Health care for homeless persons has long been rooted in caring for the emergent and episodic needs of a people whose daily lives are punctuated by uncertainty and vulnerability. Accident, injury, exposure to the extremes of heat and cold, and a range of communicable diseases facilitated by crowding repeatedly compromise the health and well being of people who are homeless. With the pressure to assure that each new event in their lives is cared for in the best way possible, the many other chronic conditions that are a part of their lives often do not get our full attention as clinicians.

Readily accessible, consistent, and continuous care from a known and trusted clinician is not always available for many people experiencing homelessness. Likewise, the systems that support our care frequently do not give us adequate information to understand the nature of each chronic condition and what parts of a care plan are yet to be completed.

Convergent with the rise in awareness of the burden of chronic illness borne by homeless populations has been the quality improvement movement in health care and other industries and systems over the past 15 years. The conversation about the definition of quality of care and the method of examining issues of quality has been going on for decades. The 1970’s were marked by peer review;
the 1980’s by quality assurance; and since the
1990’s, quality of care has been discussed in terms of
quality improvement. Not surprisingly, individual
clinicians, patients, health care organizations, and
insurance providers may have contrasting perspec-
tives on what constitutes quality of care.

Most homeless people have at least one, and
often several, chronic diseases, yet often our delivery
systems are focused on the episodic treatment of
chief complaints at a given moment in time. Since
the early 1990’s, a slow shift in emphasis has occurred
from this sporadic-type care focusing on individual
and immediate issues to an emphasis on treatment
of chronic disease in a revolutionary way. Instead of
focusing on anecdotal evidence of best treatments for
given symptom complex, the emphasis has shifted.
Now more resources are devoted to treatment based
on clinical evidence, centered on the whole patient,
and resulting in specific key improvements that are
measurable and directly related to overall health,
including morbidity, mortality, and quality of life.
All around us is a push to close the gap between
what we know – that extensive amount of evidence-
based research that relates actions to outcomes – and
what we actually do when we see a patient.

Studies consistently show that homeless people
have a higher prevalence of chronic disease than the
population as a whole, and the ability of someone
who is homeless to manage disease optimally is
severely impaired by a lack of control over living
conditions and limited opportunities to consistently
follow an optimal treatment plan. Given these
factors, it is even more important to consider just
how population-based, chronic disease manage-
ment, in conjunction with measurable outcomes, affects care and quality of life. Moving from a
dependent, provider-driven model to one in which
the patient is empowered to set goals and determine
priorities results in the inclusion of the patient in
decisions. Since in reality patients do provide most
of their own care through direct self-care and deci-
sion-making about how a recommended treatment
plan will be followed, it appears natural to shift to a
model in which the patient and the caregivers make
decisions together. Whereas the clinician may define
the main problem in a visit as non-adherence, the
patient may define the main problem as loneliness
– a priority that should result in a revised and mark-
edly different treatment plan developed by both
patient and provider.

As the quality improvement movement has
resulted in measurable outcomes, such initiatives
have fit well into the treatment of chronic disease in
this collaborative fashion. In decades past there was
little effort and even less success in measuring the
level of quality in health care. Today science has
developed significantly, partly as a natural offspring
of evidence-based medicine and partly as a result of
initiatives sponsored by managed care systems in
response to regulatory requirements. In measuring
what we do, choosing outcomes that will truly make
a difference is step one. Medical literature searches
in a given chronic disease can result in a short and
focused list of key quality outcomes to measure and
improve. In the case of diabetes, even small
reductions in HgbA1C levels result in significantly
fewer future cardiovascular events, such as strokes
or heart attacks. Measuring this value should be a
part of every on-going treatment plan for diabetic
patients, and collaborative goal setting around this
measurement should be considered as one goal to be
followed and improved.

Such goal setting highlights the need to build
awareness of a disease through an education
program that assures the patient is an informed
partner in the design of a treatment plan. Only then
can our homeless patients truly direct their care in
a manner that understands and respects the reality
of life in the shelters and on the streets. This aware-
ness and education rests not only with the primary
care provider during a clinic visit. Ideally this is a
responsibility of a multidisciplinary team of profes-
sionals who tailor the education and treatment to
the patient’s readiness, willingness, knowledge
level, and capacity to learn. This may include
written literature, group visits, and nurse and other
educator sessions, such as dietary discussion. All of
this needs to be framed in the overall context of each
homeless person, respecting their activities of daily
living, resource availability, and personal desires and
priorities. The priority for our patients is rarely
improved control of their chronic diseases; rather,
the basic priorities of safety, food, or shelter absorb
their time and energy. Self-management goals must
be set by the patient, with help from the providers
and overall delivery system.

We are approaching an era of increasing oppor-
tunities to improve the care of our patients, even as
resources remain stretched for most of us. As new
models of integrated care emerge and new informa-
sion systems become more available, clinicians will
have more tools at the time of care to assist in joint
decision-making with our patients. The weight of
clinical evidence available in primary care is over-
whelming, and none of us can know and remember
all of the information that might improve our ability
to care for our patients. As point-of-care knowledge and assistance increases, our ability to provide the best care possible at each visit will improve. We seek the skills, time, and knowledge to respond to new symptoms and new life situations facing our patients with chronic diseases. The next few years will yield dramatic changes in outcomes and better quality of life for us all.

Reference