MEDICAL RESPITE CARE FOR FARGO-MOORHEAD HOMELESS POPULATION:

A NEEDS ASSESSMENT

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Medical Respite Care for Fargo-Moorhead Homeless Population: A Needs Assessment

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ABSTRACT

Homelessness continues to increase in the Fargo-Moorhead community, and little is known about the health needs of its chronically homeless population. An informal needs assessment completed in 2010 gathered feedback from several key informants with experience working with the homeless population. Informants cited a variety of unmet health needs and barriers to access of appropriate health care services, and the priority need voiced was for a medical respite program.

The purpose of this project was to conduct a formal health needs assessment of the Fargo-Moorhead homeless population to describe and document health needs from consumers' and service providers' perspectives, assess current community resources, and involve stakeholders in program planning as appropriate. The specific need for a medical respite care program was also evaluated, based on informants' feedback in 2010. Data collection methods included written surveys and semi-structured interviews.

Consumers' priority needs were to secure a source of income and housing. Many consumers reported untreated physical or mental conditions, but primary needs were dental care and means to afford health care. Most consumers reported lack of health insurance and transportation as barriers to health care access. Lack of trust and experiences of disrespectful care were also reported.

Service providers recognized many of the same needs, but also reported needs for treatment of co-occurring physical or mental illness and chemical dependency. Appropriate levels of care were also a concern, and many service providers discussed the need for a lower level of supervised medical care for shelter residents and homeless persons discharged from hospital care. Service providers cited many of the same barriers that

consumers reported, and recognized homeless persons' inability to prioritize care above

basic needs or manage care while homeless.

Homeless Health Services and Family HealthCare in Fargo, ND remain primary

resources for health care, and many consumers reported receiving care at these clinics as a

regular source of care. Service providers reported frequent collaboration with both clinics,

among other supportive services. However, the need for a medical respite program in the

community was established. Recommendations for program planning address this and

other needs.

ACKNOWLEDGMENTS

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CHAPTER 1. INTRODUCTION

Background and Significance

Homelessness is a global issue and the numbers of homeless persons have been on the rise since the 1980's (Daiski, 2007; Nickasch & Marnocha, 2009). Each year, approximately 2.3 to 3.5 million Americans experience homelessness, including an increasing number of homeless individuals in the Fargo, ND, and Moorhead, MN metropolitan area (Wilder, 2010; Baggett, O'Connell, Singer, & Rigotti, 2010). The Wilder Foundation, based out of St. Paul, MN, conducted a survey of homeless persons in Fargo, ND and Moorhead, MN in October of 2009. According to the report published in September 2010, the total number of homeless persons in the Fargo-Moorhead area has increased 29% since 2006 and doubled since 2003 (Wilder, 2010). Homelessness affects roughly four hundred persons in Fargo, ND and Moorhead, MN on any given night, with half of North Dakota's homeless persons living in Fargo (Fargo City Commission, 2006).

The literature describes the health needs of homeless persons as complex and compounded by social, cultural, and financial barriers (Roche, 2004). Homeless persons suffer higher rates of acute and chronic illness and mortality as compared to the general population (Baggett et al., 2010). Barriers to healthcare access lead to worsened health status, and homeless persons prioritize basic needs above healthcare access (Martins, 2008). An informal needs assessment to evaluate healthcare needs of Fargo-Moorhead homeless persons gathered feedback from several key informants in homeless health (Hauff, 2010). Problems voiced by key informants included impaired access to mental health and treatment services, overuse of emergency room services, much chronic disease

and mental illness, lack of financial resources to manage care, and the need for more dental services, among many other issues (Hauff, 2010).

The primary need the informants collectively voiced, however, was for a medical respite care program (Hauff, 2010). A medical respite care program provides medical and support services for homeless persons who lack the resources to recuperate from illness upon discharge from a hospital (Health Care for the Homeless Clinicians' Network, 2007). No other formal data is available to specifically address the health needs of the Fargo-Moorhead homeless population and access to current community resources.

Problem Statement

Members of the Fargo-Moorhead community verbalized several unmet health needs among the homeless population. Insufficient data exists to describe the current healthcare needs of the Fargo-Moorhead homeless population. A comprehensive health needs assessment is necessary to document and describe the healthcare needs of the Fargo-Moorhead homeless population, how they may be addressed, and the need for a medical respite care program in the community.

Project Description

<u>Purpose</u>

The purpose of the comprehensive needs assessment was to describe and positively impact the health of the target population. The target population included persons experiencing chronic homelessness or living in permanent supportive housing in the Fargo, ND and Moorhead, MN area. The definition of the term "chronic" referred to continuous homelessness for greater than one year or homelessness four or more times in the past three years (National Coalition for the Homeless, n.d.). The federal definition of "homeless"

is the "lack of a fixed, regular, and adequate nighttime residence, or nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, designated temporary living space such as a shelter, or imminent loss of housing" (NHCHC, n.d.). Data was gathered to identify priority needs and determine available resources to support the development of a feasible respite care program design. Dissemination of assessment data and recommendations for program development will be provided to area agencies and policy makers as appropriate.

Objectives

This project aims to address the following objectives.

1. Describe health needs of Fargo-Moorhead homeless individuals from the perspective of service providers.

2. Describe health needs of Fargo-Moorhead homeless individuals from the perspective of homeless individuals.

3. Document and describe demographics, needs, factors contributing to needs, and current available community resources in collaboration with area agencies.

4. Identify and involve stakeholders in program planning to:

   - Define the scope of care and range of services needed for a medical respite program in the Fargo-Moorhead community.

   - Identify and recommend a respite care model suitable for the community.

   - Initiate the process of identifying funding sources and costs associated with development of a medical respite program.

   - Make recommendations for the overall design of a Fargo-Moorhead medical respite program.

CHAPTER 2. LITERATURE REVIEW AND THEORETICAL FRAMEWORK

Societal Views and Culture of Homelessness

Homeless persons live segregated from the rest of society, and knowledge about them comes largely from the media (Pascale, 2005). Since the 1970's, societal perceptions and ideas about homelessness have been shaped by media presentation and evolved in meaning (Pascale, 2005). The terms "drifter," "transient," "vagrant," and "bum" were used in the 1970's to refer to people who were unable to afford housing (Pascale, 2005). In the 1980's, the terms "homelessness" and "the homeless" arose to represent the social and economic issues related to homelessness, and a dichotomy of "old" and "new" poor appeared (Pascale, 2005). The "old" poor referred to homeless persons who were accustomed to street life whereas "new" poor referred to persons newly homeless because of economic hardship (Pascale, 2005). By 1983, the causes of homelessness began to change from economic to non-economic, from housing figures and unemployment rates to substance abuse, mental illness, and personal choice (Pascale, 2005). Homeless persons began to be essentially blamed for their plight, shifting attention to the problem of homelessness from proactive to reactive (Pascale, 2005). As the perception of homelessness as a personal fault began to spread, persons who were newly homeless were classified as "functioning" persons, implying two classes of homeless persons (Pascale, 2005). The longer people were homeless, the more their homelessness was attributed to personal fault, alluding to the American culture of individualistic achievement and responsibility (Pascale, 2005). By the 1990's, the media focused on controlling homelessness and its visibility to other members of society (Pascale, 2005). Policies were developed to control private behaviors in public settings, their presence in public spaces a

disturbance to other society members and order (Pascale, 2005). Until more recent years as public knowledge about homelessness has increased, substance abuse and mental illness were not thought of as effects of homelessness, only causes (Pascale, 2005). Stereotypes of homeless persons still persist, however, and include perceptions of them as alcoholics, drug abusers, deinstitutionalized mentally ill, welfare-dependent, homeless by choice, and unwilling to cope effectively with their situation (Davis, 1996; NCH, 2009).

Homelessness poses a variety of environmental and psychosocial stressors, and survival is a daily goal (Davis, 1996; NCH, 2009). Survival involves a daily search for food and shelter, and attaining money and employment are constant concerns (Davis, 1996). Documentation of personal records is necessary to receive welfare benefits, something many homeless persons do not have (Davis, 1996). Hygiene must be performed when public restrooms are open without raising suspicion, and homeless persons strive to remain invisible to avoid dangerous situations such as fights, theft, rape, assault, or murder on the streets (Davis, 1996). Health problems develop due to environmental stressors and exacerbate previous conditions, even in public shelters (Davis, 1996). Loss of role and communication with society leads to feelings of isolation, despair, devaluation, poor self-esteem, low motivation, apathy, and loss of identity (Davis, 1996; Lowe & Gibson, 2011; Stein, Dixon, & Nyamathi, 2008). Homeless persons hence have a temporal orientation to the present, striving to meet their basic needs (Davis, 1996).

In an effort to cope with the daily stress and trauma of homelessness, many homeless persons abuse substances (NCH, 2009). Three pathways to homelessness are posited, and include social selection, socioeconomic adversity, and traumatic experiences (Kim, Ford, Howard, & Bradford, 2010). The social selection pathway begins with mental

illness or substance abuse that isolate the individual, causing deficits that draw the individual out of society (Kim et al., 2010). The socioeconomic pathway begins with economic adversity that leads to homelessness and increased risk for both mental illness and substance abuse (Kim et al., 2010). The traumatic experience pathway involves trauma that may directly lead to homelessness, such as abuse (Kim et al., 2010).

Cultural disparities may exist regarding risk factors and treatment for homelessness and substance abuse. African Americans, Hispanic Americans, and Native Americans are overrepresented in the homeless population, though 30 years ago members were predominantly white (Davis, 1996). Caucasian persons who abuse substances receive treatment more often than African Americans and Latino persons, and African American men are disproportionately incarcerated for drug use (Lee & Petersen, 2009). Despite stereotypes for homeless subgroups, non-Hispanic white homeless persons are more likely to abuse drugs and alcohol, and Native American homeless persons abuse alcohol at a rate comparable to other ethnic groups (Dietz, 2009). Hispanic persons who abuse substances are more likely to have less education, lower employment rates, and higher poverty rates than Caucasian persons who abuse substances (Dietz, 2009). Older African Americans may have the highest rate of illicit drug use (Dietz, 2009). Alcohol abuse may be more common in older generations of homeless adults, whereas drug abuse may be more common in homeless youth and young adults (NCH, 2009). Rates of mental illness are comparable for all ethnic groups of young adults who abuse substances (Chisolm et al., 2009).

A cultural subgroup that has the most serious disparities and also are overrepresented in the urban homeless population are American Indians (Native Americans) and Alaska Natives (AIAN) (Whitbeck, Crawford, & Hartshorn, 2012). AIAN

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homeless persons' situation is one of "cumulative and persistent disadvantage," and is associated with multiple compounding factors (Whitbeck et al., 2012, p. 165). AIAN homeless persons face higher rates of unemployment and poverty as compared to the general population that cause them to search for opportunities off their reservation land (Whitbeck et al., 2012). Homes on reservations are overcrowded, and waiting lists for affordable housing on the reservations can be twice a long as the national average (Whitbeck et al., 2012). Additionally, available housing on reservations is often substandard, and may lack plumbing, electricity, running water, flushable toilets, and central heat (Whitbeck et al., 2012). AIAN homeless persons who move off their reservation face concerns of loss of culture, traditions, and family connections (Whitbeck et al., 2012). Regarding health, AIAN homeless persons are more likely to report problems such as headaches, asthma, stomach pain, and back pain than their housed counterparts (Whitbeck et al., 2012). Financially, AIAN homeless persons are more likely to report wage cuts, eviction, moving to a worse residence off their reservation, receipt of government assistance, reduced or lack of insurance, and postponement of medical and dental needs (Whitbeck et al., 2012). AIAN homeless persons are also more likely to report a family history of substance abuse or mental illness and parental marital problems (Whitbeck et al., 2012).

National Homelessness and Health

Challenges faced by homeless individuals are complex and interrelated, with multiple needs that compound one another (Roche, 2004). Homeless persons are "struggling with persistent physical and emotional difficulties that are exacerbated by overlapping stigmas and poor social and life skills" (Roche, 2004, p. 21). Needs and issues

faced by homeless persons include mental health disorders, high rates of substance abuse, learning disabilities, poor social and life skills, self harm, lack of restful sleep, low levels of education and literacy, and criminal activity (Roche, 2004). Other complicating issues include cultural and linguistic barriers, chronic stress, and lack of transportation, social supports, and resources (Health Care for the Homeless Clinicians' Network [HCHCN], 2010). In the face of such needs, homeless persons tend to prioritize the fulfillment of more basic needs such as shelter and food before seeking healthcare services (Martins, 2008).

In delaying or experiencing barriers to accessing healthcare, they suffer acute conditions that are preventable and treatable, as well as chronic diseases that worsen, leading to increased mortality (HCHCN, 2010). Rates of both acute and chronic illness are higher in the homeless population compared to the general population, with more than half of homeless persons having some sort of mental illness (Baggett et. al, 2010). Mortality rates are three to four times higher in homeless persons than in the general population as well (Zerger, Doblin, & Thompson, 2009). Issues with poor access and fragmented healthcare lead to overuse of emergency room services for care, increased hospitalizations, and longer hospital stays (Baggett et al., 2010). Common chronic conditions include high blood pressure, gastrointestinal and neurological disorders, peripheral vascular disease, and poor dental hygiene (Martins, 2008). Acute health challenges include respiratory, skin and parasitic infections, trauma, malnutrition, and injuries related to cold exposure (Martins, 2008). These chronic and acute conditions are compounded by a higher prevalence of alcoholism, tobacco use, and substance abuse (Schanzer, Dominguez, Shrout, & Caton, 2007). Higher rates of communicable diseases such as Tuberculosis and HIV/AIDS among homeless individuals can also pose threats to the general population (Martins,

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2008). Additionally, dangers of street life include health risks related to climate change associated with global warming (Ramin & Svoboda, 2009). Homeless populations are particularly vulnerable to effects of heat waves, air pollution, natural disasters, and West Nile Virus contraction (Ramin & Svoboda, 2009). Risk factors associated with increased adverse health effects related to climate phenomena include respiratory and circulatory disease, mental illness, older age, alcoholism, decreased immune function, and sleeping outside (Ramin & Svoboda, 2009). The only positive factor associated with climate change was decreased cold exposure injuries, due to warmer winters (Ramin & Svoboda, 2009).

Further, many homeless individuals engage in behaviors that further compromise their health, such as substance use, fighting, weapon possession, and unsafe sexual practices (Fitzpatrick, La Gory, & Ritchey, 2003). Risk factors associated with increased risky behaviors include being of nonwhite race, male, younger age, and being a witness or victim of crime (Fitzpatrick et al., 2003). Having a social support system is the only protective factor found to be significantly negatively associated with health-compromising behavior (Fitzpatrick et al., 2003).

Homeless Health Service Delivery

Programs have been established to address the unique, complex healthcare needs of homeless populations such as the Health Care for the Homeless programs. HCH programs, established in 1987, succeed in addressing the multiple health needs of homeless users, who are satisfied with the services offered (Zlotnick & Zerger, 2008). HCH users have a poorer health status than the general population, while users of usual clinic services experience more barriers to accessing care and have more unmet needs (Zlotnick & Zerger, 2008). The impact of nursing interventions to meet healthcare needs of homeless persons

have also been positive, and benefits include cost-effectiveness, reduced emergency room use, and health needs being met (Savage et al., 2006 & 2008). Interventions still needed should focus on case management for mental health and substance abuse and increasing awareness of the clinic's existence among emergency departments (Savage et al., 2006 & 2008). Most homeless users of HCH services seek dental care (Han, Wells, & Taylor, 2003). Dental services may therefore act as a link to other healthcare services, improving healthcare access (Han et al., 2003). Collaboration between hospital staff and case management at HCH programs also ensures better access, quality, and continuity of care (Han et al., 2003).

HCH users continue to have unmet healthcare needs, even with health insurance (Baggett et al., 2010; Hwang et al., 2010). In 2003, 73% of users reported at least one unmet need in the past year, and 49% reported two or more needs unmet, including medical, mental, vision and dental care (Baggett et al., 2010). The top two reasons for needs not being met were lack of affordability of care and lack of health insurance (Baggett et al., 2010). It is not enough for persons to simply have health insurance, even within a universal healthcare system (Baggett et al., 2010; Hwang et al., 2010). With insurance, homeless persons still experience "nonfinancial barriers" to healthcare access that include mistrust of providers, competing priorities, and lack of access to a primary care provider (Hwang et al., 2010, p. 1454). Risk factors for unmet needs are poor health status, younger age and victimization of assault or abuse (Hwang et al., 2010). One in six respondents of a survey reported unmet healthcare needs in the last year, greatest among women with children (Hwang et al., 2010). Measures to increase access to primary care and prevent physical

assault and abuse would help meet more healthcare needs of homeless persons (Hwang et al., 2010).

Homeless individuals experience improvement in health status when medical and support services are made available to them, such as in shelter settings (Schanzer et al., 2007). The health status of homeless persons in a New York City shelter mostly improved in an 18-month period (Schanzer et al., 2007). Access to primary care, mental health, counseling and case management services on site in shelters and clinics likely improved shelter users' health (Schanzer et al., 2007). This finding underscores the irony that homeless persons may need to enter a shelter system to experience improved health as opposed to receiving medical attention before entering a shelter system (Schanzer et al., 2007). Integration of a range of services that treat homeless clients holistically and seek first to address housing, transportation, income, and crisis management concerns benefit them most (Drury, 2003).

Healthcare access and utilization may also vary by age among homeless adults (Brown, Kimes, Guzman, & Kushel, 2010). While increased morbidity and mortality affect homeless persons of all ages, older homeless adults suffer mortality from chronic diseases as compared to younger adults who suffer mortality from homicide and HIV/AIDS (Brown et al., 2010). Older adults may also be more likely to have a regular place for healthcare, a regular provider, and health insurance (Brown et al., 2010). Factors that may be associated with older adults' likelihood of having health insurance include higher rates of chronic disease and disability, and veteran status that may make them eligible for assistance (Brown et al., 2010). Both older and younger homeless adults report equally high rates of poor health (Brown et al., 2010).

Other studies of healthcare access and utilization have analyzed the relationship of housing instability, economic status, and healthcare access (Reid, Vittinghoff, & Kushel, 2008). Results support the concept of competing priorities as previously discussed. Findings indicate an association between worsening economic standing and housing instability and worsening healthcare access and increased hospitalizations (Reid et al., 2008). Other variables to consider include insurance status, differences in need or perceptions of need for care, and the transient, ambiguous nature of housing instability (Reid et al., 2008).

Several qualitative studies report the needs of homelessness from the perspective of homeless individuals and reveal themes: lack of access to basic necessities adversely affects health, putting off seeking healthcare until an emergency arises, using illegal and unethical means to survive such as drugs and prostitution, and barriers to receiving healthcare related to treatment by providers (Martins, 2008). Other themes have been revealed: having unmet physical needs, services not being affordable, lack of resources such as transportation and a permanent address for paperwork, and lack of compassionate care from healthcare providers (Nickasch & Marnocha, 2009). The standard of health held by homeless adults equates to surviving, and they have experienced negative interactions with healthcare providers that include feeling labeled, stigmatized, ignored, and disrespected (Martins, 2008). Homeless interviewees have indicated having "an external locus of control," meaning they believe their lives are controlled versus being in control (Nickasch & Marnocha, 2009, p. 42). Needs that may aggravate chronic health problems include injury, lack of access to healthy food, difficulty obtaining a job, working dangerous or poorly paid jobs, lack of privacy, restrictive hours of shelter operation, living in fear for

safety, mental health and addiction related to coping, and feeling invisible to others (Daiski, 2007).

Nursing and other healthcare staff need education in understanding circumstances homeless persons encounter and should remember that all human beings deserve respect (Martins, 2008). Healthcare providers must tailor care to meet basic needs before health concerns, assist homeless patients in attaining resources and remember all people deserve basic health care (Nickasch & Marnocha, 2009). Understanding the needs of homeless clients is necessary in advocating for and collaborating with them (Daiski, 2007). Exploring personal biases would also be helpful in delivering appropriate care (Martins, 2008). Shelters need to provide safety and assistance, not just a place to stay (Daiski, 2007).

