

Nurse-Managed Free Clinic Fosters Care Connection for Homeless Population

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KEY WORDS

collaboration
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respect

The goal of this article is to demystify the process that healthcare providers must follow when working with homeless patients who sustain injuries or exhibit illnesses that necessitate rehabilitation care. Observations made over a period of more than 12 years at an inner-city medical/psychiatric nurse-managed free clinic that delivers cutting-edge services and educates multidisciplinary students to care for disenfranchised populations led the author to several conclusions: homeless people frequently lose their identity as individuals when facing healthcare providers; previous negative perceptions of homelessness can turn positive when care providers meet these patients on a person-to-person level; the concept of health and rehabilitation must be clearly understood in the same way by both providers and patients for nursing goals to be realistic and achievable; and a collaborative relationship must be formed between nurses and patients.

The focus of this article is to convey the difficult work that rehabilitation nurses perform with homeless patients and facilitate a greater understanding of the unique issues that homeless people bring to health care. Through the example of an inner-city clinic, prominent issues of homelessness will be identified and a process to overcome problems will be explored. A vision for effective future care also is presented.

On any given night, 760,000 people are homeless in the United States (Greater Cincinnati Coalition of the Homeless, 2004), with women and children comprising the largest growing category of homeless people (Donohoe, 2004; Toro & Warren, 1999). Among all homeless people, approximately one-third have mental illness, many with dual diagnoses related to addictions such as alcohol or cocaine dependence. Those who currently are not addicted to substances soon will join these ranks if they remain on the streets for 1 year or longer. Many homeless people have co-occurring disorders such as diabetes, hypertension, asthma, and nutritional deficits in addition to injuries, frostbite, and skin infections.

Trabert (1997) found that most homeless people are unhealthy from the beginning of their period of homelessness, and that this condition is the result of many sociological factors. Barriers to care identified by Lewis, Anderson, and Gelberg (2003) included not knowing where to go for care, long waiting hours in clinics, and being "too sick to seek care" (p. 923). In addition, homeless people often have negative experiences with medical institutions and fear asking for care. Lack of healthcare entitlement directly affects preventive care and the management of chronic illnesses such as cardiovascular disease, diabetes, metabolic syndrome, and chronic obstructive pulmonary disease in the homeless population (Donohoe, 2004; Kushel, Perry, Bangsberg, Clark, & Moss, 2002). The health of

homeless adults often is compromised by conditions left untreated that can lead to catastrophic illness, ultimately resulting in increased mortality and morbidity rates that are disproportionately high in the homeless population (Savage et al., 2006).

Although some people are episodically homeless (perhaps for only several months to a year), others are chronically homeless. Regardless of the situation, the "homeless" label is accompanied by a set of beliefs and expectations about a person. Trabert's (1997) report that homeless people often are seen as undesirable to care for is accurate. Salit, Kuhn, Hartz, Vu, and Mosso (1998) report that when homeless people are hospitalized, they tend to remain in the hospital longer than average. Based on both the undesirability of caring for this population and the fact that their care often necessitates longer hospital stays, the approach to providing medical and psychiatric care to this vulnerable population requires significant change from how care is normally provided. The Health Resource Center of Cincinnati, Inc. (HRC), was established to prevent increases in medical and psychiatric acuity among the homeless and serve them in the neighborhood in which they live.

Clinic Development and History

The HRC, a 501(c)(3) nonprofit corporation, began operating in March 1995 as a nurse-managed full-service mental health agency that also provided medical and social service care to homeless adults. Located inside the Free Store/Food Bank building in Over-the-Rhine, an old German inner-city neighborhood in Cincinnati, the HRC opened with one nursing professor and one social work intern, neither of whom had ever attempted a project of this scope. Both women had developed a passion for working with mentally ill/substance-abusing clients who were homeless, many

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of whom were receiving fewer services as healthcare costs escalated on a national scale. Because there were only four free clinics in Ohio, none of which offered combined medical, psychiatric, and substance abuse services, the idea to open a facility that could provide truly integrated treatment at no cost was ambitious.

