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Nursing Model of Protection-Engagement: A Theory of Integrated Care with Persons Living Houseless

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ABSTRACT

People experiencing homelessness have poorer health than the general population. Caring for those within this special population requires complex, non-traditional care for chronic conditions management, mental health disorders, substance use, and violence. Chronic poverty in the Appalachian Region of the United States compounds difficulties. This paper presents an innovative model of care called the Protection-Engagement nursing model of care with persons living houseless and unsheltered. The result was a process of integrated patient-centered care provided by advanced practice nurses, social workers, and counselors who deliver primary and mental health care, case management, counseling, and community outreach in a day center/clinic with those who are homeless, vulnerable, and with those who live in social and economic poverty.

Keywords: nursing, integrated healthcare, homeless

"Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" World Health Organization (WHO).

Introduction

Record levels of homelessness affected nearly all populations in the United States in 2024. Homelessness among people in families with children, individuals, people staying in shelters and unsheltered locations, and unaccompanied youth comprised a total of 771,480 people, or about 23 of every 10,000 people in the United States.[1] Persons living in homelessness, particularly those with multiple chronic conditions (MCC), substance use disorder (SUD), coexisting mental and substance abuse disorders (COD), and serious social health deficits are most intractable to sustained care. They suffer from more chronic health conditions while facing mental health challenges that result in poor communication skills, chronic substance addiction, impulsivity, violence, paranoia, and mental health symptomatology. These complex health indicators result in the inability to sustain treatment within traditional systems. The targeted population responds more readily to different models that are less structured; models that focus on engagement and relationships. In addition, the presence of interpersonal violence, particularly against those identifying as women or LGBTQ+, creates extraordinary barriers to engagement into traditional treatments.[2,3] Therefore, an environment that fosters safety and relationships framed by a model is important to health provision in this most vulnerable, marginalized group.

Background and Significance

Homelessness and poverty are almost synonymous. The Appalachian Regional Commission (ARC) identifies regions in upper east Tennessee, Southwest Virginia, Southeast Kentucky, and Western North Carolina as economically at-risk; suffering from generational poverty due to lack of resources and work; all contributing to poor health throughout the 8-county area.[4] ARC identifies the diseases of despair, alcohol, prescription and illicit drug overdose; suicide, alcoholic liver disease/cirrhosis as a crisis in our region that remain 37% higher in the Appalachian region when compared to the non-Appalachian region. Alarmingly, the rate was 49% higher in those identifying as females.[5] In Tennessee, opioid drug use is among the highest in the nation, along with cardiovascular diseases, hypertension, and diabetes.[6] With the added opioid crisis and rise in chronic conditions in our region, persons living with economic disadvantage have chronic poor health.

Aim

As need for care of this vulnerable and marginalized group of persons grew, there was need to develop a model of care that organized a structure of integrated care. We synthesized philosophical and theoretical traditions to derive the model to explain how care with persons living houseless, and marginalized groups was developed. The model derives from the nursing metaparadigm, emancipatory and strength-based traditions, and fits a practice nursing delivery model with marginalized persons and groups.[7-11]

Our model, Protection-Engagement, is supported by our research that extends the definition of protection. The perspective of women living houseless within violent environments suggested a relational dimension of protection because they described protection as connectedness through being with and caring for others.[7] Protection, as emotional safety was explored within the situational environment during the COVID-19 pandemic .[12] Again, this research supported the connection to others as a dimension of protection. Relational and advocacy dimensions of protection were expressed by Walter,[13] who provided an emancipatory nursing praxis to guide understanding of how to advocate and transform structural inequities within our systems; a learning framework that established relationships by engagement into critical dialogue and reflection.

Engagement into care, based upon relationships between patient and provider, is universally understood by health care practitioners. However, providing and structuring health care to include individual relationship with a caregiver and the environment where that caregiving takes place has not been well defined.[14,15] People experiencing homelessness (PEH) with co-occurring mental health issues and substance use disorders present a challenge to healthcare providers and public health practitioners seeking to engage and retain them in care. Providing continuous treatment is hampered by both individual characteristics, but greatly exacerbated by a fragmented health and social service system.[16]

Purpose

Extension of our understanding of protection-engagement from the perspective of a houseless population is important because those living houseless and unsheltered face unique challenges as a population. As a community they face danger from an unsheltered environment and difficulties maintaining health individually and socially. Therefore, the purpose of this article is to describe the Protection-Engagement nursing model of care, and its application to care in a nurse managed clinic and day center for care to those living houseless and unsheltered. The organizing constructs were informed by emancipatory philosophy, nursing models, from nursing research, observation and provision of nursing care with those living and suffering the injustices of unsheltered environments, houselessness, and who live within social and economic poverty, and marginalization.