While homeless individuals share similar challenges and perspectives, homeless young adults (i.e. 18 to 25 years) share some challenges unique from the needs of homeless adults. About 1.5 to 2 million teens are homeless in the United States, more than the number of homeless adults (Hudson et al., 2009). Contributors to youth homelessness may include parental conflict, familial violence, and abuse by a family member (Hudson et al., 2009). Unique problems also associated with youth homelessness include victimization, sexually transmitted diseases, and unwanted pregnancy (Christiani, Hudson, Nyamathi, Mutere, & Sweat, 2008). Health problems homeless youth may have include Post Traumatic Stress Disorder, foot problems, and lice (Hudson et al., 2009). Additional barriers to access can be categorized as financial, structural, and personal: lacking insurance and transportation to referral sites, ER bills, time-consuming paperwork, lack of continuity in care, fears of discrimination and lecturing from healthcare workers, fear of social service and legal intervention, and language and spiritual barriers (Christiani et al., 2008; Hudson

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et al., 2009). Qualitative studies of homeless youth have revealed needs such as mental health treatment, basic necessities such as clothing and a shower, and the need for connection and interaction with family and friends (Hudson et al., 2009). Interviewees desired outreach related to mental health services, mentoring, respect, better drug treatment programs, outreach programs, services utilizing electronic records, and advocacy (Christiani et al., 2008; Hudson et al., 2009). A priority for healthcare providers should be assistance of homeless clients with resources and referrals for mental health (Hudson et al., 2009). Interventions to facilitate care of youth may include needle exchange programs, vaccinations, and counseling for reduction of risky behaviors (Hudson et al., 2009).

A recent study of consumers' and providers' perspectives on homeless health service delivery and access to housing yielded important information for service providers. Current and former homeless persons, outreach workers, respite providers, and detoxification staff were interviewed in the Boston Health Care for the Homeless Program (Meschede, 2011). Perspectives on theories of homelessness, service needs, and program provisions were similar, though consumers' and providers' disagreement of major service needs pointed to a greater paradigm model. Providers viewed housing needs and residential concerns as secondary, and mental health and substance abuse services as primary. Consumers, however, were much more focused on their lack of housing, though acknowledged their need for substance abuse and medical treatment. Case management, guidance, sufficient time and assistance with transitioning, and relearning skills necessary to succeed off the streets are needed. Integration of care, maintaining client input in services, and a focus on housing are also necessary (Meschede, 2011).

Meschede's findings support the shift from the Continuum of Care delivery model,

involving outreach, treatment, transitional housing and finally permanent housing, to the

Housing First model (Tsemberis, Gulcur, & Nakae, 2004). The Continuum of Care model

assumes homeless persons with psychiatric problems to be incapable of maintaining

housing stability, requiring them to be treated for their mental health and substance abuse

issues before transitioning to housing in a "series of hurdles" (Tsemberis et al., 2004, p.

651). The Housing First model, developed by Pathways to Housing in New York to better

meet housing and treatment needs, assumes that housing is a basic right and provides a

foundation from which to begin the process of recovery. The Housing First model also

emphasizes consumer choice and harm reduction, allowing clients freedom to make

choices without adverse consequences and helping them regain a sense of control. In a

comparison of each model, the Housing First program had approximately an 80% housing

retention rate, tenants experienced higher levels of control, and the use of alcohol and

drugs did not increase, in stark contrast to held beliefs of the Continuum of Care model

(Tsemberis et al., 2004).

An emerging model of care in homeless service settings is Trauma-Informed Care

(TIC) (Hopper, Bassuk, & Olivet, 2010). Similar to the harm reduction principles of the

Housing First program, TIC involves trauma awareness and understanding, emphasis on

safety to avoid re-traumatization, opportunities to regain control, and the use of a

strengths-based approach to focus on clients' strengths and skill building. As stated

previously, homelessness is traumatic, and many homeless persons have endured

traumatic events that negatively affect their health outcomes. Review of the evidence

indicates providers need more education about TIC and dealing with trauma issues in

clients, clients want services that are empowering, and mental health services are important for most homeless persons and families (Hopper et al., 2010). More research is needed to understand and develop a definitive model for incorporation of TIC into homeless services (Hopper et al., 2010).

Homeless Medical Respite Care

Medical respite services began in Washington D.C. and Boston, MA in the mid-1980's, a movement that has spread across the nation in response to growing need (HCHCN, 2007). The Respite Care Providers' Network (RCPN) was formed to help guide the development of new and active respite programs nationally (HCHCN, 2007). A pilot initiative began in 2000 with funding from the Health Resources and Services Administration to examine the impact on clients (HCHCN, 2007). Characteristics of respite programs across the nation were found to be innovative, and offer comprehensive medical and social support (Zerger et al., 2009). Other services offered included case management, meals, transportation, housing referrals, substance abuse and mental health services, job training or placement, spiritual support, physical therapy, and educational services. Common diagnoses of clients served included fractures, injuries, diabetes, infections, respiratory problems, heart disease, hypertension, surgical recovery, and cancer. Funding for respite programs remains a challenge, as services are not eligible for Medicare or Medicaid reimbursement (Zerger et al., 2009).

Evidence supports respite programs' positive effects on homeless health and costs of healthcare. The need for respite care rests on the premise that a gap in the healthcare continuum exists for homeless persons who are too ill to be discharged to shelters or the streets, but not ill enough to remain hospitalized (HCHCN, 2007). Upon discharge there is

no safe place for homeless clients to go to recuperate, lacking the ability to follow directives for after-care and follow-up care (HCHCN, 2007). Shelters are not equipped or prepared to provide the care needed by discharged homeless persons, though care providers in the hospital often have no other options in discharge planning (HCHCN, 2007). As previously mentioned, homeless persons tend to rely on hospital emergency departments for services and have higher rates of hospitalizations than the general public, which is often medically least appropriate and the most costly (Zerger et al., 2009). Most homeless clients lack health insurance, arrive by ambulance, and undergo more diagnostic testing as compared to non-homeless persons (Oates, Tadros, & Davis, 2009). Contributing factors may include the lack of other modes of transportation or summons by a bystander, overall poorer health status, lack of regular care, and higher incidence of injuries (Oates et al., 2009). Interventions that improve healthcare access and decrease the need for emergency department visits are recommended, such as respite care (Oates et al., 2009). Other exacerbating factors include rising costs of healthcare, lack of healthcare insurance, lack of access to Medicaid benefits, and shorter hospital stays (Zerger et al., 2009). Respite care fills the service gap for those who have no home in which to recuperate, too ill to stay in a shelter but not ill enough to remain hospitalized.

However, a respite care program can ideally offer more than just a safe place to stay. The national Respite Care Providers' Network (RCPN), affiliated with the National Health Care for the Homeless Council, has formally defined characteristics of a respite program that convey a greater vision (2008). Aside from closing the healthcare continuum gap, respite care provides access to hospitality, medical care, and supportive services that assist in recuperation from illness. Various models have been developed to fit the needs of the

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given local community, pulling resources and collaborating with shelters, motels, treatment facilities, nursing homes, or even free-standing buildings to offer a network of services (HCHCN, 2007). Each length of stay is determined by medical need and individual progress, and both health and substance abuse issues are addressed. The focus is placed on the whole person, respect for human dignity of all, and promotion of active involvement by participants in the process of their recuperation and discharge planning, while continuity of care following discharge into the community is maintained (RCPN, 2008). In short, respite care programs are cost-effective, reduce hospital readmissions, and offer needed social support, service-networking benefits, and a humane option for placement after discharge (Zerger et al., 2009).

Respite care services can reduce hospitalizations and emergency room visits, and demonstrate cost savings. Case management and housing placement services for homeless clients effectively decrease hospitalizations and emergency room visits, as compared to standard discharge planning measures (Sadowski, Kee, VanderWeele, & Buchanan, 2009). In an 18-month study, hospital days were reduced by 29% and emergency department visits were reduced by 24% (Sadowski et al., 2009). For every 100 homeless persons offered case management and housing placement, about 49 fewer hospitalizations, 270 fewer hospital days, and 116 fewer emergency department visits could be expected in the next year (Sadowski et al., 2009). Comprehensive, coordinated care and tailoring of supportive housing to suit each client's needs were factors contributing to these reductions (Sadowski et al., 2009). Another study evaluated the efficacy of respite care in a one-year period following hospitalization (Buchanan, Doblin, Sai, & Garcia, 2006). Inpatient days were reduced 58% and hospital admissions were reduced 49% (Buchanan et al., 2006).

The average cost of respite care per hospital day avoided was $706, compared to $1500 per day in hospital costs, demonstrating significant cost savings (Buchanan et al., 2006). Another similar study found an approximate 50% reduction in hospital readmissions at 90 days post-discharge compared to usual discharge to streets or shelters (Kertesz et al., 2009). One other recent study found the average cost per discharge of a homeless patient was $2559 after data adjustment for age and gender, associated with longer hospital stays and excess costs (Hwang, Weaver, Aubry, & Hoch, 2011). These findings supported past research supporting the effectiveness of respite care in reducing costs and the need for community mental health services (Hwang et al., 2011).

Shelter-based convalescence, a model of respite care, has improved healthcare of homeless persons (Podymow, Turnbull, Tadic, & Muckle, 2006). Services have been tailored to fit the needs of local homeless populations based on quality improvement data (Van Laere et al., 2009). A pilot shelter convalescence project in Canada provided medical care, assistance with housing applications, ancillary therapies, and transportation for up to a 3-month stay (Podymow et al., 2006). Positive outcomes included timely discharge and treatment, especially for those with chronic diseases, alcohol and drug addictions, and 25% of homeless participants were discharged to housing (Podymow et al., 2006). Primary care was provided, and even electronic health record keeping was utilized, allowing for up-to-date, accessible information on each client (Podymow et al., 2006). Such integration of health services with homeless shelters is recommended, alluding to respite program models (Podymow et al., 2006).

Local Homelessness and Health

As previously stated, homelessness affects roughly four hundred persons in Fargo, ND and Moorhead, MN on any given night, with half of North Dakota's homeless persons living in Fargo (FCC, 2006). The Fargo City Commission initiated a ten year plan to end homelessness in the Fargo-Moorhead area in 2006 because of gaps in the system serving the homeless population, disproportionate use of resources, and the general issue of social justice in the community (FCC, 2006). As mentioned, the total number of homeless persons in the Fargo-Moorhead area has increased twenty-nine percent since 2006 and doubled since 2003 (Wilder, 2010). Among homeless adults surveyed in Fargo and Moorhead, the average age of men was 45 and of women was 35 (Wilder, 2010). Twenty percent of homeless adults in Fargo and seventeen percent in Moorhead reported having no income, the main source of income for homeless persons in both cities being day labor and steady employment (Wilder, 2010). Forty-one percent of homeless adults in Fargo and 31% in Moorhead reported having a job (Wilder, 2010). Thirty-eight percent of homeless adults in Fargo and 71% in Moorhead reported having some type of medical coverage (Wilder, 2010). Mental illness and chemical dependency are two primary health issues among Fargo-Moorhead homeless persons (Wilder, 2010). In 2009 over 40% of homeless adults in the Fargo-Moorhead area reported a diagnosed mental health disorder in the past two years, and over 40% also considered themselves to be chemically dependent (Wilder, 2010). Primary health issues of mental illness and chemical dependence echo findings among homeless persons nationally in the literature, as discussed.

Since its creation in 2006, the 10 Year Plan to End Long-Term Homelessness has spurred interventions addressing the metropolitan problem of homelessness (FCC, 2006).

While 31% of Fargo-Moorhead area homeless individuals were chronically homeless in 2006, the top four contributing factors to chronic homelessness were substance abuse, serious mental illness with inconsistent use of medications and treatment, unemployable state due to disability, and poor rental history or criminal background (FCC, 2006). Six risk factors for chronic homelessness were identified by Deborah Dennis of Policy Research Associates that became the focus of 10-Year Plan interventions: chronic health condition, mental illness, substance abuse disorders, limited or no social support network, very low or no income, and discharge from jail, prison, hospital, shelter, detoxification, treatment, or foster care (FCC, 2006).

Seven strategies were identified for eliminating long-term homelessness, the fifth point addressing discharge into homelessness (FCC, 2006). The Plan's goal in response to lack of resources existing for homeless persons after hospital discharge was distribution of updated information on housing resources (FCC, 2006). No other goals were outlined to address this specific problem, indicating probable support for a medical respite care program in the Fargo-Moorhead community.

As stated earlier, no other formal data is available specifically describing the health needs of the Fargo-Moorhead homeless population. The informal needs assessment completed in 2010 provides minimal data about the health status and needs of the Fargo-Moorhead homeless population. A formal needs assessment is necessary to evaluate the healthcare needs of Fargo-Moorhead homeless persons, the specific need for a medical respite care program, and how community resources can be utilized to address their healthcare needs.

PRECEDE-PROCEED Theoretical Model

The PRECEDE portion of the PRECEDE-PROCEED model for health promotion and community planning guided the needs assessment process (Green & Rabinowitz, 2013; Hodges & Videto, 2005; Pender et al., 2011). The PROCEED portion of the model guided recommendations for further program planning. The model contains two fundamental propositions (Pender et al., 2011, p. 74):

1. "Health and health risks have multiple determinants and

2. Efforts to change the behavioral, physical, and social environment must be multidimensional and participatory."

The four phases of the PRECEDE portion of the model were applied to conduct the needs assessment and further organize data (Green & Rabinowitz, 2013; Hodges & Videto, 2005; Pender et al., 2011):

1. Social Assessment: Both quantitative and qualitative data were gathered to assess homeless persons' priority health needs and quality of life.

2. Epidemiological, Behavioral, and Environmental Assessment: A thorough literature review of the national scope of homeless health was completed. Information about local homelessness and health was also reviewed. Priority health needs and barriers to health care were identified. Behavioral and environmental factors were analyzed among assessment data to identify priority health needs among the focus population. Factors included lifestyle, physical, and social factors influencing or contributing to priority health needs.

3. Educational and Ecological Assessment: Predisposing, reinforcing, and enabling factors were also analyzed among assessment data. Predisposing factors included

knowledge, perceived needs, and attitudes of participants. Reinforcing factors included external and internal factors supportive of meeting health needs or health care access. Enabling factors included programs, services, and resources needed in the community to meet homeless health needs.

Phase four of the PRECEDE portion and the four phases of the PROCEED portion of the model were used to formulate recommendations for program design, implementation, evaluation, and further assessment (Green & Rabinowitz, 2013; Pender et al., 2011):

4. Administrative and Policy Assessment: Administrative and policy factors that may impact program implementation were analyzed.

5. Implementation: Needs assessment data were used to create a suitable program design and intervention plan.

6. Process Evaluation: Recommendations for evaluation of whether the intervention addresses the factors in phase 3 were created.

7. Impact Evaluation: Recommendations for evaluation of whether the program addresses factors in phase 2 were created.

8. Outcome Evaluation: Recommendations for evaluation of whether the overall purpose of the program addresses the priority needs and quality of life of the target population in phase 1.

A model for this project was created from the PRECEDE-PROCEED model in Figure 1 below (Green & Rabinowitz, 2013). Steps yet to be completed with the community are shaded.

Figure 1. PRECEDE-PROCEED Project Model
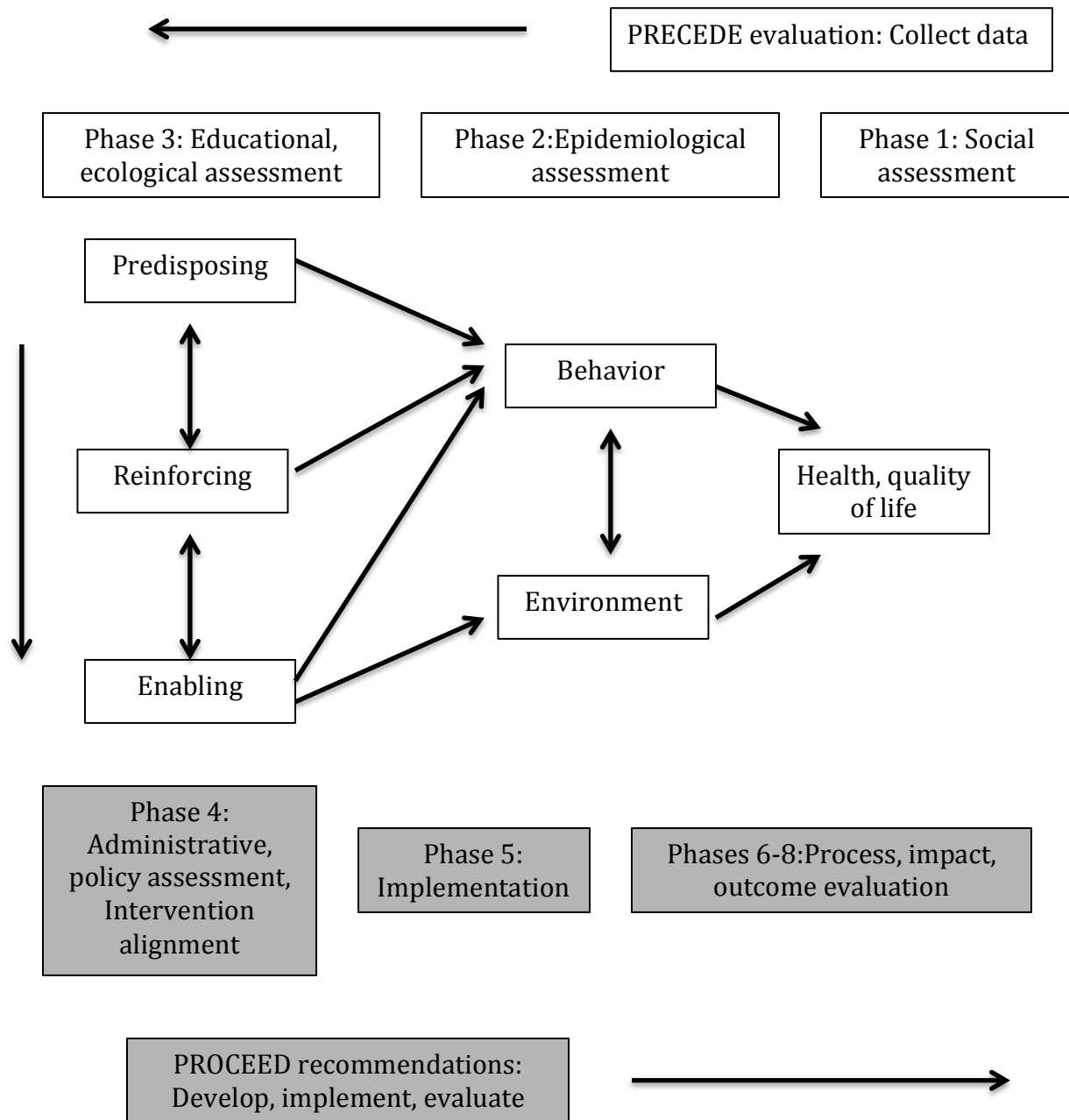
The model rests on the premise that community interventions aim to improve

members' quality of life overall (Green & Rabinowitz, 2013). The model acknowledges the

need for target population members to be involved in program planning measures (Hodges

& Videto, 2005). When members of the target population are involved in decision making

and planning efforts, long-term change is more likely to occur (Green & Rabinowitz, 2013;

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Hodges & Videto, 2005). The model provides a useful guide for conducting a thorough

needs assessment in order to depict the full picture of the population's health and needs to

create appropriate interventions (Green & Rabinowitz, 2013; Hodges & Videto, 2005).

Concept Analysis of Respite Care

The concept of "medical respite care" has been formally defined as "acute and post

acute medical care for homeless persons who are too ill or frail to recover from a physical

illness or injury on the streets, but who are not ill enough to be in a hospital" (RCPN, 2008;

HCHCN, 2007). Other terms synonymous with "medical respite" may include "interim,"

"infirmary," and "recuperative" care (RCPN, 2008). The Respite Care Providers' Network,

affiliated with the National Health Care for the Homeless Council, define the characteristics

of medical respite care:

- Short term program for homeless persons who have a medical injury or illness and

  may also have mental illness or substance abuse problems

- Comprehensive residential care to provide rest and access to medical and supportive

  services

- Individualized length of stay based on medical need and progress

- Holistic care through interdisciplinary collaboration and continuity of care following

  transition into community

- Respect for human dignity of all residents and staff

- Active involvement by participants in their care and discharge planning

- A "bridge" or "link" in the healthcare continuum of care between hospital and

  permanent housing

- Innovative, quality, and cost saving care

- Various service delivery models designed to fit community needs, priorities, and resources

- Integral component of the continuum of care for homeless services within the community

    As discussed in the literature, medical respite care is unique to the homeless population, and is a model of care developed to meet homeless persons' multiple complex needs. Expected outcomes of respite care include improved quality of life and health as determined by the resident, assistance with transition into community and permanent housing, and ongoing support as necessary for each individual. The community's specific needs and available resources must be known to develop a respite program that addresses the needs. The term "community" may describe any group of individuals who have common characteristics (Hodges & Videto, 2005). The focus community of the proposed needs assessment can refer to homeless persons living in Fargo-Moorhead and all hospital staff, shelter staff, and any other persons in contact with homeless persons within the continuum of services.

