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An interprofessional approach to a service-learning health project for area homeless: A case study

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Abstract

Providing health care services for the homeless community requires multiple health care disciplines to meet the varying needs of the community. The needs of the homeless are multifaceted and thus require expertise of an interprofessional team to help break down barriers and achieve positive outcomes for the clients served. This case study shares the work done by a team of faculty and students from a local university in Marriage and Family Therapy, Counseling, and graduate nursing. The focus of the group was to provide physical and mental health screenings and make appropriate community referrals as needed. The work was sponsored by a grant from a local foundation and was carried out in three area homeless shelters in a small town located along the interstate.

Key Words: Interprofessional, Homeless, Health promotion, Service learning

Interprofessional Education

Interprofessional education (IPE) occurs when students from two or more professions learn from and with each other in a manner that leads to effective collaboration with an endpoint of improvement in healthcare outcomes (Institute of Medicine, 2015). Learning to collaborate with other professions requires an understanding of how the roles and competencies of each profession can complement each other to reach a common goal of improving health care for a population of people (Core Competencies, 2011). The World Health Organization defines collaborative practice as multiple health professions from varying professional backgrounds working together with a population to deliver the highest quality of care (WHO, 2019).

In 2009, six national associations of health professional schools formed an Interprofessional Collaboration (IPEC) to promote interprofessional learning experiences, with a goal of preparing health professionals equipped to engage in interprofessional team-based care upon graduation (NLN, 2010). Key players in the IPEC were the American Association of Colleges of Nursing, American Association of Colleges of Osteopathic Physicians, American Association of Colleges of Pharmacy, American Dental Education Associates, American Association of Medical Colleges, and Association of Schools and Programs of Public Health (NLN, 2010). This collaborative group identified a framework for interprofessional collaborative practice which contained four key competencies:

1. Values and ethics. As students learn to work with other professions, the environment must support mutual respect and shared values.
2. Roles & Responsibilities. All participants need to understand the roles of each profession to effectively plan delivery of health care services to the populations served.

3. Interprofessional communication. There needs to be responsive and responsible communication to patients and aggregate groups in a manner that promotes health maintenance and disease management.
4. Teams and Team work. Groups need to utilize relationship building values and team dynamics to aid teams as they deliver effective and safe patient/population centered care. (NLN, 2010).

The advantages of working with IPE in a target population includes pooling of resources, a shared commitment to creating a safe and effective care environment, promoting a somewhat seamless plan of care, and learning from each other's professions and strengths. IPE may come with challenges and barriers as well. Some barriers might include: 1) variances in values and ethics of each professional group; 2) being able to articulate and understand the roles of other professions within the collaborative large group, and 3) understanding legal boundaries of each profession involved (Core Competencies, 2011).

Several studies share descriptive case stories about successful IPE activities that have improved patient outcomes in populations they served. Hunt et al. (2018) implemented a quality improvement collaborative training program for pharmacy residents, nurse practitioners, physicians, and registered nurses to promote safety and efficacy in a Veterans Affairs health system. After a year long initiative they were able to document several health improvements for clients they served. Yellowitz (2016) worked with an IPE between dental health professionals and family practice providers to promote better oral and overall health for a population of older adults. Sandhu, Hosany & Madsen (2015) utilized cross disciplinary teams to promote public health promotion. At the University of California Berkely there is a public health innovations course which directs students to work in small interdisciplinary teams with client organizations to provide health education and resources in needed areas. Kolomer, Quinn & Steele (2010) found interprofessional health fairs including nursing and social work as a positive means to reach and assist older adults in their community with health screenings and identification of helpful resources.

Accreditation bodies for health professional education programs have requirements for interprofessional education activities. For example, programs in Couple and Family Therapy require that programs must develop competency in multidisciplinary collaboration by their Commission on Accreditation for Marriage and Family Therapy Education. The American Association of Colleges of Nursing (ACEN) has essentials for undergraduate and graduate nursing programs to incorporate content that supports communication and collaboration among healthcare professionals. They stipulate particularly to graduate nursing programs that as a member and leader of interprofessional teams, master's level nurses communicate, collaborate, and consult with other health professionals. Similar requirements are noted in medical education and occupational therapy (Core Competencies, 2011).

