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HEALING HANDS

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Operation Safety Net: Outreach to Unsheltered Homeless People

To "reach out and touch someone" who is chronically homeless requires more than a phone call, flyer or public service announcement. Successful outreach to "on-the-street" homeless people entails even more than outstationing clinicians in emergency shelters, and can extend beyond the reach of mobile medical vans. Providers of health care to unsheltered homeless people are demonstrating remarkable ingenuity in their efforts to reach this increasingly reclusive population, which in recent years has retreated farther and farther from easily accessible areas of inner cities. Some homeless people are compelled to leave as a consequence of urban renewal and NIMBY sentiment; others seek refuge from the gratuitous violence of youthful persecutors.

Operation Safety Net is a primary care outreach program for on-the-street homeless people, affiliated with Mercy Hospital and Alma Illery Medical Center, a federally funded HCH project in Pittsburgh, Pennsylvania. Safety Net began in May 1992, when Mike Sallows, a formerly homeless shelter volunteer, invited internist James S. Withers, MD, to hike with him to homeless camps on the city's periphery. "One evening, we hoisted backpacks filled with medical and emergency supplies, and walked from the downtown area through alleys to the heating grates, down to the Allegheny River bank, then up river to shacks and lean-tos where homeless people gathered. Some campers who had just caught a fish invited us to dinner," recalls Jim.

Thus began an innovative and effective effort to reach the most elusive of homeless castaways, and to learn from them how the conventional health care delivery system can better meet their needs.

Dr. Jim Withers (second from right) brings supplies to unsheltered homeless men on the outskirts of Pittsburgh.

"Between 1992 and 1994, there were large homeless encampments along the river; since then, city policy has been to disperse them. Camps are more scattered and widespread now," Jim observes. To reach them, volunteers must cast their "safety net" well beyond the city limits. "We've had to become more mobile, extending into abandoned buildings in the city and farther along the Allegheny, Monangahela and Ohio Rivers," he says. "Because we can only see a limited number of people on foot, Mike eventually began taking clinicians to the most remote areas by kayak."

Half the clinician volunteers for Safety Net are physicians, half are nurses. Each is paired with a homeless or formerly homeless person – a requirement for street work. "This partnership between homeless and medical volunteers is a microcosm of the community we are trying to build," says Withers. In what follows, he describes a day in the life of an Operation Safety Net clinician:

WALKING THE WALK. It's a busy morning in the medical clinic where I teach residents and care for patients from poorer areas around Mercy Hospital. Many patients come here as a direct result of outreach by Safety Net volunteers. A homeless man comes in needing forms filled out for artificial teeth, which a social worker from Safety Net handles for him. My resident assistant is interviewing a homeless woman who just tested positive for HIV. I watch his respect for her grow as he listens to her story. This client floats between crack houses and "shooting galleries" where addicts gather to buy and inject heroin. She has progressed from total denial, to developing a relationship with our nurse, Nell, to having the guts to re-integrate with the medical system. Today she made it all the way to the clinic

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from the Hill District on her own. When the resident understands her personal history, he treats her like an honored guest. That's even more important than addressing the medical issues, initially.

At noon, I go to the hospital to check on "Grandpa," an 84-year-old homeless man admitted last week with grossly swollen, maggot-infested legs. His advanced peripheral vascular disease is exacerbated by being constantly on his feet. Grandpa walks with a slow shuffle and tries to sleep on park benches. His legs and feet stay dirty, a focus of gangrene and flies in summer. Constant elevation of his feet is needed to drain the fluid and reduce the swelling, but this isn't possible living on the street. Police won't let him sit or lie down anywhere for long. Bus drivers pull up a full length ahead of him, let other riders on, then slam the door by the time he gets there.

Grandpa is representative of a large group of homeless street folk ("bag people") whose mental illness is the gravitational force around which everything else orbits. A mild paranoid schizophrenic, his symptoms aren't bad enough to warrant institutionalization, according to judges who have repeatedly overruled requests for his admission.
I visit another homeless man whose leg was broken when "skin heads" dropped cinder blocks on it while he slept. Gangs often victimize homeless people in this way, or throw gasoline on them. What generates so much hatred? In all of us, there is the potential to treat people who are different as less than human. Even clinicians have difficulty relating to homeless people.

> Part of our mission is to provide, for a little while, a safe, nourishing environment for healers to explore themselves and find common ground with persons who are different.
>
> *– Dr. Jim Withers*

After recording information in the data base to ensure good discharge planning for these patients, I head for home, dress in blue jeans and jacket, and check the supplies in my backpack. This is my night to do street outreach with Safety Net volunteers. Because I have a family of my own, I do outreach only once or twice a week. Sometimes I bring my sons with me. My Dad, a family doctor, took me with him on house calls. These are the seeds you can sow.

