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HOUSED BEDS: A Clinical Tool for Taking a History on an Unsheltered Homeless Patient

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Abstract

The unsheltered homeless population experiences higher levels of morbidity and mortality compared to the general population and those experiencing homeless who are accessing a shelter. This population requires a specific set of history questions to better understand their reality and how any treatment plan will fit into the context of their lives. In order to reach a higher level of understanding, population-specific history questions are necessary to accurately assess their history, access to resources, and priorities. A specific set of history questions to address this need in a concise manner has not been published. An acronym, HOUSED BEDS, is proposed to assist any clinical provider or clinical student in taking a history of an unsheltered patient. This acronym is designed to ask high yield questions that will help all members of the patient's health care team adapt treatment plans, from housing applications to medication prescriptions, for patients who are currently unsheltered.

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Introduction

Acronyms have been used in many fields of study, including medicine, to assist in the acquisition and application of new information. The development of history taking skills for general and specific patient populations have relied on the use of acronyms and mnemonics to help providers obtain the most pertinent information using a series of standardized, organized, high yield questions. Common history taking acronyms such as OPPQRST, DCAP BTLS, SAMPLE and OLD CHARTS are used to ensure that critical information about a patient's chief complaint can be systematically obtained regardless of clinical practice environment, patient acuity or clinician type/experience. The unsheltered homeless population presents with a unique social construct that clinical providers and clinical students need to explore in order to provide the most realistic reality-based, patient-centered treatment plan. Though frequently grouped together, the unsheltered homeless population has consistently demonstrated their experiences are different that the sheltered population with poorer outcomes.[1,2,3] For example, the unsheltered homeless population has a higher mortality rate compared to the sheltered homeless population.[3] As a subject group, their self-reported health status is rated more poorly than the sheltered population with higher self-reports rates of victimization, substance use and mental health diagnoses.[1] Because their lifestyles, vulnerabilities, and risks are so different, individualized treatment plans are necessary.[4] Developing an effective treatment plans starts with a complete, accurate patient history. Currently, there are no published history taking frameworks designed specifically to understand the enduring reality of each unique individual's unsheltered life. Development of such a tool would help illuminate potential hazards, risks, ability to mitigate risk, likelihood of compliance, and follow up recommendations.

HOUSED BEDS OVERVIEW AND TARGETS

The HOUSED BEDS acronym was developed to help any individual working with an unsheltered homeless patient or client best understand the reality of the individual's current life. Targeted users include outreach workers, social workers, nurses, physician assistants, nurse practitioners, physicians, student learners, or any additional member of the patient's team. For the purpose of this paper, the term 'clinician' will be used with the understanding that non-clinicians can use this tool. Similarly, the term 'patient' will be used in the description of the tool with the understanding that users may refer to the individual by a different term (e.g. client, consumer). Targeted settings where HOUSED BEDS can be used include the inpatient hospital setting, outpatient office setting, or street setting when encountering a patient through outreach or Street Medicine services. All history questions should be performed with a trauma informed approach with an aim of both gathering critical information while also empowering the patient to describe their reality and be involved in decision making. Questions can be asked in any order that makes sense for the patient's experience and at the discretion of the clinician directing the interview. It should also be recognized that all information suggested by this tool may not be collected in a single patient encounter. Over time and upon building rapport with the patient, new sections may be completed or understood to a greater depth. Additionally, this tool can easily be adapted to a sheltered homeless population by omitting sections that are less relevant at the clinician's discretion. It is recommended that HOUSED BEDS be utilized when an unsheltered homeless patient is being interviewed during the first encounter and updated with each subsequent encounter. Please see appendix A for a pocket-card version of this tool.

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HOUSED BEDS Tool:

H: Homelessness

The aim of H: Homelessness is to depict the patient's history of homelessness, both current and past, and the current location of where they tend to be located. Users of this tool should be familiar with their local or nationally recognized definitions of homelessness and tailor specific questions to make sure that key information is captured and documented in the note as often meeting a specific definition of homelessness may qualify the patient for specific programing, resources or expedited housing. The patient's current duration of homelessness should be obtained with special attention to whether they are primarily utilizing a traditional shelter (e.g. rescue mission, homeless shelter, hostel) or primarily unsheltered. Unsheltered living would include those who are sleeping outside, in a car, abandoned building or other shelter not meant for short or long-term human habitation. One common method for determining history of homelessness is using regression questioning. This line of questioning starts with understanding, in this case, the current state of homelessness and then regresses chronologically to determine the last time the patient was stably housed. In addition to understanding the patient's housed vs. unhoused history, this method of questioning can uncover those who may qualify as chronically homeless due to shorter durations of homelessness that occur frequently.

