
Primary Care for those Experiencing Homelessness: Adapting your practice

Dr. Samantha Green

Family Physician

St. Michael's Hospital &

Inner City Health Associates, Toronto



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Disclosure

- I have no actual or potential conflicts of interest in relation to this presentation
- I approach this work from a privileged position as a health care provider. I do *not* speak on behalf of people who are marginalized; I speak as an ally to these individuals.



Acknowledgements

Thanks to Drs Ritika Goel, Kathleen Doukas, and Mike Benusic for comments on these slides.



Objectives

At the conclusion of this session, participants will be able to ...

1. Identify the unique health concerns of those experiencing homelessness in Canada.
2. Take a thorough social history and refer patients to appropriate community services.
3. Create a clinic that is welcoming to those who are homeless through anti-oppressive practice and a trauma-informed approach.



Objectives

4. Adapt screening, diagnosis, and management approaches for several common conditions to the experience of homelessness, including hypertension, diabetes, and communicable diseases.

5. Recognize that housing status in itself, as well as poverty, is the fundamental health issue for those who are homeless.



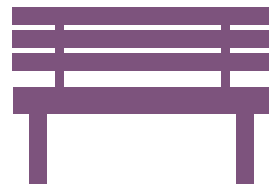


35,000 CANADIANS
ARE HOMELESS ON A GIVEN NIGHT

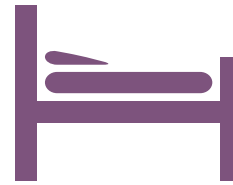


13,000 - 33,000
ARE CHRONICALLY OR EPISODICALLY HOMELESS

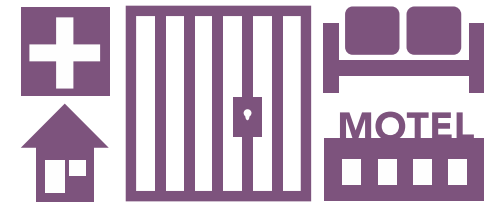
OVER
235,000
CANADIANS EXPERIENCE
HOMELESSNESS IN A YEAR



5,000
UNSHELTERED



180,000
STAYING IN
EMERGENCY SHELTERS

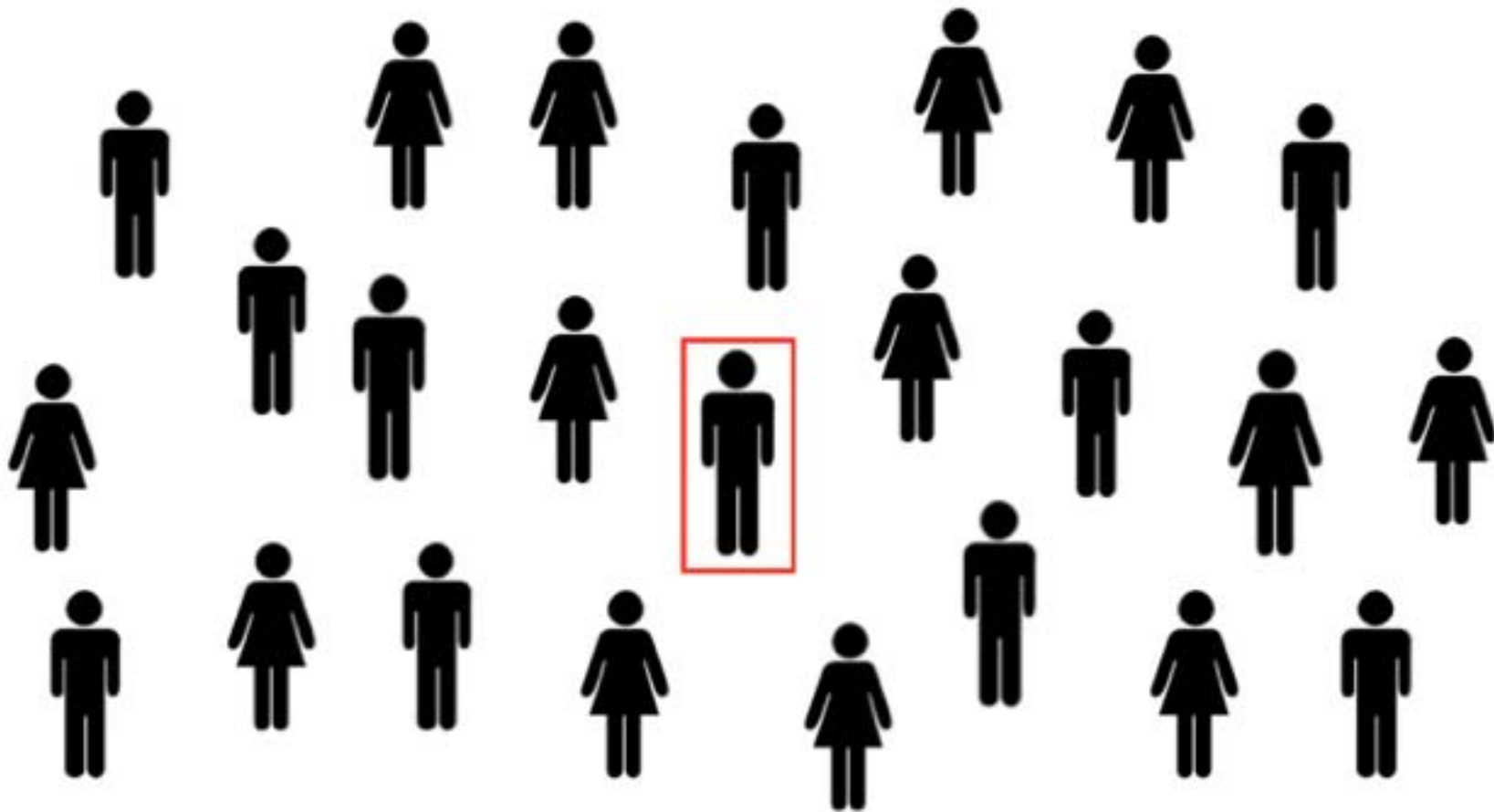


50,000
PROVISIONALLY
ACCOMMODATED

