Healthcare Safety Net for the Homeless: A Qualitative Description

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Abstract

Background: Homelessness is a public health issue across nations. The 2011 Indian national census estimated 1.77 million men, women and children living without shelter. The US Department of Housing and Urban Development found 567,715 homeless people representing a cross-section of America.

Purpose: The purpose of this qualitative descriptive study was to examine the structures, processes and critical success factors (CSF) of free and volunteer clinics in Kansas City.

Methodology: A qualitative research design using a holistic multiple case study method was used to examine a purposive sample of five safety net clinics in an urban Midwestern state. Data were collected through participant observation and semi-structured interviews. The data were analyzed for common themes that describe the clinics' structures, processes and critical success factors.

Results: The clinics' missions, structures, processes and outcomes varied. Mission focus with dignity and respect and staffing with proper resources and stewardship were the dominant themes. Five subthemes arrived from the narratives: Mission is critical to the viability of the clinic, preserving human dignity, volunteers are treasured,adapting to meet evolving needs, and money matters.

Conclusion: The results suggest that a mission fostering person-centered care, dignity and respect for humanity impact the success of safety-net clinics, especially for the homeless population. The results will lead in creating a model safety net clinic in Vellore district.

Keywords: *Safety net clinics, homeless, critical success factors, structures, processes.*

Introduction

Home is a place of safety and comfort in every culture and country. Yet, an estimated 150 million people, about 2% of the world population, lack a home or any kind of shelter [1]. An additional 1.6 billion, or 20% of the world population, lack adequate housing with access to clean water or air, healthy food, sanitation, protection from the elements or personal safety[2]. Rates of homelessness vary between and within developed and undeveloped countries, concentrated in the cities[1].

Homelessness is a public health issue. Lack of food, water, sanitation and safety contribute to acute and chronic physical, mental and social problems, substance abuse and exposure to accidents and violence[3]. Congregant living conditions in shelters and camps is associated with the spread of communicable diseases and parasites, including tuberculosis, typhus, hepatitis, influenza and sexually transmitted diseases and emerging diseases[4].

The healthcare "safety net" is a broad system that helps to meet health needs of those who "fall through the cracks" of a health system. At a circus, a safety net is placed to catch a performer or an acrobat in case of fall. Within healthcare and social services, a safety net is defined as a heterogeneous and overlapping network of organizations that provide healthcare services to the medically under served, without regard to insurance status or ability to pay[5].

Healthcare for the Homeless in India: India is the second most populous nation in the world, with 1.35 billion people[6]. The 2011 Indian national census estimated 1.77 million men, women and children living without shelter[7].

The Indian Constitution requires each of the 29 Indian states to provide services for improved nutrition, standard of living and public health among its people. The socialized healthcare programs are well-designed, but lack resources to meet the needs of the homeless[8]. Funding is allocated based on the census, but healthcare avoidance behaviors contribute to under-counting[9]. Christian Medical College (CMC) is a mission-driven organization providing wide range of hospital and community health services through education, service and research to the people of India[10].

Anthropologists have identified that 7% of the population of the Indian state of Tamil Nadu is nomadic but there is little evidence of the gypsy populations in the census of India[11]. Priya Ranjani D., a Community Health Nurse at CMC, studied the health needs of homeless Roma (Gypsy) populations in a hamlet in the city of Vellore[9]. She identified 74.8% with chronic and acute conditions, including a variety of communicable diseases. Ranjani noted that despite the availability of socialized medicine, 34.7% of the gypsies of Vellore were reluctant or unable to seek healthcare. She proposed a study of the structures, processes and critical success factors necessary to create a sustainable safety net with minimal resources. The 4-month study focused on existing safety net clinics and programs in Kansas City,USA. The MODALE Scholars program, a research exchange between the CMC and the University of Kansas Medical Center provided funding for this research[12].

Homelessness in the United States: Despite being one of the wealthiest countries worldwide, there are socioeconomic disparities and homelessness in the United States. Unlike, India, America does not have socialized medicine and private sector takes the lead. A January 2019 point in time count performed by the US Department of Housing and Urban Development found 567,715 homeless people representing a cross-section of America[13]. It is found that the top four causes of homelessness among individuals were lack of affordable housing, unemployment, poverty, mental illness and the lack of needed services, and substance abuse and the lack of needed services[14].

Darnell described the medical community, private charities, and business foundations come together to help people with no health insurance and the structure of the clinic is focused on patient care with heavy use of volunteers and no bills generated[15].

Purpose of the Study: The purpose of this qualitative case study was to examine the structures, processes and critical success factors (CSF) of multiple safety net clinics in Kansas City to inform the development of a clinic model that can be sustained in India with minimal financial resources.

