Homeless Health Care Simulated Patient Case

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The Homeless Health Care Simulated Patient Case is designed as a single station in a multi-station simulated patient program. It is intended to teach learners about the presentation, diagnosis and management of homelessness and to evaluate their skill in recognizing, screening for and responding to patients who are homeless.

A single, experienced actor portrayed the simulated patient. He was cast and trained by a professional Standardized Patient Coordinator. The training included a general orientation to the mission of this exercise, as well as training in the case history, anticipated physical examination, data collection and feedback. The simulated patient ran through the case several times with the Standardized Patient Coordinator, until she was certain the actor had mastered all aspects of the case. The total training time was six hours, though this would be expected to vary based on the experience of both the trainer and the simulated patient.

This case was implemented as one of four stations in a three-hour simulated patient program for 12 primary care internal medicine residents. The aim of the program was to teach residents about common problems in primary care and the importance of considering both biomedical and psychosocial issues.

The program was held in a simulated patient laboratory. A single faculty member remained on-site throughout the program to answer unanticipated questions from learners and simulated patient laboratory staff. Learners attended the program in groups of four. (Please see attached schedule.) First, learners were oriented to the program. Next, learners spent two hours independently evaluating each of the four patients and documenting the history, physical examination, assessment and plan in a written clinic note. While the learners completed their notes, the simulated patients completed the American Board of Internal Medicine Patient Perception Scale for each encounter. This instrument was originally developed to evaluate communication skills, humanism and professionalism in physicians seeking recertification in internal medicine. It has since been used to rate these skills and attributes in physicians and trainees. (Webster G. Final Report on the Patient Satisfaction Questionnaire Project. Philadelphia, PA: ABIM Committee on Evaluation of Clinical Competence; 1989.) All encounters were videotaped. The program concluded with a post-clinic conference.

A faculty preceptor led the post-clinic conference. Each case was discussed in the following format. Volunteers were solicited to present the history and physical examination. The preceptor then asked learners if any had elicited any additional relevant history or physical examination findings. In this way, if the initial presenter had not uncovered the history of homelessness, other learners
were able to share this history and the way in which they were able to uncover it. The group then discussed the assessment and plan, focusing on common presentations of homelessness in the office setting, screening for homelessness, and responding to patients who are homeless. At the conclusion of the program, learners received the completed ABIM Patient Perception Scales.

In the weeks following the simulated patient program, residency program faculty reviewed the residents' written notes and videotapes to determine whether each resident 1) identified the simulated patient as homeless; 2) asked questions about how being homeless impacts the patient’s ability to control his diabetes; 3) gave the patient suggestions about how and where to store his insulin; and 4) referred the patient to see a social worker. Faculty then reviewed the notes and videotapes with learners individually. These reviews gave faculty and learners opportunities to identify strengths and target areas for improvement.
<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
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<tbody>
<tr>
<td>7:30</td>
<td>Simulated patients and staff arrive and prepare for encounters</td>
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**Group 1** | **4 Learners**
---|---
8:00 – 8:15 | Staff orient learners to the Simulated Patient Program
8:15 – 8:35 | Learner sees patient #1
8:35 – 8:45 | Learner completes clinic note
8:45 – 9:05 | Learner sees patient #2
9:05 – 9:15 | Learner completes clinic note
9:15 – 9:35 | Learner sees patient # 3
9:35 – 9:45 | Learner completes clinic note
9:45 – 10:05 | Learner sees patient # 4
10:05 – 10:15 | Learner completes clinic note
10:15 – 10:30 | Break for simulated patients and staff
10:15 – 11:15 | Post-clinic conference with faculty preceptor

**Group 2** | **4 Learners**
---|---
10:15 – 10:30 | Staff orient learners to the Simulated Patient Program
10:30 – 10:50 | Learner sees patient # 1
10:50 – 11:00 | Learner completes clinic note
11:00 – 11:20 | Learner sees patient # 2
11:20 – 11:30 | Learner completes clinic note
11:30 – 11:50 | Learner sees patient # 3
11:50 – 12:00 | Learner completes clinic note
12:00 – 12:20 | Learner sees patient # 4
12:20 – 12:30 | Learner completes clinic note
12:30 – 1:30 | Lunch for simulated patients and staff
12:30 – 1:30 | Post-clinic conference with faculty preceptor