CHAPTER 3. PROJECT DESIGN

IRB Approval

The Institutional Review Board protocol was submitted for expedited review and approved by North Dakota State University on April 17, 2012. The approval letter is attached as appendix A. IRB protocol was also submitted for exempt status review and approved by Sanford Health on May 12, 2012. The approval letter is attached as appendix B. IRB protocol was submitted to Essentia Health and oversight was confirmed as not required on June 5, 2012. A representative of Veteran Affairs Hospital was contacted regarding IRB process and subsequently not sought due to time constraints. No research was performed at the Veteran Affairs Hospital.

Data Collection

Methods

This project utilized a mixed method approach to describe the health needs of Fargo-Moorhead homeless individuals from the perspectives of both homeless persons and service providers. Surveys were used to gather quantitative data and semi-structured interviews were used to gather qualitative data. Data collection took place in three phases as follows:

1. Phase one consisted of 95 surveys administered to people who were self-identified as currently experiencing chronic homelessness in the Fargo-Moorhead area or living in permanent supportive housing, were 18 years or older, able to speak, write, and understand English, and had the mental capacity to consent and participate (including sobriety) as judged by the researcher and experienced staff members. Fifteen semi-structured interviews were also completed with people selected with

assistance from staff members at the sites where phase one was conducted. Surveys and interviews were completed at the following sites: Gladys Ray shelter, New Life Center, Dorothy Day House of Hospitality, Homeless Health Services clinic, and Cooper House. Surveys alone were completed at Project Community Connect event at the Fargodome on April 25, 2012, Gateway Gardens, Churches United for the Homeless, and the YWCA shelter. Cooper House (Fargo, ND) and Gateway Gardens (Moorhead, MN) are two permanent supportive housing establishments. Residents of these establishments have a history of chronic homelessness.

2. Phase two consisted of ten semi-structured interviews with staff members from each area shelter previously listed and Cooper House apartments. The researcher was unable to connect with staff members from Gateway Gardens as time allowed.

3. Phase three consisted of 29 total surveys administered to service providers at Sanford Health and Essentia Health. A total of 14 semi-structured interviews were also conducted with service providers at Sanford Health, Essentia Health, Cooper House, Cass and Clay County Public Health Departments, Homeless Health Services clinic, and Fargo Housing Authority.

Recruitment and Protection of Rights

Convenience sampling was used to recruit members of the target population because of lack of established trust with population members and difficulty reaching population members due to the transient nature of homelessness. Homeless persons living outside of a shelter or not in permanent supportive housing were excluded for the same reasons. Homeless persons less than 18 years of age were also excluded based on lack of established trust, obligations for mandatory reporting, and the needs of this population as

likely different from homeless adults based on the previous research findings. The inclusion of persons living in permanent supportive housing was in response to a request from Laurie Baker, the Fargo-Moorhead Coalition for Homeless Persons Director. Although these persons are now housed, they have all experienced recent and chronic homelessness. Recruitment and protection of rights are discussed below for each of the three phases of data collection.

Phase one began at the Project Community Connect event at the Fargodome on April 25, 2012. The researcher staffed a booth with a poster titled "Health Survey" next to the Homeless Health Services clinic booth. Potential participants were asked about homeless status and informed regarding the purpose of the survey. Persons who volunteered to take the survey were seated at a table behind a curtain with privacy covers. The researcher obtained informed consent and assured participants' anonymity. Signature for consent was waived and consents were written at a seventh grade reading level. The researcher remained near to answer any questions participants had. Upon completion, each volunteer placed his survey in a sealed container. Remaining phase one participants were selected with assistance from staff members at each shelter, the Homeless Health Services clinic, Cooper House, and Gateway Gardens because of their expertise and established trust with the population. Flyers were posted at each shelter and placed in Cooper House and Gateway Gardens residents' mailboxes prior to visits arranged between the researcher and staff. Phase one surveys were promptly transferred to a locked file box upon completion of each site visit. Phase one participants who volunteered for interview were also selected with assistance from staff. The researcher obtained informed consent and assured participants' anonymity. Interviews were audio recorded in a private area for the purpose

of providing participants full attention and subsequent thorough transcription. The audio recording device was stored in a locked file box when not in use. Granola bars were offered as compensation to participants upon completion of each survey and interview. Resource and referral ("Help") cards were offered to participants following each survey and interview.

Phase two participants were identified as staff at Gladys Ray, Churches United for the Homeless, Dorothy Day House, the YWCA, New Life Center, and Cooper House with assistance from Fargo-Moorhead Coalition members and site staff. The researcher was unable to connect with staff at Gateway Gardens due to time constraints. Participants were recruited via e-mail invitation with information about the project. Participants volunteered to be interviewed and the researcher obtained informed consent. Interviews were audio recorded. The audio recording device was stored in a locked file box when not in use.

Phase three participants were identified as direct health service providers or support service providers at Sanford Health, Essentia Health, Homeless Health Services clinic, and Cass and Clay County Public Health Departments. Participants were recruited with assistance from Fargo-Moorhead Coalition members and staff members from Sanford Health and Essentia Health. The researcher obtained informed consent prior to all surveys and interviews with phase three participants. Surveys were administered to Essentia Health emergency department nursing staff at a meeting arranged by the researcher and staff. Surveys were also administered to Sanford case managers and social workers with assistance from Sanford staff. Interviews were conducted with staff members at Sanford Health, Essentia Health, Cass and Clay County Public Health departments, and Homeless

Health Services clinic. All interviews were audio recorded. All surveys and the audio

recording device were stored in a locked file box after each site visit.

All audio files were transcribed verbatim excluding any identifying data. Audio files

were transferred to a computer and stored in password-protected files on a password-

protected computer accessed only by the researcher. Transcribed files will be retained in a

locked office at final disposition. All surveys were transported and stored in a locked file

box accessed only by the researcher. All audio files were destroyed after final transcription.

Instruments

Phase one survey questions were taken from the Fargo, ND Survey of Persons Without Permanent Shelter Interview Schedule 2009, the Minnesota Statewide Survey of Persons Without Permanent Shelter Interview Schedule 2009, and the Project Homeless Connect 2010 registration form. Three of the survey questions were adapted to assess risks for heightened mortality and priority need for housing, via the Vulnerability Index (see appendix G) (Juneau Economic Development Council, 2009). A request to implement the Vulnerability Index came from the FM Coalition for Homeless Persons, Laurie Baker, and the three questions are marked as "adapted/VI." Phase one interview questions were taken from the 2009 Wilder Study surveys listed previously, and the Medical Respite Program Development Workbook from the National Health Care for the Homeless Council (Jaco, 2011). Two questions were added by the researcher to assess for barriers to receiving needed health care after hospital discharge, as noted.

Phase two interview questions were taken from the same Medical Respite Program Development Workbook (three of the eight questions) (Jaco, 2011). Five of the eight questions were developed and added by the researcher to assess staff members' insight into the health care needs of homeless persons they encounter who may benefit from medical respite care.

Phase three survey questions were taken directly from the Medical Respite Program Development Workbook (Jaco, 2011). No questions were adapted. Phase three interview questions were also taken from the Medical Respite Program Development Workbook

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(Jaco, 2011). The researcher developed and added five questions to assess informants' experience with persons experiencing homelessness.

Though the majority of survey and interview questions used were from reliable sources, the reliability and validity of their use in a homeless health needs assessment cannot be fully established. Reliability and validity of adapted and added questions are not established. Instruments are listed in the project appendices.

Data Analysis

Qualitative data analysis used descriptive content analysis to identify themes and patterns among interview data. Interview audio files were transcribed as notes into a Microsoft Word document and coded into themes following the interview questionnaire structure. Direct quotations were transcribed verbatim and chosen based on their reflection of the theme and the need to capture participants' full messages and tones. Finally, all interview data themes were entered into tables following the interview questionnaire structure.

Quantitative data analysis used descriptive statistical analysis to describe participant demographics, needs, contributing factors, and resources among survey data. Survey data were coded following the survey structure and entered into an Excel spreadsheet. Free text responses were entered and later reduced to themes. Descriptive statistics were used to display sample characteristics into separate tables. Finally, survey data statistics were entered into tables following the survey structure. All data were then re-organized following the PRECEDE model framework to meet objective 3 of the project. Below is a description of how the objectives were met using the PRECEED-PROCEED model framework. More information is discussed in the Results section.

- Objective 1 of the project was congruent with phases two and three of data collection. Service providers were surveyed and interviewed about their role in working with the area homeless population, health and service needs they encounter, and resources available in the community.

- Objective 2 of the project was congruent with phase one of data collection. Homeless persons were surveyed and interviewed about their health and service needs, health care utilization, and problems with health care access.

- Objective 3 of the project was evaluated using the PRECEDE portion of the PRECEDE-PROCEED model, the theoretical framework for the project. The model provided a framework for re-organizing information to gain understanding of needs, contributing factors, and available community resources.

- Objective 4 of the project was evaluated using the PROCEED portion of the PRECEDE-PROCEED model. Recommendations for program implementation and evaluation were created based on needs assessment data.

CHAPTER 5. RESULTS

Results are organized by objective and present the qualitative and quantitative data separately. The characteristics of each sample are described before each table of data. A total of 156 people participated in this project and included 124 surveys with consumer and service provider participants and 32 individual interviews .

Service Providers' Perspective on Homeless Health Needs

To address objective one, individual interviews were conducted with shelter staff and health service providers. In addition, health service providers completed quantitative surveys.

Shelter Staff Interview Data

A total of 10 shelter staff members were interviewed, eight of which were female. Shelter staff roles included shelter director, case manager, parish nurse, and other staff. Interviews at Churches United for the Homeless and YWCA shelters were done as groups. Key facilitators that made objective one achievable included the interest shown by participants in collaborating to address homeless health needs and participants' expertise. Interviews lasted from about 30 minutes to 90 minutes, and the researcher allowed for additional discussion. Responses are outlined below in table one with basic themes and are categorized according to the interview format.

Shelter staff participants spoke of homeless persons as experiencing many unmet health needs and encountering a variety of barriers to meeting their health needs. Participants related their experiences of trying to meet some of these health needs and limitations in doing so. Participants provided information about specific health and support service needs as well as factors contributing to health needs and homelessness.

Table 1. Shelter Staff Participant Interview Themes

Theme	Description	n=10
Health Needs Among Shelter Residents *(Needs)*	• Many unmet needs • Diabetic cares, supplies • Acute, chronic and undiagnosed conditions • Cultural competence among providers • Dental • Injury care • Poor diet • Pain treatment • Rapid hepatitis testing • Needle exchange program • Hospice • Medication assistance, storage • Medical supplies/equipment • Transitional level of care • Safe place to rest, recuperate • Infectious disease isolation • Sexual assault care • Support services	
Barriers to Health Care Access and Unmet Needs *(Contributing Factors)*	• Transportation • Lack of insurance, affordability of health care services • Physical or mental limitations • Lack of trust in health system or providers • Inability to prioritize health care needs above work, shelter, meals • Lack of physical address • Stigma, discrimination in care • Providers' judgment of what patient needs • Lack of knowledge of resources • Long wait for psychiatric treatment, specialty care • Nurse at each shelter once to twice weekly • Limited Homeless Health Clinic hours • Application for disability benefits complex	
Needs for Respite Care *(Needs)*	• One bed available at some shelters • Residents who could benefit from respite care frequently to occasionally encountered • Residents with conditions need to be independent with cares, mobile • Staff unable to accept many patients from hospital due to needs • Shelter Parish nurses' scope of practice excludes hands-on care • No medical supervision in shelters	

(continued)

Table 1. Shelter Staff Participant Interview Themes (continued)

Theme	Description	n=10
Support Services Needed *(Needs)*	• More case management • Trauma-Informed Care • Housing First model • Nursing staff able to do hands-on care • Better nutrition • Place to exercise • More nursing staff • More affordable housing • More medical questions on intake form	
Shelter During the Day *(Contributing Factors)*	• Veteran drop-in center at Gladys Ray • Churches United community living center • YWCA, Dorothy Day residents may stay during day • Salvation Army, New Life, Churches United provides meals • Social Club • Library • Walk the streets	
Shelter During the Night *(Contributing Factors)*	• Shelters first-come first-serve basis • Church sheltering project • Vehicles • Streets • Under bridges/underpasses • Fence lines • Entryways • Storage units	
Health Care Provided at Shelters *(Assets)*	• Public Health nurse visits each shelter once to twice weekly for hour • Some shelter staff trained in CPR/first aid • Nursing student screenings • Immunizations • Medications stored for resident to dispense • Parish nurse at Churches United and YWCA 20 hours per week • Blood pressure checks • Education on health, available resources, appropriate care • Tuberculosis testing	
Other Comments *(Contributing Factors)*	• Collaboration among discharge planners and shelter staff strained • Limited shelter resources • Staff feel liable for residents' care • Health linked to stable housing • Staff try to accommodate when possible • Homelessness increasing in area, many newly homeless • Substance abuse a cause or effect of homelessness • Staff members may act as liaison for residents • Relationships with FM Ambulance, nursing schools	

<u>Health Needs Among Residents</u>

Participants cited needs associated with acute, communicable conditions and chronic conditions that worsen. Some conditions remain undiagnosed or untreated, which sometimes becomes fatal, according to one participant. Communicable disease was cited as common given the dorm style living conditions and shared spaces in shelters. Some residents with communicable conditions such as infections need isolation or a room of their own.

> "When you just have a simple fever that could be contagious, or any kind of contagious thing, it would help all of us if they were not here while they were contagious...we try hard to wash handles on doors, we try hard to wear gloves...it would be great to know when somebody had a fever...just for 24 hours they could be somewhere else. If they're already our resident, we handle that appropriately. But when you're bringing someone in from the community that exposes the other community and it's just a trickle effect, so there is no place for isolation here..."
>   -female shelter staff participant

Diabetes was cited by almost all participants when asked about health needs they encounter. Participants discussed the difficulty diabetic residents have in regulating blood sugars due to lack of supplies, a clean area to do so, and proper nutrition. Foods donated to shelters were said to often contain sugars and starches making blood sugar regulation for diabetic residents difficult. Foot and leg problems were reported rampant among residents, especially for diabetic residents.

> "That's [foot cares] a huge, huge thing...they're on their feet all day, and I don't know if you've ever seen a homeless person's feet, but it's unbelievable...If a homeless person is diabetic, you actually have to have an RN cut their toenails...And then, you know, you end up with a sore..."
>   -female shelter staff participant

One participant discussed the lack of rapid hepatitis testing in North Dakota and its availability in Moorhead, MN. She believed current hepatitis rates among homeless

residents to be likely higher than known, and that a needle exchange program would be

beneficial.

> "The rapid testing would be helpful…just having that available in the shelter…if we had it right here and said 'alright let's do the test quick," as opposed to hop in the car…even if we had transportation, there's that thought of "no, no, I don't want it…"
> -female shelter staff participant

Participants discussed other issues related to medication needs. Many homeless

persons were reported to be without needed medications due to loss, theft, or lack of

ability to afford them. One participant related a story of a homeless man discharged from

the hospital with medications in a clear Ziploc bag. While at a shelter for the night, other

residents were said to have eyed his medications. Nearly all participants reported mental

health needs among residents, and chronically homeless persons often turn to substance

abuse to deal with homelessness. Anxiety and depression were cited as common among

nearly all residents due to the state of homelessness.

Participants reported other needs related to limited physical mobility. Some

residents may have a walker or wheelchair, though may require assistance from staff or

other residents with transfers.

> "We are not the next step [after discharge]…we've had a couple different people here needing oxygen, several people with a wheelchair, which is a challenge for us because we don't have a freight elevator…people who supposedly are mobile…but it doesn't feel like that when they're here, but we go with it…but the burden is on our staff, who feel liable for somebody seeming really vulnerable to transfer themselves…and puts the other residents in a position of having to help without any training of the right support or lift, and possibly causing harm…or the person does it on their own, or the staff feels they have to do it…we want to be helpful, but the person who's going to be the loser is probably the person who's sick…we are not a medical facility."
> -female shelter staff participant

Some participants also discussed the need for sexual assault care among female residents who often do not report the assault. Shelter staff were said to deal internally with issues related to rape and abuse crises.

<u>Barriers to Care</u>

Many of the health care needs reported by shelter staff were tied to barriers to access or fulfillment of needs. All participants cited transportation as a common barrier though some resources are available for fare. Lack of medical insurance and ability to afford services and medication was also commonly cited. One participant remarked on the difficulty of navigating the health care system among multiple barriers presented with homelessness.

> "I think of...how fortunate it is to have health insurance...but how still difficult it is to get your doctors appointment, go there, find out what's wrong, get your meds, have the meds work...even having health care insurance is hard for us. And then if you have all these other barriers of not having a home, of not having health insurance, not having transportation, not having an advocate...I mean, that's very challenging for them, even more so, because I'm challenged in the health care field trying to take care of myself and my family. I can't imagine not having the resources that I have, and they don't have those resources."
>
> <div align="right">-female shelter staff participant</div>

Some participants noted resistance to seek health care among some residents due to lack of trust in providers or the health care system. One participant told a story of a homeless patient who experienced significant pain and was not prescribed pain medication. The physician would not prescribe medication for fear the homeless patient would sell his medication. The participant stated the importance of education among providers about discrimination and appropriate care. Another participant said it took her a minimum of three weeks to build trust with residents to connect them with a primary care provider, and residents do not readily commit to seeing one provider for their needs.

Access to an appropriate level of care was also discussed among barriers. Participants remarked residents are unable to prioritize their health needs above other needs, and desire to work rather than go to a clinic. Many participants spoke of residents seeking care in the emergency room for non-emergent needs, though the Homeless Health Services and Family HealthCare clinics are available during the week. However, participants stated that the only place for residents to seek care during the weekends is the emergency room. Other barriers to access mentioned included physical and mental illness, long wait times for appointments for specialty care, lack of knowledge of resources, and limited nursing care at shelters. Some participants stated the wait time to be seen for psychiatric needs can be up to 6 months or longer, and providers at Family HealthCare and Homeless Health Services must provide care in the interim. Two shelters have a parish nurse that provides blood pressure screenings, education, and counseling, though participants stated their scope of practice does not include hands-on nursing care such as dressing changes. Participants also stated a Homeless Health nurse visits each shelter once to twice weekly for about one hour to provide immunizations, medication set-up, blood pressure screening and hands-on cares. They said, however, that many residents have needs beyond this time frame, and residents sometimes help other residents with cares.

> "If it's a basic dressing change, sometimes we can do it…and they have to be able to do it themselves. It's outside my scope of practice as a parish nurse to do hands on. I can help coach them what they should do…but as far as actually dressing the wound, we don't have a doctor on staff or orders for that…And the advocates [staff] end up doing some of it [dressing changes and other cares] and other residents end up doing some of it"
>
> -female shelter staff participant

Some participants also discussed a high incidence of unreported sexual assault among female residents and difficulty connecting with appropriate care while avoiding re-

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traumatization. Assaulted residents will turn to shelter staff for support, and staff struggle

to advocate for the residents.

> "We'll have people that come and maybe they've just been abused, and I want them to be assessed because there's no provider here. Sometimes they're afraid to go out, thinking they're abuser's going to see them, if they have a car. And to send them on a bus is scary, too, because they maybe have never ridden a bus, they don't even know where they're going, they're afraid..."
>
> <div align="right">-female shelter staff participant</div>

One participant talked about the difficulty of application for disability benefits and

the barrier of lacking a physical address. She told a story of one female resident who had

applied for benefits and was not receiving the mail she needed to continue the application

process. Her mail was being sent to her old residence where her abuser lived, who was not

forwarding her mail. She was subsequently denied benefits because she did not maintain

the needed contact to complete the process. Two participants recognized depression

among residents when challenged to overcome barriers to meeting needs.

> "It is very challenging, I feel like a lot of these ladies have so many barriers, and they might overcome one, and then that pops up another one...three steps forward and two back, you know, and you can just see it literally on their faces sometimes, they just start to fade, like, their energy level is...they're just done, just used up, they can't do any more work..."
>
> <div align="right">-female shelter staff participant</div>

<u>Respite Care Needs</u>

Most participants stated medical respite is a frequent need among the residents

they encounter, and most shelters reported encountering several residents per month who

would benefit from respite care. Participants spoke of receiving calls from hospital staff for

patients with medical needs beyond what staff could handle, and were required to turn

them away. However, the need may be greater, given the number of patients that are not

sent or must be turned away. One participant spoke of the need for a transitional level of

care for some residents, and having to learn how to perform tasks to accommodate needs.

