



Complete Summary

GUIDELINE TITLE

Adapting your practice: general recommendations for the care of homeless patients.

BIBLIOGRAPHIC SOURCE(S)

Bonin E, Brehove T, Kline S, Misgen M, Post P, Strehlow AJ, Yungman J. Adapting your practice: general recommendations for the care of homeless patients. Nashville (TN): Health Care for the Homeless Clinicians' Network, National Health Care for the Homeless Council, Inc.; 2004. 44 p. [48 references]

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE
METHODOLOGY - including Rating Scheme and Cost Analysis
RECOMMENDATIONS
EVIDENCE SUPPORTING THE RECOMMENDATIONS
BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS
QUALIFYING STATEMENTS
IMPLEMENTATION OF THE GUIDELINE
INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES
IDENTIFYING INFORMATION AND AVAILABILITY
DISCLAIMER

SCOPE

DISEASE/CONDITION(S)

Chronic and acute conditions for which homeless people are at increased risk

GUIDELINE CATEGORY

Counseling
Diagnosis
Evaluation
Management
Prevention
Screening
Treatment

CLINICAL SPECIALTY

Emergency Medicine
Family Practice
Infectious Diseases
Internal Medicine
Nursing
Obstetrics and Gynecology
Pediatrics
Preventive Medicine
Psychology

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Dietitians
Emergency Medical Technicians/Paramedics
Health Care Providers
Nurses
Pharmacists
Physician Assistants
Physicians
Psychologists/Non-physician Behavioral Health Clinicians
Public Health Departments
Respiratory Care Practitioners
Social Workers
Speech-Language Pathologists
Students
Substance Use Disorders Treatment Providers

GUIDELINE OBJECTIVE(S)

- To recommend adaptations in standard clinical practices to foster better health outcomes for homeless adults and children
- To guide health professionals who work with individuals who are homeless or at risk of homelessness

TARGET POPULATION

Homeless adults and children, or individuals at risk of homelessness

INTERVENTIONS AND PRACTICES CONSIDERED

Note: Refer to the "Major Recommendations" field for context.

Diagnosis/Evaluation

1. History, including assessments of current living conditions; prior homelessness; acute/chronic illness; prior health providers; mental illness/cognitive deficit; developmental/behavioral problems;

- alcohol/nicotine/other drug use; health insurance/prescription drug coverage; sexual history; history and current risk of abuse; legal/violence history; regular/strenuous activities; work history, literacy, nutrition/hydration, cultural heritage/affiliations/supports; and patient strengths such as coping skills, abilities, and resourcefulness
2. Physical examination, including comprehensive exam; serial, focused exams; dental assessment. Consideration for special populations such as victims of abuse and sexual minorities
 3. Diagnostic tests, including screenings for interpersonal violence; mental health; substance abuse; sexually transmitted infection (STI); cancer (for adults) and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (for children); cognitive and developmental assessments; baseline labs; tuberculosis test using purified protein derivative (PPD); forensic evaluation (if applicable); and health care maintenance

Plan/Management

1. Plan of care, including basic needs; patient goals and priorities; action plan in simple language; availability of health care after hours; and plans for safety, emergency, and adherence
2. Education and self-management, including patient/parent instruction, prevention/risk reduction, behavioral change, nutrition counseling, peer support, and education of clinic/shelter staff
3. Medications with consideration of a simple regimen, onsite dispensing, storage of/access to medications, patient financial assistance, potential for misuse, side effects, and need for pre-authorization. Special issues involving analgesics, immunizations, antibiotics, and dietary supplements
4. Recognition of associated problems and complications, such as no place to heal, masked symptoms/misdiagnosis, developmental discrepancies, functional impairments, dual diagnoses, and loss of child custody
5. Follow-up using contact information; medical home; increased frequency of visits; drop-in system; transportation assistance; outreach and case management; monitoring of school attendance; peer support, and referrals

Model of Care

1. Service delivery design components, including multiple points of service, integrated and interdisciplinary services, flexible service system, and assured access to mainstream health system
2. Outreach and engagement components, including outreach sites where homeless people receive services, a multidisciplinary clinical team, building nonjudgmental therapeutic relationships, and use of incentives to promote engagement
3. Use of evidence-based medicine as standard of care

MAJOR OUTCOMES CONSIDERED

Health disparities between homeless and general U.S. populations

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Searches of MEDLINE, SocABS, PsycInfo databases were performed. Bibliographies compiled by the Bureau of Primary Health Care's Homeless Information Resources Center were also searched.

NUMBER OF SOURCE DOCUMENTS

This guideline is adapted from 7 primary sources.

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus (Committee)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not applicable

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

An advisory committee comprised of six health and social service providers devoted several months during 2004 to development of these general recommendations for the care of homeless patients, drawing from their own experience and from that of their colleagues in Health Care for the Homeless (HCH) projects across the United States. These recommended practice adaptations reflect their collective wisdom about the optimal care of individuals who are homeless or marginally housed.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The guideline developer's Advisory Committee identifies, in the original guideline document, the clinicians who reviewed and commented on the draft recommendations prior to publication.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Diagnosis and Evaluation

History

Living conditions. Ask every patient about his or her living situation to assess residential stability and the possibility that s/he may be marginally housed or homeless.* ("Where do you live? Who lives there with you? How long have you lived there?") Ask where the patient sleeps, where s/he spends time during the day, and how s/he can be contacted. Ask explicitly about access to food, water, shelter, restrooms, and a place to store medications. Assess environmental factors that may expose the patient to toxic substances, allergens, or infection or otherwise threaten health and safety.

*A homeless person, as defined by the Bureau of Primary Health Care, is "an individual without permanent housing who may live on the streets; stay in a shelter, mission, single room occupancy facility, abandoned building or vehicle; or in any other unstable or non-permanent situation. An individual may be considered to be homeless if that person is 'doubled up', a term that refers to a situation where individuals are unable to maintain their housing situation and are forced to stay with a series of friends and/or extended family members. In addition, previously homeless individuals who are to be released from a prison or a hospital may be considered homeless if they do not have a stable housing situation to which they can return. A recognition of the instability of an individual's living arrangement is critical to the definition of homelessness." (Principles of Practice: A Clinical Resource Guide for Health Care for the Homeless Programs, Bureau of Primary Health Care/HRSA/HHS, March 1, 1999; PAL 99-12.)

