Suitcase Clinics: A Possible Economic Answer to Healthcare for the Homeless

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Objectives:

- To describe community assessment skills that target the needs of homeless populations
- To analyze the specific health risks of the homeless
- To examine a potential community level model for creating healthcare for the homeless using Nurse Practitioners.

Federal Definition of Homelessness (Updated Jan. 2012)

- People who are living in a place not meant for human habitation, in emergency shelter, in transitional housing, or are exiting an institution where they temporarily resided.
- People who are losing their primary nighttime residence, which may include a motel or hotel or a doubled up situation, within 14 days and lack resources or support networks to remain in housing.
- Families with children or unaccompanied youth who are unstably housed and likely to continue in that state.
- People who are fleeing or attempting to flee domestic violence, have no other residence, and lack the resources or support networks to obtain other permanent housing.

Literature Review on Healthcare for Homeless

- Previous research on healthcare for the homeless recommend a "TEAM APPROACH" which focuses on the homeless populations multiple and complex problems in order to deliver comprehensive, continuous health care.
- Solutions to the problem have long acknowledged that medical case management and clinic services AT THE SHELTER SITES are the most efficient and most effective for providing care.
- Targeted interventions that are focused in places where homeless people are gathered are the most efficient for providing care (deVries & van Hest, 2006; deVries, van Hest, Richardus, 2007; Altice, Bruce, Walton & Buitrago, 2005)
- Mobile clinics, sheltered clinics, case management, mobile clinics: all have been published and shown effectiveness
- **Most importantly, understanding that helping individuals obtain safe, affordable, and permanent housing will offer the greatest benefit for improvement of health.**
  See "Housing First" model (JAMA, May, 2009)

Report of the Virginia Coalition to End Homelessness (Oct 2009)

Critical components to the success of any comprehensive community-based initiative to prevent and end homelessness:

1) Community planning
2) local, regional, and state collaboration
3) improved data collection
4) outcome-oriented flexible funds for both prevention and homelessness assistance programs
5) refinement of housing-strategies such as rapid re-housing

Causes of Homelessness (Jackson, 2012)

- Economy, federal laws and regulations, personal choices
- Specifically:
  - Inability to pay rent or mortgage payments
  - Mental illness
  - Domestic violence
  - Unaffordable health care

(National Coalition for the Homeless, 2010).

Health Issues

- Multiple burdens potentiate vulnerability including chronic and acute illnesses (hypertension, DM, asthma, HIV/AIDS, and TB).
- Mental illness, substance abuse, poor dental hygiene, and visual impairments are common in the homeless (Baggett et al., 2010).
- Experience poor access to health care, often delay treatment, tend to utilize emergency departments for primary care, are hospitalized at higher rates, and have a higher incidence of mortality and morbidity (Savage et al., 2006, Schanzer et al., 2007; Zlotnick & Zerger, 2008)

Health-seeking behaviors of Homeless: Overarching Themes

- Lack of available resources (Martins, 2008; Nickash & Marnocha, 2009)
- Lack of compassionate care (Hudson et al., 2008)
- Labeling and stigma (Darbyshire et al., 2006; Diaski, 2007)
- Putting off healthcare until an emergency (Martins, 2008; National Coalition for Homeless, 2010)
- Feeling unwelcome and out of place (Wen, Hudak, & Hwang, 2007)
- Barriers related to communication (Hatton et al., 2001).

Needs Assessment: Collecting Data….

Data Points: The Tools

- *HMIS (Homeless Management Information System)*
  - System-wide information over time
  - Captures characteristics, service needs, and history of those experiencing homelessness
- *Point in Time Survey*
  - Demographics, employment history, mental health status
  - Can identify service needs

Stats in Our Community
Point in Time Survey (January 2010)

- 163 homeless (97 adults; 66 children) residing in five shelters
- 56 % reported no health insurance; 33% had Medicaid
- 77% of those surveyed stated that they received their healthcare from the ED; 22% go to the Free Clinic
- Only 7% of respondents (5) indicated they were veterans.
- Thirty-six per cent (27) reported they were experiencing their first episode of homelessness in the last three months.