> "Even if they don't appear to have a health related emergency or situation on their
> hands at that moment, so many of them have diabetes and high blood pressure and
> heart conditions…so much lung disease, foot and leg problems…and really their
> bodies could use a break if they just had a place to be…but as far as any chronic stuff,
> like those folks…should not be outside…at any given time we could have three or
> four guests in a medically vulnerable respite-type situation…I get tons of calls…for
> people who needed to come here who in no way shape or form are we equipped to
> serve…I think hospitals are doing a better job of trying to discharge people to
> something…I've learned a ton about oxygen in the last six months because of
> hospice and everything else…it's one of those accidental things."
> -female shelter staff participant

Other participants spoke of the issue of dealing with medical emergencies without

medically trained staff.

> "And, like, a lot of the evening staff are college students and weekend staff are
> college students, and we have like on call, like I'm on call this weekend. And I'll
> come in, but I'm here by myself. So you have a medical emergency, when I was
> part time…I had a woman go into diabetic shock and someone came down and
> said 'she can't move, she's not coming out of her room,' I'm here by myself, and
> that's really scary. So…thank god the other resident knew a lot about being a
> diabetic and had those glucose tabs…and things like that, and just having that
> knowledge base…that's a concern."
> -female shelter staff participant

Two shelters are equipped with one private room that participants said is used to

shelter a medically vulnerable resident who may need to stay during the day. They said the

private rooms are almost always in use, and staff members make decisions day to day

about who stays in the private room that historically has been used for residents with

mental health crises. Other shelters allow people to stay during the day or allow residents

to lie down if not feeling well. Participants stressed that residents must be independent

with any medical cares because no medical staff are available to assist or monitor. Some

residents were reported to need recuperation for mental health needs, which may worsen

in the stimulating shelter environment. Participants said mental health needs are often tied

to residents' medical state and any chronic health conditions they may have. They made the

point that normally sick persons have a home to be discharged to recuperate from illness,

and there is currently no alternative in the community.

<u>Health Care Provided at Shelters</u>

As stated, a Homeless Health nurse visits each shelter once to twice weekly for

about one hour to perform tasks including immunizations and medication set-up. She also

provides tuberculosis testing for Gladys Ray residents as it is required to stay at the shelter.

A parish nurse is employed at two shelters, Churches United for the Homeless and the

YWCA, for 20 hours per week. They provide blood pressure screenings, education, and

health counseling.

> "A nurse from Homeless Health comes here one time a week and it's for a brief period of time so about a half hour that she comes, and she can provide TB testing or flu shots during the flu season. She also can set up medications, that's been really helpful for us because again we don't' have that training necessarily at shelters, so, and just helping educate staff…she's a good resource to staff too, and to guests. She explains why they might be on certain medication and the importance of taking them, because that's another issue sometimes is people following their medication regimen. But often times I find just an explanation goes a long way of, you know, the importance of taking them and why they are taking them…"
> -female shelter staff participant

> "We have a nurse that comes twice a week, Tuesdays and Thursdays, from three to four-thirty, sometimes five, she's through Homeless Health Services, and then now they've also got a rotating schedule where we'll have a nurse here every fifth Monday from six to eight, so those guys who are working during the day and can't necessarily see somebody who do need to see somebody for medical reasons then
>
> can have that opportunity to meet with a nurse. I guess they're rotating them throughout the shelters in the area, from what I understood."
> -male shelter staff participant

<u>Support Services Needed</u>

Participants voiced support service needs at the shelter and community level. Participants reported having funds for cab vouchers or bus passes to help with transportation needs, though funds are limited. Needs among the shelters included more case management staff, nursing staff at each shelter to perform hands-on cares, and staff dedicated to helping persons in the community who drop in during the day. Participants said having an on-site case manager to help residents connect with services and coordinate appointments would be ideal. Churches United staff members give priority to residents for services, though also assist persons who stay at the shelter during the day. One participant commented on the need for a place where residents to exercise or play and for healthier meal options. Other services identified were long term psychiatric care, addiction counseling, and medical assistance revision. A participant explained that it can take a month for a resident to connect with a primary care provider, be seen and referred for a service, then actually receive the service. Participants at the YWCA suggested the need for having a sexual assault nurse examiner on call, and adding a question about medical needs on the shelter intake form.

Other needs voiced were directed to the health care community. Participants talked about the need for cultural competence and understanding of Trauma Informed Care principles among health care providers.

> "You know, I always wish that Sanford or Essentia had some sort of homeless liaison working there…sometimes I go with the guests to emergency rooms and I think there is a need for cultural understanding with Native people. I've seen things and heard things that are not very nice…when Native people do go to the hospital for different things, I've seen them being accused of med seeking…someone who is actually dying and in pain."
>
> -female shelter staff participant

"...better education in the health care system...I have witnessed first hand what happens to the uninsured or underinsured especially if they're repeat visitors...you know I want to just sit that nurse or doctor down and say, 'listen, do you realize that if we just invest in programs that kept people from getting this sick in the first place that you wouldn't deal with this anymore, and you as a community member would save a ton of money in healthcare costs and insurance...we're very committed to crisis driven care...so that's a big piece too, the ways that people are treated is just unbelievable...and again I think that every individual out there doing that is a good person, something just happens...in the system...they don't realize that the person they're looking at is trying to survive. This is truly survival. They're not just trying to come in and be a pain...it's survival."

-female shelter staff participant

Participants acknowledged the difficulties that health care professionals have with discharge planning for homeless patients, and the understanding that there is no transitional alternative available. Relationships among hospital staff and shelter staff are strained when hospital policies prohibit patients from staying longer than medically necessary and shelters are not equipped to handle medical needs.

"...other situations, we've had people that have had surgery, really significant surgery, the hospitals call us, and you know they probably don't feel good about it either, but they don't know what else to do...their own policies don't allow them to keep people beyond what their needs are. They know full well we are not equipped to deal with those folks..."

-female shelter staff participant

Other participants voiced concerns about the lack of affordable housing and affordability of health care services. Some participants said medical bills are a big problem for some residents, and are unable to pay. Current health care costs present a barrier for residents who wish to access health services without insurance. Affordable housing was also reported as another problem contributing to homelessness. One participant talked about the increase in the number of homeless persons in the area. He said the issue is a combination of factors, namely the national economy and the oil boom in western North Dakota.

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"It's a combination of the economy…we are getting folks from all over the country…they've [sheriff department] been sending them either to Bismarck or Fargo…if you don't have work you don't have housing…you're gonna be on the street, which is a community issue…there was a story about other sheriffs…sending men here…so it's not that folks are necessarily always choosing to come here, there's a lot of reasons…back-migration now of going out there, can't find work, or that I did find work, the realization that I might be making more money, but housing costs so much more, so percentage wise I'm really not that far ahead…and housing out that way is a huge issue…nonexistent…looking at our statistics…January through August, of the new check-ins who came here, 41% said they'd been homeless for 1 month or less…the wave of folks that we're seeing now a lot of new homeless… "

-male shelter staff participant

One participant suggested the need for lenient landlords who would allow residents with a section eight voucher, and the apartment vacancy rate in the Fargo area is currently two percent. Shelter residents are often allowed to stay beyond the time frame allowed when waiting for housing. The waiting list for housing was reported to take six months to two years.

Shelter Options During the Day and Night

Participants said the options are few for shelter during the day and night. Shelters vary in resident capacity and policies for stay and departure. As previously mentioned, residents at the Churches United, Dorothy Day, and YWCA shelters may stay during the day. Residents at New Life Center may stay on a first-come-first-serve basis, and though they must leave during the day, meals are provided at scheduled times. The Gladys Ray shelter is a drop-in center for Veterans, though staff members choose to allow other residents to stay as needed.

"They walk the streets…otherwise they go to the Social Club next door, or they'll go from place to place for meals like Salvation Army and New Life…and basically just kind of walk around. They can't hang out in one place, you know, the police will move them around…you have to have a diagnosed mental illness to go there [Social Club]…and especially if you're drinking, you know, if you have chronic addiction there's not a place where you can go and hang out, you know here, you're allowed to

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be here if you've been drinking, we just go by behavior...but then again, it's hard because...our funding is only for Veterans..."

<div align="right">-female shelter staff participant</div>

"...really there isn't any place for people to go, they can only go to anywhere that they're going temporarily and everywhere that they're going they have to put up with traffic and the weather and whatever conditions are out there. As shelters we would love to have it be different, but we don't have the resources either. It's not like I have staff and a bus that I can start bussing people so they can at least get to breakfast at Sallies [Salvation Army] early enough or without having to walk in twenty below or whatever. So right now there're just so few places, in fact when you read the sign on our front door that says, you know, there's no trespassing, you can't be hanging out on this property until 15 minutes before and we really discourage you from hanging out on, you know, other areas, surrounding properties, it's a respect issue for the neighborhood. But it says right in there, we understand there are very few places for you to go, and I wish we could change that, either way we have to protect this shelter and respect for the neighborhood...people don't have anywhere to go."

<div align="right">-female shelter staff participant</div>

During the night, homeless persons were reported to be sleeping in a variety of places aside from shelters. Some homeless persons were said to prefer sleeping outside, and often shelters are full, especially during the winter season. With reports of homelessness increasing, the FM Sheltering Churches Project began in 2012 to provide temporary overflow shelter. Nine local churches have participated in the project.

" Yep, they do have the church sheltering...they do sleep out, you know they   have the sleeping bags that are for, you know, forty below or something like that, and that is usually a lot of the veterans, will sleep out or can't deal with being around people...But they do sleep out down by the river, or in different parks, areas where they can hide..."

<div align="right">-female shelter staff participant</div>

"I really believe we have more people sleeping outside now than we ever have. And one of the things that we were always able to do was figure out where to put people, either at other places in our building...like other shelters, we're always so full...we can't get so full that we can't keep everybody safe...we know lots of people are sleeping in their vehicles...I've found people sleeping anywhere there's a fence line...smack in the middle of the city...homelessness is so invisible here...found a guy sleeping directly on 32nd avenue, and it was seven in the morning, traffic was crazy...so I've learned to look at things differently...underpasses are big...people are sleeping everywhere...entrances to apartment buildings are huge...also storage

units…if you were to just hang out down here on the corner and just sit for a minute, and all of a sudden people just seem to come right up out of the ground, it's like, where'd you just come from…that's why."

-female shelter staff participant

Health Service Staff Interview Data

Two data collection methods were used with health service providers. A total of 14 health service providers were interviewed individually or as a group based on participants' preference. All participants interviewed were female, and included registered nurses, case managers, and social workers. Interviews lasted from about 20 minutes to 90 minutes, and the researcher allowed time for additional discussion. Health service staff participants' responses are categorized in the table below and follow the same format.

Table 2. Health Service Staff Participant Interview Themes

Theme	Description	n=14	
Health Needs Encountered *(Needs)*	• Similar to general population • Counseling • Rehabilitation, life skills training • Sub-acute needs • Isolation for infectious disease • Comorbid conditions • Co-occurring mental illness and chemical dependency • Primary care/consistent care • Dental care • Prescription assistance • Safe place to store belongings		
Barriers to Health Care Access *(Contributing Factors)*	• Transportation • Difficulty coordinating care • Lack of insurance/finances • Diminished self worth • Fear of judgment • Mental, physical limitations • Substance abuse • Limited hours at Homeless Health Clinic • Prevalence of treatment first principles	• Limited access to substance abuse treatment in ND and MN • Lack of trust in providers • Inability to prioritize health care • Lack of life skills • Societal views of homelessness • Stigmatization • Long waiting lists for psychiatric care • Limited affordable housing	

(continued)

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Table 2. Health Service Staff Participant Interview Themes (continued)

Theme	Description	n=14
Discharge Planning *(Contributing Factors)*	• Difficult to place • Often need cares beyond shelter capabilities • Detox/crisis center if intoxicated • Bus station • Estrangement from family • Shelters, often full • Shelter staff hesitant to accept discharged patients • Delayed discharge • No transitional level of care available • Difficulty securing medical supplies • Home needed to provide home services	
Services Available *(Assets)*	• Psychiatric agencies, outreach • Public Health clinic services, street outreach • Prescription assistance programs, limited access • Shelters, church sheltering project • Salvation Army • Hospital services • Detox centers • HERO • Housing assistance programs, referrals • State/Federal programs if meet criteria • Substance abuse treatment programs, limited access	
Services Needed *(Needs)*	• Transitional level of medical care • Hands-on nursing care, more staff in shelters • Shelter case management • Long-term care • Trauma-Informed Care/Harm Reduction training • Housing First model • More affordable housing	
Respite Needs *(Needs)*	• Frequent need among homeless patients, residents • Shelters unable to provide step-down level of care • Many sub-acute care needs • Risks for readmission without transitional care/recuperation	

<u>Health Needs Among Homeless Patients</u>

Many of the health needs reported by healthcare staff participants echoed the needs

reported by shelter staff. Needs commonly mentioned were lack of transportation to

appointments, lack of insurance and ability to fill prescriptions, and inability to manage

chronic conditions. Some participants said homeless health needs are similar to those of

the general population but with significantly more barriers to managing their health.

> "…I think their healthcare needs are just like the healthcare needs of anybody
> else, the only difference is, I think, managing…they have a more difficult time
> managing…if you and I were on multiple medications for a complex condition
> like diabetes, we would have the where-with-all, the support at home, and
> education…and it would still be hard for us to manage…a lot of mental illness,
> though…I would be 90 percent of homeless people have some sort of mental illness
> they're dealing with…"
>
> <div align="right">-female health service participant</div>

Medical needs of homeless patients were said to be more complex and increasing,

and the ability to get comorbid issues treated is limited.

> "Seems like we have issues all the time, especially someone just needing a couple
> days worth of antibiotics, or something that they can't go to the shelter because
> there isn't a nurse there long enough to help assist them…there's always a need.
> Something simple, too, just to get oxygen for a couple days…keep their O2
> saturations up after getting over a pneumonia, that's really common. However, it's
> really frowned upon in the local shelters. I find isolation and any infectious disease
> to be a barrier sometimes. It used to be, 10 years ago when I started here, the big
> thing was, 'are they HIV positive?' But now we're talking, you know, CRE, KPC,
> MRSA, CDIFF, and we have these bigger superbugs that are becoming so much more
> commonplace…so it becomes something as simple as changing your socks or
> showering in a homeless shelter can become an infection problem…I find the
> problems are getting bigger and bolder around here, with the shelters being full, and
> the medical things…even a wound vac for a week becomes an issue…they're more
> complex patients that are being discharged to the shelters…"
>
> <div align="right">-female health service participants</div>

> "Definitely the complexity is growing, and the volume is growing…and the ability to
> get their comorbid conditions treated. You know, a lot of these people have
> secondary addiction and mental health issues, and you can't get them in on either
> side of the border to see mental health professionals anymore. Everything is being
> offset to Family HealthCare, and they're exhausted, I mean they can't get it done…A
> lot of service providers feel that the mentally ill and the chemically dependent are,
> of course, there's the balance of, is the treatment being sought for the purpose of
> housing? So then we have a lot of denials for the homeless population that maybe
> wouldn't be denied if they had a place to go afterwards."
>
> <div align="right">-female health service participants</div>

The frequency of encounters with homeless patients varied and depended on work setting, role, and time of year. Participants reported that homeless persons seek care at Sanford Health more often than Essentia Health, likely due to location. During the winter, more needs are seen among homeless patients with conditions exacerbated by cold, such as congestive heart failure, chronic obstructive pulmonary disease, hypothermia, and loss of digits. Emergency room staff members encounter homeless patients daily, whereas encounters are occasional to weekly on general floors. Typical needs for hospitalization were said to be for complications of uncontrolled conditions. Emergency room visits were said to often be for medication needs, exposure to cold, or detoxification, though many visits are also for food and temporary shelter. Homeless patients were reported to seek health care sporadically or for emergent needs, and may not see a primary provider. Participants stressed the need for homeless patients to be connected to a regular provider to shift away from crisis-driven care.

Barriers to Health Care Access

Reported barriers to health care access and unmet health needs also mirrored responses from shelter staff participants. Comments were consistent with the theme of impaired ability to manage care. One participant stated that homelessness itself translates to unmet health needs, and health is not a priority if a person does not have a home. Lack of health insurance and assistance was contrasted with views of homeless persons as resourceful.

> "We also I think do have some of the patients that fall in the state of North Dakota that don't get any medical assistance. So, they aren't permanently disabled by social security standards, they may not be able to actually even pursue that, and they're between 21 and 65. We're seeing a few more of those, and there's very little you can tap without a payment source."
> -female health service participant

"...for instance just to go to Homeless Health...they say if your patient's really not there and waiting by 8 or 9, they said they probably won't be seen, and that's it. So if you have somebody on a Friday afternoon that needs medications, we'll send them home more than likely with a week's worth of meds, but they're gonna be billed for it. And if they don't pay their bill in ten days that gets turned over to collections, and they do that too many times and we'll stop giving them the meds from Mills Avenue even. So, it's tough...I don't believe every homeless person is vulnerable...they're very self-sufficient people for the most part...users of resources and very system savvy...many times they teach me a thing or two when they come in, but it's these medical barriers that are a challenge for us."

-female health service participant

Homeless persons are often offended by providers or fear judgment, and some lose trust in providers to the point of unwillingness to return for care. Some participants said it takes weeks to establish trust with homeless patients or residents at a minimum. One respondent commented on the prevalence of a history of trauma, abuse, and exposure to violence at a younger age seen among homeless persons, and often their ability to cope and work through conflict is impaired. One participant commented at length about the historical and cultural views of homelessness and mental illness as barriers.

"I think the biggest barrier, though, is the same barrier that makes somebody homeless in the first place, which is inability to prioritize care. And that's often a very organic inability that comes from mental illness. And I think in our country in general we do not treat mental illness like other illnesses...we have a mind-body separation that's very clear and distinct. Other countries have managed to integrate that a lot better than we have...as long as you have money and insurance, you can see psychiatry and get medications and you can better manage those things...but if you don't, you're just kinda out of luck. And we also just don't take care of people who simply can't take care of themselves. We need to judge them, we need to say the reason is because they refuse this or they won't do that, they're lazy or they, you know, want to use the system...and it's just not the case...and I think that we just don't value people who we consider to be as highly functioning as we think people should be...and that extends to how much care they should receive, even how much compassion they should receive...we can't be okay with saying, you know, some people just need to be taken care of...there's an innate moral and ethical obligation to care for people who can't..."

-female health service participant

Other barriers identified among participants included limited access to appropriate substance abuse treatment services. One participant discussed the programs available for homeless persons with co-occurring mental illness and chemical dependency in contrast to the limited resources for those with chemical dependency alone. Harm reduction principles were said to be used with those dually diagnosed persons, but only traditional sobriety-based programs are available for substance abuse treatment, which was said to be ineffective. Some homeless persons have never been engaged in substance abuse treatment services.

<u>Discharge Planning</u>

Participants collectively voiced that discharge planning for homeless patients is difficult. Homeless patients were said to be medically stable to leave the hospital but in need of a lower level of care that is not available. Medically stable to leave the hospital was not viewed as stable to go to a shelter. Some participants voiced concerns about homeless patients' ability to access appropriate resources after discharge, as well as the scarcity of appropriate places for discharge.

> "In the emergency setting, unfortunately we, as I say, "treat and ship," we treat the immediate problem and send them to detox, we send them to shelters that will take them. We don't do a whole lot. I try to give them business cards for case managers if they'll take it, most of the time they have a case manager, but especially at night we don't contact...I try to provide the emotional support to tell them that there are the resources out there for them...we try to not just discharge them to the streets and say 'here's the door'...we try to get them somewhere safe, whether that's detox or one of the shelters...if they've been drinking it's easy, they go to detox...you run into the problems when the shelters are full, especially if it's winter time,
>
> because then you have nowhere to send this patient, and you have to put them somewhere, you can't just let them go outside..."
> <div align="right">-female health service participant</div>

A participant stated roughly 90 percent of homeless persons seek care in the

emergency room for medication refills or are found on the street or in a park. Other

reasons homeless persons access care in the emergency room included food and temporary

shelter.

Other participants said hospital discharge may be delayed if an appropriate place is

not available, and length of hospital stay was said to be longer.

> "We could just all confirm it's [length of hospital stay] longer. If they need
> assistance or services, it will be longer. We don't have programs designed for
> homeless after care. And weather does make a difference on that. You just can't
> send somebody out with no clothes, no home, and no plan when it's twenty below
> out. You have to at least try to come up with some way to help.
> -female health service participants

Housing status is not specifically assessed beyond nursing admission form

questions, and some patients provide a post office box number or shelter address. Hospital

admissions of patients who are homeless are also not tracked due to the lack of admission

questions that would trigger an assessment as homeless. No formal discharge protocols are

currently in place for homeless patients but are being developed.

<u>Supportive Services Available</u>

Participants verbalized several agencies and programs in place that they collaborate

with, listed in table 2. Family HealthCare and Homeless Health Services were viewed as

critical in support of the area homeless population's health needs.