I pick up an intern in psychiatry and drive downtown to the medical van, a converted bread truck with a clinic in back. The driver was once homeless. There I meet my partner, Mike, and we head out to visit deserted warehouses and camps along the river. Although we carry clinic appointment reminders with us, many of the men we encounter have already memorized theirs. We're seeing fewer and fewer "no-shows." We often meet newcomers at these camps, give them pointers about where to stay, which areas are safe, how to get sleeping bags-we're a veritable Chamber of Commerce for homeless people. Expecting hostility, they are shocked by our reception. This hospitable approach has improved our interactions with patients. Boundaries between health care providers and homeless persons have blurred over the years. Working as members of the community enhances our credibility.

One fellow had fallen down with a seizure and is bloody. I give him a haircut and a beard trim while the intern cleans up his face with gauze and saline. There's something very intimate about cutting hair or toenails. It promotes conversation, gives you something to do with your hands, inspires trust. Thinking our night's work is done, we head back to the car, only to be intercepted by a fellow with a hand wound. We finish up around 11:30 p.m.

Providing wrap-around services to street people is an enormous challenge. Most are refugees from broken families and victims of abuse, with very limited job skills. Mental illness, addiction, racism and combat disabilities are additional factors. Healing such wounds takes a re-creation of family, trust and self-esteem. Other things will follow.

Editor's Note: *James Withers is a recipient of the Network's 1998 Local Hero Award for dedication to improving homeless peoples' health and quality of life.* ■

For These Things We Are Thankful...

■ A 69-year old client, orphaned when she was a teenager and homeless for the past ten years, was finally stabilized on medications for hypertension, diabetes and hypothyroidism. Now she is in a high-rise apartment, has help with her budget and laundry, and keeps her clinic appointments. Case management by our project has helped, but it's been a community effort. She says she's finally comfortable, and feels pretty happy with her life!
– *Carla Odegaard, social worker, Fargo-Cass Public Health, Fargo, North Dakota*

■ A young female alcoholic we worked with for five years stopped drinking a year ago and has been sober ever since. Formerly a prostitute, routinely beaten up, she could never keep a job for more than a month. Now co-leader of an AA group, she has been employed for almost a year – long enough to qualify for medical benefits! We're also thrilled about a homeless man, in and out of treatment for co-occurring depression and alcoholism, who has maintained sobriety for a full year.
– *Diana Hobden, nurse practitioner, Thundermist Health Associates, Inc., Woonsocket, Rhode Island*

■ One of our homeless patients, a pregnant substance abuser, decided she wanted to raise the baby on her own. She got cleaned up, received prenatal care through a high-risk pregnancy program, completed drug treatment, and withdrew from drugs completely. Her baby, now three months old, was born without an addiction. We enrolled her in an outreach program and helped her get an apartment. It was a real team effort.
– *Julie Stoneroad, physician assistant, HCH Phoenix, Arizona*

Using Expired Medications: A Murky issue

Karen Holman, MD, MPH, Medical Director of Healing Hands Health Care Services in Oklahoma City, and Stacey Abby, Pharm.D., Clinical Pharmacist at Family Medicine of St. Louis and Assistant Professor at the St. Louis College of Pharmacy, collaborated in writing this article.

Many clinicians who care for homeless persons rely on the donation of medications as a resource in treating patients. Frequently these medications are at or past their expiration date. What does the expiration date mean, and are expired drugs still safe and effective to use? These questions are difficult to answer based on the current published literature, and pharmaceutical manufacturers are reluctant to comment because of liability concerns. Dispensing expired medications is illegal in some states. However, the practice appears to be widespread, as resource limitations require practitioners to make difficult ethical decisions daily. The National Council and the HCH Clinicians' Network do not condone or encourage dispensing expired drugs, but present the following information to promote informed discussion.

The expiration date reflects the time it takes under "normal storage conditions" for the product's potency to fall below a clinically acceptable limit.[1] The expiration date applies to unopened medication and is usually two-to-five years past the date of production.[4] Except for reports of tetracycline degradation resulting in fanconi syndrome,[3] no serious reactions have been linked to outdated medications. There is a significant concern, however, with loss of pharmacologic activity over time. The loss of potency is further influenced by storage conditions such as light, moisture and oxygen exposure. For example, epinephrine must be stored in a dark bottle and quickly oxidizes when exposed to air.[4]

TABLE 1: Medication Storage

- Rotate your stock of medications.
- Read package insert for recommendations on storage of particular medications.
- Store medications in a low-light area, out of direct sunlight.
- Store medications in a low-humidity area; avoid basements. If this is the only option, consider air-tight containers.
- Avoid extreme temperatures.
- Keep medications in original containers for as long as possible.

A review in the *Medical Letter* estimates that unopened medication will retain 70-80% of potency for ten years or longer. Drugs in opened containers probably retain 70-80% of potency for one-to-two years beyond expiration date. With ophthalmic drugs, the limiting factor is the stability of the preservative, not the drug; consequently, multi-dose ophthalmic solutions generally should not be used beyond the expiration date.[4]

Sometimes the potential risks outweigh the benefits of using certain medications – for example, narrow therapeutic index drugs or drugs that with any percentage of efficacy loss may result in serious repercussions (e.g., nitroglycerin, oral contraceptives).

