

**HEAD CASES, from page 1**

behaviors.

Liora Berry of Cascadia Behavioral Healthcare says that spontaneous anger can be a misunderstood symptom of someone with TBI. "It's the inconsistencies in brain trauma that make it so difficult for providers to understand," says Berry. "It's easy to get the impression that they're just not interested in services."

Andrew Ellis, clinical director of the Brain Injury Rehabilitation Center in Beaverton, gives another example of the difference between mental illness and TBI. "Someone who is clinically depressed will have days when their mood is better and problems dissipate," says Ellis. "For someone with a TBI, those problems won't dissipate."

Personal acquaintances can help by identifying changes in pre-TBI and post-TBI behavior, says Ellis. Some of his TBI patients are "floored at the changes others perceive."

Screening for TBI does not have to be complicated. The Defense and Veterans Brain Injury Center's "Brief Traumatic Brain Injury Screen" uses three basic questions to detect TBI:

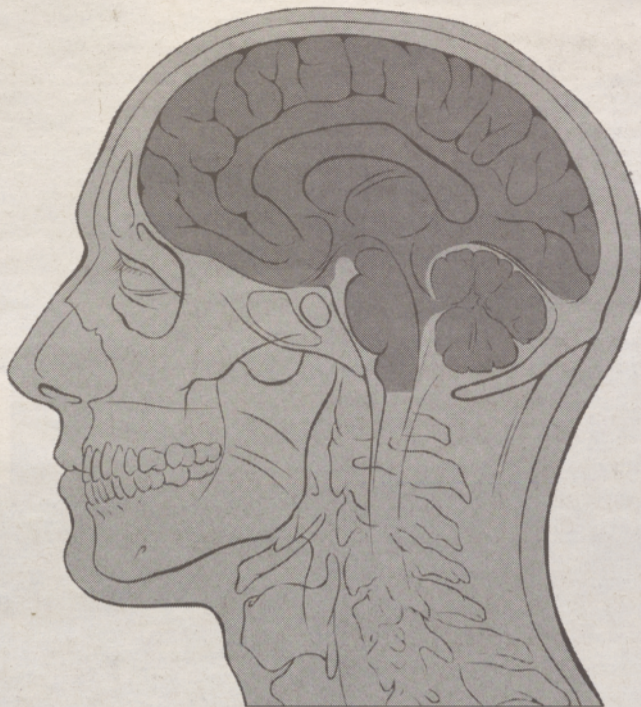
1. Did you have any injury(ies) during your deployment from ... fragment ... bullet ... blast ... ?
2. Did any injury received while you were deployed result in ... being dazed, confused or "seeing stars" ... losing consciousness ... having any symptoms of concussion afterward (such as headache, dizziness, irritability, etc.) ... ?
3. Are you currently experiencing any of the following problems that you think might be related to a possible head injury ... headaches, dizziness, memory problems, balance problems ... irritability, sleep problems?

Ellis believes such a basic screening could be easily adapted for the homeless population.

Mellani Calvin, program director of a disability benefits training and consulting company and former manager of Central City Concern's B.E.S.T. program, says she interviews homeless clients for personal history and does a series of basic cognitive tests to look at levels of functioning. "I always ask about TBI," says Calvin. "When I was at B.E.S.T., about half of our clients answered yes to mild TBI, and about a quarter to severe-knocked-out-cold TBI."

"Ideally, I hope we get to the point (with homeless health care) where we take time to ask questions and do mini-assessments ... starting with front door staff," says Berry. "I don't know how often that's actually happening."

"What clearly has to happen when TBI-folks get into housing is everybody has to understand what TBI is," says Dr. Jim O'Connell, president of Boston's Health Care for the Homeless Program. He cites the program's Barbara McInnis House, a 104-bed medical respite care center, as a creative outlet for times when tensions arise between clients with TBI and staff at other shelters. "If you understand their outbursts as a manifestation of their illness and expect



them, you can set up an environment that's conducive. Otherwise, they're more likely to get evicted."

**Taking the time**

"With most systems – whether it's medical, mental health or social work – you have a brief amount of time to talk to someone," says Berry. When providers spend more time with clients, they build trust, which can make all the difference in the cognitive impairment cases, says Berry. "Sometimes our staff begins to pick out themes of what's going on with people they see over time. Then we have to sort out how we can help them," says Berry.

Steve Mattsson, manager of Hooper Sobering Center, agrees wholeheartedly. "Getting to know individual people makes a huge difference when it comes to recognizing brain injury," says Mattsson. "Homeless people are notoriously poor historians, but our EMTs will often recognize a person and remember his history."

Berry cites techniques developed by psychologist Virginia Luchetti to help TBI clients: "First you have to address daily living by helping them figure out how to use the phone, handle money, take public transit, then you have to work on social skills, concentration and memory." Luchetti's strategy emphasizes spending quality time with a TBI patient by removing distractions and framing questions respectfully.

**Connecting health care systems**

"Electronic health records would be a significant tool if someone walks into one clinic and has been going to another clinic without making a connection himself," says Sam Chase, executive director at Coalition of Community Health Clinics.

But we're not there yet, (see "The Good, The Bad and The Ugly: Tracking Health Care

for the Homeless"). Each safety-net agency in Portland has its own independent database that is typically incompatible with other databases. Shelter records, medical records, mental health records, substance abuse records and incarceration records are all separate islands, making it daunting to track care across multiple systems.

When it comes to TBI, the notorious "invisible disease," sharing health records is especially important. One study by the San Francisco Department of Public Health found that a homeless person is much more likely to self-report asthma, heart disease, diabetes and substance abuse, than to self-report TBI.