> "You do what you can…we certainly do try and be proactive with the homeless
> population so that on day one of admission as opposed to day three trying to figure
> out when they can get their appointments at Family HealthCare so you can get the
> transition as close to the day of discharge as you possibly can…so I think we try and
> do all that and get them as much equipment and as much staff   as we can service
> them with when they're on their way out the door. But it's a huge barrier and a huge

challenge for us…we have cab vouchers…ten dollar Wal-Mart gift cards…we're able to give some medications through our Friends of the Family fund…again, it's transportation…we do whatever we can with community projects…"

<div align="right">-female health service participants</div>

"Starting with a new patient…through our grant we are required to provide assessment and options for mental health and substance abuse. With the spread of Housing First models…we also now incorporate that housing assessment at the first visit…I have an intake that I do with them to figure out where they're staying, how'd they end up there, how long have they been there, what kind of history do they have as far as criminal or psychiatric…my approach is Harm Reduction, so it's very engagement related, meeting them where they're at, so whatever they think is important to them might not be the same things that we see as important to them, and just starting to work with them there…earning trust and building a relationship so that down the road we can address those other things as well…we have relationships with service providers in the community…so we can get people connected…

<div align="right">-female health service participant</div>

Homeless Health Services staff members were reported to work closely with Public Health staff members to provide testing for tuberculosis and immunizations, and a nurse from Homeless Health Services performs street outreach. Additionally, residents in permanent supportive housing such as Cooper House receive health education in a group and individual setting, and a nurse assists with minor cares and medication management 20 hours per week. Residents who need surgery may quality for Sanford Health's Community Care program we well.

<u>Supportive Services Needed</u>

Participants expressed concerns about the limited hours and scope of shelter nurses, and many agreed more nursing staff who could provide hands-on care is needed. Some participants said shelters could use more staff members in general. Other concerns were voiced regarding service delivery for mental health and substance abuse.

"…Our providers can prescribe psychiatric medications and so we are often the gap filler for the mental health providers because it is so hard to get in to see psychiatry. So our providers will prescribe medications until they get hooked

up with the appropriate services…we have a very traditional approach to substance abuse in North Dakota, and our patients do not fit well in those…that real traditional approach, too, kind of shame-based, in your face, sobriety and abstinence is the only acceptable option, doesn't work for these patients. We have a dual-diagnosis treatment program through Southeast [Human Services] but their capacity is so limited and those individuals that they serve are dually- diagnosed so they have to have serious, persistent mental illness to be qualified…a lot of our patients have never been diagnosed…so they don't really fit that criterion…so that's a really big barrier that I see for some of the more vulnerable, high-risk individuals that are out there that have never been engaged in services…because nobody's looking at the fact that these are very chronic individuals that will probably never stop drinking or stop using, but we can reduce the harm…"

-female health service participant

The Harm Reduction approach described above was recommended for use by all service providers working with homeless persons, and is not widely embraced. Coverage for substance abuse treatment was also a concern, as many homeless persons have never been engaged in services and lack health insurance.

Affordable housing was said to be another significant need in the community. Housing First principles rest on the premise that a homeless person needs a home to be able to break the cycle of homelessness. Long term housing for people who cannot care for themselves was also viewed as a need.

"…it [homelessness] was directly related to the deinstitutionalization, and all those places shut down and all of a sudden we started seeing a lot of homeless people who had a lot of severe mental illness because there was nowhere else for them to go. Their homes were shut down…and this is where we are now…we need more long-term care…we don't have long-term care facilities to help people recover…I think that we still aren't addressing that we need some of those institutions back…I know that we have a much too loose definition of what's considered potential for harm to self or others…so I think we've swung too far…the other way, we need to back it up a little and say you know what, sometimes people are hell-bent on destroying themselves and we have to intervene…"

-female health service participant

An example of the need for long-term care was provided with the story of a homeless male who was noncompliant with care, had a history of schizophrenia, and was

admitted repeatedly for severe hypertension. He was said to exhibit volatile behavior in

public settings and swallow batteries, and could not be committed to any sort of institution

because he was not considered a direct threat to himself or others.

<u>Respite Care Needs</u>

Participants corroborated the need for a medical respite facility in the community.

Many participants provided examples of cases in which respite care was a need, and

reported a variety of situations in which homeless persons would benefit from respite care.

Relationships were said to be strained among hospital staff, shelter staff, and Public Health

staff because of the lack of a lower level of care for homeless persons to access.

> "...I would venture to guess that there is probably a pretty significant need for
> that because the shelters generally, I would imagine, aren't equipped to be
> providing care, recuperative care for people. They just aren't staffed to do that.
> And we're not really providing care for that either...so, there is a gap in what we do.
> A home care agency has to have a home to go to provide a service...I have no idea
> what happens with those people, frankly...we really aren't addressing those
> needs...as Public Health...I think we would need it, too, because we send people out
> of the jail...we have our detox, and we have people there that could probably use
> another level of care...we're part of the problem, too, in a sense, we're discharging
>
> out there without a real plan for people...with the clients we do see, trying to keep
> them in their homes, keep them stable, keep them growing but we're not filling a
> gap either..."
>
> <div align="right">-female health service participants</div>

Participants in Public Health stated that a respite program would ideally

accommodate residents from both North Dakota and Minnesota, and that the location will

make a difference in funding sources.

A respite care program was viewed as a place to connect homeless patients with

services and resources, facilitate recovery from illness or surgery, store and administer

medication, and a chance to perform in-depth education. Participants confirmed the

burden currently placed on shelter staff to accommodate health needs, and that a respite program would help alleviate this burden. Participants in the hospital setting viewed a respite program as beneficial for nearly all homeless patients. Even in the permanent supportive housing setting, Cooper House residents who have surgery and are discharged to their apartment were said to often need a lower level of care and monitoring. Cooper House staff members check on residents, but do not have any medical training.

Respite care was also viewed as a potentially a significant cost-saving program, and a solution to address the need for a transitional level of care in the community.

> "…it [respite program] sounds wonderful…I think most people agree that Housing First is the goal, but until we get there, and I don't know that we ever can get there because it keeps growing, it'd be really nice to have something to be able to look at whether it's a day or a week even…in the long run it would probably save the health system a lot of money…who pays for that?…I think if we saw the Cooper House and Gateway Gardens and the Gladys Ray shelter, I believe anything's possible if you get the right people in the room…it's too good to be true…to go directly to living in a shelter where you have to walk the streets all day is a lot of times a recipe for readmission and failure because truthfully any of us who have been hospitalized know, what do you do the first couple of days, you just want to lay down…that transition period may not keep them from being homeless in the future, but be huge in that ability to get somebody to a strength level that they can…be able to do the things they need to do to prepare for housing…could really be huge for the health care system and those people…the conversation in the community has been long-standing about if you just keep putting all the money into shelter beds, that's the only resource we're gonna have…"
> -female health service participants

Most participants reported encountering homeless persons weekly to monthly who would benefit from respite care services. The issue of funding for a respite program was questioned by some participants, and was said to depend on community partnerships and states. Funding may have to be creative, involving many different agencies and partnerships.

Health Service Staff Survey Data

A total of 29 health service staff members responded to a written survey at Sanford

Health and Essentia Health. Sixteen participants were employed in the ER setting, eleven

were employed in case management, and two were employed in the critical care setting.

Most participants identified themselves as registered nurses working the day shift.

Table 3. Health Service Staff Sample Characteristics

Characteristics	n(%) n=29
Department (n=29)	
Emergency	16(55%)
Critical Care Services	2 (7%)
Case Management	11 (38%)
Role (n=29)	
Registered Nurse	21 (72%)
Social Worker	6 (21%)
Case Manager	1 (3%)
Paramedic	1 (3%)
Shift Worked (n=29)	
Day	19 (66%)
Night	4 (14%)
Rotating	6 (21%)

Health service staff members' survey responses are categorized in table 4 below and

follow the survey format.

Table 4. Health Service Staff Survey Data

Care for Homeless Patients *(Needs, Contributing Factors)*	n(%) n=29
Hospital Census (n=25)	
Full/over capacity	19 (66%)
Low/under capacity	3 (10%)
Variable	3 (10%)
Housing Status Tracked (n=29)	
Yes	17 (59%)
Tracked on admission (n=17)	12 (41%)
Encounter Homeless Patients (n=29)	
More than once a week	9 (31%)
Once a week	7 (24%)
Once a month	8 (28%)
Once every few months	4 (14%)
Varies	1 (3%)
Whom Encountered (n=29)	
More single homeless men	23 (79%)
Equal numbers of single homeless men/women	6 (21%)
Hospital Discharge Policy (n=27)	
Yes	6 (21%)
Policy needed (n=20)	15 (52%)
Discharge Planning Difficult (n=29)	
Very difficult	10 (34%)
Difficult	13 (45%)
Somewhat difficult	5 (17%)
Not at all difficult	1 (3%)

(continued)

Table 4. Health Service Staff Survey Data (continued)

Care for Homeless Patients _(Needs, Contributing Factors)_	n(%) n=29

Barriers to Discharge (n=28)
- No safe place to discharge
- No finances or insurance
- No family or support
- No transportation
- Shelters unable to accommodate medical needs/are full
- Most shelters do not accept intoxicated patients
- Noncompliance with treatment
- Unwillingness to go to shelter or leave facility
- Winter weather
- Personality conflicts
- No follow-up
- Extra time needed to place
- Language barriers
- Requirement for guardianship without anyone to accept
- Difficulty attaining medications and medical supplies
- Case management not readily available
- Lack of patient information

_____

Discharge Delayed (n=29)

More than once a week	2 (7%)
Once a week	3 (10%)
Once a month	9 (31%)
Once every few months	5 (17%)
Once a year	1 (3%)
Less than once a year	8 (26%)
Don't know	1 (3%)

_____

Discharge Location (n=15)
- Shelters
- Detox
- Nursing home
- Wherever available

_____

Adequate Existing Resources (n=29)

Yes	5 (17%)
Don't know	1 (3%)

_____

(continued)

Table 4. Health Service Staff Survey Data (continued)

Care for Homeless Patients *(Needs, Contributing Factors)*	n(%) n=29

Resources Referred (n=26) *(Assets)*
- Transportation
- Case Management
- County Social Services
- Homeless Health Services
- Family HealthCare
- Shelters, Detox
- Rape & Abuse Crisis Center
- Public Health
- Psychiatric Services
- Salvation Army
- Nursing home
- Home Health
- WIC
- VA
- Parish nursing
- Prescription coverage
- LTAC facilities

Health Status Upon Discharge (n=29)	
Not sick, fully recovered	3 (10%)
Still sick, mostly recovered	19 (66%)
Sick, more time needed to recover	6 (21%)
Other	1 (3%)

Medical Respite Needs (n=29)	
24-hour care/observation	6 (21%)
Intermittent care and/or case management	16 (55%)
No care, just safe place to stay during day	6 (21%)
Respite services not needed in community	1 (3%)

Length of Respite Stay After Discharge (n=29)	
No medical respite needed	4 (14%)
Less than one week	7 (24%)
1-2 weeks	17 (59%)
Other	1 (3%)

(continued)

Table 4. Health Service Staff Survey Data (continued)

Care for Homeless Patients *(Needs, Contributing Factors)*	n(%) n=29
Needs Upon Discharge (n=29)	
Rest	24 (83%)
Medication management	22 (76%)
Dressing changes, nursing cares	19 (66%)
Coordination of follow-up care	24 (83%)
Transportation to follow-up appointments	21 (72%)
Help accessing insurance/benefits	20 (69%)
Oxygen	10 (34%)
IV therapy	13 (45%)
Health Education	22 (76%)
Other needs*	

*Rehab (life skills), Home Health, PT, OT, Hospice, Diabetic education, wound care, 24-hour supervision, anticoagulation injections, long-term antibiotics

Patient Conditions (n=29)	
Physical illness or injury	19 (66%)
Mental illness	24 (83%)
Chemical dependency	28 (97%)

Diagnostic Related Group [DRG] Codes Used (n=26)	
Yes	16 (55%)
DRG report created (n=16)	4 (14%)

Sobriety Not Required if Respite Patient (n=29)	
Less than 50%	7 (24%)
About 50%	13 (45%)
More than 50%	9 (31%)

Other Comments *(Needs, Contributing Factors)*
- Population often see as not following through but lack of finances, transportation to follow-up appointments are barriers
- Glad this is being looked into
- Need shelters open 24 hours per day and accepting intoxicated persons
- See a lot of injuries versus medical needs for care
- Need more case managers in community
- Many homeless patients have addictions that cause traumatic brain and spinal cord injuries
- Often no family or financial support
- Area has limited appropriate services
- Uninformed or limited experience
- Definitely a need for respite program in Fargo-Moorhead community

<u>Care for Homeless Patients</u>

Two-thirds of the sample considered their hospital census to be full or over capacity. Most participants reported encountering homeless patients more than once a week, and the majority were said to be homeless men. Many participants were unsure or denied knowledge of specific discharge policies in place for homeless patients, and most viewed the discharge of homeless patients as difficult. Barriers to discharge reported by participants are illustrated in Table 4 and characterize a lack of sufficient resources. Delay of discharge was reported to be mostly once per month, and the majority of participants reported discharging homeless patients to shelters. Two-thirds of participants felt that homeless patients are typically not well, though mostly recovered upon discharge.

<u>Respite Needs</u>

Most of the sample reported that most homeless patients they cared for would need intermittent nursing care and case management, though six participants also felt 24-hour care would be necessary. Participants anticipated the length of a respite stay to be about one to two weeks after discharge. The needs upon discharge illustrated in Table 4 were considered necessary by most participants. Some participants also reported other services that they felt were typically needed upon discharge. The majority of participants viewed homeless patients as suffering from physical and mental illness, and all but one participant also reported chemical dependency as well. Participants also thought that about half of patients who could use respite care would need a place where sobriety is not required. Other comments made at the end of the survey allude to views of the need for expanded resources for homeless patients.

Homeless Participant Interview Data

To address objective two, surveys and individual interviews were conducted with homeless individuals to capture the consumer perspective. A key facilitator that made objective two achievable was collaboration with shelter and clinic staff members who had established trust with homeless participants. Staff members were able to help recruit appropriate participants.

A total of eight homeless persons were interviewed privately with the researcher. Seven participants were male and interviewed at shelters. The female participant was interviewed at Cooper House apartments. Interviews lasted from about 10 to 45 minutes, and the researcher allowed time for additional questions and discussion about homeless situation and participant elaboration. Homeless participant interview responses are categorized in table 5 below and follow the interview format.

Table 5. Consumer Participant Interview Themes

Theme	Description	n=8
Usual Place for Health Care & Emergency Room Use *(Contributing Factors, Assets)*	• Family HealthCare clinic, Homeless Health Services clinic most reported • VA • Emergency room use rare to occasional	
Health Status *(Contributing Factors)*	• Fair to poor • Some medical and mental health issues being treated, others not • Waiting for surgery, concern • Quality of life impairment • Inability to work related to medical issues	
Hospitalization *(Contributing Factors)*	• Medical reasons • Detoxification • Some evidence of disrespectful treatment	
Discharge Location *(Contributing Factors, Assets)*	• Friends, family if available • Motel, Single Room Occupancy, or shelter	
Barriers to Health Care *(Contributing Factors)*	• Lack of insurance or funds for treatment • Difficulty getting transportation • Trying to find or maintain a job before addressing medical needs	
Unmet Health Needs *(Needs)*	• Most health needs met at FHC and HHS • Medication coverage • Treatment or surgery • Rehabilitation after stroke • Pain management • Transportation • Eyeglasses	
Other Comments *(Contributing Factors)*	• Homelessness due to medical reasons, family dynamics, economic/job related, substance abuse • Desire to get "back to normal life" and find work • Lack of family or support system • Focus on ability to survive • Estrangement from family	

<u>Usual Place for Care and ER Use</u>

All homeless participants except for one who was a Veteran identified their usual

source of care as Homeless Health Services or Family HealthCare. The emergency room was

also identified as a usual source but rarely utilized.

"I used to before this place I'd just go to the emergency room, and a lot of people still do. I used to use it [ER] once a month for meds, now never."

-male consumer participant

"Once in a while because it's hard for me to breath because I go to dialysis four times a week, and too much fluid build up in me…so they keep me overnight…"

-female consumer participant

"Usually I am working and go the clinics and things like that…I came up here because I was having some problems…I go to Homeless Health…they know me pretty well there. If something's going on with me and I'm getting worse and worse, I go there every two months to get antibiotics and mostly because of my ears…"

-male consumer participant

Most participants reported utilizing ER services once or twice a year for problems associated with ongoing health issues. Some also reported seeing a primary care provider at Family HealthCare.

Health Status

When asked about their health status, participants discussed current health issues and views of how their health could be different. Many explained how they currently work to manage their health needs and expressed a desire to move forward in their lives. Health issues discussed included chronic medical problems, pain, injuries, and mental health issues. Some participants were considering the need for filing for disability benefits or were awaiting benefits due to health status.

"Right now it's…hard for me to breath at times, I can't really focus on things, on my tasks at hand. I feel, like, dizzy most of the time, even with the medication I have, sometimes it's hard for me to even go up these stairs…to do my chore…I'm gasping for breath…and I still have to take my time to work and do my job. It's gotten worse and worse…when I am feeling good I try to push it…I get dizzy…I talk to them up there 'til I'm blue in the face, I don't know what to do half the time, what paperwork I gotta fill out and all this other stuff, I don't know if it's red tape or not…I just like to have an answer…if I can't get it [inner ear surgery] here, I'll go some place else…it's painful…I've tried [working a regular job]…they're working with me…heading towards…file for disability…that's good and dandy, but let's take one step at a time…see what the doctors say…"

-male consumer participant

"Oh it's [health status] better, I mean, because of Family Health…they have made it a lot better for me, you know, working with me…for a while there they had me going every day…they have done a lot of good things…I'm trying to get back to somewhat a normal life…pluggin' away, waiting to see if I'm gonna get disability or not, 'cause they told me I can't work…last time they checked me for congestive heart failure, they said I'm very high risk…I do have it checked at least three or four times a week…I'm very cautious about what I eat, no sodium…my favorite, dill pickles, and I can't eat 'em…

-male consumer participant

Most of participants' health issues were currently being managed, while others were waiting or chosen not to be addressed. Many participants reported working with a primary care provider and a case manager to address their health needs.

"…can't afford surgery…if it [back, herniated disc] goes out, I'm through, you know what I mean, I'm not gonna be able to go to work or anything…they said if it bothers me again they've got in on record, you know…then they can look it up…I had an MRI and all that junk…

-male consumer participant

"…and pain medication for my shoulder which I dislocated a couple years ago, and they wanted to send me to Omaha to get surgery, you know…I'm kind of at a lack of funds, and I don't want to go all the way to Omaha, need some money to cover myself…so I'm trying to tough it out, you know, see if my shoulder gets any better. It hasn't came out in a while, but I did daily labor a week ago…still kinda sore…"

-male consumer participant

Hospitalizations

Some participants reported no hospitalizations while experiencing homelessness. The participants who did report hospitalizations were for chronic medical issues, injuries, and substance abuse or detox. Most experiences during and after hospitalization were said to be positive or satisfactory, though one participant reported positive and negative experiences.

"...the last two years I'm just wore out...I think they could've done better...my congestive heart failure, that was in April of 2011, at that time they took pretty good care of me. When I had my stroke, basically they in a couple days, they wanted me out of that hospital because I did not have insurance...when I left there, my blood pressure was extremely high...190 over 114...here [shelter] because I had no other place to go. And I contacted Homeless Health, and they couldn't believe they discharged me with that kinda blood pressure...no, because I didn't have insurance [for rehabilitation], when I went there they asked for a co-pay, which I didn't have, and said 'well, there's nothin' we can do for you'...one time type visit...so a lot of that stuff goes on...when I was there [hospital] in 2011, they treated me like a king. When I had my stroke, I had a doctor, the only thing he said to me was, 'how're you gonna pay for your hospital bill?'...and my comment was...'I thought you were suppose to be a doctor, not a bill collector'...but the nursing staff and the other doctors that talked to me were fantastic...and he's the one that said you're good enough to go out the door [discharged]..."

-male participant

Participants who had been hospitalized while homeless reported being discharged to a shelter, a temporary apartment, motel, with friends and family as able, or back to permanent supportive housing if a resident. Most of these participants said they received the care or services they needed after discharge.

Barriers to Health Care

The two barriers most frequently cited by participants were lack of insurance or finances, and limited transportation. Few participants reported a source of health coverage. Some participants were not able to walk distances due to chronic medical issues. Other participants reported a need for surgery, but were uncertain how their surgery would be covered and where they would go afterward.

"Insurance...yeah, that's a big thing, you don't get the health care that other people do..."