History of homelessness. If the patient is staying in a shelter, a vehicle, on the street, or in any other unstable living situation, ask if this is the first time s/he has been without a home. Be aware that some people are too embarrassed to admit that they are homeless or don't consider themselves homeless if staying with a relative or friend. Gently ask a parent with an unstable living situation if his/her child has ever been in foster care ("Has your child ever had to live away from you? Have you and your child ever been separated?") Living in foster care increases risk for future homelessness. If there were prior episodes of homelessness, try to determine whether residential instability is chronic or episodic. If currently homeless, try to understand the circumstances that precipitated homelessness and explore available housing options that might be acceptable to the patient.

Medical history. Ask about medical conditions for which homeless people are known to be at increased risk (e.g., asthma, chronic ear infections, anemia, diabetes, cardiovascular diseases, tuberculosis, human immunodeficiency virus [HIV] and other sexually transmitted infections [STIs]). If the patient is school age, inquire about missed days due to illness. Ask whether s/he has ever stayed in a hospital; if so, where and for what reason(s). Request available medical records from hospitals and other clinicians to gather information about prior diagnoses and treatments, but do not withhold care if records are unavailable. If medical records and patient recollection are insufficient to identify specific medications taken, ask if the patient can show you old prescriptions or medicine bottles.

Prior providers/medical home. Inquire about other health care providers the patient has seen and what the patient/family liked or disliked about prior health care. Ask if the patient has a "medical home" (regular source of primary care) and whether access to the primary care provider is limited in any way (e.g., by a change in health insurance or lack of transportation).

History of mental illness/cognitive deficit. Ask if the patient has ever been told s/he had a mental illness or cognitive impairment and if ever hospitalized for an emotional, nerve, or psychiatric condition. Ask about and observe for problems with stress, anxiety, appetite, sleep, concentration, mood, speech, memory, thought process and content, suicidal/homicidal ideation, judgment, impulse control, and social interactions. Normalize discussion of mental health issues by asking whether the individual has been experiencing "stress, low energy, difficulty focusing, or mood swings" rather than "mental illness." Ask if the patient has ever been treated for depression, anxiety, or other concerns and if s/he is currently experiencing any of these problems. Assess the patient's ability to take pills daily and return for follow-up care. If mental health problems are suspected, ask if the patient would like an appointment with someone (preferably a mental health professional on the clinical team) to discuss his/her concerns further. If the patient is reluctant to discuss a mental health problem with another clinician, ask what s/he would like you to do to address it and revisit the issue of referral at a later point.

Development/behavior. Evaluate the special needs of every patient, including possible developmental delays. If the patient is a child, inquire about interaction with family members and behavior at daycare or school. If problems are reported, assess for possible hearing loss and/or speech delays secondary to chronic ear

infections, commonly seen in homeless children. Recognize that behavior problems frequently occur in response to the stress of being homeless and are not necessarily indicative of underlying pathology. Behaviors that are adaptive while homeless may be maladaptive in other settings.

Alcohol/drug use. Ask about current and previous use (amount, frequency, duration) of alcohol and drugs, including nicotine, recognizing that smoking is more common among homeless than domiciled people and often begins at a younger age. To engage the patient in conversation about this topic, ask "What are the good things about using?" followed by "What are the not so good things?" Assess the individual's level of readiness for behavioral change. Provide relevant information about health risks related to substance use. Look for substance use disorders that may complicate treatment adherence for other health and mental health issues.

Health insurance, other resources. Ask whether the patient has health insurance that covers prescription drugs and how s/he obtains medicine. If uninsured or without prescription drug coverage, provide assistance in applying for entitlements, including Medicaid, the State Children's Health Insurance Program (SCHIP), Supplemental Security Income (SSI), or other assistance for which the patient may be eligible.

Sexual history. Ask about gender identity, sexual orientation, sexual behaviors, partners, pregnancies, and sexually transmitted infections, including hepatitis. Obtain a detailed history of sexual practices, including number/gender of sex partners and their risk for HIV, use of condoms or other barrier methods, and types of sexual intercourse. Ask if the patient has ever exchanged sex for money or other needs. Use written questions so the patient knows it is standard procedure to ask them. Ask the same questions of both males and females in a nonjudgmental way.

History/risk of abuse. Assess for a history of emotional, physical, or sexual abuse and exploitation; ask all patients if they have ever been physically hurt, afraid of being hurt, or made to do things sexually they didn't want to do. Ask about family stress and relationship problems, recognizing that chronic illness in a child can increase the child's risk for abuse. Discuss medical confidentiality and its limits (e.g., in cases of child abuse, threat to self or others). If abuse is suspected, evaluate patient safety and follow mandatory reporting requirements in your state. (For resources where this information can be obtained, see Web sites listed in the Major Recommendations, under "**Plan and Management, Plan of Care, Safety plan**".)

Legal/violence history. Ask about the patient's current/past legal problems and if there is any history of violence against persons or property. Be alert for indications of domestic violence. If a history of violence is indicated, assess the patient's potential for current/future violence. Ask about arrests and incarceration and whether the person ever received medical or mental health treatment while incarcerated. A history of incarceration is associated with increased risk for infectious diseases, interrupted treatment, and barriers to housing following discharge.

Regular/strenuous activities. Ask if the patient has any sort of schedule or daily routine. Explore evidence of consistency in the patient's life to assess whether a medical regimen can be integrated into his/her regular schedule of activities. Ask the patient to describe strenuous activities (e.g., walking — how far in blocks?). Knowledge of activity level can be useful in designing an exercise program to prevent or reduce complications of cardiovascular disease or diabetes.

Work history. Ask what types of work the patient has done and the longest time s/he held a job to identify abilities and interests, assess stability, and determine risk for comorbidities associated with toxic exposures (e.g., to asbestos, silica, coal). Ask about any work-related illnesses or injuries and whether they have interfered with gainful activity (i.e., made it difficult to do work, resulted in job loss, presented obstacles to hiring). If so, consult the Association of Occupational and Environmental Clinics for referrals and assistance (www.aoec.org).

Literacy. Ask if the patient has trouble reading or wants help filling out the intake form. This can serve as a non-threatening way to evaluate ability to read English while allowing the patient to save face, since "trouble reading" can indicate vision, literacy, or language problems.

