



## Complete Summary

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### GUIDELINE TITLE

Adapting your practice: treatment and recommendations for homeless patients with diabetes mellitus.

### BIBLIOGRAPHIC SOURCE(S)

Brehove T, Joslyn M, Morrison S, Strehlow AJ, Wismer B. Adapting your practice: treatment and recommendations for homeless people with diabetes mellitus. Nashville (TN): Health Care for the Homeless Clinicians' Network; 2007 Jun. 14 p. [10 references]

### GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Brehove T, Bloominger MJ, Gillis L, Meierbachtol DA, Richardson VJ, Strehlow AJ. Adapting your practice: treatment and recommendations for homeless patients with diabetes mellitus. Nashville (TN): Health Care for the Homeless Clinicians' Network, National Health Care for the Homeless Council, Inc.; 2002 Jun. 10 p.

## COMPLETE SUMMARY CONTENT

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## SCOPE

### DISEASE/CONDITION(S)

- Diabetes mellitus in homeless adults
- Complications of diabetes mellitus

### GUIDELINE CATEGORY

Diagnosis  
Evaluation  
Management  
Treatment

### **CLINICAL SPECIALTY**

Emergency Medicine  
Endocrinology  
Family Practice  
Internal Medicine  
Nutrition  
Ophthalmology

### **INTENDED USERS**

Advanced Practice Nurses  
Dentists  
Dietitians  
Health Care Providers  
Nurses  
Physician Assistants  
Physicians  
Podiatrists  
Public Health Departments  
Social Workers  
Students  
Substance Use Disorders Treatment Providers

### **GUIDELINE OBJECTIVE(S)**

To recommend adaptations in standard clinical practices to improve quality of care and health outcomes for homeless adults with diabetes mellitus

### **TARGET POPULATION**

Homeless adults with diabetes mellitus

### **INTERVENTIONS AND PRACTICES CONSIDERED**

#### **Diagnosis/Evaluation**

1. History, including living conditions; eating habits, nutritional status; the condition and fit of footwear, how much walking the patient does, history of foot problems (sores/ulcers); sexual/ reproductive history, contraception use; current medications; use of tobacco/alcohol/illicit drugs; patient's literacy level
2. Diagnostic tests, such as dipstick urinalysis; albumin-to-creatinine ratio in a random spot collection; use of a diabetic monitoring card to record test results and exams

## **Management/Treatment**

1. Assessing the patient's current living situation, food sources, and medical/psychosocial/economic factors that may affect adherence to the plan of care; referral to social services, as needed
2. Patient education and self-management, including educating patients about diet and nutrition, oral health, exercise, and foot care
3. Insulin therapy including use of a basal insulin such as insulin glargine with insulin lispro, insulin aspart, or regular insulin before meals if eating patterns are erratic; decreasing insulin dosage when food is unavailable; using premixed insulin when possible; encouraging patient to inject insulin into the abdomen and rotate injection sites; assisting patients with insulin and syringe storage; use of insulin pens
4. Treatment with oral anti-diabetic agents including: assessing liver function and screening for alcohol abuse before starting metformin; teaching patients to hold or decrease the dosage of sulfonylureas when food is unavailable
5. Self-monitoring of blood glucose using glucometer (if available) or urine strips (cut in half if supply is limited)
6. Contingency plan for managing hypoglycemic episodes, including teaching shelter staff, as well as family members and friends (if available), the signs and symptoms of hypoglycemia; assist patient in obtaining a medic alert bracelet and encourage them to keep with them a written plan and glucose that is easy to carry
7. Management of associated problems and complications, including ensuring convalescent care for patients with foot ulcers and access to eye exams for patients with diabetic retinopathy; assessing the patient's access to bathroom facilities and water when prescribing a diuretic to reduce blood pressure; more frequent liver function screening for patients using statins for hyperlipidemia and those with co-occurring substance use disorders; finding free/discounted dental services within the community; assisting patients with alcohol and nicotine dependence in changing their behavior; connecting with agencies that offer counseling and therapy for patients with a mental impairment; managing concurrent cardiovascular problems and diabetes simultaneously

