Homelessness and Health Care: Considerations for Evaluation, Management, and Support Within the Primary Care Domain

Adam D. Koon, MPH, Vivek S. Kantayya, MD, FAAFP, and Bechara Choucair, MD

Introduction

There are significant challenges to addressing the health needs of the homeless. The complex nature of homelessness, coupled with the crippling effects of poverty, limit the extent to which primary care providers are able to effectively deliver care within a traditional clinical environment. To provide appropriate and supportive patient care, the clinical practice of the primary care provider should be augmented to include considerations for the broader social determinants of health. Only then can we begin to assure the human right to health for the most visibly impoverished among us.

The definition of “Homelessness” reveals that individuals who are homeless are not always visible. According to the Federal Bureau of Primary Health Care, an individual is considered homeless if (1) s/he is without permanent housing (eg, lives on the streets; stays in a shelter, mission, single-room occupancy facility, abandoned building or vehicle; or any other unstable or nonpermanent situation); (2) s/he 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; and/or (3) s/he was released from prison or a hospital and does not have a stable housing situation to return to. Health Resources and Services Administration, an agency of the US Department of Health and Human Services, emphasizes that the distinguishing feature of homelessness is the instability of an individual’s living arrangement, rather than the physical space that one may call her or his own. Because this definition of homelessness is broad, accurate
estimates of the prevalence of homelessness are hard to determine.\textsuperscript{3-5} The latest data seem to indicate that approximately 800,000 individuals are homeless in the USA and approximately 2 to 3 million individuals experience homelessness in an average year.\textsuperscript{6}

Homelessness occurs through the interaction of several other interdependent variables, known commonly as the social determinants of health.\textsuperscript{7} It is important to recognize that homelessness itself is a social determinant of health, but the promulgation of homelessness at the individual and population level results from the interaction of many factors. Conceptualizing homelessness through this framework is important because it attempts to excavate the “causes of the causes.”\textsuperscript{8} In this way, homelessness is not merely the result of risk factors, such as low socioeconomic status, mental illness, diet, or alcohol, but rather social conditions that increase an individual’s exposure to communicable disease, create unhealthy behaviors, or force individuals to lead extraordinarily stressful lives. These social determinants of health are related to the social gradient, stress, early life experiences, social exclusion, work/unemployment, social support, addiction, food, and transport.\textsuperscript{8} The collusion of these social determinants of health creates an epidemiologic profile unique to the individual experiencing homelessness.

The health of the homeless individual is marked by increased exposure to communicable disease, increased risk for chronic disease, increased prevalence of psychosocial problems, and limited access to health services.\textsuperscript{9-14} Little access to personal hygiene and direct exposure to the elements place individuals at risk for infections and episodic illness.\textsuperscript{15,16} Also, transitional housing, shelters, and doubling-up can create unsanitary environments in which pathogens are easily transmitted through frequent human contact or risk-taking behaviors.\textsuperscript{15,17,18} As a result, individuals experiencing homelessness are more likely to suffer from parasitic skin infections, dermatologic conditions, gastrointestinal illness, respiratory infections (particularly tuberculosis), and sexually transmitted infections (particularly HIV/AIDS).\textsuperscript{15,19-21} In addition to communicable disease, stress, diet, chemical dependency, disability, and mental illness all increase the risk of developing chronic disease.\textsuperscript{22} Consequently, high rates of diabetes, obesity, anemia, asthma, hypertension, chronic obstructive pulmonary disease, peripheral vascular disease, and chronic liver and renal disease are reported among the homeless.\textsuperscript{22,23} The physical effects of communicable and chronic disease are often caused or exacerbated by psychosocial problems. Among the homeless, there exists a high prevalence of mental illness, exposure to physical and sexual abuse, crime, and substance use, all of which can cause and perpetuate homelessness.\textsuperscript{24-27}
Finally, sporadic access to fragmented or uncoordinated health services not only limits the ability to receive treatment for urgent conditions, but also prohibits the individual from using cost-effective preventive services, such as immunizations, cancer screening, prenatal care, and chronic disease management.\textsuperscript{10,11,14,22,28}

