Addressing Health Care Needs in the Homeless Population: A New Approach Using Participatory Action Research

Tammy Kiser¹ and Linda Hulton¹

Abstract
This article explores a unique approach to addressing the health needs of a rural homeless population using core principles relevant to community-based participatory research (CBPR). The objective of the Healthcare for the Homeless Suitcase Clinic (HHSC) project is to create a community-based practice model of health care through unconventional portable, mobile “Suitcase Clinics” staffed by volunteer providers and a Nurse Case Manager. These clinics address complex health concerns of the homeless in five unique shelter settings in a rural Mid-Atlantic community. Using CBPR, community-academic partners worked systematically to explore the issues of homelessness in one community using data collection cycles, reflection, and capacity building. This program description discusses the various aspects of the development, implementation, and evaluation of the HHSC and the expansion of services that have resulted from this project.

Keywords
community-based participatory research, vulnerable populations, homeless persons, access to health care, rural, mobile clinic

Background and Significance
Given the known association between socioeconomic status and health, it is not surprising that individuals who become homeless bear a heavy disease burden and require an unconventional approach to meet their health care needs. Health disparities exist among the homeless population members with multiple chronic conditions including severe and persistent mental illness, substance abuse, and depression (Chambers et al., 2013). Serious mental illness exacerbates morbidity in cardiovascular disease, diabetes, obesity, asthma, epilepsy, and cancer, often resulting in barriers to health care services and lack of treatment adherence (Broadbent, Kydd, Sanders, & Vanderpyl, 2008; Kessler, Chiu, Demler, & Walter, 2005). These compounding risk factors often end in adverse health outcomes and must be addressed to promote the ability to find and maintain stable housing.

In this highly susceptible population, communicable diseases spread easily and lead to outbreaks that become serious public health issues. For example, overcrowded shelter conditions increase risk for airborne infections. Inadequate hygiene and a lack of clean clothing can lead to parasite infestations and diseases, and in many cases, drug use and unsafe sexual behavior lead to sexually transmitted and bloodborne illnesses.

There has been little research conducted on the unique health care perspectives of homeless people in rural areas, despite the fact that the incidence and prevalence of homelessness in rural areas is often equal to that found in more urban areas (Whitley, 2013). Homeless people in rural setting have reported negative encounters with health care professionals, describing examples of demeaning and disparaging nature. However, they often speak fondly of other social and voluntary services that attempt to help them (Whitley, 2013). Other factors that contribute to and sustain health disparities in the rural region have been identified such as lack of accessible resources, low paying and limited jobs, lack of public transportation, low health literacy, language barriers, lack of health care insurance, and geographic challenges in the more remote parts of rural communities (Garner, 2014).

In a recent national study, the unmet health needs for the homeless, as compared with the general population, could be 6 to 10 times greater (Baggett, O’Connell, Singer, & Rigotti, 789750

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2010). The inability to access medications and treatments can become insurmountable barriers when there is a need to focus on basic survival skills including nutrition, safety, hygiene, and shelter.

Because conventional approaches to service delivery have been found to be ineffective when targeting people affected by homelessness, population health management calls for health care systems to better align their strategies to deliver more efficient quality care. Therefore, innovative ways of supporting these vulnerable groups must be developed (Zaworsky & Johnson, 2014).

A promising approach is using community-based participatory research (CBPR), a model that emphasizes local relevance of public health problems and ecological perspectives that acknowledge the multiple determinants of health and disease (Minkler & Wallerstein, 2008). The purpose of this project is to describe the development, implementation, and evaluation of a creative model of health care for the homeless, Suitcase Clinics, using principles of CBPR and share lessons learned.

**Overview of CBPR**

CBPR is a collaborative approach where community-academic partners work systematically in cycles to explore concerns and issues that disrupt and/or impact people’s lives. Collaboratively, these partners use cycles of data collection and reflection to problem-solve and build capacity (Koch & Kralik, 2006). CBPR addresses health disparities and inequities in diverse communities, making it well suited for homeless populations that are socially disadvantaged, marginalized, and stigmatized. In particular, it highlights community resilience, resources, and opportunities for positive growth rather than focusing solely on health problems or other concerns (Coughlin, Smith, & Fernandez, 2017).