Nutrition/hydration. Look for signs and symptoms of malnutrition and dehydration. Ask where the patient has meals and what kinds of food s/he eats. Inquire about access to water and other liquids, especially in summer months. Understand that homeless people are at risk for malnutrition and obesity because of limited dietary choices. Evaluate the patient's knowledge of proper diet and food resources (pantries, soup kitchens, delivered meals, nutritional supplements), as well as cooking skills and availability of cooking facilities. If the patient is not eating well, determine why (e.g., limited access to nourishing food, poor dentition, use of resources for other needs).

Cultural heritage/affiliations. Ask about the patient's cultural background, faith community, and/or other affiliations, to identify potential social supports. Be aware of health disparities between cultural/ethnic minorities and the general population (higher risk for cardiovascular disease, asthma, cancer, depression, etc. among ethnic minorities and other medically underserved populations).

Strengths. Ask about the patient's perceived strengths and abilities, as well as present and past interests. Recognize that it takes a great deal of resourcefulness, patience, and tenacity to meet survival needs while one is homeless. Seeking health care, keeping appointments, and adhering to treatment are all examples of basic strengths that should be acknowledged. Homeless people also have vocational and artistic skills or other talents that may go unnoticed. Comment on strengths you see in the person.

Physical Examination

Comprehensive exam. A full-body, unclothed examination of a homeless adult is rarely possible before engagement is achieved. The patient may be too fearful to be examined, indicating the need to build a therapeutic relationship first. Be sensitive to the patient's comfort level. Explain at the first visit what a comprehensive physical examination entails, and ask permission to perform one. If the patient prefers not to disrobe at the first visit, defer the genital exam until

the second visit or whenever his/her comfort level allows, especially for young adolescents or if a history of sexual abuse is suspected. Once engaged, a more complete examination can be performed. For children, use every patient visit as an opportunity for a general physical examination, including height, weight, head circumference, and other screenings recommended by standard clinical guidelines (American Academy of Pediatrics: www.aap.org/policy/paramtoc.html).

Serial, focused exams. If the patient is not ready for a comprehensive physical examination, conduct serial, focused examinations until a therapeutic relationship has been established (e.g., examine the patient's feet, listen to his/her chest). Ask permission to perform each physical exam. Be attentive to the patient's comfort level and pay attention to nonverbal cues; do whatever s/he can tolerate at the time. Schedule a return visit within a short period of time and plan frequent follow-up encounters to complete the examination.

Dental assessment. Screen infants and children for age appropriate teeth and obvious tooth decay. In a child 6 months to 2 years of age, chalky white or brown areas on upper anterior teeth are signs of Early Childhood Caries and require referral to a dentist experienced in the care of pediatric patients. If the patient complains of ear ache, sore throat, or sinus pain with no evidence of infection, check for decayed molars or other dental disease and refer for an oral health assessment, recognizing that referred pain to the ears and throat can be a symptom of dental problems. Ask adult patients whether they are experiencing any dental pain, bleeding gums, or foul mouth odor and when their last dental examination was. Be aware that dental disease is common among homeless people, especially those with diabetes mellitus. A dental assessment is particularly important for diabetes patients with poor blood sugar control.

Abused patients. Recognize that a high percentage of homeless people have experienced physical and/or sexual abuse. Whenever possible, offer patients the option of being examined by a health care provider of the same sex. To decrease anxiety, explain at the outset the purpose of each visit and what the patient can expect to happen. Always explain what you are going to do before you do it.

Sexual minorities. Recognize that homeless people with a non-traditional sexual orientation or gender identity experience even greater obstacles to health care than do other homeless people, and may not have seen a primary care provider for years. Cancer, sexually transmitted infections, and depression are among the health conditions that are less likely to have been detected or treated in gay, lesbian, bisexual or transgender (GLBT) individuals ("A healthy people 2010 companion," 2001). Be aware that GLBT individuals who are homeless are more often victims of sexual or physical assault, use highly addictive substances more frequently, and have higher rates of psychopathology (including depression and suicidal ideation) than their heterosexual counterparts (Noell et al., 2001; Cochran et al., 2002; Kushel et al., 2003). A male taking estrogen needs to have mammograms; a female taking testosterone still requires Pap smears and breast exams/mammograms according to standard schedules. Any patient who has had a silicon or other implant should receive both physical and radiological examinations and be carefully monitored. Patients who have had sexual reassignment surgery require genital examination as part of regular health care maintenance.

Diagnostic Tests

Screening for interpersonal violence. Routinely assess for domestic/interpersonal violence. A screening tool recommended for this purpose is the Posttraumatic Diagnostic Scale Modified for Use with Extremely Low Income Women. (To obtain this questionnaire, contact The National Center on Family Homelessness, formerly The Better Homes Fund: 181 Wells Ave, Newton Centre, MA 02459; Tel: 617-964-3834; Fax: 617-244-1758. See also: Melnick and Bassuk, 2000).

Mental health screens. Screen every patient for depression. National measures recommended by the Health Disparities Collaborative on Depression are based on the 9-item Patient Health Questionnaire (PHQ-9), a depression scale developed for primary care, available at:

English: www.ihc.com/xp/ihc/documents/clinical/103/8/5/depression_phq9.pdf

Spanish: www.depression-primarycare.org/images/pdf/phq_9_quest_spanish.pdf

A 2-item pre-screen (PHQ-2), using the first 2 questions in the PHQ-9, has also been validated for use in primary care (Staab and Evans, 2001).

To screen for a range of psychiatric conditions, consider using the Mental Health Screening Form III, a public domain instrument that takes about 5 minutes to administer (available at: www.asapnys.org/Resources/mhscreen.pdf).

Substance abuse screening. Screen homeless adults and adolescents to determine risk for substance use problems. Consider using the Simple Screening Instrument for Alcohol and Other Drug Use (SSI-AOD), also in the public domain, which is validated for use in general populations and short to administer. The SSI-AOD screening tool may be administered as an interview or as a self-administered test. Both versions are available at: www.health.org/govpubs/bkd143/11m.aspx

Cognitive assessment. Assess for cognitive impairment related to mental illness, chronic substance use, acquired immune deficiency syndrome (AIDS)-related dementia, opportunistic infection, or medication side effects, which may affect adherence to treatment regimens. Test for specific competencies: Can the patient understand directions, make competent decisions, organize time well? The Mini-Mental Status Examination (MMSE), an 11-item questionnaire that can be answered in 10 minutes, is a widely used assessment tool for adults. The MMSE tests orientation, attention, immediate and short-term recall, language, and the ability to follow simple verbal and written commands. For information about how to obtain it, see: www.minimental.com/.