-male consumer participant

"...they're [shelters] not really equipped...I don't think, they wouldn't purposely just boot me out on the street and say 'fend for yourself,' but in the event that they do do a bypass or something like that...I'm sure that a person needs to rest for a period of time and then go back to doin' what he's doin'...even at an old folks home, at least they got medical staff aboard...funds is a big concern, I mean, if it's not, well

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then you're just looking for something, you know, but nothin's for free, and you know that...bus passes would be a good thing...I don't know how you'd get them to people deserving...I've seen people get those and not here, per se, but get those and have a pocket full of 'em and run down to the corner and say, half price, you know, crap like that, and then the system doesn't work anymore because of that...people bein' greedy and takin' advantage of stuff like that..."

<div align="right">-male consumer participant</div>

Some participants viewed a respite or transitional care program as beneficial or needed in the community based on needs they have encountered.

<u>Unmet Health Needs</u>

The majority of unmet health needs reported by participants were related to lack of health insurance or funds, such as inability to afford medications or access specific services. Some participants, as stated, were considering or awaiting disability benefits. Most participants reported working with a case manager to access resources and following up with staff at Family HealthCare or Homeless Health Services for care.

"The only one [health need] that's not being met right now, that I'm not pushing for, is the psychological, okay...I'm not gonna push on that issue right now, that's for a different date, that's what I been trying to tell them...when I need you, I will call you...I'm talking about...the mental aspects of it..."

<div align="right">-male consumer participant</div>

"...I believe that Family and Homeless health, they have [met my needs] to the best of their ability...rehab [unmet need], yep my medications, that's no problem, 'cause...that program of Homeless Health, they take care of quite a bit of that, so, thank goodness for that..."

<div align="right">-male consumer participant</div>

Some participants also expressed concern about unmet health needs among other homeless persons they had encountered as well.

"...there's a lot of people that need to have other care that's just not getting done..."

<div align="right">-male consumer participant</div>

<div align="center">71</div>

"...yeah, they need to concentrate more on homeless health, they really do, 'cause there's a lot of people out there that're sick, and they're not tellin' anybody, they're just livin' with it, you know, 'cause they think, 'well if I go somewhere and I don't have any money, so, why even bother?'..."

<div align="right">-male consumer participant</div>

Other Comments

Some participants discussed the history of how they became homeless and factors that had contributed to their homeless situation. Some had moved to the area for medical care, while others moved to find work. Many reported estrangement from or falling out with family members and lack of support. Some also expressed the desire to live a life that they deemed normal, and issues that impaired their quality of life.

"...I was working for this place [shelter], I was an employee here...and then when I couldn't work for 'em, I didn't have no place to go anymore, so this is how I ended up here, which I'm thankful for...there's days I think I can [work] but then, when I try doin' something, whoa, better not..."

<div align="right">-male consumer participant</div>

"...it isn't so much of bein' homeless, or anything like that, I came up here because I didn't have any means to take care of myself. The family? No...there was some bad blood between us, and I will not accept their help, even if they offered it...I just leave that part alone...I have...step brothers and sisters around here, but I don't want anything to do with 'em, too much bad blood in the past...so I stay away from them, they stay away from me...I don't want, how do you say, interfere in their lives, and they don't interfere in mine...really bad memories...when I'm not working...I just feel out of place, I don't feel like I'm good enough to do anything...feel helpless...when this is feelin' better...ear isn't botherin' me, pain, I'm happy go lucky...but now, I just kinda look at ya like, hum drum..."

<div align="right">-male consumer participant</div>

Some participants' comments alluded to the ability to survive in the midst of other barriers to overcoming homelessness. One participant's comments characterized changed views of homelessness since experiencing homelessness himself.

"...well I work right now, steel construction, between forty and fifty-five [hours worked weekly], I just got this job...since February [been homeless]...bottom of the economy fallin' out [reason for homelessness], I come from Kentucky and

there was no work, so I tried to come to where there was work…I didn't even want to bother with that [going to Williston] 'cause there's no housing. I mean, there's plenty of work, but no housing…I now found an apartment…I'm what you could call probably a success story, you know, 'cause I gave it my best interest, I knew what I had to do, and I knew I didn't want to be in a shelter…tryin' to get on your feet's really hard, but if you're determined enough, you can do it…survival's first…keepin' food on the table, that's the main thing for me…I wanna do it for myself…I had my own business, you know, I used to look at people out there flyin' signs and think 'that'd never happen to me, man you know, why don't they just get a job,'…and then I am in that situation, and it just gave me a whole different outlook…"

<div align="right">-male consumer participant</div>

"…I got my application in for housing, but they said it was somethin' like three to six months, well, geez that's next summer…I need one now…many years [been homeless] since I got divorced 'in 85…I went wherever I could get work…I'm just waitin' on housing now, contact me, that's why I'm stayin' here, 'cause I wanna keep this address, 'cause if I move outta here and they send me a letter and it gets mailed back, well they'll cancel me out…and that's automatic. It's the same way with Social Security, they get a letter back, 'well, he's not in the state,'…I gotta keep in contact with Social Security, let 'em know where I'm at…when you deal with the government, they get a letter back, they shut ya off, no more money. And I sure don't wanna lose that. I don't get much a month, but what I do get I survive on…so I don't have to live this way anymore, have a place of my own, I know how to cook, I can survive, but I'm on a waiting list…"

<div align="right">-male consumer participant</div>

Homeless Participant Survey Data

The ages of consumer participants who completed the survey ranged from 18 to 63 years, and the mean age was 45 years. The majority of participants were male and reported Caucasian ethnicity. Just over half of participants reported there perceived health status as fair, while about one-third reported good health. While roughly half of the sample reported current physical and emotional or mental health needs, less than one-quarter perceived needs related to alcohol or drug use. Dental needs were reported by two-thirds of the sample. The majority of participants reported having a condition that limited their ability to work. Just under half of the sample reported some type of memory impairment that interfered with their daily activities. About one-third viewed their relationships as

sometimes close and warm due to their health, while another third denied having any close

relationships. Of the 38% of participants that reported past consideration of suicide, about

one-quarter made an attempt and sought help. Forty-seven percent of the sample had

medical coverage, and 21% were currently employed. Consumer demographics and

characteristics are shown below in Table 6.

Table 6. Consumer Sample Characteristics and Demographics

Characteristics	n (%) n=95
Age (years) (n=94)	
18-25	4 (4%)
26-35	14 (18%)
36-45	25 (26%)
46-55	35 (37%)
56-65	16 (17%)
Mean age	45 years
Age range	18-63 years
Gender (n=93)	
Male	55 (58%)
Ethnicity (n=94)	
American Indian/Alaskan Native	21 (22%)
Caucasian	57 (60%)
Black/African American	6 (6%)
Hispanic/Latino	3 (3%)
Multiracial/Mixed race	7 (7%)
Current Health Status (n=95)	
Good	35 (37%)
Fair	51 (54%)
Poor	9 (9%)
(Needs, Contributing Factors)	
Physical Health Needs (n=95)	
Yes	49 (52%)

Table 6. Consumer Sample Characteristics and Demographics (continued)

Characteristics	n (%) n=95
Emotional/Mental Health Needs (n=94)	
Yes	43 (45%)
Alcohol/Drug Problem Needs (n=94)	
Yes	20 (21%)
Dental Needs (n=95)	
Yes	69 (73%)
Limiting Condition (n=95)	
Yes	60 (63%)
Self Care Impaired (n=94)	
Yes	18 (19%)
Memory Impairs Function (n=95)	
Yes	44 (46%)
Relationships Due to Health (n=90)	
Very close and warm	18 (19%)
Sometimes close and warm	33 (35%)
Rarely close and warm	10 (11%)
I have no close/warm relationships	29 (31%)
Considered Suicide (n=95)	
Yes	38 (%)
Attempted (n=38)	22 (58%)
Sought help (n=38)	26 (68%)

Homeless participants' survey responses are categorized in Tables 7 through 10 below and follow the survey format.

Table 7. Consumer Survey Data: Medical History in Past 12 Months

Characteristic	*(Contributing Factors)*	n (%) n=95
Asthma (n=93)		
Yes		14 (15%)
Treated (n=14)		8 (57%)
Respiratory problems (n=91)		
Yes		13 (14%)
Treated (n=13)		9 (69%)
Exposure/Hypothermia (n=92)		
Yes		2 (2%)
Treated (n=2)		1(50%)
Hypertension (n=93)		
Yes		32 (34%)
Treated (n=32)		15 (47%)
Cardiovascular problems (n=92)		
Yes		12 (13%)
Treated (n=12)		7 (58%)
Diabetes/Renal Failure (n=94)		
Yes		17 (18%)
Treated (n=17)		11 (65%)
Tuberculosis (n=91)		
Yes		3 (3%)
Treated (n=3)		3 (100%)
Hepatitis/Cirrhosis (n=89)		
Yes		11 (12%)
Treated (n=11)		1 (9%)
Sexually Transmitted Infection (n=91)		
Yes		1 (1%)
Treated (n=1)		1 (100%)
HIV/AIDS (n=92)		
Yes		3 (3%)
Treated (n=3)		2 (67%)

Table 8. Consumer Survey Data: Mental Health History in Past 2 Years

Characteristic	*(Contributing Factors)*	n (%) n=95
Schizophrenia (n=91)		
Yes		6 (6%)
Paranoia/Delusions (n=92)		
Yes		9 (9%)
Manic Depression (n=90)		
Yes		26 (27%)
Major Depression (n=94)		
Yes		50 (53%)
Antisocial or Obsessive Compulsive Disorder (n=89)		
Yes		25 (26%)
Alcohol Abuse Disorder (n=91)		
Yes		38 (40%)
Drug Abuse Disorder (n=92)		
Yes		11 (12%)
Post-Traumatic Stress Disorder (n=94)		
Yes		24 (25%)

Table 9. Consumer Survey Data: Substance Use in Past 30 Days

Characteristic	*(Contributing Factors)*	n (%) n=95
Cigarettes/Tobacco Products (n=94)		
Yes		69 (73%)
Alcohol (n=94)		
Yes		43 (45%)
Marijuana (n=95)		
Yes		21 (22%)
Cocaine (n=95)		
Yes		2 (2%)
Heroin (n=95)		
Yes		1 (1%)
Inhalants (n=95)		
Yes		1 (1%)
Methamphetamines (n=95)		
Yes		2 (2%)
LSD/Hallucinogens (n=95)		
Yes		1 (1%)
Self-Reported Chemical Dependence (n=93)		
Yes		39 (41%)
Need or Use Prescriptions (n=94)		
Yes		61 (64%)

Table 10. Consumer Survey Data: Health Care Utilization

Characteristic	(Contributing Factors)	n (%) n=95
Regular Place for Medical Care (n=93)		
Yes		71 (75%)
Regular Care Location (n=71)		
Free clinic		24 (34%)
ER		5 (7%)
Clinic with fees		21 (30%)
Other		17 (24%)
*VA, Lakeland Mental Health, Homeless Health, Family HealthCare, Bible, Sanford Health		
Barriers to Health Care (n=95)		
Yes		56 (59%)
Main barriers		
No money/insurance		37 (66%)
No transportation		10 (18%)
Rather not go		2 (4%)
Care I need isn't available		1 (2%)
Other		6 (11%)
*Lack of trust, dislike physician, anxiety, amnesia, physicians filled, conservatism		
ER Use in Past Three Months (n=46)		
More than 3 times		31 (67%)
Less than 3 times		10 (22%)
Missing data/Don't know		5 (11%)
Hospitalization in Past 3 Months (n=46)		
More than 3 visits		4 (9%)
Less than 3 visits		27 (58%)
Missing data/Don't know		15 (33%)
ER Use or Hospitalization Greater Than Three Times in Past 12 Months (n=39)		
Discharge location		
Shelter		13 (34%)
Street		4 (11%)
Housing		12 (32%)
Other		9 (23%)
*Car, friends, home, motel, shelter, apartment, brother		

(continued)

Table 10. Consumer Survey Data: Health Care Utilization (continued)

Characteristic	*(Contributing Factors)*	n (%) n=95
Care Coordinated (n=95)		
Yes		23 (24%)
No/Don't know		72 (76%)
Injury/Illness Due to Violence in Past 12 Months (n=95)		
Yes		18 (19%)
No/Don't know		77 (81%)
Attacked While Homeless (n=95)		
Yes		32 (34%)
Head Injury/Rendered Unconscious (n=62)		
Subsequent emotional/mental effects		
Yes		41 (66%)
Age of Head Injury (n=62)		
Less than 5 years		10 (16%)
5-10 years		8 (13%)
11-15 years		6 (10%)
16-20 years		9 (14%)
21-30 years		10 (16%)
31-40 years		6 (10%)
41-50 years		6 (10%)
51-62 years		2 (3%)
Medical Coverage (n=95)		
Yes		45 (47%)
Currently Employed (n=94)		
Yes		20 (21%)
Unmet Health Needs	*(Needs)* *most reported need*	

- Dental *
- Birth control, OB/GYN issues
- Medical procedure
- Untreated physical, mental health issues
- Medical assistance or coverage
- Smoking cessation
- Primary care
- Memory loss issues
- Pain management
- Medications
- Unsure

<u>Health History</u>

The most commonly reported medical conditions were hypertension (n=32) and

diabetes or renal failure (n=17). Respiratory (n=13) and cardiovascular (n=12) problems

were the second most commonly reported conditions. About half of the participants who

reported hypertension were currently receiving treatment. Though most reported

conditions appeared to be treated, only one participant of 11 that reported hepatitis or

cirrhosis also reported treatment. A very small percentage of participants reported

sexually transmitted infection and HIV/AIDS. Major depression was reported by half of the

sample, and was the most commonly reported mental health problem. Alcohol abuse was

the second most commonly reported issue (n=38), while roughly a quarter of the sample

reported other issues of manic depression (n=26), antisocial or obsessive compulsive

disorder (n=25), and post-traumatic stress disorder (n=24).

Three-quarters of the sample reported using tobacco products in the past 30 days.

Almost half of participants reported alcohol use (n=43) and less than one-quarter reported

using marijuana in the past month. Less than five percent of participants reported using

other substances. Over one-third viewed themselves as chemically dependent, and most

participants reported the need for or use of prescription drugs.

<u>Health Care Utilization</u>

Most participants identified their usual place of care as a free clinic (n=24) or clinic

with fees (n=21), though 23% denied a usual place for care. Only about half of participants

reported barriers to health care, with lack of insurance or money as the primary barrier

identified. Lack of transportation (n=10) was also reported as a primary reason for barriers

to care. While about half of the total sample reported using ER services in the past three

months, only a small percentage confirmed hospital admission as a result of those ER visits. Thirty-nine participants reported ER use or hospitalization more than three times in the past year, and most of these participants were discharged to a shelter. Only a quarter of the sample reported having someone arrange or coordinate care.

While most participants denied injury or illness related to violence, one-third reported being attacked while homeless, and two-thirds reported a history of head injury. Of those who confirmed a history of head injury, two-thirds reported enduring mental or emotional effects as a result. The age at which participants were injured varied widely, though most reported an injury at less than five years or between 21 and 30 years old.

Unmet Health Needs

Dental care was by far the most significantly reported health need. Many participants wrote "teeth" or "dental" among other such responses. Other prominent issues reported included treatment for various physical and mental health issues. Physical issues included headaches, eye problems, pain, leg and foot problems, respiratory issues, hypertension, diabetes, joint disease, cancer, hepatitis, and insomnia. Mental health issues included anxiety, bipolar disorder, short-term memory loss, depression, and amnesia. A few participants reported the need for primary care or "a regular check-up," and some were unsure what needs were unmet.

PRECEDE Model Application

Data were labeled within each results table as corresponding needs, contributing factors, and assets (available resources) according to the PRECEDE model, congruent with project objective 3. Tables 11 through 13 below show the data re-organized into these categories from consumers' and service providers' perspectives. Given the volume of data

applicable for all categories, the top five primary needs and factors are listed only. A summary of the community's available resources for homeless health services and supportive services is also provided.

Table 11. PRECEDE Needs

Consumers' Perspective	Service Providers' Perspective
Unable to afford care	Treatment for physical, mental health issues
Transportation	Medical assistance/insurance
Dental care	Safe place to rest, recuperate from illness, post-acute care
Physical, mental health	Primary care
Secure source of income/job	Chemical dependency treatment

Table 12. PRECEDE Contributing Factors

Consumers' Perspective	Service Providers' Perspective
Lack of funds, insurance	Lack of insurance, transportation
Lack of trust, stigmatization	Discharge planning difficult, strained relationships
Physical, mental limitations	Inability to prioritize health care
Transportation a barrier	Benefits applications complex, require address
Waiting list for housing	Limited access to substance abuse treatment, psychiatric care

Table 13. PRECEDE Available Community Resources

Health Services	Supportive Services
Family HealthCare	Psychiatric agencies
Homeless Health Services	Shelters
Outreach	Permanent supportive housing
Nursing at shelters	Case management
Public Health	County Social Services
Detox centers	State and Federal assistance programs
Hospital services	Housing assistance programs
	Rape and Abuse Crisis Center
	HERO program

Consumer participants' priority needs were to secure a source of income and housing. While many reported untreated physical and mental conditions or conditions limiting the work they could do, the primary unmet need was dental care. The other primary need was for health insurance, or means to afford care. Service providers also recognized homeless persons' needs for health insurance, and saw needs for treatment of co-occurring physical or mental illness and chemical dependency. Appropriate levels of care were also a concern among service providers, and discussed the need for a lower level of supervised medical care for many shelter residents and homeless persons discharged from hospital care. Hence, while service providers recognized the need for respite care, consumers did not perceive this need.

Consumer participants discussed their lack of trust in service providers and experiences of disrespectful care. Other barriers to access were lack of health insurance and transportation. Service providers corroborated these barriers, and spoke of difficulties with discharging homeless patients into the community, primarily to shelters. Without a pay source, they said, access to needed support services is limited. Conversation with

providers also focused on homeless persons' inability to put their health needs above needs

such as housing or food, and often an inability to coordinate their own care.

Community assets in table 13 are resources reported by all participants for health

and supportive services. Family HealthCare and Homeless Health Services were cited by

most participants as primary resources for homeless health needs. Many consumer

participants reported receiving care at these clinics as a regular source of care. Service

providers reported collaborating frequently with both clinics and referring to other

supportive services listed.

CHAPTER 6. DISCUSSION AND RECOMMENDATIONS

Interpretation

Homelessness continues to increase in the Fargo-Moorhead area, and hence the health and service needs of homeless persons living in the community continue to increase (Wilder, 2010). North Dakota may be a current attraction with the oil boom boosting the state economy and promising work, however housing is virtually "nonexistent" as one participant stated. Persons looking for work from out of state are sent or migrate to other parts of the state, including Fargo, with limited to no resources. Persons who are "newly homeless" include families, and the number of homeless children is also increasing. Other causes of homelessness included substance abuse, family dynamic issues, and disabling health conditions (Kim et al., 2010; NCH, 2009). Homeless participants in this project desired to work, support themselves, and "get back to a normal life." Their attitudes likely counter stereotypes and presumptions about homeless persons (Davis, 1996; NCH, 2009). However, they do what they can to secure an income and housing, among fulfilling basic needs of temporary shelter and food (Davis, 1996). Shelters are often over capacity, with variable policies for stay and drop-in. With virtually no place to go during the day, they move about the community for temporary shelter and food, going without needed health care and rest (Martins, 2008). The waiting list for housing in the area is six months to two years, and more affordable housing is a significant need.

Health issues and barriers to health care access found in this project echoed findings of other studies. Homeless persons choose not to seek care due to lack of trust in health providers or desire to avoid disrespectful treatment (Martins, 2008; Nickasch & Marnocha, 2009). Others may not seek care because of barriers to access, such as lack of

transportation, health insurance, or a permanent address, and may not know where to go

or who to contact (Daiski, 2007). Physical or mental health limitations and chemical

dependency may also complicate the ability to seek or manage care (Martins, 2008). Mental

illness and chemical dependency were reported to often occur together, further

complicating treatment and management of care. Without insurance, homeless persons are

unable to access substance abuse treatment, and many homeless persons have never been

engaged in treatment services. Wait times for psychiatric care are long as well. Consumers'

perceptions of their health status and needs underlined the importance of having health

insurance, though few participants perceived many unmet health needs or need for

substance abuse treatment. Most consumer participants reported their usual place for care

was Family HealthCare or Homeless Health Services, an indication of community work to

connect area homeless persons with appropriate health services.

