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HEALING HANDS

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Highlights of the HCH Conference

Over 600 health care professionals and advocates attended the 1999 National Health Care for the Homeless Conference and the HCH Policy Symposium in Washington, DC, April 29–May 1. "New Solutions to Old Problems" were avidly discussed in 44 workshops focusing on myriad topics, organized into clinical, administrative and policy tracks. Three of these sessions are briefly summarized here for the benefit of HCH clinicians who attended others instead — and for those who stayed at home working. Healing Hands also reflects upon the central message of Dr. Lewis Mehl-Madrona's keynote speach at the Network's annual membership meeting, held on the second day of the conference.

These selected presentations illustrate several points at which the concerns of HCH clinicians, administrators and advocates currently intersect: 1) finding alternatives to acute care facilities for persons without a stable residence where physical and emotional healing can take place; 2) identifying fundamental elements of healing that are independent of available technology; 3) evaluating health care for homeless people; and 4) protecting vulnerable populations within a managed care environment. Although coverage of these important topics is limited to brief synopses here, we hope these "take-home points" will stimulate readers to pursue the topics in greater depth through cited references and ongoing dialogue with others engaged in the care of persons experiencing homelessness.

Respite Care: A Safe Place to Heal

A distinctive feature of this year's conference was a two-part, three-hour mega-session on *Creating Respite Services for Homeless People*. During the first session, presenter Jim O'Connell, MD, Boston HCH, discussed clinical and fiscal rationales for respite care.

> On the street, even simple problems become complex because people don't have a place to recuperate and rest.
>
> *– Jim O'Connell, MD*

"People die on the streets during every month of the year as a result of routine conditions from which housed people with social support systems usually recover without acute medical intervention," observed Dr. O'Connell. He cited a recent publication on homeless street deaths in New York City [Barrow SM *et al*, April 1999, *Am J Public Health*, 89(4): 529-534].

Providing a safe place where people without a stable residence can rest and recuperate promotes the resolution of subacute medical conditions, prevents disability and often precludes the need for tertiary care, he said. Respite services also promote healing following day surgery or hospital discharge.

Narrowly focused on the bottom line, health care administrators tend to be unresponsive to such clinical or ethical arguments, warns O'Connell. HCH providers in search of support to begin or maintain respite services will obtain a more sympathetic hearing from hospitals, MCOs and emergency facilities if they are prepared to argue that respite care can reduce utilization of more costly urgent and emergent care.

Such arguments are based on demonstrating that the cost and utilization of tertiary care for homeless people is significantly higher than for low-income, housed populations. Researchers at Boston HCH found that homeless patients account for a high percentage of admissions to medical services at both public (25%) and private (12%) hospitals, their average length of stay is three times longer than for other patients, and their daily hospital charges are twice as high.

HCH projects should gather their own cost/utilization statistics where possible, advised O'Connell, but if this isn't feasible, they can cite published data from other projects. [See O'Connell JJ, "Utilization and Costs of Medical Services by Homeless Persons: A Review of the Literature and Implications for the Future," now available on the HCH website at *www.nhchc.org/publist/utilization.html*.]

Barry Bock, RN, Director of Clinical Operations, Boston HCH, described four different respite service models along a continuum of care from 24-hour shelter alone, to shelter-based medical services, to shelter plus clinical and social services. HCH projects needn't choose just one model, Bock suggested; they can start with shelter beds and hotel vouchers, and move on to nursing care and support services as financial capacity and staffing allow.

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The second session featured a roundtable discussion by providers from HCH projects offering respite services which exemplified these various approaches: **Sarah Ciambrone, MA,** McInnis House, Boston; **Janelle Goetcheus, MD,** Christ House, Washington, DC; **Ed Farrell, MD,** Stout Street Clinic, Denver; and **Jeff Gittelman, RN,** Albuquerque HCH. Panelists responded to questions about medical and non-medical services, referrals, discharge protocols, funding and staffing at their facilities.

Tara Scherer, MSN, FNP, CS, nurse practitioner at the Campus for Human Development in Nashville, Tennessee, found the sessions on Respite Care — her main reason for attending the conference — to be "extraordinarily helpful." Most important was learning about models that work, she said. Scherer is searching for ways to expand the few shelter beds the Campus sets aside for convalescence to a more comprehensive respite care facility offering clinical and social services, with support from the public health department and area hospitals. One of the issues she will have to address is licensure.

On the Sunday after the conference, Scherer spent eight hours at Christ House, which exemplifies the holistic model of care she is seeking to emulate. "Respite care centers extend a sense of humanity and dignity to people who can feel safe and cared for during their recovery or, in a growing number of cases, in their final days before death," she said. "They are true havens for the medically fragile homeless." ■

Lessons for Clinicians from Traditional Healers

In his keynote speech at the Fourth Annual Network Membership Meeting, **Lewis Mehl-Madrona, MD, PhD,** advocated the use of alternative therapies and traditional Native American healing practices to improve the care of homeless clients. His hypnotic story-presentation revolved around patients with chronic and terminal conditions, unresolved by medical interventions, whose positive response to alternative therapies confirmed his conviction that "there's more to health care than drugs and surgery."

