Healthcare

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Homeless Patients: Meeting the Needs of a Vulnerable Population

According to a recent estimate, about 600,000 Americans are homeless on a nightly basis.* This population suffers from a variety of disadvantages, both medical and social. The unhoused are more susceptible than others to chronic disease, mental illness and substance abuse, and these health issues – compounded by poverty, lack of insurance coverage, limited access to community resources, weak support systems, and the dangers and stresses of living on the street – place them at significantly higher risk for early death. These risk factors also make caring for this large and growing demographic a significant challenge for healthcare organizations. (See sidebar, page 2.)

Consider the following hypothetical liability scenario:

> *A 58-year-old homeless patient was admitted to the hospital for observation due to uncontrolled high blood pressure and diabetes. Presenting to the emergency department (ED) with an open wound on his right foot, he also complained of dizziness, headaches, nausea and vomiting. After a week-long stay, the patient was prepared for discharge, at which time he was given written prescriptions for a beta blocker, diuretic and antibiotic; instructions for a low-sodium diet and foot care; a single meal voucher; and a three-day supply of foot bandages. Although the patient was known to live in a homeless encampment under a bridge and to obtain most of his food by rummaging through garbage receptacles, he was not connected to a local shelter, soup kitchen or food pantry.*

The patient returned to the ED one week later with a blood pressure of 210/110 mmHg, complaining that he could not afford to fill the prescriptions. The discharge physician, nurse and social worker documented efforts to provide him with a one-week supply of beta blocker, after which he was discharged to the streets. There is no record of the patient's foot wound being assessed or of the patient being referred to a local clinic for a routine blood pressure check.

For the next two weeks, the patient "hospital hopped" among facilities, unsuccessfully attempting to receive care for his foot and treatment for his high blood pressure. He eventually returned to the admitting hospital with a worsening foot infection, but there received neither antibiotic infusion therapy nor wound debridement. Instead, discharge notes indicate that he was referred to a free foot-care clinic – located across town from his encampment – for bandage changes. There is no record of further follow-up.

A week later, the patient returned to the ED a third time with a severe foot infection requiring hospitalization and, ultimately, partial amputation. He subsequently filed a lawsuit against the hospital and providers, alleging negligent discharge and failure to follow up. Noting the pattern of inadequate discharge procedures and follow-through, legal counsel advised the defendants to settle the case.

* See "2019 Point in Time Estimates of Homelessness in the U.S." from the U.S. Department of Housing and Urban Development. (Click on the link for "2007-2019 Point-in-Time Estimates by CoC [XLSX]" and go to column D for overall regional and national totals.)

For hospitals, serving homeless patients presents both liability and cost concerns. Medical treatment for homeless individuals often involves a revolving door of ED visits and hospitalizations. This pattern of fragmented and discontinuous care may expose providers and healthcare organizations to allegations of delayed care, failure to treat, misdiagnosis and other serious lapses. In addition, homeless patients are five times more likely than others to be admitted to a hospital unit, where they tend to stay four days longer on average than do housed patients with a similar diagnosis, at a cost of $2,000 to $4,000 per day.

Already a major problem throughout the United States, homelessness will likely worsen as, due to the COVID-19 crisis, unemployment remains at historically high levels and temporary economic support measures and stays against eviction lapse. Hospitals and other healthcare organizations should take measures to assess and strengthen their ability to manage the medical and social challenges posed by homeless patients, who cannot shelter in place to protect themselves from viral infection, and who are heavily affected by the social and economic disruptions associated with the pandemic.

This issue of *AlertBulletin*® presents five strategies designed to enhance care delivery to this vulnerable population, focusing on such key areas as patient screening and service coding, team-based care, provider competencies, and care and discharge planning.

