all the important points during a visit and clearly states that wound care patients need to see a provider or a nurse if it has been more than two weeks since the last visit. This helps us avoid repetitive treatments that are not helpful and ensures that assessment and treatment steps don't get missed."

The Role of Medical Respite

For clients whose wounds cannot be adequately treated in an outpatient clinical setting, but who don't require hospital-level care, medical respite programs can be a crucial resource. **Leslie Enzian** is the Medical Director at Edward Thomas House, a medical respite program at Harborview Medical Center in Seattle, Washington. She explains the role of medical respite programs in treating non-healing wounds:

Medical respite programs can greatly impact the clinical outcomes for patients with wounds. Wounds are difficult to properly care for when patients are on the streets or in emergency shelters where adequate hygiene is challenging, wound supplies limited, and infection control practices inadequate. Many foot wounds require limited weight bearing in order to heal, and this is more difficult to abide by for patients without homes. Inadequate wound care can lead to chronic non-healing wounds and wound complications such as osteomyelitis and amputations. Respite offers the opportunity for complete healing of wounds so as to avoid these complications and can offer patients education about prevention of future wounds. Many wounds determined to be chronic are non-healing wounds due to inadequate care. Often these seemingly chronic wounds can be healed with appropriate medical attention that can be provided in respite.



EXAMPLE OF CHRONIC ABSCESS
(PHOTO COURTESY OF DR. SUSAN PARTOVI)

Because space is limited in medical respite care facilities, Dr. Enzian's criteria for establishing the need for medical respite care are: "If a wound requires less than every-other-day dressing changes, then it can likely readily be managed in an outpatient clinic. If a patient has received appropriate wound care in respite for three months without healing, we consider the wound to be chronic and arrange for outpatient management." Dr. Enzian also notes that "medical respite programs may be able to care for complex wounds, such as those requiring wound vacs or healing skin grafts or burns. Without medical respite, many patients with complex wounds would spend a substantially longer time in the hospital." Therefore, even when clinics utilize new technologies in wound dressings, which can be more costly than traditional wet-to-dry dressings, the increased speed of healing and the avoidance of repeated hospital stays often still represent significant cost avoidance.

Jean Scheid, an Outreach Nurse with Yakima Neighborhood Health Services in Yakima, Washington, notes that non-healing wounds represent at least 60 to 70 percent of medical respite care patients at her facility. She sees clients recovering from abscesses, open wounds, stab wounds, gunshot wounds, and other non-healing wounds. Their medical respite program, which operates on referrals from the hospital, is usually full and currently trying to expand due to need. "I often see folks that are needing wound care on the street," explains Ms. Scheid, "and if possible I try to get them into medical respite and get direction from a physician on what needs to happen next. I can only do quick and dirty assessments on the street. If they get into medical respite, then we can put a plan into place for their recovery, but a key part of the respite process is getting them a plan."

Medical Respite Wound Care Supply List

From Jean Scheid, Outreach Nurse at Yakima Neighborhood Health Services

- » Antibacterial wipes or alcohol wipes
- » 4X4 gauze pads
- » Non-adhering dressings like telfa in a variety of sizes
- » Telfa adhesive in a medium size—about 3x2.5—this has adhesive on the edge
- » Curlex in a variety of sizes
- » Economy elastic bandages like ace wrap in a variety of sizes
- » ABD pads
- » All sizes of regular adhesive bandaids
- » Single-use packets of Bacitracin ointment
- » Sterile tongue depressors and swab sticks
- » Towelettes to put under your wound care set-up
- » Gloves
- » Paper tape
- » Scissors
- » Tweezers
- » Tender tape that sticks to itself, in a variety of widths
- » 100 ml bottles and small-unit doses of sterile saline
- » Small biohazard garbage bags

The Role of Outreach Workers

Though chronic and non-healing wounds often require intensive intervention in clinics, hospitals, or medical respite care facilities in order for full healing to occur, “wound care represents a huge part of outreach care,” explains Ms. Scheid. “Folks are often hesitant to go to a doctor—maybe they are not documented or afraid of the health care system.” Most of Ms. Scheid’s street outreach work involves wound care and the monitoring of chronic illnesses.

