

The Homeless in America: Adapting Your Practice

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In 2004, the National Guidelines Clearinghouse placed eight guidelines from the National Health Care for the Homeless Council on its Web site. Seven of the guidelines are on specific disease processes and one is on general care. In addition to straightforward clinical decision making, the guidelines contain medical information specific to patients who are homeless. These guidelines have been endorsed by dozens of physicians who spend a large part of their clinical time caring for some of the millions of adults and children who find themselves homeless each year in the United States. In one guideline, physicians are prompted to keep in mind that someone living on the street does not always have access to water for taking medication. Another guideline points out the difficulty of eating a special diet when the patient depends on what the local shelter serves. As the number of homeless families and individuals increases, family physicians need to become aware of medically related information specific to this population. This can help ensure that physicians continue to offer patient-centered care with minimal adherence barriers. (*Am Fam Physician* 2006;74:1132-8. Copyright © 2006 American Academy of Family Physicians.)



ILLUSTRATION BY MARK E. SCHULER

The online version of this article, available at <http://www.aafp.org/afp>, includes supplemental content.

See related editorial on page 1099.

Each day in the United States, at least 800,000 persons are homeless. This includes 200,000 children in homeless families.¹ As of the beginning of the 21st century, 2.3 to 3.5 million persons were homeless at some time during an average year.² Approximately 33 percent of these are families with children, and another 3 percent are unaccompanied minors.³ Two percent of children in the United States are homeless in the course of a year.⁴ *Figure 1*³ shows the composition of the homeless population in the United States.

The Federal Bureau of Primary Health Care defines homelessness using the following descriptors⁵:

- An individual without permanent housing who may live on the streets; stay in a shelter, mission, single-room occupancy facility, abandoned building or vehicle; or in any other unstable or nonpermanent situation.
- An individual may be considered homeless if that person is “doubled-up”, a term

referring to a situation in which individuals are unable to maintain their housing situation and are forced to stay with a series of friends or extended family members.

- Previously homeless individuals who are to be released from prison or a hospital may be considered homeless if they do not have a stable housing situation to return to.
- Recognition of the instability of an individual’s living arrangement is critical to the definition of homelessness.

State, city, or private definitions (e.g., ones used for grants or to receive certain subsidies) may differ from this.

At the beginning of this century, clinicians from the National Health Care for the Homeless Council (NHCHC) began to adapt clinical practice guidelines for patients who are homeless. In 2004, the National Guidelines Clearinghouse placed eight NHCHC guidelines on its Web site, including seven relating to specific disease processes and one on general care (*online Table A*). Well-researched evidence that differentiates



SORT: KEY RECOMMENDATIONS FOR PRACTICE

| <i>Clinical recommendation</i> | <i>Evidence rating</i> | <i>References</i> |
|--|------------------------|-------------------|
| Caring for persons who are homeless: | | |
| To help promote successful treatment, develop an individualized plan of care that incorporates plans to meet some basic needs as well as medical needs. | C | 6 |
| Become familiar with what food is available in local shelters and soup kitchens before suggesting to patients how to restructure their diet for chronic illness prevention or care. | C | 6 |
| Anticipate and accommodate unscheduled clinic visits. Create a drop-in time when no appointment is required, particularly for new patients. Include some evening appointment times to accommodate day workers. | C | 6 |
| Avoid prescribing medications likely to have significant sedative side effects unless they initially can be tried in a safe environment to avoid compromising the patient's safety. | C | 6 |
| If a patient appears to be emotionally fragile, consider using an assistant, even for clothed examinations. | C | 6, 8, 15 |
| Provide a client advocate to accompany patients who are unable to navigate through the health care system on their own. | C | 6 |

A = consistent, good-quality patient-oriented evidence; B = inconsistent or limited-quality patient-oriented evidence; C = consensus, disease-oriented evidence, usual practice, expert opinion, or case series. For information about the SORT evidence rating system, see page 1079 or <http://www.aafp.org/afpsort.xml>.

care for the homeless population from the general population is almost nonexistent. Therefore, the method used to assess the quality and strength of the evidence for those criteria and to formulate recommendations was based almost entirely on expert consensus.

This article summarizes some of the NHCHC guidelines that apply to a variety of conditions that pertain to persons who are homeless. Although some of this information is duplicated in other NHCHC guidelines, most

of it comes from the NHCHC's general recommendations,⁶ except when noted otherwise. In addition, some relevant information from more recent literature on the topic is included.