Knowledge about the myriad factors contributing to social, psychological, and physical suffering among the homeless is necessary for the primary care practitioner to address the multiple risk factors to which this special population is exposed.\textsuperscript{1} Recognizing that reliable evidence-based guidelines for the care of homeless patients were scarce, a group of experts from the Homeless Clinician’s Network of the National Healthcare for the Homeless Council organized a set of 8 detailed guidelines to be followed by primary care providers. The following is based primarily on a superb overview of those guidelines by Bonin and colleagues.\textsuperscript{29}

**Diagnosis and Evaluation**

**History**

Developing a multifactor understanding of the histories of people experiencing homelessness is particularly important for treatment, care, and prevention.\textsuperscript{1} When treating homeless patients, the primary care practitioner must consider many contextual risk factors associated with acute and chronic disease such as the patient’s history of homelessness, current living conditions, access to healthcare, and past history of medical care. Some questions to ask the patients may include “Where do you live? Who do you live with? How long have you lived there and with that person?” If the patient is staying in a shelter, a vehicle, on the street, or in any other unstable living situation, ask if this is the first time s/he has been without a home. Be aware that some patients may be too embarrassed to admit that they are homeless or do not consider themselves homeless because they live with a family member or friend.

Developing an understanding of the patient history of homelessness will open other doors to ask about medical conditions they are known to be at risk for (eg, asthma, chronic ear infections, anemia, diabetes, cardiovascular diseases, tuberculosis, HIV, and other sexually transmitted infections). Inquire if the patient has recently been in the hospital and seek medical records, but do not withhold care if medical records are not available. Ask the patient if s/he has a regular source of primary care (or “medical home”) and whether access to the primary care provider is limited in any way (eg, by a change in health insurance or lack of
transportation). Ask whether the patient has health insurance that covers prescription drugs, and how s/he obtains medications. If uninsured or without prescription drug coverage, provide assistance in applying for entitlements.\(^a\)

Once the structural risk factors are addressed, the psychosocial issues must be addressed, including mental illness or cognitive impairment, developmental delays, drug and alcohol abuse, sexual history, legal history, and exposure to abuse or exploitation. These psychosocial factors are particularly important to explore when considering treatment for the individual experiencing homelessness, as they are often interconnected with structural factors and material deprivation. Ask if the patient has ever been hospitalized for an emotional, nerve, or psychiatric condition and observe for problems with stress, anxiety, appetite, sleep, concentration, mood, speech, memory, thought process and content, suicidal/homicidal ideation, judgment, impulse control, and social interactions. Normalize this discussion by asking whether the individual has been experiencing “stress, low energy, difficulty focusing, or mood swings” rather than “mental illness.” Evaluate possible developmental delays and, if the patient is a child, inquire about interaction with family members and behavior at daycare or school. If problems are reported, assess for possible hearing loss and/or speech delays secondary to chronic ear infections, commonly seen in homeless children.

Explore risk-taking behaviors, such as abuse of alcohol and drugs and ask about current and previous use (amount, frequency, duration), including nicotine, recognizing that smoking is more common among this patient population and often begins at a younger age. Ask about gender identity, sexual orientation, sexual behaviors, partners, pregnancies, and sexually transmitted infections, including hepatitis. Obtain a detailed sexual history, including number/gender of sex partners and their risk for HIV, use of condoms or other barrier methods, and types of sexual intercourse. Ask if the patient has ever exchanged sex for money or other needs. Ask about the patient’s legal history and if there is any history of violence against persons or property. Ask about arrests and incarcerations and whether the person ever received medical or mental treatment while incarcerated. Be alert for domestic violence indication and assess the patient’s potential for current/future violence. Assess for a history of emotional, physical, or sexual abuse and exploitation; ask all patients if they have ever been physically hurt, afraid of being hurt, or made to do

\(^a\) Social Service programs vary by state and region, but federal programs should be sought, including Medicaid, Medicare, the SCHIP, SSI, or other assistance for which the patient may be eligible.
things sexually that they did not want to do. Social support and family-related stress are a particularly important issue to address among children, as chronic illness in a child can increase the child’s risk for abuse.