In this Healthcare for the Homeless project, community members, homeless individuals, representatives from homeless shelters, and the academic community jointly participated and shared control over all phases of the development, implementation, and evaluation of the project from assessment (discovering the needs of the homeless community) to dissemination (sharing the outcomes). Together, this collaborative team developed strategies to increase the adoption, implementation, and maintenance of evidence-based interventions in the health care for the homeless community.

CBPR aims to be participatory, cooperative, empowering, and justice-oriented and used as an orientation to research rather than a specific research method (Minkler & Wallerstein, 2008). While many of the traditional data collection methods are appropriate, there are additional core components of phases in conducting CBPR as described by Israel, Eng, Schultz, and Parker (2012):

1. Forming partnerships  
2. Assessing community strengths and dynamics  
3. Identifying priority health concerns and research questions  
4. Designing and conducting etiological intervention and/or policy research  
5. Feeding back and interpreting research findings  
6. Disseminating and translating research findings

A number of techniques can be used to accomplish these phases, but there is no set of activities that defines each component (Kendall, Nguyen, Glick, & Seal, 2017). However, in recent years, a selection of participatory reflection and action approaches have been developed including direction observation, storytelling, case stories, group meetings, timelines and change analysis, and shared presentations and analysis (Koch & Kralik, 2006).

**Case Study: Health Care for the Homeless Needs Assessment**

In recent years, a community in a mid-Atlantic state mobilized efforts to address the growing issue of homelessness. The poverty rate in this rural community with a combined city and county population of 130,000 was 33.5% compared with the state average of 11.3%, with a 15% minority population (U.S. Census Bureau, 2015). A Healthcare for the Homeless Coalition formed comprised of public health nurses, academic nursing faculty from two universities, local community hospital leadership, local shelter managers, representatives from the local Housing and Urban Development (HUD) office, and a homeless representative. The coalition began to meet monthly to dialogue on a plan and establish trusting relationships. These group conversations were a source of rich data generation and provided the impetus and motivation for action (Koch & Kralik, 2006).

This coalition completed a targeted needs assessment which included windshield surveys and direct observation. The coalition leadership team completed key informant interviews of shelter managers and staff at each shelter site to understand the context and culture of each setting. Most importantly, homeless individuals were interviewed and completed surveys. Demographic information using census reports and the annual Homeless Point in Time (PIT) counts were compiled and analyzed for trends. This annual PIT count is mandated by the Department of HUD for communities across the country to receive funding. This count occurs during the last 10 days in January. Volunteers canvas communities to count and survey individuals and families experiencing homelessness, including those who live on the streets or emergency shelters, transitional housing, or domestic violence shelters (Corporation for National & Community Service, 2017).
The coalition concluded that providing appropriate and comprehensive health care for the homeless was a major health issue in the community, but numerous obstacles to care existed including lack of insurance, lack of money for copayments, lack of access to medications, and challenges with transportation. Shelter managers reported that 100% of individuals in the local homeless population had ongoing mental health and/or substance abuse issues. Treatment options within the local area for mental health were extremely limited, and local substance abuse treatment options for homeless individuals were nearly nonexistent.

After numerous planning meetings and funding initiatives, the launch of the HHSC began in June 2011. The mission of the HHSC is to prevent and end homelessness for vulnerable individuals and families in the local area by providing quality, integrated health care and promoting access to affordable housing and sustainable incomes through direct service, advocacy, and community engagement.