**Realistic treatment plans**

"We need to expand services like neuropsych evaluations and treatment and rehabilitation. Having something effective to do once a person screens for brain injury might increase the chance the practice is done more routinely," says Caughlan.

"Psychiatric treatment and speech and occupational therapy are critical," says Ellis, although he admits those resources are more challenging for homeless clients. "Even 40-hour-a-week, middle-class people may not get rehab covered depending on their flavor of insurance," he says.

"The more integrated, one-stop-shop health care we can provide for the homeless, the better. One vision I have is offering neuropsych testing and occupational therapy in-house (at Health Care for the Homeless Baltimore)," says Caughlan.

Both Caughlan and Ellis say a more realistic, key step to helping a TBI patient is identifying their deficits and creating a compensation plan made up of small goals. "One of the hardest parts of rehabilitation for a TBI survivor is readjusting your lifestyle and letting go of goals you had before your injury," says Ellis.

Some of those lifestyle changes can be small. "There's little things that can help with TBI, like keeping a notebook, calendar, watches, all things that are not in the backpack of a homeless person," says Berry.

Another realistic treatment method is rest. "Rest is critical to treating TBI, says Ellis. "Routine and structure having a consistent abode can be key, he says.

In Portland, the new Bud Clark Commons takes TBI symptoms, such as memory loss, disorganization, weak social skills and poor anger management, into account when prioritizing who receives beds, which will provide a unique recovery space for TBI clients.

**Funding surveys**

Whether the reasoning is to lower health care costs, reduce rates of incarceration, strengthen families, or reduce homelessness, studying TBI on the streets is a worthy funding cause.

Dr. Theresa Petrenchik, who helped lead two studies that found significant rates of TBI among the homeless, believes cities need to survey for TBI on the streets. Whether the surveys focus on the rate of TBI, links to other health problems, patterns of clinic visits, or financial costs of addressing TBI, "the point ... is there is now enough evidence to suggest a link between (TBI) and homelessness," says Petrenchik. "Each city must ... decide what it will do in response."

Doctors Stephen Hwang and Barbara Wismer, both proponents of documenting TBI among the homeless, independently estimate that \$10,000 is the minimum required to conduct a barebones TBI survey in a single city.

Hwang and Wismer are part of a national team of researchers interested in conducting a 10-city study of TBI. They are hoping to receive \$10,000 - \$300,000, with the ultimate goal to develop an intervention to improve the health of homeless patients with TBI.

**Making the dream a reality**

"I just feel like this is a huge issue. If we as a community and as a nation wrapped our heads around (TBI) we could create real services and be more respectful rather than jumping to conclusions," says Berry.

"My dream is that cognitive rehabilitation will become as available as mental health and substance abuse treatment to people who need it," says Caughlan. "Realizing this vision isn't solely a funding problem; we need to also develop a trained workforce, and infrastructure – none of which will happen overnight.

"I don't blame anyone for not wanting to look at this. It's a bit daunting if you take in the totality. At the same time, we provide these other treatment services for very good reasons: to help people maximize their potential and to reduce the harm in the community that is linked to untreated disease.

"These are reasons enough to get busy building the work-force and infrastructure."

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Boston's Health Care for the Homeless Program. "If I'm seeing someone at the Pine Street Inn shelter on a Friday night and they had been seen at a soup kitchen the day before, I see that on their record."

The Homeless Youth Service Continuum in Portland is another example of shared systems, albeit a micro-approach that only targets homeless youth ages 13-21. Outside In, New Avenues for Youth and Janus Youth Programs double-enter records into a common database that is available to several youth homeless providers.

Double-entering gets challenging when organizations are interested in tracking different things, often motivated by grant reporting, or when agencies have different definitions of data points, says John Duke, health clinic director at Outside In.

MiVIA is an online health database launched in California in 2003 to provide electronic health records for migrant

workers, whose transient lifestyle means discontinuity in health care. The mission of MiVIA revolves around saving time and money by avoiding duplicate tests. Web-based records like MiVIA have enormous potential among the homeless population.

**The bad**

"We're trying to make sure all clinics are connected but it depends on which clinic you go to," says Chase.

"Right now, (healthcare for the homeless) isn't really tracked that easily," says Duke, who must request records from other clinics once patients tell him they've been to those clinics.

Portland's closest thing to a homeless tracking system is the Homeless National Information Systems (HMIS), a U.S. Department of Housing and Urban Development (HUD) sponsored program. HMIS is limited, however, because only data from HUD-funded agencies is collected. And clinical information is excluded.

"HMIS could potentially work like CCMS if it collected information from non-HUD safety-net agencies and included clinical records," says Maria X. Martinez, who headed the creation of CCMS and works in the Director's Office of the Department of Public Health in San Francisco.

**And the ugly**

"There are not always incentives to create a common database for homeless health care," says Duke. "Hospitals are competitive."

"Even though it is completely legal to share records through electronic databases, physicians from different hospitals get nervous about increased liability," says Martinez, a former specialist in health information privacy laws. "Picking up the phone to discuss a case is one thing, but codifying information is unnerving for institutions."

With the exception of substance abuse

records, however, records from social workers, primary care physicians, psychiatrists, case managers and shelters are all fair game to share among providers of care, says Martinez.

Martinez will be the first to admit that even CCMS has major flaws. Despite being an enormous wealth of information about a homeless client, CCMS usually comes in second to an agency's own database. Social workers might make time to look at both sets of records, but physicians who are pressed for time may not, says Martinez.

Then, there's the question of what to do after data is shared. "So-what-now-what?" asks Martinez. "What's the next step? We've seen that sharing information alone doesn't change practice. (Sharing information) is a whole new way of delivering care because you don't just have your toolkit; you have many agencies' toolkits. So we've got to change our protocols and our whole way of thinking."