Access and Use of Primary and Preventive Care in the Homeless Population: An Analysis

Ashley Bridges

Ferris State University

Abstract

The purpose of this paper is to analyze the quality and safety measures associated with the unique challenge nurses have when providing care for patients who suffer from homelessness. A theoretical analysis of the healthcare environment, barriers to access and use of primary and preventive care, and interventions specific to the RN role were completed using the Behavior model, ADKAR model, and Orem’s self-care deficit theory. Furthermore the proposed interventions are evaluated using the American Nurses Association Standards of Education, Communication, Collaboration, Ethics, and Resource utilization in relationship to quality and the recommended QSEN Institute competencies of safety, patient-centered care, and teamwork and collaboration.

*Keywords:* patient-centered, theoretical models, quality care, interdisciplinary collaboration

Access and Use of Primary and Preventive Care in the Homeless Population: An Analysis

Homelessness is a problem that still troubles the healthcare system worldwide. In 2011 it was estimated 672,000 people could be found without a stable home on any given night in the United States alone, with up to 42% of them unsheltered (National Healthcare for the Homeless Council, 2012). These patients often have unmanaged chronic disease, acute illness in critical stages, and traumatic occurrences that lead to lengthy hospital admissions, increased emergency room use, and three times greater mortality rates than their housed peers (O’Toole et al., 2011). Most of the homeless population have limited or no insurance and are 40 times less likely to have a primary care provider (Tansley, 2008). Because of this, this population frequents the emergency room for services better offered by primary care or chronic illness that have become exacerbated to the point where they cannot be managed on an outpatient basis. By increasing access and use of primary or preventive care nurses can reduce misuse of emergency or crisis services, improve the patients’ quality of life, and save considerable amounts of healthcare dollars. Riley (2012) writes, “Inadequate, inaccessible, and/or poor medical care further exacerbates increasing healthcare costs that have broad implications for the overall quality of care experienced by all Americans” (p. 167-168). Nurses in acute care in both rural and urban settings are bound to care for patients who are, have been, or will be homeless at some point in their lives. Nurses can play more of a role in improving access and use of primary and preventive care for the homeless than they realize, and as patient advocates it is imperative that they become involved. This paper analyzes this role, the proposed interventions, and associated quality and safety concerns in regard to the healthcare environment through reflection on the American Nurses Association Standards or practice and professional performance and interdisciplinary theoretical models.

**Implications and Consequences**

**Barriers to Access and Use**

 It is important to recognize barriers in order to identify measures that may increase access or facilitate use. Being uninsured is only one of many reasons why the homeless may not have access to preventive care measures. Poverty, limited transportation, mental or physical disability, or inflexible facility hours are others. Even with *access* issues aside, barriers to *use* have to be overcome. With limited access to food and water or bathing facilities, many may not view preventive healthcare as a pressing need to be met. In Khandor et al.’s study (2011) 40% of participants felt marginalized or discriminated against merely for the living conditions or medical history of drug use. Some are unsure of where to obtain care, may not have child care available, or may simply have their prescriptions or needles stolen or medications compromised.

**Nursing Interventions**

 The first thing nurses need to recognize is that merely the state of homelessness alone is traumatic. Whether the individual or family is chronically homeless or experiencing it for the first time, patients are faced with the stress of increased violence, high risk of exposure to communicable diseases, medication compromise, and lack of resources before even having to manage an acute or chronic illness. One of the biggest roles nurses can perform is to identify needs specific to the individual as early as possible upon entering the healthcare system. Discharge planning begins with admission. Recruiting interdisciplinary collaboration from social workers, case management, discharge planners, and outpatient services is crucial to providing care to this population of vulnerable patients. It truly takes a village. Advocating for specific needs and establishing patient-centered goals will create a mutually respectful and trusting relationship, allow for identification for individual barriers, and help obtain the needed resources to improve quality care.