**Group 3** | **4 Learners**
---|---
1:15 – 1:30 | Staff orient learners to the Simulated Patient program
1:30 – 1:50 | Learner sees patient # 1
1:50 – 2:00 | Learner completes clinic note
2:00 – 2:20 | Learner sees patient # 2
2:20 – 2:30 | Learner completes clinic note
2:30 – 2:50 | Learner sees patient # 3
2:50 – 3:00 | Learner completes clinic note
3:00 – 3:20 | Learner sees patient # 4
3:20 – 3:30 | Learner completes clinic note
3:30 – 4:30 | Post-clinic conference with faculty preceptor
Simulated Patient Program
Learner Instructions

1. You are scheduled to see four patients in the office today. Patients are scheduled at half-hour intervals. You will have 20 minutes to see each patient, during which time you are expected to take a focused history and perform a focused physical examination based on the patient’s chief complaint. Following each patient visit, you will have 10 minutes to write a note documenting your history, physical examination, assessment and plan.

2. The patient’s chart is located on the examination room door. The chart provides you with the patient’s name, chief complaint and vital signs, as recorded by the clinic nurse.

3. After you have spent 15 minutes with the patient, a staff member will knock on your door. This is your signal that you have 5 minutes remaining to complete the encounter.

4. After you have spent 20 minutes with the patient, a staff member will knock on your door and announce that time is up. At this point, you are expected to leave the examination room. (If you complete the encounter before time has elapsed, you may leave the examination room and begin working on your clinic note. However, once you leave an examination room, you may not return to it.)

5. When you have completed the patient encounter, please sit at a desk outside the examination room and begin your clinic note. You have 10 minutes to complete the note.

6. Remain seated at your desk until the clinic staff informs you which patient you are to see next.

7. All of the encounters are being videotaped. You will have the opportunity to review your videotape with a faculty preceptor in the next few weeks.

8. After you have seen all four patients today, you will participate in a post-clinic conference with a faculty preceptor.
Door Chart

**Patient:** Lester Greene

**Chief Complaint:** Medication Refill

**Vital signs:** 138/88 – 76.
Simulated Patient Case

**Case Chief Complaint:** Medication refill ("med" refill)

**Case Name:** Lester Greene

**Presenting Situation:** 35-55 year old man presents to the clinic as a walk-in for a medication refill

**Keyword Description:** Medication refill, diabetes

**Differential Diagnosis:** Poorly controlled diabetes due to inadequate medication regimen or to noncompliance with dietary and/or medical regimen

**Actual Diagnosis:** Poorly controlled diabetes due to homelessness

**Designed For:** Residents in internal medicine and family medicine, fourth year medical students

**Activities and Time Required:** Learners will be given twenty minutes to interview the patient and perform a focused physical examination. They will then have ten minutes to document the history, physical examination, assessment and plan in a clinic note. The activity will conclude with a post-clinic conference.

**Objectives:**
1) To recognize the impact of homelessness on the control and management of chronic disease.
2) To recognize that homeless people must have primary care issues addressed whenever they present to the clinic because they often miss scheduled appointments. For this reason, the learner should address blood sugar control even though the patient presents only for a medication refill.
2) To incorporate the challenges posed by homelessness into the management plan. For example, because insulin may require refrigeration, it is important to address where the insulin will be stored.
3) To respond appropriately to patients who are homeless, including referral to a social worker so the patient can be assessed for eligibility for Supplemental Security Income (SSI), Temporary Assistance for Needy Families (TANF), supportive housing, employment assistance and other services. A homeless diabetic patient who gets off the street is likely to improve his diabetic control even if nothing else is changed.

**Station Requirements:** An ophthalmoscope is required at this station.
Aspect of Performance to be Attended to and Method for Observing Performance: The learner will obtain the history, perform the physical examination and document these findings as well as the assessment and plan in a written clinic note. All sessions will be videotaped. The patient will complete the ABIM patient perception scale for each learner. After the learners have seen and evaluated all of the patients, the learners will participate in a post-clinic conference to review and discuss the patients seen. In the weeks following this program, a faculty preceptor will review the videotapes and clinic notes with each learner individually.