Gaetz, S. The State of Homelessness in Canada 2014. A Homeless Hub Research Paper. <http://homelesshub.ca/sites/default/files/SOHC2014.pdf>



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For every 1 person in shelters, 23 vulnerably housed individuals and households

Health and Housing in Transition Study, 2010
<http://www.stmichaelshospital.com/pdf/crich/housing-vulnerability-and-health.pdf>



Vulnerably Housed

- >50% income = rent
monthly income after rent = \$470
- poor conditions
- instability, recent or episodic homelessness
- comorbidity prevalence comparable to homeless

Housing Vulnerability and Health: Canada's Hidden Emergency. A Report on the Reach3 Health and Housing in Transition Study. November 2010.



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WHAT MAKES CANADIANS SICK?

50%

YOUR LIFE

INCOME
EARLY CHILDHOOD DEVELOPMENT
DISABILITY
EDUCATION
SOCIAL EXCLUSION
SOCIAL SAFETY NET
GENDER
EMPLOYMENT/WORKING CONDITIONS
RACE
ABORIGINAL STATUS
SAFE AND NUTRITIOUS FOOD
HOUSING/HOMELESSNESS
COMMUNITY BELONGING

25%

YOUR HEALTH CARE

ACCESS TO HEALTH CARE
HEALTH CARE SYSTEM
WAIT TIMES

15%

YOUR BIOLOGY

BIOLOGY
GENETICS

10%

YOUR ENVIRONMENT

AIR QUALITY
CIVIC INFRASTRUCTURE



THESE ARE CANADA'S SOCIAL DETERMINANTS OF HEALTH #SDOH



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-
- Life expectancy: 34-47 years
 - Mortality rates: 2.3-4x

O'Connell JJ. Premature mortality in homeless populations: a review of the literature. Nashville (TN): National Health Care for the Homeless Council, Inc; 2005. Available at: <http://www.nhchc.org/wp-content/uploads/2011/10/Premature-Mortality.pdf>.
World Health Organization Global Health Observatory Data Repository. Available at: <http://apps.who.int/gho/data/node.main.688?lang5en>.