Methodology

A multiple case study method using a sample of five safety net clinics in Kansas City, Kansas. Case study research is a qualitative approach in which the researcher explores a real-life, contemporary bounded system(a case) or multiple bound systems(cases) over time, through detailed, in-depth data collection involving multiple sources of information, and reports a case description and case themes[16].

Research Questions/Framework

The research questions were:

1. What are the structure and processes of the safety net clinic in the Kansas City area?
2. What are the critical success factors of the safety net clinic in the Kansas City area?

The Donabedian model of Structure-Process-Outcomes guided the study.

Sample Selection: Researchers verified a homeless population in Kansas City. The January 2018 HUD point in time count confirmed 1,798 homeless people in Kansas City [13].Twenty-one safety net clinics served the vulnerable populations of Kansas City during 2019. A purposive sample of 5 safety net clinics representing different structures were selected for study.

Method of Data Collection: Data collection was done through in-person semi-structured interviews(lasting for 1 to 1.5 hours) which were audio taped. The semi-structured interview guide was used to ask open-ended questions to facilitate open answers.

One clinic leader/founder was given the official information sheet as an invitation to participate in the interview. Exclusion criteria was the inability to understand and speak English, or a non-leadership role

in the clinic. The principal investigator (PR) also spent approximately 10 hours in each clinic, observing clinic flow and operations. She also volunteered (3 months) with a mobile medical clinic to observe clinical processes in care provision to the homeless.

Data Analysis: Narratives were transcribed from the interviews after listening to the recordings to ensure accuracy of the transcription. The researchers read the transcripts line-by-line and highlighted meaning units that were then coded. After coding, common phrases across the interviews that supported the initial codes were highlighted. The transcripts were read again to support and analyze the data which did not support the codes. The codes were organized into categories to develop narratives. The archival records, observations, and field notes were also analyzed and coded into the categories developed from the analysis of the interview narratives. Five themes were developed from the codes and categories that describe the cross-cutting critical success factors, structures, and processes in all five clinics. Triangulation of multiple sources,peer debriefing,and audit trail of decisions made from inception of the study through development of the report support confirmability,credibility,and dependability.

Ethics: Potential risks to the human subjects were minimal. The study was IRB approved and written informed consent was obtained from all individuals who volunteered to participate in the study. No protected health information was collected. Data are reported in aggregate and identifiers in the transcripts were replaced with pseudo names.

Results

The missions, structures, processes and outcomes varied, as shown in Table(1). The interview process provided rich insight into the choices made to provide services in the studied clinics. A sampling of those comments helped the researchers identify 5 CSF for safety net clinics during 2019.

Table 1. Structure/processes of selected clinics

Structure/ process	Clinic (A)	Clinic (B)	Clinic (C)	Clinic (D)	Clinic (E)
Target population	87% immigrant and uninsured	Homeless	Homeless	Homeless men	65% Hispanic, immigrants and homeless
Individual patients served/yr	2000	>1000	6720	66000	Not sure
Clinic site	Multi-specialty clinic building on church premises	Mobile clinic in a converted bus at 3 scheduled stops	Mobile clinic in a van at multiple stops	Permanent shelter for housing, clinic, meals and training	Multi-specialty clinic located in a public school
Supporting organization	Faith based	Non-faith based	Faith based	Faith based	Non-faith based
Mission statement (MS)	Has/follows MS	Has MS, but does not remember	No MS for clinic	Has/follows MS	No MS
Budget/year	$1.5M USD budgeted	No planed budget	$14k expenses No planned budget	$113.5M USD budgeted	$1M USD budgeted
Charge patients	Free or as able to pay	Free	Free	Free	Free
Staffing	23 paid staff; 40 volunteers	45 volunteers	60 volunteers	135 paid staff; 300 volunteers	5.5 paid staff;students, volunteers
Governance	Church board, not specific to clinic	7 active volunteer board members	No board	12 active board members supported by staff	University board, not specific to clinic
Scope of services	Primary care; care coord; medications, supplies	Primary care; medications, supplies	Spiritual support; hygiene supplies; food; clothing	Spiritual support; Primary care; care coord; medications, supplies; life skill classes	Primary care; supplies

The interviews provided rich detail related to the structures, processes and critical success factors for the safety net clinics.