**Suitcase Clinic Updates and Expansion**

The HHSC now addresses the unconventional and complex concerns of homeless adults at five local shelters. Onsite at the shelters, the HHSC provides 18 to 20 clinic hours/week and is staffed by volunteer providers, a full-time nursing case manager, and numerous volunteers. Specifically, the HHSC provides onsite urgent care services, chronic illness management, and preventive care to homeless clients enrolled in local shelters while simultaneously providing onsite case management services when more comprehensive services are needed. The program does not function within a permanent clinic setting; rather, the supplies are transported in a suitcase on wheels and the clinic functions in private space within the various shelter sites. Through an efficacious collaboration with the local Free Clinic and a local pharmacy, medications are obtained for the HHSC clients at a reduced cost. These medications are paid for by the HHSC. Funding for the HHSC ensues through local grants and donations from individuals and churches. This new model of health care delivery to homeless populations has offered an effective and economic model of service for the local homeless community that aims to break the cycle of homelessness by providing safety net care and appropriate referrals when comprehensive services are needed.

On average, the HHSC has provided care each year to over 269 unduplicated homeless clients with more than 1,200 annual care encounters, including providing approximately US$12,000 worth of free prescription medications. Nearly 60% of patient encounters were related to management of chronic illness. A breakdown of the most common conditions is found in Table 1.

### Ongoing Collaboration Using CBPR

The Healthcare for the Homeless Coalition continues to meet monthly for ongoing dialogue, reporting of evaluation findings, funding opportunities, and the analysis of difficult cases for group problem-solving. A systematic approach to data collection, analysis, and interpretation has been high priority for validation by the group and promotes reflection and capacity building together.

Based on feedback by the coalition, four expansion clinics have been implemented since the clinic’s inception in 2011. These expansion services included a Mental Health Suitcase Clinic, Podiatric Clinics, Dental Clinics, and the launch of a new student-led Interprofessional Clinic at one shelter site.

### Mental Health Suitcase Clinic

The mental health needs of homeless individuals continued to be an unmet in this community. Mental Health Suitcase Clinics began in the fall of 2014, using a collaboration of graduate psychology students and undergraduate nursing students from two local universities. A new partnership was formed with the local Community Service Board (CSB) for psychotropic medication management. The CSB is the designated prescriber for psychiatric medications and the HHSC provides medications at no cost to homeless clients. Undergraduate nursing students conduct mental health service screenings in the local homeless shelters using the Patient Stress Questionnaire (2012). This 30-item questionnaire is a tool used in primary care settings to screen for behavioral health symptoms including generalized anxiety disorder, posttraumatic stress disorder, alcohol use disorders identification, and depression. Four scales include the Alcohol Use Disorders Identification Test (AUDIT), Patient Health Questionnaire (PHQ9), Generalized Anxiety Disorder (GAD-7), and the primary care PTSD screen (PC-PTSD).

Homeless individuals with high scores on the Patient Stress Questionnaire received information on the mental health services available and signed a release of information form. The client is then presented to an interprofessional triage team, consisting of HHSC staff, interprofessional faculty, and participating students. Any individuals who are

### Table 1. Breakdown of Most Prevalent Conditions (N = 269).

| Type of disorder                  | Percentage of population treated |
|----------------------------------|----------------------------------|
| Hypertension                     | 29                               |
| Diabetes                         | 14                               |
| Chronic obstructive pulmonary disease or asthma | 14   |
| Serious clotting issue           | 5                                |
| Hepatitis C diagnosis            | 5                                |
| Orthopedic pain                  | 5                                |
HHSC clients who qualify receive weekly counseling with the graduate psychology students and an intake and follow-up at the local CSB. Current evaluation activities have resulted in additional grant applications to continue these partnerships and also provide additional transportation for the mental health services.

Podiatric Clinics

A podiatric clinic began in January 2015 because numerous shelter managers and HHSC volunteers had reported podiatric care as an unmet need. Homeless individuals have extended exposure to moisture, poor footwear, prolonged standing and walking, poor foot hygiene, and repetitive trauma (Muirhead, Roberson, & Secrest, 2011). In addition to being exposed to environmental living conditions that increase their risks for multiple foot and skin conditions, peripheral neuropathy associated with alcoholism and diabetes often complicates these problems. Initial assessment for the onsite podiatric clinics includes a health assessment and diabetic screening. Clean socks, free shoes, and appropriate referral services are part of the Podiatric Clinic services. Podiatric clinics are held monthly during the winter and spring at the shelters and are conducted by nursing students from a local university. The clinics are held in conjunction with the traditional HHSC, allowing for immediate follow-up with the HHSC provider as needed.