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- 1+ chronic disease: 75%
 - HCV: 28x
 - Heart Disease: 5x
 - Cancer: 4x
 - severe depression: 30%
 - Diabetes: 2x
 - elderly: 10%

Erika Khandor and Kate Mason, The Street Health Report, Toronto:
Street Health, 2007



Steve:



“A guy who is part of the John Howard Society got me into this housing program that offers subsidized rent and services around the clock. He knew that I was having a rough time. I was lucky...The program is in an effort to get people off the streets.”

“I love it here. I like the structure of it because it keeps me in line a little bit too, right? They give you your meds. You get three square meals a day. Each unit has its own kitchenette so you can buy your own food, but they prefer that you eat their food. A chef works here. And nobody can get in without going through the front door, so when you have guests they have to sign in, which I like. There are no group sessions or anything; it’s not a rehab. But you’re quite welcome to talk to any of the staff here. The counsellors are phenomenal. Any time you have an issue, you just talk to them. You can knock on the door anytime, 24/7. And it’s clean as a whistle.”

“I almost feel like somebody is going to reach out and grab it all away from me. I think that a lot of guys who are here feel the same thing. It’s not going anywhere, but it feels like it might because we are so used to the streets, and to disappointment on the streets. I really can’t believe my luck.”



“How is it different from living in a homeless shelter?”

“Well, first of all, it’s living quarters. Shelters are not living quarters, they are very temporary. This is permanent, and each person has their own unit. In a shelter, you might get a room on one side, but anybody can walk in whenever they want. There’s no lock on the door. Here, you have got lots of privacy.”

“It is hard to abstain from drugs at a shelter. You’ve got a lot of people out front hustling the street and they want you to buy their dope. It’s very hard to abstain when it’s blatantly right in front of you. It’s all a big hustle, you know what I mean?”

“It seems like everyone around you is involved – there are those who want it and those who have it and those who will get it for you. Abstaining in that situation is hard. But here, it’s not hard at all.”

“I can tell you honestly that I love it at this place. I think it’s been a total godsend. I like the structure, which I didn’t think I would like. But I do.”



VANCOUVER NEWS

Homeless deaths preventable with homes: report



44



g+1

1



0



by [Canadian Press - BC Local News](#)

posted Nov 6, 2014 at 5:34 PM — updated Nov 10, 2014 at 2:13 PM

By Tamsyn Burgmann, The Canadian Press

VANCOUVER - He was a wily character with a bright personality, known for philosophical musings as he sold flowers from the streets of downtown Vancouver where he also lived for 15 years.

But there would be no storybook ending for Tom Sawyer, a homeless man who died of blunt force trauma in an alleyway, believed to be the victim of unknown assailants.

A report released Thursday highlighting the risks of vagrancy found that homelessness cuts a person's life span in half in British Columbia, with the majority of deaths by accident, suicide or homicide.



Heterogeneous population

- men aged 25-55: 47.5%
- youth aged 16-24: 20%
- families: 4% of individuals
but 14% of total bed nights in shelters
- Indigenous Peoples are over-represented
- 20% become chronically homeless



Case: David, age 44

- PMHx: chronic low back pain previously investigated with MRI negative for significant nerve impingement, Hep C never treated
- Regular EtOH use & occasional crack, would like to cut back
- Smoker
- No current medications
- NKDA

- Chief Complaint(s) today: foot pain; insomnia



Case: David, age 44

Activity: taking a social history





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Case: David, age 44

- at Seaton House x 3 mths; jail & shelters x 4 yrs
- no housing worker or agency support
- previously worked as a roofer, last worked 3 yrs ago, stopped working due to back pain; completed grade 11
- Income = Ontario Works = \$305/mth
- Walks everywhere, cannot afford transit
- Single, heterosexual; daughter +son, last in touch 4 years ago; mother & 2 sisters in Halifax, communicate over Facebook occasionally
- has a pay-as-you-go mobile phone, but it is often not in service; uses the Internet at the library
- Food often inadequate



Homelessness causes ill health

- Crowded shelters → exposure to scabies, lice, TB
- long periods of walking and standing & prolonged exposure of the feet to moisture and cold → cellulitis, venous stasis, fungal infections
- Uncertainty, stress → exacerbation of mental illness, addiction, chronic diseases
- Lack of personal/safe space → violence, medications lost or stolen



Poverty & other risk factors for ill health lead to homelessness

- Many who are homeless remain at risk for poor health even when housed
- Some health conditions may contribute to the onset of homelessness
- improved health and adequate housing
→ improved quality of life



