Assessment of Physical Therapy Needs at Third Street Clinic

Susan Wheeldon

University of North Dakota

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ASSESSMENT OF PHYSICAL THERAPY NEEDS
AT THIRD STREET CLINIC

by

Susan Wheeldon
Bachelor of Science of Physical Therapy
University of North Dakota 1994

An Independent Study
Submitted to the Graduate Faculty of the
Department of Physical Therapy
School of Medicine
University of North Dakota
in partial fulfillment of the requirements
for the degree of
Master of Physical Therapy

Grand Forks, North Dakota
May
1995
This Independent Study, submitted by Susan L. Wheeldon in partial fulfillment of the requirements for the Degree of Master of Physical Therapy from the University of North Dakota, has been read by the Faculty Preceptor, Advisor, and Chairperson of Physical Therapy under whom the work has been done and is hereby approved.

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PERMISSION

Title Assessment of Physical Therapy Needs at Third Street Clinic

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Date April 27, 1995
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Health care is being provided free of charge at the Third Street Clinic in Grand Forks, North Dakota, for those people who are uninsured or who do not qualify for Medicare or Medicaid. Physical Therapy is not presently offered as a service at the Clinic.

Physical Therapy is part of comprehensive health care. Therapists provide caring and expertise in the areas of neurological rehabilitation, orthopedic/musculoskeletal problems, pediatrics, and work hardening. As volunteers, therapists are involved in providing care at free clinics across the nation.

The Third Street Clinic agreed to have a needs assessment performed to identify those clients who could potentially benefit from physical therapy services. The needs assessment was conducted via a chart review of the Clinic's patients. Out of 120 charts that were reviewed 34 charts or 28.3% were determined to be potential physical therapy patients. Demographic data describing Third Street Clinic clientele are also presented.
CHAPTER 1
INTRODUCTION

Health care is a national concern. The rising costs of health care and health insurance make health care unaffordable for many Americans. Two groups, the uninsured and the homeless, find it particularly difficult to obtain health care. To help meet the needs of these populations, free clinics have been started across the United States. Physicians, nurses, medical technologists, pharmacists, social workers, physical therapists and other professionals volunteer their time to provide needed services.

The Third Street Clinic, a free clinic in Grand Forks, North Dakota, opened in 1989 to provide health care to individuals who are uninsured or who do not qualify for Medicare or Medicaid. While a variety of health services are provided at the Third Street Clinic, physical therapy is not available. This project, Assessment of Physical Therapy Needs at Third Street Clinic, was developed in the interest of identifying those clients who could potentially benefit from physical therapy services. The study may show if the Clinic is missing an area of enrichment that would add to the array of services already being offered. The survey results will add to the base of information needed to provide health care to the uninsured and homeless populations.
Health care is a concern for all Americans. Despite the fact that the United States is one of the most affluent countries in the world, a significant portion of its citizens have inadequate access to medical care. Health care is expensive and even health insurance is unaffordable for many Americans. With health insurance the costs of medical care may be manageable, but without coverage health care may become a luxury beyond reach. Health care is particularly difficult for the uninsured and the homeless to obtain. Since these two populations are very different in their demographics and their needs, each one will be discussed individually. Free clinics are becoming an important means of providing health care to the uninsured and the homeless. Pros and cons of free clinics and the concept of volunteerism will be explored. Physical therapy is part of comprehensive health care and is being provided at free clinics across the country. Physical therapy's role in meeting health care needs at free clinics is presented.

The Uninsured

To understand the health care needs of the uninsured it is important to look at this population more closely. Why do people become uninsured? How many people are involved? Who are the uninsured and what quality of health care do they receive? The answers to these questions will lead to a better understanding of the problem.
Reasons for Being Uninsured

Historically, there have always been people without health insurance. Until recently, private philanthropy provided the resources for meeting the medical needs of the poor. Churches, public hospitals, and other charitable organizations accepted responsibility for providing health care to the indigent. Doctors donated their time and expenses were shifted. Around 1910, formerly independent medical schools became components of universities and affiliated with or operated charity hospitals. Care of the poor became a substantial component of the educational process. In the 1930's the Great Depression prevented many Americans from having access to medical care and there were serious inequities in the distribution of health care among geographic regions and socioeconomic groups. After World War II the Hill-Burton Act was passed by Congress. This act provided for a loan program to encourage the building of hospitals in underserved areas. The hospitals repaid their loans in cash or by providing care to the indigent. Private insurance was introduced in the 20th century and those who could afford it bought it. Then coverage became a problem of more specific groups, especially the elderly and the poor. Medicare and Medicaid were passed in 1965 to cover these populations and the problem was thought to be solved.

Today, there are theoretically four routes for health care coverage for virtually all Americans: Medicare for the elderly and disabled, Medicaid for low-income women, children, and people with certain disabilities; employer-subsidized coverage at the work place; or self-purchased coverage for those ineligible for the previous three. But evidently something is not working considering the high numbers of uninsured people.
Of the four possible routes to coverage, Medicare has aged the best. Each year Medicare covers increasing numbers of more Americans for most acute care. However, beneficiaries' out-of-pocket costs remain high, and coverage for long-term care remains skimpy especially with the repeal of Medicare catastrophic care coverage.\textsuperscript{2}

Medicaid was passed by Congress, but it is a state-level program with each state defining income levels and other standards of eligibility. Coverage varies from state to state. By the government's own definition over half of the population living in poverty is not eligible for federal health care assistance. This population consists disproportionately of women and children.\textsuperscript{1} In the early 1980's both the federal and state governments tried to reduce Medicaid expenditures in the face of tax cuts, growing costs, and reduced federal funds for the program. This led to freezes and reductions in both eligibility and provider payments. The result is a basically stable number of beneficiaries despite an increase in the poverty population.\textsuperscript{2}

Most people obtain their insurance through work, but having a job does not guarantee coverage.\textsuperscript{1,4} Because of changes in the work place economy health insurance benefits are no longer a given. Benefits are not provided to those who work part-time or are self-employed. Small businesses do not have the opportunity to spread their insurance costs over a large number of employees; this results in higher premiums that may be cost prohibitive for the employer and the employee. Insurance may be provided for the employee but not his dependents and the wage may not be great enough to purchase family coverage.
Private insurance or self-purchased coverage depends on the individual's health status and ability to pay. This eliminates those who are sick, poor, and/or unable to acquire workplace-based insurance. The market for health insurance permits the exclusion of coverage for future expenditures related to pre-existing medical conditions. For example, if a child is found to have or develops a chronic health problem while uninsured, it is likely to affect that child's insurability in the future. Overall, insurance is becoming less affordable simply because the cost of the services covered is doubling every few years. All of these factors affect the increase in numbers of the uninsured population.

Demographics of The Uninsured

The numbers of the uninsured vary according to the source, but all sources agree the numbers of uninsured are increasing. Figures indicate that 38.9 million Americans lack health insurance at any one point in time. A large proportion of this group consists of low-income working individuals and their families.

The uninsured and the underinsured cannot be stereotyped for they include many people who are employed, the elderly, children, minorities, persons with disabilities, pregnant women, and other vulnerable populations. The uninsured population is a diverse group in terms of age, ethnic heritage, and gender. Concerning age, the most likely group to be uninsured is 19-24 years old. Another study indicates that the age group most likely to be uninsured is persons older than 55. Children younger that 18 years are the next most likely to lack coverage with almost one in four uninsured all or part of the year.
Racial and ethnic differences affect rates of coverage. Studies going back as far as 1978 have shown that Hispanic Americans are the most likely to be uninsured of any ethnic group. This is important to consider as Hispanics represent the fastest-growing ethnic population group in the nation.

Men are slightly more likely to be uninsured than women. This may be because men are excluded from Medicaid. Other characteristics of the uninsured population include fewer than 12 years of education, a low family income, unemployment, low self-rated health, and little or no leisure exercise.

Quality of Care

Not only is it difficult to access health care without insurance, there is increasing evidence to suggest that the amount and type of medical care a person receives depends on whether the individual has health insurance. The results of a study comparing uninsured and insured hospital patients are enlightening. Lack of insurance is associated with reduced access to medical care, fewer physician visits, delayed or absent medical care for serious symptoms, and a lower prevalence of recommended preventative services. The process of care may be inferior with the uninsured having an increased risk of suffering medical injury due to substandard care. The uninsured are more likely to be admitted in urgent need of care with a condition that has a higher expected risk of death. They have consistently shorter lengths of stay, and a higher relative risk of in-hospital death when compared with the privately insured. Racial differences in access and utilization of health care also persist. Even when there is entry into the health care system blacks receive less aggressive medical care.
Lack of access to health care, primary and preventive, has pronounced consequences for the health care system and for society in general. When the poor do not have access to medical care in physician's offices, clinics, or other settings, they ultimately seek care in the hospital emergency department even though they may not require emergency treatment.\(^1\) This adds to the costs and strains on an already overloaded system.