Sexually transmitted infection (STI) screening. For sexually active patients, concurrently assess for and treat STIs, recognizing higher incidence and need for more frequent STI screening of patients engaging in risky sexual behaviors. Test for gonorrhea, chlamydia, syphilis, HIV (following local regulations regarding patient consent), hepatitis B antigen, trichomonas, bacterial vaginosis, and monilia. If a pelvic examination is refused by a female patient, urine gonorrhea and chlamydia screening combined with self-administered vaginal swab for saline and potassium hydroxide (KOH) preparations may be useful screening tools.

Baseline labs. Perform laboratory tests as specified in standard clinical guidelines. Pay more attention to liver function tests in a homeless patient whose risk for liver damage (secondary to hepatitis, history of intravenous drug use, or heavy alcohol use) is high. Patients on hormones or statins should also have regular monitoring of liver functions.

Purified protein derivative (PPD). A number of practitioners recommend PPD tuberculin skin testing for homeless patients every six months because of their higher risk for contact with active tuberculosis and unpredictable follow-up. Various agencies (including shelters) require proof of tuberculosis (TB) testing. It is not unusual for a homeless person to have been tested multiple times for tuberculosis by different providers. Provide a written record of test results on a wallet-sized card that patients can carry with them.

Health care maintenance. At every visit, follow standard clinical guidelines for routine health maintenance screenings, including mammograms and other cancer screening, recognizing that the patient may not have seen a health care provider in a long time. When possible, do standard screenings when the patient is seen for an acute problem, rather than rescheduling (e.g., offer to perform a Papanicolaou [Pap] smear at the same visit when a woman comes in for an upper respiratory infection [URI]). Offer pregnancy testing (urine chorionic gonadotrophin [UCG] urine test) to all heterosexually active female patients of childbearing age.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screening. For children, follow standard procedures for EPSDT services as a routine part of primary care. These are mandatory covered services under Medicaid, for which most homeless children qualify. (A description of these services is available at: www.mchlibrary.info/KnowledgePaths/kp_EPSDT.html. Other resources are Bright Futures and the American Academy of Pediatrics [AAP] Guide to Health Supervision.)

Developmental assessment. If developmental delay is suspected, assess the patient's developmental level using a standard evaluation tool (e.g., Denver Developmental Screening Tests: www.denverii.com/DenverII.html). For a child, use an assessment tool that does not rely solely on parental report. Conduct the assessment with the parent present, to demonstrate that a delay does or does not exist. Partner with the parent to address any delay identified. An annotated list of developmental and behavioral screening tools can be found at: www.dbpeds.org/articles/detail.cfm?id=5.

Forensic evaluation, if warranted. If sexual abuse of a child is suspected, facilitate the patient's referral through Child Protective Services or the police to a center experienced in forensic interviewing and evaluation.

Plan and Management

Plan of Care

Basic needs. Understand that health care usually is not the most urgent problem for individuals or families who are homeless unless they are acutely ill; food, clothing and housing may be perceived as more important. Developing an individualized plan of care with the patient that incorporates strategies to meet

these basic needs will strengthen the therapeutic relationship, increase patient stability, and promote successful treatment.

Patient goals & priorities. Carefully assess the patient's immediate and long-term health care needs and what s/he identifies as priorities. Ask what the patient or family would like you to do. Address immediate medical needs first (the patient's reason for the visit) rather than underlying causes (e.g., provide cough medicine or pain relief, where indicated, even if you don't think they are medical priorities). Be sensitive to the patient's beliefs and values; encourage adults to select their own goals, even if they differ from the providers' or are prioritized differently. When a goal is chosen, work in every way possible to help the patient overcome barriers to achieving it.

Action plan. A written action plan can give the patient and/or parent a sense of control. Most important is to clarify the plan of care in language they can understand. For those who are comfortable with written information, summarize key points on a pocket card that can be carried with them. Ask if there is another person who can help the patient or family cope with illness.

After hours. Extend clinic hours to accommodate working patients who cannot take time off for clinic appointments without risking their jobs. Inform the patient about after-hours clinic schedules and how to contact a medical provider by telephone when the clinic is closed.

Safety plan. If interpersonal violence or sexual abuse is suspected, help the patient develop a safety plan; explain and follow your state's mandatory reporting requirements. (A summary of state reporting requirements for domestic violence/adult abuse is available at <http://endabuse.org/statereport/list.php3>. For information about reporting requirements for child abuse or neglect in all 50 states, see: <http://nccanch.acf.hhs.gov/general/statespecific/index.cfm> and the National Clearinghouse for Child Abuse and Neglect Information: <http://nccanch.acf.hhs.gov/>. Hot line phone numbers for reporting suspected abuse and neglect are available at: www.acf.dhhs.gov/programs/cb/publications/rpt_abu.htm) If suspected child abuse is reported, let the parent know you are doing this to help the child. Offer support to a parent whose child has been abused by someone else. An abused parent may also need protection. Part of treating the child is helping the parent avoid future abuse.

Emergency plan. Help the patient/family make a plan for emergencies. Be sure they know the location of emergency facilities. Instruct them to contact a primary care provider, if possible, before going to the emergency department. Provide a phone number where a medical provider can be reached after hours. Inquire about telephone access; if they do not have ready access to a telephone, ask if there is a friend or case manager who can call on their behalf.

Adherence plan. Recognize that adherence problems often result from unrealistic expectations of the provider. Explain the plan of care in simple language and elicit patient feedback to confirm understanding. Avoid medical jargon and euphemisms that can be confusing and perceived as "talking down" to the patient (e.g., with an adolescent, talk about "having sex" not "intercourse"). Use an interpreter and/or lay educator (*promotoras*) to facilitate communication

and ensure culturally competent care for patients who do not speak English or have limited English proficiency. At the end of every clinic visit, ask the patient or parent, "Is there anything we talked about today that is unclear? Is there anything in the plan of care that will be difficult for you?" Work with the patient/family to find ways to reduce potential barriers to adherence or modify the plan of care.

