

NATIONAL
HEALTH CARE
for the
HOMELESS
COUNCIL

Overcoming Challenges in Street Medicine

May 22, 2019 | Grand Hyatt Washington

Mission Moment: Carmón Ryals: Albuquerque, NM

Quality | Access | Justice | Community | nhchc.org

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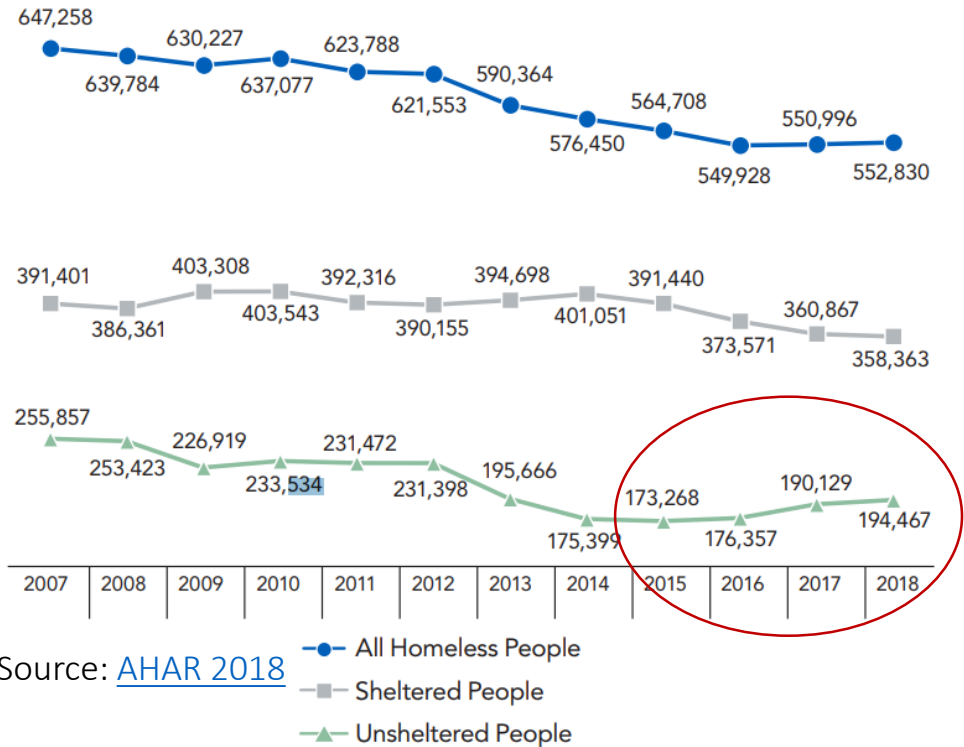
Icebreaker

- Find someone you don't know
- Tell each other what sustains you in this work (serving people experiencing homelessness)
- Bonus points if you exchange business cards
- Time permitting, do this again with someone else

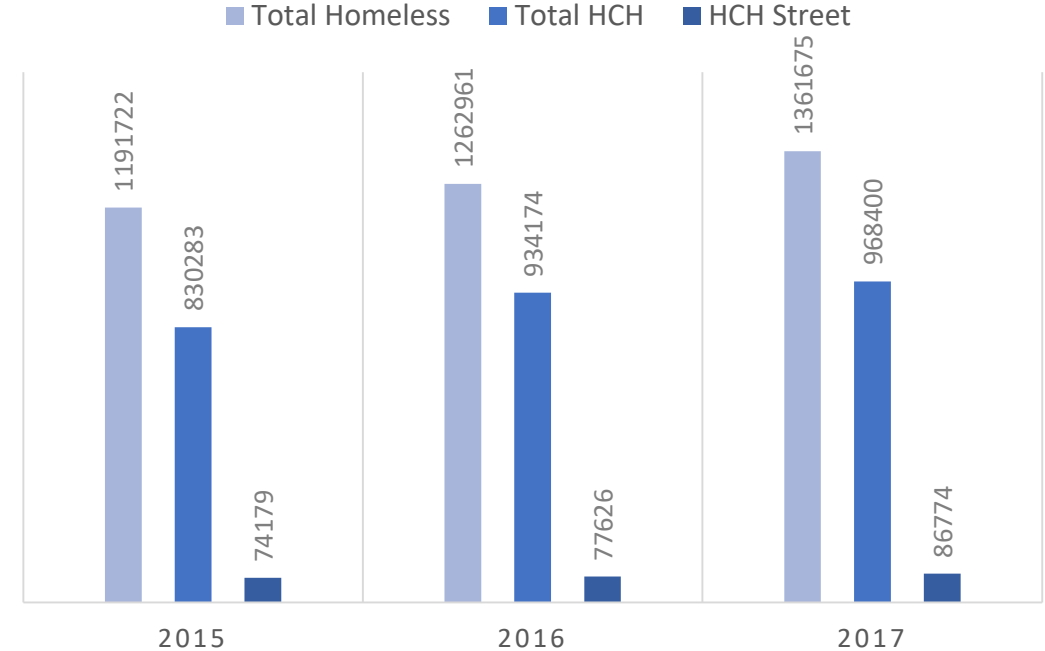
Speaker Introductions

- Jim Withers, MD: Operation Safety Net
- Pat Perri, MD: Center for Inclusion Health
- Brett Feldman, PA: USC Keck School of Medicine
- Liz Frye, MD: Street Medicine Institute
- Joel Hunt, PA: JPS Health Network
- Kevin Sullivan, MD: Boston Health Care for the Homeless Program
- Jim O'Connell, MD: Boston Health Care for the Homeless Program

PIT COUNT



HEALTH CENTER PATIENTS



Why are we here?

- Unsheltered homelessness is on the rise, especially in the largest US cities.
- There are dozens of meaningful reasons why those on the street won't come to the clinic.
- Outreach is intrinsic to the HCH model of care, centering patients' autonomy and dignity. But not everyone understands this.
- The Council has seen an increase in Technical Assistance requests on street medicine.

Developmental Stages of a Street Medicine program



street medicine institute

'Go to the People'

“Starting the Fire”



Jim Withers MD
Street Medicine institute

Defining Street Medicine

The delivery of health care directly to those sleeping outside

- *Walking teams*
- *Mobile units (cars, bicycles, vans, kayak, horse back, etc)*
- *Open air clinics*

- *Go to the people...*











Consider Values and Philosophy

- Person based (*their reality*)
 - Non-judgmental
 - Self determination “goal negotiated”
 - Flexible (“whatever it takes”)
 - Advocacy based – persistent (the long view)
 - Apply the Golden Rule
-
- *A RELATIONSHIP*

Harm Reduction Principles for Healthcare Settings

- Humanism
- Pragmatism
- Individualism
- Autonomy
- Incrementalism
- Accountability without termination

- Hawk et al Harm Reduction Journal (2017) 14:70

Other good reads

- To Dance With Grace: Outreach and Engagement to Persons on the Street
 - Sally Erickson et al Published 1969
- Souls in the Hands of a Tender God
 - Craig Rennebohm

Starting a good fire

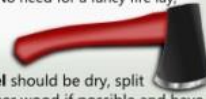




HOW TO BUILD A CAMPFIRE

GATHER tinder, kindling and fuel together in the sizes and quantities shown *before any matches are struck*. Sizes and quantities are just a 'rule of thumb' - get close to the descriptions and you'll do fine. Don't make any of it too short or too big around.

BUILD the fire by adding kindling wood to the burning tinder and then adding fuel to the fire as it grows. No need for a fancy fire lay, build it as you go.



Tinder from *dead* twigs found on the lower branches of trees and shrubs that snaps off easily when bent. No green wood!

Kindling should be dry, don't gather wet wood from the forest floor. Look for branches that are dead and down, not on the tree.

Fuel should be dry, split larger wood if possible and have a good sized stack on hand before you light the fire.

TINDER



Around the size of a pencil lead.



No shorter than your outstretched hand



Enough to fill a circle made with your hands

KINDLING



No thicker than your thumb.



About as long as your elbow to your fingertips



Enough for a generous armload

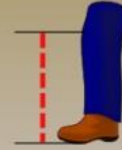
FUEL



About as thick as your wrist



About as long as your arm



A stack about as high as your knee



1 Bend the tinder in half and light the center.

2 Add kindling, keep piling it on loosely, give the fire plenty of kindling to keep growing.

3 As the kindling begins to burn begin adding fuel.

Preparing for success



Preparing

- Contact the Street Medicine Institute
- Perform a reconnaissance (keep journal!)
- Visit community elements
- Consider ramifications
- Find trusted outreach component....
- Get out there!

Get the view from the street

- Listen and Learn...adapt.....repeat

Key Ingredients

- Outreach Component
- “Medical Champion”
- Records System
- Supportive organization
- Staff (Volunteer vs Paid)
- Funding

Classic Considerations

- Danger
- Liability
- Follow-up (scope of practice)
- Confidentiality/boundaries
- Sustainability

- Others?