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Homelessness in the United States: Basic Characteristics and Statistics

A homeless person is defined as an individual who lacks a fixed, regular nighttime residence. Some homeless people are exposed to the elements; others spend the night in shelters, cars, tents or other temporary abodes, or "couch surf" with friends or family. Many are unemployed, but some have jobs and still cannot afford decent housing. While the homeless population varies in size and makeup over the course of the year, the following characteristics tend to remain fairly constant:

- **Age:** The average age of homeless men and women is 50, up from 37 in 1990.
- **Gender:** The homeless population is approximately 61 percent male, 39 percent female and less than 1 percent transgender.
- **Race:** The homeless population is both large and diverse. Of every 10,000 African Americans in the U.S, 54 are homeless, compared with 20 Hispanics, 11 Caucasians and four Asians.
- **Family status:** Families with children constitute approximately one-third of the unhoused population.
- **Mental illness:** One in five homeless persons experience persistent mental illness, most commonly bipolar disorder or schizophrenia, or are subject to substance abuse. (In the general population, by comparison, about one in 100 adults is estimated to live with schizophrenia.)
- **Death rates:** Mortality is high, with many homeless men dying in their early 50s due to untreated health problems.
- **Emergency department (ED) usage:** The homeless utilize the ED three times more often than others, in large part due to a lack of access to primary or preventive care.
- **Shelter use:** Approximately 65 percent of unhoused individuals frequent a supervised public or private homeless shelter.
- **Other living spaces**: The remaining 35 percent of the homeless population live in vehicles or abandoned or squatter-occupied buildings, on couches or in open places, including parks, fields and under viaducts.

Sources: Stevenson, E. and Purpuro, T. "Homeless People: Nursing Care with Dignity." *Nursing Management*, June 2018, volume 48:6, pp.58-62. Also Moses, J. "New Data on Race, Ethnicity and Homelessness." National Alliance to End Homelessness, August 2, 2019.

Screening and Coding for Homelessness

As homelessness is not always obvious and can take many forms, patients should be screened for housing status and stability of living situation upon admission to EDs, urgent care centers or clinics. By posing a short series of housing-related questions, staff can quickly identify patients without a permanent residence, ensure that their housing status is prominently noted in records, and refer them to appropriate in-house and ambulatory services, including mobile and chronic care programs. Sample queries include the following:

- **What is your housing situation today,** and is it a reasonably stable arrangement?
- **Where have you been living** for the past two months?
- **Do you have your own residence,** or are you staying with others?
- **Following discharge, can you return to and remain in your residence** for more than 90 days?
- **Are you worried about losing your current housing** and having nowhere to sleep?

Accurate assessment of housing status helps ensure that homeless patients receive the social services they need, while facilitating coding under the Centers for Medicare and Medicaid Services ICD-10-CM code for homelessness – Z59.0. Accurate coding in turn permits organizations to track homeless patients within healthcare systems, analyze their utilization of services and medical outcomes, and receive appropriate reimbursement for services rendered to high-needs populations.

For more information about "ask and code" protocols, as well as additional screening questions, see "Ask & Code: Documenting Homelessness Throughout the Health Care System," a policy brief from the National Health Care for the Homeless Council (NHCHC).

Utilizing Team-based Care

Effective treatment of unhoused patients involves recognizing the connection and interaction between illness and homelessness, with the goal of reducing reliance on emergency care and enabling the patient to move toward a more stable and protected situation. Rather than limiting treatment to isolated health problems and current crises, providers should examine the patient's history, social circumstances and overall environment. Such holistic care requires a case management approach, involving frontline medical and nursing personnel, as well as disciplines such as social services, community and behavioral health, emergency medicine, addiction services, pharmacy and chaplain.

The process typically begins with the designation of a coordinator, preferably a medical provider with training in the assessment and care of homeless persons, who can call upon the assistance of specialty internists and psychiatrists, when necessary. The next step is to create a multidisciplinary team that can offer a wide range of vital inpatient and ambulatory services, including primary care, addiction treatment, mental health counseling and health education. Social workers and case managers play a key role, with responsibility for assessing available community resources, informing patients of relevant services and assisting them in signing up for benefits. Because homeless patients typically require extensive, long-term interventions, both nursing and social work staff should be available to serve this population at several points along the continuum of care, including urgent and emergency care settings, primary care ambulatory and mobile clinics, and acute and long term care settings.