The implementation concept for the HRC arose from a problem first identified by the author and psychiatric emergency service staff at a large indigent-care hospital. Nurses continually treated people who were identified as “hard to serve” because of their mental illness diagnoses, frequently occurring substance abuse problems, and other more medically focused comorbidities. These patients continually rotated through the emergency department but did not seem to benefit from the care provided there, which added to the frustration of healthcare providers. There was a strong belief that nurses who were located in the neighborhoods in which these people lived could provide a form of care to the mentally ill homeless population that was different than what was offered by larger systems. The goal of the HRC was to provide both immediate service in the geographic area in which patients lived to reduce emergency visits and to enable already-connected patients (those with case managers) to reconnect to service providers.

When the clinic first opened, the procedure was to triage any person who said they wanted care, regardless of the type of care required. No limitations or criteria were placed on admission, and staff attempted to meet the requests of patients, not just focus on what the staff perceived the patient needed. It was found that a patient presenting with a question often had more pressing issues, but was using their initial question to evaluate the providers’ level of reception. For example, a young woman came to the door to ask if we performed pregnancy exams. If we had answered “no,” she would have left to seek help elsewhere. Instead we answered “Not yet, but if you would like to come in and sit for a while, we will see where you can get those services.” Within 1 hour, we found that she had left her home in another state because of parental abuse and had traveled to Cincinnati. She spent the night in a shelter, where she was robbed of her purse, which contained her identification and money. Shelter staff told her to go out and find housing. She was 4 months pregnant and terrified. The first intervention, which took less than 1 hour, was to listen to her story and then help her replace necessary identification, without which she could not move to the next step, which was finding services and housing. We first secured her birth certificate from her home state (this entailed several phone calls, followed by a letter of request with a personal check). The next step was to schedule an appointment at the high-risk pregnancy center, which included an appointment with the financial office because she had no money or

identification. The intervention also allowed time for her to talk through the terror of being alone in a strange city and having to stay in a shelter that was less than safe. She checked in at the HRC once a week until her birth certificate arrived, told us her prenatal care was instituted, and moved on with her life.

Services Provided

Twelve years later, our original philosophy—that clients can self-heal if we listen to them, provide the things they initially request, and educate them about their diagnoses, rights, and how to best access the healthcare system—continues to be realistic. The clinic now has four advanced practice nurses, one physician, one psychiatrist, two family practice/psychiatric residents, two counselors, an operations manager, and a full-time development director. Two counseling graduate interns and various medical and nursing students rotate through the agency for 1 month to 1 year.

Each year, close to 4,000 encounters are logged, with care provided to approximately 380 people. Approximately 80% of clients are not eligible for Medicaid because they are unable to meet criteria or navigate the bureaucratic system. Seventy-five percent of clients are unhoused; 71% are unemployed; 44% have no income at all; 21% have some college education, with four people having master’s or doctoral degrees; 64% have fair-to-poor health; and 78% have either a felony or misdemeanor record.

More than 48,000 no-cost encounters have been provided during the last 12 years. Approximately 58 students have rotated through the clinic during each 2-year period, resulting in more than 8,000 hours of student/client interactions during the 24 months. Services now include psychiatric assessments, pharmacotherapy, counseling, medical care, health education, and addiction and social services. HIV/TB testing, labs, referrals to outside agencies that will accept nonreimbursable clients, and advocacy for social justice also are provided.

To make the healthcare process more seamless for people who are unable to navigate the complex systems, HRC has studied how to alleviate barriers to healthcare access such as bureaucratic rules requiring an address or proof of citizenship status. The HRC is certified by the Ohio Department of Mental Health and the Ohio Department of Alcohol and Drug Abuse Services and is accredited by the Commission on Accreditation of Rehabilitation Facilities. The HRC is supported in part by contracts with the Hamilton County Mental Health and Recovery Services Board, the Cincinnati Health Network (which is the recipient of Healthcare for the Homeless dollars), and the Adult Parole Authority (APA). The APA is responsible for accessing integrated treatment services for postfelony offenders. However, similar to

other nonprofit agencies, much of the remaining HRC budgeted needs must be secured through fundraising and donations, a process that the already-overworked staff and board must add to their daily activities.