3 Developmental Stages

Stage I Program

- Grassroots
- Ongoing street outreach
- Intense learning phase/Needs assessments
- Establish identity/build trust
- Basic records and follow-up plans

- “Robin Hood”













Pointers

- Start small
- Cause no harm
- Don't promise more than you can deliver (don't play God)
- Be consistent – Be honest
- Be careful – reflect regularly together
- Don't front load your expectations

- ***Let the street teach you***





Stage II

- Centralized organization – regular staff
- Social Workers
- Improved records system
- Higher community profile
- Funding/ Grant writing
- Collaborative specialist services
- Follow-up systems
- “Transitional Primary Care”

Philosophical Dilemma

“Robin Hood”

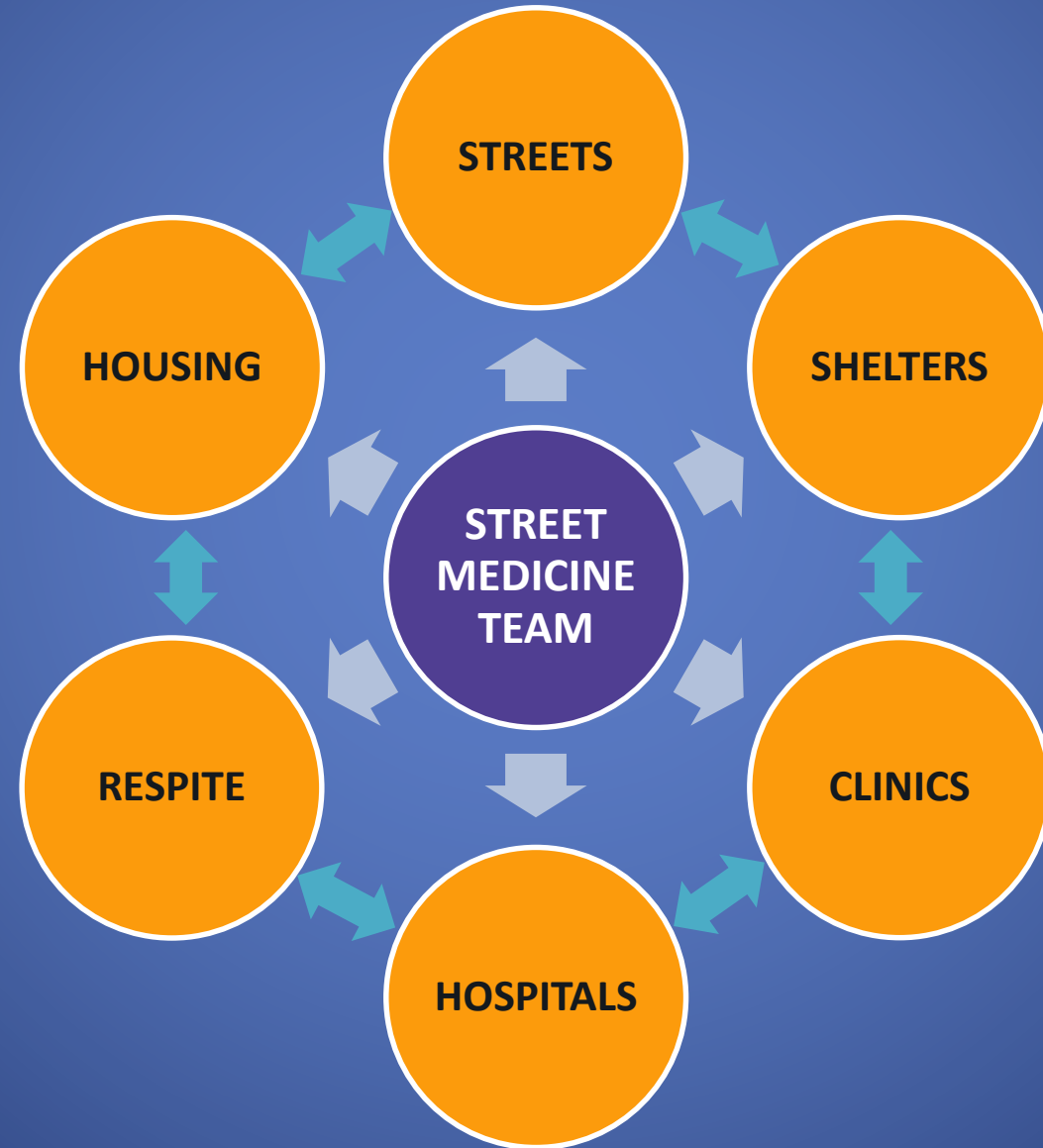
VS



“The Sheritt”



Continuous Care Model



OUTREACH

(Going to the People)

- Getting to know the streets
- Getting to know *yourself* – on the streets
 - *Finding that place where we're just people
(solidarity)*

“INREACH”

(Walking with people to the services they need)

- ***Collaborate***
 - With all those relevant to your street friends
- ***Advocate***
 - Educate and work for justice
- ***Innovate /Create***
 - Build new solutions in collaboration
- ***Integrate***
 - Work for inclusion and social justice
- ***Celebrate!***
 - Create and Heal the greater Community

Exclusion



Segregation



Integration



Inclusion



Stage III

- Multidisciplinary integrated primary care
- 24/7 coverage/continuity of care
- Consult services etc.
- Respite care
- Winter/weather shelter
- Housing/legal/higher levels of service
- Advocacy/research
- Medical Home - telemedicine
- Regional/national service learning





JS



Jimmy The Resident

Today 9:53 PM



We found the foot guy

Not as bad as I was afraid. Do you have the clean up stuff?

Yeah we irrigated with saline and I covered most of his foot with iodine. Packed it and covered it with gauze then kerlex and an ace bandage. He's going to come to clinic on Friday for a dressing change

Perfect



iMessage





Street Medicine Consults





Housing









Coordinate with the community



Additional Considerations

- Don't just "follow the money"
- Fitting into "the system"
- Personal/group balance
- Listening/responding to the homeless
- Measuring stuff
- The media (Street Medicine symbolism)
- Nobody Owns the Street
- Medical education – passing it on
- Sustainability

Share your lessons



Classroom of the streets





Student Initiated programs







Deep Thoughts....















street medicine institute

'Go to the People'

Street Medicine Network



A photograph of the Rotterdam skyline at dusk, featuring the Erasmus Bridge on the left and several modern skyscrapers. The sky is a clear blue with some light clouds. The text is overlaid on the top half of the image.

**14th annual International
Street Medicine Symposium**
October 3-6, 2018

Rotterdam, the Netherlands

Pittsburgh!

2019



www.streetmedicine.org





Thank you!





Go To the People
Live among them.
Learn from them
Love them
Serve them.
Plan with them
Start with what they know
Build on what they have

Go To The People



Live Among Them



Love Them



Serve Them



Learn From Them



Build On What They Know



Work With What They Have



But With The Best Leaders, When The Work is Done, The
Task Accomplished,



The people will say, 'We have done this' – Lao Tsu



www.streetmedicine.org

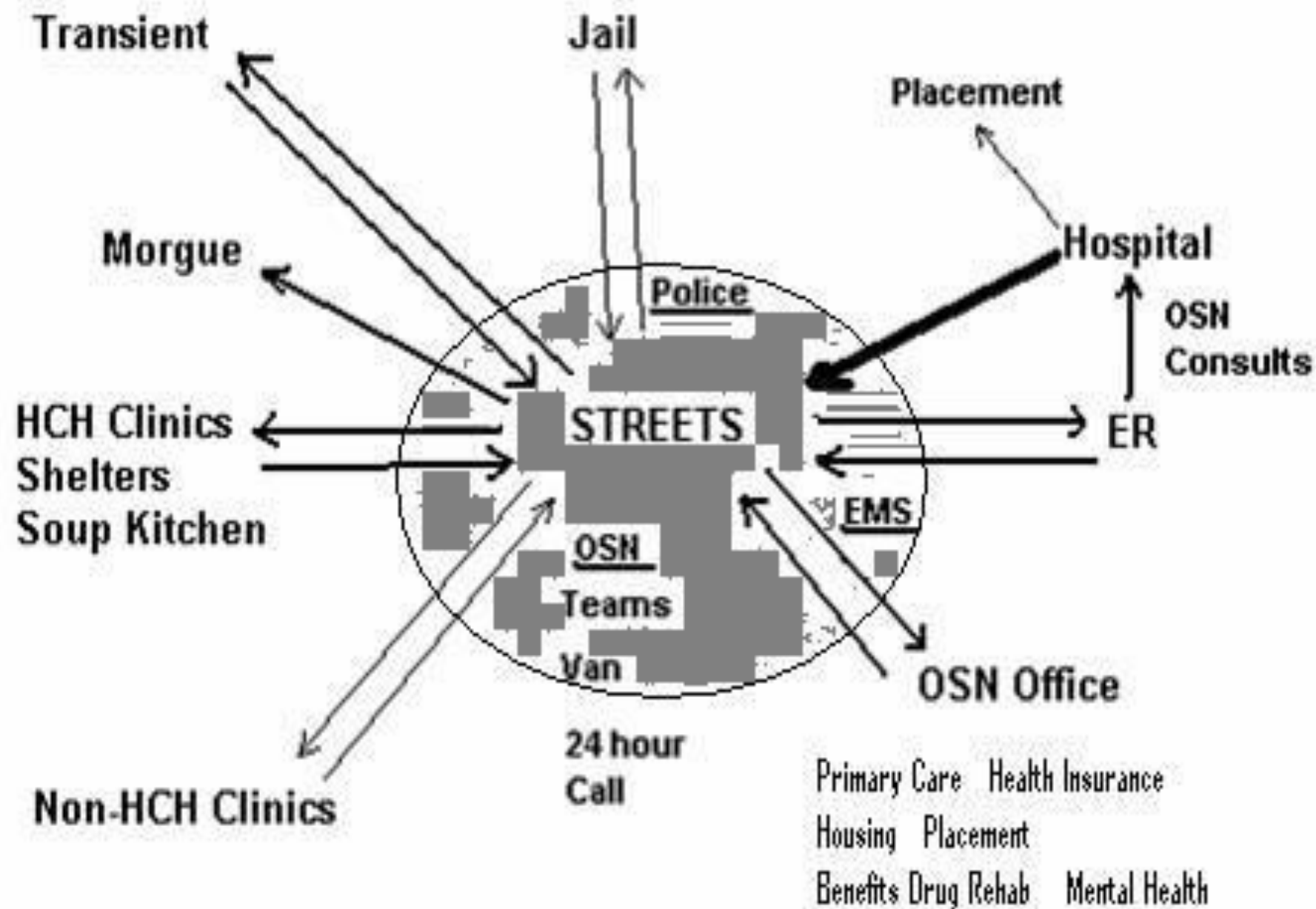


Thank you!