 “Motivational Interviewing is an empathetic, person-centered counseling approach that prepares people for change by helping them resolve ambivalence, enhance intrinsic motivation, and build confidence to change. In other words, helping people talk *themselves* into changing” (Morrison, 2007, p.34). The nurse has the opportunity to empower these patients by allowing them to share their story and define their *own* goals taking into consideration their complex social needs. This holistic and empathetic approach to care helps to truly engage clients and increase self-efficacy. When change occurs when the patient is ready rather than pressured, it is much more likely to become a part of life.

 On a community level nurses should support the advanced practice role to practice at the full capacity their education allows and help reduce the strain on the insufficient amount of primary care providers. Nurses should increase public awareness to the alarming number of people suffering from homelessness in our communities and educate them on how they can become involved in meeting the basic needs of this population. In addition to volunteering or donating resources, nurses should be active members in legislation (Nelson, 2012). Nurses are considered experts in healthcare in the political arena and should make their voices heard in regards to health care concerns. If there are no healthcare providers being represented and involved in the decision making process, how can one expect to see the changes that are truly needed?

**Theoretical Base**

The ADKAR model is a business theory used as a tool to help organizations guide employees through the change process. ADKAR is an acronym for the five elements necessary for change: awareness, desire, knowledge, ability, and reinforcement (Change Management Tutorial Series, n.d.). This model can easily be used in *any* setting where change needs to occur. While discussing the nurse’s role in attempting to increase access and use of primary and preventive care, this model fits perfectly. It “has the ability to identify why changes are not working and help you take the necessary steps to make the change successful. You will be able to break down the change into parts, understand where the change is failing and address that impact point” (Change Management Tutorial Series, n.d., para 1). For example, patients who lack the *desire* to make the change need the positives and negatives consequences laid out clearly before them, they will not benefit from hearing over and over again why the change is needed. For those who lack knowledge about how to *implement* the change need further education. Those lacking *ability* need guidance, mentoring, encouragement, and support. Finally, reinforcement strategies can encourage compliance through incentives and identified consequences (Change Management Tutorial Series, n.d.).

The behavioral model explains the change theory from the patient’s perspective. In order for a patient to seek out or obtain healthcare they need view it as important to them personally. In order for a behavior or change to occur three things should be present: predisposing factors (motivation), enabling factors (ability), and need factors (trigger) (O’Toole, 2011). Predisposing factors include patient demographics, state of housing, and social status and attribute to the perception of care provided. The enabling factors include the social, community, and personal support, resources, and assistance. Competing needs, or barriers to care, such as lack of transportation, income, or insurance should be acknowledged. The need factors include the perceived or diagnosed illness that finally induces the potential for change (O’Toole, 2011).

Orem’s Self-Care Deficit theory combines three theories, the theory of self-care, the theory of self-care deficit, and theory of nursing systems. Self-care is defined as, “the activities carried out by the individual to maintain their own health” (Nursing Theories, 2011, para. 3). There are three basic requisites universal (air, shelter, food, and social interaction), development (maintenance of environment and management of threats to that environment), and health deviation (adherence, awareness, or adjustment). Whenever there is inadequacy in one of these requisites there is a deficit in self-care. The nurse bases the level of care in relationship to the degree of deficit identified-total, partial, or supportive. By helping the patient to meet more of the requisites through mutual planning, individualized care, and interdisciplinary collaboration, fewer deficits are identified, and self-efficacy is increased (Nursing Theories, 2011). This is especially important to the homeless population because when basic needs (universal requisites) are met, maintenance and management of health become more of a priority, and patients are more likely to pursue primary and preventive care.

**Assessment of Healthcare Environment**

 By 2016 it is estimated that 20 to 23 million people will be newly insured and an additional 16-17 million will qualify for Medicaid or the Children’s Health Insurance Program (Nelson, 2012). Although the healthcare reform will undoubtedly play a significant role in increasing access to care for the homeless population, *use,* on the other hand, will depend largely on outreach, advocacy, and discharge planning (Nelson, 2012). It is not enough to create an avenue for care if they have no idea how to access it. Providers need to meet patients where they are to engage them in the system and empower them to prioritize healthcare. Withers says it best,

“The American health care delivery system has become a victim of its own success. While the system’s scope and efficiency are impressive, this has come at the cost of flexibility. Patients are forced to come to the structure of health care delivery and mold themselves to the needs of that system…Our rigid structure prevents us from reaching people…[and] we need to explore the reality of those for whom the system is not working” (2011, p.1-2).