In a recent study of the demographic characteristics of the HRC (Wilson, Wilson, Earle, & Selzer, 2007), it was noted that of the 158 current active mental health patients, numerous Axis I diagnoses were seen during the course of 1 year (Table 1). Of the 380 people served in 1 year, 222 were homeless people who came in off the street seeking treatment for medical (not mental) problems. These patients had chronic health conditions including obesity and disorders of the cardiovascular, endocrine, skeletal, and respiratory systems (Table 2). Homeless people frequently require inpatient care or specialized services in hospital-affiliated clinics. Many have chronic illnesses that require long-term care, but instead they receive episodic care for portions of their disorders, with no practitioner managing their overall treatment. In addition, homeless patients often erect barriers to protect themselves against perceived emotional assaults from caregivers.

Nurses need to understand these barriers to help patients navigate the system more effectively. Rehabilitation nurses must learn to cope with chronic conditions that have gone untreated for years, in addition to addressing the current healthcare crisis.

Issues to Overcome

Nurses working in emergency departments, chronic care clinics, and long-term care facilities especially need to be cognizant of homeless people as they seek treatment, often initially, for presumably insignificant issues. These relatively minor issues may mask a patient's attempt to judge the quality of care he or she may receive.

People labeled as "homeless" often lose their identity when seeking treatment providers because of the stigma attached to their lifestyle. Consequently, destigmatization should be institutionalized early on in both student and provider environments. Society commonly believes that homeless people are lazy, willing to live off of others, just need to get a job, "are only a bunch of drug-seeking bums," and "could change their lot if they wanted to." These attitudes creep into and are reinforced in both inpatient and outpatient settings. Blankertz, Cnaan, White, Fox, and Messinger (1990) report that not only are dually diagnosed homeless people (i.e., those who are diagnosed with both substance abuse and mental illness) prone to isolation and mistrust, but they often resist accepting help when it is offered. People with mental illness diagnoses are much more likely to receive inadequate or inappropriate care (Bartels, 2004), while those with substance abuse disorders often are stigmatized when presenting for care. Overworked emergency department and hospital staff can become callous if their well-meaning

Table 1. Diagnoses Among Mental Health Patients at the Health Resource Center of Cincinnati

Psychiatric Diagnoses (n = 158)	
Bipolar disorder	31.6%
Major depressive disorder, recurrent	36.7%
Schizoaffective disorder	5.7%
Schizophrenia	7.6%
Psychotic disorder NOS	3.8%
Anxiety disorders	31.0%
Posttraumatic stress disorder	22.8%
Attention deficit/hyperactivity disorder	5.1%
Substance Use Disorders	
Psychoactive substance dependence	43.7%
Psychoactive substance abuse	5.1%
History of psychoactive dependence/abuse	5.7%
General Medical Conditions	
Circulatory system	18.4%
Skeletal system	17.7%
Endocrine system	9.5%
Nervous system	9.1%

Table 2. Chronic Health Conditions Among Medical Patients at the Health Resource Center of Cincinnati

Medical Diagnoses (n = 222)	
Cardiovascular system	60%
Endocrine system	36%
Skeletal system	10%
Respiratory system	25%
Nutritional disorders (obesity)	75%

attempts to work with homeless patients go unfulfilled. Statements related to expectations of poor compliance often are shared among staff, and there is little time for patients, who have not experienced much trust from nurses and physicians, to begin the process of trusting. There is less time for nurses to teach patients about the things they need to know to survive. Both parties may leave the encounter feeling they have failed, and the myths are perpetuated.