Methods

The model originated in our practice, first using observation, then through our research.[7,11,12] It was observed that a safe, non-judgmental environment where safe behaviors were privileged over sobriety resulted in more engagement with persons who had the most difficulty maintaining consistent health care. By linking protection with engagement in the care of persons experiencing homelessness, the framework organizes nursing care specific to population needs.

Definitions

Our definition of homelessness is more inclusive than other definitions that consider only those currently living on the street or in an emergency shelter. Those who meet our definition of homelessness self-report as currently living without shelter, have experienced unstable housing, or who have lived without a permanent home for one day or greater, or describe sleeping on the street, sidewalk, vehicle, park, abandoned building, bus or train station, under bridges/overpasses, in the woods or outdoor

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encampment, motel/hotel, house or apartment of family or friend, or jail.

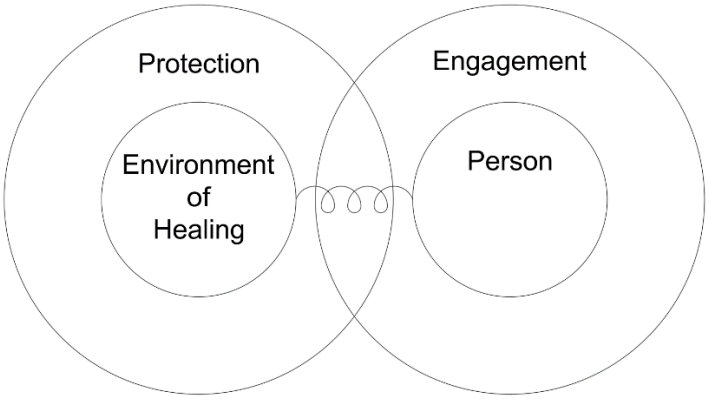
Environment

Environmental care was informed from Nightingale[17] and application of Neuman's Systems Model in practice.[18] Nightingale's concept of the environment emphasized nurses' provision of a safe, healing place where the reparative process can occur.[19] Neuman's concepts of the environment included the internal physiological threats and external social/familial/community threats, with the nurse developing interventions along the lines of defense in response to both internal environmental and external environmental stressors.[20]

The environment of PEH includes those who are episodically homeless with unstable access to shelter and those who are chronically homeless. The risk of all types of violence against people without access to shelter is considerable. Additionally, houseless people, including undocumented migrant workers, face difficulties maintaining cleanliness, have limited or no access to safe medication storage or dressing/wound treatments, are at increased risk of environmental exposure to unsafe drinking water, pollution, and chemicals, and extreme weather events. These environmental inequities are strongly linked to economic and social inequities.[21]

Protection

People experiencing homelessness need protection from the adverse events they face within their unsafe environments. There was a shift in the U. S. policy toward using permanent supportive housing (PSH) rather than shelters and transitional housing. However, the housing crisis, including inequitable access to affordable housing or shelter has exacerbated the homeless problem in the United States. Persons living houseless or who have housing instability experience higher morbidity and mortality compared to stably housed persons. Therefore, health care provision that is organized according to their needs is one piece of the continuum of care required. Essentially, PEH need access to holistic care by embedding services together to support seamless transitions to address needs as they arise.[22]



Protection-Engagement Model

Concept dimensions include: non-violent non-judgmental interactions, active listening, person enters/reenters into a safe environment; person centered care, integrated care. In this framework, engagement represents a continuous spiral because the population lacks trust in systems and must be intermittently engaged back and forth into a healing environment. Healing requires small, incremental steps that lead to optimal health. Only after engagement occurs can screening, treatment/care management, and referrals take place.

Case Description

The results are described as protective services and engagement services. The model was patient/population generated. PEH enter through clinic outreach efforts, self-referral, word of mouth, or through referral from other providers and health systems. Nurse-managed primary care was new at the time of the clinic's inception in 1990. Primary care and mental health services provided by family and psychiatric nurse practitioners was first integrated in 1993. The organizational model for integration included registered nurses who established their own patient pool, and nursing students and faculty who organized health screenings. The team organized care management to reduce fragmented care. Care focused on primary prevention, immunizations, well child care, chronic disease management, dispensing medication, education, and adaptive treatment care plans, such as feeding patients and administering their medications for diabetes. The nurses acted as liaisons for hospitals, service agencies and medical specialists. The JCDDC expanded to include a permanent transdisciplinary team of social workers, nurse practitioners, nurses, outreach workers, and clients in remission, to provide psychiatric, social support, street outreach, and mental health and primary care health services to the target population of homeless persons with SUD and COD. The unique format is that interprofessional services are integrated as small teams within one location that is easily accessed.