Community Level Factors

- Considerable population growth in past 20 years: 29%
  - Increased number of college students
  - Increased number of immigrants and minority population
- Changes in housing stock

Community Resource Analysis: Harrisonburg Shelters

First Step
A Response to Domestic Violence

The Salvation Army

Mercy House

Harts
Harrisonburg/Rockingham
Thermal Shelter

Our Community Place

Community Health NSG DX:

- Risk of episodic and inadequate healthcare of homeless populations R/T:
  - Lack of primary care providers
  - Lack of education on available resources
  - Lack of health insurance despite eligibility
  - Lack of medical case management
  - Lack of adequate shelter

The Intervention: “Suitcase Clinics”

"Suitcase Clinic" description

- Partnership between the Harrisonburg Community Health Center, Institute for Innovations in Health and Human Services at James Madison University.
- Part-time Nurse Practitioner and RN Case Manager visit each clinic over the course of a week. Tues/Thurs rotations
- All supplies are carried in a Suitcase on Wheels.
- The model adopted originally from retail clinics that offer a limited menu of medical services on a walk-in basis for episodic care.
- Model has expanded to include treatment of chronic illnesses and some self-scheduling by the homeless shelters.
- Laptop computers articulate with the Harrisonburg Community Health Center's EMR system.

Medical Case Management Description

- Coordination of the physical health/mental health/chemical dependency treatment/spiritual needs.
- Acquiring health insurance and benefits that they are qualified for, but unable to attain due to lack of knowledge or the ability to complete the paperwork.
- Assist with transportation, accompanying clients to appointments, or otherwise helping to resolve barriers.

Personnel needed:

- Nurse Practitioner
- Medical Case Manager
- NP students, undergrad nursing students (EMU/JMU)

Domains of Health Risks of Homeless

- *Physical Domain*: sexually transmitted diseases, communicable diseases, hygiene, and drug and alcohol use.
- *Psychological Domain*: low self-esteem, suicide, rejection, and lack of supportive relationships
- *Social domain*: failure at academics, lack of healthcare access, problems with law (both crime victims and perpetrators)
- *Spiritual domain*: loss of meaning, purpose, or hope for the present or future

Physical Domain:

- Acute Illness (communicable/non-communicable)exam-provide appropriate treatment; focus on prevention-hygiene, food safety, environmental threats, vaccinations.
- Chronic Illness-exam and laboratory screening for diagnosis, provide appropriate treatment and management, education and support, imaging and specialty referrals as appropriate.
- Wellness Care-history and physicals, screening labs and imaging/procedures (ie-mammograms/colonoscopy)
- Sexually Transmitted Diseases- Screening, referral , education
- Alcohol and Drug Screening
- Injuries/Assaults-advocates for personal safety

Other Domains:

- Psychological
- Every new patient assessment involves psychological history. Depending on past or active mental health disorder and its severity, treatment initiated and/or referral is made.
- Social/Spiritual
- Evaluated with new patient assessment and filled in over time as patient continues to present for care. Referrals made as appropriate and available within community. Knowledge of these challenges are factored in to overall patient care and advocacy.

Partnership between NP and RN case manager critical to address what can be on site and where the patient needs to be directed for further collaborative services.

Community Partnerships

- Health Department (vaccinations, STD screening/treatment; birth control, gynecological services)
- JMU/EMU Nursing: health education and screening fairs
- HCHC-referral for women's health screens or other examinations
- RMH/AMC-specialty care and imaging services; ER services when appropriate (financial assistance programs)
- Pharmacy Services –discount drug assistance (340-B), samples, MAP , People Helping People
- CSB-Community Service Board-mental health and substance abuse resource
- IIHHS/JMU- CAPS program-individual counseling Services; VAN-Valley AIDS network-HIV Rapid Testing; Crossroads-case management for individuals with head injury/mental illness
- Social Security Admin./Medicare/Medicaid/TANFF/WIC/ DRS/APS/AS/CPS-case management and entitlement services
- Free Dental Clinic
- The Lion's Club-eye glasses; vision care
- Homeless Shelters-referrals for appropriate placement (ie-domestic violence)

Project Timeline/Milestones

	August, September 2011	October, November, December 2011	January, February, March 2012	April May June, July 2012
1). NP hired, oriented. Suitcase Clinics piloted, expanded and established in shelter locations.				
Milestone: Successful Implementation of E-clinical works for Electronic Medical Records and Tracking Systems. Data Collection Tools: E-clinical Works: documentation of nursing interventions, referrals, tracking and follow up of clients, Quality Management Chart Reviews.				
2). Program expansion with addition of health fairs, immunization clinics, foot care clinics, and chronic care clinics at all locations.				
Milestone: Increased number of student, faculty, and health care professionals working with project. Data Collection Tools: Encounter forms, Student evaluation of practicum sites/course evaluations.				
3). Evaluation of "Suitcase Clinic" model.				
Milestone: Determining costs of services and types of encounters; Client Satisfaction Cost/Benefit Analysis. Data Collection Tools: E-clinical Works, an electronic medical record data base system.				

