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Improving Care for the Homeless Population Using the Chronic Care Model

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PEER REVIEWED

The objective of this study was to adapt the chronic care model to improve outcomes among the homeless population in the Health Care for the Homeless Program at Crusader Clinic in Rockford, Ill.

A major goal of *Healthy People 2010* is to eliminate health disparities. Obtaining baseline data to assess clinical quality is a necessary step toward identifying areas for eliminating health disparities between the homeless population and the general population.

Diabetes, hypertension, and asthma were the chronic conditions chosen for study because of their prevalence among the Rockford, Ill, homeless population. Staff members were divided into 3 teams, each addressing one of the chronic conditions. A registry was established to track the outcome of each condition. The Patient Electronic Care System (PECS), provided by the Health Disparities Collaborative, was used to track outcomes.

The number of hypertension patients with a blood pressure of less than 140/90 mm Hg increased from a baseline of 31% to 48%, despite the addition of newly diagnosed patients. Homeless clients with diabetes had an average HbA1c of 7.9%. Among asthma patients, 25% had a severity assessment documented, and 50% had received an influenza vaccine.

Using the chronic care model and intensive follow-up, improvements in outcomes can be significant, despite many barriers to optimal care among the homeless population.

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