Overcoming Barriers to Care

Millions of persons in the United States with minimal health care access experience barriers to care, but persons who are homeless face additional unique obstacles. Difficulties can arise when a physician tries to build trusting relationships in a population where histories of mental illness and abuse are often the norm. Even when trust is won, finding the appropriate prescribing patterns and education techniques to help ensure adherence can be a challenge for any physician, particularly when food and housing concerns often outweigh those for ongoing health care. Ideally, physicians should develop individualized care plans that incorporate the meeting of basic daily needs.

Unrealistic expectations by physicians are a key cause of patient nonadherence.⁵ When adherence is a problem, the physician should reassess goals with the patient. Knowing some of the issues that affect adherence for persons who are homeless may help clarify any unrealistic expectations (*Tables 1 and 2*⁶⁻¹⁰).

BUILDING TRUST

A full-body, unclothed, comprehensive examination of an adult who is homeless is rarely possible before patient-physician trust

Composition of the U.S. Homeless Population, 2005

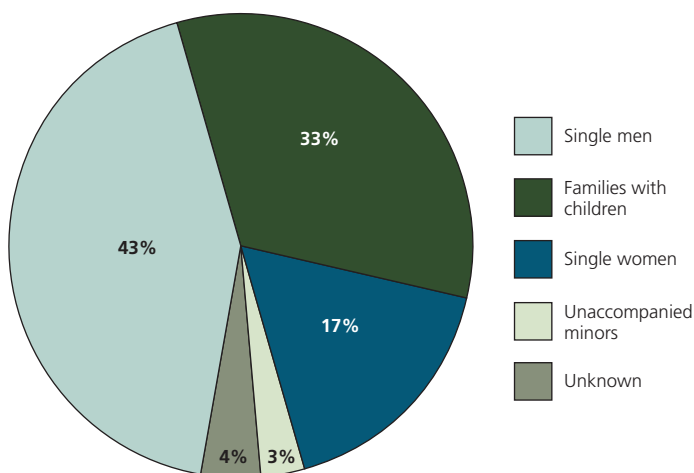


Figure 1. Who becomes homeless?

Adapted with permission from U.S. Conference of Mayors—Sodexo, Inc. Hunger and Homelessness Survey. Accessed April 4, 2006, at: www.usmayors.org/uscm/hungersurvey/2005/HH2005FINAL.pdf.

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and engagement is achieved. Approximately 25 percent of these patients have at some time experienced severe mental disorders such as schizophrenia, major depression, or bipolar disorder, and many are survivors of physical or sexual abuse and/or assault.¹¹⁻¹⁴ In addition, many have experienced negative interactions with authority figures, and because anxiety is highly prevalent in the homeless population, these patients may be averse to the private aspects of the physical examination.

At the first visit at which a full physical examination is appropriate, explain what a comprehensive physical

examination entails and ask permission to perform one. If the patient prefers not to disrobe at the first visit, defer nonurgent genital examinations until comfort levels allow.^{7,8} Consider using an assistant for examinations of all clothed and unclothed patients who appear emotionally fragile.^{8,15}

Persons who are homeless can feel vulnerable within the health care system; some have never used it. Others have no idea how to navigate the system and may not follow through for that reason alone. Providing a client advocate to accompany such patients can be invaluable.

TABLE 1

Determinants of General Care Adherence in the Homeless and Potential Enhancements