Education, Self-Management

Patient/parent instruction. Explain health problems and proposed treatment in language the patient/parent can understand, and confirm understanding. Use illustrations to facilitate comprehension. If giving written instructions, provide educational materials in the patient's first language, using simple terminology and large print to compensate for any visual limitations. Develop your own patient education materials or use existing resources. (For examples, see materials prepared by the National Center for Farmworker Health for low-literacy patients who speak English or Spanish: http://www.ncfh.org/00_ns_rc_pateduc.php and Healthfinder for Kids, Office of Disease Prevention and Health Promotion: www.healthfinder.gov/kids/.) Provide a pocket card listing immunizations, any chronic illnesses, test results, and current medications to document medical history for the next caregiver or school authorities.

Prevention/risk reduction. Explain risks associated with any health problems for which the patient is being treated and discuss ways in which s/he can reduce them for him/herself and others, in the case of communicable disease. Make parents aware of risks to their child from exposure to people who are sick. Explain what they can do to reduce the child's susceptibility to future infections (e.g., smoke-free environment, frequent hand washing, coughing into the crook of one's elbow to prevent spread of viral infections, covering a small infant's face with a blanket in crowded areas). Don't recommend use of antibacterial soaps, which are thought to increase the risk of bacterial resistance.

Behavioral change. To encourage behavioral change, use individual, small group, and community interventions based on careful investigation of actual patient behaviors. Motivational interviewing, risk reduction, and social skills training can facilitate engagement and help to resolve ambivalence about behavioral change (Miller and Rollnick, 2002; HCH Clinicians' Network, 2000.) Help homeless parents learn effective parenting skills. Recognize that plans to shape new behaviors in children or extinguish old ones are difficult to carry out in congregate living situations, where parent-child interactions may be subject to public scrutiny, criticism, and interference from others.

Nutrition counseling. Educate patients about nutritional health, diet, and dietary supplements. If possible, include a nutritionist on the clinical team who is knowledgeable about the limited food choices that homeless people typically have. Give examples of how to make the best dietary choices possible in settings where food is obtained. Educate parents of infants about the nutritional, immunologic, and developmental benefits of breastfeeding as well as contraindications for doing so (i.e., potential for maternal transmission of drugs or infection [such as HIV] in breast milk). For infants who are bottle feeding, recommend use of powdered formula that can be prepared as needed. (Keeping liquid preparations safe from spoilage can be difficult for homeless families.) Ask about access to clean water

and refrigeration, and assess the parent's capacity to manage formula feeding with appropriate hygiene. Explain the importance of using clean water to prepare formula milk and cleanse bottles and nipples. Review how long prepared formula or milk is safe to use without refrigeration.

Peer support. For patients experiencing extreme stigmatization or isolation, create support groups where they can share concerns and learn how others are coping with similar health problems. Consider using consumer advocates (formerly homeless persons) to accompany homeless patients to appointments with specialists and attend clinic sessions with the patient and primary caregivers.

Education of service providers. Educate yourself and other service providers about the special needs of homeless patients. Recognize that treatment adherence and successful outcomes are possible, even for homeless individuals with mental health/substance use problems. Take time in a safe setting to explore your own feelings about people who are homeless. Talk about your experiences, biases, and stereotypes with other providers who are more experienced in caring for homeless patients. (For information about providers who work with homeless patients, contact the Health Care for the Homeless [HCH] Clinicians' Network: network@nhchc.org, 615/226-2292; or consult the Directory of HCH grantees and subcontractors, available online at: www.bphc.hrsa.gov/hchirc/directory/. Educate shelter staff, food workers, and volunteers about the health needs of your homeless patients.

Medications

Simple regimen. Use the simplest medical regimen warranted by standard clinical guidelines, to facilitate treatment adherence. Consider expense, frequency, storage requirements, and duration of treatment in selecting medications for homeless patients. If clinically indicated, once daily, directly observed therapy is preferable, especially for patients who may be unable to adhere to a more complex regimen. Make sure the patient/parent understands how to take/administer prescribed medications appropriately. For children over 5 years of age, use pills, tablets, or capsules instead of liquid formulations to avoid the need for measurement or refrigeration. Some capsules can be opened and sprinkled in food, if necessary.

Dispensing. Negotiate the amount of medications to dispense at a given time with the patient, based on clinical indications, the patient's wishes and ability to hold onto the medications, transportation issues, etc. Dispensing small amounts of medications at a time can provide an incentive to return for follow-up if transportation to and from the clinic is available and affordable for the patient. (Some homeless patients frequently lose medications if larger quantities are provided.) Dispensing medications on site is more advantageous than sending homeless patients to a pharmacy with a prescription.

Misuse. Recognize the potential for medications/delivery devices to be misused. Inhalants, bronchodilators and spacers, pain medications, syringe needles, and some anti-hypertensives may be lost, stolen, and/or sold to persons with chemical dependencies. Albuterol is used to enhance the effects of crack cocaine. Clonidine extends the effects of heroin and reduces withdrawal symptoms for persons addicted to opioids. Insulin syringes may be misused to inject intravenous (IV)

drugs. These factors may provide an incentive for some individuals to report having a condition not actually diagnosed. Dispense smaller amounts of medications to patients known to "lose" them; this allows for closer follow-up and prompt identification/elimination of barriers to adherence and can limit opportunities for misuse afforded by multiple authorized refills.

Storage/access. Educate the patient about safe storage of prescribed medications. If the patient is staying in a shelter, ask if medicine can be stored there. Explain to shelter staff that the medications are necessary for the patient's health, costly to replace, and should be made easily available to him/her when needed. Or allow homeless patients to store medications at the clinic and come there daily for treatment. If medications are not stored in the clinic and the patient does not have access to refrigeration, avoid prescribing medications that require it.

Patient assistance. Recognize that even a small co-payment for prescription drugs can be excessive for homeless people; for those without health insurance or access to programs that provide free medications, the cost of medical treatment may be prohibitive. Help uninsured patients obtain all entitlements (Medicaid/State Children's Health Insurance Program [SCHIP], Supplemental Security Income [SSI]) or other assistance for which they may be eligible, including reduced-cost drugs available through the U.S. Public Health Service 340B Pharmaceutical Discount program (<http://bphc.hrsa.gov/opa/>) or pharmaceutical companies' programs for low-income individuals (www.rxassist.org; www.needymeds.com). If co-payments required by the health plan present a financial barrier to treatment, or if reduced-cost drugs are not readily available and immediate treatment is required, consider providing free medication samples when available; but recognize the potential for difficulty in obtaining medications for continued use. Assure continued access to medications before initiating treatment.