The Homeless

The homeless population is a unique and interesting group. Why do people become homeless? How many people are homeless? Who are the homeless? What kind of medical problems do homeless persons experience? Is it true that there are barriers to these people receiving care? Answers to these questions will lead to a fuller understanding of the homeless population and their problems obtaining care.

Homelessness has always been a feature of this country's demographics. The United States was founded by homeless people. In the nineteenth and early twentieth centuries agriculture, mining, logging, and construction required large numbers of workers able to follow the seasonal demands for labor. The term "skid row", which is associated with the homeless, alcoholic bum of the fifties, derived its name and connotation from the collection of lumbermen who wintered at "Skid Road" in Seattle.\(^9\) Seattle's "Skid Road" is the route over which logs were moved into the city for shipment via Puget Sound. However, the face of homelessness has changed over time. Today it is a social and political problem worthy of national concern.
Reasons for Homelessness

The notion exists that homelessness is a matter of choice in spite of published research findings to the contrary. There is no single, simple reason for an individual's becoming homeless. Rather, homelessness is the final stage in a lifelong series of crises and missed opportunities, the culmination of a gradual disengagement from supportive relationships and institutions.\(^{10}\)

Multiple determinants—economic factors, deinstitutionalization of the chronically mentally ill, and personal problems increase the risk of homelessness.\(^{11,12}\)

**Economic factors.**—Economic factors that increase the risk of homelessness include lack of affordable housing, unemployment, and a reduction in entitlement benefits.\(^{11}\) There is a shortage of affordable low income housing. From the end of the Great Depression until 1980, the federal government was the primary source of direct subsidies for the construction and maintenance of low-income housing. Government support for the development of new low-income housing has essentially disappeared.\(^{13}\) Since 1980 there have been significant cutbacks in low-income housing development by private industry.\(^{11}\) In addition to these cutbacks, up to 2.5 million people are displaced from their homes annually as a result of rent increases, losses in income that prohibit paying rent, and condominium conversion.\(^{14}\) In essence there is not enough low income housing available for the people who need it.

Changes in employment have added to the growing dilemma of homelessness.\(^{11,13}\) During the recession of the early 1980's, unemployment peaked at 10.7%. Between 1981 and 1985 more than 11 million industrial jobs were abolished. Forty percent of those losing jobs were unable to find employment as survival in today's job market requires increasingly higher levels
of education, technical competence, and skill. The demand for casual labor has practically disappeared, thus many were not able to find employment. Many were left with no source of income. For those able to find work, employment at minimum wage did not provide enough income to pay for housing and utilities. Many people have survived economic crises by utilizing entitlement programs such as Food Stamps, Aid For Dependent Children (AFDC), and housing assistance. Cuts in these entitlement benefits further compound the risk of homelessness. Benefits have failed to keep pace with inflation and fall well below the federally established poverty level in most states. Reduction in the Food Stamp programs, child nutrition programs, AFDC, and housing assistance increases the stress and the probability of homelessness among people living on the edge of financial instability.\textsuperscript{11,14}

**Deinstitutionalization of mentally ill.**— The homeless population increased with the deinstitutionalization of the chronically mentally ill which began in the 1960s. The purpose of the movement was to provide a community setting, under better living conditions, with greater respect for the clients' civil rights than had been provided by state institutions. It was also thought that community mental health centers would be cheaper to operate than large state hospitals.\textsuperscript{10,11} The federal government passed a law in 1963 promising federal funding for the construction of community mental health centers. State and county mental institutions began releasing large numbers of patients, but an adequate number and range of community based programs were never developed to serve this population.\textsuperscript{12,15} Instead, the chronically mentally ill were left to fend for themselves without support or assistance. Today, large numbers of mentally ill persons live on the streets and in shelters. They are
often robbed or assaulted because they are among the easiest prey. They are visible, leading to the stereotypic perception that most homeless persons are mentally ill.\textsuperscript{16}

**Personal problems.**— Personal problems such as domestic violence, an increase in the number of families headed by women, and lack of a support network contribute to the number of homeless people.\textsuperscript{17} Disturbed relationships in families can produce homelessness, particularly of women. Battered spouses leave, abused children run away, and when a crisis occurs families are evicted from homes where they have been living with another family in a doubled-up situation.

The number of families headed by women has increased due to higher divorce rates and the growing numbers of mothers who have never married. Families headed by women are far more likely to be poor than two parent families.\textsuperscript{14} Women traditionally receive less pay than men for the same work, resulting in less money to pay bills and provide child care.\textsuperscript{11} They are at an increased risk for losing their homes and ending up in emergency shelters.

Lack of a support network, consisting of extended family and friends, contributes to the number of homeless. Research indicates that homeless women have few or no social supports in a time of crisis.\textsuperscript{14} When comparing homeless families with housed poor families, the main difference is the nature and extent of the family's support network.\textsuperscript{18} Homeless women's support networks are fragmented and include proportionately more men, while the housed mothers have frequent contact with their mothers, other female relatives, and extended family. When homeless mothers were asked to name persons on whom they could depend during times of stress, some were unable to name
anyone, some named only a professional or shelter contact, and some named a minor child. To talk with homeless people is to be struck by how alone they are. Family and friends may be exhausted or lack the ability to help; the overburdened social worker may be unable to respond; and the homeless themselves may be unwilling or unable to communicate their needs and make use of support that is available.

Demographics of the Homeless

The size of the homeless population in the United States is estimated between 250,000 and 3 million persons. These numbers are an estimate only as this population is extremely hard to count. There is not a universal definition of homelessness and there are various methods used to count the homeless; both of these factors make it very difficult to know how many people are homeless within a given area. Differences in numbers, sociodemographic characteristics, and the prevalence of health problems between localities may be a reflection of true differences in population characteristics and/or a difference in study techniques. Despite the differences, it is agreed that the number of homeless people is growing and is a matter of national concern.

In the sixties and seventies the homeless population largely consisted of older, white, uneducated, alcoholic men. Alcohol and drug addiction continue to be a problem but the age, sex, racial configuration, and educational levels of the homeless have changed. The homeless now include families, children, single mothers, single women, single men, the recently unemployed, substance abusers, adolescent runaways, the mentally ill, and Vietnam War veterans. Families with children make up one third of the overall population and are the
most rapidly growing subgroup.\textsuperscript{10,14,15} The average age of the homeless person has sharply decreased to the mid-thirties as members of the baby boom generation enter the ranks.\textsuperscript{11} The typical homeless person is a high school graduate, 20\% to 40\% have some education beyond high school.\textsuperscript{16,21}

The Children

Homeless families with children are considered to be one of the largest growing subgroups of the homeless population in this country.\textsuperscript{14,24} Estimates of the numbers of homeless children range from 100,000 to 750,000. More than half of them are younger than five years of age. Homelessness and poverty have dynamic, negative effects on the health of children.\textsuperscript{11} Homeless children, many living in shelters, form a special subpopulation with specific problems and needs that must be addressed.

Children constitute a fragile and vulnerable population and have specific nutritional, developmental, and educational requirements. If these needs are not met, the children most likely will grow up inadequately prepared for the demands placed on them as they mature and become adults.\textsuperscript{24} Shelters do not meet the needs of children. First, it is not always possible to keep the family together.\textsuperscript{22} Shelter directors exercise some control over admission in the form of a written admission policy. Many have specific criteria regarding children. About half of the shelters will accept women with children but they may restrict the age and sex of the children they will accept. Some will not accept male children over twelve years of age. Second, most shelters do not have facilities or space for children to play.\textsuperscript{24} Some facilities require children to stay in their rooms after a certain hour and in some cases parents will not let their children out of their room for fear of accidents or injury. Third, homeless children
frequently experience the loss of friends and familiar neighborhood surroundings, school disruptions, and situations that are strange and threatening.\textsuperscript{25} Finally, shelter life is stressful and shameful compounding the children's problems.