O: Outreach

The aim of O: Outreach is to better understand who else may be engaging with the patient outside. Outreach is differentiated from utilization for social services in that outreach specifically refers to services or teams that go to the patient. Utilization of social services is defined as services that the patient takes themselves to. This can help to avoid duplication of services and to enable collaboration between multiple teams of people aiming to assist the patient with their priorities. Details such as specific names of organizations or individuals on outreach teams, locations where they commonly meet and contact information should be obtained and documented when possible. It may also help to uncover an existing support system that can be leveraged to help the patient.

U: Utilization

The aim of U: Utilization is to better understand how the patient utilizes health care, social services and the judicial system.

Healthcare: Utilization of health care resources should be divided into acute services (i.e. emergency department and inpatient hospitalizations) and outpatient or preventative medicine services (i.e. primary care outpatient visits). The patient should be asked how many emergency department visits they have had in the last year (if this is the first encounter with the patient) or how many emergency department visits since the last visit (if being seen in follow up). Date of visit, reason for visit and location of the emergency department should be documented. In addition, patients should be asked about number of hospitalizations and reason for admission in the last year or since last visit. Date of admission, date of discharge and hospital location should be documented. While there are always accuracy concerns related to self-reported utilization of acute health services, patterns of utilization can be accurately determined in broad terms (e.g. the exact number of emergency department visits may not be accurate, but a team may be able to accurately determine if the emergency department is being utilized a lot or a little based on self-

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reported data). Information may also serve to explain the acquisition of medications and gaps in medication compliance if the patient is relying on hospital services for medication access. The patient should also be asked who they identify as being on their primary care team. Electronic medical record documentation of who a patient is empaneled to or otherwise assigned to from an insurance carrier is often irrelevant to the actual reality of the patient's active health care team. If a patient reports being seen by a health care provider in the past, time of last visit and issues addressed should be obtained in addition to the location of the visit. Access to the health care provider (e.g. transportation, know how to get to appointment) should be evaluated. Finally, the patient's perception of acceptability of care should be explored. For example, patients can be asked if they felt their needs were addressed, if they felt cared for by their provider and/or if they want to see that provider in the future for care.

Social services: The patient should be asked about any social services being utilized by the patient and the frequency of utilization. Examples of social services include soup kitchens, food banks, clothing closets, support groups or day programs.

Judicial system: The patient should be asked about involvement in the judicial system (recent or remote). The purpose of this question is twofold; understanding healthcare that the patient may have received through the justice system and understanding outstanding legal responsibilities or issues the patient may need assistance with. For example, patients often have difficulty maintaining required reporting with parole officers or could benefit from connection to a medical-legal partnership. It should be noted that health care providers are not agents of the law however should remember any local or federal reporting mandates that apply to their professional licensure.

S: Salary

The aim of S: Salary is to better understand a patient's financial resources including federal or state support, medical insurance or other sources of income like panhandling or selling one's self. This information can be critical when understanding resources that may be leveraged for housing, medical care, medications and meeting basic human needs. Many patients have difficulties planning and prioritizing the use of resources and a better understanding of how to best use resources if often of great value to patients. Barriers such as lack of identification or birth certificate often surface during these conversations and assists the team in navigating solutions. In addition, this discussion can expose vulnerabilities in behavior surrounding these resources such as sharing debit care PIN numbers or other sensitive information.

E: Eat

The aim of E: Eat is to better understand the patient's access to food and frequency of food intake and meals. When asking about access to food, it is recommended that patients are asked how they get food (e.g. soup kitchen, outreach groups, trashcans/dumpsters). If a pattern of food access is recognized (e.g. a patient always gets lunch from a particular church on Tuesdays) outreach teams and Street Medicine teams may be able to coordinate seeing the patient with the patient's typical food routine. Eliminating competing priorities (e.g. get food or see a healthcare provider) is critical in the care of the unsheltered population. Frequency of food intake and meals should also be obtained. Food intake is described as accessing snacks or left-overs from a trash can in contrast to a meal. Number of meals per day or week should be documented. Understanding meal frequency and nutritional status may influence the choice of medications or

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dosages chosen. For example, an insulin regimen may need alterations, or a medication that must be taken with food may not be chosen if a patient only eats 2-3 times a week.