Student Initiated Programs

- Rapidly growing demand
- Natural connection
- Produces leaders and a new culture
- Create groundwork
- Find mentor(s)
- Connect to Street Medicine Institute Student Coalition





Crafting the Argument for Street Medicine: What Funders, Health Systems, and Communities Need to Hear



2019 National HCH Conference
Street Medicine Pre-conference Institute

Patrick J. Perri, MD
Treasurer & Immediate Past Chair, Board of Directors
Street Medicine Institute
Medical Director and Co-founder, Center for Inclusion Health
Allegheny Health Network

Presentation Outline

- 1) Why do people experiencing chronic street homelessness suffer disproportionate morbidity and mortality? *Should anybody care?*
- 2) How are mainstream health care systems falling short in meeting their needs? *Who needs to hear it?*
- 3) Could the Street Medicine care model be part of the solution? *How do we convince them?*

Learning Objective:

Formulate an effective argument for the value of a Street Medicine program on the grounds of human rights issues, reduction in health outcomes disparities, potential acute care cost avoidance, and medical education opportunities

Why should we care?

Moral responsibility

- “The right thing to do”
- Charity vs. Justice

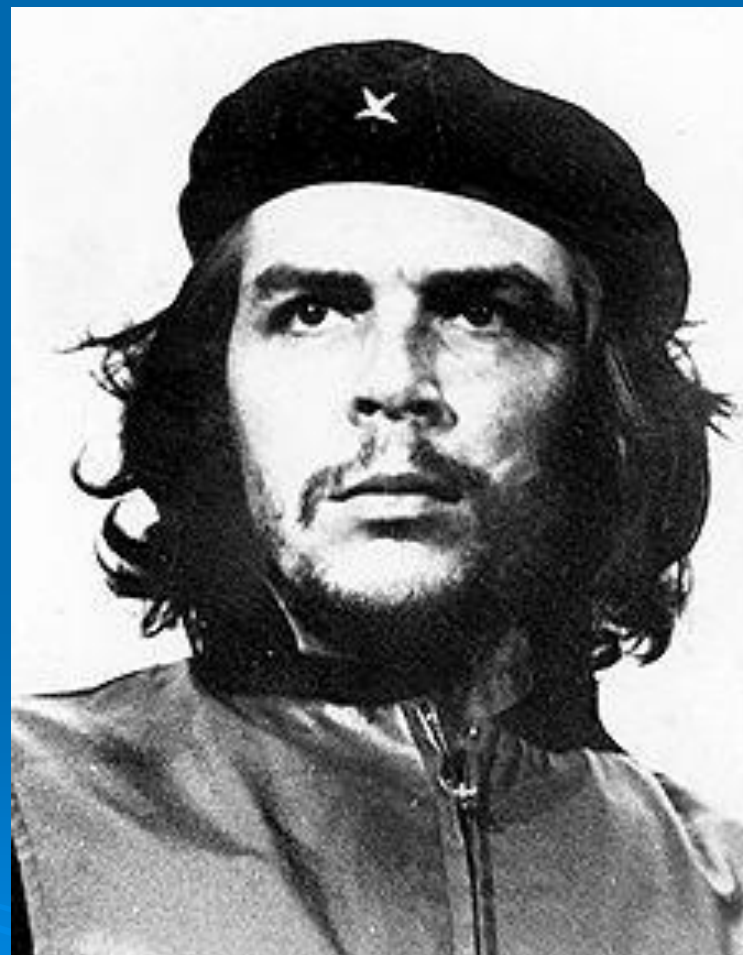
Professional responsibility

- Excess morbidity, mortality, and health care utilization
- Relief of suffering

Social responsibility

- Increased and misdirected costs
- Community building

How should we care?



What is Exclusion?

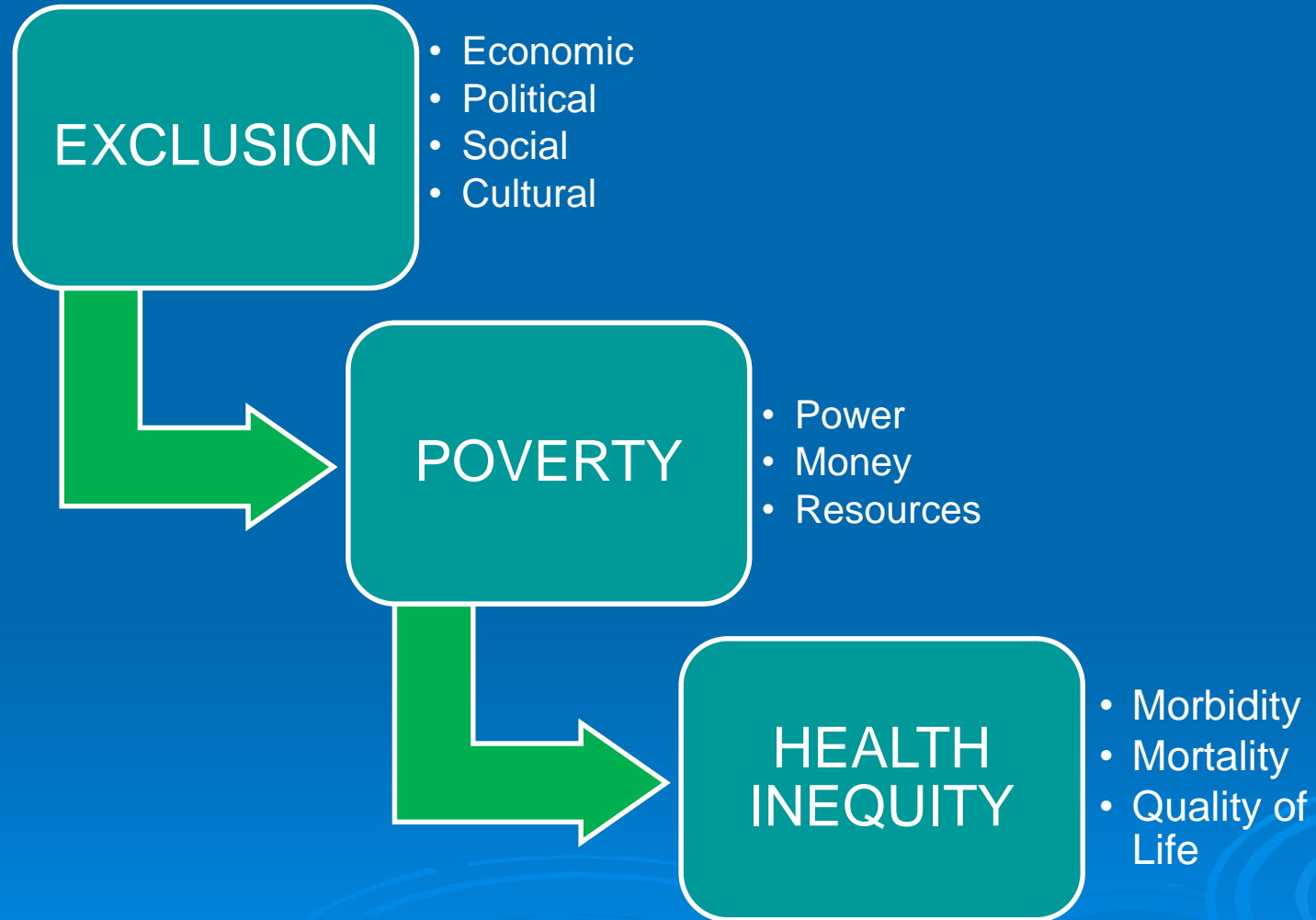
Exclusion consists of dynamic, multi-dimensional processes driven by **unequal power relationships** interacting across four main dimensions - economic, political, social and cultural - and at different levels including individual, household, group, community, country and global levels.

This results in a continuum of inclusion/exclusion characterized by **unequal access** to resources, capabilities, and rights which leads to **health inequalities**.

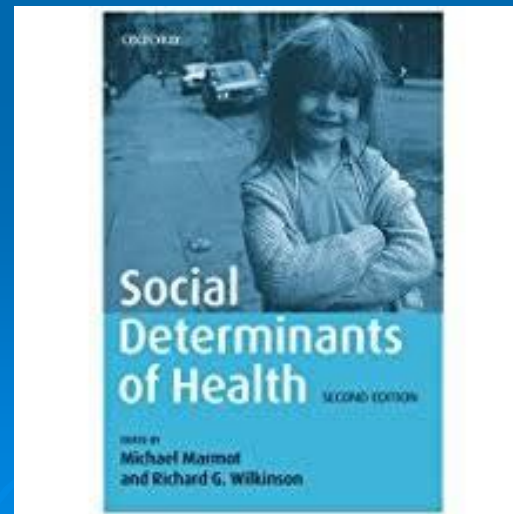
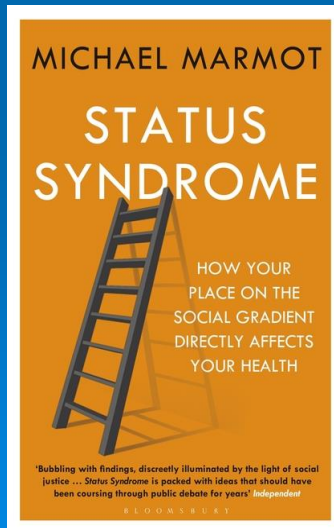
Social exclusion is the **failure of society** to provide certain individuals and groups with those rights and benefits normally available to its members, such as employment, adequate housing, health care, education and training, etc.