| Potential determinant | Potential enhancements |
|---|--|
| Inappropriate physician expectations | Reevaluate expectations. |
| Erratic food and water sources | Educate shelter staff about the role of nutrition in managing major chronic diseases; plan relevant therapies around food and water access; provide multivitamins; provide nutrition education pertinent to actual food sources. |
| Physician discontinuity | Promote communication among physicians; establish where the patient considers his or her medical home to be; supply patients with a wallet-sized medical history review. |
| History of negative interactions with authority figures (physician needs to win trust of the patient) | Address patient's perceived immediate medical needs first; carefully assess how prescribed therapies affect patients' lifestyles; convey a nonjudgmental attitude toward all patients; employ consumer advocates; identify free or discounted services; supply small incentives; verbally emphasize patient strengths. |
| Alienation from health care system | Provide a patient advocate to accompany appropriate patients to appointments for diagnostic tests or ambulatory surgery. |
| Substance abuse | Know signs, symptoms, and side effects of psychoactive substances; maintain safety of patients and staff by periodically reviewing what to do for overdoses or acute negative psychotic or manic presentations; treat symptoms of withdrawal whenever appropriate. |
| Nomadic lifestyle | Request emergency contact information (e.g., address and phone number of a family member, friend, or case manager with a stable address); verify contact information at each visit. |
| Multiplicity of chronic health conditions | Educate the patient about usual course of diseases and conditions; encourage adults to make their own goals and prioritize them; supply the patient with information necessary to make his or her own health goal priorities. |
| History of physical and emotional abuse | Ask permission to perform physical examinations; consider using assistants for all examinations; defer genital examination until patient comfort level allows; encourage and help develop safety plans; explain what a physical examination entails. |
| Shelter | Encourage patients to seek shelter on nights when weather is extreme; identify where and with whom patients are staying. |
| Transportation | Ask patients about transportation if related to expected adherence; supply health access-related bus or subway tokens. |
| Clinic access | Have after-hours clinic times; give appointment cards and allow unscheduled clinic visits; prioritize patient order when there are too many to be seen. |
| Crowded shelter conditions | Encourage coughing into elbow crook and hand washing; keep vaccinations up to date; recognize that practicing new parenting skills is difficult in group living situations. |
| Educational, developmental impairment | Teach patients how to keep symptom logs; write out preventive action plans; ask about last grade of school completed. |

Information from reference 6 through 10.

Consider contacting a local homeless advocacy group, a faith-based group involved with community service projects, or a hospital auxiliary. Such groups may be able to identify a person to assist the patient by providing transportation or directing guidance regarding appointments, testing, and other issues.

Emphasizing patient strengths is important. Seeking health care, keeping appointments, and adhering to treatment are all examples of basic patient strengths that should be acknowledged. Thank patients for showing up (even if they are late) and for any attempt by them to follow a plan of care. The NHCHC guidelines point out that just meeting survival needs while homeless takes resourcefulness, patience, and tenacity.⁶

DIET

Many shelters and soup kitchens serve food that makes adherence to special diets difficult for those with

chronic medical conditions such as diabetes or hypertension. It is imperative to be familiar with the types of food available to patients before suggesting how to structure their diet.

ACCESS

Approximately 18 percent of adults who are homeless are employed.¹⁶ After-hours clinic time is essential if physicians hope to accommodate working patients who cannot take time off without risking their jobs. Whenever possible, create a drop-in time when no appointment is required, particularly for new patients. Encourage routine follow-up for established patients, supplemented by an open-door policy for drop-ins.

Consider using small incentives (e.g., phone cards, bus tokens, hygiene kits, free condoms, new socks, food coupons) to encourage patients to return for laboratory results.^{8,9}

TABLE 2

Determinants of Medication Adherence in the Homeless and Potential Enhancements

| <i>Potential determinant</i> | <i>Potential enhancements</i> |
|---|--|
| Ethical reliability of certain medications may be in question | Keep in mind that albuterol (Ventolin) is used to enhance the effects of crack cocaine, clonidine (Catapres) extends effects of heroin and reduces its withdrawal symptoms, insulin syringes may be used to inject illicit drugs, and pseudoephedrine is used to make methamphetamine. |
| Life is already complex | Once-daily, directly observed therapy often is preferable; use simplest medical regimen warranted by standard clinical guidelines. |
| Patients may keep possessions with them at all times | Always consider frequency, storage, and treatment duration; whenever possible, fill prescriptions on site at time they are ordered; simplify medical regimens. |
| Side effects may be particularly difficult to cope with | Prescribe medications least likely to have severe negative side effects; avoid prescribing medications with even a moderate likelihood of having significant sedative or gastrointestinal side effects unless the patient has a day to test them while safely sheltered; be aggressive in changing medications to minimize side effects; treat side effects symptomatically if alternative medications are contraindicated; if a medication needs to be taken with food, provide a nutritious snack. |
| Storage may be an issue | Educate patients and shelter staff about appropriate medication storage and access; do not prescribe medications for which appropriate storage is not possible; for children older than five years, use pills, tablets, or capsules instead of liquid formulations to avoid the need for measurement or refrigeration; consider allowing medications to be stored at the clinic. |
| Missed immunizations | Update childhood immunizations at each clinic visit; give a wallet card to parents with immunizations listed and dated; provide hepatitis A and B vaccines and tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis absorbed vaccines for adults; provide influenza vaccines for all patients. |
| Crying child may disrupt other shelter residents | To allow the child to sleep, consider providing a cough suppressant, diphenhydramine (Benadryl), or analgesia for acute ear infection. |
| Many patients depend on Medicaid's formulary | Know which medications are on state's Medicaid and State Children's Health Insurance Program drug formularies; to avoid delaying treatment, prescribe medications that do not require prior authorization, when possible. |

Information from reference 6 through 10.