The biggest challenges to treating non-healing wounds on the street are hygiene and mobility: “People are often living in pretty unsanitary conditions and

often don’t have access to hygiene supplies, so it’s difficult to take showers and get cleaned up, especially for people that are camping out ... There is also a lot of debris and the possibility of being exposed to viruses and

bacteria.” Some of these agents can cause particularly dangerous wounds and infections; Ms. Scheid notes that she recently worked with two patients who had developed necrotitis from living alongside a river, and that both patients ended up in the hospital for several weeks, and then spent three months in respite recovering. The other major challenge is establishing follow-up with highly mobile populations: “Sometimes I try to find them a few days after doing a dressing and oftentimes they’ve moved on, or I don’t see them until weeks later,” says Ms. Scheid.

Carol Blank is a Registered Nurse who manages a community health clinic and rural community health center for RiverStone Health in Billings, Montana. She explains that rural populations can face distinct challenges when it comes to wound care, requiring an emphasis on outreach services. “Bigger cities often have more shelter resources available,” she notes. “In Billings ... we have lots of folks sleeping in encampments out of sight by the river, or in caves or under overpasses, living outside all year long.” This can make it difficult to reach people and assist them in accessing health care for their wounds. There are a variety of reasons that people might elect to stay outside. Perhaps they prefer to be alone, or they’re mistrustful of people in town, or they don’t have a relationship with the shelter. “In some cases,” says Ms. Blank, “people are actively trying to stay hidden.”

In Billings, where temperatures can reach 30 degrees below zero during the winter, people who are exposed to the elements tend to be disproportionately affected by frostbite and other acute and chronic wounds. Ms. Blank explains that their clinic has one outreach worker and one case manager, but all team members are “encouraged to get out and about” to get to know people who are living in shelters and staying in hospitals. “Everyone is trained in how to identify someone that may be homeless,” she says, “because we want people to know that services are available.”

“Wound care represents a huge part of outreach care ... Folks are often hesitant to go to a doctor.”

Jean Scheid, Yakima Neighborhood Health Services, Yakima, WA

Collaborating with Other Community Programs to Facilitate Wound Healing

Because proper healing of wounds is a holistic process—influenced by a host of other lifestyle factors like housing, hygiene, and nutrition—care plans should seek to integrate assistance in these other areas. Some organizations may be able to provide multifaceted, holistic care to their clients, but others may need to cultivate relationships with other community organizations that can provide elements of care for clients in need of healing. For example, Pat Buckley describes the case of a patient with lymphedema. This manifested as chronic swelling, recurrent

blisters, and open sores on his legs; moreover, because his legs had been wrapped for so long in non-waterproof bandaging, he was unable to shower and had developed a buildup of scales on his legs.

While consulting with the patient, Ms. Buckley discovered that he was only eating bananas and potatoes

and was malnourished. When she created a care plan for him, she emphasized cleaning and re-wrapping services in the clinic, but also helped connect the patient with the FoodRx Program through Care Oregon, which helped him access a vegetarian diet that met his ethical considerations while also providing sufficient protein. In addition, clinic staff helped him upgrade his Medicare and food stamps and enrolled him in a nutrition education program. Once his protein levels improved, they found that the swelling went down, they were able to put him in compression stockings instead of wrappings, and his problem has since been resolved.

Outreach Backpack Wound Care Supply List

From Jean Scheid, Outreach Nurse at Yakima Neighborhood Health Services

Jean uses a rolling bag with individual packing bags to organize the supplies. She includes smaller amounts of most of the items on the respite care list, as well as:

- » Methylex dressing that is gel-based and can stay on for longer in two sizes (4x4 and 6x6)
- » Foam tape (flexible and stays on longer)
- » Super-Glue
- » Butterfly bandages
- » Burn ointment
- » Basic toenail care supplies, including toenail clippers in multiple sizes and tea tree oil for fungus
- » Triangle slings (for quick immobilizations)
- » Gloves in at least two sizes (in case someone else needs to assist in an emergency)