Phased Implementation Model

- **Phase 1: "pilot phase"**
  - Goal: finalize finer points of clinical model and operating procedures, build trust within local homeless community, begin to deliver basic care through the "Suitcase Clinics".
  - Our Community Place and HARTS : "street homeless"
  - Clinical staff in place, EMR, evaluate data security and evaluate the integrity of data collection systems
  - Length: 1-6 months

- **Phase 2: Implementation Stage**
  - Ramping up to provide services at all 5 shelters and expanding services to include addition of undergrad nursing student outreach, multi-disciplinary health and human services,
  - Faculty practice model
  - Length: 6-12 months

Foot Clinics

Screenings and Immunizations

- **Phase 3: Expansion phase**
  - Goal: firmly establish continuous and more comprehensive care by meeting additional chronic care and counseling needs on site at shelters and monitor health outcomes.
  - Establish mental health clinic services on site, chronic care clinic, lay health promoters model, podiatric and dental clinics,
  - Incorporate the "Suitcase Clinic" as a sustainable outreach service under the Harrisonburg Community Health Center.

Why is this working?

- 1). Our "suitcase" clinics and medical case management is linked to the Harrisonburg Community Health Center and provides coordinated services across the full spectrum of the community.
- 2). Our intervention recognizes the heterogeneity within the homeless population and is tailored to support services to the participants needs and characteristics.
- 3). Our intervention represents a community wide coalition which facilitates a comprehensive and coordinated effort to obtain medical case management and HOUSING for every homeless participant in the program.

The Evaluation

Useful Data to collect:

ED utilization data:

- Confidential patient identifiers
- Age
- Gender
- Race
- Insurance Status
- Type of Visit (ER, Community Health Center, Suitcase Clinic)
- Primary DX
- Secondary Dx
- Prescribing drug data
- Procedure Codes
- Indication of inpatient admission

Vulnerability Index: Prioritizing the street homeless population by mortality risk

- > 3 hospitalization or ER visits in a year
- > 3 ER visits in previous 3 months
- Aged 60 or older
- Cirrhosis of liver
- End-stage renal disease
- History of frostbit, immersion foot, or hypothermia
- HIV/AIDS
- Tri-morbidity: co-occurring psychiatric, substance abuse, and chronic medical condition.

Evaluation: Donabedian Model for Healthcare

Structure	Process	Outcome of Services
Physical properties of the provided space for onsite clinic	Working alliance between partners	Health Status (physical, mental, emotional) Quality of Life
Safety	Cultural Competence	User/client satisfaction
Staffing/Qualifications	Privacy and Confidentiality	Housing status
Access to services	Client involvement in planning and evaluation	Social/employment status
Financial resources	Patient rights	Health insurance/benefit status

Evaluation and Outcomes

- Improvement of Access to Care through "Suitcase clinic" and case management
  - **Outcomes:** increase use of "Suitcase clinic" services; increase knowledge about health promotion, self-care, and accessing care services;
  - **Data Collection:** Homeless Client Health Profile Tool
- Demonstrate cost effectiveness and cost savings of "Suitcase clinic" and case management
  - **Outcomes:** documentation of costs;
  - **Data Collection:** documentation of characteristics of clients; referrals to providers/services, tracking and follow-up; establishing quality assurance processes, documentation of client outcomes
- Increase number of HCPs (students, nurses, social workers, physicians) who are prepared to work effectively with homeless clients
  - **Outcomes:** increasing knowledge and changing attitudes of HCP related to care of homeless clients, increase self-efficacy of HCP in their competency and confidence of working with homeless populations.
  - **Data Collection:** questionnaires, interviews, focus groups, student course evaluations.

Current Data

- In 1st nine months, the Suitcase Clinic provided care to over 116 unduplicated clients.
- 60% of patient encounters were for chronic conditions.
- 100% of clients surveyed in a Patient Satisfaction survey (n = 49) said they would use the suitcase clinic again.
- 78% of clients considered the Suitcase Clinic their medical home.
- 79% of clients surveyed stated that they used the Suitcase Clinic in the past year when they previously might have gone to the RMH Emergency Room.

Lessons Learned: Strengths and Challenges

Strengths

- On site services: Increase in health care accessability that discourages unnecessary ED use-by virtue of convenience, reliability and trust.
- Community Collaboration-motivated partnerships
- Relationally Driven-involved clinical staff through the process of holistic care.
- Empowerment driven-education and prevention

Challenges

- **FUNDING! FUNDING! FUNDING!**
- Expanding partnerships to meet the needs for psychological/spiritual care
- Data Sharing: HIPAA issues
- Billable Visits due to setting
- Faculty Practice Model: financial, collaboration, space

In the End…..

- No one solution will be a panacea – requires a multi-faceted approach
- Requires willingness to invest resources in non-traditional areas
- Requires willingness to collaborate to make many pieces work together
- Requires all parts of the system to make changes

“When you bring health to a community, you bring peace to that community”

Royal Highness Princess Muna Al Hussein, Jordan