(WHO)

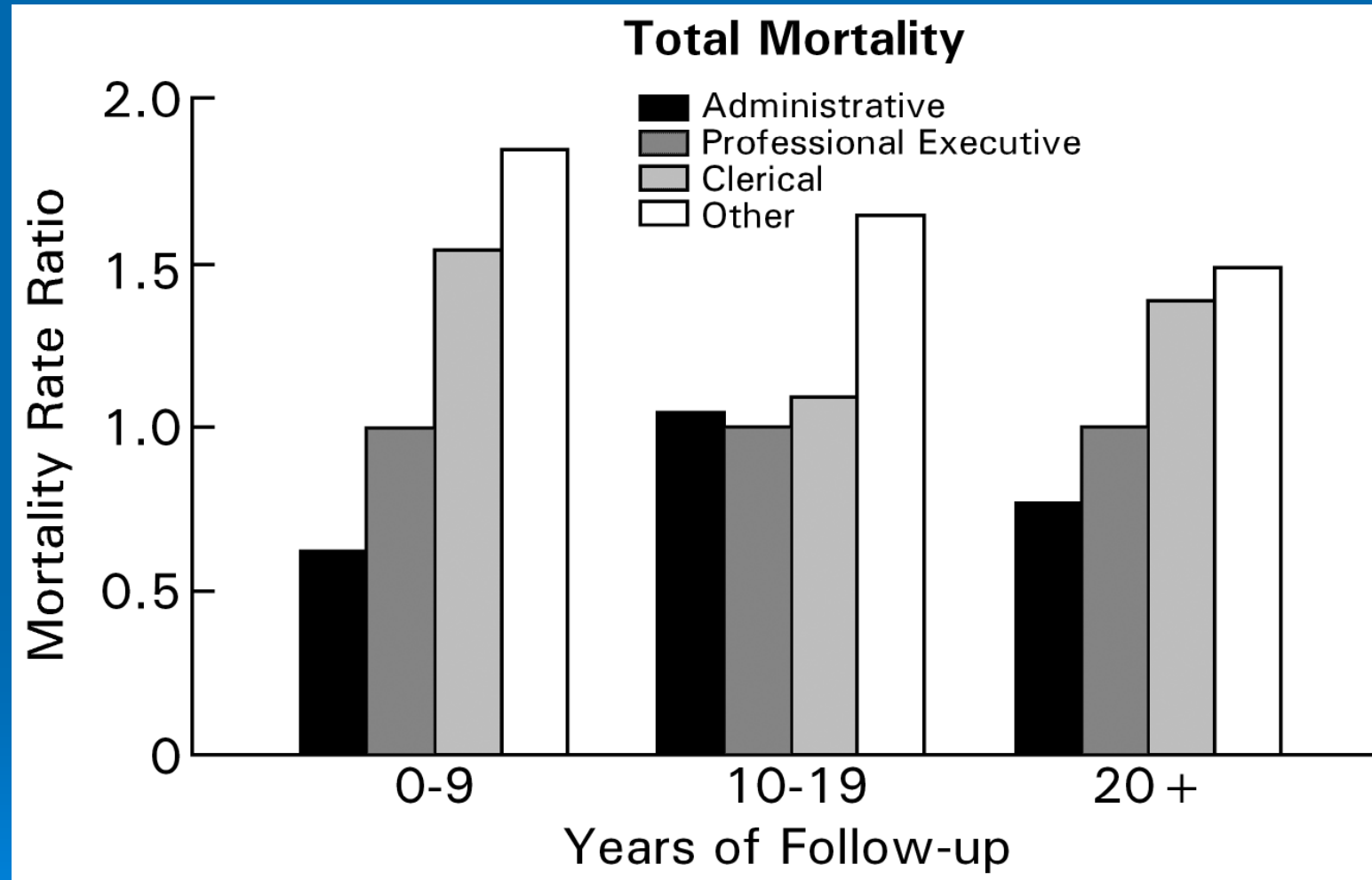
Predictors of Health Inequity



Sir Michael Marmot



Whitehall Study



Marmot et al., *Journal of Epidemiology and Community Health* (1978)

Proportionate Universalism

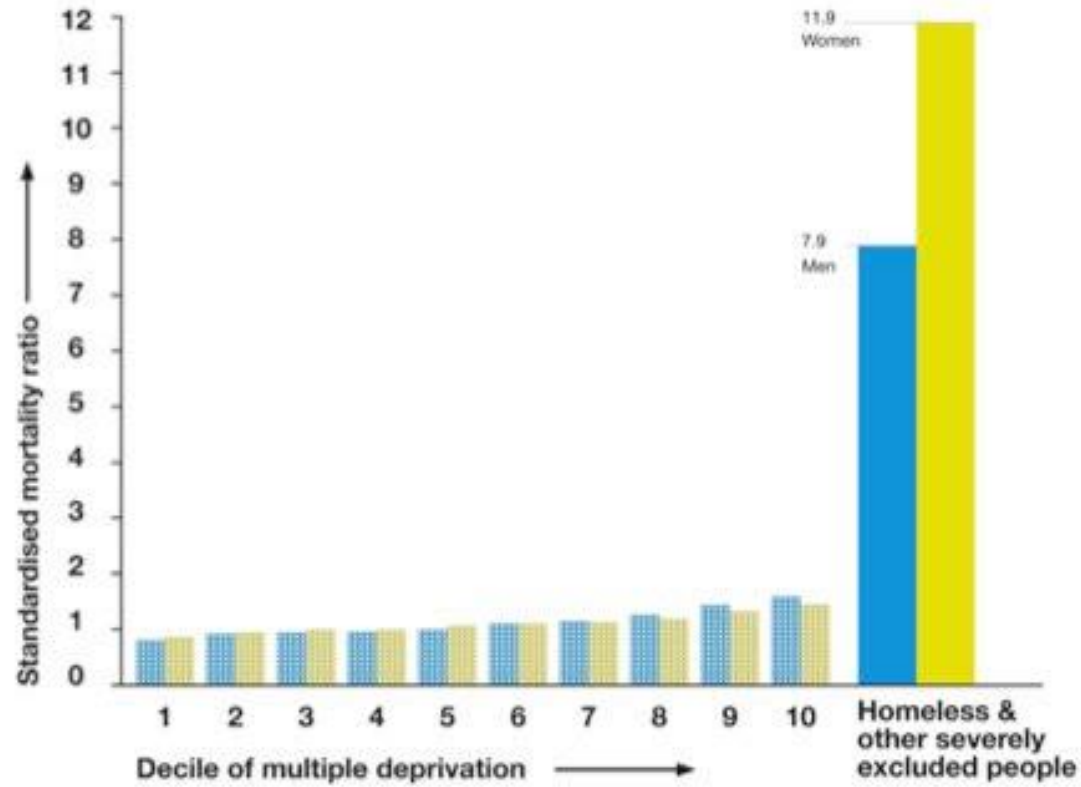
To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage.

Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently.