## **MAJOR OUTCOMES CONSIDERED**

- Albumin-to-creatinine ratio
- Hemoglobin A1C level; number of assessments/year
- Self-management goals set by diabetic patients
- Hyperglycemia, hypoglycemia
- Blood pressure
- Diabetic foot ulcers
- Health disparities between homeless and general U.S. populations
- Diabetic retinopathy
- Dental and periodontal lesions

## **METHODOLOGY**

### **METHODS USED TO COLLECT/SELECT EVIDENCE**

Hand-searches of Published Literature (Primary Sources)  
Hand-searches of Published Literature (Secondary Sources)  
Searches of Electronic Databases

## **DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE**

Searches of MEDLINE, SocABS, Psycinfo databases were performed.  
Bibliographies compiled by the Bureau of Primary Health Care's Homeless Information Resources Center were also searched.

### **2007 update**

Not stated

## **NUMBER OF SOURCE DOCUMENTS**

This guideline is adapted from one primary source.

## **METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE**

Expert Consensus

## **RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE**

Not applicable

## **METHODS USED TO ANALYZE THE EVIDENCE**

Review

## **DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE**

Not stated

## **METHODS USED TO FORMULATE THE RECOMMENDATIONS**

Expert Consensus

## **DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS**

In 2002, the Health Care for the Homeless (HCH) Clinicians' Network assembled an advisory committee of primary care providers working in Health Care for the Homeless projects to provide specific recommendations for the clinical practice of working with homeless persons with diabetes. For the 2007 update, the new committee comprised of a mix of members from the 2002 team along with new members, reviewed the guidelines to assure that the recommendations reflect updated American Diabetic Association (ADA) guidelines. Additions were made to reflect changes within the homeless healthcare field as well.

## **RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS**

Not applicable

## **COST ANALYSIS**

A formal cost analysis was not performed and published cost analyses were not reviewed.

## **METHOD OF GUIDELINE VALIDATION**

Clinical Validation-Pilot Testing  
External Peer Review  
Internal Peer Review

## **DESCRIPTION OF METHOD OF GUIDELINE VALIDATION**

The 2002 guideline was field tested by clinicians in designated Health Care for the Homeless projects during the summer of 2003. Evaluation criteria included clarity, flexibility and ease of use; relevance to the care of homeless clients or those at risk of becoming homeless; inclusion of strategies to promote outreach and case management and ensure follow-up; sufficiently detailed to ensure that similar practitioners would offer similar treatment in the same circumstances; and sufficiently complete to enable new clinicians to use them for homeless clients. Evaluators found that the guideline met all of these criteria and recommended future development of "short forms" of this and other adapted clinical guidelines to facilitate use in a variety of clinical settings.

The guideline developer's Advisory Committee identifies, in the original guideline document, the clinicians who reviewed and commented on the draft recommendations prior to publication.

## **RECOMMENDATIONS**

### **MAJOR RECOMMENDATIONS**

#### **Diagnosis and Evaluation**

#### **History**

- Assess where the patient is living (e.g., shelter, on the street, doubled up\*).
- Ask when the patient last had a permanent or regular place to live, and if they have ever had their own apartment or home.
- Ask the patient about eating habits and patterns including nutrition status, weight history, and food sources (e.g., soup kitchens). Many food sources supply only one meal a day so that the homeless person must visit multiple places for food.
- Ask the patient if they have access to food and water when they want or need it (e.g., snacks).

- Assess and often reassess how much walking the patient is doing as well as the condition and fit of footwear.
- Ask patient if they have ever had foot sores or ulcers or any problems with their feet.
- Obtain a sexual history including contraception and reproductive history.
- Ascertain the patient's current medications and how they are obtained.
- Explore the use of tobacco, alcohol and illicit drugs, and the frequency and route of use. Assess the patient's readiness to change behavior.
- Assess patient's literacy level.

\* "Doubled up" is a term that refers to a situation where individuals are unable to maintain their housing situation and are forced to stay with a series of friends and/or extended family members.