- Healing takes time, and time is healing.
- The journey is more important than the destination.
- Healing takes place within the context of relationship.
- Healing occurs through listening to each person's story.
- The healing unit is the family or community.

– Dr. Lewis E. Mehl-Madrona

Medical Director at the Center for Complementary Medicine, University of Pittsburgh, Dr. Mehl-Madrona is a family practitioner with special interests in behavioral medicine, psychiatry and geriatrics. His interest in the integration of traditional and modern health care practices derives from the dual influences of his Cherokee-Lakota heritage and his medical education within the western scientific tradition.

Fundamental elements of healing recommended by Mehl-Madrona which he attributes to the Native American tradition include: storytelling, spirituality, valuing the role of time in healing, active patient involvement in self-care, building relationships through individual and group therapy, and involvement with community through ceremony. Mehl-Madrona explicates these principles of healing more fully in his book, *Coyote Medicine* (New York: Scribner, 1997), and on his website: *http://hometown.aol.com/mmadrona.* ■

Measuring Outcomes, Step by Step

How can clinicians determine whether and to what extent their work actually makes a difference in clients' lives? How can they learn what interventions are more effective than others? Answering such questions is fundamental to *outcomes evaluation* — measuring change in client health status that is attributable to an antecedent health care intervention.

Suzanne Cashman, ScD, researcher at the University of Massachusetts Medical School in Worcester, introduced the workshop on *Measuring Incremental Outcomes* by sketching the basics of outcomes assessment which any HCH project can accomplish. Despite heightened interest in this topic within and beyond the health care setting, most HCH projects still evaluate only *structure* (technical and professional characteristics of providers and the work environment) and/or *process* (activities and means by which care is provided). Evaluation of all three — structure, process and outcomes — is necessary for quality assurance and improvement, asserted Cashman, who went on to give examples of HCH evaluation criteria used in multi-site studies. [See BPHC. "HCH Outcome Measures…20 Pilot Studies," Oct 1998, http://access.gov; select PAL99.07.]

Do not depend on the hope of results. …[C]oncentrate on the value, the rightness, the truth of the work itself…the reality of personal relationships….

– Thomas Merton

Non-medical clinicians often encounter outcomes measurement with a sense of caution, according to **Ken Kraybill, MSW,** Harborview Medical Center, Seattle. For one thing, "outcomes that are most meaningful are often least measurable, " he said. For another, focusing on outcomes can compromise or subvert the therapeutic process. "In providing care, we are wise not to overvalue the prize of the outcome and undervalue the power of the process." Moreover, a client's progress toward a particular goal usually is not linear, alternating between progress and regress. "Failures often define the lives of our clients more than successes," observed Kraybill, "but one step forward and two steps backward can also be defined as success."

"We must never forget the importance of being genuinely present, listening with great care, and moving ahead based on the individual's readiness and tolerance for change," he concluded. "The true power and value of our efforts is imbedded in the process of working with someone in a consistent, predictable relationship."

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Measuring Outcomes, *continued*
HCH clinicians in Seattle are focusing simultaneously on assessing both client outcomes and the therapeutic process. Their hypothesis is that the quality of the provider-client relationship is predictive of the success of all homeless health care, particularly in non-medical interventions. Under the leadership of **Jeannie Macnab**, program planner for the Seattle-King County Department of Health, they are measuring the impact of relationship building on client stability and independence, as determined by financial, health care, social support and residential status.

Defining and measuring degrees of relationship and linking them to indicators of client stability and independence is most useful for monitoring the effectiveness of care for long-term clients, notes Macnab. It may be more problematic for clients who disappear after a short time. In Seattle-King County, only 38% of clients have at least a six-month relationship with non-medical providers, she said.

This method of practice evaluation encourages providers to track client access to referrals, promoting integrated systems of care. Other HCH projects interested in assessing the quality of provider-client relationships don't have to reinvent the wheel; they can replicate Seattle's QA/QI project. For more information, contact Jeannie Macnab at 206/296-4338; *jeannie.macnab@metrokc.gov*. ■

Managing to Care for Special Needs Populations

Although mostly "policy wonks" attended the HCH Policy Symposium workshop on *Managed Care for Homeless People: A Federal Special Needs Agenda,* all HCH clinicians should understand the potential barriers for homeless persons under managed care and how they can protect their clients through education and advocacy. Clients' access to health care and the financial viability of HCH projects depend on the active involvement of knowledgeable clinicians. Presenters at this session specified ways in which HCH clinicians can make a difference.

David Cade, Director of the Family & Children's Health Programs Group, Health Care Financing Administration (HCFA), explained that the goal of new federal Medicaid regulations is to assure access and quality of care for special (including homeless) populations who qualify for Medicaid. Realistically, strong advocacy at the state and local levels will be required for these rules to be implemented as intended, he said.

Because homeless beneficiaries have not been exempted from managed care at the federal level, it is important to identify and articulate the challenges that make it difficult to serve this population under managed care, Cade said. It is also important to advocate strongly for state Medicaid programs that are responsive to the special needs of this population.

