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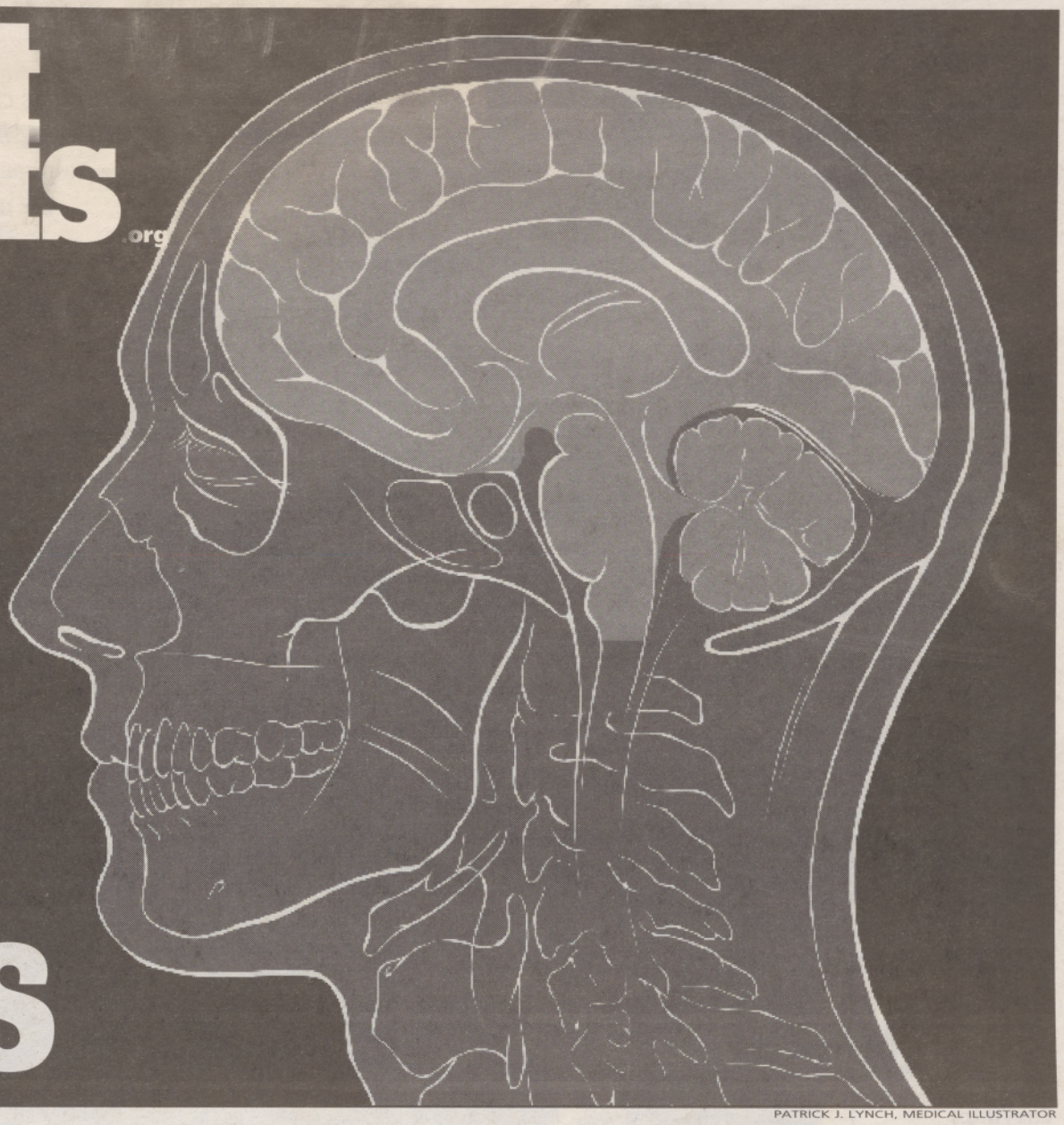
Head cases



PATRICK J. LYNCH, MEDICAL ILLUSTRATOR

Screening, tracking and treating traumatic brain injury on the street is possible

BY STACY BROWNHILL
STAFF WRITER

This is the third report in our ongoing coverage of traumatic brain injuries among people experiencing homelessness. Go to www.streetroots.wordpress.com to read the first two installments in this series.