### **Diagnostic Tests**

- Perform dipstick urinalysis to test for ketones, glucose, protein and sediment.
- The use of portable HbA1c test kits is a valuable tool for point of care information. The results, available in fewer than ten minutes can be used to enhance follow-up and patient education.
- To assess kidney status, the best test for homeless patients is the albumin-to-creatinine ratio (urine for microalbumin) in an early morning collection. If the test is elevated, repeat. Twenty four-hour urine testing is no longer recommended for screening and is not practical for many homeless patients.
- Since homeless patients can be transient, consider using a diabetic monitoring card to record labs and exams (Ridolfo & Proffitt, 2000). Patients can use this card to share information with their next health care provider and it is also useful as a self-management tool. Designed specifically for homeless individuals with diabetes, the monitoring card is available through the Health Care for the Homeless (HCH) Clinicians' Network (cards come 100 to a pack; for a sample or to order call 615-226-2292).

### **Plan and Management**

At each visit the clinician should:

- Assess the patient's current living situation including where they live, how long they have lived there, who lives with them and their relationship to that person.
- Assess the psychological, sociological and economic factors that may affect the management plan. Refer the patient to community resources, as needed (e.g., Department of Social Services).
- Assess food sources.
- Obtain an emergency contact with a phone number.
- Obtain a phone number for the patient if possible. Some patients have cell phones, voice mail numbers or can receive messages at shelters or programs.

**Tip:** Patients receiving food stamps or other public entitlements may exhaust their resources by the end of the month.

### **Patient Education and Self-Management**

- Patients who are dependent on tobacco, alcohol or illicit drugs may not be ready or able to abstain from these substances. Helping the patient move in that direction may be the final goal. Many therapeutic interventions help decrease health risks until they are ready to change their behavior. Motivational interviewing, for example, is a successful technique to reduce risk of complications (Miller & Rollnick, 2002).
- Self management goal setting can be a useful method to involve patients in their health care. Allow the patient to decide what is important for them in their contribution to their health, even if the goal is not directly related to a diagnosis of diabetes. This first step can provide the patient with confidence to make further changes as needed.
- Providing culturally suitable education that involves the patient in the learning process is critical. Successful approaches to teaching homeless persons include peer interaction and support groups.

### *Diet and Nutrition*

Homeless persons are usually dependent on soup kitchens or shelters for meals, and it may be difficult to plan meals to coincide with insulin administration. Clinicians should work with shelters and soup kitchens to promote healthy food choices and to provide supplemental snacks to those with diabetes.

The clinician should:

- Assess where and when the patient is eating, and the frequency and healthfulness of meals.
- Recognize that patients may choose to eat at local fast food restaurants and provide them with a list of healthier food choices available within these locations.
- Provide suitable documentation for the patient with diabetes to use at food pantries, soup kitchens and shelters to obtain healthful snacks and foods.
- Encourage the patient to make the best choices that they can from what is available, for example, taking a smaller portion of macaroni and cheese and a larger portion of vegetables.
- Ask the patient to save part of the meal for later when only one or two meals are available per day.
- Provide multivitamins with minerals.
- Acknowledge the patient's limitations given food choices and work to adjust medications to address glucose control.

**Tip:** Tight glycemic control may be dangerous for patients on insulin or sulfonylureas who cannot reliably predict the number or timing of meals that they will eat that day.

### *Oral Health*

Access to preventive dental services is often difficult for patients experiencing homelessness. The clinician can:

- Provide toothbrushes, toothpaste, and dental floss.
- Teach basic oral health care (e.g., demonstrating proper brushing and flossing).

- Advise patient to rinse mouth with water after eating when brushing is not possible.
- Teach patient the importance of an annual oral examination even if they do not have teeth.
- Refer patients for an annual oral exam when possible.

### *Exercise*

For people who are homeless, walking is their typical exercise and they usually carry their belongings, which increases the exercise effort. Patients with peripheral neuropathy or foot problems should take precautionary measures such as proper footwear. The clinician should:

- Chart how far the client walks daily.
- When appropriate, suggest that the patient take steps instead of elevators.
- Assess the condition of the patient's shoes and socks at every visit.
- Research possibilities for exercise monitors such as pedometers and options such as the YMCA or other local fitness centers that can offer membership at reduced rates.