Integrated care is an essential component of any treatment initiative geared toward meeting the needs of the homeless. By scheduling multidisciplinary "huddles" at the bedside of inpatients, team members can review existing problems, revisit the plan of care and resolve issues well in advance of discharge. With respect to outpatient care, the outreach team should be prepared to utilize mobile health clinics and meet patients where they congregate – such as homeless shelters, soup kitchens, food pantries and schools – in lieu of asking them to schedule and keep appointments at medical offices and clinics. In this way, teams can address multiple needs in one encounter, thus reducing appointments and enhancing the efficiency and reliability of service delivery.

Maintaining Core Competencies of Providers and Staff

Homeless persons contend with the same basic medical concerns as others. However, due to long-term exposure to adverse living conditions – including poor nutrition, weather extremes, lack of sanitation, sleep deprivation, overcrowding, sporadic care, and sometimes violence and abuse – their health problems may be both more numerous and more acute than those of other patients.

To ensure that clinicians have the requisite skills, training and hands-on experience to care for the homeless population, leadership should establish core competencies relating to the diagnosis and treatment of the following common medical needs:

- **Bodily injuries,** e.g., cuts, contusions, broken bones and internal injuries due to accidents or physical/sexual assault.
- **Exposure-related conditions,** e.g., frostbite, immersion or trench foot, chilblains, and hypo- or hyperthermia.
- **Infectious illnesses,** e.g., influenza, tuberculosis, pneumonia, and AIDS and other sexually transmitted diseases, as well as hepatitis and other bloodborne infections associated with intravenous drug use.
- **Traumatic brain injury signs and symptoms,** e.g., headaches, anxiety, short attention span, depression, dementia and seizures.
- **Nutrition-related disorders,** e.g., uncontrolled diabetes, deficiency diseases, metabolic syndrome and elevated blood cholesterol.
- **Skin ailments,** e.g., lice, scabies, secondary bacterial infections, fungal conditions, abrasions, ulcerations, abscesses and rashes.
- **Dual diagnosis of mental illness and substance abuse,** e.g., major depression, bipolar disorder and schizophrenia, exacerbated or precipitated by drug or alcohol use.
- **Post-traumatic stress disorder,** e.g., emotional, cognitive and/or behavioral manifestations of past violence, abuse or neglect.
- **Dental needs,** e.g., tooth loss, periodontal disease, and oral pain and infections.
- **Podiatric concerns,** e.g., corns and calluses, nail pathologies and infections.

Provider proficiencies in these areas should be evaluated and documented on an annual basis. In addition, providers and staff should undergo sensitivity training in regard to homeless patients, as successful engagement with others often depends upon discovering and addressing one's own unconscious biases and stereotypes.

For webinars and clinical guidelines on the treatment of homeless patients, see "Adapting Your Practice: Treatment and Recommendations for Homeless Patients" from the NHCHC and "Adapting Your Practice: General Recommendations for the Care of Homeless Patients" from the Health Care for the Homeless Clinicians' Network (2010 edition).

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Establishing Realistic Care Goals

Many homeless individuals derive a sense of achievement from their survival skills and are wary of what they may perceive as disruptions of their lifestyle. Effective care planning therefore depends upon forging an honest, respectful and nonjudgmental relationship with the patient.

The following strategies can help enhance the planning process for unhoused patients by fostering trust, improving compliance and strengthening coordination of care:

- **Focus first on basic life care needs,** prioritizing pain relief and problems involving teeth, skin and feet, as well as signs of malnutrition and infectious or chronic disease.
- **Offer infectious disease screenings** to ambulatory patients, using multidisciplinary teams in accessible locations.
- **Ask open-ended questions** – e.g., *"What would make your life better today?"* – to elicit practical and relevant suggestions addressing pressing patient needs.
- **Engage patients in storytelling,** which can reveal key events and experiences that have affected their health and housing status. Encourage them to tell their stories by asking, for example, where they are from, whether they have served in the military or if they have been in recent contact with family members.
- **Articulate clear, simple, practical goals** that can be accomplished within a few days. For example, *"Return to the mobile clinic tomorrow for a bandage change."*
- **Utilize telemedicine tools** to communicate patient data from mobile and off-site clinics to hospitals and ambulatory provider offices.
- **Assign a case manager** and document all referrals to community and government agencies, as well as patient follow-through.
- **Create electronic health records whenever possible,** and include a signed HIPAA Privacy Notice.
- **Be consistent, predictable and reliable.** Broken promises, canceled appointments and frequent changes in caregiver personnel will quickly erode patient trust.

