SAMPLE CONCLUSION #1

The size of the homeless population is substantial, and their needs cannot be overlooked. Homelessness as a whole is a broad social issue that cannot be addressed overnight, but public health officials can help alleviate some of the health issues that affect the homeless.

As I discovered during my literature search, there have not been enough research studies conducted around the topic of healthcare access for the homeless. As a result, there is minimal understanding of the population and its healthcare and other needs. Healthcare workers cannot reach out to and treat a population they do not understand or are all together unaware of. The bulk of research that has currently been conducted and published focuses on a few geographical areas, including California and the New England region. Nearly all studies of the homeless population are conducted in large, urban communities. Results from such studies may not be applicable to health workers in other areas around the country. For example, while studies conducted in Los Angeles, California, may provide beneficial concepts for outreach efforts to health workers in Detroit, Michigan, health workers in Los Angeles do not have to take into account the dramatically changing climate of Michigan or the difference in social, political, and economic conditions those in Detroit may experience in comparison. It is crucial that additional studies be conducted throughout the various regions of the country. If we are to address the issue of homelessness and lacking access to healthcare, we must understand the cohort we are looking to affect. However, in a time when funding for such research is limited, we may need to focus
our immediate efforts on potential solutions that have proven effective in a great number of studies.

Based on my literature research and field study, I have found nursing outreach to be the best current method for reaching the homeless population. With little to no health insurance coverage for homeless individuals, they are often forced to completely forgo healthcare or utilize hospital emergency facilities for more critical health concerns. If outreach clinics staffed by registered nurses and nurse practitioners were developed, in the form of mobile units or stationary buildings, the homeless population could be better served. These clinics should focus on the preventive care needs of the homeless, including vaccinations, screenings for diabetes and hypertension, sexual health education, STI testing, prenatal care and education, and mental health services, such as psychological analyses, physician referrals, and coping counseling.

Even if these nursing outreach clinics were only open a few designated days each month, they would have a visible impact on the homeless populations they serve. It would be important to advertise the clinic location, hours and services in various locations throughout the community, especially those locations most frequented by homeless individuals, such as meal programs and homeless shelters.

It would require a great deal of planning and cooperation between organizations to successfully establish and run such clinics as well as establish relationships between these clinics, hospitals, housing and benefits advocacy services, and employment assistance services. The initial funding requirements may be substantial, as they would include the purchasing or renting of a proper
venue, paying staff wages, and purchasing necessary medical supplies. However, if a well-organized business plan were presented to local hospitals, community organizations, and social and political leaders, funding assistance may be willingly provided to assist in efforts to reach out to the vulnerable, homeless population. Especially given the current social and economic climate of the United States, and the disarray of the current healthcare system, the issue of lacking access to healthcare for the homeless population cannot be put off any longer.
SAMPLE CONCLUSION #2

We conclude by offering several specific recommendations based largely on initiatives currently in place in other locales. These initiatives have been shown to make a measureable difference in their current application, and are readily adaptable to the Southern Nevada Childhood Lead Poisoning Prevention Program / Healthy Homes program model.

1. **Education and Risk Assessments**: Provide widespread community outreach/education, including in-home education and case management to identify hazards and undertake lead-safe home repair, cleaning and nutrition changes. Lead inspections for lead paint hazards as well as dust wipes and risk assessments should be completed by experienced Epidemiological Investigators. Landlords and contractors should also receive education on low-cost interventions, lead-safe work practices, and disclosure rules.

2. **Plan to Reduce Hazards**: Institute an intensive media campaign to ensure that all Clark County residents are fully aware of the problem and have easy access to fact sheets on testing, including a list of certified inspectors and interim controls. This information should be made available via television, radio, newspapers, clinic and physician offices, flyers sent home from schools, buses and other venues as appropriate. Awareness should be the number one immediate goal. To enhance proactive awareness, a written management plan can guide landlords and occupants of rental housing units on how to maintain units after remediation activities are completed.
Institute a phased-in program that would prohibit the sale or rental of any residential property unless it is certified lead-safe by a reputable laboratory. Require testing by a certified inspector of all residential buildings. Require testing by a certified inspector of all schools, day care centers, playgrounds, and other areas where children spend large amounts of time as part of the permitting process. Such facilities would have to be certified lead-safe before use.

3. **Relocation:** Families that are required to temporarily leave their dwellings due to lead hazard control work will be given a relocation plan. A Housing Specialist should work with the families and the landlord to find an amenable solution. Relocation plans should include a stipend for the family if they choose to stay with a friend or family member, an option to stay at the Lead Safe House or other transitional/temporary housing via a program partner, or a temporary move to another unit owned by the landlord.