### *Foot Care*

Foot problems often result from prolonged standing and walking. When combined with diabetes, the patient is at high-risk for foot ulcers. The clinician should:

- Encourage patient to keep feet dry and take shoes and socks off at night.
- Instruct patient to wash socks nightly, if possible, and dry thoroughly.
- Teach patients how to examine their feet. If they cannot see the bottom of their feet, teach the patient how to use a mirror. Urge patients to visit the clinic immediately if they have open foot sores or areas of redness.
- Identify community resources for free shoes and socks, and refer patients as needed. Maintain a supply of clean socks to give to patients as needed.
- Consider having foot care products for patients (e.g., skin care lotions, corn cushions, mole skin and lamb's wool).
- Instruct patient to elevate legs to a level at or above their heart whenever possible to prevent/alleviate fluid stasis in lower extremities. This is especially important for patients who are sleeping in chairs.
- Refer patient to respite care if available for relief of diabetic foot conditions.
- Secure a podiatrist for referrals and consultation.

## **Insulin Therapy**

Tight glycemic control can increase the risk of hypoglycemic episodes in homeless individuals due to a variety of physiological and adherence factors, including excessive caloric expenditures (e.g., extensive walking), uncertain caloric intake (e.g., availability, content, and timing of meals), and behavioral factors that may negatively affect adherence (e.g., mental illness and substance abuse).

- Consider using a basal insulin such as insulin glargine with insulin lispro, insulin aspart, or regular insulin before meals to accommodate erratic eating patterns.

- Consider decreasing insulin dosage when food is unavailable.
- Use premixed insulin when possible.
- Consider teaching the patient to adjust his or her insulin dose based on food availability and blood sugar readings
- The use of insulin pens has proven convenient and successful to reduce the risk of theft for patients who might otherwise need to carry syringes. Providers should inquire in their area on how to access pens for patient use.
- If they are walking a great deal, encourage patient to inject insulin into the abdomen to avoid erratic absorption.
- Remind the patient to rotate injection sites to avoid lipodystrophy.

### *Insulin Storage*

Since patients have little or no access to refrigeration, consider these options:

- Assess if the patient can use a shelter's refrigerator and if the insulin will be accessible when needed.
- Store the patient's insulin at the clinic and dispense one vial at a time.
- Suggest that the patient store insulin in an insulated lunch bag.
- Provide insulated lunch bags for insulin storage.
- Avoid pre-filling syringes and storing them in a communal refrigerator (e.g., in a shelter), where the medication integrity cannot be monitored safely.
- If refrigeration is unavailable, insulin can be safely stored at temperatures between 36 and 86 degrees Fahrenheit for up to one month.
- Therefore, recommend that patients avoid carrying insulin inside pants or shirt pockets. An alternative such as outer clothing or tote bag may be suggested.

### *Syringe Storage/Disposal*

- Advise patients against cleaning needles with alcohol for reuse. If alcohol is not properly rinsed, remains on the needle and is injected it can cause a sterile abscess.
- Caution patients to store syringes securely since they can be stolen for illicit drug use.
- Advise patients that a pharmacy may provide one or two syringes if needed. The patient will need to show the pharmacist their insulin supply.
- Instruct patient on proper syringe disposal emphasizing safety and offer options available in their area.

### **Oral Anti-diabetic Agents**

People experiencing homelessness have high rates of hepatitis and a high incidence of substance use disorders (50 percent nationally; Koegel, Burman, & Baumohl, 1996) with associated liver dysfunction. The clinician should:

- Assess liver function on a regular basis.
- Screen carefully for alcohol abuse before starting metformin due to an increased risk of lactic acidosis.

For the patient taking sulfonylureas, the clinician should:

- Recommend that the patient hold or decrease the dosage when food is unavailable to avoid hypoglycemic episodes.