Dental Clinics

Dental care is another unmet need for the homeless community. To address this locally, the HHSC partners with two local dental offices to provide emergent dental services, including an initial evaluation and dental extractions. Additional grant writing resulted in a transportation grant and additional resources from a community block grant.

Student Engaged Interprofessional Clinic

In response to a need for an expanded clinic at one additional shelter site, in August 2017, faculty from nursing, physician assistant (PA), and dietetics programs at a local university initiated new clinic services at a faith-based shelter, utilizing a community-based participatory approach of engaging shelter staff and shelter residents to guide the project implementation. By working with staff and residents as key informants, relationships are being fostered that contribute to the success and sustainability of the project. Currently, weekly teams of undergraduate nursing students and second-year PA students conduct weekly clinics at the site with their clinical instructors. Coinciding with these clinic services is a nutritional intervention implemented by a team of dietetic students who work to recover food that is “leftover” from campus dining services to repurpose for others in the community. The dietetic students also provide education on chronic disease-related dietary considerations by modifying a meal each month for the shelter residents. Students involved in this project attend a weekly interprofessional team meeting with their program-specific clinical instructors and the HHSC case manager. They participate in triage activities, present case studies, and develop interprofessional plans of care.

Evaluation Model

The evaluation of the project follows a well-known model by Donabedian that highlights structure, process, and outcomes (Donabedian, 1982). The HHSC evaluation model is outlined in Table 2 and highlights the aspects and data sources for ongoing evaluation and feedback.

Structure includes the human, physical, and financial resources needed for the service delivery to homeless clients.

Table 2. Donabedian Evaluation Model.

| Structure                                      | Process                                    | Outcome of services and measurements                              |
|------------------------------------------------|--------------------------------------------|------------------------------------------------------------------|
| Physical properties of the provided space for onsite clinic. | Working alliance between partners          | Health care utilization patterns via billing records for medications and ED visit data |
| Safety                                         | Cultural competence of health care professionals | User/client satisfaction                                      |
| Staffing/Qualifications                        | Privacy and confidentiality                | Readiness for interprofessional learning and attitude toward homeless scales |
| Access to services                             | Client involvement in planning and evaluation | Housing status social/employment status                        |
| Financial resources                            | Patient rights                            | Health insurance/other benefit programs                        |
|                                                |                                            | ED data Billings records                                        |
|                                                |                                            | Health care for the homeless patient satisfaction tool          |

Note. ED = emergency department.
persons. Process pertains to the relationship between the characteristics of the care process and their consequences to the health and welfare of individuals and the community. A measurement of cultural competency of the health care professionals and the working alliance between academic-clinical partners are examples of process evaluation. Outcomes are the tangible results of the actions undertaken and pertain to changes in a client’s current and future housing, health, and employment status that can be attributed to service delivery (Ervin, 2002). The overall quality of life of homeless persons and their satisfaction are considered significant outcome measures in this evaluation and includes transition of homeless clients into permanent and transitional housing.

Current Outcomes

Focusing on outcomes evaluation from the Donabedian model (Donabedian, 1982) highlighted in Table 2, health care utilization patterns via billing records for medications and transportation vouchers/invoices are some unconventional measurements of outcomes for this project. A current ongoing project with the local community hospital including a sample of known HHSC clients who were high Emergency Department (ED) utilizers demonstrated reduced cost to the hospital due to receiving care through the Suitcase Clinic and having access to and receiving free medications for chronic illness management.

Another critical evaluation tool is a yearly client satisfaction survey that measures cultural competence, privacy and confidentiality, and client provider partnerships (Patient Satisfaction Survey, 2017). In the most recent sampling of the Patient Satisfaction Survey (n = 47), 60% of the HHSC clients surveyed indicated that the HHSC kept them from going to the ED. Additional results from the Patient Satisfaction survey demonstrated that 70% of the respondents listed the HHSC as their primary source of care. Moreover, 77% of those surveyed indicated satisfaction with the level of privacy and confidentiality provided by the HHSC, and 96% indicated a willingness to use the HHSC again.