The Homeless Population

The 2019 State of Homelessness National Alliance to End Homelessness reports a staggering 552,830 homeless persons in the United States each night. These numbers are particularly high in some large, major cities including New York City, San Francisco, Washington DC, New Orleans and others. In the state of California, the per capita incidence of homelessness is 17/10,000 persons on any given night. In our state of Louisiana, that number is 7/10,000 per night. Housing and Urban Development (HUD) defines homeless as lack of a fixed, regular, and adequate nighttime residence. HUD statistics

indicate that 20% of homeless have some form of mental illness, 16% have chronic substance abuse problems and 44% have some type of medical or mental disability.

Homelessness presents serious health care challenges related to the lack of access to health care. Barriers to health care access for the homeless population include lack of transportation, lack of available providers willing to provide care to homeless, lack of specialists for particular health care needs of the homeless (mental health, HIV, wound care, infectious diseases, women's health, dental care, etc.), and patient unwillingness to seek care due to perceived discrimination from health care providers. Kertesz et al. (2013) surveyed homeless patients in Birmingham and discovered several barriers to access to health care and prescription medications. Barriers they found include inability to pay for services, inability to procure an access card for the health services, did not know where to go for assistance, lack of transportation, inconvenient office/clinic hours, lack of childcare, and long waiting times to be seen.

Homelessness is not just an American problem. Several countries report significant problems in trying to provide care for their homeless citizens. In France, homeless populations face similar barriers. Vuillermoz, Vandentorren, Brondeel & Chauvin (2017) interviewed 656 homeless women and noted barriers and unmet health care needs related to food insecurities, poor spatial health access (transportation, safety around clinics, and lack of providers in their area), victimization, and poor self-perceived health, both mental and physical. A Canadian study looked at their homeless population barriers to health care in the Calgary Homeless Foundation (Campbell, O'Neill, Gibson, & Thurston, 2015). Health care providers surveyed in this study identified significant needs for addiction and mental health services for the homeless, identifying this as one of the biggest barriers. Other unmet health needs were related to nursing care, dentistry, optometry, pharmacy and rehabilitation. The authors interviewed patients in the same study who identified their barriers, including:

1. Fear of bad news during a time when they were already highly stressed by their circumstances.
2. Fear of the provider, fear of authority.
3. Feelings of shame and low self-esteem
4. The atmosphere in the clinics which made them feel discriminated against
5. Lack of transportation or money

Another study of homeless in Brazil (de Oliveira et al. 2018) identified health care unmet needs stemmed from a lack of close access to health providers and a lack of required identification to grant them access to health care. Respondents in their survey wanted health clinics located in the area near homeless shelters and reduce the documentation required to gain access to the system.

Many studies across the United States cite solutions for mitigating those unmet medical needs for the homeless include providing interdisciplinary interventions that promote continuity of care and are timely and responsive as well as effective and coordinated to meet the complex needs of the homeless (LaManna et al., 2018; Rose, Lyons, Miller, & Comman-Levy, 2003; & Goodier, Uppal, & Ashcroft, 2014).

Mental health needs represent a significant unmet need for the homeless for a variety of reasons. Duhoux et al. (2017) noted high usage of hospital emergency room services by the homeless for mental health issues due to uncertainty of providers in their area, long wait times to see a provider, embarrassment or discomfort in seeking care, and competing priorities for basic needs of survival. Lee et

al. (2010) noted very limited access to care for mental health services and developed a plan to integrate mental health service providers with welfare service officers to improve access for the homeless. Another group (Stergiopoulos et al., 2018) developed a successful bridge program to connect homeless with mental health needs into an interdisciplinary intervention which offers a case manager, peer support, and access to psychiatric care. Participants in this study (n = 223) demonstrated improvement in overall mental health symptoms, substance abuse and number of hospital admissions.

The Case Study

With grant support from a local community foundation, faculty from graduate programs in nursing, marriage and family therapy, and counseling collaborated to form a Mobile Bridge to Health project. The mission of the project was to provide physical and mental health screening assessments for homeless participants in three area homeless shelters. The uniqueness of the project for this community was to provide an interprofessional collaborative effort to bring health promotion and health/mental assessments to local homeless populations in the three area shelters. The team worked to establish a bridge to sustainable health care with local established health care agencies by identifying individual's referral needs and making connections to the agencies as needed. The goal was to develop trusting relationships with the homeless population and Mobile Bridge faculty and students, then help the homeless person transition from a state of distrust of established health care agencies to a more accepting state in order to receive the sustainable health care services that they needed.

A key element of the project for faculty was to encourage student participants to treat all clients served with dignity and respect in a manner that strives to gain their trust and eventually to help stabilize their health conditions. This project was also designed to help students learn to engage with other professions in a cooperative team to be able to deliver a full complement of health services for physical and mental health needs of the homeless in our community.