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Simulated Patient Demographics

**Gender:** Male

**Age:** 35-55

**Race:** Any

**Socioeconomic:** Lower class

**Patient Characteristics:** Mr. Greene is a quiet, respectful man appearing 10 years older than his stated age. He is dressed in clothes that are worn, but he is clean and not disheveled. He answers questions honestly and appropriately in general, but his manner is reserved and he is ashamed about his social situation.
Simulated Patient Training Materials

History of the Present Illness

You have come to the clinic today because you have diabetes and have run out of medication. You are hoping that this will be a quick visit – you just want to get your prescriptions and leave. You take sugar pills and insulin for your diabetes.

You feel glad that your regular doctor is not in and that you will be seeing one of his partners today. You have not been to see your doctor in a long time, over a year. You know that you have missed several appointments. Before you came to the clinic today, you worried that if your regular doctor were in, he’d lecture you about the importance of coming to the clinic regularly. You don’t want to deal with all of that today.

You’ve had diabetes for many years. You were diagnosed when you were in your late 20s after you went to see the doctor because you were urinating frequently. The doctor took blood and urine tests and told you that you were diabetic. He gave you some pills to take. Back then you had health insurance and received regular health care from a private doctor in your neighborhood, not from the public health clinic where you are currently seeking care.

Initially, your blood sugars got better with the pills. Over time, your sugars became increasingly difficult to control and about five years ago your doctor recommended that you use insulin in addition to pills. Your sugars were well controlled for several years on insulin. You never needed to be hospitalized for diabetes and never even had to call your doctor with blood sugars that were too low or too high.

When you became an insulin-requiring diabetic, you lost your job as a truck driver. Your boss told you that no one who uses insulin is allowed to drive a truck in this country. Something about it being too dangerous or something like that. When you lost your job, you lost your insurance.

You were able to find part-time work as a package handler with United Parcel Service (UPS). But, the new job didn’t give you any health benefits because you were only part-time. Because you didn’t have health insurance, you couldn’t see your community doctor any more. It was too expensive. You heard that the County (public health) clinics would take anyone, even if they didn’t have insurance, so you started seeing Dr. Buchanan at the Austin Clinic on the west side.

Approximately nine months ago, you were laid off from your job and haven’t been able to find another one. You quickly depleted your financial reserve and were unable to pay your rent. At that time, you moved out of your apartment and went to live with some friends temporarily.
Approximately four months ago, when it became clear that the living arrangement was more than temporary, your friends asked you to leave. You had no money for rent and no other family or friends to stay with, so you began staying at the Pacific Garden Mission, a shelter in Chicago.

You continue to receive your medical care at the Austin Clinic. You obtain all of your medication there, as well.

You take your sugar pills faithfully every day. You have difficulty using your insulin, but will only reveal this if asked in a manner that makes you feel comfortable. Because you are homeless, you rarely have access to a refrigerator so you leave your insulin sitting out at room temperature. This causes it to gradually congeal over a period of weeks and it becomes difficult to draw up out of the bottle with the needle and syringe.

You try to maintain a diabetic diet as best you can. You have seen a nutritionist in the past and know how to prepare healthy meals. Now, though, you don’t have access to a kitchen to do your own cooking. Most of your meals are from soup kitchens. In the soup kitchens, the meals are not always the right foods for a diabetic. You try to avoid regular soda and desserts as much as possible, but overall your diet has gotten worse since you became homeless. When the doctor asks you about your eating habits, you will tell him that you know which foods to stay away from and that you avoid soda and dessert. If the doctor speaks with you in a supportive manner, you will confide that your financial situation prevents you from eating better. If you feel very comfortable, you will explain that you eat in soup kitchens.

You have not been able to monitor your blood sugars because your blood sugar machine was stolen along with your other belongings three months ago. You are somewhat ashamed to admit that you have not been monitoring your blood sugars because you know it is important. If the doctor makes you feel uncomfortable, you will say that your blood sugars “haven’t been too good” which you suspect is true. If you are made to feel comfortable, you will reveal that you don’t have a glucometer any more because it was stolen.

**Patient Behavior, Affect and Mannerisms:**

You come across as honest, but reserved. You are ashamed that you are homeless and won’t admit this unless you are asked in a supportive and understanding way. If you are made to feel comfortable, you will answer questions about the impact of homelessness on your diabetes and your daily life.

**Past Medical History:**
1. High blood pressure: You were diagnosed with high blood pressure a few years ago. You take medication for this daily and rarely miss a dose. Your high blood pressure has always been well controlled and has never gotten so bad that you've needed to be hospitalized for it.

