



Chronic Medical Diseases in Homeless Populations

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Health care for homeless persons has long been rooted in caring for the emergent and episodic needs of a people whose daily lives are punctuated by uncertainty and vulnerability. Accident, injury, exposure to the extremes of heat and cold, and a range of communicable diseases facilitated by crowding repeatedly compromise the health and well being of people who are homeless. With the pressure to assure that each new event in their lives is cared for in the best way possible, the many other chronic conditions that are a part of their lives often do not get our full attention as clinicians.

Readily accessible, consistent, and continuous care from a known and trusted clinician is not always available for many people experiencing homelessness. Likewise, the systems that support our care frequently do not give us adequate information to understand the nature of each chronic condition and what parts of a care plan are yet to be completed.

Convergent with the rise in awareness of the burden of chronic illness borne by homeless populations has been the quality improvement movement in health care and other industries and systems over the past 15 years. The conversation about the definition of quality of care and the method of examining issues of quality has been going on for decades. The 1970's were marked by peer review;

Ellen Hoey, RN, embraces this wheelchair-bound man and his uncle. The uncle had several admissions to the hospital for recurrent cellulitis until Ellen taught his nephew how to change his uncle's daily dressings. Photo by James O'Connell MD

the 1980's by quality assurance; and since the 1990's, quality of care has been discussed in terms of quality improvement. Not surprisingly, individual clinicians, patients, health care organizations, and insurance providers may have contrasting perspectives on what constitutes quality of care.

Most homeless people have at least one, and often several, chronic diseases, yet often our delivery systems are focused on the episodic treatment of chief complaints at a given moment in time. Since the early 1990's, a slow shift in emphasis has occurred from this sporadic-type care focusing on individual and immediate issues to an emphasis on treatment of chronic disease in a revolutionary way. Instead of focusing on anecdotal evidence of best treatments for a given symptom complex, the emphasis has shifted. Now more resources are devoted to treatment based on clinical evidence, centered on the whole patient, and resulting in specific key improvements that are measurable and directly related to overall health, including morbidity, mortality, and quality of life. All around us is a push to close the gap between what we know – that extensive amount of evidence-based research that relates actions to outcomes – and what we actually do when we see a patient.

Studies consistently show that homeless people have a higher prevalence of chronic disease than the population as a whole, and the ability of someone who is homeless to manage disease optimally is severely impaired by a lack of control over living conditions and limited opportunities to consistently follow an optimal treatment plan. Given these factors, it is even more important to consider just how population-based, chronic disease management, in conjunction with measurable outcomes, affects care and quality of life. Moving from a dependent, provider-driven model to one in which the patient is empowered to set goals and determine priorities results in the inclusion of the patient in decisions. Since in reality patients do provide most of their own care through direct self-care and decision-making about how a recommended treatment plan will be followed, it appears natural to shift to a model in which the patient and the caregivers make decisions together. Whereas the clinician may define the main problem in a visit as non-adherence, the patient may define the main problem as loneliness – a priority that should result in a revised and markedly different treatment plan developed by both patient and provider.

As the quality improvement movement has resulted in measurable outcomes, such initiatives have fit well into the treatment of chronic disease in

this collaborative fashion. In decades past there was little effort and even less success in measuring the level of quality in health care. Today this science has developed significantly, partly as a natural offspring of evidence-based medicine and partly as a result of initiatives sponsored by managed care systems in response to regulatory requirements. In measuring what we do, choosing outcomes that will truly make a difference is step one. Medical literature searches in a given chronic disease can result in a short and focused list of key quality outcomes to measure and improve. In the case of diabetes, even small reductions in HgbA1C levels result in significantly fewer future cardiovascular events, such as strokes or heart attacks. Measuring this value should be a part of every on-going treatment plan for diabetic patients, and collaborative goal setting around this measurement should be considered as one goal to be followed and improved.

Such goal setting highlights the need to build awareness of a disease through an education program that assures the patient is an informed partner in the design of a treatment plan. Only then can our homeless patients truly direct their care in a manner that understands and respects the reality of life in the shelters and on the streets. This awareness and education rests not only with the primary care provider during a clinic visit. Ideally this is a responsibility of a multidisciplinary team of professionals who tailor the education and treatment to the patient's readiness, willingness, knowledge level, and capacity to learn. This may include written literature, group visits, and nurse and other educator sessions, such as dietary discussion. All of this needs to be framed in the overall context of each homeless person, respecting their activities of daily living, resource availability, and personal desires and priorities. The priority for our patients is rarely improved control of their chronic diseases; rather, the basic priorities of safety, food, or shelter absorb their time and energy. Self-management goals must be set by the patient, with help from the providers and overall delivery system.

We are approaching an era of increasing opportunities to improve the care of our patients, even as resources remain stretched for most of us. As new models of integrated care emerge and new information systems become more available, clinicians will have more tools at the time of care to assist in joint decision-making with our patients. The weight of clinical evidence available in primary care is overwhelming, and none of us can know and remember all of the information that might improve our ability

to care for our patients. As point-of-care knowledge and assistance increases, our ability to provide the best care possible at each visit will improve. We seek the skills, time, and knowledge to respond to new symptoms and new life situations facing our patients with chronic diseases. The next few years will yield dramatic changes in outcomes and better quality of life for us all. ■■

Reference

Chassin, MR. Quality of health care, Part 3: improving the quality of care. *New England Journal of Medicine* 1996; 335(14): 1060-1063.