Another example of community collaboration comes from Carol Blank in Montana. Due to the frigid winter temperatures, RiverStone Health clinics reach out to the community for assistance with clothing for their clients. They ask for donations of heavy socks that will help prevent frostbite and white cotton socks which are suitable for placing over wound dressings. "We give out a lot of socks," says Ms. Blank. They also request new items such as hats, gloves, and scarves. Every December, they hold a candlelight memorial vigil and ask donors to bring "warmth items." In the main clinic they place a "tree of warmth" where people can donate warm clothing and items. This work of distributing supplies is preventative in more than one way; as Ms. Blank explains, "It goes back to that basic HCH grant language about outreach and building trust so that ... people come to us before they get into big trouble or end up in the emergency room or freeze to death." She notes that their organization also collaborates with other care providers at an annual summer health fair, which provides a hot breakfast and provides health education, "in hopes that people might remember us when they have a need."

Conclusion

Ultimately, as Carol Blank notes, "Having a home is health care. If you have a place to be that is warm and clean, you aren't going to have as many problems with wounds. We have clinics available to patients, and they can come in for care, but it isn't the same as a person who has resources and supplies in their homes." The work of providing housing for all people is part of the work of health care, but in the meantime, care providers in clinics, medical respite care facilities, and outreach programs all have a part to play in preventing and treating chronic and non-healing wounds for patients dealing with homelessness.

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Disclaimer

This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U30CS09746, a National Training and Technical Assistance Cooperative Agreement for \$1,625,741, with 0% match from nongovernmental sources. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

Appendix: Abscess Incision and Drainage: The Basics

With Dr. Susan Partovi of Homeless Health Care Los Angeles.

- » 1. Clean area.
- » 2. Inject local anesthesia.
- » 3. Needle aspiration.
- » 4. Make incision.
- » 5. Break septations.
- » 6. Squeeze out pus.
- » 7. Sop up pus.
- » 8. Pack and dress.

For a visual demonstration of each of these steps, see Dr. Partovi's tutorial at www.youtube.com/watch?v=YDDcgwPA6cU.

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Suggested citation: National Health Care for the Homeless Council. (January 2017). Best Practices and Considerations for Wound Care. *Healing Hands*, 21:1. (Author: Melissa Jean, Writer). Nashville, TN: Available at: www.nhchc.org.

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Patient-Centered Care: Case Studies on End of Life

Introduction

People experiencing homelessness have diverse and complex health needs that can become increasingly difficult to manage when individuals are diagnosed with terminal or life-limiting conditions. As **Dr. Pia Valvassori** of Health Care Center for the Homeless in Orlando, Florida, explains, "We're seeing people experiencing homelessness in their 50s and 60s with a number of chronic health conditions that have gone untreated for extended periods of time (such as Chronic Obstructive Pulmonary Disease, diabetes, infectious diseases, severe mental illness, etc.). We have a shortage of affordable housing units so we try to house those who are most vulnerable in permanent supportive housing. Some of the challenges our patients face include severe mental illness, competing priorities, and barriers and stigma associated with accessing care. It is well documented in the literature that the life expectancy of people who experience chronic homelessness is 12 years less than that of the general population." Mortality rates amongst people experiencing homelessness are estimated to be three-to-four times greater than the general U.S. population¹, and the number of older adults without homes is expected to increase to 95,000 by 2050.²

In order to respond to these types of complex situations,

patient-centered care is a therapeutic approach that places the patient at the center of the treatment process. Patient-centered care involves focusing on the needs, values, and wishes of the patient when developing a health care plan. The process of providing patient-centered care can become even more complex when clients are facing the end of their lives. Patient-centered palliative care seeks to relieve suffering and improve the quality of life for individuals who are not likely to recover from their diseases, while also respecting their autonomy and their right to make their own decisions about their health care. The five case studies presented in this issue of *Healing Hands* will highlight issues and challenges that clinicians may confront while providing palliative care to patients experiencing homelessness.