A new gap in care has emerged in the past several years, the need for a medical

respite program (HCHCN, 2007; Zerger et al., 2009). A project completed two years ago

with community informants revealed some evidence of this need (Hauff, 2010). While

homeless participants in this project did not perceive the need for respite care, service

providers overwhelmingly verified the need for such a program in the community. Many

comments highlighted the difficulties with discharging homeless patients and trying to

connect them to appropriate services. Shelters are not equipped to accommodate the

health needs of many homeless persons who are discharged, and encounter many residents

who are viewed as "medically vulnerable." Shelter staff feel liable for residents' care and try

to accommodate as able. However, shelter resources are already strained and limited, and

very little hands-on nursing care is provided on site. Hospital staff are required to

discharge patients as soon as "medically stable," which is not suitable for shelter stay (HCHCN, 2007). Sometimes discharge must be delayed because another level of care cannot be accessed, or shelters must turn patients away with needs beyond what can be accommodated (HCHCN, 2007). Homeless patients may not be able to comply with discharge instructions and treatment, and without needed recuperation, may be readmitted (HCHCN, 2007). Inclement weather further complicates discharge efforts. Additionally, Gladys Ray is the only shelter able to accept intoxicated persons. Service providers perceived a respite program as a place for discharged patients to rest and recuperate, access supportive services, and receive medical care as needed. Medications could be stored and administered, in-depth education could be provided, and care would be provided for physical and mental health needs. A respite program in the Fargo-Moorhead community may prove to be a cost savings for the community and health systems, though is only one solution to address the needs of the homeless population (Zerger et al., 2009). Service providers may benefit from education about Harm Reduction and Trauma-Informed Care principles, as well as available resources in the community (Hopper et al., 2010; Tsemberis et al., 2004).

Project Strengths

Strengths identified in this project were related to sampling and design, and included:

1. The consumer sample was representative of all area shelters, the Homeless Health Services clinic, and one permanent supportive housing establishment, Cooper House.

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2. The service provider sample was representative of all area shelters, two area hospitals, the Homeless Health Services clinic, Cooper House, and Cass and Clay Public Health. Participants at these sites provided multidisciplinary perspectives.

Project Limitations

Possible limitations identified in this project were also related to sampling and methodology, and included:

1. This project may have involved a personal bias. The researcher had anecdotal experience and preconceived ideas about medical respite care prior to the project. This project sought to evaluate the need for respite care among other health needs and may have been biased based on the results of the informal needs assessment done in 2010 (Hauff, 2010).

2. The sample included both persons living in permanent supportive housing and homeless persons. Data from each site were not analyzed separately. It is possible that participants living in permanent supportive housing may have less unmet health care needs than those who are homeless. Hence project data may not reflect the full measure of unmet health needs and contributing factors for the area homeless population.

3. The sample may be biased because of the convenience sampling technique used. Participants were self- selected as chronically homeless. Findings are not generalizable to homeless teens, young adults, unsheltered homeless persons, and persons experiencing homelessness for less than one year due to exclusion criteria. These subpopulations may have needs different from the project target population

and may include persons most at risk for complications related to health and access to care.

4. Though participants were ensured anonymity and confidentiality during the informed consent process, homeless participants may have responded out of bias or fear of consequence. Data regarding substance use or health issues may have been affected by this response.

5. No previous community assessment research was available. Project design and methods were partially original. The reliability and validity of adapted and added survey and interview questions cannot be established. The use of the Wilder Study survey questions also have not been established as reliable and valid in the context of use in a homeless health needs assessment.

Recommendations and PROCEED Model

In conjunction with project objective four, recommendations for planning a medical respite program are provided below according to steps provided in the practical planning manual (McMurray-Avila, 2009):

1. Identify the Need: As discussed, service providers verified the need for a transitional level of care or respite program in the Fargo-Moorhead community. Consumers did not perceive this need, though voiced needs for other supportive services that may be included in a respite program.

2. Identify the Stakeholders: Participants were classified as stakeholders in planning a respite program. However, it would be beneficial to include feedback from other stakeholders in the community such as VA Hospital, psychiatric agencies, jails, detox centers, and treatment centers, among others.

3. Define the scope of care and range of services: Based on needs assessment data, a respite program in Fargo-Moorhead would offer medical care and supervision, in the very least intermittent care and case management. Most participants reported an anticipated length of respite stay to be one to two weeks post-discharge. Post-discharge needs to address would include medication management, nursing cares, coordination of follow-up care, transportation, benefits acquisition, and health education. Other possible needs reported were rehabilitation, physical and occupational therapy, and hospice. Specific nursing cares would need to be delineated based on admission criteria. Ownership and sponsorship of the program will need to be determined.

4. Identify a Model: A specific model cannot be determined by project data but by the specific community resources available for use. The Fargo Housing Authority is an agency to collaborate with to choose an appropriate facility.

5. Design the Program: Decisions will need to be made regarding admission criteria, policies and procedures, care provision and staffing needs, regulations and licensing, discharge planning, and partnerships to provide services. Fargo-Moorhead Coalition members and staff from and Homeless Health Services would be best to collaborate with to accomplish this task.

6. Determine Costs and Identify Funding Sources: Many service providers asked about how to fund a respite program. Funding may at best be legislated, as one participant suggested, and may likely come from multiple sources such as hospital contracts, grant monies, community partnerships, and donations. A cost analysis needs to be completed to determine the measure of projected benefit for stakeholders involved.

A cost analysis may utilize hospital data regarding length of stay, rates of readmission, delays in discharge, and emergency room utilization. Other costs to determine include start-up and continuing costs. This analysis will form the basis for a business plan and proposal to area stakeholders.

7. Market the Program: Marketing the respite program is essential, and may start with the creation of a business plan, proposal, and brochure with information about its mission, activities, and projected benefits. Collaboration with other agencies is paramount, and regular meetings are beneficial.

8. Implement the Program: Once the above decisions are made, funding is secured, and set-up is complete, the respite program may begin servicing patients.

9. Collect Data and Assess Outcomes: In order to assure quality improvement and assess outcomes, the outcomes and evaluation process must be decided early on in the process. Outcomes measured may include improvement of patient health and ability to function, and improved continuity of care.

10. Continued Evaluation: Continuous evaluation of outcomes is a necessary part of monitoring program quality, and will likely be part of agreements with funding agencies.

An appropriate next step following dissemination of needs assessment data to Fargo-Moorhead area stakeholders would be to form a committee or task force to direct the development of the respite care program. Further analyses will need to be completed, primarily a cost-benefit analysis. Once the program is ready for implementation, developers may choose to pilot the program before full implementation.

Implications for Practice

Needs assessment findings will be disseminated to area stakeholders including, but not limited to, Sanford Health, Essentia Health, and the Fargo-Moorhead Coalition for Homeless Persons. Recommendations for respite program planning will be specifically addressed in detail. Although the need for a respite care program was identified, other needs to be addressed are listed below with suggestions for focused intervention as appropriate:

- Cultural competence among service providers—Participants verbalized concerns about cultural competence among service providers. One participant suggested utilizing an appropriate staff member to act as a "homeless liaison" between patients and providers. Area service providers must reflect on their own attitudes and understanding of homelessness and cultural sensitivity.

- Trauma-informed care, harm reduction among service providers—Participants reported a need for understanding of the principles of trauma-informed care and harm reduction among service providers. Provider training on the culture of homelessness and these principles may be beneficial. However, it is the duty of all service providers to treat clients with respect.

- Hands-on nursing care in shelters—Shelter staff participants expressed a need for more hands-on nursing care to be provided in all shelters.

- Consumers' need for dental care—Service providers may need to educate homeless patients on the availability of free dental clinic resources, such as Family HealthCare, in the area.

- Consumers' need for insurance—Some participants expressed the need for more case management who may assist with acquisition of benefits and other resources. With the changing health care landscape of the Affordable Care Act, enrollment efforts are to be streamlined, and Medicaid may be expanded to include all non-disabled, non-elderly adults aged 19 to 64 years earning at or below 138% of the Federal Poverty Level (KCMU, 2012; NHCHC, 2012). If passed in North Dakota, about 24,000 more people will gain coverage; if not, about 14,000 persons may still purchase private insurance through the state exchange but will be ineligible for premium tax credits (Calsyn & Lee, 2012). Minnesota has already committed to expanding Medicaid (Calsyn & Lee, 2012). Administrative and staffing challenges may remain an issue with increased enrollment if passed in North Dakota (KCMU, 2012). The expansion's magnitude of effect on each state varies, and costs of expansion are weighed against savings from reduced state payments for uncompensated care and reduced administrative costs (DHHS, 2012). States may, however, incur a short-term increase in administrative costs of implementation (DHHS, 2012).

- Consumer coverage for substance abuse treatment—Issues of lack of coverage for substance abuse treatment are similar to discussion above.

- Affordable housing in Fargo-Moorhead area—As previously discussed, more affordable housing is needed in the community and is the base solution of the Housing First model. Participants expressed a need for Housing First programs to be fully embraced in the area.

Implications for Future Research

This project is the first homeless health needs assessment to be performed and documented in the Fargo-Moorhead area. Current data may be expanded with statistical analyses to assess for correlations among data. Data were also not analyzed using the Vulnerability Index tool (appendix G) and may be done to identify participants who were in most need of housing at the time project data were collected. The community may desire to perform a health needs assessment for this population periodically or following implementation of preferred interventions. The target population may also be expanded or altered to include homeless teens, young adults, unsheltered homeless persons, and families. Data collection for this project was completed with one researcher. Future needs assessments would best be done with a team of researchers to involve more stakeholders and perform more in-depth analyses. The use of both qualitative and quantitative data proved to be beneficial for thorough assessment of homeless health needs among both consumers and service providers. However, data collection tools used need to be refined and further validated in other community homeless health needs assessments. This project adds to the growing body of knowledge of homeless health needs, though further research in other communities may be beneficial.

Application to DNP Roles

<u>Leadership and Collaboration</u>

Doctorate of Nursing Practice (DNP) roles are multifaceted (Chism, 2013). The researcher chose to focus on homeless health in 2010 as an area of interest, and interest grew from the completion of a small class project to a greater initiative to assess and improve the health of the area homeless population. Community members verbalized the

need for a formal homeless health needs assessment and findings will bolster action to improve current programs and create new interventions. The DNP graduate is prepared to improve practice in this and many other ways and is part of the role of every advanced practice nurse (Chism, 2013). Collaboration with area agencies and stakeholders is necessary to achieve mutual goals and outcomes. DNP graduates possess the skills and abilities necessary to lead such initiatives and attract others to achieve a common goal (Chism, 2013). The researcher intends to continue to address intervention strategies and needs for program planning in the community upon graduation in collaboration with the Coalition.

Health Policy and Advocacy

DNP graduates possess the skills needed to be effective advocates for the public and the nursing profession (Chism, 2013). Every nurse has the responsibility to address issues of social justice and equity in health care, and reflects the nursing profession's commitment to the health of all (Chism, 2013). "Disparities in health care, education, food distribution, and housing demand the attention of the DNP graduate," and graduates have the ability to act as catalysts for change (Chism, 2013). Findings from this project reflect the documented health disparities of homeless persons and shed light on interventions needed to improve these disparities. However, interventions must be a collaborative effort among other community members and stakeholders, including legislative personnel. It is the duty of the researcher and DNP graduates to remain informed and involved in community needs and efforts to create needed change.

Conclusion

Findings from this project often echoed findings from current literature. Homelessness is a direct threat to health, and the importance of addressing homeless persons' basic needs must be balanced with needs for health care and supportive services. Service providers must recognize the need for harm reduction in service provision and the need for appropriate long-term solutions to prevent homelessness. Fargo-Moorhead area stakeholders must be informed and involved in taking action to address homeless persons' barriers to health care access and corresponding health disparities.

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APPENDIX A. NDSU IRB APPROVAL

NDSU   NORTH DAKOTA STATE UNIVERSITY

701.231.8995
Fax 701.231.8098

Institutional Review Board

Federalwide Assurance #FWA00002439

Office of the Vice President for Research, Creative Activities and Technology Transfer
NDSU Dept. 4000
1735 NDSU Research Park Drive
Research 1, P.O. Box 6050
Fargo, ND 58108-6050

April 17, 2012

Molly Secor-Turner
Department of Nursing
Sudro

IRB Approval of Protocol **#PH12183**, **"Health Needs Assessment of Fargo, ND and Moorhead, MN Persons Experiencing Chronic Homelessness"**
Co-investigator(s) and research team: **Alicia Hauff**

Approval period: **4/17/2012** to **4/16/2013**   Continuing Review Report Due: **3/1/2013**

Research site(s): **varied**   Funding agency: **n/a**
Review Type: Expedited category # 7
IRB approval is based on original submission (received 4/3/2012).

Additional approval is required:
- o   prior to implementation of any proposed changes to the protocol (*Protocol Amendment Request Form*).
- o   for continuation of the project beyond the approval period (*Continuing Review/Completion Report Form*). A reminder is typically sent two months prior to the expiration date; timely submission of the report is your responsibility. To avoid a lapse in approval, suspension of recruitment, and/or data collection, a report must be received, and the protocol reviewed and approved prior to the expiration date.
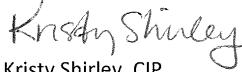
A report is required for:
- o   any research-related injuries, adverse events, or other unanticipated problems involving risks to participants or others within 72 hours of known occurrence (*Report of Unanticipated Problem or Serious Adverse Event Form*).
- o   any significant new findings that may affect risks to participants.
- o   closure of the project (*Continuing Review/Completion Report Form*).

Research records are subject to random or directed audits at any time to verify compliance with IRB regulations and NDSU policies.

Thank you for cooperating with NDSU IRB procedures, and best wishes for a successful study.

Sincerely,

Kristy Shirley

Kristy Shirley, CIP
Research Compliance Administrator

Last printed 4/17/2012 4:38:00 PM

NDSU is an EO/AA university.

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APPENDIX B. SANFORD HEALTH IRB APPROVAL

SANFØRD™
HEALTH

May 14, 2012

PI: Molly Secor-Turner, Ph.D., RN
Project: 03-12-031 Health Needs Assessment of Fargo, ND and Moorhead, MN Persons Experiencing Chronic Homelessness
Project Review Level: Exempt 2 applies to Phase III only. Sanford participates only in Phase III of this project
Project Risk: No more than minimal
Approved through exempt review: 05/12/2012

The study submission and informed consent for the proposal referenced above has been reviewed and approved via the procedures of the Sanford Health Institutional Review Board (IRB).

Attached is your original consent document that has been stamped with the IRB approval date. You must keep this original on file. Please use this original consent document to make copies for subject enrollment/re-consent. No other consent form should be used. In addition, each subject must be given a copy of the consent form.

Prior to initiation, promptly report to the IRB, any proposed project updates / amendments (e.g., protocol amendments/revised informed consents) in previously approved human subject research activities.

The forms to assist you in filing your: project closure, continuation, adverse/unanticipated event, project updates /amendments, etc. can be accessed online at SanfordConnect.

You have approval for this project starting from the approval date. Exempt projects do not expire; however, please update the IRB of your study status annually. Exempt projects can be closed when data collection is completed. When this study is completed please notify the Human Research Protection office.

Sincerely,

Deb Langstraat, CIP
Sanford Health
Director-Human Research Protection Program

APPENDIX C. SERVICE PROVIDER INTERVIEW TOOL

Hospital and Healthcare Staff

1. What do you know about the health needs of homeless persons living in the Fargo-Moorhead area? (Hauff, 2010)

2. How do you work to meet their health needs? (as applicable) (Hauff, 2010)

3. To your knowledge, what services or programs are provided or available to help meet their health needs in any course of care? (Hauff, 2010)

4. What do you see as barriers to their access to healthcare or having their health needs met? What services are needed? (transportation, cost, fear of judgment) (Hauff, 2010)

5. How often do you encounter patients experiencing homelessness? (Jaco, 2011)

6. Do you assess housing status in order to determine whether or not patients are experiencing homelessness? (Jaco, 2011)

7. What are the most common medical problems or needs you see in patients experiencing homelessness? (Jaco, 2011)

8. What support services do homeless clients need following hospital discharge? (Jaco, 2011)

9. How long, on average, do homeless patients stay in the hospital? (Jaco, 2011)

10. How does average length of stay for homeless patients compare to average length of stay for housed patients? (Jaco, 2011)

11. Are any discharge policies in place for patients experiencing homelessness? (Jaco, 2011)

12. Is discharge planning difficult for patients experiencing homelessness? To where are they usually discharged? (Jaco, 2011)

13. How might the availability of medical respite improve your patients' healthcare needs? (added, Hauff)

14. How often do you encounter patients who would benefit from medical respite care? (adapted from Jaco, 2011)

Shelter Staff

1. How many people continue to need a bed during the day due to illness? (Jaco, 2011)

2. Are day beds provided? (Jaco, 2011)

3. Where do homeless persons go during the day? (added, Hauff)

4. What support services are needed but not currently provided by the shelter? (Jaco, 2011)

5. Where do homeless persons go for the night if no shelter is available? (added, Hauff)

6. What are common health care needs of homeless individuals you encounter? (added, Hauff)

7. Is any health care provided at the shelter? (added, Hauff)

8. How often do you encounter homeless persons who require health care beyond the shelter setting that may benefit from respite care? (added, Hauff)

Sources

Jaco, M. (2011). *Medical Respite Program Development Workbook.* Nashville: National Health Care for the Homeless Council, Inc.

APPENDIX D. SERVICE PROVIDER SURVEY TOOL

Needs Assessment of Hospital Staff

For the purposes of this survey,

- *__Homeless__ means having no regular place to sleep: staying at a friend's house,
  sleeping at a homeless shelter, or sleeping in a place not fit for habitation (i.e., in a
  car, outdoors, or an abandoned building).

- **__Medical respite care__ means services for homeless single adults who are too sick
  for the streets, but not sick enough to stay in the hospital. Most homeless shelters
  require people to leave during the day. Respite care provides a place for homeless
  patients to stay inside during the day to rest and recover, and it often includes other
  support services.

1. What city/county do you work in: _____

2. What department of the hospital do you work in: _____

3. What is your role at this facility (nurse, social worker)? _____

4. What shifts (day, evening, night) do you typically work? _____

5. Which statement best describes your hospital? (Mark all that apply).
   a.) Emergency department patient volume is over capacity
   b.) Emergency department has capacity to service more patients
   c.) Inpatient hospital beds are often not available for new admissions
   d.) A higher inpatient census is desired

6. Does your hospital ask about housing status in order to determine whether or not a
   patient is experiencing homelessness*? ____ Yes ____ No ____ Don't know

7. If yes, how is housing status tracked?
   _____

8. On average, how often do you encounter patients who are experiencing homelessness?
    a.) More than once a week
    b.) Once a week
    c.) Once a month
    d.) Once every few months
    e.) Once every six months
    f.) Once a year
    g.) Less often than once a year

9. In general, whom do you encounter?
    a.) More single homeless men
    b.) More single homeless women
    c.) Equal numbers of single homeless men and women

10. Does your hospital have a policy for the discharge of patients who are experiencing homelessness? ＿＿ Yes ＿＿ No ＿＿ Don't know

11. If your hospital does not have a policy on discharge planning for people who are experiencing homelessness, do you feel that one needs to be developed?
    ＿＿ Yes ＿＿ No

12. Working with patients who are experiencing homelessness makes discharge planning...
    a.) Very difficult
    b.) Difficult
    c.) Somewhat difficult
    d.) Not at all difficult

13. What, if anything, makes discharge planning difficult?
    ＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿
    ＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿

14. How often have you helped to delay discharge due to a person's lack of residence?
    a.) More than once a week
    b.) Once a week
    c.) Once a month
    d.) Once every few months
    e.) Once every six months
    f.) Once a year
    g.) Less often than once a year

15. Where are patients who are experiencing homelessness usually discharged to (name specific places if able)?
    ＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿
    ＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿

16. Do you feel there are adequate existing resources for patients who are experiencing homelessness?   _____ Yes   _____ No

17. What types of resources, agencies, or services do you refer patients to?
    _____
    _____

18. In your opinion, how sick are the majority of homeless patients when they are discharged?
    a.)   Not sick – fully recovered
    b.)   Still sick but mostly recovered
    c.)   Sick and more time needed to recover
    d.)   Very sick and recovery not likely

19. If medical respite care** services were available, what would the majority of homeless patients who you encounter need?
    a.)   24-hour nursing care and/or observation
    b.)   Intermittent nursing care and/or case management
    c.)   No care – just a safe place to stay during the day
    d.)   Medical respite services not needed in our community

20. How long, on average, would most homeless patients require medical respite care following discharge?
    a.)   No medical respite needed
    b.)   Less than one week
    c.)   1-2 weeks
    d.)   2-3weeks
    e.)   3-6 weeks

21. What are the needs – in your experience – of homeless patients who are being discharged? (Assuming that housing is a need) (Mark all that apply)
    a.)   Rest – safe place to stay during the day
    b.)   Medication management
    c.)   Dressing changes or other nursing care
    d.)   Coordination of follow-up care
    e.)   Transportation to follow-up appointments
    f.)   Help accessing insurance and benefits
    g.)   Oxygen
    h.)   IV therapy
    i.)   Health education
     j.)   Other: _____
    k.)   Other: _____

22. In general, what are the homeless patients who you work with suffering from? (Mark all that apply)
    a.) Physical illness or injury
    b.) Mental illness
    c.) Chemical dependency

23. Does your hospital utilize DRGs (Diagnostic Related Groups)?
    ____ Yes   ____ No   ____ Don't know

24. If yes, is your hospital able to create a report of DRG codes for people who are experiencing homelessness?   ____ Yes   ____ No   ____ Don't know

25. Of those who could use medical respite care, what percentage would need a place where sobriety is NOT required?
    a.) Less than 50%
    b.) About50%
    c.) More than 50%

26. Any additional comments you would like to make regarding discharge planning with patients who are experiencing homelessness:

    _____
    _____

    You are finished with the survey. Thank you for participating!

