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# HEALING HANDS

National Health Care for the Homeless Council

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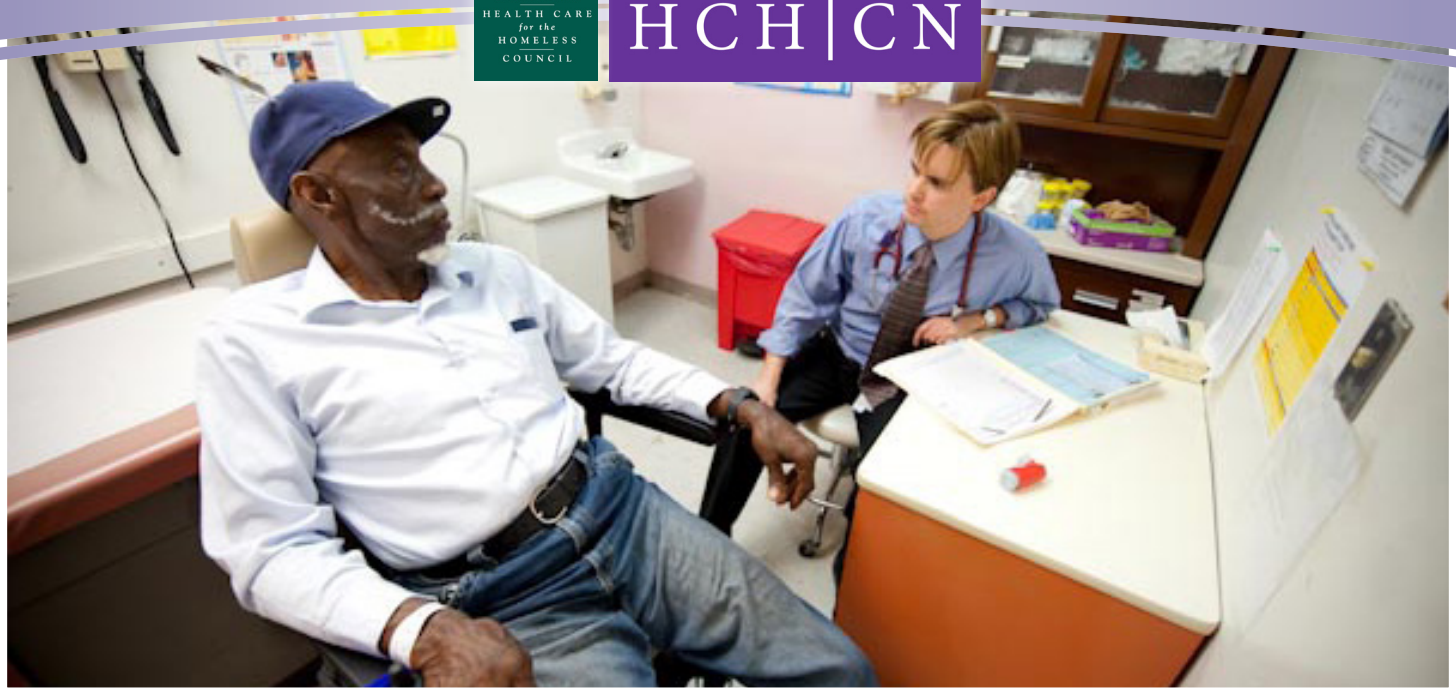