TABLE 2: Medications Which Should NOT Be Given Past Expiration Dates *(This list is not comprehensive.)*

- Anticonvulsants (Dilantin®, Tegretol®)
- Nitroglycerin
- Coumadin® (warfarin)
- Procan SR® (sustained release procainamide)
- Theophylline SR (sustained release theophylline)
- Lanoxin® (digoxin)
- Thyroid preparations
- Paraldehyde
- Oral contraceptives

THE BOTTOM LINE. Check the expiration date on the medications you use. Although expired medications are unlikely to be harmful, it is important to analyze the risks versus the benefits of using them. Base your decision on an evaluation of each patient's needs and circumstances, together with the following factors:

TABLE 3: Factors to Consider in Deciding Whether to Use an Expired Medication

- Dosage form (Solutions are less stable.)
- Container closure system
- Conditions under which drug is shipped, stored, handled
- Length of time between initial manufacture and final use
- Reconstituted medications
  – Avoid maintaining past recommended expiration.
- Appearance of medication – Do NOT use IF:
  – Tablets are brittle or breaking apart.
  – Tablets or capsules have loss of sheen.
  – Tablets or capsules are soft.
  – Emulsions or suspensions remain separate despite shaking.
  – Injectables appear discolored or a precipitate has formed.
- Laws and professional standards governing your practice
- Patient's informed consent to use expired medications

Sources:

1 *The United States Pharmacopoeia, 22nd rev.*, and *The National Formulary, 17th ed.*, The United States Pharmacopoeia Convention, Rockville, MD 1989; 10.

2 Strauss, S, Sherman M. Regulations pertaining to expiration dating of drug products. *US Pharmacist*, 1985; 10:40-70.

3 Primpter GW, et al. "Reversible fanconi syndrome caused by degraded tetracycline," *JAMA* 1963; 154:111; Gross JM. "Fanconi syndrome (adult type) developing secondary to the ingestion of outdated tetracycline," *Ann Int Med* 1963; 58:523; Sulkowski SR, Hascrick JR. "Simulated S.L.E. from degraded tetracycline," *JAMA* 1964; 189:152.

4 "Drugs past their expiration date," *Med Lett Drugs Ther*, 1996 Jul 19; 38(979):65-6; response to this article in *Med Lett Drugs Ther*, 1996 Sep 21; 38(989).

Free and Reduced-Price Drugs

If HCH projects are availing themselves of the following four programs, their need for other sources of free or reduced-price medications should be minimal, according to Freda Mitchem of the National Association of Community Heath Centers (NACHC). For information about how to access these programs, call her at 202/659-8008, ext. 133.

- **PHS Drug Pricing Program(340B).** Federal program in effect since 1992 that benefits all Federally Qualified Health Centers (FQHCs) including HCH projects. Enables health centers to obtain discounted drugs at an average of 15.1% below the manufacturer's price. (See the October 1998 issue of HRSA's HCH newsletter, *Opening Doors*, for a detailed discussion of the advantages and obligations of participation in the 340B federal Drug Pricing Program.) A recently proposed rule (FR 63, 204, 10/22/98) would require HRSA grantees that purchase covered outpatient drugs above a total annual cost of $30,000 to participate in this program, unless the requirement is waived by HRSA for good cause. Good cause includes demonstrating access to drug prices at or below the current 340B ceiling price.
- **Sharing & Caring NACHC-Pfizer Program.** Source of free drugs available to participating health centers that have their own licensed pharmacy, for patients who are at or below the federal poverty level and pharmaceutically uninsured.
- **Directory of Indigent Drug Programs.** Compendium of all free drug programs for indigent patients, published by the Pharmacy Research and Manufacturing Association in Washington, DC. These programs require extensive paperwork to participate, and delivery of medications may take several weeks. (See website for 1998 Directory of Prescription Drug Patient Assistance Programs: www.phrma.org/patients/index.html.)
- **NACHC Prescription Drug Settlement Program.** Additional subsidy for health centers in 11 states providing pharmaceuticals to non-Medicaid eligibles.

How to Contact Your HCH Ombudspersons

Two Network members serve as liaisons with the Bureau of Primary Health Care. Their primary charge is to communicate issues of concern to HCH projects directly to Bureau Director, Dr. Marilyn Gaston. Help your Ombudspersons keep their fingers on the Network's pulse by reporting clinical, demographic or utilization trends in your area; policy issues that impact health care for the homeless clients you serve; and models of care or research findings you would like to share with the BPHC and other projects. You may communicate concerns via the Members' Forum on the HCH website (www.nashville.net~hch), or by contacting the ombudspersons directly:

- **G.G. Greenhouse, MSW:** Alameda County HCH
  1900 Fruitvale Ave., Ste 3E, Oakland, CA 94601;
  510/532-1930 phone, 510/532-0963 fax.
- **Jim O'Connell, MD:** Boston HCH Program
  729 Massachusetts Ave., Boston, MA 02118;
  617/414-7779 phone, 617/414-7776 fax, oconnelljj@aol.com.

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