Only 43% of homeless Canadians report a family doctor as a usual source of healthcare despite the fact that the country offers universal healthcare to its citizens (Khandor et al., 2011). This data suggests the idea that simply increasing access and expecting vulnerable patients to face the healthcare system alone is unreasonable and ineffective.

There are several state and federal initiatives and organizations in place to help increase access and use of primary and preventive healthcare for homeless individuals or families including the National Coalition for Homelessness, Health Care for the Homeless, Health Resources and Services Administration and Michigan’s Campaign to End Homelessness, as well as Michigan’s Coalition against Homelessness (Institute for Children, Poverty, and Homelessness, 2012). There are also several local shelters, donation centers, and soup kitchens established to meet some of the basic needs for the homeless.

One cannot offer solutions or interventions without acknowledging the associated assumptions. People may not to utilize the initiatives, resources, or options set in place for them despite family, friends, or healthcare provider’s best efforts. Another assumption is that these resources and coalitions will continue to meet the demands of this population, and more so that they will even remain funded as the state and national economy continue to struggle. Although previous research suggests that housing first and housing ready methodologies have contributed to increased use of primary care and in, turn, improved chronic disease management, it is an assumption that studies will continue to have the same results (Parker, 2010). With minimal interaction with the healthcare system and hesitancy to ask for help, many providers may not even identify housing or basic need deficiencies in these patients, nevertheless establish an effective patient-centered plan post discharge.

**Recommendations for Quality and Safety**

Quality and safety measures are critical to meet the standard of care for *any* patient population. Specifically for homeless individuals, patient-centered care, team work and collaboration, and safety are key knowledge, skills, and attitudes essential to delivery of competent and quality care (QSEN Institute, n.d.). Safety concerns significant to the homeless include disproportionate illness burden, lack of knowledge about disease process or resources available, and obvious physical safety concerns associated with the state of homelessness. Being able to increase access and use of primary and preventive care to ultimately increase wellness begins with meeting standards of care as with any other population.

Healthcare disparities are almost synonymous with a challenge to ethics. According to the American Nurses Association a registered nurse practicing ethically “advocates for equitable healthcare,” “assists healthcare consumers in self determination,” and “delivers care in a manner that preserves and protects healthcare consumer autonomy, dignity, rights, values, and beliefs” (ANA, 2010, p.47). Providing unbiased care is an expectation to competent practice.

As mentioned earlier 40% of participants in Khandor et al.’s 2011 study felt discrimination from a healthcare provider, unfortunately this perception of poor treatment is cited by several other authors including Flanagan & Hancock (2010) and Tansley (2008). Thus in addition to providing ethical treatment, fostering positive relationships through effective communication is another ANA standard critical for delivering care to this population.

Additional ANA professional performance standards of particular importance with providing care to the homeless is collaboration. In order to improve the transition of care from the healthcare system and promote involvement in preventive care, collaboration with physicians, social work, outpatient resources, family members, and, of course, the patient himself is absolutely essential (ANA, 2010). “Offering services that people want is a key facilitator for engagement” Flanagan & Hancock explain that by merely offering a hot meal and creating more flexible opening times demand increased by 50% (2010, p.7). Resource utilization and education are intricately connected to collaboration as you cannot be effective in one without the other. Nurses practicing professionally educate their patients and peers regarding available resources, as well as *how* to access those resources. Finances are extremely important to those with limited income. Helping patients secure these critical resources requires collaboration, communication, and education. Furthermore, acquiring these resources relates directly to improved quality and safety of care.