Mission is critical to the viability of the clinic. The mission was important for clinic success long-term. The mission guided grant opportunities and programming. *"If the clinic is focused on its vision and mission the viability of the clinic is assured. The staff and volunteers need to be constantly reminded about why they are doing what they are doing."*

Preserving human dignity was key issue for clinic success. Clinic directors discussed the importance of preserving human dignity and providing culturally sensitive care. *"It's really up to them (patients), to participate in the way that they can".*Each clinic mentioned the importance of building trust within the community. Trust was vital to engagement between the clinic and the community for ongoing provision of care.

Volunteers are treasured:*"My volunteers are compassionate people and our patients know that they care about them and they embrace them".* "*I believe in the community…. the religious people are responsible for it (the outreach). They are empowered and everybody takes a little part in it".*

Adapting to meet evolving needs was identified in every interview."*We are very intentional about how we set up the clinic and how we can meet the current needs of people in the current neighborhood. We change as the needs of the neighborhood change throughout time.*"

The clinic directors reported diverse needs that they often struggled to meet. Specialists and bi-lingual providers are particularly rare. Woman's health was a recurring issue.*"We do so much women's health. We have 2 volunteer gynecologists…we built their capacity to do colposcopy as the care is so hard to get."*Dental care and ongoing psychiatric support are particularly difficult to find. *"Yesterday was a perfect example of somebody a brand-new patient that had the needs of psychiatric care and he can't access…I can't access it for him and he really needs it but not sick enough. He had no option but to come to us and I have no other option but to put not so well trained psychiatric add on to the best I can."*

Money Matters: Each of the clinics relies on donations from individuals, organizations and foundations. Clinic directors expressed frustration that their services save health systems and insurers a great deal of money, but consistent financial support has been difficult to find. *"Part of the problem was timing and the federal Government here in the United States we were saving the hospital tremendous amount of dollars by keeping people well and out of the hospital and out of the ER and we did do a small study to show that we were saving 1000s and 1000s of dollars."*Local hospitals and health systems have been willing to provide diagnostic procedures, pharmaceuticals and treatments to the larger clinics, but do require documentation that the clinic patients are residents of the county, or a letter of attestation that they are homeless. This procedure preserves hospital sources of funding targeted to specific populations.

Critical Success Factors: During the interviews, the clinic directors were asked to identify, define and discuss the operational implications of the list of critical success factors identified by Marion in 2006[18]. Participants ranked the top 5 critical success factors essential for the success of their clinic on a Likert type scale of 1 to 5. The CSF responses were analyzed using content analysis by matching the verbatim responses to appropriate content categories

Ranking of Critical success factors for Kansas City clinics

Rank 1: Mission Focused: Viability assured if focusing on mission and will be assured if staff and volunteers constantly reminded about why they are doing what they are doing.

Rank 2: Community Engagement: Awareness and engaging the community for care, support and volunteering

Rank 3: Collaboration Reach out, building collaborations and partnerships on common grounds for caring the vulnerable.

Rank 4: Ongoing Evaluation/Research: Evaluation changes mundane work and research open doors for more scope

Rank 5: Fund Raising/Stewardship: Grant writing, community activities, searching for available donors and foundations will generate clinic revenues. Proper account keeping and accounting will ensure stewardship.

Discussion

Every one of these clinics was unique in the organizational structure, history, mission, vision, objectives budget and management of finances, staffing, volunteers, hours of operation, services provided, and public/client relations. Within this study, the faith-based clinics were more driven towards providing medical care, basic necessities and comfort to the clients with dignity and respect and according to their mission and vision and their objectives. The non-faith based clinics were more driven towards giving quality medical care, healing ailments, and providing healthcareto the underserved and uninsured. This is consistent with Dr. Maryon's Critical Success Factors in free clinics in Michigan[17].

One clinicfocused exclusively on the spiritual and basic physical needs of the people. The clinic's main service is going to the people, showing love and care by giving a hug, listening and talking to them, hold hands with them and pray with them, share food, clothing and hygiene supplies to them.Persons needing medical or psychiatric care were referred to other clinics or theemergency room. This clinic demonstrated that health starts with love and care, good nutrition and getting the basic necessities to live.

Conclusion

This study helps to fill a gap of qualitative studies on free and safety net clinics. The interviews and critical success factor rankings provide rich insight to nurses or organizations wanting to create or sustain a safety net clinic. A multi-step process will be used to create a safety net clinic for gypsies and other homeless in Vellore, India. The first step, underway now, is development of a community advisory board will be formed which will include a doctor, nurse, philanthropists, veterans,lawyer/ police, pastors/nuns, social worker and most importantly, a representative/leader of the community. The board will use results of this study to devise a sustainable safety net for unserved populations. The scope of services will evolve over time, consistent with the funding available.

Conflict of Interest: Nil

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