Case #1: Mr. J

CASE STUDY

Mr. J was a man in his mid-50s who was admitted to a recuperative care program in Portland, Oregon, after living outside for 15 years, mostly in a forest. He was admitted to the hospital with severe lung problems and then referred for recuperative care to a residential medical respite care program that provided short-term housing for people with acute medical needs. When first referred for care, Mr. J was

difficult to engage and closed off. He had various beliefs not consistent with the care providers' medical knowledge regarding the impact of any inhaled powder. As a result, he would not take any inhaled powders or anything with steroids in it, believing that they would harm him. Despite his care providers' explanations that steroids are an essential part of effective management of lung problems, Mr. J did not want to take them. The care providers did what they could to arrange his treatment within those limitations, but his fixed beliefs about medications significantly limited therapeutic options.

After Mr. J was referred to the medical respite care program, his case managers learned that he had been receiving a regular disability check but was spending most of the money paying for two storage units filled with furniture from the house that he had left 15 years earlier. At first, Mr. J did not feel he could give up that furniture, but after a month in respite care, he was reunited with a family member and began to pass on some of the stored items to her. Soon after, Mr. J requested of his own volition to be discharged from respite care. He was depressed and had begun speaking about his partner who had died in his arms 10 years prior and was buried in the woods where he had lived; he was heartbroken to think about her being alone in the woods and felt he needed to return to live near her burial place. Despite offers, Mr. J was not remotely interested in treatment for mental health conditions or therapy for depression; instead, he insisted that all he wanted was to be discharged so he could return to the forest.

Dr. Eowyn Rieke, Associate Medical Director of Primary Care at the Old Town Clinic of Central City Concern, explains of this case: "I knew he was discharging himself to likely death... It forced me to question whether he had the capacity to make decisions, [given that he was making a decision] with the likely outcome of him dying... Prior to being discharged back to the woods, there was a moment when I wasn't sure whether I was engaging in traditional medical care where the goal is to get better, or whether it was palliative care with the goal of feeling better, or maximizing function recognizing that he had a life-limiting illness. He was experiencing so much depression and cognitive problems that it was hard to identify whether he could honestly make a decision to forego his medication and the oxygen he needed."

CHALLENGES PRESENTED

- Capacity: At what point do people have the capacity to make their own decisions, and how can

care providers accurately assess their capacity?

- Mental health: What if a person has a mental health issue interfering with his decision-making process? What if depression is playing a significant role and may affect whether the patient makes choices that may lead to likely death?
- Patient's beliefs: What should a care provider do when the patient's beliefs conflict with medical evidence or the care provider's experience?
- Patient's goals: How can a care provider respond when a patient's goals are not in his own best interest?

LESSONS LEARNED

1. Work within patients' frameworks. This is especially important with homeless care and people who are disaffected with the system. In this case, Dr. Rieke transferred all of Mr. J's medications to non-powder form and managed to convince him to take steroids when he realized that he would be giving up oxygen. From a harm reduction standpoint, Dr. Rieke prescribed more than she typically would, realizing that Mr. J would probably not use the medications optimally but that the risk of long-term side effects from misuse were less than the risks of not taking them. The care team then discharged him, as he wished, and encouraged him to come back to respite care by going to the hospital and telling them that he wanted to return for care. Mr. J never returned to the hospital, and Dr. Rieke believes that Mr. J did not survive his return to the forest.

"Work within patients' frameworks. This is especially important with homeless care and people who are disaffected with the system..."



2. Have direct and specific conversations about the patient's goals, particularly in cases that teeter on the edge of curative versus palliative care. As Dr. Rieke explains, "From a palliative care perspective, the questions would have been: How can I make you comfortable, recognizing that your time is limited? But I was still really focused on the getting better piece. In retrospect, I probably would have had a more direct conversation with him about exactly what his goals were, because then it would have been even more patient-directed. I could have said, 'I'm worried you'll die.'"
3. Engage with patients as a team. Dr. Rieke believes that an important component of responding to Mr. J's case was engaging a team of case managers and people to help him get to appointments and access care. "We didn't think he was going to be willing to engage at all," said Dr. Rieke, "so it was especially important in his case to facilitate him in making decisions about his own care. We tried to be explicit about the power he had in the situation and emphasize that he was in charge of his own care." Still, Dr. Rieke wishes that agencies had more capacity to interact with people on the far edges of engagement due to logistical and attitudinal barriers. "More outreach could help overcome these barriers," she says, "and create more opportunities to have these crucial conversations."