-Sir Michael Marmot

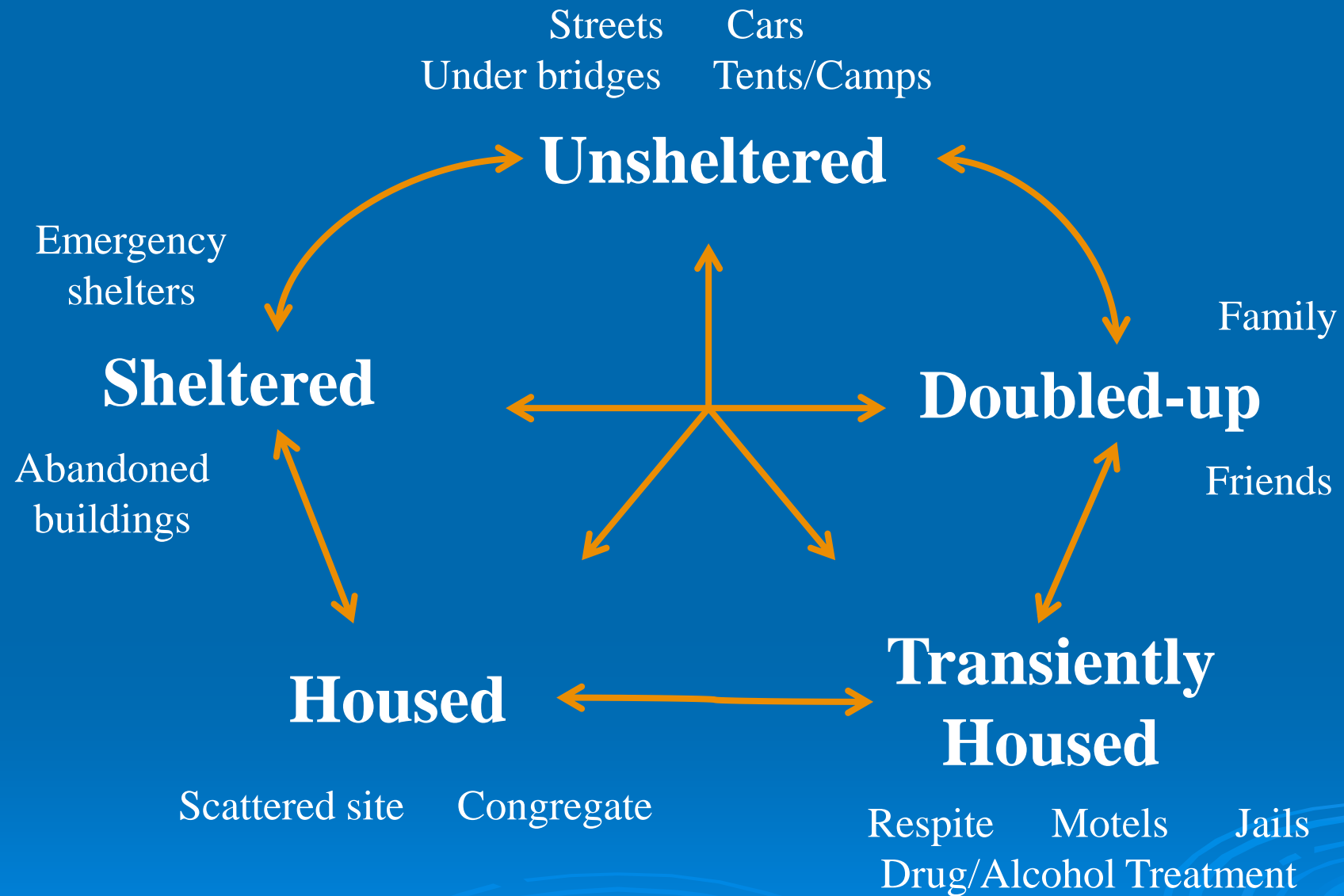


Mortality and multiple exclusion: the cliff edge effect



Deaths by underlying cause, deprivation decile areas, 5 year age groups and sex, England and Wales, 1981 to 2015.
Populations by deprivation decile areas, 5 year age groups and sex, England and Wales, 2001 to 2015.





Transient vs. Chronic Homelessness

- 80% have duration of homelessness of one month or less
 - Utilizing one third of the system's resources
- 10% remain homeless for more than six months
 - Utilizing over half of the system's resources

National Alliance to End Homelessness, 2010

Homelessness and Illness

CAUSE

- *Major mental illness*
- *SA/addiction*
- *Physical disability*

MAINTENANCE

- *Major mental illness*
- *SA/addiction*
- *Physical disability*
- *Chronic medical diseases*

COMPLICATION

- *Major mental illness*
- *SA/addiction*
- *Physical disability*
- *Exposure-related injury*
- *Traumatic brain injury*
- *Physical/sexual violence*



The Morbidity Cycle



Mortality Rates

- Hwang looked at data from 17,292 homeless adults seen by BHCHP from 1988 to 1993
 - Cohort observed for average 2.9 yrs/person
 - 558 deaths recorded, giving crude mortality rate of 1114 per 100,000 person-years.
 - Mean age of death: **47** (median 44)
- Subsequent studies in six other major urban areas have demonstrated similar premature mortality

Mortality Risk Factors

- Among the 558 people who died between 1988-1993, Hwang looked at RFs other than homelessness associated with death
- Each case paired with a control, age-matched homeless individual who was alive at the end of the follow-up period
 - Average age of first contact 44.8
 - Death occurred at average of 25.2 mo after first contact

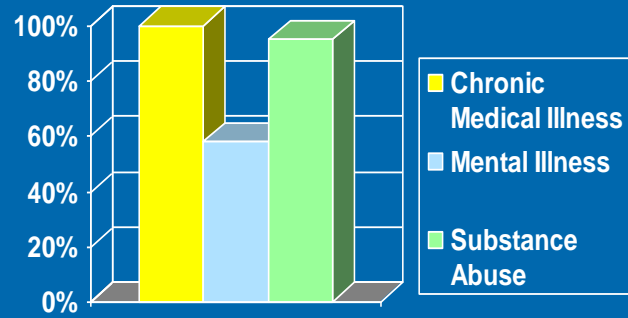
Results

Variable/Disease	Odds Ratio
Schizophrenia	0.7 (0.5-1.0)
Alcohol abuse	2.3 (1.7-3.0)
Opiate abuse	3.1 (2.1-4.4)
CHF	3.2 (1.3-7.9)
Arrhythmias	3.3 (1.1-9.49)
Liver disease	6.2 (2.4-15.9)
Renal disease	6.5 (1.5-28.8)
Frostbite, Hypothermia, Immersion foot	6.7 (2.0-22.4)
AIDS	55.8 (14.4-215.9)

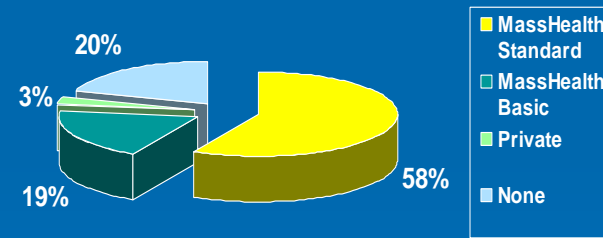
“High Risk” Street Cohort

- In 2000, BHCHP established cohort of 119 chronically-homeless “rough sleepers” at high risk for mortality by the following criteria:
 - >18 yo and sleeping on streets for >6mo and with one or more of the following:
 - age > 60
 - tri-morbidity (major medical, mental health, and substance abuse diagnoses)
 - multiple ED visits/hospitalizations in past 6 mos.
 - HIV/AIDS
 - cirrhosis /CKD
 - h/o exposure-related injury (hypothermia, frostbite, immersion foot, hyperthermia)

Illness Burden



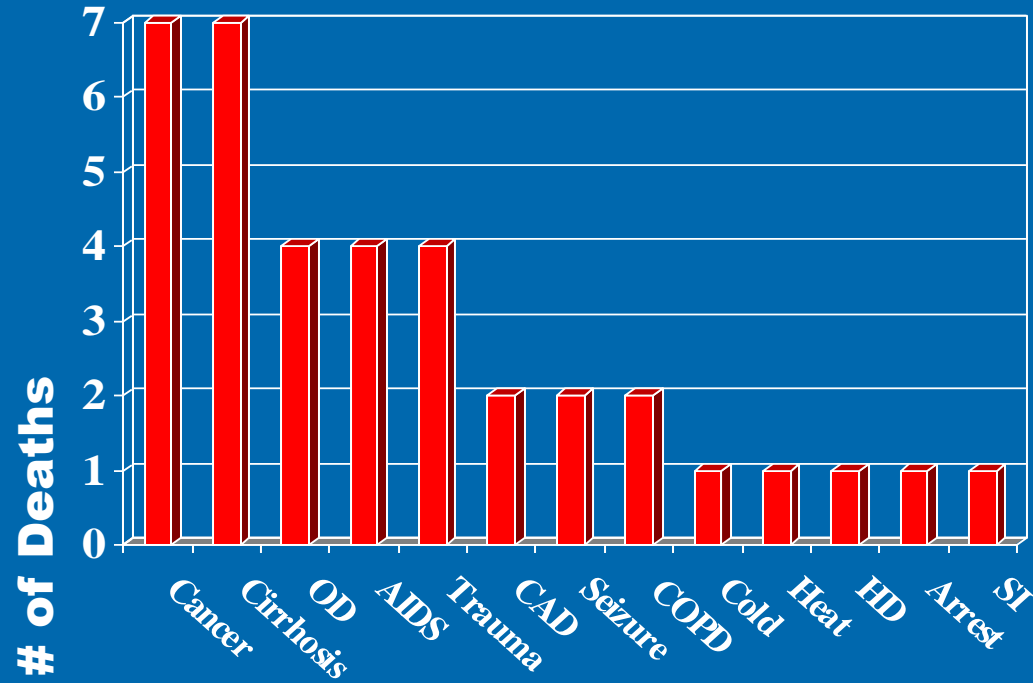
Health Insurance Status



Five Years Later: Whereabouts of Original High Risk Street Cohort (1/1/2005, N = 119)

➤ Deceased	38 (32%)	➤ Housed	30 (25%)
➤ Nursing Home	8 (7%)	➤ Apartment/SRO	22
➤ SNF	7	➤ DMH	2
➤ Assisted Living	1	➤ DMR	2
		➤ Family/Friends	4
➤ Incarcerated	3 (2%)	➤ Still “on Streets”	28 (24%)
➤ Shelter	8 (7%)	➤ Streets	20
➤ Emergency	5	➤ Respite (BMH)	7
➤ DMH	3	➤ Detox	1
		➤ Unknown/LTFU	4 (3%)

Causes of Death



Mortality Among Unsheltered Homeless Adults in Boston, Massachusetts, 2000-2009

Jill S. Roncarati, ScD, MPH, PA-C

Travis P. Baggett, MD, MPH

James J. O'Connell, MD

et al.

JAMA Intern Med. 2018;178(9):1242-1248

Rough Sleeper-specific Mortality Study

Why

Are rough sleepers at uniquely high mortality risk?