Remind providers and staff that most homeless patients live on the edge and honor their relationships with their peers, which can affect compliance and follow-through. For example, those who live on the street may be tempted to share antibiotics or other pharmaceuticals with friends, or to sell prescribed medications in order to obtain food, alcohol or illicit drugs.

Quick Links

Resources:

- Angoff, G. et al. "Electronic Medical Record Implementation for a Healthcare System Caring for Homeless People." *Journal of the American Medical Informatics Association*, April 2019, volume 2:1, pages 89–98.
- "Discharge Planning for Homeless Patients," a presentation prepared by the California Hospital Association, November 1, 2018.
- Fact sheets from the National Health Care for the Homeless Council.
- Homelessness programs and resources offered by the federal Substance Abuse and Mental Health Services Administration.
- "Housing and Homelessness as a Public Health Issue," a policy statement of the American Public Health Association, November 7, 2017.
- "Housing and the Role of Hospitals." American Hospital Association, August 2017.
- McEnroe-Petitte, D. "Caring for Patients Who Are Homeless." *Nursing2020®*, March 2020, volume 50:3, pages 24-30.
- Maness, D. and Khan, M. "Care of the Homeless: An Overview." *American Family Physician*, April 15, 2014, volume 89:8, pages 634-640.

Organizations:

- Association of Clinicians for the Underserved.
- National Coalition for the Homeless.
- National Health Care for the Homeless Council (NHCHC).
- Respite Care Providers' Network (RCPN), a standing committee of the NHCHC.

Documenting Discharge Provisions

Discharge planning for unhoused patients must reflect a realistic estimate of their physical and mental condition, as well as their basic needs, shelter preferences and overall best interests. In addition to providing useful, comprehensible health-related information, providers and staff also should focus on connecting them to available community resources, including housing options and support services.

Discharge plans for homeless patients require scrupulous documentation of the following core elements:

- **Medical and behavioral healthcare services delivered,** including date and time of scheduled follow-up appointments, as well as names and contact numbers of providers.
- **Medications provided directly to the patient** or dispensed by an on-site pharmacy. If the patient declines offered pharmaceuticals, note his/her refusal in the patient healthcare information record.
- **Prescriptions given for pharmaceuticals not available on-site,** as well as efforts made by staff to help the patient – who may lack ready access to a pharmacy – obtain the medications.
- **Infectious disease screening,** whether performed on-site or via outside referral. If screening is declined, indicate the patient's refusal and the reasons given in the patient healthcare information record.
- **Vaccinations,** including those actually administered and those offered but declined, in which case the patient's stated reasons for refusal should be recorded.
- **Food and water consumed,** including meals offered upon discharge. If food intake is medically contraindicated, note this in the patient healthcare information record, as well as refusal of food or water by the patient.
- **Possessions, health aids and other items either returned or given to the patient,** including any weather-appropriate clothing offered.
- **Address of post-discharge destination,** or a note that the patient declined to inform provider of immediate plans.
- **Name of the person who has agreed to accept the patient,** who also should be informed in writing of the patient's healthcare needs.
- **Transportation arrangements,** including the mode of transport offered and whether it was accepted or declined.
- **Removal of the patient identification wristband,** to indicate that the patient has been officially discharged and has not eloped.

Request that patients sign and date the discharge plan, thus indicating that they have been involved in the process and that they understand and accept the plan's provisions. If a patient declines, then the provider should document the refusal and sign the form. A copy of the plan should be retained in the patient healthcare information record, and a log should be created to track and facilitate follow-up.

Across the country, hospitals and clinics are devising creative solutions to the challenges associated with serving the homeless. By focusing on critical clinical and administrative processes – such as patient screening, team selection and evaluation, care planning and patient discharge – leadership can help enhance the quality, continuity and efficiency of care delivered to these exposed and underserved individuals, while minimizing associated risk.

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