"I have been able to see how managing withdrawal and managing substance abuse in the context of a palliative care treatment plan does not always exist for patients experiencing homelessness."

- LAWANDA WILLIAMS, DIRECTOR OF HOUSING SERVICES, HEALTH CARE FOR THE HOMELESS, BALTIMORE, MD

Case #2: Ms. L

CASE STUDY

Ms. L is a 47-year-old African American woman who was diagnosed with vulvar cancer at the beginning of 2017. She is also HIV-positive. By the time Ms. L engaged in care, the cancer had proliferated quite quickly in the setting of a compromised immune system. Upon discovery of the Stage 4 cancer, doctors recommended a dose of radiation and chemotherapy. However, during the course of this episode Ms. L was struggling with substance use. During her hospitalization, she tested positive for a number of substances, including heroin and cocaine.

As a result, care providers had many discussions about pain management and which pain medications could be given to her. She was not on methadone treatment maintenance at first, so she was self-medicating to address

her pain. While Ms. L wanted to seek help for her addiction to substances, some of the traditional models were not appropriate given the magnitude of her physical issues. There were expectations that she would get into outpatient treatment but she did not follow through, primarily because it was difficult for her to tolerate being in groups for long periods. (Given the location of her cancer, she could not sit upright for long periods or on the bus for transportation.)

Ultimately, **Lawanda Williams**, Director of Housing Services at Health Care for the Homeless in Baltimore, Maryland, and her team were able to provide Ms. L with transportation and cab vouchers so she could access the full course of radiation that doctors had recommended. Her pain was never well controlled, because her physician refused to prescribe her any pain medications, due to the magnitude of her substance use. The radiation center gave her Percocet while she was there but would not give her anything that could not be directly supervised. After treatment, they sent her home with prescriptions for Tylenol and instructions to return and follow up with pain management teams, which she was unable to do because of her difficulties with transportation and sitting.

Ms. L completed radiation and is in a period of holding to assess effectiveness of the initial course

of radiation, but she still does not have a prescription for her significant pain and, as a result, continues to use substances to manage her pain. Ms. Williams observes, "I have been able to see how managing withdrawal and managing substance abuse in the context of a palliative care treatment plan does not always exist for patients experiencing homelessness. She does not fit very neatly into any mainstream treatment model."

CHALLENGES PRESENTED

- Harm reduction: How can care providers best advocate for a harm reduction approach while seeking to deliver palliative care services, including hospice care?
- Withdrawal: What role should withdrawal management play in the development of a palliative care plan?
- Pain management: What are the best pain management approaches for cases in which extreme pain is combined with active addiction? What is the dynamic between balancing a physician's sense of risk

management and concern about overdose with the client's need for adequate pain control?

- Location: What treatment locations can be considered as options for people who need intensive care and palliative care? How do the options change when addiction is also involved?

LESSONS LEARNED

1. Recognize the impact that addiction has on health care. Harm management principles can provide useful perspective on how to best assess the relationship between addiction, addiction treatment, and pain management. According to Ms. Williams, "there's a need for really being able to balance treating addiction as a component of end-of-life care. How does one do that, and how can physicians achieve that as safely as possible?"
2. Consider the client's priorities and desired outcomes. In this case, doctors had at first proposed a radical surgery that would have involved taking off an entire side of her labia, but Ms. L had deep concerns regarding the aesthetic impact of such a surgery. The care plan changed to instead focus on a course of radiation, and Ms. L was relieved that the treatment would not involve disfigurement. Ms. Williams notes: "Initially I was pleasantly surprised to see how well her body responded to the treatment. There are still concerns about what might be going on inside, but aesthetically her result—which was really important to her actually, as it related to her relationship—she got the result there that she wanted."
3. Consider the client's location. As Ms. Williams explains, care providers should develop "an appreciation for the client's location—including where they are staying and whether they are homeless on the streets or in a housed environment that is not conducive to healing or recovery from substance abuse." She notes that actual and potential locations are key for integrating substance abuse treatment, as well: "Often when people have a myriad of different issues, you want to refer out. In some ways, I feel like when individuals are facing end of life, those services should be collapsed in. When we're doing palliative care, I can pull from these other areas. For example, having palliative care physicians and providers who are willing to do substance abuse treatment in tandem, or provide medications that will prevent withdrawal or manage withdrawal. How can the physician manage withdrawal symptoms in the context of end-of-life care?"



