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Home Health Care for Patients Without Shelter

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Abstract

Home health care (HHC) is a well-established model of caring for patients in their homes, which has not been robustly applied to benefit patients without regular access to shelter. This article describes Chicago Street Medicine, an organization that implements HHC to improve health outcomes and care continuity for patients experiencing homelessness.

Home Health Care

Home health care (HHC) delivers a wide range of services directly to patients in their homes, including nursing care, physical and occupational therapy, and social services.[1] Historically, HHC allowed sick patients to receive routine care where they resided. In the 19th century, health service organizations began sending nurses to homes of patients experiencing poverty or chronic illness, ushering in new health insurance models.[2] With the COVID-19 pandemic, HHC evolved again, integrating telehealth visits with patients in their homes. The Centers for Disease Control and Prevention reported a 154% increase in telehealth visits during the last week of March 2020 compared to that same week in 2019.[3] Some organizations still de-emphasize the advantages of HHC,[4] but caring for elders and patients recovering from acute illness or injury are common HHC practices in the United States today.[5] HHC can reduce barriers to health care access and provide comprehensive, socially informed care to patients without shelter, some of whom consider the streets to be their homes.

Home Health for Patients Experiencing Homelessness

Context. The current US health care system prioritizes sickness over proactive health maintenance practices.[6,7] But this approach offers no incentive to make care accessible to patients experiencing homelessness, whose barriers to care range from stigma to lack of insurance.[8] Episodic emergency care neglects the social circumstances and basic needs of unsheltered patients,[9] who have higher emergency department utilization than sheltered patients who are homeless and higher hospital admissions and readmissions than housed patients due to their lack of access to consistent primary care.[10,11,12] Consequently, housing instability is a predictor of negative health outcomes, with patients experiencing homelessness nearly 10 times more likely than sheltered

Medicaid patients to return to an emergency department 6 months after an initial visit,[13] placing increased burden on the health care system overall.

Benefits. In a cross-sectional study of US hospitals, only 24% of patients experiencing homelessness reported regular screening for housing and food insecurity, demonstrating a devastating lack of holistic care.[14] In HHC, however, clinicians, seeing unsheltered patients where they reside (eg, a tent, mattress, or underpass), become acutely familiar with risks unsheltered patients face and observe their domestic and social relationships, enabling contextualization of their care plans.[15] Contextualized care plans emphasize patients' experiences. In one study evaluating the relation between favorable health outcomes and contextualized plans of care, 71% of patients had positive outcomes when their care plan was contextualized vs 46% when it was not.[16]

Finally, bringing care to the streets strengthens health care workers' ability to engage in shared decision making (SDM) with patients experiencing homelessness, since patients may feel safer and more autonomous in their home environment. SDM, applied in venues like patient-centered medical homes, helps patients actively engage in their health decision making.[17,18] In addition, trust between physicians and patients is found to be an independent predictor of successful SDM,[19] and, unlike traditional models of care, HHC allows for true social bonding in a familiar environment. Especially in the setting of chronic illness and when intervention involves multiple encounters, SDM is an effective model to achieve treatment agreement and adherence.[20]

Barriers. Despite the numerous advantages of the HHC model, it presents some limitations. Logistically, health practitioners would require further training on how to provide care in an unknown environment. Additionally, given that Medicaid reimbursements are already restrictive, the need to enroll many individuals experiencing homelessness in Medicaid might discourage clinicians from participating in the Medicaid program.[21,22] Even if these problems could be overcome, continuity of care and integration of HHC into the larger health care system pose challenges for the HHC model. Follow-up care can be difficult, since individuals experiencing homelessness often migrate throughout the city and lack a permanent address. Integration requires coordinating HHC with care provided through health care systems using electronic health records and documentation. Finally, HHC models must make considerable effort to establish connections to social support programs, which are linked with successful health outcomes.[23]