One early observation among the area homeless clients was their distrust of established health care providers. Issues that triggered this distrust stemmed from their personal fear or distrust of bureaucracy and their fear of loss of privacy. Some agencies had made some attempts to provide physical health services previously, but the timing of their services was sparse and unpredictable. We were very careful to make sure that our services were scheduled regularly and consistently. The primary goal of the Mobile Bridge to Health program was to establish trust by providing dependable, consistent, and approachable services to establish an atmosphere of trust and respect for their needs. We also worked to provide needful, relevant health education and to make appropriate referrals to agencies as needed.

In the initial phase of the program, while equipment and supplies were being ordered and received, faculty from each profession met frequently. These meetings allowed the team to explore roles, responsibilities, and legal/professional limitations of each profession for this endeavor. As the team worked together, they formulated a collaborative plan to begin the shelter visits. Some of the early preparatory work involved developing tools for physical and mental assessments, patient satisfaction tool, informed consents, and guidelines on how referrals and resources would be utilized.

Health care assessments could include diagnostic assessments of blood pressure, height/weight, and physical assessments of heart and lung and any presenting symptoms. Equipment was available to check fingerstick glucose, hemoglobin A1c, hemoglobin, pulse oximetry, spirometry, and doppler analysis of peripheral vascular status (ankle brachial index). Basic wound care supplies were included in our mobile suitcases for any wound care or dressing changes needed.

Marriage and Family Therapy students and Counseling students and faculty provided one-on-one listening sessions for those interested in this service. Oftentimes the faculty members actually provided the service themselves to allow students the ability to directly observe. The initial struggle for the MFT and Counseling faculty and students was the development of a therapeutic alliance and the gaining of trust with this vulnerable and distrusting population. To break down those barriers, faculty and students would approach individuals very respectfully and casually. It was not expected that anyone would seek out services of their own accord, initially. This approach worked beautifully and very soon members of the homeless population were delighted to have someone to talk to about anything and everything. Once that rapport was established, assessing for any mental health concern, such as suicidality, was relatively easy as it was approached very conversationally, with care and compassion, and without judgement. A major portion of the interviews included discussions on how to best provide for the mental health needs of the individuals in specific, and the greater community as a whole.

Initially there were some scheduling issues that created conflicts with the Mobile Bridge, but these were quickly resolved. Staff in the agencies were very helpful in scheduling our activities and helping to encourage patients to take advantage of the services. In one agency we arrived right after their morning Bible study time and just prior to their noon meal time. This timing was beneficial to our project, as patients were less likely to leave the agency before meal time, so they were willing to partake of our services while waiting for their noon meal. In the other major agency that we worked, patients checked in to the facility at 2:00 p.m. each day, which is when we set up our mobile units of operation. This agency was a Salvation Army, which allowed ample space for our operations. Marriage and Family Therapy and Counseling students and faculty could talk with participants in the quiet sanctuary area and nursing set up in the adjacent large meeting area. There was a continuous flow of patients for nursing and mental health services from 2:00 p.m. until the supper mealtime. Lessons learned by the team members here is that equally as important as approaching the homeless individuals themselves with dignity and respect is the development of working relationships and buy-in from the agencies and shelter staff too. Additionally, allowing for flexible scheduling is a must for anyone considering replication of this type of interdisciplinary training and community service.

Another lesson learned through interacting with the population was the need to tailor interactions to fit the specific needs of the population. Across multiple interviews individuals indicated what kind of interactions would be beneficial, and what they would be interested in discussing and learning about, both from members of the Mobile Bridge unit and from peers within their own population. This led to evolving and changing interactions and services provided, as adaptations were made to accommodate the desires and needs of the population.

Each person who participated in our Mobile Bridge to Health was treated with dignity and respect. Students and faculty provided assessments and screenings as well as health education. Every participant received a small backpack filled with snacks, socks, underwear, and toiletry items as a thank you for their participation. We had a fair number of repeaters among our participants, some from the

same agency and some who were utilizing the services of both agencies. It was encouraging to hear them share things that we had suggested to them from the last encounter they had with our students and faculty.

Over the course of the five months of actual service under this grant, we had 118 medical/nursing visits and 37 mental health visits. Many of the medical issues identified were related to diagnoses of hypertension and diabetes, some well controlled on medications, but others not as well controlled. Other medical needs seen included asthma, wound care for stasis ulcers, CHF exacerbations, and seizure disorders, pregnancy, and upper respiratory infections. Many were on medications for their diagnoses, though not consistently compliant due to cost factors. Counseling and Marriage and Family therapy visits commonly reported depression, anxiety, grief, relationship problems, and struggles with drug addictions. A binder with community resources was compiled to assist participants with various physical and mental health concerns and included bus tickets to help them access resources.