### **Self-monitoring of Blood Glucose**

Although self-monitoring of blood glucose has replaced urine testing to measure glucose control, patients who are homeless often have difficulty obtaining glucometers or strips. If self-monitoring is not possible, the clinician should:

- Teach patient to use urine strips to check glucose.
- Recommend frequent clinic visits to monitor blood glucose and complications.

### **Contingency Plan for Managing Hypoglycemic Episodes**

People who are homeless often do not have family members or friends available to help in an emergency. Clinicians should teach shelter staff the signs and symptoms of hypoglycemia. This is critical since hypoglycemia may be mistaken for intoxication. If the patient is conscious and able to swallow, the shelter staff can give oral glucose (e.g., an orange drink). If the patient is unresponsive or unable to swallow, the shelter staff should immediately call 911 for help.

Work with shelter staff to provide before bedtime diabetic appropriate snacks for patients.

If the patient has family members or friends available, they should be taught to recognize the signs and symptoms of hypoglycemia and how to administer a subcutaneous or intramuscular injection of glucagon should the patient ever be unresponsive or unable to swallow.

Assist patients to obtain a medic alert bracelet and to keep a written plan and a form of glucose that is easy to carry.

### **Management of Associated Problems and Complications**

#### **Diabetic Foot Ulcers**

Sufficient bed rest may not be possible for the homeless person since many shelters are not open during the day. Clinicians need to work with shelter staff and other homeless service providers to ensure that convalescent care is available. Convalescent care may include access to a motel room or 24-hour shelter beds for those needing bed rest.

Diabetic foot ulcers can be slow-healing wounds that respond well to basic clean wound care and off-loading of weight. Off-loading of weight can be achieved either through obtaining convalescent care (bed rest) or if available, by out-patient, specialty medical (Podiatric or Orthopedic) care which can provide boots or casting. It is rare that ulcers alone can qualify for hospital-level care, although medical respite or medical rehabilitation facilities can be utilized where available.

However, diabetic foot ulcers may also lead to serious and rapidly progressive infections requiring hospital level care. Because of the difficulty of monitoring

infections in the homeless context, as well as the short amount of time in which infection can progress in the diabetic patient, referral to a higher level of care should be considered and attempted early.

When referring patients for hospital level care, it may be helpful to emphasize not only key clinical data, but also helping the evaluating hospital clinicians appreciate the context and confounders to what might otherwise be appropriate out-patient care.

- Presence of redness and warmth around the wound, especially if the patient is already getting good daily wound care or taking an antibiotic (expect little improvement in the first 24 hours, but tolerate no progression)
- Fever (temperature > 100.5 degrees Fahrenheit)
- Diagnosis of Diabetes and a recent blood glucose level; also, a general statement about the patient's usual control (e.g. "poorly controlled"), and the need for insulin ("insulin dependent") for daily management
- Context of Homelessness is an important consideration in judging the success of out-patient monitoring and the patient's ability to self care and self-refer upon worsening
- Ongoing substance abuse is *very high risk* for poor attention to progression of infection and the person's ability to self-refer for care upon worsening
- Some symptoms of mental illness (e.g. paranoia, apathy, delusion) also can be barriers to self-care and a person's ability to self-refer upon worsening
- Offering post-hospital care and follow-up can help alleviate non-clinical barriers to homeless patients being admitted to hospital level care

### **Diabetic Retinopathy**

Access to eye exams may be difficult for homeless patients due to a lack of insurance. Networking with local ophthalmologists to obtain free exams has been successful in several communities.

### **Hypertension**

When considering using a diuretic for blood pressure control, the clinician should:

- Assess the patient's access to bathroom facilities.
- Assess the patient's access to water and other fluids if the patient is living outside in a hot climate.

### **Lipid Management**

Consider screening liver functioning more frequently for patients using statins for hyperlipidemia if the patient is abusing alcohol and other drugs.

Consider using direct low density lipoprotein (LDL) testing, which does not require the patient to fast before having the test drawn. This is especially important for patients who often miss appointments.

### **Oral Health**

Poor oral hygiene is common among homeless people. Dental abscesses and periodontal disease contribute to poor glycemic control. The clinician should identify free or discounted dental services available within the community. Dental schools, public health departments, and private dentists who volunteer their services can be valuable resources for homeless people.