Interactions on a person-to-person level must occur if negativity is to dissipate. For nurses working in the clinic or in emergency departments, taking time to listen to a story is not only mandatory, but the first step toward developing a sense of trust and achieving a realistic treatment plan. Nurses must not appear rushed (even though they may be) and they must look the person in the eye when speaking. Instead, nurses often identify the things they think these patients need while out of their sight. When developing a course of treatment, one often assumes compliance or non-compliance without testing the hypothesis. Students have to unlearn their new sense of expertise if they are to meet these patients on an individual level. Older or experienced homeless people do not take well to younger or less-experienced providers, or to those who use expert approaches to care or education. It

Key Practice Points

1. Lack of healthcare entitlements directly affects prevention care and the management of chronic illnesses in the homeless population.
2. Homeless clients are capable of self-healing if providers listen to them, try to provide what they request, and educate them about their diagnoses, rights, and how to access the healthcare system in their city.
3. Interactions must occur on a person-to-person level; nurses should take time to listen to a homeless person's story as the first step in developing trust and achieving a realistic treatment plan.

is more beneficial if the provider asks the patient to describe the things that have helped him or her in the past and the things they want and are willing to do this time. Melnick and Bassuk (2000) explain that the foundation of the therapeutic interaction is "built on trust, understanding, and respect" (p. 3), and caution staff to seek out a client's strengths as well as their limitations. According to Melnick and Bassuk, patients often appear hostile and refuse help, which is really a strategy for compensating with feeling vulnerable or admitting that "they need help from anyone" (p. 6).

Another issue is that both providers and patients must understand the concept of health care and rehabilitation in the same way if nursing goals are to be realistic and achievable. As a first step to working in unison, ask the patient to describe their goals for recovery and then use their words to develop the objectives and outcomes. It may be premature and not in the best interest of the nurse/patient relationship to rely only on outcomes that a hospital has identified as achievable for that condition. For example, a homeless person who has cancer often is prescribed chemotherapy and/or radiation to achieve remission or recovery. Staff can become discouraged when a patient chooses to not continue treatment without realizing that a person may not seek public shelter if they are experiencing nausea, vomiting, or diarrhea. Patients often must decide between having a bed to sleep in or treating their disease. When a person is homeless, today's problems are more important than what tomorrow may bring because tomorrow may never come.

Vision for the Future

As health care becomes more costly and homelessness persists, providers must develop new approaches to educating students and providing care if client-centered care is the ultimate goal. Best-practice guidelines in working with disenfran-

chised populations must be developed and then modeled by both academicians and healthcare providers. Restricting services to "self-pay" patients (those not on Medicaid, Medicare, or some other form of reimbursement) is unlawful if an agency receives federal dollars, yet the practice continues in a subtle manner among agencies caught in the healthcare crisis.

Current attitudes and regulations toward undocumented patients (many of whom are homeless) that forbid agencies from using federal, state, or county tax dollars to provide care must be abolished. The priorities of our founding fathers that identify Americans as "one people" regardless of where they come from must be realized and put into action once again. Health care, both preventive and restorative, must be available for all who currently live in this country if we are to avoid medical calamities and the spread of rampant, highly lethal, infectious diseases.

Implications and Ramifications

- Because many homeless people seen for medical problems are dealing with chronic conditions, previous negative perceptions must change if providers and patients are to achieve success. Establish team meetings that focus on discussion, education, and case presentations of the homeless population to help to make homelessness less threatening and frustrating for staff.
- People labeled as "homeless" often lose their identity as individuals and become compartmentalized as part of the bigger "homeless" problem when seeking health care. Encourage staff to take a few extra minutes to talk with patients about life in general and not just symptoms and issues that are related to illness. This can improve interactions for both parties. Providers and patients must agree on the goal of medical care or the rehabilitation program if the outcome is to be effective. Problem solving will expand knowledge and introduce new information.
- Rehabilitation personnel and nurses working in chronic-care environments need to form a collaborative relationship with homeless patients by first taking time to listen to what they wish for, as well as telling them what may be best for their health. Asking patients to describe their perceived strengths and limitations changes the focus of the relationship. Adding a little bit of time at the beginning of the interaction may result in better cooperation and satisfaction—for both parties—on the day of discharge.

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