Homeless children have serious unmet medical needs. Homeless children are at risk for delayed preventive care, poor nutrition, higher frequency of acute and chronic illness, developmental lags, emotional and behavioral problems, and learning difficulties.\textsuperscript{14} The most common acute illnesses are upper respiratory tract infections, minor skin problems and otitis media. Chronic physical conditions include anemia, heart disease, peripheral vascular disease, and neurologic disorders.\textsuperscript{11,14}

Access to health care, particularly pediatric preventive health care, is impaired for homeless families. Health care for anyone in the family has low priority as parents struggle to obtain daily food and shelter.\textsuperscript{26} Homeless parents often delay seeking care for their children until emergency treatment is necessary. Health professionals not familiar with the homeless population may accuse the parents of neglect or abuse. Parents terrified of neglect or abuse accusations avoid the health care scene. By delaying treatment, the child may develop complications that are expensive and possibly life-threatening.\textsuperscript{27,28}

Homeless Lifestyle

Conditions associated with homelessness have a profound effect on an individual's ability to maintain good health, get treatment when health is compromised, and to recover even after treatment is received. The basics of health maintenance depend on adequate nutrition, shelter, and sanitation which are difficult to come by in the homeless lifestyle.\textsuperscript{29} Nutrition is compromised by
lack of money and the inability to meet special dietary needs on soup kitchen menus. Lack of shelter exposes people to extremes in temperature. They are often not protected from rain or snow. Cleanliness is difficult to maintain when access to showers and clean clothes is restricted. Sleeping arrangements are often bizarre. All of one's possessions must be carried, and shelters are crowded so that lining up for hours is a standard part of the day. The homeless tend to be transient, walking to keep warm, moving to seek shelter, and searching to find work. This transient state results in fragmentation of health care when and if health care is available.

The homeless in America receive less care and poorer quality health care than anyone else. They have major health problems and yet are nine times more likely to have no health insurance and five times more likely to report no regular source of health care. Homelessness increases the risk of developing certain medical conditions, magnifies the severity of various common illnesses, and almost always makes treatment more difficult.

Common Medical Problems

Specifics of children's medical problems have been discussed. The most common health problems of homeless adults include upper respiratory tract infections, trauma, skin conditions such as rashes and lice infestation, foot problems, and accidental injuries involving musculoskeletal damage from trauma or work-related injuries. The most prevalent chronic illnesses are genitourinary tract problems, gastrointestinal tract illnesses, hypertension, and peripheral vascular disease.

Common viral respiratory diseases, ranging from a cold to influenza, are easily transmitted from person to person in crowded shelters and food lines.
Although illnesses of this nature produce acute disability, the long-term consequences to patients are ordinarily not severe.\textsuperscript{16,23}

Trauma

Trauma is a major cause of death and disability among homeless persons, with the lack of a safe refuge contributing to their vulnerability and risk.\textsuperscript{13,16,23} The homeless are particularly at risk because life on city streets is unsafe for those who are perceived to be weak. Major injuries include stab wounds, head trauma, blunt trauma, multisystem trauma, gunshot wounds, suicide attempts, sexual assaults, burns, fractures and lacerations. Homeless women who lack the protection of a physical shelter are particularly at risk for rape.\textsuperscript{13} Minor traumas include bruises, abrasions, burns, fractures, concussion, sprains, puncture wounds, eye injuries, and cellulitis.\textsuperscript{29} Recovery from injuries may be hampered by malnutrition, outdoor exposure, and inadequate follow-up care.

Foot Problems

Foot problems represent 20\% of health related complaints of homeless people.\textsuperscript{32} Blisters, chronic heel pain, Achilles tendon disorders, plantar fascitis, chronic metatarsalgia, hallux valgus, ulcers, infections, immersion foot and frostbite are a few of the many foot problems found in the homeless population. Since feet are a homeless person's major form of transportation even relatively minor foot problems can cause major inconvenience.\textsuperscript{33} Homeless persons walk and stand in line for shelter or food for hours, often in insufficient footwear which compounds any foot problem. They may sleep sitting up, which promotes edema and along with alcoholism and malnutrition may lead to peripheral neuropathy.\textsuperscript{16} Foot infections, poor nail care, and chronic exposure to moisture
occur in part because shoes are not removed due to cold temperatures or the fear that shoes will be stolen.\textsuperscript{32}

Chronic Disease

Chronic disease occurs no more frequently in the homeless than in the general population, but it is more difficult to manage in the homeless population.\textsuperscript{7,16,23} Optimal control of chronic disease is difficult if not impossible due to the lack of stable housing, the inability to select one's diet, and difficulties in storing and taking medications on schedule. For example, diabetes may need a controlled diet, regular injections of insulin, and monitoring of blood sugar levels. Shelters offer adequate food but no special diets. Insulin, if it can be obtained on a regular basis, must be refrigerated to maintain its potency. Refrigeration for medications is probably not available. Syringes and even the alcohol swabs used to cleanse the injection site are subject to theft for their street value. The temptation to sell the syringes is also high.\textsuperscript{16,23} The difficulties in managing chronic disease in homeless patients leave them vulnerable to immediate and long-term complications of disease.

Barriers to Care

Health care is needed by the homeless population but it has a lower priority than obtaining food, shelter, or finding a job. It is only when health care needs can no longer be ignored that homeless clients attempt to access the system. At this point treatment is provided in an emergency room, in a hospital outpatient clinic, or by some other public provider.\textsuperscript{34} Even when health care is available many individuals are unable or unwilling to seek access to it.\textsuperscript{29} Several barriers to care have been identified and include: lack of transportation,
cost of care, a transient, fragmented lifestyle, and negative attitudes from providers.\textsuperscript{15,20,34}

Lack of transportation keeps the homeless from obtaining health care. The provider may be located outside of the person's present neighborhood. A car is usually not available and a taxi is expensive. The city bus schedule may conflict with soup kitchen times and shelter schedules. The cost and effort required to get to the health care provider may end up being too great to be worthwhile to the homeless client.

Cost of care also prevents the homeless from receiving health care. According to a study by Wood,\textsuperscript{34} about one fourth of homeless families reported no health insurance. Most of the homeless families (67\%) relied on Medicaid for health insurance coverage, and a few (7\%) had private insurance. Medicaid coverage may be lost due to administrative problems and not due to a change in eligibility for the program. Loss of a home address and difficulty receiving and returning the monthly eligibility report can lead to a loss of coverage. Nationally, the average family on Medicaid spends one fourth of the year uncovered. Many of the homeless are entitled to VA and other benefits, but the lack of a permanent address and difficulties in handling money result in disuse of these entitlements. For example, during the winter of 1984-1985 a man in Washington D.C. froze to death because he was unable to seek shelter for the night. Upon his death it was discovered he had been a medal recipient during World War II and had been eligible for VA benefits.\textsuperscript{15}

The fragmented lifestyle of the homeless is also a barrier to care. The homeless tend to be transient, walking to keep warm, moving to seek shelter, and searching to find work.\textsuperscript{11} Families may move frequently and need to deal
with housing instability. Families also tend to be sheltered outside their original neighborhood so they are unfamiliar with and apprehensive about new health care providers.\textsuperscript{35}

Attitudes of health care professionals discourage the homeless population from receiving care. Caregivers not familiar with the homeless population perceive them to be dirty, frightening, crazy, and unworthy of high-quality care.\textsuperscript{29} Some homeless families have had prior frustrating experiences with the traditional health care system. It is not uncommon for a mother to be considered neglectful or even immoral for missing an appointment for immunizations.\textsuperscript{14,35} Insensitivity or ignorance of the homeless situation leaves the client unable to follow the treatment plan. There may not be enough money to purchase prescriptions, or a refrigerator for storage. Following a medication schedule may be impossible due to the lifestyle and a watch may not be available for timing medications. It is difficult to keep wounds cleaned and dressed without bathing facilities, and bedrest is impossible if shelters are not open during the day.\textsuperscript{29} In most cases, homelessness will increase the potential for noncompliance and consequent treatment failure.\textsuperscript{23} It is easy to understand why providers and homeless clients are frustrated with each other. Without some knowledge of the difficulties of street life and of the resources available to homeless people, the clinician is doomed to feelings of frustration and helplessness as he or she sees the same people returning to the acute setting with the same problems.\textsuperscript{36} In order to meet the health care needs, the health care system—not the clients—must remove the barriers to care. The barriers can be removed through targeted programs such as free clinics.
Free Clinics

Free clinics have formed nationwide as a grass-roots effort to provide health care to the uninsured and homeless populations.\(^{37}\) Free clinics started in the 1960's and have evolved into well-respected health care centers providing outpatient services to the homeless and working poor. The recently published *Directory of Free and Community Clinics in the United States* lists more than 1500 not-for-profit, free, and community clinics. Clinics can be run very economically, but some source of revenue is needed. Grants from national corporations, the United Way, local medical and dental societies, hospitals, local and state governments, and individuals may all play a part in supporting a community free clinic. Pharmaceutical companies may provide medications free of charge.