Aids to adherence. To facilitate treatment adherence, use motivational enhancement skills; negotiate with the patient; adopt a harm reduction approach*; provide outreach, intensive case management, directly observed therapy, and medication monitoring. Explore obstacles to taking medications appropriately and problem-solve with the patient. Ask, "What concerns do you have about being able to take your medicine regularly?" "Is there someone who might help you take your medicine and keep track of it?" If clinical symptoms or test results indicate nonadherence, find out why the patient is not taking medication(s) as prescribed and address the reasons. The use of pillboxes may help patients keep track of medications and discourage resale. Give parents a cross-off chart to keep track of medication administered to their child; explore other methods they might use to increase adherence.

*Harm or risk reduction refers to activities that are designed to reduce or minimize the damage caused by high-risk behaviors, with the ultimate goal of eliminating them. Examples include needle exchange, methadone maintenance, and outreach programs that distribute educational materials, syringes, condoms, and bleach kits, and facilitate contact with other services. (HCH Clinicians' Network, 2000)

Side effects. Prescribe medications with fewer/less severe negative side effects, which are a primary reason for nonadherence. Avoid prescribing medications with significant sedative or gastrointestinal side effects. Medications that make homeless people feel sicker or diminish alertness may compromise their safety on the streets or in shelters. (Homeless individuals are often victims of gratuitous violence while sleeping out-of-doors. Those experiencing prolonged homelessness are at especially high risk for severe head injury from assault or being hit by cars.) If prescribing diuretics, be sure the patient has easy access to a restroom and bathing facilities and will be able to return for laboratory tests required to monitor them. If medications can be taken with food, provide nutritious snacks to prevent nausea, which often results from taking medicine on an empty stomach. Be more aggressive in changing medications for homeless patients to minimize negative side effects; treat side effects symptomatically if alternative medications are contraindicated.

Immunizations. Update immunizations at every clinical encounter, recognizing that many homeless people tend to seek care only when sick, often miss scheduled appointments for well-child care or health care maintenance, and may lose track of records. Given their high risk of exposure to respiratory infections in congregate living situations, all homeless patients should receive the influenza vaccine annually and be immunized against pneumococcus according to standard clinical guidelines. For homeless adults, provide hepatitis A and B vaccines and update tetanus (Td) if the last immunization was more than 10 years ago. (See recommended immunization schedules for children, adolescents and infants at: www.cdc.gov/vaccines/recs/schedules/default.htm ; for adults: www.cdc.gov/vaccines/recs/schedules/adult-schedule.htm).

Antibiotics. Emphasize that all prescribed antibiotic regimens must be completed. ("Don't stop when symptoms cease or use for the next infection.") Urge patients to use standard measurements for liquid preparations (not just "a swig") and provide a measuring device. If the patient is an infant, determine whether s/he is a candidate for respiratory syncytial virus (RSV) prophylaxis.

Analgesia/symptomatic treatment. Recognize that a number of morbidities commonly seen in homeless patients, including untreated dental problems, hepatitis, and traumatic injuries, can result in chronic pain. It is important to remember that some drugs, such as methadone and other narcotics, can increase or decrease the effects of pain medications. Work with the patient to understand the underlying cause of pain. Prescribe appropriate pain medication and document why you prescribed it. To avoid overmedicating or contributing to drug-seeking behavior, specify the plan of care in a written contract with the patient, designating a single provider for pain prescription refills. Consider providing a cough suppressant or analgesia for a child's acute ear infection, if not detrimental, to allow the child to sleep. A crying child will disrupt other shelter residents, which could place the family at risk for eviction.

Dietary supplements. Prescribe multivitamins with minerals. Assure that pregnant patients receive appropriate vitamin supplements (with folic acid). Consider prescribing nutritional supplements with less familiar brand names that have lower resale value to reduce the likelihood of theft.

Managed care. Know what medications are on your state's Medicaid/SCHIP drug formularies and which ones require pre-authorization by a managed care plan. If possible, prescribe medications that do not require prior authorization to avoid delaying treatment. Help homeless patients fill their prescriptions, especially if they are required to use an approved pharmacy within a managed care network that is far from where they are staying.

Associated Problems, Complications

No place to heal. Provide recuperative care/medical respite facilities where homeless patients can convalesce when ill, recuperate following hospitalization, or receive end of life care. Medical respite services are cost effective because they prevent future hospitalizations (Buchanan et al, 2003). (For information about medical respite/recuperative care alternatives, see *Medical Respite Services for Homeless People: Practical Models* by Marsha McMurray-Avila, 1999: www.nhchc.org/.) Facilitate entry into permanent housing to alleviate many of the associated problems and complications listed below.

Masked symptoms/misdiagnosis. Realize that disease symptoms may be difficult to differentiate from comorbidities in patients with multiple disorders. For example, weight loss in an individual who is homeless may be due to primary malnutrition rather than HIV wasting syndrome. Dementia may be secondary to chronic mental illness/chemical dependency, opportunistic infection, neurological changes associated with AIDS, or normal aging. Dependent edema may result from excessive ambulation for long periods or sleeping in chairs, and is not necessarily related to heart failure. Lactic acidosis symptoms (abdominal pain, shortness of breath) may be secondary to diabetes or chronic obstructive pulmonary disease (COPD). Chronic bronchitis, emphysema, and/or tuberculosis may mimic asthma symptoms.

Developmental discrepancies. Recognize that homeless adolescents and youth may be developmentally less advanced than peers of the same chronological age in some respects and more precocious in others (e.g., survival skills). Concrete thinking predominates over abstract reasoning skills. Homeless adults with mental illness or chronic substance use may have impaired reasoning and delayed social development, that cause them to act like young adolescents. When discussing behavioral change with these patients, focus on immediate concerns rather than possible future consequences.

Functional impairments. Functional deficits secondary to chronic illness or injury can limit a patient's capacity to follow a plan of care. Musculoskeletal impairments, lack of facilities, or the area where a patient lives may limit exercise alternatives. Impaired cognitive functioning can interfere with follow-up care and treatment adherence. Tailor the plan of care to the patient's needs and capacities. Document the patient's medical conditions and functional status with cognizance of disability determination procedures required for Federal assistance under Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) (Quick, Zevin and O'Connell, 2004). Facilitate applications for disability assistance and SSI-related Medicaid.