Caring for those experiencing homelessness: key elements

1. **anti-oppressive framework** is crucial

Be aware of one's own

- **power and experience of privilege**
- systemic biases



2. Patient-centred care

- attend to the **patient's priorities**
- develop a collaborative plan that addresses the patient's main concerns
- allow the patient to dictate the pace and extent of your history-taking
- longitudinal relationship



3. develop a **clinic-wide** approach and clinic-wide expertise

- train clerical staff, nurses, allied health staff, and learners to be welcoming, respectful, and non-discriminatory
 - consider providing special **training**
- accommodate walk-ins whenever possible
- flag patients who might require longer appointments



-
4. ensure appropriate follow-up plan is made
- establish a follow-up visit
 - consider providing written instructions
 - ensure **contact information** is up-to-date
 - obtain **pharmacy information**
 - connect to social resources
 - ex. using allied health staff or <http://www.211.ca>



Key components of medical history for homeless patients

Component	Examples
To build rapport, address acute concerns.	"What do you want to make sure we talk about today?"
Update personal and emergency contact information.	"How can I get in touch with you between now and your next visit?" "How do you get your mail?" "Do you accept text messages? Do you have enough minutes on your cell phone to receive calls?" ^a
Ask about specific refuge details.	"Where did you sleep last night?" "What shelter do you usually use?"
Inquire directly about common asymptomatic conditions.	"Have you ever been diagnosed with hypertension, or high blood pressure?" "Has a doctor ever told you that you have hepatitis C?"
Ask about stress and mood before directly questioning about mental health conditions.	"How have you been sleeping?" "How has your mood been lately?" "It sounds like you have been under a lot of stress recently."
Probe about food insecurity	"Where do you usually eat your meals?" "Tell me about what meals you ate yesterday?"
Inquire about personal safety.	"Do you feel safe where you are staying?" "Have you ever been harmed by someone else?"



Mental Illness

- One-third of those with serious mental illness have experienced homelessness
- Developmental Delay & Traumatic Brain Injury more common
- Homelessness can exacerbate mental illness

Hulchanski et al. Mental Health, Mental Illness, and Homelessness in Canada.
Chapter in Finding Home: Policy Options for Addressing Homelessness in Canada.
2009.



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Mental Illness

- Housing First model = housing + case management
 - better quality of life
 - reduction in substance use
 - decreased need for intensive support services
 - improved housing retention



Mental Illness

- case management alone
 - improved housing outcomes
 - ↓ substance use
 - ↓ psych Sx
- Assertive Community Treatment
- Critical Time Intervention



Trauma

- Adverse Childhood Experiences (neglect, violence) powerful risk factor for homelessness (OR = 13-26)
- homelessness is itself traumatic
 - loss & sense of neglect
- ↑injuries
 - pedestrian vs. MVCs
 - traumatic brain injuries
 - falls
 - stab wounds & other penetrating trauma
 - self-inflicted trauma



Trauma-informed approach

1. Trauma awareness

2. Safety

3. Empowerment

4. Resiliency



Addiction

- co-occurring mental illness & substance use common
 - address both simultaneously
- one-on-one counselling, groups, AA meetings, day programs, motivational interviewing
- For IVDU, suggest needle exchange, naloxone training
- For opioids consider methadone or Suboxone
- For EtOH, consider naltrexone or acamprosate
- For chronic severe EtOH misuse, case management + supportive housing can end homelessness & ↓ service costs



Diabetes

- **consider screening all** homeless patients once
- challenging to manage while homeless
 - few dietary choices
 - difficult to organize/store insulin and supplies
- avoid BG extremes
 - Consider using a **target HbA1c <8%**
- **simplify** regimens, d/c unnecessary BG testing
- insulin pens = greater adherence & improved control
- insulin can last 1 month if kept at room temperature
- address food insecurity & advise on good food choices
- remain vigilant about **foot complications**



Hypertension

- Ensure patient understanding: long-term disease, usually silent
- Consider prescribing a calcium channel blocker since no follow-up bloodwork required
- diuretics → increased urination



CAD

- Heart disease 3x
- more likely to have underdiagnosed and undertreated HTN & DM2
- higher rate of smoking, substance misuse, and **chronic stress**
- consider more aggressive screening
 - ex. inquire about chest pressure with walking