What

10-year prospective study of 445 rough sleepers

Where

Boston, Massachusetts, USA

When

BHCHP Street Team patient encounters in 2000, then cohort followed for 10 years

How

Calculate age-standardized all-cause mortality and compare to sheltered homeless population and general MA population

Rough-sleeper Mortality Study Results

- 134 deaths observed during 10-year follow up
- Cancer and heart disease among leading causes of death
- Mean age at enrollment 44
- Mean age at death 53
- 10x higher mortality rate compared to general Massachusetts population
- 3x higher mortality rate compared to primarily sheltered homeless population (with equivalent access to services)

Utilization of Medical Services

1999-2003 (N=119)

- Emergency room visits: 18,384 (31 pp/py)
- Medical hospitalizations: 871

- Total CMS costs (ER only): \$13,000,000
- Cost per person per year: \$22,000

Avg. annual rent for 1BR in Boston, 2003: \$10,000

Hospital Length of Stay

- LOS for homeless inpatients 9 days, nearly double the national average¹
- In Toronto, homeless individuals stayed in the hospital longer than their housed counterparts²
 - Average increased cost of \$2,559 extra per person per admission
 - Total excess hospital cost of \$8 million over five year period

1. Agency for Healthcare Research and Quality, 2008

2. Hwang S, et al. Medical Care. April, 2011

Challenges

- Medical and psychosocial complexity
- Minimal preventive care or chronic disease management
- Problems present in advanced stages (or not at all)
- Chronic conditions difficult to treat without adequate housing and social stability
- Recurrent, compounding negative encounters with mainstream medicine
- Fragmented, ineffective, and unnecessarily costly health care

Continuous Care Model



Street Medicine Care Model Characteristics

- Patient-centered
- Longitudinal
- Continuous
- Comprehensive
- Interdisciplinary
- Cost-effective
- Expert
- Integrative
- Mobile
- Accessible
- Flexible
- Comfortable
- Respectful
- Trustworthy
- Credible
- Compassionate

How Jim got stuck

- 54 y.o. chronically-homeless man (living on the streets/shelters for >15 years)
 - EtOH and heroin dependence
 - s/p mechanical MVR for endocarditis of bioprosthetic porcine valve; not anticoagulated 2/2 poor adherence, high seizure/fall risk when actively substance abusing, and fired by several hospital anticoagulation management clinics
 - h/o hemorrhagic septic embolic stroke
 - Chronic active HCV w/ cirrhosis and recurrent encephalopathy
 - Seizure disorder from multiple traumatic ICHs
 - CAD s/p IMI
 - Prostate CA
 - Major depression and anxiety disorders
- 25 ED visits and 8 inpatient admissions in one year period, totaling 108 hospital days

The Morbidity Cycle

Inadequate care →

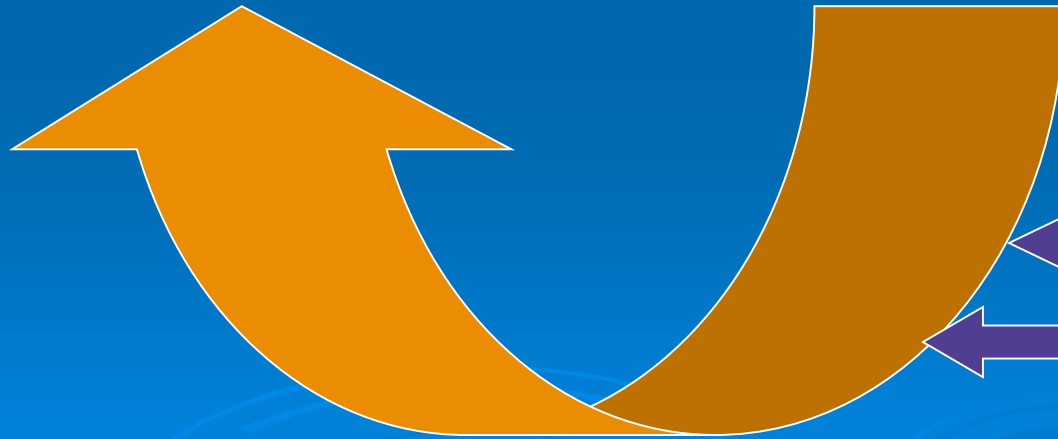
Disability →

Poverty →



POOR HEALTH

HOMELESSNESS




← Trauma

← Shame

← Despair



How Jim got unstuck

- 25 ER visits and 8 inpatient admissions in one year period
 - 108 hospital days
 - During 4 mos. of the year living on the streets
 - 20 ER visits and 5 admissions
 - 94 hospital days
 - During 8 mos. of the year in respite/housing
 - 5 ER visits and 3 admissions
 - 14 hospital days
- 

The Cycle is Broken



Continuous Care Model





15th annual International Street Medicine Symposium
Pittsburgh, Pennsylvania, USA



Dave DiCello

Sunday through Wednesday October 20 - 23, 2019

Break for 15 minutes



Quality | Access | Justice | Community | nhchc.org

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Developing a Quality Assurance Program in Street Medicine: An Essential Step to Health Equity

Brett J. Feldman, MSPAS, PA-C

Director of Street Medicine Keck School of Medicine of USC

Vice Chair Street Medicine Institute

May 23, 2019 | Washington, DC

Objectives

- Identify key components of a quality assurance program and how they are applied in a street medicine setting
- Illustrate strategies to delivering high quality care on the street will be shared including the development of a policy and procedure manual, determining a safe scope of practice, safety guidelines and specific quality metrics.
- Translate street medicine quality assurance principles to attendees' program

LVHN Street Medicine

- Coverage area Lehigh and Northampton Counties
- 725 square miles
- Population 660,000
- Serves 1300 unique patients yearly

Shelters and Soup Kitchens

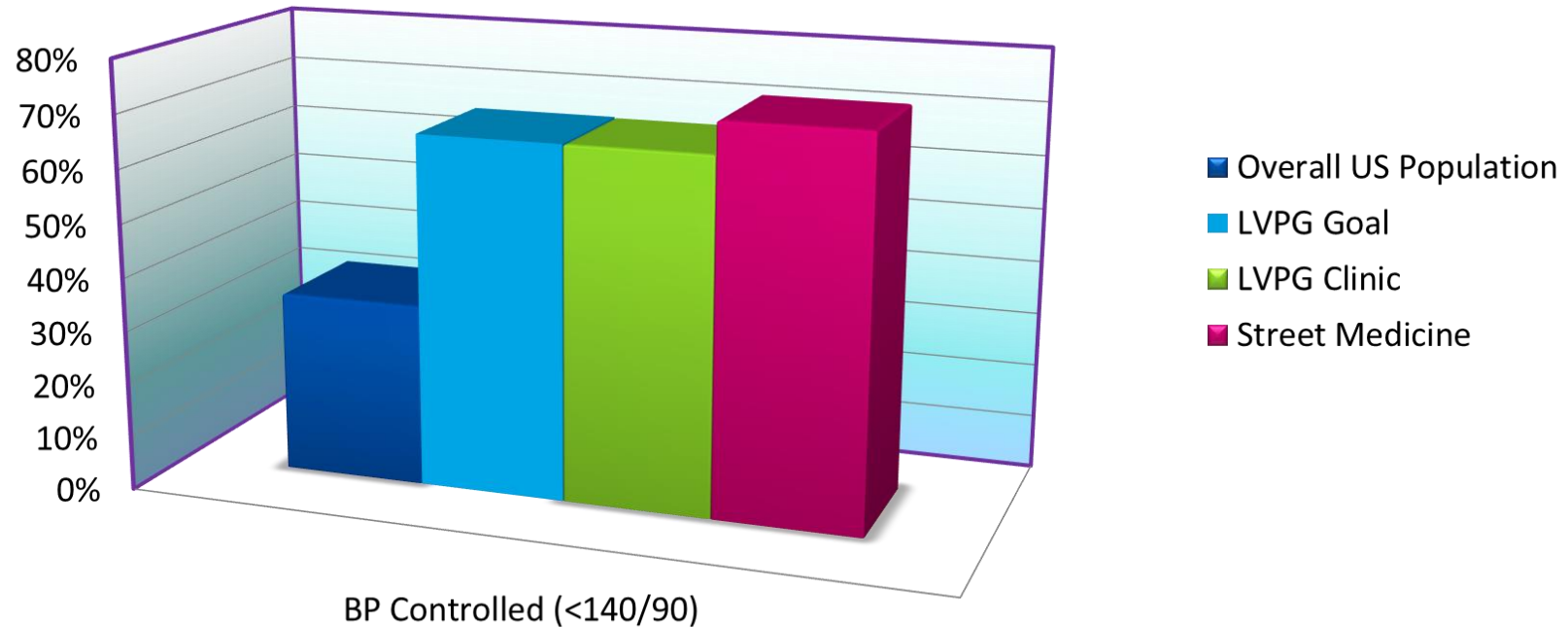
- 8 Clinic sites
- includes youth and sex trafficking specialty care