The primary care practitioner may find it beneficial to conclude the history interview with less personal and sensitive questions, such as those addressing the patient’s engagement in regular or strenuous activities, and what types of work s/he has done, toxic exposures (eg, asbestos, silica, or coal). Ask where the patient has meals and what kinds of food s/he eats and where the patient accesses food. Understand that people experiencing homelessness are at risk for malnutrition and obesity because of limited dietary choices. Evaluate the patient’s knowledge of proper diet and food resources (pantries, soup kitchens, delivered meals, nutritional supplements). Ask about the patient’s cultural background, faith community, and/or other affiliations to identify potential sources of social support. Ask about any work-related illnesses or injuries and whether they have interfered with gainful activities (eg, made it difficult to work, resulted in job loss, etc). Ask if the patient has difficulty reading or wants help filling out the intake form. This can serve as a nonthreatening way to evaluate their ability to read English while allowing the patient to not feel uncomfortable or ashamed, since “trouble reading” can indicate vision, literacy, or language problems.

Finally, be aware of health disparities among ethnic/racial minorities. Recognize that it takes a great deal of resourcefulness, patience, and tenacity to meet survival needs while one is homeless. Comment on strengths you observe in the person and try to cultivate a trusting relationship, as homeless individuals can be more hesitant to complete physical examinations than other patients.

**Examination**

A full body, unclothed examination of an adult experiencing homelessness is rarely possible before engagement is achieved. The patient may be too fearful to be examined, indicating the need to build a therapeutic relationship first. Be sensitive to the patient’s comfort level. Explain at the first visit what a comprehensive physical examination entails and ask permission to perform one. If the patient prefers not to disrobe at the first visit, defer the genital examination until the second visit or whenever his/her comfort level allows, especially for young adolescents or if a history of sexual abuse is suspected. Be aware that some patients may have experienced physical and/or sexual abuse. Whenever possible, offer
patients the option of being examined by a health care provider of the same sex.

Homeless people with a nontraditional sexual orientation or gender identity may experience even greater obstacles to health care than do others and may not have received medical attention by a primary care provider for years. Cancer, sexually transmitted infections, and depression are among the health conditions that are less likely to have been detected or treated in lesbian, gay, bisexual and transgender individuals. Lesbian, gay, bisexual and transgender individuals who are homeless are more often victims of sexual or physical assault, use highly addictive substances more frequently, and have higher rates of psychopathology than their heterosexual counterparts.\textsuperscript{30,31}

If the patient is not ready for a comprehensive physical examination, conduct serial, focused examinations until a therapeutic relationship has been established. Once engaged, a more complete examination can be performed. Ask permission to perform each physical examination. Be attentive to the patient’s comfort level and pay attention to nonverbal cues; do what s/he can tolerate at the time and schedule a return visit within a short period.

Screen infants and children for age-appropriate teeth and obvious tooth decay. For instance, in a child 6 months to 2 years of age, chalky white or brown areas on upper anterior teeth are signs of early childhood caries and require referral to a dentist experienced in the care of pediatric patients. If the patient complains of an earache, sore throat, or sinus pain with no evidence of infection, check for decayed molars or other dental disease and refer for an oral health assessment.

**Diagnostic Tests**

1. Screening for interpersonal violence (eg, Posttraumatic Diagnostic Scale Modified for Use with Extremely Low Income Women)
2. Mental health screens (eg, 9-item Patient Health Questionnaire, PHQ-9)
3. Substance abuse screening [eg, Simple Screening Instrument for Alcohol and other Drug Use (SSI-AOD)]
4. Cognitive Assessment (eg, the Mini-Mental Status Examination (MMSE)).
5. Sexually transmitted infection screening (eg, gonorrhea, Chlamydia, syphilis, HIV, hepatitis B antigen, trichomonas, bacterial vaginosis, *Monilia*)
6. Baseline laboratories
7. Purified protein derivative tuberculin skin testing: recommended for people experiencing homelessness every 6 months because of risk for contact with active terabits.
8. Health care maintenance (eg, mammograms and other cancer screening, standard screenings for acute problems, and pregnancy tests for sexually active women)
9. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services
10. Developmental assessment (eg, Denver Developmental Screening Tests)
11. Forensic Evaluation, if warranted (eg, if sexual abuse of a child is suspected, facilitate the patient’s referral through Child Protective Services or the police)

Plan and Management

Plan of Care

When treating individuals experiencing homelessness, the primary care practitioner must recognize that meeting the basic needs of their patients, such as food, clothing, and housing, preempts the ability to address health issues, as health care usually is not the most urgent problem for individuals or families who are homeless unless they are acutely ill. Carefully address immediate needs first (the patient’s reason for the visit) rather than the underlying causes (eg, provide cough medicine or pain relief, where indicated, even if you do not think they are medical priorities). Be sensitive to the patient’s beliefs and values.