Chicago Street Medicine

Chicago Street Medicine, a nonprofit, student-run organization based in Chicago, Illinois, provides a robust example of how HHC can be applied in the care of patients experiencing homelessness. According to the City of Chicago point-in-time count, in 2020, there were 5390 people experiencing homelessness in Chicago. Of these, 38.1% were female, 61.6% male, and 0.3% transgender.[24] Black people composed 77% of this population and White people, 20.2%.[24] Finally, 21% of the population were under the age of 18, and 10.2% were over the age of 60.[24]

In tandem with the rise of street medicine programs across the United States, Chicago Street Medicine (CSM) was founded in 2017 by students and residents at the University of Illinois College of Medicine (UIC) to serve the unsheltered population.[25] The organization has since grown into a multidisciplinary 501(c)(3) nongovernmental organization[25] that operates through chapters at UIC, University of Chicago, Rush

University, and Northwestern University. CSM's mission is to provide medical and social services to homeless communities in Chicago "on their terms, on their turf."[26] The mission emphasizes meeting patients experiencing homelessness where they are, both geographically and medically, and reinforcing their autonomy in decision making. CSM collaborates with numerous community partners, including clinics like Mile Square Health Center, a federally qualified health center (FQHC). FQHCs like Mile Square help reinforce continuity of care by reserving appointment times solely for CSM patient follow-ups.

The crux of CSM's work is street runs conducted by CSM's team of medical students, social workers, occupational therapists, dental students, medical residents, and attending physicians, who address the health care needs of and establish rapport with people living on the streets of Chicago. This team of street-run volunteers, usually 4 to 5 people at a time, triage and plan care, which often constitutes taking a basic medical history, prescribing medications, and making health care referrals. Volunteers also provide food, over-the-counter medications, hygiene products, and clothing. The food is supplied through local partnerships with pantries, and other supplies are donated or purchased. Street runs at the UIC chapter occur once a week on Thursdays from 6 pm to 9 pm and once a month on Sundays from 6 pm to 9 pm.

Most volunteers have a strong interest in trauma-informed care—that is, in sensitively and intentionally addressing the possibility of past trauma in patients in an equitable manner. Many volunteers have an established relationship with patients, making it easier to aptly listen to their concerns. Volunteers work to ensure that people feel safe in conversing about sensitive topics like drug use and sexual history that are crucial to health care. As the third author (CR) has remarked, "I can't even count the number of times people went out of their way to stop, stare, and scoff at the members we worked with … be kind…" By building trust through social bonds, patients become more willing to collaborate with medical practitioners.[27]

While some might argue that HHC in the form of street medicine could become disconnected from traditional health care systems, CSM strives for continuity of care. Recently, CSM implemented an electronic medical record (EMR) system using athenahealth to track continuity of care. CSM also formally joined the Chicago Continuum of Care, a group of more than 100 organizations that systematically strategizes provision of services and housing for people experiencing homelessness. CSM does not currently have data on how many patients have continuity of care or robust data on the specific demographics its teams serve; however, the combination of an EMR system and coordination with other Chicago service organizations will improve efforts to document and track patients and to set monthly and yearly goals to measure success.

Conclusion

HHC, especially in the form of street medicine, focuses on patients' experience, inviting caregivers to understand patients' medical needs in their sociocultural context. Such insight is invaluable in strengthening community relationships and bridging cultural divides that bias patient care. The rise in telemedicine has revitalized the HHC model, encouraging insurers, clinicians, and patients to adapt traditional health care models,[28] which often center service within the 4 walls of a clinic or hospital.[29]

Adoption of the HHC model could fundamentally improve the health care system and uplift historically marginalized populations, such as patients experiencing homelessness. In practice, CSM's innovative version of the HHC model has potential to deliver COVID vaccines to at-risk patients experiencing homelessness who may not have confidence in a traditional health care system. As the medical community works to envision a future of equitable access to health care, it is imperative that innovative, human-centered health care delivery models, such as street medicine programs, be enveloped within the broad spectrum of medicine.

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