The HHSC has demonstrated positive outcomes through community-wide collaborations, including a number of homeless clients acquiring health benefits including Medicaid, Veteran’s benefits, and disability benefits. In addition, finding a medical home through the Free Clinic or other safety net providers has become a reality for homeless clients with the HHSC as a connecting link. Most importantly, homeless clients have moved into housing which has demonstrated success to improve health outcomes and decrease cost (Larimer, Kaysen, Lee, & Kilmer, 2009).

Lessons Learned

Health care for the homeless is a great need, and there have been many models used to address this concern. Some have been effective, others not as effective. The inherent approach of CBPR has been integral to this project by giving a voice to the key members of the community in the development, implementation, and evaluation of the HHSC. However, these findings may not be replicable or applicable to other communities. A targeted needs assessment and community resource analysis is key for any community planning. This example of community–academic partnership using CBPR has required high levels of time, trust, turf-sharing, and respect for each member of the coalition. Transcendent partnerships involve partners working together on endeavors of mutual interest irrespective of a person’s community and/or academic background (Kendall et al., 2017). The homeless individual who has served on the coalition has taken an active role in the ongoing needs assessment and evaluation activities. His input is integral to understanding the life of a homeless individual in the community and he frequently is a guest speaker in courses on this campus. It is noteworthy to mention that this individual is now housed and continues to receive services from the HHSC during this transition.

Several factors have accounted for the success of this unique project. First, the HHSC has strong linkages with each shelter site and the safety net resources across the full spectrum of the community. Second, the project recognizes the heterogeneity within the homeless population and tailors the support services to the homeless client’s needs and characteristics. Homeless individuals are unlike any other in that having no shelter intensifies challenges that outweigh health. Exposure to the elements, poor nutrition and hygiene, addictions and criminal victimization are compelling problems that become overwhelming until the sequelae of a once simple illness becomes an emergency (Corrigan, Pickett, Kraus, Burks, & Schmidt, 2015). Third, the project represents a community-wide coalition that facilitates a coordinated effort to obtain health care and housing for every homeless participant in the program.

The Housing First model has been described as the “clear solution” to chronic homelessness by developing immediate access to private-market, scatter-site housing without prerequisites for sobriety, psychiatric stabilization, or completion of previous treatment programs (United States Interagency Council on Homelessness, 2010). However, the implementation and adaptation of this model to rural areas has not been sufficiently examined. Challenges for rural communities who attempt to use the model include low population density, large geographic distances, limited public transportation, workforce shortages, and limited housing stock with less care coordination (Meyer & Morrissey, 2007). Stefancic et al. (2013) propose the use of hybrid assertive community treatment-intensive case management teams and innovative and widespread inclusion of technology and telehealth for improved efficiency and mobility in rural environments.

The HHSC project has been provided many opportunities to enhance understanding of the homeless population in the local area, including the barriers to health care, deficits
within this population, and possible strategies for meeting those needs. According to the research reviewed, direct access to care offered in a nonthreatening space, a team approach with respectful consideration of the homeless as individuals, and collaboration between many agencies are all key to providing quality health care for the homeless (Daiski, 2007; Savage, Lindsell, Gillespie, Lee, & Corbin, 2008; Weinstein et al., 2013). Safe, accessible, and affordable housing is also vital in preventing many health problems and limiting the development of long-term disabilities (Daiski, 2007). In the experience of the HHSC, all of these elements play an essential role in addressing the complex health concerns of the local homeless population. The delivery of health care in a space within the shelters, where the client feels comfortable, by practitioners who treat the client with respect and who are committed to connecting the individual to any other services needed allows for the provision of quality care, as well as increasing the potential to find and maintain stable housing.

**Declaration of Conflicting Interests**

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

**Funding**

The author(s) received no financial support for the research, authorship, and/or publication of this article.

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