Providing the patient with a written action plan may give the patient and/or parent a sense of control over her or his health and well-being. Most important is to clarify the plan of care in language they can understand. If interpersonal violence of sexual abuse is suspected, the primary care practitioner should help the patient develop a safety plan (explain and follow your state’s mandatory reporting requirements). Explain the plan of care in simple language and explicit patient feedback to confirm understanding. Avoid medical jargon and euphemisms that can be confusing and perceived as “talking down” to the patient. Use an interpreter and/or lay educator (promotoras) to facilitate communication and ensure culturally competent care for patients who do not speak English or have limited English proficiency. Also, recognize that adherence problems often result from unrealistic expectations of the provider.

There are also some important institutional issues that the primary care practitioner can address to improve care for individuals experiencing
homelessness, such as extending clinic hours to accommodate working patients who cannot take time off for clinic appointments without risking losing their jobs, helping the patient/family make a plan for emergencies, and instructing them to contact a primary care provider, if possible, before going to the emergency department. Be aware that some individuals may be unaware of the location of emergency facilities so provide this information, in addition to a phone number where medical provider can be reached after hours. Remember to inquire about phone access and provide information that is most convenient for the patient if possible.

**Education and Self-Management**

Explain health problems and proposed treatment in language the patient/parent can understand and confirm understanding (using illustrations if necessary). If giving written instructions, provide educational materials in the patient’s first language, using simple terminology and large print to compensate for any visual limitations. Explain risks associated with any health problems for which the patient is being treated and discuss ways in which s/he can reduce them for him/herself and others, in the case of communicable disease. Explain what parents can do to reduce the child’s susceptibility to future infections (eg, smoke-free environment, frequent hand washing, coughing into the crook of one’s elbow to prevent spread of viral infections).

Encourage behavioral change using individual, small group, and community interventions based on careful investigation of actual patient behaviors. Motivational interviewing risk reduction and social skills training can facilitate engagement and help to resolve ambivalence about behavior change. For patients experiencing extreme stigmatization or isolation, create support groups where they can share concerns and learn how others are coping with similar health problems.

Educate patients about nutritional health, diet, and dietary supplements, in addition to specific locations of where to access nutritious foods, such as a local food pantry. If possible, include a nutritionist on the clinical team who is knowledgeable about the limited food choices that this population typically has. Give examples of how to make the best dietary choices possible in settings where food is obtained.

Recognize that treatment adherence and successful outcomes are possible, even for homeless individuals with mental health and substance abuse problems. Take time in a safe setting to explore your own feelings about people who are homeless. Seek out guidance from and talk about your experiences, biases, and stereotypes with other providers who are more experienced in caring for homeless patients.
Medications

1. Use the simplest medical regimen warranted by standard clinical guidelines to facilitate treatment adherence.
2. Negotiate the amount of medications to dispense at a given time with the patient, based on clinical indications, the patient’s wishes, and their ability to hold onto the medications, transportation issues, etc.
3. Recognize the potential for medications/delivery devices to be misused and dispense smaller amounts of medications to patients known to “lose” them. Inhalants, bronchodilators and spacers, pain medications, syringe needles, and some antihypertensives may be lost, stolen, and/or sold.
4. Educate the patient about safe storage of prescribed medications. If the patient is staying in a shelter, ask if medicine can be stored there. Explain to shelter staff that the medications are necessary for the patient’s health, costly to replace, and should be made easily available to him/her when needed. Offer to store medications at a clinic where patients can come daily for treatment.
5. Recognize that even a small copayment for prescription drugs can be excessive for individuals experiencing homelessness.
6. To facilitate adherence, use motivational enhancement skills; negotiate with patient; adopt a harm reduction approach; provide outreach, intensive case management, directly observed therapy, and medication monitoring.
7. Prescribe medications with fewer/less severe negative side effects, which are a primary reason for nonadherence.
8. Update immunizations at every clinical encounter, recognizing that many tend to seek care only when sick, often missing scheduled appointments for well-child care or health care maintenance and losing track of records.
9. Emphasize that all prescribed antibiotic regimens must be completed.
10. Recognize that a number of morbidities commonly seen in this patient population, including untreated dental problems, hepatitis, and traumatic injuries, can result in chronic pain.
11. Prescribe multivitamins with minerals and assure that pregnant patients receive appropriate vitamin supplements (with folic acid).
12. Know the medications on your state’s Medicaid/State Children’s Health Insurance Program drug formularies and identify which ones require preauthorization by a managed care plan.
Associated Problems and Complications