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NOMADIC LIFESTYLE

Although some patients who are homeless become well known to their physicians and have relatively good follow-up potential, others are nomadic and often travel across several neighborhoods, cities, or even states in the course of a month. A key aspect of caring for these patients is to assess their mobility and the likelihood that they may stay in one place long enough to work on gaining better control of a chronic medical condition.

Evaluate all patients for residential stability. Note their form of shelter and how often they have access to bathing facilities. Check to see if they have a safe place to keep hygiene items and medications, including those that require refrigeration.

Children who are homeless have a higher incidence of trauma-related injuries, developmental delays, visual and neurologic deficits, and poor academic performance.

If the patient is not living in a shelter or on the street, ask if they are doubled-up.

Consider using wallet-sized monitoring cards or cards kept in pouches worn around the neck to record laboratory results, vital signs, examinations, and follow-up visits. Patients can use these cards as a self-management tool or share the information with their next health care provider.^{9,10}

MEDICATIONS

When recommending the use of water, including for ingestion of medications, be sure the patient has access to it.

Avoid prescribing medications likely to have significant sedative side effects unless they initially can be tried out in a safe environment.⁹ Medications that make the patients feel nauseous or that diminish alertness may compromise their safety on the streets or in shelters.

Be aware that diuretics can be problematic for persons who have little access to bathroom facilities throughout the day.⁹

Use caution if prescribing medications such as alpha or beta blockers that can result in rebound hypertension. Do not use beta blockers for persons who may also use cocaine because the combination is dangerous unless an alpha blocker (e.g., clonidine [Catapres]) or a combination blocker (e.g., labetalol [Normodyne]) also is used. Be sure to include careful education about the medication.⁹

There is a high prevalence of hepatitis among persons who are homeless. Liver function tests should be

followed with particular care when using medications such as statins.⁹

Medications with significant gastrointestinal side effects, particularly diarrhea, can be exceptionally difficult to handle in a homeless setting.^{8,9}

Aside from the more obvious ethical reliability concerns about prescribing scheduled medications, a few unscheduled medications (e.g., albuterol [Ventolin], clonidine, pseudophedrine) and some tools (e.g., insulin syringes) also can be sold or traded on the street (*Table 2*⁶⁻¹⁰). Their illicit use is uncommon, but physicians should still be alert to multiple lost prescriptions of these medications.

Provide particularly clear instructions for patients with diabetes about the use of insulin or oral hypoglycemic agents when food is not available.¹⁰

Negotiate the amount of medications to dispense at a given time based on clinical indications, the patient's wishes and ability to hold onto the medications, and availability of transportation. Some patients lose medications if larger quantities are provided. For some patients, dispensing smaller amounts can provide an incentive to return for follow-up, but only if transportation to and from the clinic is available and affordable.⁹

Patient Education

Adult patients with mental illness or chronic substance use may have impaired reasoning and delayed social development. When discussing behavioral change with such patients, focus on immediate concerns rather than possible future consequences.

Ask patients what has prompted them to use emergency departments in the past. Use their answers to educate them about appropriate emergency department use. Help the patient or family make a plan for emergencies. Be sure they know the location of emergency facilities as well as how to contact a primary care physician, if one is available, before going to the emergency department.

The prevalence of smoking is significantly higher in the homeless population than in the general population.¹⁷ Physicians should acknowledge that smoking cessation may be a low priority for the patient in this situation, but the importance of reducing nicotine use should still be stressed. Use the harm reduction approach (e.g., encourage patients to reduce the number of cigarettes daily).

At the end of each clinic visit, consider asking the patient if anything discussed was unclear or if there was anything in the plan of care that would be difficult for the patient to do.