## Preventive Care for People Experiencing Homelessness

### 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

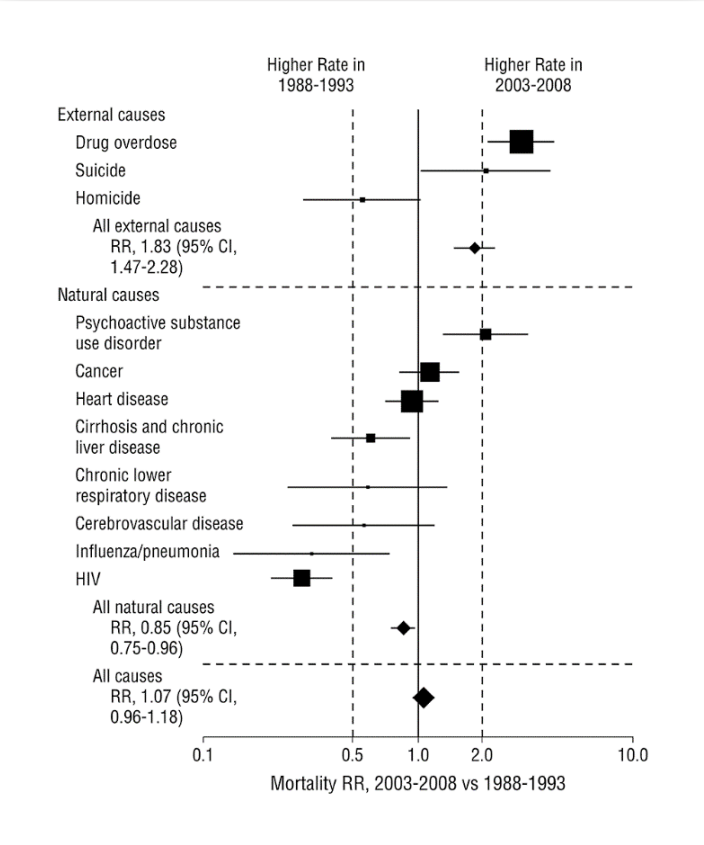


FIGURE FROM BAGGETT ET AL. (2003)

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.

## 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]

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

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
- Pneumonvax
- Prevna
- 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.

### 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

## 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

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.

*"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."*

*- Greg Morris, Homeless Clinic Program Director, Peak Vista Community Health Center; Executive Director, Ascending to Health*

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.

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.

*"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."*

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.

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HEALING HANDS

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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.

*"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."*

*- Dana Basara, Dean of Nursing, Grantham University*

**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.

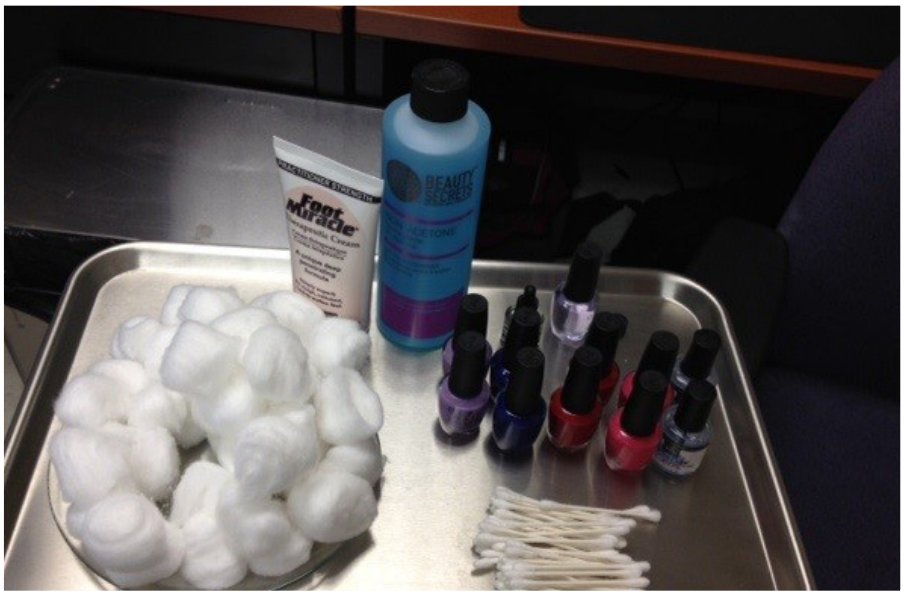
Mr. Colbert explains that the creation of supportive networks of care is also a form of preventive care—"because if you're bored and you don't have anything to do," he says, "you look to what you're used to, and it's really easy to fall into old habits." His program hosts regular community meetings to 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.

Participants in a "Cooking Matters" class prepare healthy vegetables

## 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, 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.

*"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."*

"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

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.

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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