Specific problems or complications that tend to be more prevalent in homeless communities should be sensitively and thoroughly addressed when developing a treatment plan. Often patients need recuperative care/medical respite facilities for convalescence or when receiving end of life care. Indeed, establishing permanent housing should be tenant of any treatment program, clinical or otherwise. Additionally, physical symptoms often emerge from a complicated and opaque network of disorders. Distinguishing the most threatening of comorbidities and developing an effective treatment plan requires patience and perseverance on behalf of both the provider and patient. By recognizing that substance use and mental health disorders frequently occur simultaneously, the diagnosis of I should prompt screening and assessment for the other. Subsequent treatment plans should be offered in a comprehensive and integrated fashion. If this proves ineffective and the illness becomes debilitating, referral to a mental health program may be warranted. Furthermore, this may be the best option for patients who have been legally separated from their children and have lost access to shelter and benefits. Addiction treatment and mental health care are essential to promote recovery as well as family reunification.

The history of homelessness is particularly important to remember when providing primary healthcare to the homeless, as significant periods of homelessness can create conditions that impede growth and development. It is important to develop lines of communication and treatment that accommodate any potential developmental deficiencies associated with chronic malnutrition, abuse, mental illness, or substance use. It can be helpful to focus on immediate concerns as opposed to long-term consequences when discussing behavior change. Similarly, functional impairments associated with chronic illness or injury may limit a homeless patient’s ability to adhere to a treatment plan and use care. Efforts should be made to not only document the patient’s medical condition and functional status, but also to connect the patient to guidance in understanding and applying for federal assistance under SSI/SSDI.

Follow-Up

The unique circumstances surrounding a patient’s homelessness creates several barriers that make following up more difficult for this segment of society than any other. The first step to creating an effective system of following up with patients is to verify that the patient has provided accurate and current contact information. While this information should
have been obtained at the beginning of the patient history, the patient’s current contact information, and the patient’s emergency contact information (eg, case manager, friend, or family), should be repeatedly verified.

Efforts should be made to encourage the patient to seek and follow-up with you as the primary care provider if the patient does not already have 1. Create an environment in which follow-up visits for homeless patients are frequent and rewarded (eg, clean socks, meal vouchers, hygiene products, etc). Eliminating or reducing barriers to accessing care, such as time schedules and transportation costs, and accommodating drop-in appointments, can help to ensure that homeless patients feel welcome and encouraged to follow-up.

School attendance should be a frequently monitored outcome for patients of school age. Work with the family, patient, and school to help address individual shortcomings or factors preventing the child from achieving academic success. This is just 1 example of 1 of the most important factors that must be considered when following up: the degree to which you and the patient are connected to a diverse support network. This can be accomplished by collaborating with caseworkers, other homeless healthcare providers, community advocates, homeless peer support networks, and specialty providers willing to accept pro bono or Medicaid/Medicare referrals.

**Model of Care**

In tailoring health services to meet the needs of individuals experiencing homelessness, it is essential to develop an integrated and flexible model of care that is compatible with the existing health system. Because the health needs of the homeless are complex, effective healthcare requires a coordinated response from an interdisciplinary team of service providers. Medical, dental, and psychosocial services that span multiple disciplines and incorporate different delivery systems provide the patient with a holistic continuum of care. Patients should not only receive direct medical attention, but should also have access to food, housing, bathing facilities, storage of personal belongings, and transportation to service sites. As such, it is important that the structural risk factors of the homeless patient be addressed to ensure the success of any acute or long-term health care.