Source

Jaco, M. (2011). Medical Respite Program Development Workbook. Nashville: National Health

   Care for the Homeless Council, Inc.

APPENDIX E. CONSUMER INTERVIEW TOOL

1. Where do you usually go for medical care? (Jaco, 2011)

2. How often do you use hospital emergency department services? (Jaco, 2011)

3. How would you describe your health currently? (Jaco, 2011)

4. Have you ever been hospitalized? (If yes) What was your experience during and after your stay? (added, Hauff)

5. Where did you go when you were discharged? Did you get the health care you needed afterward? (added, Hauff)

6. Is there anything that prevents you from getting the health care you need? (If yes, what?)   (MN/ND Wilder Survey, 2009)

7. What health care needs do you have that are not being met?   (adapted, Jaco, 2011)

Sources

Jaco, M. (2011). Medical Respite Program Development Workbook. Nashville: National Health Care for the Homeless Council, Inc.

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Wilder Foundation. (2009). Minnesota Statewide Survey of Persons Without Permanent Shelter Interview Schedule.

APPENDIX F. CONSUMER SURVEY TOOL

1.   What is your age?   _____ Years   □ Refused

2.   What is your gender?
       □ Male   □ Female   □ Refused

3.   Is your race or ethnic background:
       □ American Indian or Alaskan Native
       □ White
       □ Black or African American
       □ Hispanic/Latino
       □ Asian
       □ Native Hawaiian or Other Pacific Islander
       □ Other Multi-Racial
       □ Unknown
       □ Refused

4.   How would you describe your current state of health?   *(PHC 2010 Registration)*
       □ Good
       □ Fair
       □ Poor

5.   Do you feel that you **now** need to see a health professional about any physical health problems?

       □ Yes   □ No   □ Refused   □ Don't know

6.   Do you feel that you **now** need to see a health professional about any emotional or mental health   problems?
       □ Yes   □ No   □ Refused   □ Don't know

7.   Do you feel that you **now** need to see a health professional about any alcohol or drug problems?

       □ Yes   □ No   □ Refused   □ Don't know

8.   Do you feel that you **now** need to see a dentist about tooth or gum problems?

       □ Yes   □ No   □ Refused   □ Don't know

9.   Do you have a physical, mental, or other health condition that limits the kind or amount of work you can do?
       □ Yes   □ No   □ Refused   □ Don't know

10. Do you have a physical, mental, or other health condition that makes it hard for you to bathe, eat, get dressed, get in or out of a bed or chair, or get around by yourself?
   □ Yes   □ No   □ Refused   □ Don't know

11. Do you often feel confused or have trouble remembering things, or have problems making decisions, to the point that it interferes with daily activities?
   □ Yes   □ No   □ Refused   □ Don't know

12. During the **last 12 months**, did you have any of the following illnesses, conditions, or problems? **(CHECK A RESPONSE FOR EACH ITEM)**

	Yes	No	Refused	Don't know	If you checked **YES,** have you received care for this in the last 12 months?	
					Yes	No
1. Asthma?	□ ➡	□	□	□	□	□
2. Other chronic lung or respiratory problems?	□ ➡	□	□	□	□	□
3. Frostbite, trench foot, or hypothermia?	□ ➡	□	□	□	□	□
4. High blood pressure?	□ ➡	□	□	□	□	□
5. Other chronic heart or circulatory problems such as anemia or heart disease?	□ ➡	□	□	□	□	□
6. Diabetes or kidney failure?	□ ➡	□	□	□	□	□
7. Tuberculosis (TB)?	□ ➡	□	□	□	□	□
8. Hepatitis or cirrhosis?	□ ➡	□	□	□	□	□
9. Syphilis, gonorrhea, or another sexually transmitted disease other than AIDS/HIV?	□ ➡	□	□	□	□	□
10. Have you ever been told that you tested positive for HIV or AIDS?	□ ➡	□	□	□	□	□

13. During the **last two years**, have you been told by a doctor or nurse that you have…
(CHECK A RESPONSE FOR EACH ITEM)

	Yes	No	Refused	Don't know
1. Schizophrenia?	☐	☐	☐	☐
2. Paranoid or delusional disorder, other than schizophrenia?	☐	☐	☐	☐
3. Manic episodes or manic depression, also called bipolar disorder?	☐	☐	☐	☐
4. Major depression?	☐	☐	☐	☐
5. Anti-social personality, obsessive-compulsive personality, or any other severe personality disorder?	☐	☐	☐	☐
6. Alcohol abuse disorder?	☐	☐	☐	☐
7. Drug abuse disorder?	☐	☐	☐	☐
8. Post-Traumatic Stress Disorder (PTSD)?	☐	☐	☐	☐

14. During the **last 30 days** have you used… **(CHECK A RESPONSE FOR EACH ITEM)**

	Yes	No	Refused
1. Cigarettes or other tobacco products?	☐	☐	☐
2. Alcohol (beer, wine, hard liquor)?	☐	☐	☐
3. Marijuana (reefer, hash, THC, pot)?	☐	☐	☐
4. Crack or any other kind of cocaine?	☐	☐	☐
5. Heroin?	☐	☐	☐
6. Inhalants (aerosol sprays, glue, amyl nitrite, poppers)?	☐	☐	☐
7. Meth (methamphetamines)?	☐	☐	☐
8. LSD, other hallucinogens, or any other drug which is illegal for you to have?	☐	☐	☐

15. Do you consider yourself an alcoholic or chemically dependent?
☐ Yes   ☐ No   ☐ Refused   ☐ Don't know

16. Do you currently need or use medicine prescribed by a doctor, other than vitamins?
☐ Yes   ☐ No   ☐ Refused   ☐ Don't know

17.   Because of your health, your relationships are generally:
        □ Very close and warm   □ Sometimes close and warm   □ Rarely close and
                                                                                        warm

        □ I have no close and warm relationships

18.   Have you ever considered suicide?

□ Yes ➡	18a. Have you ever attempted suicide?
□ No	□ Yes □ No □ Refused
□ Refused	
□ Don't know	18b. Have you ever sought help for this?
	□ Yes □ No □ Refused

19.   What are your greatest unmet health care needs?

        _____

        _____

20.   Do you have a regular place where you go for medical care?

□ Yes ➡	20a. Is that …**(CHECK ONE)**
□ No	□ A free clinic,
□ Refused	□ The emergency room,
□ Don't know	□ A clinic that requires insurance or fees, or
	□ Somewhere else? **(SPECIFY)**_____
	□ Don't know

21.   Is there anything that prevents you from getting needed health care?

□ Yes ➡	21a. What is the **main** reason you do not get the health care you need?
□ No	Please tell me just the **one** most important reason. **(CHECK ONE)**
□ Refused	□ No money or no insurance □ Don't know where to go
□ Don't know	□ No transportation □ The care I need isn't available
	□ Rather not go □ Something else **(SPECIFY)**
	_____

22. Did you receive any care in an emergency room in the last **three** months?

☐ Yes ➡
☐ No
☐ Refused
☐ Don't know

> 22a. How many times have you been to the ER in the last 3 months?
>
> ☐ More than 3 times   ☐ Less than 3 times   ☐ Don't know
>
> 22b. How many of those ER visits resulted in a hospital admission?
>
> ☐ More than 3 times   ☐ Less than 3 times   ☐ Don't know

23. In the past **12 months** did you receive care in an emergency room or were you hospitalized <u>more than 3 times</u>?

☐ Yes ➡
☐ No
☐ Refused
☐ Don't know

> 23a. Where did you go when you were discharged?
>
> ☐ Shelter ☐ Street ☐ Housing ☐ Other **(SPECIFY)** _____

24. Does anyone help you arrange or coordinate your care among the different doctors or services that you use?

☐ Yes   ☐ No   ☐ Refused   ☐ Don't know

25. During the last 12 months have you had to seek health care because of an injury or illness   resulting from violence?

☐ Yes   ☐ No   ☐ Refused   ☐ Don't know

26. Have you ever been physically or sexually attacked or beaten while you have been without a regular place to stay?

☐ Yes   ☐ No   ☐ Refused   ☐ Don't know

27. Have you ever been hit in the head so hard that you saw stars or were knocked unconscious –for example, from a blow, or a fall, or a motor vehicle accident?

☐ Yes ➡
☐ No
☐ Refused
☐ Don't know

> 58a.   After your head injury, did you start having problems with headaches, concentration or memory, understanding, excessive worry, sleeping, or getting along with people?
>
> ☐ Yes   ☐ No   ☐ Refused   ☐ Don't know
>
> 58b.   How old were you when you were injured? **(IF MORE THAN ONE SUCH INJURY, GIVE AGE OF FIRST ONE)**
>
> [ ]   Years old   ☐ Don't know

28. Do you have any kind of medical coverage?

☐ Yes ☐ No ☐ Refused ☐ Don't know

29. Are you currently employed?

☐ Yes ☐ No ☐ Refused ☐ Don't know

You are finished with the survey. Thank you for participating!

Source

Wilder Foundation. (2009). Fargo North Dakota Survey of Persons Without Permanent

Shelter Interview Schedule.

Wilder Foundation. (2009). Minnesota Statewide Survey of Persons Without Permanent

Shelter Interview Schedule.

APPENDIX G. VULNERABILITY INDEX TOOL

The Vulnerability Index is a tool for identifying and prioritizing the street homeless population for housing according to the fragility of their health. It is a practical application of research into the causes of death of homeless individuals living on the street conducted by Boston's Healthcare for the Homeless organization, led by Dr. Jim O'Connell. The Boston research identified the specific health conditions that cause homeless individuals to be most at risk for dying on the street. For individuals who have been homeless for at least six months, one or more following markers place them at heightened risk of mortality:

1)   more than three hospitalizations or emergency room visits in a year

2)   more than three emergency room visits in the previous three months

3)   aged 60 or older

4)   cirrhosis of the liver

5)   end-stage renal disease

6)   history of frostbite, immersion foot, or hypothermia

7)   HIV+/AIDS

8)   tri-morbidity: co-occurring psychiatric, substance abuse, and chronic medical condition

Source

Juneau Economic Development Council [JEDC] (2009). Vulnerability index tool. Retrieved from http://jedc.org/forms/Vulnerability%20Index. pdf.

APPENDIX H. EXECUTIVE SUMMARY

Introduction

In the fall of 2010, interviews with eight community members about homeless health needs revealed a variety of needs and barriers to health care access. The primary need voiced, however, was for a medical respite care program. The need for a full-scale homeless health needs assessment was determined, and was conducted June through December 2012. Interviews and surveys were completed with shelter staff, health service staff, persons experiencing chronic homelessness, and persons living in permanent supportive housing. The following report summarizes the feedback from these participants and outlines recommendations for program planning.

Who Participated in the Homeless Health Needs Assessment?

Surveys and interviews were conducted with three separate sample groups (Consumers, Shelter Staff, and Health Service Staff) to collect a sufficient amount of information about homeless health needs, factors affecting such needs, and current available resources in the community.

1. First, a total of 95 people identified as chronically homeless or living in permanent supportive housing were surveyed at Gladys Ray, Churches United, YWCA, New Life Center, and Dorothy Day House of Hospitality shelters, plus Cooper House and Gateway Gardens. Participants' were mostly men, the mean age was 45 years, and ages ranged from 18 to 63 years. Eight persons were also interviewed at the sites listed.

2. Then a total of 10 staff members from the shelter sites listed were interviewed. These participants were mostly female, and consisted of shelter directors, case managers, parish nurses, and other staff.

3. Finally, a variety of health service staff members were surveyed and interviewed. A total of 29 staff members completed surveys at Sanford Health and Essentia Health. These participants were mostly female and worked in the emergency setting or case management. A total of 14 staff members were interviewed at Sanford Health, Essentia Health, Cooper House, Homeless Health Services, and Cass and Clay County Public Health. All participants interviewed were female, and included registered nurses, case managers, and social workers.

Consumers' and Service Providers' Perspectives Compared

All of the survey and interview data was analyzed and organized into the categories of health needs, factors contributing to these needs, and current community resources for health and supportive services.

Table H1. Needs

Consumers' Perspective	Service Providers' Perspective
Unable to afford care	Treatment for physical, mental health issues
Transportation	Medical assistance/insurance
Dental care	Safe place to rest, recuperate from illness, post-acute care
Physical, mental health	Primary care
Secure source of income/job	Chemical dependency treatment

Consumers' most important needs were to secure a source of income and housing. While many reported untreated physical and mental conditions or conditions limiting the

work they could do, their primary unmet need was for dental care. The other primary need

was for health insurance or ability to afford care. Service providers also recognized

homeless persons' needs for health insurance, and saw needs for treatment of co-occurring

physical or mental illness and chemical dependency. Appropriate levels of care were also a

concern among service providers, and discussed the need for a lower level of supervised

medical care for many shelter residents and homeless persons discharged from hospital

care. Hence, while service providers recognized the need for respite care, consumers did

not perceive this need.

Table H2. Contributing Factors

Consumers' Perspective	Service Providers' Perspective
Lack of funds, insurance	Lack of insurance, transportation
Lack of trust, stigmatization	Discharge planning difficult, strained relationships
Physical, mental limitations	Inability to prioritize health care
Transportation a barrier	Benefits applications complex, require address
Waiting list for housing	Limited access to substance abuse treatment, psychiatric care

Consumers talked about their lack of trust in service providers and experiences of

disrespectful care. Other barriers to access were lack of health insurance and

transportation. Service providers agreed with these barriers, and spoke of difficulties with

discharging homeless patients into the community, primarily to shelters. Without a pay

source, they said, access to needed support services is limited. Service providers also

discussed homeless persons' inability to put their health needs above needs such as

housing or food, and often an inability to coordinate their own care.

Table H3. Available Community Resources

Health Services	Supportive Services
Family HealthCare	Psychiatric agencies
Homeless Health Services	Shelters
Outreach	Permanent supportive housing
Nursing at shelters	Case management
Public Health	County Social Services
Detox centers	State and Federal assistance programs
Hospital services	Housing assistance programs
	Rape and Abuse Crisis Center
	HERO program

Community assets in table 3 are resources reported by all participants for health and supportive services. Most participants said Family HealthCare and Homeless Health Services are primary resources for homeless health needs. Many consumers reported receiving care at these clinics as their regular source of care. Service providers reported collaborating frequently with both clinics and referring to other supportive services listed.

What Does This Mean for Program Planning?

A medical respite program was viewed as a potential cost savings for the community and health systems, and provides an appropriate level of care needed in the area. An appropriate next step would be to form a task force or committee to direct the development of the program. Recommendations for development of this program include the following:

- *Identify the Stakeholders:* Participants were classified as stakeholders in planning a respite program. However, it would be beneficial to include feedback from other stakeholders in the community such as VA Hospital, psychiatric agencies, jails, detox centers, and treatment centers, among others.

- *Define the scope of care and range of services:* Based on needs assessment data, a respite program in Fargo-Moorhead would offer medical care and supervision, in the very least intermittent care and case management. Most participants reported an anticipated length of respite stay to be one to two weeks post-discharge. Post-discharge needs to address would include medication management, nursing cares, coordination of follow-up care, transportation, benefits acquisition, and health education. Other possible needs reported were rehabilitation, physical and occupational therapy, and hospice. Specific nursing cares would need to be delineated based on admission criteria. Ownership and sponsorship of the program will need to be determined.

- *Identify a Model:* A specific model cannot be determined by project data but by the specific community resources available for use. The Fargo Housing Authority is an agency to collaborate with to choose an appropriate facility.

- *Design the Program:* Decisions will need to be made regarding admission criteria, policies and procedures, care provision and staffing needs, regulations and licensing, discharge planning, and partnerships to provide services. Fargo-Moorhead Coalition members and staff from Family HealthCare and Homeless Health Services would be best to collaborate with to accomplish this task.

- *Determine Costs and Identify Funding Sources:* Many service providers asked about how to fund a respite program. Funding may at best be legislated, as one participant suggested, and may likely come from multiple sources such as hospital contracts, grant monies, community partnerships, and donations. A cost analysis needs to be completed to determine the measure of projected benefit for stakeholders involved.

A cost analysis may utilize hospital data regarding length of stay, rates of readmission, delays in discharge, and emergency room utilization. Other costs to determine include start-up and continuing costs. This analysis will form the basis for a business plan and proposal to area stakeholders.

- *Market the Program:* Marketing the respite program is essential, and may start with the creation of a business plan, proposal, and brochure with information about its mission, activities, and projected benefits. Collaboration with other agencies is paramount, and regular meetings are beneficial.

- *Implement the Program:* Once the above decisions are made, funding is secured, and set-up is complete, the respite program may begin servicing patients.

- *Collect Data and Assess Outcomes:* In order to assure quality improvement and assess outcomes, the outcomes and evaluation process must be decided early on in the process. Outcomes measured may include improvement of patient health and ability to function, and improved continuity of care.

- *Continued Evaluation:* Continuous evaluation of outcomes is a necessary part of monitoring program quality, and will likely be part of agreements with funding agencies.

What About Other Health Service Needs?

Although the need for a respite care program was identified, other needs to be addressed are listed below with suggestions for focused intervention as appropriate:

- *Cultural competence among service providers*—Participants verbalized concerns about cultural competence among service providers. One participant suggested utilizing an appropriate staff member to act as a "homeless liaison" between

patients and providers. Area service providers must reflect on their own attitudes and understanding of homelessness and cultural sensitivity.

- *Trauma-informed care, harm reduction among service providers*—Participants reported a need for understanding of the principles of trauma-informed care and harm reduction among service providers. Provider training on the culture of homelessness and these principles may be beneficial. However, it is the duty of all service providers to treat clients with respect.

- *Hands-on nursing care in shelters*—Shelter staff participants expressed a need for more hands-on nursing care to be provided in all shelters.

- *Consumers' need for dental care*—Service providers may need to educate homeless patients on the availability of free dental clinic resources, such as Family HealthCare, in the area.

- *Consumers' need for insurance*—Some participants expressed the need for more case management who may assist with acquisition of benefits and other resources. With the changing health care landscape of the Affordable Care Act, enrollment efforts are to be streamlined, and Medicaid may be expanded to include all non-disabled, non-elderly adults aged 19 to 64 years earning at or below 138% of the Federal Poverty Level (KCMU, 2012; NHCHC, 2012). If passed in North Dakota, about 24,000 more people will gain coverage; if not, about 14,000 persons may still purchase private insurance through the state exchange but will be ineligible for premium tax credits (Calsyn & Lee, 2012). Minnesota has already committed to expanding Medicaid (Calsyn & Lee, 2012). Administrative and staffing challenges may remain an issue with increased enrollment if passed in North Dakota (KCMU, 2012). The expansion's

magnitude of effect on each state varies, and costs of expansion are weighed against

savings from reduced state payments for uncompensated care and reduced

administrative costs (DHHS, 2012). States may, however, incur a short-term

increase in administrative costs of implementation (DHHS, 2012).

- *Consumer coverage for substance abuse treatment:* Issues of lack of coverage for

    substance abuse treatment are similar to discussion above.

- *Affordable housing in Fargo-Moorhead area:* As previously discussed, more

    affordable housing is needed in the community and is the base solution of the

    Housing First model. Participants expressed a need for Housing First programs to be

    fully embraced in the area.

Conclusion

Homelessness is a direct threat to health, and the importance of addressing

homeless persons' basic needs must be balanced with needs for health care and supportive

services. Service providers must recognize the need for harm reduction in service

provision and the need for appropriate long-term solutions to prevent homelessness. Area

stakeholders must be informed and involved in taking action to address homeless persons'

barriers to health care access and corresponding health disparities. The need for a medical

respite program in the community was established with this project. It is hoped that this

information may help direct further interventions to address the health needs of the Fargo-

Moorhead homeless population.