Our grant funding has ended, but faculty and students remain committed to the project and will continue to offer services to these agencies and their homeless residents. There is a clear need to continue to break through barriers with screenings, health education, and counseling services. Plans are already in the works to request a Phase Two of this grant which could also include other health professions located within our campus including speech and language, occupation therapy, and dental hygiene students.

An analysis of the project

For the homeless community. Each participant in the Mobile Bridge project was asked to complete a brief satisfaction survey following their encounter with us. Responses were recorded confidentially in Survey Monkey. Every response was positive (100%), many were complimentary. Some requested additional services to be considered including eye glasses, prescribing blood pressure medications, appointments with psychiatrist, and handouts on diabetes. In conversations with the homeless in the shelters, several expressed a desire for more small group therapy sessions and more education on psycho-education topics for future visits.

For the graduate students. Nursing students at this university are required to complete four hours of community service hours each semester, which made it easy to keep a full complement of nursing students involved in the project. Many of the nursing students who worked with the project returned for additional days of work above and beyond their required service hours because they enjoyed the service opportunity so much. Students in Counseling and Marriage and Family Therapy benefitted from an additional opportunity to earn clinical hours required to graduate. There was also a surprising depth to the clinical work given that it was not a typical therapy situation, and even seeing a particular client on a regular basis was unlikely. It was an environment in which skills learned in the Marriage and Family Therapy program had to be practiced quickly. In one instance, students acted on their duty to warn with a client who trusted them enough to disclose her perceived danger to herself. This is an experience that is rare for students to have, but crucial to performing protective elements of the therapist role competently. In the case of a different client, a student learned their life story and collaborated to achieve an understanding of this client's family background over four "sessions" at both sites. This experience is worth mentioning because in contrast to the instability the client's typically

faced in their everyday lives, the therapy services offered were not superficial. They reached similar levels of intimacy to therapy that a client who entered the on-campus MFT clinic might receive.

For the faculty. Faculty in MFT program were involved in the project on multiple levels. Faculty went to experience what kind of interactions could feasibly be provided before seeking student participation. Supervision was provided for students by faculty in multiple forms, including advising on dress to appear approachable, and how to interact in ways that would be non-judgmental and potentially beneficial to individuals in the shelter. Student volunteers were also prepped on ways to remain aware of their environment, to travel in groups, and to remain within relative proximity of one another in order to increase personal safety. In addition to this preparatory role, faculty were also available to students for debriefing or discussion of any issues that were raised by individuals in the homeless population. Faculty also went to on-site locations and interacted directly with individuals and staff members in the shelters.

The nurse practitioner faculty were committed to providing free healthcare to the homeless community and providing meaningful clinical opportunities for the graduate nursing students. This project allowed faculty to meet both goals. The graduate nursing program is an online program of study, which limits faculty-student interaction times in a face to face format. Supervising graduate nursing students in the homeless shelters allowed faculty more insight into student clinical performance, critical thinking processes, and their level of professionalism. Time commitments for faculty generally consumed four hours each week to travel to the homeless shelters and supervise student activities.

Graduate nursing faculty members in the nurse practitioner programs participated in the weekly visits and helped coordinate student participation. They also provided healthy snacks and bottles of water for the participants. Faculty commented that “It was so moving to develop relationships with members of the homeless population”. The two primary barriers that the team had to overcome included: 1) having students agree to participate in the weekly activities; and 2) having homeless members of the shelter come to the area in the shelter that was designated for care. Ultimately the support of faculty and shelter workers contributed to the success of having large numbers of participants at each weekly event.

Next steps

The team is presently working on a letter of intent for a larger grant to expand our services to the homeless population. The end goal is to have a mobile unit that allows us to be able to offer our services outside of our parish and truly meet the needs of the homeless in north Louisiana where they are.

There is a need for continued support for this vulnerable population. The project identified that there are gaps in care for the homeless. The hope is that through continued outreach and early identification of potential problems, the delivery of care to this population will improve. The simplicity and adaptability of the program makes it easily measurable, sustainable, and replicable in other homeless shelters. Addition of a shared decision -making tool might help identify issues that are concerning to participants. Monthly or quarterly huddles between the shelter workers, team members, and students might also contribute to buy in.

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