D: Drink

The aim of D: Drink is to better understand the patient's access to clean water. It is important to emphasize clean water access as many patients will report access to water, however, they are drinking from a water hose, hydrant, stream or other untreated water source that is not meant for consumption. Determining number of ounces or glasses/bottles of water consumed in a day along with the source of the water should be documented. Understanding the reliability to water access may alter the treatment plan or medication chosen. For example, the use and dosage of diuretics in the setting of heart failure may be altered based on access to water. It may also aid in the diagnosis of symptoms such as diarrhea when it is understood that the patient is drinking from a stream. If access to clean water is poor, continued inquiry into methods the patient has used to purify water should be explored, (e.g. patient's mixing bleach in water before drinking).

B: Bathroom

The aim of B: Bathroom is to better understand the patient's access to a toilet. This information could be obtained by asking the patient how many times per day they are able to use a toilet. Additionally, the patient should be asked about accessibility on a scale of one (access as if they were housed) to five (impossible or almost impossible to access). If patients express difficulty with access to a bathroom, documentation of barriers (e.g. businesses refuse, need to pay for bathroom) should be documented. Frequency or necessity of open urination/defecation should be documented. The importance of this question lies in the ability to assess for possible unsanitary living conditions. It can also lead to barriers to completing treatment recommendations for osmotic medications and diuretics.

E: Encampment

The aim of E: Encampment is to better understand the actual sleeping environment the patient experiences. Key questions include understanding their *exact sleeping location* (e.g. cross streets, landmarks, nearby businesses), *type of shelter available* (e.g. blanket, tent, protection from elements, building), *position of sleep* (e.g. sitting up, lying down), and *time of day* sleeping typically occurs. Many outreach teams and Street Medicine providers deliver services early in the morning or late in the evening so, exact sleeping location is often a reliable way of finding patients outside. Type of shelter available can illustrate potential environmental exposures or physical safety concerns. Position of sleep can help teams understand the etiology of complaints that commonly occur when, for example, the legs are always in a dependent position like when sleeping sitting up. Finally, time of day sleeping typically occurs can help providers understand disruptions in normal sleep cycles, medical effects of intermittent or off-cycle sleeping and ask follow-up questions about concerns about physical safety at night preventing night time sleeping. Learning details of sleep patterns, or lack thereof, may assist in the diagnosis of a mental health disorder or provide insight into substance abuse (e.g. use of cocaine to stay awake all night due to concerns for personal safety).

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D: Daily Routine

The aim of D: Daily routine is to better understand how the Street Medicine or outreach team can fit naturally into a patient's daily routine and minimize competing priorities often felt by patients. Some providers may choose to ask about daily routine earlier in the conversation as a way to start to understand the patient's daily life and habits surrounding obtaining basic necessities like food, showers, clothing, social support, and social service utilization (e.g. utilizing a women's center on Monday's because that is shower day). This information also serves the practical purpose of knowing where a team may be able to locate a patient on a particular day and the priorities the patient has and values. When a team is willing to work around or within the patient's preferred routine, it is acknowledging the value of the patient's self-determination and supporting the acquisition of critical resources during the day. If a team would like to meet a patient at a particular location frequented by the patient, the team should ask patients for permission to engage with them at the specific location. Some patients are hesitant for their street community to know they are meeting with health care providers. It is critical that teams understand some patient's may feel their trust was betrayed if a team shows up un

S: Substance Use

The aim of S: Substance Use is to obtain an accurate substance use history. Tobacco, alcohol and illicit drugs (e.g. marijuana, cocaine, heroin, methamphetamines, unprescribed opioids) current and past use should be explored. Frequency of use, last use, quantity used, preferred route, daily or weekly cost of use and history of withdrawal symptoms should be documented. History of overdose should also be elicited. Prior rehab experiences and openness to quitting should be discussed and documented. Motivators for quitting should also be explored.

CONCLUSION:

Patients who are experiencing homelessness in an unsheltered setting have a unique set of circumstances that must be thoroughly understood by their medical team in order to develop a reality-based treatment plan. Bringing an element of standardization to the components of a history on this population helps to focus on high-yield questions to enhance the probability of the development of a successful treatment plan.