In any year, the staff at the JCDDC provide over 13,966 encounters to 1237 unique homeless individuals. The professional staff provides consistent psychiatric, social, and primary care services. ETSU Clinical Staff developed recovery-oriented service systems and coordinated clinical treatment with recovery support systems designed to prevent or delay the onset of and complications from substance abuse and mental illness. The staff is proficient and trained to identify and respond to emerging behavioral health issues. Monthly peer support group sessions are provided to prevent and reduce prescription drug and illicit opioid misuse and abuse. The Projects for Assistance in Transition from Homelessness (PATH) grant through Substance Abuse and Mental Health Services

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Administration (SAMHSA), supports screening, diagnostic treatment, community mental health, and referrals for education, job training, and housing directly to the clinic case manager. If the person requires primary care, the nurse practitioner is available for immediate consultation. JCDDC staff provide HIV education to reduce HIV/AIDS risk behaviors. Community linkages included coordination with community medical specialists, the public school system, rehabilitation facilities, Department of Human Services, Legal Aid, City Community Development, city and county jails, Hope for Tennessee and ETSU Infectious Disease Physicians' Ryan White Program for HIV drug access and connect with Housing Opportunities for Persons with AIDS (HOPWA) permanent supportive housing.

Sustainability is difficult when caring for the poor and underserved populations who suffer from chronic illnesses exacerbated by their unsheltered, unsafe living environments. However, the nurses maintained a community presence by talking about the care efforts at local organizations, churches, schools, with political leaders, and the news media. Participatory management included open, egalitarian communication amongst clinical personnel and outside medical specialists, and other collaborators in care. Careful staff selection of those with high interest in providing care to high-risk populations resulted in sustained continuity of care. Most importantly, the clinic was sustained on governmental grant monies, donations, and university support. Third - party reimbursement was available starting in 1995.

Discussion

The purpose of this paper was to describe a nursing model known as Protection-Engagement that frames care provided at a nurse managed clinic with a rural/urban population of persons living houseless, underserved, and vulnerable. Established in 1990, East Tennessee State University, College of Nursing, established a nurse managed clinic, first as a primary care clinic, then, in 1993 developed mental health and outreach services to those living houseless, underserved, and for those who had difficulties maintaining care within established health clinics and systems. Concepts derived from the Protection-Engagement are care integration and community linkage. A flexible entry system to the clinic with services provided in one small building allowed for care integration of primary care, mental health, formal and group substance use counseling and other treatment modalities. In 2009, services expanded to provide a day center where people could find a safe space, receive case management, and personal hygiene services all within the same building. The unique organization of a small area where consistent interprofessional care providers provide care has resulted in increased interprofessional communication, with sustainable outcomes, including presence in the community and in continued services. Consistent personnel including professionals with unique interpersonal skills who are able to provide a safe environment, engage into care, screen, and manage complex health conditions has positively influenced treatment outcomes.[23]

Consistency supports engagement that has resulted in maintaining those with chronic health conditions including endocrine, pulmonary, and cardiovascular problems, recurring SUD and COD into continuous health care. The clinical staff developed recovery-oriented service systems and coordinated clinical treatment with community recovery support systems, all designed to prevent or delay the onset of and complications from substance abuse and mental illness. PEH have poorer health status than the general population. Complex care management is needed due to the impact of somatic and psychiatric medical problems, and particularly when those in need live in economic and social poverty. Primary health care programs aimed at caring for the homeless should emphasize a multidisciplinary approach and consider our nursing integrated care model.[24]

We must also consider the multiple complex health and social factors in order to modify the plan of care for PEH. As this case illustrates, PEH can benefit from receiving primary health care, mental health care, and social services support available in the same location.[22] Multiple comorbidities are common among PEH and accessible and available health and social care is necessary for effective health interventions. Fragmented care is considered a major barrier that must be addressed in order for people living houseless to have easy access to the full range of health and social care services. However, an assumption of the care fragmentation is that persons living houseless do not care about their health. This assumption is contradicted by evidence.[25-28] The strength of the JCDC is face-to-face engagement into care that allows for immediate support, no matter how time-limited or small.

A major characteristic of providing care to PEH is that a provider may have only one encounter with the person. Single session counseling has been used in vulnerable populations who, due to mental health issues, external stressors such as in war torn areas, teenaged runaways, or those fleeing from intimate partner violence, may only have access to a counselor once. Providing hygiene items and foot washing, while listening closely with humility, we acknowledge their humanity. Only then can providers engage with and partner with the patient to co-manage complex health problems despite the structural societal supports needed to achieve holistic health. Outcomes vary, but listening and allowing persons to express their traumatic experiences begins the process of connection and self-reflection.[29-32] Those living houseless and unsheltered require unique interventions leading to safety followed by engagement. Those most vulnerable and marginalized require a shift in understanding of how positive outcomes are defined.[7]Unless we demand societal and structural changes in health provision, those most marginalized populations will continue to suffer from the inequities in our society and health care systems.