One of the most helpful and healthful services that the

physician can perform is to send for old patient records, review them, and write out one succinct wallet-sized medical history review for the patient to carry.

Children and Adolescents

Homelessness in childhood is an independent predictor of poor health and the frequent need for medical care. Children who are homeless have a higher incidence of trauma-related injuries, developmental delays, sinusitis, anemia, asthma, bowel dysfunction, eczema, visual and neurologic deficits, and poor academic performance. However, their verbal and nonverbal intelligence scores are similar to those of their housed peers.^{18,19}

Many homeless adolescents have experienced violent physical or sexual abuse for many years. A higher rate of abuse has been reported in females compared with males and in persons with an alternative sexual orientation compared with heterosexuals.^{15,20,21}

Use every patient visit as a potential opportunity to perform a general physical examination, including standard screenings and oral screenings for age-appropriate teeth and obvious tooth decay.

Assist parents in learning effective parenting skills. Recognize that plans to shape new behaviors in children or extinguish old ones are difficult to carry out in group living situations where parent-child interactions may be subject to public scrutiny, criticism, and interference from others.

Update childhood immunizations at every clinical encounter. Given the high risk of exposure to respiratory infections in group living situations, immunize against influenza annually.

Ancillary Care

Whenever possible, provide recuperative care or medical respite facilities where patients can convalesce when ill, recuperate following hospitalization, or receive end-of-life care. Medical respite services are cost-effective because they prevent future hospitalizations.²²

Permanent housing will help alleviate many of the barriers that individuals and families who are homeless face. Work with social workers and case managers to pursue all entitlements for which a family is eligible. Connect with outreach programs and coalitions, physicians, mental health board members, alcohol and drug abuse organizations, or other advocates for at-risk populations in the community.

Education

Physicians should educate themselves and their colleagues about the special needs of patients who are home-

less (*Table 3*). Dialogue with consultants, shelter staff, food workers, and volunteers about the health needs of these patients. Recognize that treatment adherence and successful outcomes are possible, even for persons with mental health or substance abuse problems.

An additional educational tool, a slideshow entitled Health Care for the Homeless 101, can be downloaded free of charge from the NHCHC Web site (<http://www.nhchc.org/HCH101/>). It contains information on the history and service delivery of health care for the homeless, successful approaches to care, and a list of resources that may be useful when caring for this patient population.

TABLE 3

Resources for Caring for Individuals and Families Who Are Homeless

National Health Care for the Homeless Council (<http://www.nhchc.org/>)

Advocacy and policy information
Clinical resources
HCH Clinicians' Network (phone: 615-226-2292, e-mail: network@nhchc.org)
HCH publications
Medical respite or recuperative care alternatives
General information on homelessness
Disability and advocacy tools
Research
Training and education

Bureau of Primary Health Care Patient Assistance Programs (<http://www.hrsa.gov/opa/links.htm>) and American Society of Health-System Pharmacists Patient Assistance Program Resource Center (<http://www.ashp.org/PAP/>)

Food stamps
Medicaid, State Children's Health Insurance Program
Pharmaceutical companies' patient assistance programs for low-income individuals
Supplemental Security Income
U.S. Department of Health and Human Services' 340B pharmaceutical discount program
Women, Infants, and Children program

Bureau of Primary Health Care – HCH Information Resource Center (<http://www.bphc.hrsa.gov/hchirc/>)

Directory of HCH grantees and subcontractors (<http://www.bphc.hrsa.gov/hchirc/directory/>)
Local HCH projects (<http://www.bphc.hrsa.gov/hchirc/directory/default.htm>)

HCH = Health Care for the Homeless.

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National Guidelines for Health Care for the Homeless and Supporting Recommendations**1. Adapting Your Practice: General Recommendations for the Care of Homeless Patients**

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Table A continues

TABLE A (continued)

National Guidelines for Health Care for the Homeless and Supporting Recommendations**4. Adapting Your Practice: Treatment and Recommendations for Homeless Patients with Asthma**

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5. Adapting Your Practice: Treatment and Recommendations for Homeless Patients with HIV/AIDS

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Table A continues

TABLE A (continued)

National Guidelines for Health Care for the Homeless and Supporting Recommendations**5. Adapting Your Practice: Treatment and Recommendations for Homeless Patients with HIV/AIDS** (continued)

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HIV = human immunodeficiency virus; AIDS = acquired immunodeficiency syndrome.

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