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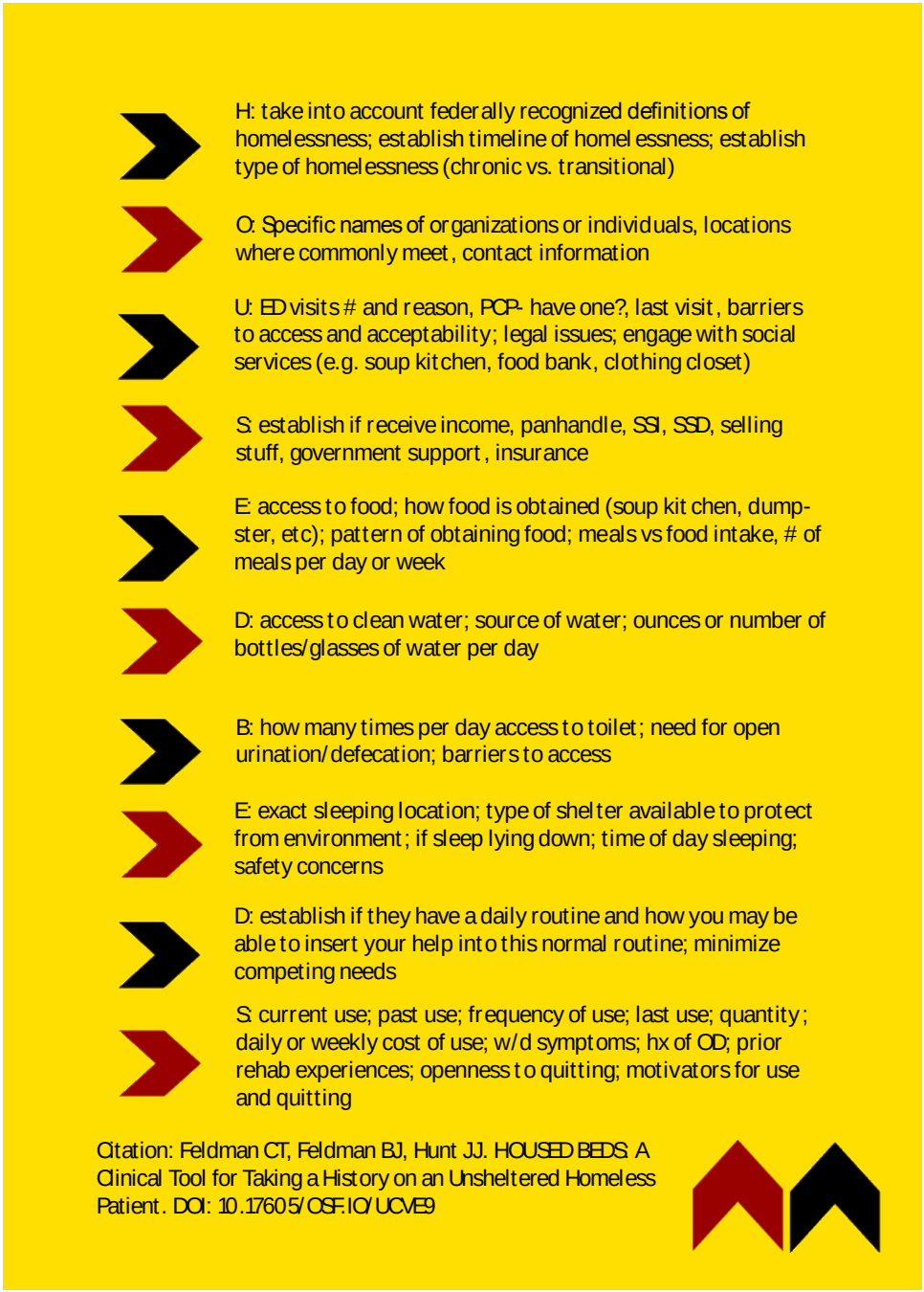
H: take into account federally recognized definitions of homelessness; establish timeline of homelessness; establish type of homelessness (chronic vs. transitional)
O: Specific names of organizations or individuals, locations where commonly meet, contact information
U: ED visits # and reason, PCP- have one?, last visit, barriers to access and acceptability; legal issues; engage with social services (e.g. soup kitchen, food bank, clothing closet)
S: establish if receive income, panhandle, SSI, SSD, selling stuff, government support, insurance
E: access to food; how food is obtained (soup kitchen, dumpster, etc); pattern of obtaining food; meals vs food intake, # of meals per day or week
D: access to clean water; source of water; ounces or number of bottles/glasses of water per day
B: how many times per day access to toilet; need for open urination/defecation; barriers to access
E: exact sleeping location; type of shelter available to protect from environment; if sleep lying down; time of day sleeping; safety concerns
D: establish if they have a daily routine and how you may be able to insert your help into this normal routine; minimize competing needs
S: current use; past use; frequency of use; last use; quantity; daily or weekly cost of use; w/d symptoms; hx of OD; prior rehab experiences; openness to quitting; motivators for use and quitting
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