Case #3: Mr. D

CASE STUDY

Mr. D was a man in his early 60s. After being unsheltered and uninsured for 5-to-6 years, with an underlying diagnosis of alcohol and substance use disorders, he developed liver disease. **Dr. Pia Valvassori** and her team at Health Care Center for the Homeless managed to help him secure housing, but due to issues with identification, Mr. D was unable to get immediate access to specialty care services. Three weeks after being placed in permanent supportive housing, a caseworker found him unconscious in his unit and took him to the emergency room, where it was discovered that his end-stage liver disease had progressed to the point where the only option was palliative care. However, care providers had no advance directive for the patient, nor documentation of his wishes for end-of-life care.

After being placed in residential hospice care, Mr. D regained consciousness and was able to vocalize his wishes. He expressed that he wanted to be a "full code," meaning he wanted hospital staff to intervene if his heart stopped beating or if he stopped breathing. In the end, he was readmitted to the hospital and his status rapidly deteriorated. The hospital and hospice care provider contacted his daughter, who lived out of state, and he died within 10 days.

CHALLENGES PRESENTED

- Autonomy: Are conversations with patients about their wishes and goals being conducted as soon as possible?
- Beneficence: Are care providers assuming that they know the wishes and best interests of clients without consulting them directly?

LESSONS LEARNED

1. Train staff on the usage and development of advance directives, and introduce documentation early in the process. At Health Care Center for the Homeless, staff are trained by hospice care providers on developing plans for end-of-life care with patients. Staff members now have Five Wishes documents ready to review with clients and scan into electronic health records. "For us," explains Dr. Valvassori, Mr. D's experience "was a lesson that... we are going to uncover all kinds of things once we're able to engage patients, and we really need to put advance directives at the top of list of conversations to have. We can't make assumptions, since we want people to be engaged in making their decisions on their own."
2. Try to access insurance as soon as possible. Mr. D had no health insurance, "sick as he was," explains Dr. Valvassori, "and I feel like a lot of this could have gone differently. For example, if we could get him in to see a specialist, which we couldn't because of insurance, we could have had a diagnosis and could have discussed these things." It can take time to access services because of a wide variety of access challenges and technicalities, so if a patient is very sick, care providers cannot afford a delay in accessing any specialty care that is available.
3. Acknowledge patients' right to autonomy and self-determination. As Dr. Valvassori says, "I think probably one thing I learned is not to impose our own personal views on what we think a patient will want... We were surprised when in a lucid moment he verbalized 'full code'... So we learned about having respect for the patient's perspective, and not going in with your own preconceived notions."

"I think probably one thing I learned is not to impose our own personal views on what we think a patient will want..."

- DR. PIA VALVASSORI, NURSE PRACTITIONER AND CLINICAL PROFESSOR, HEALTH CARE CENTER FOR THE HOMELESS, ORLANDO, FLORIDA

Case #4: Mr. X

CASE STUDY

Mr. X is 61-year-old Army veteran. He was a healthy furniture repairperson until his 50s, avoiding doctors, and living with his wife and son until about five years earlier when, unfortunately, both his wife and son passed away. He became depressed, increased his drinking, and lost his job and his housing. He became connected to care through the homeless primary care clinic and housing resources at the US Department of Veterans Affairs (VA). He was fearful

and paranoid about all doctors, blaming them for the deaths of his wife and son.

Over the next three years, he slowly engaged with VA care and services. Currently, Mr. X receives a small disability stipend and chooses to live in a long-term motel. He was diagnosed with depression, alcohol use disorder, B12 deficiency, and progressive loss of function of his arms and legs. He was also diagnosed with cervical spondylotic myelopathy after C3-C6 laminectomies and fusion in 2015, which were unsuccessful in restoring function. At present, he has significant upper extremity bilateral weakness and spasticity in his lower legs, and has sustained countless falls in the community.