Street Team

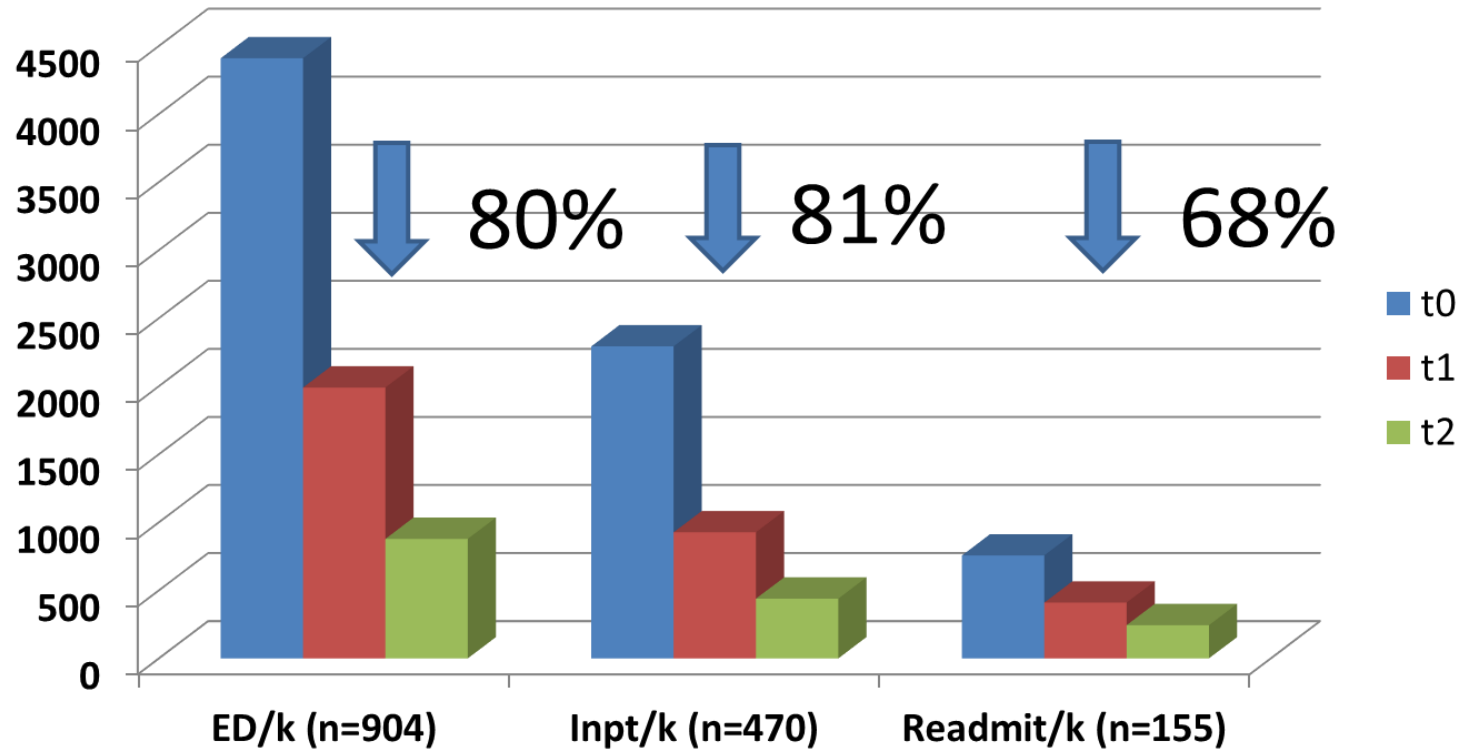
Hospital Consult Service

- Covers 3 hospital locations
- 286 Consults FY 2017

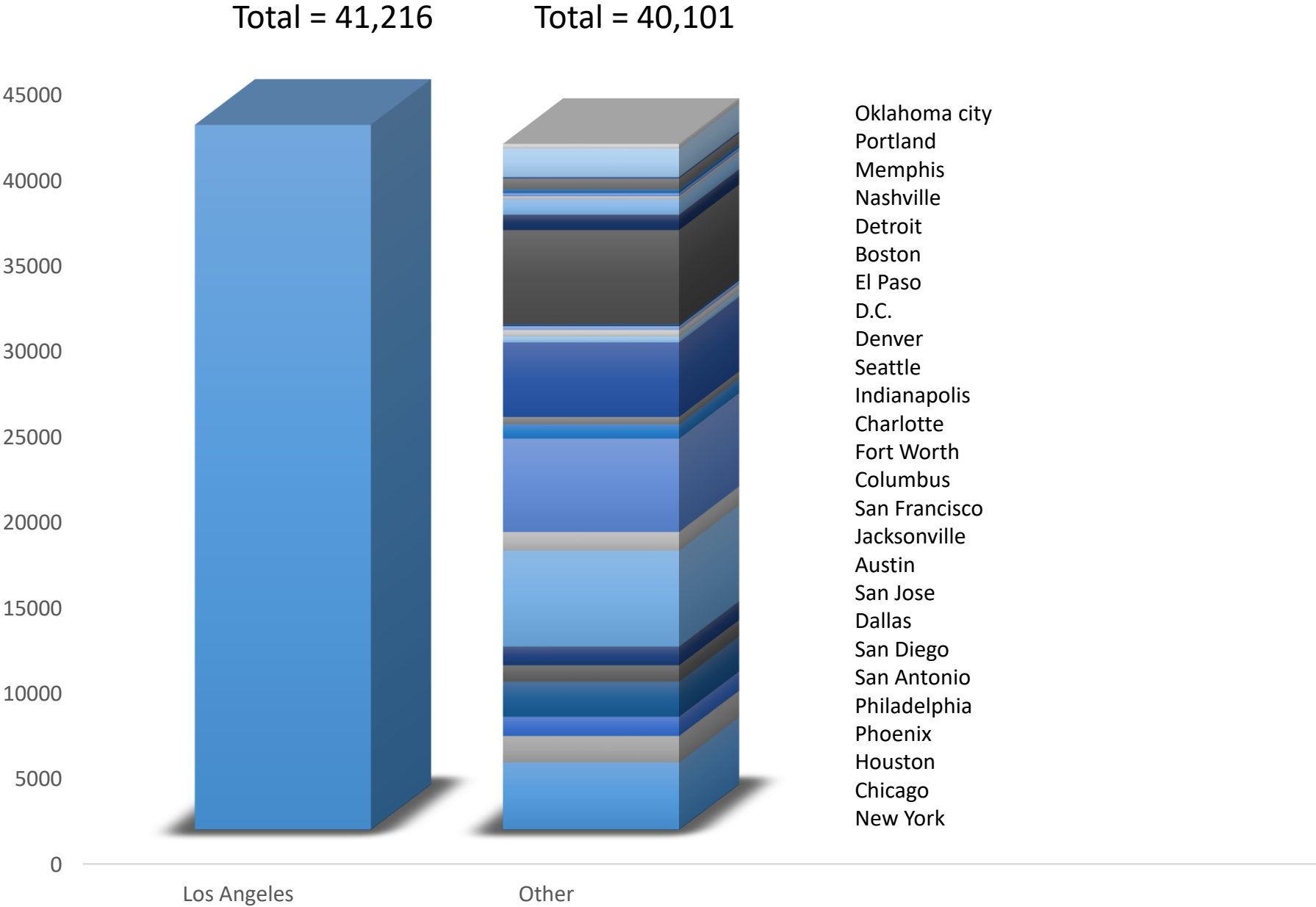
Health Outcomes: Hypertensive Management



Health Outcomes: Improved Healthcare Utilization (Consult Service) Longitudinal Analysis

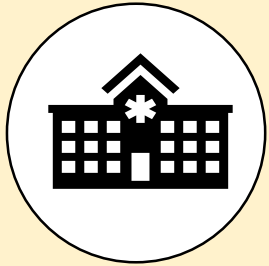


Unsheltered Homeless of America



Keck School of Medicine(KSOM) Street Medicine

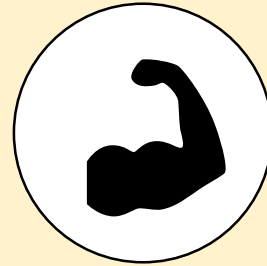
Vision: All unsheltered homeless in LA have access to basic healthcare



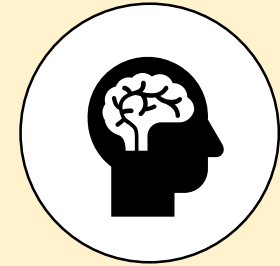
**Hospital-based
consult service**



Street-based care



**Workforce
development
Education**



Research



Quality Assurance vs Quality Improvement

- Quality Assurance (QA)
 - a program for the systematic monitoring and evaluation to ensure that standards of quality are being met
 - development of criteria based on standards of care and outcomes
- Quality improvement is a systematic, formal approach to the analysis of practice performance and efforts to improve performance.

Miller-Keane Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health, Seventh Edition. © 2003 by Saunders, an imprint of Elsevier, Inc. All rights reserved

AAFP Practice Improvement, <https://www.aafp.org/practice-management/improvement/basics.html>

Quality Assurance Program Concepts

- Effective: evidence base and results in improved outcomes based on need
- Efficient: maximized resource use and avoids waste
- Accessible: timely, in setting where skills and resources appropriate to need

World Health Organization. (2006). Quality of care : a process for making strategic choices in health systems. Geneva : World Health Organization.

Quality Assurance Program Concepts

- Acceptable (patient centered): patient preferences and aspirations
- Safe: minimizes risk and harm patients(caregivers)
- Equitable: care doesn't vary in quality because of personal characteristics such as gender, race, ethnicity, geographic location or socioeconomic status

Effective: Start with Current State

- Consider scope of practice and care goals
- Will services provided match outcome measures desired?
- Consider Organizational Capacity/ Consider Community Resources
- How will you evaluate findings? Are benchmarks available?