Smoking

- rate of smoking 4x
- Just half of homeless smokers have been advised to quit
- Use motivational interviewing as with all pts even when other substance use present



COPD

- simplify medication regimens as much as possible
 - Newer once daily long-acting beta agonist/anticholinergic medications
- vaccinate against influenza and Strep pneumo
- greater exposure to sick contacts and close quarters → ↑COPD exacerbations



Liver disease

- Higher rates Hep B, Hep C, EtOH misuse
- Screen at least once for Hep C
- Counsel on risk of EtOH & IVDU & refer to needle exchange programs as indicated
- homelessness not a contraindication to Tx for Hep C but reasonable to delay Tx
- education important re: newer Hep C treatments & disease course
- when lactulose or diuretics needed for ESLD, counsel pts to use them whenever convenient



HIV

- Screen at least once
- counsel on safe needle and sex practices
- Despite increased difficulty with adherence, homelessness not a contraindication to ARVs
- once daily regimens (Atripla, Complera, Triumeq, Stribild) → greater adherence and virologic control in those who are homeless
- Blister packing or more frequent dispensing may improve adherence
- patients may be eligible for unique housing and support resources such as Fife house in Toronto



Infectious Diseases

- Last TB outbreak in Toronto shelters 2007
- Offer TST screening & Tx latent TB as appropriate
- Influenza outbreaks common
- Routine hygiene measures & universal vaccination
- Increased exposure to cutaneous parasites:
scabies, bedbugs, body lice, and fleas
- index of suspicion should be high for those with pruritis
- secondary bacterial infections common
- Offer specific treatment (ex. permethrin cream)
+also must launder clothes & bedding



Characteristics of cutaneous parasites

Diagnosis

Clinical Presentation

Scabies

Burrows and excoriations in the hands, axilla, and inguinal regions

Bedbugs

Small red papules in areas not covered by bedclothes

Body lice

Distribution can vary; lice or eggs can often be found on clothing

Fleas

Hemorrhagic papules typically over ankles



← body lice



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Chronic Pain

- up to 2/3 of those who are homeless
- most physicians unaware of their homeless patient's pain
- physical therapy & CBT for pain should be offered, but limited by competing demands
 - those on social assistance may have some coverage for physio ex. in Ontario
- Nonopioid medications first line: acetaminophen, NSAIDs
- Gabapentin, TCAs, SNRIs for neuropathic pain
- Injections
- As with all patients, opioids to be used with caution, at low doses, with frequent (daily?) dispensing ex. Kadian
- McMaster Pain Guidelines helpful re: opioid prescribing



Preventive Care

- often loses priority in light of more pressing health concerns BUT crucial
- ensure Td UTD (high rates of injury!)
- offer pneumococcal vaccine if appropriate
- flu shot
- screen with TST for TB
- screen for HTN
- ensure contact information is accurate for follow-up to cancer screening (pap, mammogram, FOBT)



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- Income = Ontario Works = \$305/mth
- Walks everywhere, cannot afford transit
- Single, heterosexual; daughter +son, last in touch 4 years ago; mother & 2 sisters in Halifax, communicate over Facebook occasionally
- has a pay-as-you-go mobile phone, but it is often not in service; uses the Internet at the library
- Food often inadequate



Case: David, age 44

- Allow David to set the pace of the Hx-taking
- Take comprehensive social Hx including Hx of trauma
- Inquire about goals
- Document contact info

- Address foot pain: tinea? infxn? overuse injury or #? Adequate footwear?
 - Consider chiropody for orthotics
- Address sleep & consider exploring mood



Case: David, age 44

- Address income: in Ontario can write letter for medical transportation (AA counts!), discuss special diet form, discuss EI & ODSP
- Address housing: shelter-based housing worker? On housing list?



Case: David, age 44

- Address EtOH: may be eligible for Tx program in transitional housing; consider pharmacotherapy
- Address smoking
- Vision or dental concerns?
- Screening BW: HIV, VDRL, lipids, HbA1c, Hep A & B serology, LFTs, CBC
- Screen for HTN, for TB with TST
- Tdap, pneumovax, flu shot



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Care of the Homeless Patient 1035

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