Imagine two scenarios.

In the first, a once clever and outgoing young man experiences a traumatic brain injury (TBI), loses his job, isolates his family and friends and winds up on the streets. When he tries to get help, his erratic behavior frustrates his social workers. He forgets his follow-up appointments. When he goes to a health clinic, the question of prior head injury is never raised, overshadowed by a litany of other issues and lack of time. Even if he thinks to tell the doctor himself, the TBI record is not shared with other clinics. As his own behavior becomes increasingly unfamiliar, the man starts self-medicating with alcohol, decreasing his chances for disability benefits and amplifying his already antisocial behavior. His chances of rebuilding his life are slim.

In the second scenario, the employer, social workers and doctor recognize symptoms of the man's TBI. The man takes a basic screening assessment that supports the diagnosis, and when he is asked, he recalls the brain injury incident. The TBI is systematically highlighted in a shared database so that all safety-net agencies are aware of his history. His TBI qualifies him for prioritized housing at a shelter, giving him rest, structure and a network of advocates. He is given a day planner so he can remember his appointments. Social workers are able to get him disability benefits. He builds a new life.

Unfortunately, if you've been following our series on traumatic brain injuries and homelessness –"All in their heads" (Street Roots, May 27) and "What we don't know will hurt us" (Street Roots, June 10)–you'll recall the first scenario is much closer to the truth. Studies show TBI is common on the streets, even a cause of homelessness, but screening, tracking, treatment and recovery are rare.

However, there are tangible ways to move Portland towards scenario two, and improve how we share homeless health care information in general.

It starts with screening

"When I went to a brain injury conference, I realized, it's not all mental illness, it's brain injury," says Dr. Jan Caughlan, Director of Mental Health and Social Work at Baltimore's Health Care for the Homeless. "We should call ourselves Health Care for the Brain Injured," she jokes.

Caughlan, who started out as a case manager in 1991, says she's learned that, as a rule, TBI is not recognized and patients do not self-identify. "To diagnose TBI, you have to pay attention. You have to get a good history. You may be working on your gut, but the behavior of a brain-injured client is really different from a mentally ill client," she says, "and it's common."

Caughlan describes her TBI cases as "very individual," but often marked by erratic, frustrated

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The good, the bad and the ugly: tracking health care for the homeless

BY STACY BROWNHILL
STAFF WRITER

Complaining about health care and health insurance is a national pastime, but when you're homeless and mobile, without insurance or a regular doctor, health care is truly an uphill battle. Tracking and sharing the health history of a homeless person across multiple systems is fundamental in providing better care, reducing costs, and creating a more efficient and successful system of safety nets. But it's rare.

The good

Every night when the clock strikes 12 in San Francisco, records from over a dozen incompatible safety-net databases – including data from shelters, ambulances, mental health services, hospitals and sobering centers – are dumped into one central digital warehouse called the Coordinated Case Management System (CCMS). Once there, the data is collated and duplicates are deleted for an end result of around 270,000 individual profiles of vulnerable people, most of who are homeless.

The noble success of CCMS is that it provides a benefit to overburdened agencies without requiring them to change their systems or do any extra work. The next time a homeless person walks into any safety-net agency in San Francisco, a social worker or physician can simply click a link to CCMS and see a client's complete health and social service history.

And it's inexpensive. Three committed employees of the San Francisco Department of Public Health created CCMS, without extra funding, using the software Oracle.

Boston is another innovative hub for health care for the homeless systems. From 1993-1995, Boston merged records of 75 different clinics and soup kitchens into one database using Centricity software. "It has helped us begin to understand homeless people's patterns of behaviors," says O'Connell with

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