Free clinics are located in neighborhoods where there is need. The clinic is physically accessible and many have night hours to fit the patients' and volunteers' schedules. The clinics are inexpensive. Most services are provided by volunteers and the space may be donated. A strong identification occurs with a neighborhood clinic that encourages responsibility and pride. Individuals that have been helped often respond by volunteering to support the clinic.

There are three main objections concerning free clinics: providing health care for the nation's uninsured through volunteer efforts seems ridiculous; free clinics represent a two-tiered health care system and inferior care; and because of multiple providers continuity of care is affected.\(^{37}\) Each objection will be addressed.

America has a long history of volunteerism and volunteerism has worked in the past to solve many national and international problems.\(^{37}\) Expecting
volunteerism to solve the health care problems of the homeless and uninsured may seem idealistic, but there are many reasons why volunteerism should work. Costs to the health care system are decreased. By centralizing indigent care, no one physician carries the burden of unreimbursed care. Bad-debt patients are fewer and practice overhead is lowered. Use of the hospital emergency room for routine care is lessened. Volunteers at the clinic are recognized and honored by their communities. The patients recognize the volunteer effort and are unlikely to abuse volunteers.

The second most common objection is that free clinics represent a two-tiered health care system and inferior care. Our health care system is already two tiered in that those who can afford better care purchase it while those that do not have the financial means go without it. Nationalized health care systems are also two-tiered as the wealthy have access to fee-for-service care if they wish to purchase it. Free clinics are able to centralize indigent care and make available the array of social services provided for this population. Free clinic care may be superior as the staff is able to tailor its capabilities to the special needs of its clients.

Continuity of care is a concern due to the multiple providers that volunteer at a free clinic. This is also a concern with large group practices where it is difficult to see the same physician each time an office visit is warranted. Quality assurance reviews and simplified charting are necessary and helpful when so many providers are involved to ensure clients are receiving the appropriate care.

Once the objections are resolved, it is vital to understand that free clinics must be organized to meet the special needs of the populations they serve. Outreach clinics need to establish trust with clients, provide a nonjudgemental
atmosphere, and utilize multidisciplinary teams in order to be successful. Trust must be established between providers and patients. A homeless patient may be supersensitive and imagine slights. The provider needs to be aware of such feelings and respond reassuringly to establish trust. The provider's greeting and manner can communicate to the client that he will be treated as a human being and worthy of care.

The atmosphere must be nonjudgemental. No patient should ever hear judgmental, negative remarks on his health problems or appearance. Nonverbal messages or closed body language that communicate discomfort, disapproval, or indifference are just as harmful.

Multidisciplinary teams should be used to provide care. The diverse health-related needs of homeless persons require a coordinated, comprehensive response from those giving care. The interdisciplinary team approach, which integrates the skills of physicians, nurses, social workers, physical therapists, and other professionals, is an invaluable strategy for establishing thorough and continuous care. Members of the health care team must be sensitized to the plight of the indigent and must acquire the knowledge and skills necessary to effectively meet the needs of this population.

Health care should not be another 'handout' but should encourage self-reliance. Homeless persons' quality of life is greatly influenced by what others are willing to give, but such assistance does not have to foster dependency. Individuals are capable and have the right to care for themselves. The provider and patient may have very different perceptions of what services are needed. The client may reject the services provided if they do not fit his or her frame of reference. Unless the client's input is considered, the likelihood of goal
attainment is greatly reduced. Providing health care that fosters dignity and self-esteem will increase service use and increase self-esteem.

Volunteerism through the formation of free clinics may not be the ultimate solution to the problem of the uninsured and the homeless. There probably is no ultimate solution. But with approximately 39 million Americans uninsured or underinsured for health care there is a tremendous need for pro bono health care in this country. This is a solution that trusts in our humanity and our willingness to care for one another and immediately provides help to our citizens in crisis.

Physical Therapy Playing a Part

Free clinics provide a variety of services depending on the needs and the professionals willing to provide free care. Physical therapists are involved in providing services at free clinics around the United States. Therapists are making a difference with HIV/AIDS patients at the Whitman-Walker Clinic in Washington DC, with Mexican children and their parents along the Arizona-Mexico border, and at the Camillus Health Concern, a free clinic in Miami, Florida caring for the city's poor and homeless. Dr. Joe Greer, the founder and director of the Camillus Health Concern, inspired physical therapists to volunteer at the free clinic. He admits that he was not sure what role physical therapy would play at the clinic. Now, Dr. Greer says, "If you want to see how important it (physical therapy) is, just try and take it away. We'd have a riot." Tracy Williford PT, one of the first physical therapists to volunteer at Camillus, encourages other physical therapists to get involved. In a conversation with Tracy (July 1994), she shared that "They (the clients) were some of the most gracious and grateful people you can find. Just get your foot in the door. You'll
find so much to do." Christa Foti PT, who also volunteered at Camillus, recommended talking to the physicians about offering physical therapy services because others do not understand what physical therapy has to offer (personal conversation July 1994). Physical therapists can provide needed health care services to the homeless and uninsured populations by volunteering at a free clinic or through their own practices.

Therapists generally treat the same types of dysfunction in the homeless population as they treat in the general population. Therapists provide debridement, wound care, splinting, and exercise programs for people with traumatic injuries; patient education, balance training, and gait training for people with foot problems or neurological disorders; and chest physical therapy for people with respiratory problems. Although physical therapy treatment may vary depending on the patient's environment, the goals of the treatment plan remain the same: to accurately assess the problem, to make appropriate physician referral, to educate the patient, and to provide a treatment program that helps improve the patient's quality of life.

The Third Street Clinic

The Third Street Clinic, a free clinic located in Grand Forks, North Dakota was established in 1989. It is dedicated to providing free medical evaluation, care, and referral to area residents who do not have health insurance or who do not qualify for Medicare or Medicaid. There are no restrictions based on race, sex, religion, or residence.

The clinic is located on the second floor of the City Center Mall at 27 1/2 South Third Street. It is open Tuesday evenings beginning at 7:00 p.m. Care is provided to approximately 15-20 people each Tuesday evening. Appointments
can be made by phone. If a volunteer is not on hand to answer the call an answering machine will record the message and return the call. Third Street Clinic is staffed by community volunteers; physicians, nurses, lab personnel, receptionists, nurse practitioners, x-ray technicians, optometrists, dentists, and pharmacists guarantee personalized care and attention to the patients. Presently, physical therapy services are not offered at Third Street Clinic.

The Research Question

Since it has been shown that physical therapy services are useful at free clinics in the United States, a needs assessment seemed appropriate to determine if physical therapy services could make a contribution at the Third Street Clinic in Grand Forks, North Dakota. The overriding research question is: Could the Clinic's patients benefit from physical therapy services? Other considerations include demographics of the clients, their health care needs or diagnosis, and recognition of any diagnoses appropriate for physical therapy services. This study will be limited to clients 18 years of age and over.
CHAPTER 3

METHODS

In order to gain a better understanding of the health care needs of the homeless and uninsured served by the Third Street Clinic, this project was developed with the agreement of The Third Street Clinic's Board of Directors. The proposal for the project was presented at a regular Third Street Clinic board meeting (Appendix A). The Board gave permission for the chart review in February 1994. An agreement was made between the University of North Dakota's Department of Physical Therapy and the Third Street Clinic for provision of a chart audit (Appendix B). Subsequent methodology included subject selection, development of a data collection tool, and data analysis.

Subjects

Subjects' charts dated between January 1993 and July 1994 were selected randomly. Charts of clients 18 years and younger were excluded. Charts that met the requirements for date of visit and age were randomly selected and reviewed until a total of 120 charts were obtained. Data were collected to assess clients potential needs for physical therapy, to provide direction for future physical therapy programming at Third Street Clinic, and to increase the understanding about individuals who are homeless and/or working poor in order to provide them with better health care. The data were collected in a codified form to insure confidentiality. Permission to collect data at the Third Street Clinic was granted by the University of North Dakota's Institutional Review Board and The Third Street Clinic (Appendix C).
Data Collection Tool

After extensively reviewing articles pertaining to chart audits and need assessments it was determined that a data collection tool appropriate for this project did not already exist. The data collection tool was developed in consultation with University of North Dakota Physical Therapy instructors and telephone interviews with physical therapists involved in pro bono work. The Third Street Clinic's health intake form, follow-up visit form and a literature review of chart audit methods contributed to the tool's development (Appendix D).