According to **Dr. David Rosenthal**, Assistant Professor of General Internal Medicine at Yale Medical School and

Medical Director of the Homeless Patient Aligned Care Team for VA Connecticut, throughout Mr. X's illness and multiple hospitalizations related to intoxication and falls/fractures, he has maintained a fiercely independent streak and regularly refuses care by home agencies. On multiple occasions, Dr.

Rosenthal's team has been informed by VA or Mr. X himself that he has fallen, but he refuses to seek medical care. He refuses most medical care and all mental health care and substance use treatment recommendations.

CHALLENGES PRESENTED

- Substance use: If a patient is able to clearly understand risks and benefits of treatment while sober, but not while intoxicated, how can a care provider account for the role of substance use in determining decision-making capacity?
- Refusal of care: How can care providers respond to patients who refuse care that would be in the best interest of their health?
- Outside agencies: What role could or should elderly protective care play in a case like this?

LESSONS LEARNED

1. Capacity is not static. A patient's capacity for decision-making is constantly changing and should be assessed regularly by clinicians. "Competence" refers to a patient's legal ability to make decisions, while

"capacity" refers to their clinical ability; as a result, a patient's capacity can wax and wane.

2. When a patient has capacity to make decisions for themselves, patient autonomy trumps medical beneficence. The core of patient-centered care is a principle of autonomy that allows patients to guide the clinical process. Patient-centered care requires respecting and responding to the patient's values, needs, preferences, goals, and hopes for the future.
3. Remember the emotional needs of the care team, too. As Dr. Rosenthal explains, "When witnessing significant human suffering, as in this case, it is vitally important for teams to openly discuss their concerns and, as a team, validate emotions to avoid caregiver distress and burnout."



Case #5: Ms. Q

CASE STUDY

Ms. Q was a 43-year-old Vietnamese woman who came to the US in 1990 and was diagnosed with HIV and Hepatitis C at that time. She came to the United States with her husband, who was also HIV-positive; her daughter was not infected. Her husband was abusive and their marriage eventually ended. Since her diagnosis, however, Ms. Q has struggled with adherence to antiretroviral therapy. She has been in and out of homelessness since the end of her marriage, often working as a nail technician. At one point, she moved to another state and came back with a CD4 count under 100 and a viral load of 700,000.

According to **Mary Tornabene**, Family Nurse Practitioner at Heartland Health Outreach in Chicago, Illinois, care providers were able to get Ms. Q's CD4 count up to 400, but around that time, Ms. Q complained of constipation. She received medication for the constipation, but it did not help, and care providers learned that the full scope of her symptomology had not been clear due to the language barrier. (Ms. Q persistently refused interpretive services, leading to miscommunications.) Three large tumors were discovered in Ms. Q's colon, and she was diagnosed with Stage 3 colon cancer. The first round of chemotherapy did not help, and the cancer progressed to Stage 4.

Since her cancer diagnosis, Ms. Q has had increasing difficulty securing housing due to her difficulties paying rent and keeping resources, even with financial help from her church and her 25-year-old daughter who lives out of state. Though she qualifies for some rental assistance programs due to her HIV-positive status, she does not want to reveal her status to potential landlords; this is also complicated by the fact that she holds a green card but is not a citizen of the United States. As a result, Ms. Q lived in a shelter and

"When witnessing significant human suffering... it is vitally important for teams to openly discuss their concerns and, as a team, validate emotions to avoid caregiver distress and burnout."

- DR. DAVID ROSENTHAL, ASSISTANT PROFESSOR OF GENERAL INTERNAL MEDICINE, YALE MEDICAL SCHOOL; MEDICAL DIRECTOR, HOMELESS PATIENTS ALIGNED CARE TEAM FOR VA CONNECTICUT

couch-surfed while undergoing chemotherapy. At this stage, she has been placed in a hospice program in a nursing home and is being provided with palliative care.

CHALLENGES PRESENTED

- Language barriers. How can care plans, particularly palliative care plans, be adequately explained to clients with language barriers?
- Cultural barriers. What role does cultural background play in the choices a client may make about their health care?
- Housing issues. What can be done if a client refuses housing assistance or chooses not to connect with resources that are disease-specific out of a preference not to disclose their health status?
- Citizenship or legal status. Consider what reasons immigrants who are undocumented or green card holders might be hesitant to access health care or housing resources that are available to them.