Dual diagnoses. Recognize that individuals with either a non-addictive mental health disorder or a psychoactive substance use disorder are at increased risk for

developing co-occurring disorders. In clinical samples, the lifetime prevalence of co-occurring mental health and substance use disorders exceeds 50 percent (Winarsky, 1998). The presence of one condition should prompt screening for and assessment of co-occurring conditions. In dually diagnosed patients, both conditions should be viewed as primary; outcomes improve when care is provided in a comprehensive and integrated fashion (Drake et al., 2001). Motivational interviewing can be used to promote readiness for behavioral change in persons with co-occurring disorders (Miller and Rollnick, 2002). When the severity of the illnesses creates significant disability, consider referral to a mental health program while maintaining coordination between behavioral health care and primary care.

Loss of child custody. Patients with substance use disorders and/or mental illness may fear legal separation from their children. Realize that a parent who loses child custody may also lose access to shelter and benefits, and may not be able to get the child back until housing is obtained. Specify shelter options and other resources for parents whose children are placed in foster care. Refer the parent for addiction treatment/mental health care, to promote recovery and family reunification.

Follow-Up

Contact information. Verify contact information at every visit. Ask where the patient is staying (shelter, street, doubled up with other families), where s/he usually sleeps or obtains meals, and how s/he can be contacted (e.g., phone/cell numbers, e-mail address). Request emergency contact information — address and/or phone number of a family member, friend, or case manager with a stable address.

Medical home. Encourage every patient to find one primary care provider (PCP) to coordinate health care. Be active in following up with the patient's regular PCP (if you are not that person) to communicate what has been done and facilitate continuity of care. Let the PCP know that the patient is living in a shelter; tell the patient/family you will contact their regular provider to share this information.

Frequency. Encourage more frequent follow-up visits for patients known to be homeless. Positive incentives can be used to encourage follow-up (e.g., snacks, clean socks, hygiene items, or meal vouchers for every kept appointment or group meeting attended). Keep lines of communication open, even if the patient does not adhere to the plan of care.

Drop-in system. Anticipate, understand, and accommodate unscheduled clinic visits. Create a drop-in time in primary care clinics with no appointment required, particularly for new patients. Encourage routine follow-up for established patients, supplemented by an open-door policy for drop-ins.

Transportation assistance. Help homeless patients arrange for transportation to and from clinic visits and specialty referrals. Help them connect with your state Medicaid program's non-emergency transportation system, if eligible, or provide transportation/carfare (e.g., bus tokens, taxi vouchers) to facilitate follow-up. Become familiar with transportation resources in your community. (For a list of Medicaid transportation contacts in each state, see: www.ctaa.org/ntrc/medical/contacts.asp.)

Outreach, case management. Collaborate with outreach workers and case managers to facilitate treatment adherence and follow-up care, including referrals to other facilities. A premature infant born to a homeless mother should be reconnected to an established Premie Follow-up Clinic and early intervention program, where available. Connect with homeless outreach programs, homeless health care providers, homeless coalitions, or other advocates for underserved populations in your community. (For information about Health Care for the Homeless projects in your area, see: <http://www.bphc.hrsa.gov/hchirc/directory/default.htm>.)

School attendance. For a patient of school age, monitor missed school days due to illness. Work with the patient, family, and school to address health and developmental problems of homeless children that interfere with learning and emotional stability, and to help homeless adolescents remain in school or obtain a graduate equivalency diploma (GED). Develop a relationship with the School District Homeless Liaison.

Peer support. Provide a client advocate to accompany the patient to appointments for diagnostic tests or ambulatory surgery.

Referrals. More aggressive referrals are needed for homeless patients who require access to professionals in multiple clinical disciplines. To facilitate access to specialists, develop referral relationships with providers willing to accept patients with Medicaid/Medicare or provide *pro bono* care for those ineligible for public health insurance. Refer the patient or family to community resources/social services if there are psychosocial problems that may interfere with adherence. Provide a client advocate to accompany homeless patients to appointments for diagnostic tests or ambulatory surgery.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

REFERENCES SUPPORTING THE RECOMMENDATIONS

[References open in a new window](#)

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

This guideline was adapted from the following sources:

HCH Clinicians' Network. *Adapting Your Practice: Treatment and Recommendations for Homeless Patients with Cardiovascular Diseases: Hypertension, Hyperlipidemia, and Heart Failure*. Nashville, Tennessee: National Health Care for the Homeless Council, 2004:
www.nhchc.org/clinical/2.28.04CVDguide.pdf

HCH Clinicians' Network. *Adapting Your Practice: Treatment and Recommendations for Homeless Patients with HIV/AIDS*. Nashville, Tennessee:

National Health Care for the Homeless Council, 2003:
www.nhchc.org/Publications/HIVguide52703.pdf

HCH Clinicians´ Network. *Adapting Your Practice: Treatment and Recommendations for Homeless Patients with Asthma*. Nashville, Tennessee: National Health Care for the Homeless Council, 2003:
www.nhchc.org/Publications/asthma.pdf

HCH Clinicians´ Network. *Adapting Your Practice: Treatment and Recommendations for Homeless Children with Otitis Media* Nashville, Tennessee: National Health Care for the Homeless Council, 2003:
www.nhchc.org/Publications/otitis.pdf

HCH Clinicians´ Network. *Adapting Your Practice: Treatment and Recommendations on Reproductive Health Care for Homeless Patients*. Nashville, Tennessee: National Health Care for the Homeless Council, 2003:
www.nhchc.org/Publications/reproductive.pdf

HCH Clinicians´ Network. *Adapting Your Practice: Treatment and Recommendations for Homeless Patients with Chlamydial or Gonococcal Infections*. Nashville, Tennessee: National Health Care for the Homeless Council, 2003: www.nhchc.org/Publications/STDs.pdf

HCH Clinicians´ Network. *Adapting Your Practice: Treatment and Recommendations for Homeless Patients with Diabetes Mellitus*. Nashville, Tennessee: National Health Care for the Homeless Council, 2002:
www.nhchc.org/Publications/clinical_guidelines_dm.pdf

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- Improved prevention and management of disease in homeless adults and children
- Prevention/resolution of homelessness through improved access to appropriate health care

POTENTIAL HARMS

- Potential for medications/delivery devices to be misused. Inhalants, bronchodilators and spacers, pain medications, syringe needles, and some anti-hypertensives may be lost, stolen, and/or sold to persons with chemical dependencies. Albuterol is used to enhance the effects of crack cocaine. Clonidine may be inappropriately used to extend the effects of heroin and other opioids. Insulin syringes may be misused to inject intravenous drugs. These factors may provide an incentive for some individuals to report having a condition not actually diagnosed.
- Sedative or gastrointestinal side effects of medications may be especially problematic for homeless individuals.