Data Analysis

Chart data were entered into the computer for statistical analysis. This was performed by the researcher and the advisor. Statistical data for Third Street Clinic clients were compiled via the Statistical Package for the Social Sciences (SPSS-X). Included were descriptive statistics for gender, age, marital status, type of household, household income, income source, disabled family members, functional loss, and potential physical therapy patients. Patient's complaints, the diagnosis, and treatment relative to musculoskeletal problems were recorded in open ended format. The data were sorted and compiled using Microsoft Works spreadsheet application.
CHAPTER 4

RESULTS

One hundred twenty charts of Third Street Clinic clients were reviewed. Charts of children 18 years of age and younger were excluded. Data was collected to assess the need for physical therapy services, to provide direction for future physical therapy programming at the Third Street Clinic, and to increase the understanding of the homeless and/or working poor in order to provide them with better health care.

Data were analyzed using descriptive statistics. Information is reported in table format.

The adult clients seen at Third Street Clinic range in age from 19 to 65 years (table 1). Clients are fairly equally divided among three age groups: 19-29 years, 30-39 years, and 40-49 years. The largest group is the 30-39 year category. The smallest group is the 60-69 year category.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Percent Seen</th>
</tr>
</thead>
<tbody>
<tr>
<td>19-29 yrs</td>
<td>25.0%</td>
</tr>
<tr>
<td>30-39 yrs</td>
<td>30.0%</td>
</tr>
<tr>
<td>40-49 yrs</td>
<td>27.5%</td>
</tr>
<tr>
<td>50-59 yrs</td>
<td>12.5%</td>
</tr>
<tr>
<td>60-69 yrs</td>
<td>5.0%</td>
</tr>
</tbody>
</table>
Patient gender is almost equally divided between males and females (table 2). Females account for a larger proportion of the total.

<table>
<thead>
<tr>
<th>Table 2.—Gender of Patients Sampled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
</tr>
<tr>
<td>----------</td>
</tr>
<tr>
<td>Males</td>
</tr>
<tr>
<td>Females</td>
</tr>
</tbody>
</table>

Single persons account for the largest proportion of the patients sampled (table 3). Married persons account for 18.3%.

<table>
<thead>
<tr>
<th>Table 3.—Marital Status of Patients Sampled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marital Status</td>
</tr>
<tr>
<td>------------------</td>
</tr>
<tr>
<td>Single person</td>
</tr>
<tr>
<td>Married</td>
</tr>
</tbody>
</table>

Single person households account for the largest proportion of the sample (table 4). Two parent families are the next largest group with 16.8%. Single parent males and females together account for 10% with single parent male being the smallest percentage of the sample. Married, no child is also a small percentage of the sample with 1.7%.

Ten percent of the sample stated they had no income (table 5). Fifty one point seven percent of the sample had an annual income of $9,999 or less. Only 5% of the sample had an annual income of $15,000 to $24,999.
Table 4.—Type of Household of Patients Sampled

<table>
<thead>
<tr>
<th>Type of Household</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single person</td>
<td>42.0%</td>
</tr>
<tr>
<td>Single parent female</td>
<td>9.2%</td>
</tr>
<tr>
<td>Single parent male</td>
<td>0.8%</td>
</tr>
<tr>
<td>Two parent</td>
<td>16.8%</td>
</tr>
<tr>
<td>Married, no child</td>
<td>1.7%</td>
</tr>
</tbody>
</table>

Table 5.—Annual Income of Patients Sampled

<table>
<thead>
<tr>
<th>Annual Income</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0</td>
<td>10.0%</td>
</tr>
<tr>
<td>$100-$4,999</td>
<td>14.2%</td>
</tr>
<tr>
<td>$5,000-$9,999</td>
<td>27.5%</td>
</tr>
<tr>
<td>$10,000-$14,999</td>
<td>19.2%</td>
</tr>
<tr>
<td>$15,000-$19,999</td>
<td>4.2%</td>
</tr>
<tr>
<td>$20,000-$24,999</td>
<td>0.8%</td>
</tr>
</tbody>
</table>

The decision about potential physical therapy clients is based on two criteria (table 6). The first is a physical therapist's training to evaluate and treat musculoskeletal and neurological dysfunction. The second criteria is the patient diagnosis. If a patient diagnosis fell in a musculoskeletal category the client was considered as potentially benefitting from physical therapy. Twenty eight point
three percent of the 120 adult clients in the sample appear to qualify as potential physical therapy clients.

<table>
<thead>
<tr>
<th>Potential Client</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>28.3%</td>
</tr>
<tr>
<td>No</td>
<td>71.7%</td>
</tr>
</tbody>
</table>

The patient diagnoses are divided into fourteen diagnostic categories (table 7). The two largest categories the Upper Respiratory Infection and Medical categories with 35 and 34 cases respectively. Tension headache, Wounds, Diabetes, Arthritis, and Depression are the smallest categories with less than 5 cases in each.

Of the initial fourteen diagnostic categories, five fit the criteria for potential physical therapy treatment (table 8). These include the Arthritis, Back, Upper Extremity Complaints, Lower Extremity Complaints, Tension headache and Wounds categories. Complaints relative to the Back is the largest group with 12 cases, followed by Lower Extremity Complaints and Upper Extremity Complaints. Tension headache is the smallest group with only one case. When the charts were reviewed some clients complained of more than one problem. For purposes of the review each problem was listed (Appendix E). This resulted in more diagnoses than the number of charts reviewed.

Treatment procedures for the physical therapy related categories are listed along with the type and numbers of treatments performed (table 9). Exercise, a major physical therapy treatment technique for musculoskeletal
dysfunction, was recommended three times. Medications, primarily analgesics and muscle relaxants, were prescribed 19 times. Five times a musculoskeletal complaint was documented but not addressed further by the medical staff.

<table>
<thead>
<tr>
<th>Categories</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthritis</td>
<td>3</td>
</tr>
<tr>
<td>Back</td>
<td>12</td>
</tr>
<tr>
<td>Depression</td>
<td>4</td>
</tr>
<tr>
<td>Diabetes</td>
<td>2</td>
</tr>
<tr>
<td>Eye exams</td>
<td>9</td>
</tr>
<tr>
<td>Genitourinary</td>
<td>6</td>
</tr>
<tr>
<td>Hypertension</td>
<td>7</td>
</tr>
<tr>
<td>Lower extremity complaints</td>
<td>8</td>
</tr>
<tr>
<td>Medical</td>
<td>34</td>
</tr>
<tr>
<td>Physical exam</td>
<td>5</td>
</tr>
<tr>
<td>Tension headache</td>
<td>1</td>
</tr>
<tr>
<td>Upper extremity complaints</td>
<td>7</td>
</tr>
<tr>
<td>Upper respiratory infection</td>
<td>35</td>
</tr>
<tr>
<td>Wounds</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Categories</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthritis</td>
<td>3</td>
</tr>
<tr>
<td>Back</td>
<td>12</td>
</tr>
<tr>
<td>Upper extremity complaints</td>
<td>7</td>
</tr>
<tr>
<td>Lower extremity complaints</td>
<td>8</td>
</tr>
<tr>
<td>Tension headache</td>
<td>1</td>
</tr>
<tr>
<td>Wounds</td>
<td>2</td>
</tr>
</tbody>
</table>
Table 9.—Treatment Procedures Performed Per Diagnostic Category

<table>
<thead>
<tr>
<th>Category</th>
<th>Treatment performed</th>
<th>Occurrences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lower extremity complaints</td>
<td>walk don't jog</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>ice, elevate, ace wrap</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>medications</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>not addressed</td>
<td>2</td>
</tr>
<tr>
<td>Back</td>
<td>bedrest x 48 hours</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>referred to Rehab PT</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>exercise program</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>pain relievers, mm relaxants</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>renal work up</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>not addressed</td>
<td>1</td>
</tr>
<tr>
<td>Upper extremity complaints</td>
<td>rest</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>ice</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>home exercise</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>medication</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>not addressed</td>
<td>1</td>
</tr>
<tr>
<td>Tension headache</td>
<td>muscle relaxants</td>
<td>1</td>
</tr>
<tr>
<td>Arthritis</td>
<td>medication</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>not addressed</td>
<td>1</td>
</tr>
<tr>
<td>Wounds</td>
<td>elevate leg</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>cleansing, ointment</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>support stockings</td>
<td>1</td>
</tr>
</tbody>
</table>

An attempt was made to gather information concerning the source of patient income, the presence of disabled household members, and the patient's functional loss, but data were not available.
CHAPTER 5
DISCUSSION

To gain a clearer understanding of Third Street Clinic's clients and their health care needs a chart review was performed. Demographic data concerning age, gender, marital status, type of household, yearly household income, source of income, and disabled family members were collected to describe the types of persons and families the clinic serves. Information concerning diagnostic categories, treatment procedures, functional losses, and the potential for physical therapy services was gathered.