The success of this integrated approach to managing the homeless patient rests heavily upon the efficient coordination of services through sensitive case management. It is ideal for the team to retain a certain degree of flexibility with respect to the service delivery apparatus. Providing care at multiple points, through outreach workers or where
homeless people congregate, as well as accommodating walk-in appointments, will significantly increase the team’s ability to address the needs of homeless patients. In complex cases, the team should ensure that patients have access to receptive secondary and tertiary care. Indeed, the only effective treatment and management strategy is 1 in which primary care providers and specialists collaborate fully. Homeless patients easily can fall out of contact upon discharge if the interdisciplinary team does not participate in discharge planning and education for patients about existing ambulatory services. For patients with serious medical conditions, this planning process may include facilitating a patient’s access to convalescent care or housing with supportive services.

Both prevention and treatment services can be made available to patients through increased community outreach and engagement. Outreach opportunities are available through patient contact, regardless of the setting. This means that members of the interdisciplinary clinical team, such as outreach workers, case managers, nutritionists, medical/dental providers, mental health professionals, substance abuse counselors, and recipients themselves, can provide outreach to homeless individuals on the streets and in soup kitchens and shelters. Access to a translation service, meal vouchers, food, hygiene products, transportation cards/tokens, and other incentives can help to ensure that services are used. When team members are actively engaged in outreach, it is crucial that interactions remain nonjudgmental and supportive. When working with patients who are in recovery, primary care practitioners must understand that relapse can be part of the cycle of behavioral change. Above all, caring for the homeless through active community engagement involves building relationships as much as clinical expertise.

These recommendations accommodate the unique needs of homeless patients and should enhance, rather than diminish, the standard of care. As with all patients, clinical standards should be based on scientific evidence, expert opinion, and recommendations from other practitioners who provide care for the homeless. The primary care physician working with homeless patients should adapt clinical practices to optimize care for homeless patients and thus consciously work toward reducing health disparities. For example, homeless patients have greater difficulty altering their diet and lifestyle; therefore, primary care practitioners and members of the clinical team may need to initiate medical treatment and case management earlier in the course of a patient’s disease. Also, measures should be taken to involve patients in their own care.

Service recipients and formerly homeless patients provide valuable guidance through peer support, program governance, advocacy, and
community-engaged research activities. Primary care practitioners should encourage homeless patients to participate in these forms of social, legal, and economic support programs whenever possible and appropriate. This particular brand of consumer involvement can help to raise awareness for people experiencing homelessness, engage other patients, increase a provider’s understanding of effective outreach and interventions, and stimulate personal development by empowering patients to make informed decisions.

Finally, an effective model of care for homeless individuals must consider the role of advocacy in reinforcing the provision services. Through advocacy, members of the interdisciplinary team wield a potent instrument for shaping public policy to address the broader social determinants of health. Ensuring that direct service providers are included in advocacy work helps to boost morale and offset burnout. Furthermore, participation of homeless individuals in their clinical care decisions reinforces the message, while potentially contributing to the healing and recovery process. In this way, the model of care for providing services to homeless individuals extends beyond the narrow confines of the community health center. Through community engagement, outreach, and advocacy, healthcare providers can play a central role in not only addressing the health needs of homeless, but also in installing anchor points for a new social safety net that helps individuals to more fully realize their human capabilities.

Conclusions

The primary care provider has a significant role to play in providing sensitive and effective care to individuals experiencing homelessness. The unique needs of homeless individuals create an environment in which traditional patient care is both inadequate and insufficient. To effectively evaluate, manage, and treat individuals experiencing homelessness, primary care providers must work within an interdisciplinary team to experiment with different approaches of reducing health risks associated with homelessness. The primary care provider can help to guarantee the basic human right to health, while working to generate sustainable community level support for those experiencing homelessness. To learn more about the National Health Care for the Homeless Council or to get copies of the adapted guidelines, please visit http://www.nhchc.org. You also can become a member of the Clinician’s Network.

REFERENCES