LESSONS LEARNED

1. Approach the conversation about interpreters up front. In Ms. Q's case, she carried a lot of stigma and shame around her HIV-positive status, and did not want anyone—even, for many years, her own daughter—to know that she had the disease. For this reason, she refused interpretive services even though her English skills were not strong enough to successfully navigate the health care system. Ms. Tornabene notes that other options—such as tele-interpreting services that use an anonymous process and do not know the patient's name—can be used whenever a clinician wants to ensure a client that their identity will be protected.
2. Be attentive to ways in which cultural context may affect interactions. Ms. Tornabene explains that she wishes she could have found a Vietnamese nurse to assist with explaining Ms. Q's options to her; for example, she had difficulty understanding the meaning and implications of being placed in hospice care. In some cases, and with the patient's consent, there may be community resources available to assist with cross-cultural communication in cases when clients need to be apprised of their options.
3. Establish ties with family members whenever possible. With the patient's consent and permission, end-of-life care plans can incorporate an element of family reunification or family involvement. In Ms. Q's case, her daughter lives in another state, but Ms. Tornabene has been able to develop a strong supportive rapport with the daughter. Clinicians have the opportunity to promote reunification between the family members while also developing a clinician-family relationship.

Conclusion

Care providers often face difficult and complicated situations when patients experiencing homelessness develop chronic, terminal, or life-limiting health conditions. Patient-centered care requires the development of a standard of care that is accessible, non-judgmental, consistent, multi-disciplinary, evidence-based, persistent, and creative. By focusing on the stated needs and desires of the patient, care providers can provide careful and sensitive care even when thorny and challenging issues arise.

Appendix

What follows is an example of a script (shared by **Annie Nicol**, Director of Homeless Services at Petaluma Health Center in Petaluma, California) that may be used to present the concept of advance directives to patients.

Script for Advance Health Care Directives

HAVE YOU HEARD OF AN ADVANCE HEALTH CARE DIRECTIVE?

- We are encouraging everyone 18 years and older to have one.
- It's a way for you to give instructions about your own health care if you became very sick.
- It also lets you appoint a person to make medical decisions for you if you could not speak for yourself.
- This can be difficult to talk about, but everyone has different things that are important to them in life, and no one is a mind reader. If something were to happen to you and you couldn't speak for yourself, having a written plan makes it a lot easier on family/friends and your health care team, because they won't have to guess what you would have wanted.

WE HAVE A VERY SIMPLE FORM THAT CAN BE COMPLETED. CAN WE GET STARTED ON THAT FOR YOU TODAY?

Part 1: Choose a Medical Decision Maker to make decisions for you if you could not speak for yourself. This should be someone who knows you well and would be able to make decisions for you as you would want.

Do you know whom you would choose?

- **If yes:** great, when you are done with your Advance Directive, it's important to talk to your Medical Decision Maker about your wishes.
- **If no:** here is some information on how to choose a Medical Decision Maker.
- **No one appropriate:** That's okay; you can still complete Part 2.

Part 2: Instructions for Health Care

- Your provider will talk to you about different choices you have for life-sustaining treatment such as CPR, breathing machines, and feeding tubes.
- This section helps guide your Medical Decision Maker and health care team in following your wishes.
- Here are some things to think about that might help in filling out this section.
- **Handouts:** Prepare Sheet / Reflecting on Values

I'm going to play a video for you that explains a little more about Advance Care Planning.

- If you are not sure today about your wishes or you are not ready to fill out the form, it's okay. Please review the handouts/videos and we can talk about it more at your next visit.
- The form needs to be signed by two witnesses. You can take the form home to have it signed, and return it to the health center.

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Disclaimer

This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U30CS09746, a National Training and Technical Assistance Cooperative Agreement for \$1,625,741, with 0% match from nongovernmental sources. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

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Suggested citation: National Health Care for the Homeless Council. (January 2018). Patient-Centered Care: Case Studies on End of Life. *Healing Hands*, 22:1. (Author: Melissa Jean, Writer). Nashville, TN. Available at: www.nhchc.org.

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