Jeff Crowley, MPH, reported what the National Association of People with AIDS is doing to help their constituents negotiate managed care. In collaboration with the HIV/AIDS Bureau, NAPWA has developed a "Passport to Managed Care" that explains patients' rights, how people with HIV/AIDS can access health services under managed care, and what to do if services are denied. It also includes a personal diary which patients can use to keep track of medications, health care visits, encounters with health plans and questions to ask their provider.

> Although appropriate care management is good for homeless people, they need to be protected from bad managed care systems.
> *– Bob Taube, PhD*

Bob Taube, PhD, clinical psychologist and Executive Director, Boston HCH, summarized policies necessary to protect homeless people under Medicaid managed care:

- Explicit inclusion of homeless people as a special needs population with special protections under managed care;
- Risk-adjusted payment systems to allow for homeless patients' higher utilization of services and higher cost of care;
- A requirement that service providers for homeless beneficiaries have special expertise;
- A standard definition of homelessness and reliable ways of identifying people who are homeless.

These proposed policies were included in standards documents developed by Care for the Homeless, NYC, and the National HCH Council, and disseminated by HCFA. [See *http://www.nhchc.org/guidance.html*.]

Because effective control over health care has devolved from the federal government to the states, and from states to managed care organizations, state contracts with MCOs have become key vehicles of accountability, Taube said. Once appropriate language gets into managed care contracts, provider groups are often held accountable for meeting the standards set. The active involvement of knowledgeable clinicians in the development of such language is therefore essential.

Several Network members are currently assisting researchers at George Washington University's Center for Health Policy Research in the development of managed care contract language for states to use in purchasing services for homeless people. The BPHC Center on Managed Care, which provides technical assistance to HCH projects, commissioned this endeavor.

HCH providers generally agree that a unitary ("single-payer"), publicly funded system assuring universal access is preferable to privatized managed care. Some states are moving toward this alternative. [See the April *HCH Mobilizer: http://www.nhchc.org/mobilizer/1999/apr28mobilizer.html*] In many states, clinicians are faced with the dual tasks of challenging bad managed care systems (or protecting homeless clients from them), while continuing to manage the care of impoverished, uprooted and very ill people — whether they are insured or not. ■

What Did You Find Interesting?

Edward Bonin, FNP, Adolescent Health Services, New Orleans – "The Network breakfast meeting and workshops on sexual minorities and electronic charting, which gave me confidence in the work we are doing and showed me our charting system has a long way to go!"

Vicki Bodey, LSW, CCDCIII, Good Samaritan Hospital Homeless Clinic, Dayton, OH – "Appreciated focus on the need for chemical dependency treatment; would have liked more information about specific approaches that work with homeless people. Was surprised at research findings linking child abuse with PTSD."

Marlene Cote, RN, HCH nurse case manager, Anchorage Neighborhead Health Center, Alaska – "The workshop on outreach to homeless substance abusers was directly relevant to what I hope to do in Anchorage, where many chronic alcoholics camp out in –20° weather!"

Ann Deutsch, MA, RN, CS, psychiatric clinical nurse specialist, Portland Public Health HCH, Maine – "Presentations on violence and abuse in the lives of homeless women; I will definitely use the screening tool being piloted. I'm also intrigued by the tool mentioned in the outcomes session for tracking provider-client relationships."

Betty Schultz, FNP, RNC, HCH Baltimore – "Networking with clinicians from the other nine children's HCH projects and sessions on health care for homeless children and violence in the lives of homeless women. The legislative agenda and visiting on the Hill were also top priorities."

Pia Valvassori, PhD (public health)**, FNP,** HCH Orlando, Florida – "The podiatry workshop was fantastic, and I liked the clinical portion of the session on TB. I brought back lots of wonderful materials for my staff, and plan to check out the Network website and Message Board."

Frances Wray, LSW, medical social worker, The Boise Clinic, Idaho – "The dental workshop gave me tools to help fill in service gaps in Boise, where dental services aren't very supportive of homeless people. I was also impressed with the session on hospice care. I'm mostly interested in creative ways to improve service delivery." ■

1999 AWARD WINNERS

AWARD FOR OUTSTANDING SERVICE:

Susan M. Kline, ARNP, Senior Consultant, Seattle HCH Network, Seattle, Washington
[Read her acceptance speech at http://www.nhchc.org/network.html.]

LOCAL HERO AWARDS:

Michelle Logan, RN, Community Health Nurse, Mobile Community Health Team Project, Manchester, New Hampshire
Jeanne Lowry, MSN, RN, Homeless Outreach Nursing Center Manager, American Red Cross, Milwaukee, Wisconsin
Susan Spalding, MD, Medical Director, Homeless Outreach Medical Services, Parkland Memorial Hospital, Dallas, Texas
Rachel Rodriquez-Marzec, BSN, RN, HIV Case Manager, Albuquerque HCH, Albuquerque, New Mexico
Barbara Morita, PA, Alameda County HCH Program, Oakland, California

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