### **Alcohol Dependence**

For the patient who is not ready or able to abstain from alcohol use:

- Stress the importance of eating.
- If patient is drinking alcohol, assess amount. Teach patient caloric content of alcohol and effect on glucose management.
- Encourage the patient to seek shelter on nights when weather is extreme (e.g., cold, hot, or wet).
- Consider using motivational interviewing techniques and risk reduction methods to guide the patient toward abstinence.
- Suggest more frequent office visits to encourage goal setting and closely monitor the diabetes progression.

### **Nicotine Dependence**

For the patient who is dependent on nicotine, the clinician should refer or enroll the patient in a smoking cessation program. Smoking causes vasoconstriction that increases the risk of frostbite. For patients living outside or in poorly heated places, the clinician should:

- Explain the relationship between smoking vasoconstriction and diabetes.
- Recommend that the patient always wear gloves and carry an extra pair of socks to change into when feet get damp.

Smoking increases risk of pulmonary infection and may contribute to vitamin C deficiencies that can affect wound healing. The clinician should:

- Stress hand washing to decrease the transmission of organisms.
- Provide annual influenza vaccines and encourage the administration of the pneumococcal vaccine.
- Teach the patient about good food sources of vitamin C.
- Consider providing vitamin supplements.

### **Mental Impairment**

About 25 percent of homeless people have at some time experienced severe mental disorders such as schizophrenia, major depression, or bipolar disorder (Koegel, Burnam, & Baumohl, 1996). Homeless patients may have developmental delays and impaired cognitive functioning. Patients with mental impairments may experience the following:

- Impaired thinking processes that result in disorientation and a disorganized lifestyle
- Lack of motivation to seek help

- Lack of insight or understanding of their illness, which may result in denial of the need for services
- Negative experiences with mental health institutions
- Unpleasant medication side effects

Patients prescribed atypical antipsychotic medications are at increased risk for the development of obesity, hyperlipidemia, and hyperglycemia. For these patients, providers should carefully monitor weight, lipids, and glucose.

For providers not in health care for the homeless projects that offer mental health services, connecting with other agencies that offer counseling and therapy will help greatly in managing the plan for the homeless patient with a mental impairment.

### **CLINICAL ALGORITHM(S)**

None provided

## **EVIDENCE SUPPORTING THE RECOMMENDATIONS**

### **REFERENCES SUPPORTING THE RECOMMENDATIONS**

[References open in a new window](#)

### **TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS**

The type of evidence supporting the recommendations is not specifically stated.

## **BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS**

### **POTENTIAL BENEFITS**

Appropriate quality of care for homeless patients with diabetes mellitus in order to improve treatment adherence and patient outcomes

### **POTENTIAL HARMS**

- *Metformin* increases risk of lactic acidosis in alcohol abusers.
- *Sulfonylureas* can cause hypoglycemic episodes in patients unable to eat regular meals.
- Tight *insulin* control can increase the risk of hypoglycemic episodes in homeless individuals due to excessive caloric expenditures, uncertain caloric intake, and behavioral factors affecting adherence.

## **QUALIFYING STATEMENTS**

### **QUALIFYING STATEMENTS**

The information and opinions expressed in the guideline are those of the Advisory Committee on Adapting Clinical Guidelines for Homeless Individuals with Diabetes Mellitus, not necessarily the views of the U.S. Department of Health and Human Services, Health Resources and Services Administration, nor the National Health Care for the Homeless Council, Inc.

## IMPLEMENTATION OF THE GUIDELINE

### DESCRIPTION OF IMPLEMENTATION STRATEGY

This revised guideline will be distributed electronically to all Health Care for the Homeless (HCH) grantees across the United States and to several academic programs that train primary care practitioners. Many of these projects are participating in a Health Disparities Collaborative on Diabetes. The guidelines will be cited in the August 2007 edition of the HCH Clinicians' Network newsletter Healing Hands that will focus on self management support in diabetes care. The HCH Clinicians' Network uses this venue to educate mainstream providers about the special needs of homeless patients. The National HCH Council is currently conducting a workshop series designed to train providers to set self management goals with their patients for all chronic illnesses as recommended by the Bureau of Primary Health Care. These guidelines are referenced within this workshop. These and other recommended clinical practice adaptations to optimize care for homeless persons are also being used in workshops at national and regional conferences including the Health Disparities Collaborative Learning Sessions and the National HCH Conference sponsored by the Bureau of Primary Health Care/HRSA/HHS).