4. **Training Support:** Parents, community members, contractors, and landlords should be referred to the Southern Nevada Health District (SNHD) for lead-safe work practices in accordance with the U.S. Department of Housing and Urban Development (HUD) Lead-Safe Housing Rule. The University of Nevada Las Vegas and the SNHD are in the process of becoming certified training centers through the National Center for Healthy Housing and will be capable of providing training for the Nevada Environmental Health Association’s *Healthy Homes Specialist* credential.
5. Partnerships: The Healthy Homes project should create and strengthen collaborations between major community stakeholders, such as the University of Nevada Las Vegas Department of Environmental and Occupational Health; Southern Nevada Health District; Rebuilding Together, a low socioeconomic status rehabilitation organization; local code, police and fire departments; health care providers; community/faith based organizations; and local social services programs.

A lead-elimination task force that would include representatives from public health, area residents, developers, the Clark County School District, daycare centers, and others as appropriate should be formed. Such collaboration is important for obtaining funding from multiple sources, putting in place a comprehensive and consistent lead-elimination plan, and making it well known throughout the community. Ideally, this would be in the context of a Healthy Homes or similar initiative, of which lead-safe housing would be a key component.

6. Budget: Identifying new revenue streams should be accomplished at the community, state, and federal levels. At the community level, the Healthy Homes program can collaborate and utilize partnership resources, such as private companies (Lowes and casinos) or donations from local hospitals and residents. At state and federal levels, we can explore different available funds and grants, but this would require having an effective, ongoing, open dialog with our legislators. For example, we can ask our partners to contact and communicate with their elected officials on a regular basis. The Legislative Affairs subcommittee of the CLPPP can also be very helpful in accomplishing and coordinating an open dialogue with our legislators.
7. Increase screening rate: Require blood-lead screening of all children as a prerequisite for enrolling in day care or kindergarten, with all data made available to parents and the school system. Education and psychosocial help should be available, possibly through volunteer organizations, for all children with positive blood lead levels. A bilingual or multi-lingual list of investigative resources and actions to identify and reduce exposure should also be provided to parents along with the positive blood-lead results.

8. Use of Socioecological Model: Integrate use of the Socioecological Model in the Healthy Homes program and Childhood Lead Poisoning Prevention Program planning and protocols. This model is a framework that can be used to examine and assess the various social elements in a given environment. The use of this model shows the effects and interrelations inherent in these social elements. Ultimately, use of the Socioecological Model provides a comprehensive framework for understanding and impacting the social and environmental factors of lead poisoning prevention and the reduction of health disparities.

<table>
<thead>
<tr>
<th>System Level</th>
<th>System Focus</th>
<th>Intervention</th>
<th>Intervention Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interpersonal</td>
<td>Knowledge, attitude, behavior, self concept, social networks/social support</td>
<td>Awareness, sharing information</td>
<td>Flyers, handbooks, websites, training, mail updates</td>
</tr>
<tr>
<td></td>
<td>system (family)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community</td>
<td>Relationships among organizations and stakeholders</td>
<td>Community coalition, coordination</td>
<td>Door to door, campaigns, training</td>
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<tr>
<td>Organizational</td>
<td>Management style, communication network, structure</td>
<td>Incentives</td>
<td>Parents get their children tested</td>
</tr>
<tr>
<td>Policy</td>
<td>Legislation, policy, taxes, regulations, penalties</td>
<td>Mass media, politics, lobbying</td>
<td>Ordinances to require lead risk assessment on all rental properties prior to renting</td>
</tr>
</tbody>
</table>
The Socioecological Model is preferred for both the reduction of blood lead levels and the reduction of health disparities in the community due to the environmental and personal nature of exposure sources. Interpersonal level approaches focus on education and awareness initiatives, as personal hygiene habits in the home environment have been shown to have a considerable impact on lead exposure risk. Community, organizational, and policy level approaches reflect the environmental nature of lead exposure and the importance of organizational coordination in reduction of risk factor on a broad scale.

By combining the distinctive viewpoints afforded by the model, an integrated treatment plan emerges that accounts for many aspects of the patient’s functioning. ("Human Behavior, An Introduction for Medical Students" Stoudemire, Alan, 1998)

Ultimately, the choice of one or more of the above recommended interventions is likely to be influenced by a number of different factors, including overall population screening rate, location, identity of populations in greatest need, competency and qualification of staff, opportunities to deliver culturally-sensitive, cost-effective interventions, and availability of tracking systems. Also affecting the viability of recommended interventions are funding allowances, existing infrastructure of public health services, coordination among partner groups, community stakeholders, and state and federal agencies, existing legislation or legislative changes, as well as program accountability to the needs of individual stakeholders.