Several limitations to the study materialized while the chart review was in progress. After the data collection tool had been approved and data collection started, it was discovered that the Clinic's health intake form had changed between January 1993 and July 1994, the time frame during which original data was collected. While some topics on the forms were unchanged, the question format was altered; answers did not fit into the divisions selected for data collection. In some instances the same information was not elicited. Consequently, parallel information was not gathered from each chart.

Another drawback included the inability to determine if a client was in the homeless or housed working poor category. Some clients identified the city mission as a place of residence. Other addresses did not confirm homelessness or a regular place of residence. For treatment purposes it would be necessary to ask the client about their place of residence.
The chart review was also limited by the data provided within the chart. More accurate and complete information could have been collected if the client had been personally interviewed, but this process would have been much more time consuming.

There was much missing data. Missing data accounted for 19.2% in marital status and up to 62.5% in source of income. Possible reasons for missing data will be addressed in categories as applicable. In spite of study limitations, conclusions may be drawn about Third Street Clinic's clients.

Age Groups

The adult clients seen at Third Street Clinic range in age from 19 to 65 years. The average age of a client falls in the 30-39 years group. The smallest group is the 60-69 age category. This group should be small as this age category becomes eligible for Medicare.

This study focuses on the clinic's adult clientele. Children are seen at the clinic but were not included in the chart review. The literature review indicates that children have physical therapy related diagnoses. Children's needs should be considered in future physical therapy programming.

Gender

Patient gender is almost equally divided between males and females. Females account for a larger proportion of the total. When related to the numbers of uninsured it is reasonable to find more males as they do not qualify for Medicaid. When related to the homeless it may be reasonable to see more women since families headed by women are the largest growing subgroup. In this study a reason for the numbers of males and females cannot be absolutely
determined. It is possible that the numbers are a reflection of the percentages of males and females in the area served by Third Street Clinic.

Marital Status and Type of Household

Even though Marital Status and Type of Household are two separate categories on the questionnaire they will be discussed together as the information overlaps. In both categories, the single person and single person head of household account for the largest proportion of the sample. It is difficult to determine if the singles are living in a truly single person household or if they possibly live with a significant other, a friend, or a relative. If the single person household actually represents one adult living within the home, the amount of social and family support available may be slim. When planning care the lack of a support network needs to be considered.

Families are also clients of the clinic. Twenty-seven percent of the sample represents families with children. Two parent, single parent male, and single parent female families are all clinic clients. Families are the fastest growing segment of the homeless population. Whether uninsured or homeless, families are a vulnerable population in today's health care scene. Their needs must be considered and planned for in free clinic programming.

Yearly Household Income

Fifty one point seven percent of the sample have an annual income of $9,999 or less. In terms of treatment, it is not reasonable to expect this population to purchase prescription medications or extra modalities to enhance their well-being. The clinician needs to be receptive and creative in finding effective treatment techniques with little or no financial expenditure.
Source of Income

Responses to source of income clarify how people are surviving financially. Answers indicate whether an individual is employed, receiving government assistance, or family assistance.

Information is available for only 37.5% of the sample. This question has the largest percentage of missing data. It is possible the client did not feel the clinic had a need to know the information requested. Or perhaps he or she was uncomfortable sharing this information. It is also possible an individual may have been reluctant to state their means of income. For whatever reason, it is impossible to draw a conclusion about how or where this group gets its support.

Disabled Household Members

Only 3.6% of the sample claimed a disabled household member. This information is helpful when determining treatment and understanding the household situation to which a client must return. It appears only a small proportion of the sample includes a disabled member. But for this proportion treatment success may depend on this knowledge.

Functional Loss

Functional aspects of a patient's problem are not discussed in nurse or doctor interviews. Only one chart gave an indication of functional loss. In any patient population it is important to know how a health problem affects the client's ability to work or to take care of self. Addressing needs from a functional perspective increases the potential success of the treatment program.

Diagnostic Categories and Treatment Procedures

The patient health care complaints were divided into fourteen categories. The Upper Respiratory Infection and Medical categories account for the major
share of the problems which also fits the description of health problems reported in other articles. Physical therapy related diagnostic categories include Arthritis, Back, Upper Extremity, Lower Extremity, Tension Headache, and Wounds. Physical therapy related diagnoses comprise 27.5% of all diagnoses seen.

Treatment procedures for the physical therapy related categories were examined. Exercise plays a major role in the rehabilitation of musculoskeletal problems. Of all of the diagnoses an exercise program was advised three times; for two back problems and one shoulder problem. Medications, including pain relievers and muscle relaxants, were prescribed 19 times.

The researcher excluded diagnoses that were questionably related to physical therapy. Tension headache may appear to be a questionable physical therapy diagnosis but the patient was prescribed muscle relaxants. In this instance it appeared the patient could benefit from relaxation, cervical exercises, and postural training taught by a physical therapist.

Physical therapy treatment encompasses the patient's functional losses, patient education, and exercise. It is important that the individual be functional in daily living skills and employment requirements. Deficits are addressed and the patient is educated concerning his/her diagnosis and the process to attain wellness. An exercise program is designed for each patient based on deficits unique to the individual. The ultimate responsibility for wellness is given to the individual with the therapist serving as an educator and guide.

Potential Physical Therapy Patient

Physical therapists are trained to evaluate and treat musculoskeletal dysfunction. Clients complaining of musculoskeletal dysfunction were included
as potential physical therapy patients. Based on this, 28.3% of the 120 clients sampled or 34 individuals would benefit from physical therapy services. Of 135 total health complaints, 37 complaints or 27.5% are physical therapy related. The percentage of physical therapy clients and physical therapy related diagnoses is greater than 25%. It appears that a significant number of Third Street Clinic clients would benefit from physical therapy services.

This study focused on the adult clientele served by the Clinic. Children are also treated at the clinic but were not included in this review. It has been documented that children have physical therapy related needs. The number of children treated and their physical therapy needs must also be considered when determining the benefit of physical therapy services for Third Street Clinic clients.
CHAPTER 6

CONCLUSION

Free clinics have risen across the nation as a grass roots response to provide health care to the uninsured and homeless populations. The Third Street Clinic in Grand Forks, North Dakota provides health care to individuals who are uninsured or who do not qualify for Medicare or Medicaid. Physicians, nurses, medical technologists, pharmacists, social workers, and other professionals volunteer their time to provide needed services. Even though physical therapy is part of comprehensive health care and physical therapists are involved in free clinics across the nation, physical therapy is not offered at the Third Street Clinic.

This project, Assessment of Physical Therapy Needs at Third Street Clinic, was developed to identify those clients who could potentially benefit from physical therapy services. Study results suggest more than 25% of the adult clients could benefit. Study results will be presented to Third Street Clinic's Board of Directors to allow them to determine if physical therapy services should be provided at the Clinic. It is the opinion of this researcher that physical therapy services is an area of enrichment that should be added to the array of services already offered. Future programming is left to Third Street Clinic.
MEMORANDUM

February 23, 1994
TO: The Third Street Clinic Board of Directors

From: Susan Wheeldon--senior UND Physical Therapy student

Concerning: A proposed needs assessment to determine if Physical Therapy would be beneficial to the Clinic.

I am seeking your permission to perform a needs assessment which would determine if Physical Therapy is a needed service at the Third Street Clinic. This study would involve a chart review of the Clinic's clients. Immediately, the concern as to how to protect the clients confidentiality arises. Confidentiality can be protected and/or assured in several ways.

Anytime a research study involving human subjects is undertaken at UND the project must be approved by the University of North Dakota's Institutional Review Board (IRB). This process includes describing the risks to the subject and precautions that will be taken to minimize them. A risk in this study is the accidental breach of confidentiality. This can be minimized by collecting data in a codified form to insure confidentiality of each subject (i.e. using the subjects medical record number for identification). Therefore, names of subjects will never be disclosed. Data would only be collected on the clinic premises and aggregate data would be stored at the UND Physical Therapy department. This would minimize any inadvertent loss of information through travel.

An agreement can be made between UND's Department of Physical Therapy and the Third Street Clinic for the provision of chart audit for students in Physical Therapy. Prototype form is attached. This agreement may include any provisions necessary concerning patient confidentiality. The agreement also states that UND's Physical Therapy department will provide faculty that will be responsible for the overall supervision of my project.