Controversies

The spontaneous engagement-disengagement presents a dialectic that requires different perspectives when organizing health care for those living houseless and unsheltered. Both internal health, mental, and behavioral patterns of interaction with others result in episodic care. Plus, competing priorities, such as constant search for food and shelter, job loss, disconnection from family and friends, insufficient numbers of interprofessional

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providers, legal barriers, all result in fragmented care. Maintaining interprofessional, comprehensive health care for those living houseless is difficult because of the financial constraints. Initially, the clinic services were free to those who needed care. Reliance on private donations, grants from the city, state, or federal government are fleeting and change with differing priorities. Therefore, point in time care, crucial to meeting the health needs of PEH, is difficult because limited health provider's available time allotted for care are also reserved for patients with health insurance. Healthcare is not considered a universal right in the United States, hence, maintaining this type complex health care for those with no monetary, societal, or community social supports, is difficult to sustain. In order to sustain care to include primary care, mental health care, nursing care, and a day center, accepting those who have health insurance and relying on grant funding is an imperative.

The Accountable Care Act (ACA), enacted into law in 2009, provided subsidies to those who could not afford health insurance, prohibited discrimination against individuals with pre-existing conditions, and reduced the uninsured rate in the United States. However, in order to obtain third party payment, individual health centers, such as the JCDDC, must provide all specialty medical services and address the social determinants of health. The requirement has resulted in formation of Accountable Care Organizations (ACO) that combine small practices, clinics with larger organizations, as has occurred with the JCDDC. The result is better access to specialties but protections-engagement is still maintained locally at the JCDDC. Insurance payments are based on positive outcomes; health outcomes intertwined with and dependent upon social conditions are not considered positive when compared to unrealistic expectations expressed in the dominant narrative. For example, how does a PEH, living on the streets, manage diabetes type 2, or hypertension, or sleep hygiene? It is nearly impossible.

Therefore, PEH, who have complex health problems, who suffer from health and social and resource poverty, such as multiple chronic and mental health conditions, and live without safe shelter, have difficulties achieving standard health outcomes required for payments. PEH outcomes are much different from those living with social, societal, and personal supports. In essence, health insurance premiums rise, PEH who must live transient lives looking for work, shelter, food, clean water, and moving over and over again for these basic necessities, have difficulty sustaining consistent care in one place. Addressing these social determinants of health requires policy changes, the political will to address health inequities, and controlling the rapacious take- over of health by private equity. Therefore, the ACA has not resulted in more government support for health care but has resulted in a mandate to buy health insurance.

Technology is touted as a solution, and telehealth has bridged some of these gaps. However, most under resourced persons, especially those who are houseless cannot afford the cost of internet service or computers. Many children do not have laptops or computers. Children, and particularly vulnerable children living without homes have lost connections to schools where they learn social and emotional intelligence when playing with other children. These relationships cannot be solved with technology alone. Social isolation associated with technology will not prevent intimate partner violence, child abuse, malnutrition, or escalating suicidality. The need for nurses aimed at community outreach, case finding, health history taking, and tracking could never be greater. Those vulnerable, persons without homes, and those with intellectual challenges require engagement into care, and need those personal relationships for health continuity. McCabe and Macnee[33] suggested that integrated care of mental and behavioral health located within one environmental setting was still a separate entity and not integrated. However, their model included structural and physical environmental components as part of their integration model, contradicting their premise. Expert knowledge required to manage complex multi-morbidities experienced by those living houseless cannot be synthesized by one or two practitioners. A team approach, with focus beyond the medical model, with access within one location has been demonstrated to result in more positive outcomes, and care that may occur in only one chance encounter. More research is needed in types of outcomes that result from engagement from one encounter.

Conclusion

The Protection-Engagement Model provides a different framing for health care provision with PEH. The physical and human/social environments require that there first must be a space for protective physical and emotional environments. When engagement results in one encounter, health outcomes must be defined differently. Health outcomes have been defined by a dominant culture that is framed by well-resourced populations who have both social, community, and monetary resources to maintain consistency in health care. Persons living houseless and unsheltered are not well-resourced. Therefore, using a framework of health with assumptions associated with those who have social supports, wealth, and a safe place to live result in distorted and unrealistic health outcomes applied to PEH. Understanding these differences should be a clarion for a change in the structures of health care systems that require health for all.

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