2. A hernia in your right groin many years ago

**Medications:**

1. Benazepril 40 every day
2. The big round pill, twice a day… I think it’s a 500. (If asked, you will recognize the name Glucophage.)
3. Insulin, 30 in the morning and 20 in the afternoon. (If asked what kind of insulin, you will say that it is “70 30.” You will also recognize this as a mixture of NPH and regular in one bottle.)

**Allergies:**

None

**Family History:**

Your mother has diabetes, but she takes pills and doesn’t need insulin. You don’t know about your father’s medical health. You have three siblings (two sisters and one brother). One of your siblings has diabetes and uses insulin, another has high blood pressure, the other one is healthy. There are no other medical problems that run in the family.

**Social History:**

You are single and have never been married. You have no children. You used to work as a truck driver, but lost your job because you needed to take insulin. After that, you worked part-time as a package handler for UPS. You were laid off about nine months ago and haven’t been able to find another job. You have found it especially difficult to find work since you moved into a shelter. Employers think there must be something wrong with you since you have no address or phone number.

You have no family in the Chicago area. You have two sisters and a brother. They all have families of their own and you do not feel particularly close to them. You have not contacted them to ask for money or other help.

In the past, you were quite concerned about your health. You checked your blood sugars daily and had your blood pressure checked every other week at a neighborhood pharmacy. Since becoming homeless, your daily routine leaves little time to care for your diabetes. Each day, you are forced to leave the shelter
at 6 AM. You then walk 4 miles north to a soup kitchen where you eat breakfast. The line is long, and it takes over 1-½ hours to get in and eat. You don’t like to ask people for money, so you collect cans every morning until 12:30 when you eat at another soup kitchen 2 miles to the west. In the afternoon, you collect more cans until about 3 or 4 PM when you redeem them for cash (usually about $4-7). You use the money to buy food, cigarettes and beer. Last week you saved up money to get a pair of shoes from a second hand store. You also use the money for bus fare to get to the clinic. By 7 PM you have to return to the Pacific Garden Mission to check in. After check-in you have to listen to a 1-hour sermon before being taken to the dinner line. After dinner, you have to strip down completely, put your clothes in a hot room to disinfect them, and then take a shower with 25 other men in a large room. After the shower, you are given a thin gown to wear which doesn’t cover you in the back, and you go to your assigned bunk to sleep for the night. Your daily life is humiliating. You are embarrassed about your situation and do not talk about it freely, however you will reveal any of these details if you are asked in a respectful manner.

You smoke about ½-pack of cigarettes per day and have done so for many years. You used to be a heavier smoker, but cut down. You drink a 40-ounce beer when you have the money, which generally is 3-4 days per week. Generally, once a week you have two 40 oz beers in a day. You do not consider yourself to have a problem with alcohol. You have used marijuana in the past, but do not use it currently. You have never used any other illicit drugs.

**Questions the Clinician is Likely to Ask:**

**Why do you think your sugars have been running so high?**

“Well, I’ve been under a lot of stress lately, and I’ve been eating some food that I shouldn’t be eating.”

**Do you adhere to your dietary regimen? What kinds of foods do you eat? What kinds of food do you avoid?**

“I used to follow my diet pretty good. I ate lots of fruits and vegetables, and no sweets. Lately though, I have been eating some foods I shouldn’t be eating.”

**Do you adhere to your medication regimen?**

“Well, let me tell you doctor, I do my best. With the pills I do pretty well, but the insulin has sometimes been a problem.”

**If the doctor probes for additional information, about the stress, the change in your eating habits or your adherence, you will say,**
“About 9 months ago, I lost my job. Since then, it seems like everything has been going down hill.”

If the doctor asks further questions about your social situation, you will then reveal that you are homeless and answer other questions.

**When was the last time you saw an eye doctor?**

A few years ago.

**Do you have any numbness or tingling in your hands or feet?**

No.

**Do you have any chest pain or shortness of breath?**

No.

**Is there a place where you could store your insulin when you are not using it?**

Yeah, I think there is a clinic at the shelter where I’m staying. I bet they could hold on to it for me when I’m not using it.

**Physical Examination:**

The doctor examining you will be expected to do a physical examination focused on your diabetes. He may look in your eyes with an ophthalmoscope, listen to your heart and lungs, examine your abdomen and your feet. The physician will NOT perform a genital or rectal examination.