My study will provide several benefits to the Third Street Clinic. By the conclusion of the project a needs assessment will have been performed. The Clinic will have the information available to help decide if Physical Therapy should be available. Next, the study results will help the Clinic determine if needed services are not being delivered. Finally, the study may show if the Clinic is missing an area of enrichment that would add to the array of services already offered.
I sincerely hope you will approve my request to perform a needs assessment for Physical Therapy at Third Street Clinic. Thank you for your time and consideration.

Sincerely,

Susan Wheeldon

Susan Wheeldon
AGREEMENT BETWEEN
UNIVERSITY OF NORTH DAKOTA DEPARTMENT OF PHYSICAL THERAPY
GRAND FORKS, NORTH DAKOTA

AND

THIRD STREET CLINIC
GRAND FORKS, NORTH DAKOTA

FOR PROVISION OF CHART AUDITS
FOR STUDENTS IN PHYSICAL THERAPY

(April 1, 1994 through May 30, 1995)

I. It is hereby agreed by and between the parties hereto, that:

A. The University of North Dakota Department of Physical Therapy will provide physical therapy faculty to be responsible for the students' learning experience in the Agency. The University and the Agency will plan cooperatively for appropriate orientation for faculty and students, and for selection of agency clinical preceptors where mutually agreed upon.

B. The University of North Dakota Department of Physical Therapy retains the responsibility for the design, overall supervision, and evaluation of students' learning experiences.

C. The University of North Dakota Department of Physical Therapy and Agency will jointly decide upon areas of the Agency that will be utilized, experiences planned, dates and times for experiences, and the supervisory responsibilities of each.

D. Neither party to this agreement will discriminate against persons because of race, creed, sex, age, national origin, or against persons with handicaps who are otherwise qualified.

E. The Agency will assist in facilitating research efforts by faculty, staff and students.

II. The University of North Dakota Department of Physical Therapy shall:

A. Provide liability insurance for all students and faculty assigned to the Agency.
III. The Agency shall:

A. Keep faculty and students informed as to information gained about clients.

B. Provide conference space for student to analyze charts on-site. This will ensure confidentiality.

IV. Other University of North Dakota Department of Physical Therapy/Agency specific items: NOTE (must be agreeable by both parties/to be typed in by the Department of Physical Therapy secretary before signatures are obtained.

A. Students will be required to read and sign Agency Confidentiality Policy.

Karen Schelinder  
Board President  
Third Street Clinic

Renee Mabey, M.S., P.T.  
Instructor  
UND-PT

Susan Wheeldon  
Physical Therapy Student
APPENDIX C
DATE: August 12, 1994

NAME: Susan Wheeldon

DEPARTMENT/COLLEGE: Physical Therapy

PROJECT TITLE: Assessment of Physical Therapy Needs at the Third Street Clinic

The above referenced project was reviewed by a designated member for the University's Institutional Review Board on August 22, 1994 and the following action was taken:

☐ Project approved. EXPEDITED REVIEW NO. ___.
Next scheduled review is on ____________________.

☑ Project approved. EXEMPT CATEGORY NO. 4. No periodic review scheduled unless so stated in REMARKS SECTION.

☐ Project approved PENDING receipt of corrections/additions in ORPD and approval by the IRB. This study may NOT be started UNTIL IRB approval has been received. (See REMARKS SECTION for further information.)

☐ Project approval deferred. This study may not be started until IRB approval has been received. (See REMARKS SECTION for further information.)

☐ Project denied. (See REMARKS SECTION for further information.)

REMARKS: Any changes in protocol or adverse occurrences in the course of the research project must be reported immediately to the IRB Chairman or ORPD.

If the proposed project (clinical medical) is to be part of a research activity funded by a Federal Agency, a special assurance statement or a completed 596 Form may be required. Contact ORPD to obtain the required documents. (7/93)
EXPEDEED REVIEW REQUESTED UNDER ITEM 8 (NUMBER(S)) OF HHS REGULATIONS
EXEMPT REVIEW REQUESTED UNDER ITEM 1 (NUMBER(S)) OF HHS REGULATIONS

UNIVERSITY OF NORTH DAKOTA
HUMAN SUBJECTS REVIEW FORM
FOR NEW PROJECTS OR PROCEDURAL REVISIONS TO APPROVED
PROJECTS INVOLVING HUMAN SUBJECTS

MCICAL INVESTIGATOR: Susan Wheeldon
TELEPHONE: 746-0235 DATE: 8/8/94

RESS TO WHICH NOTICE OF APPROVAL SHOULD BE SENDED: 501 North Columbia Road

OOL/COLLEGE: Medicine DEPARTMENT: Physical Therapy PROPOSED PROJECT DATES: 4/1/94-5/95

JECT TITLE: Assessment of Physical Therapy Needs at the Third Street Clinic

TING AGENCIES (IF APPLICABLE): N/A

E OF PROJECT: _____ NEW PROJECT _____ CONTINUATION _____ RENEWAL _____ DISSERTATION OR
THESIS RESEARCH _____ STUDENT RESEARCH PROJECT

RTATION/THESIS ADVISER, OR STUDENT ADVISER: Renee Mabey, M.S., P.T.

POSED PROJECT: _____ INVOLVES NEW DRUGS (IND) _____ INVOLVES NON-APPROVED USE OF DRUG
_____ INVOLVES A COOPERATING INSTITUTION

ANY OF YOUR SUBJECTS FALL IN ANY OF THE FOLLOWING CLASSIFICATIONS, PLEASE INDICATE THE CLASSIFICATION(S):

MINORS (<18 YEARS) _____ PREGNANT WOMEN _____ MENTALLY DISABLED _____ FETUSES _____ MENTALLY RETARDED

PRISONERS _____ ABORTUSES _____ UND STUDENTS (>18 YEARS)

YOUR PROJECT INVOLVES ANY HUMAN TISSUE, BODY FLUIDS, PATHOLOGICAL SPECIMENS, DONATED ORGANS, FETAL MATERIAL, OR PLACENTAL
ERIALS. CHECK HERE

ABSTRACT: (LIMIT TO 200 WORDS OR LESS AND INCLUDE JUSTIFICATION OR NECESSITY FOR USING HUMAN SUBJECTS.

Alth care is being provided free of charge at the Third Street Clinic in Grand Forks, North Dakota, for those people who do not have insurance, Medicare, or Medicaid. Physical Therapy is not presently offered as a service at the clinic. Physical Therapy is part of comprehensive health care. Therapists provide caring and expertise in the areas of urological rehabilitation, orthopedic/musculoskeletal problems, pediatrics, and work hardening. As volunteers, therapists are involved in providing care at free clinics across the nation. The Third Street Clinic has agreed to have a needs assessment performed to entitle those clients who could potentially benefit from physical therapy services. The needs assessment will be accomplished through a chart review of the Clinic's patients. The charts are records of human patients and in order for this assessment to be accomplished, the cords must be reviewed. Thus, the use of human subjects, via medical records, is necessary for this study.

ased on those clients eligible for physical therapy, the demographic data will help focus the way physical therapy is implemented at Third Street Clinic.
NOTE: Only information pertinent to your request to utilize human subjects in your project or activity should be included on this form. Where appropriate attach sections from your proposal (if seeking outside funding).

PROTOCOL: (Describe procedures to which humans will be subjected. Use additional pages if necessary.)

METHODS:

Methodology will entail reviewing 120 charts* randomly from January 1993 to July 1994 of clients over 18 years of age at the Third Street Clinic in Grand Forks, North Dakota. A data sheet--Appendix A--will be used to record various factors (e.g., musculoskeletal and physical therapy related diagnosis) to assess the clients' potential need for physical therapy services. Selected demographic data will also be collected to provide direction for future physical therapy programming for this population. Data will be collected in a codified form to insure confidentiality. Factors will be analyzed with descriptive statistics to show if there are clients who could benefit from physical therapy treatment.

Appendix B - Sample Third Street Clinic Chart
BENEFITS: (Describe the benefits to the individual or society.)

The results of this study will help the Clinic determine if needed services are not currently being delivered to their clients. The study may show if the Clinic is missing an area of enrichment that would add to the array of services already being offered. The survey results will add to the base of information needed to provide health care to the population of individuals who are homeless and/or working poor.