HCH projects use outcome measures recommended by the Health Disparities Collaborative on Diabetes in which the HCH Clinicians' Network is a national partner (available at: <http://www.healthdisparities.net>).

### IMPLEMENTATION TOOLS

Patient Resources

For information about [availability](#), see the "Availability of Companion Documents" and "Patient Resources" fields below.

## INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

### IOM CARE NEED

Living with Illness

### IOM DOMAIN

Effectiveness  
Patient-centeredness

## IDENTIFYING INFORMATION AND AVAILABILITY

### **BIBLIOGRAPHIC SOURCE(S)**

Brehove T, Joslyn M, Morrison S, Strehlow AJ, Wismer B. Adapting your practice: treatment and recommendations for homeless people with diabetes mellitus. Nashville (TN): Health Care for the Homeless Clinicians' Network; 2007 Jun. 14 p. [10 references]

### **ADAPTATION**

The guideline was adapted from: American Diabetes Association. Standards of medical care for patients with diabetes mellitus. Diabetes Care 2007; 25:S33-49.

### **DATE RELEASED**

2002 Jun (revised 2007 Jun)

### **GUIDELINE DEVELOPER(S)**

National Health Care for the Homeless Council, Inc. - Private Nonprofit Organization

### **SOURCE(S) OF FUNDING**

Health Resources and Services Administration, U. S. Department of Health and Human Services

### **GUIDELINE COMMITTEE**

Advisory Committee on Adapting Clinical Guidelines for Homeless Individuals with Diabetes Mellitus

### **COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE**

*Committee Members:* Theresa M. Brehove, MD, Venice Family Clinic, Venice, California; Matthew Joslyn, MD, Boston Health Care for the Homeless Program, Boston, Massachusetts; Sharon Morrison, RN, MAT, Health Care for the Homeless Clinicians' Network, Nashville, Tennessee; Aaron J. Strehlow, RN, PhD, FNP-C, UCLA School of Nursing Health Center at the Union Rescue Mission, Los Angeles, California; Barbara Wismer, MD, MPH, Tom Waddell Health Center, San Francisco, California

### **FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST**

Not stated

### **GUIDELINE STATUS**

This is the current release of the guideline.

This guideline updates a previous version: Brehove T, Bloominger MJ, Gillis L, Meierbachtol DA, Richardson VJ, Strehlow AJ. Adapting your practice: treatment and recommendations for homeless patients with diabetes mellitus. Nashville (TN): Health Care for the Homeless Clinicians' Network, National Health Care for the Homeless Council, Inc.; 2002 Jun. 10 p.

## **GUIDELINE AVAILABILITY**

Electronic copies: Available in Portable Document Format (PDF) from the [National Health Care for the Homeless Council, Inc. Web site](#).

Print copies: Available from the National Health Care for the Homeless Council, Inc., P.O. Box 60427, Nashville, TN 37206-0427; Phone: (615) 226-2292

## **AVAILABILITY OF COMPANION DOCUMENTS**

The National Health Care for the Homeless Council has developed a variety of resources to support health care providers in their service to persons experiencing homelessness. These resources are available for purchase as well as free of charge from the [National Health Care for the Homeless Council, Inc., Web site](#).

## **PATIENT RESOURCES**

Educational material on diabetes and homelessness including personal care items are available free of charge and/or for purchase on the [National Health Care for the Homeless Council, Inc Web site](#).

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

## **NGC STATUS**

This NGC summary was completed by ECRI on May 24, 2004. The information was verified by the guideline developer on June 24, 2004. This NGC summary was updated by ECRI Institute on June 29, 2007. The information was verified by the guideline developer on July 13, 2007.

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