QUALIFYING STATEMENTS

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The information and opinions expressed in the guideline are those of the Advisory Committee on Adapting Clinical Practices for Homeless Patients, not necessarily the views of the U.S. Department of Health and Human Services, the Health Resources and Services Administration, or the National Health Care for the Homeless Council, Inc.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

The guideline was distributed to 161 Health Care for the Homeless (HCH) grantees across the United States and to the National Association of Community Health Centers (NACHC), the Association of Clinicians for the Underserved (ACU), and the National Association of Social Workers (NASW), who offered to share this information with their members. In addition, a number of clinical training programs were made aware of the publication by reviewers working in academic centers and through a collaborative relationship with Community-Campus Partnerships for Health (CCPH). Adapted clinical guidelines including this one are being used in workshops at national and regional conferences (e.g., Health Disparities Collaborative Learning Sessions and the National HCH Conference sponsored by the Bureau of Primary Health Care/HRSA/HHS).

Model of Care

Service Delivery Design

Multiple sites. Provide care where homeless people congregate, at multiple points of service (e.g., clinics, drop-in centers, and outreach sites), as feasible. Consider using electronic medical records to promote continuity of care among multiple service sites.

Integrated, interdisciplinary services. Coordinate medical and psychosocial services across multiple disciplines and delivery systems, including the provision of food, housing, bathing facilities, and transportation to service sites. Optimally, medical and psychosocial services should be easily accessible at the same location; fragmented service systems do not work well for homeless people. Resolution of the patient's homelessness is prerequisite to resolution of numerous health problems and should be a central goal of the health care team.

Flexible service system. Access to care for initial evaluation or ongoing treatment depends on the existence of a flexible service system that homeless individuals can use on a walk-in basis or through outreach workers. Provide drop-in centers or designated slots for walk-in clients in every primary care clinic so that appointments aren't necessary. Help to identify and resolve system barriers that impede access to care, recognizing that some barriers are not within the patient's capacity to control. Enlist the patient's assistance, and with his/her

permission, utilize everyone in the community with whom s/he has contact to facilitate delivery of care.

Access to mainstream health system. Ensure that all homeless patients requiring referrals for secondary or tertiary care have access to the mainstream health care delivery system. Full collaboration between primary care providers and specialists is the only effective treatment and management strategy. Network with other community service providers who are sensitive to the needs of homeless patients to facilitate specialty referrals; assist with transportation and accompany patients to appointments. Frequently, the main problems for homeless clients are systems and access barriers rather than differences in intent or desire to adhere to a plan of care.

Outreach and Engagement

Outreach sites. Conduct outreach on the streets, in soup kitchens, in shelters, and other places where homeless people receive services.

Clinical team. Use outreach workers and case managers to promote initial engagement with the patient. Hire staff proficient in languages used by the populations served. Involvement of all members of the clinical team (outreach workers, case managers, medical providers, mental health professionals, substance abuse counselors, and a nutritionist) in care planning and coordination is important to facilitate engagement, diagnosis, treatment, and follow-up of persons experiencing homelessness.

Therapeutic relationship. Nonjudgmental and supportive patient interactions with members of the clinical team are essential for successful engagement in a therapeutic relationship. Recognize that caring for homeless patients is as much about building relationships as about clinical expertise.

Incentives. Offer incentives to promote engagement (e.g., food and drink [or meal vouchers], hygiene products [toothpaste, brushes, socks], subway/bus cards or tokens).

Standard of Care

Evidence-based medicine. Provide the same, evidence-based standard of care to patients who are homeless as to patients who have more resources. Elimination of health disparities between these patients and the general population should be a clinical goal.

IMPLEMENTATION TOOLS

Personal Digital Assistant (PDA) Downloads
Pocket Guide/Reference Cards
Wall Poster

For information about [availability](#), see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness
Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Bonin E, Brehove T, Kline S, Misgen M, Post P, Strehlow AJ, Yungman J. Adapting your practice: general recommendations for the care of homeless patients. Nashville (TN): Health Care for the Homeless Clinicians' Network, National Health Care for the Homeless Council, Inc.; 2004. 44 p. [48 references]

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HCH Clinicians' Network. *Adapting Your Practice: Treatment and Recommendations for Homeless Patients with Diabetes Mellitus*. Nashville, Tennessee: National Health Care for the Homeless Council, 2002: www.nhchc.org/Publications/clinical_guidelines_dm.pdf

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GUIDELINE COMMITTEE

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

The Health Care for the Homeless (HCH) Clinicians' Network has a stated policy concerning conflict of interest. First, that all transactions will be conducted in a manner to avoid any conflict of interest. Secondly, should situations arise where a Steering Committee member is involved in activities, practices or other acts which conflict with the interests of the Network and its Membership, the Steering Committee member is required to disclose such conflicts of interest, and excuse him or herself from particular decisions where such conflicts of interest exist.

No conflicts of interest were noted during preparation of this guideline.

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the [National Health Care for the Homeless Council, Inc. Web site](#).

Print copies: Available from the National Health Care for the Homeless Council, Inc., P. O. Box 60427, Nashville, TN 37206-0427; Phone: (615) 226-2292.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Recommendations for the care of homeless patients (pocket cards). Nashville (TN): Health Care for the Homeless Clinicians' Network, National Health Care for the Homeless Council, Inc.; 2005. Electronic copies: Available from the [National Health Care for the Homeless Council Web site](#). Laminated cards can be ordered from the National Council for \$5.00 per set at: [National Health Care for the Homeless Council Web site](#).
- Homelessness and health: challenges to care (poster). Nashville (TN): Health Care for the Homeless Clinicians' Network, National Health Care for the Homeless Council, Inc.; 2005. Electronic copies: Available from the [National Health Care for the Homeless Council Web site](#). Order hard copies from the National Council for \$2.00 each: [National Health Care for the Homeless Council Web site](#).

The following are also available:

- An outline of main points contained in the guideline, is also available for Palm Download from the [National Health Care for the Homeless Council Web site](#).
- See the related QualityTool summary on the [Health Care Innovations Exchange Web site](#).

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI on July 28, 2004. The information was verified by the guideline developer on August 13, 2004.

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