RISKS: (Describe the risks to the subject and precautions that will be taken to minimize them. The concept of risk goes beyond physical risk and includes risks to the subject's dignity and self-respect, as well as psychological, emotional or behavioral risk. If data are collected which could prove harmful or embarrassing to the subject if associated with him or her, then describe the methods to be used to insure the confidentiality of data obtained, including plans for final disposition of destruction, debriefing procedures, etc.)

With a chart review process, there is a risk of an accidental breach of confidentiality. In this study, all data will be collected in a codified form to insure confidentiality of each subject. A patient number will be devised using the first four letters of the last name, the first two letters will be correlated with the number of the letter in the alphabet.
CONSENT FORM: A copy of the CONSENT FORM to be signed by the subject (if applicable) and/or any statement to be read to the subject should be attached to this form. If no CONSENT FORM is to be used, document the procedures to be used to assure that infringement upon the subject’s rights will not occur.

Describe where signed consent forms will be kept and for what period of time.

The signed consent form will be used. Each subject will be identified by his/her codified number. Names of participating subjects will not be disclosed. Data will be reported in aggregate.

Permission has been granted by Third Street Clinic personnel to conduct the chart review. Appendix C.

For FULL IRB REVIEW forward a signed original and thirteen (13) copies of this completed form, and where applicable, thirteen (13) copies of the proposed consent form, questionnaires, etc. and any supporting documentation to:

Office of Research & Program Development
University of North Dakota
Box 8138, University Station
Grand Forks, North Dakota 58202

On campus, mail to: Office of Research & Program Development, Box 134, or drop it off at Room 101 Tramley Hall.

For EXEMPT or EXPEDITED REVIEW forward a signed original and a copy of the consent form, questionnaires, etc. and any supporting documentation to one of the addresses above.

The policies and procedures on Use of Human Subjects of the University of North Dakota apply to all activities involving use of human subjects performed by personnel conducting such activities under the auspices of the University. No activities are to be initiated without prior review and approval as prescribed by the University’s policies and procedures governing the use of human subjects.

SIGNATURES:

Susan J. Wheelan
Principal Investigator

DATE: 8-12-94

Dene Maling
Project Director & Student Advisor

DATE: 8-9-94

Kahye M. Ylvanov
Treasurer & Center Grant Director

DATE: 5-12-94

(Revised 3/1992)
APPENDIX D
PHYSICAL THERAPY NEEDS ASSESSMENT
THIRD STREET CLINIC

PATIENT NUMBER_____________________________________________________

Date __________________________________ Gender: _____ M _____ F

Date of Birth ____________________________________________ Age __________

Marital Status: Single ______ Married _______ Other ________

Type of Household: Single person ______ Married, no child ______
Single parent F ______ Single parent M ______ Two parent ______

Members in Household: Father _____ Mother ______ Grandparents ____
Sister ______ Brother ______ Children (# of) ________ Other ________

Household Income: __________________________________________________

Income Source: Family support (alimony, child support) ___________________

Occupation __________________ Government programs ___________________

Are any household members disabled? Yes ________ No __________

Patient complaints: (What the patient came into the clinic for)

Is there a functional loss? (Cannot work, take care of self, etc.)

Treating Diagnosis: (Doctor’s diagnosis)

If it is a musculoskeletal problem, what treatment was done?

Potential physical therapy patient? Yes ________ No ________
HEALTH INTAKE FORM
THIRD STREET CLINIC
223 South Third Street
Grand Forks, ND 58201

NAME ________________________________ DATE __________________

ADDRESS __________________________________________________

City __________________ State __________________ Zip Code __________________

DATE OF BIRTH __________________

TELEPHONE ________________________ GENDER: __ Male __ Female

SOCIAL SECURITY NUMBER ___________ MARITAL STATUS: __ Single __ Married

TYPE OF HOUSEHOLD: __ Single Person _____ Single Parent-Female _____ Married

_____ Two Parent _____ Single Parent-Male

 Members in Household:

<table>
<thead>
<tr>
<th>NAME</th>
<th>DATE OF BIRTH</th>
<th>RELATIONSHIP</th>
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</tbody>
</table>

Household Income:

<table>
<thead>
<tr>
<th>NAME</th>
<th>INCOME SOURCE</th>
<th>AMOUNT PER WEEKLY/MONTHLY/YEAR</th>
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TURN PAGE AND ANSWER ADDITIONAL QUESTIONS
### Medical History

**Family Physician:**

- Are you taking any medications? Please list:

- Do you have any allergies? Please list:

- Were you under a physician's care?


### How did you learn of this clinic?

---

**Patient Acknowledgement and Request for Service**

I understand that the Third Street Clinic is a health screening clinic for lower income people who do not have health insurance or medical assistance.

I am aware that all medical care is provided by physicians, registered nurses, and other health professionals. I understand that the clinic is unable to provide a full range of medical, laboratory, or x-ray services, and that I may need a referral for further medical care. No information from my medical records will be released without my written consent, except in the case of an emergency or as required by legal proceedings.

The clinic is staffed entirely by volunteers. Supplies and medications are purchased with donations made to the clinic. The services promoted by this clinic are free, but donations are accepted.

I understand the above information and hereby request and authorize the services offered by this clinic. Information listed above is, to the best of my knowledge, true and accurate.

**Signature** __________________________ **Date** __________________________
APPENDIX E
APPENDIX E

DIAGNOSTIC CATEGORIES

LOWER EXTREMITY
painful knees
B foot pain
sprained L ankle-inversion
black/blue R toe, stubbed
achilles bursitis
painful L knee
sprained L ankle
B leg pain with weakness

BACK
back pain
thoracic strain
painful back
mm pulling when walking
recurrent back and leg pain
recurrence of back pain, possible renal
lumbar spasm
chronic low back pain
back pain, abdominal wall strain
possible rib fracture
back pain
mm sprain?

UPPER EXTREMITY
L shoulder strain, rotator cuff
injured finger-swollen
L elbow tendonitis
tennis elbow
painful R shoulder blade
R lateral epicondylitis
suggest rotator cuff injury

TENSION HEADACHE
posterior cervical mm contractions

ARTHRITIS
motrin for arthritis in neck
swollen, painful hands
painful L shoulder
APPENDIX E

WOUNDS
L leg ulcers that aren't healing
2o burn on thumb, minor burn on finger tips

DIABETES
diabetes-med refill
diabetes mellitus type II

HYPERTENSION
hypertension, bronchitis
hypertension
blood pressure check
hypertension
monitor blood pressure
blood pressure check
blood pressure check

GENITOURINARY
bladder infection
Norplant insertion problems
vaginal yeast infection
urinary tract infection
vaginal yeast infection
vaginal yeast infection

MEDICAL
alcoholic, cold
mixed headaches
esophageal reflex--early ulcer
hemorrhoids
near syncope
chronic depression
fainting episodes
infected lip
productive cough
menopause
abdominal pain
scabies
vertigo
tinea cruris
body rash
menopausal symptoms
APPENDIX E

MEDICAL cont.
lipoma
chest pain-unsure etiology
asthma
pregnancy test
hand tremors-not remarkable
cyst in lower lip
acne vulgaris
bulimia
hemorrhoids
seizure disorder
seizures
dizzy spells
acne flare-up
infected insect bite
warty elevations on penis
re-check open sores legs-healed
schizophrenic
asthma

PHYSICAL
chest pain
physical
physical
physical

UPPER RESPIRATORY INFECTION
exacerbation COPD, otitis medis
B otitis media
bronchitis
bronchits
possible strep
sore throat
sinusitis
cold, sore throat
bronchitis
sinus infection
cold and flu
bronchitis
flu
bronchitis
APPENDIX E

UPPER RESPIRATORY INFECTION cont.
bronchitis
sinusitis
strep?
bronchitis with reactive airway disease
chest cold and cough
chest cold
bronchitis
sinusitis
pharyngitis, lymphadenitis
persistent sinusitis
cold
bronchitis
laryngitis
bronchitis
sinus
viral infection
bronchitis
pharyngitis
bronchitis
bronchitis
cold

EYE EXAM
eye exam
eye exam
eye exam
eye exam
eye exam
eye exam
eye exam
eye exam
eye exam
eye exam
eye exam

DEPRESSION
depression
depression-suicide attempt
hx of depression
major depression
REFERENCES


34. Wood D, Baldez RB. Barriers to medical care for homeless families compared with housed poor families. *AJDC.* 1991;145:1109-1115.


41. Ryujin KA, Ward SR. "In a civilized society". *PT Mag Phys Ther.* 1993;1:49-54.

42. Legacy. Grand Forks, ND. United Health Foundation; March 1993.

43. Third Street Clinic. *Miracle workers needed.* Grand Forks, ND; George's Quick Printing.