Hookey (2012) explains despite every effort put forth from the healthcare system, “sometimes patients may not accept offers of help or react in the way you expect” (p.69). It is important for nurses to accept these choices, even if they cannot understand them. It may take several approaches and numerous attempts before the patient is ready or able to make the change. That is okay. Raven et al. quoted, “There is no ideal client. You catch people where they are and then provide them with what they need at that point” (2011, p.6). The key to meeting people where they are is to provide unbiased, empathetic and coordinated patient-centered care. An accurate assessment, advocating for your patient self-identified needs, and collaborating with other disciplines for increased resource allocation, empower patients to achieve the goals established together*.*

**Conclusion**

 Nearly every nurse will come into contact with an individual who has suffered from homelessness at one point or another in his or her life. Thus analyzing how to competently provide care according to the ANA standards of professional performance is highly relevant to the nursing profession. Understanding barriers to access and use, reviewing interventions registered nurses can execute, and analyzing the implications they have on the healthcare environment from a theoretical standpoint is critical to providing patient-centered safe and quality care.

References

American Nurses Association [ANA] (2010). *Nursing:Scope and Standards of Practice* (2nd Ed.). Silver Spring, Maryland: Author.

Change Management Tutorial Series. (n.d.). "ADKAR" - a model for change management. Retrieved from http://www.change-management.com/tutorial-adkar-overview.htm

Flanagan, S.M., & Hancock, B. (2010). ‘Reaching the hard to reach’ – Lessons learned from the VCS (voluntary and community sector). A qualitative study. BMC Health Services Research 2010, 1-9. doi: 10.1186/1472-6963-10-92.

Hookey, S. (2012). Street health: Improving access to primary care. *Australian Family Physician 40*(1-2), 67-69.

Institute for Children, Poverty, and Homelessness. (2012). National Survey of programs and services for homeless families: Michigan. Retrieved from http://www.icphusa.org/pdf/reports/icph\_michigan\_brief.pdf

Khandor, E., Mason, K., Chambers, C., Rossiter, K., Cowan, L., & Hwang, S.W. (2011). Access to primary health care among homeless adults in Toronto, Canada: Results from the street health survey. *Open Medicine 5*(2), E94-E103.

Morrison, S. (2007). Self management support: Helping clients set goals to improve their health. Retrieved from http://mpca.affiniscape.com/associations/14191/files/SelfManagementSupport052907.pdf

National Health Care for the Homeless Council. (2012). Frequently asked questions about health care for the homeless. Retrieved from http://bphc.hrsa.gov/technicalassistance/taresources/hchfaqupdated.pdf

Nelson, R. (2012). Will healthcare reform increase access for the homeless? *American Journal of Nursing 112*(10), 19-20.

Nursing Theories. (2011). Application of Orem’s self-care deficit theory. Retrieved from http://currentnursing.com/nursing\_theory/

O’Toole, T.P., Pirraglia, P.A., Dosa, D., Bourgault, C., Redihan, S., O’Toole, M.B., & Blumen, J. (2011). Building care systems to improve access for high-risk and vulnerable veteran populations. *Journal of General Internal Medicine 26*(2), S683-S688. doi: 10.1007/s11606-011-1818-2.

Parker, D. (2010). Housing as an intervention on hospital use: Access among chronically homeless persons with disabilities. *Journal of Urban Health 87*(6), 912-919. doi:10.1007/s11524-010-9504-y.

QSEN Institute. (n.d.). Graduate KSAS. Retrieved from http://qsen.org/competencies/graduate-ksas/

Raven, M.C., Doran, K.M., Kostrowski, S., Gillespie, C.C., & Elbel, B.D. (2011). An intervention to improve care and reduce costs for high-risk patients with frequent hospital admissions: a pilot study. BMC Health Services Research 2011, 1-10. doi: 10.1186/1472-6963-11-270.

Riley, W. J. (2012). Health disparities: Gaps in access, quality and affordability of medical care. *Transactions of the American Clinical and Climatological Association, 123,* 167-174.

Tansley, K. (2008). Health without a home. *Community Practitioner 81*(10), 38-39.

Withers, J. (2011). Street medicine: An example of reality-based health care. *Journal of Health Care for the Poor and Underserved, 22*, 1-4.