Phase 2: Evaluation and Improvement

- Metrics based on CMS Core Measures—Triple Aim
 - Patient experience of care
 - Health related quality of life measures
 - Self-reported
 - Document ongoing engagement and continuity
 - Improved healthcare outcomes
 - Healthcare quality metrics
 - HTN control, A1C, PHQ-9
 - Reducing cost of healthcare or BETTER care
 - Decrease ED visits, hospital admissions

****pick a few you can impact.... Or not**

QA Concept: Efficient

- Ease of data collection and tracking
 - Limit number of measures
- Clinic location/process and staffing
- “Wait times”—efficient street rounds

QA Concept: Accessible

- “Go to the People”- Street Medicine Institute
- Consider design that promotes Engagement
 - frequency of visits (weekly vs. monthly)
 - Continuity of providers
 - predictable schedules

Accessible: Beyond the Office Visit

- Direct Care Delivery
 - Medication Dispensing
 - Laboratory Testing
 - Point of Care Testing

Medication Dispensing

- Prescribing vs. Dispensing
- Prescribing: The ordering of the use of medicine
- Dispensing: The preparation, packaging, labeling, record keeping, and transfer of a prescription drug to a patient or an intermediary, who is responsible for administration of the drug.
- Administering: transferring medication for immediate use, not for future use

QA Concept: Acceptable

- Let the Streets Build the Program
 - “Go to the People”
 - Deliver care where people feel most comfortable
- Consumer Input
 - Advisory Board
 - Needs assessment
 - Address their priorities (food vs BP meds)

QA Concept: Safe

- Applies to providers AND patients
- Provider Safety
 - Address in Policy and Procedure Manual
 - Guidelines with intervention
 - De-escalation techniques
 - “Code Grey” evacuation
 - Role of Street Guide is essential
- Patient Safety
 - Harm reduction in harsh environment
 - Behavior modification

Cultural Cues & Code of Conduct

- Mind your manners
- Always announce self
- Ask approval
- Never over commit

QA Concept: Equitable

- Goal to deliver same quality on street as in clinic
 - Equitable resources
- Patient defines the goals
- Reimagining definition of success

VA Programs

- Cincinnati VA Medical Center
- Oklahoma City VA
- VA Connecticut
- VA Puget Sound VA Los Angeles

University-based Programs

- Touro University
- UCLA
- USC
- University of Southern Maine

Hospital-based Programs

- Allegheny Health Network
- UCLA Medical Center
- Maine Medical Center
- Tower Health Medical Group
- JPS Health Network

HCH Standalones (- public entities)

- Boston HCH
- Care Alliance, Cleveland
- Cincinnati Health Network
- Colorado Coalition for the Homeless
- HCH Baltimore
- Heartland Alliance Health, Chicago
- St Vincent de Paul, San Diego

Public Entities

- Alameda County HCH Program
- Santa Clara - Valley HCH
- Harris Health System
- Seattle-King County
- Manchester NH
- Pinellas County FL
- San Mateo County
- LA County Dep of Public Health
- Orange County Health Care Agency
- San Francisco DPH

Non-Health-Center Nonprofits

- Access Services
- BronxWorks
- DESC
- Hawaii Home Project
- Integral Care
- Janian Medical Care
- Journey Home
- Lincoln Park Community Svcs
- Micah Projects
- Mid-South Health Systems
- The Night Ministry

Community Health Centers – California!

- Clinica Sierra Vista – Bakersfield
- Care Link – Stockton
- LifeLong Medical Care – Berkeley
- Los Angeles Christian Health Center
- San Francisco Community Health Center (API)
- Shasta Community Health Center – Redding
- Tri-City Health Center – Fremont
- Venice Family Clinic – CA
- Antelope Valley Community Clinic – Lancaster CA
- Saban Community Clinic – Los Angeles
- Ravenswood Family Health – Palo Alto

Community Health Centers – East Coast

- Community Health Center, Inc. – CT
- Unity Health Care – DC
- Cornell Scott Hill – New Haven
- Greater Lawrence Family Health Centers – MA
- Lynn Community Health Center – MA
- Philadelphia FIGHT
- Southwest Community Health Center – Bridgeport CT

Community Health Centers – Mountains/PNW

- Heritage Health – Coeur D’Alene
- North Country HealthCare – AZ
- El Rio Health – Tuscon
- Peak Vista Community Health Center – Colorado Springs
- Amador Health Center – Las Cruces
- Outside In – Portland

Community Health Centers – Elsewhere!

- PrimaryOne Health – Columbus OH
- NEW Community Clinic – Green Bay WI
- Front Street Clinic – Juneau AK
- Carrboro Community Health Center – NC
- Health First Bluegrass – Lexington KY
- Lawton Community Health Center – OK

LUNCH
Find
your
people!

Reality Based Street Medicine

Liz Frye, MD, MPH

Joel Hunt, PA

Kevin Sullivan, MD

Case 1: Lucy

- Lucy is asking for money in front of Dunkin Donuts.
- Lucy asks if the team has any other supplies, including works
- She mostly injects heroin, but really does everything from meth to gabapentin.
- Usually buys buprenorphine on the street
- Has word-finding problems, unsure of cause

Case 1: Lucy

You offer to make the script legitimate if she comes to clinic for her scripts.

What risks and benefits do we weigh in making treatment decisions in this context?

Case 1: Lucy

- She and her partner make it to clinic, mostly sober and alert
- Lucy still has trouble finding words
- She is missing part of her skull after she had a brain injury
- Living on the streets missing a palm-sized portion of her skull
- Trying not to fall or get punched., but she doesn't always succeed.

What are our concerns from the mental, physical, and substance use perspectives?

Case 1: Lucy

- Lucy worries she's pregnant
- She's not sure who the father would be
- Unprotected sex with her partner and trades sex for drugs or money
- The pregnancy test is negative.

How do we decide what treatment options to offer Lucy and how do we offer it?

Case 1: Lucy

- Lucy comes weekly for suboxone
- Urines show suboxone most of the time, still some other drugs
- Anger and not wanting to feel her emotions drives her substance use
- Told she is Bipolar in the past, rapid mood swings
- No decreased need for sleep, grandiosity, messages from the TV
- Explosive anger triggered by not getting what she wants
- Old scars from intentional cutting on physical exam

Case 1: Lucy

- Refuses connection to psychiatry because:
 - “You are the best”
 - Other people on the team don’t understand her; can’t trust others
 - Bad experience with a psychiatrist in the past

As a street team, what can we do to improve Lucy’s whole health?

Pearls from working with Lucy

- There are no “clean” or easy cases; we treat patients with complex issues
- Weighing risks and benefits
 - Durable medical equipment?
- Go slow and follow their lead (let the patient set the agenda)
- Long-acting meds
- Where is the pain and how do we address it?
- Maintaining safety and managing risks

Case 2: Oliver

- Oliver is a tall, well spoken, engaging 45 year old white male
- Recently homeless again after getting in a fight with his ex-boyfriend.
- From a fervently religious home; rebellion in youth
- History of street drugs (meth), but alcohol is drug of choice
- Diagnosed with Hepatitis C; past treatment caused suicidality
- Has cirrhosis, PTSD, congenital QT prolongation, depression, and portal vein aneurysm

What are our concerns from the mental, physical, and substance use perspectives? What do we prioritize?

Case 2: Oliver

- Oliver's days are not filled with joy
- Wants treatment for his HCV and to stop drinking
- Unsuccessful attempts to obtain mental health/SUD treatment
- Frequently being beat up
- Liver disease worsening – out of meds, feels more inebriated, poor balance, shortness of breath with some clinic visits/hospitalizations
- No SUD treatment and still drinking
- Tired of this kind of existence but, no intent to harm himself.

Case 2: Oliver

How do we reduce Oliver's suffering?

How do we adjust our plans to play to Oliver's strengths?

Case 2: Oliver

- Family's lack of acceptance due to his sexual orientation compels Oliver to drink
- Significant traumatic experiences
- Does not elaborate on what his sexual orientation is specifically.

How do we talk with our unsheltered patients about trauma? How do we work in gray areas, how do we heal without hurting?

Pearls from working with Oliver

- Prioritize safety
- Street medicine prescribers as advocates for care
 - Harder/slower to get treatment/referrals otherwise
 - Oliver can continue on his goals without having to divert to a clinic or hospital
 - least disruptive way for him to complete his goals
- Time is different for unsheltered people and street medicine
- What can the health system learn from this approach?

Case 3: Betty

- Betty, overweight woman, appears to be 60-65 years old, sitting on a bench with multiple trash bags
- Appears to be hallucinating, responding to voices loudly
- Initial attempts to engage are minimally successful; quickly consumed in conversations with hallucinations after 2-3 minutes
- Social worker learns Betty sleeps outside waiting for her son
- Attempts to discuss health issues are thwarted by hallucinations

Case 3: Betty

The social worker is able to determine that Betty:

- Used to have diabetes and believes she is cured
- Chain smokes cigarettes
- Eats packaged food and fast food only
- Refuses to give her son's name or her own last name

Case 3: Betty

What is the next best step for assessing and addressing Betty's health?

Case 3: Betty

- Betty wants cream for itchy skin and consents to be evaluated through the social worker
- Has taken risperidone in the past
- Will take risperidone again if she gets itch cream
- Social worker gives Betty the first dose

Case 3: Betty

- She keeps losing the risperidone, but will take a dose occasionally from the social worker
- Betty continues to deny health problems, but is losing weight and is notably hoarse
- Refuses to go do the ED

Case 3: Betty

What are our concerns from the mental, physical, and substance use perspectives?

What do we prioritize?

When/how do we think about an involuntary commitment?

Case 3: Betty

- More weight loss; becomes so hoarse she can barely speak
- Finally agrees to the ED as long as the team agrees to keep her belongings safe
- Over 6 weeks of hospitalization, Betty:
 - Is diagnosed with squamous cell carcinoma of the neck
 - Takes risperidone daily and can consent to surgery
 - Surgery results in tracheostomy and PEG tube at discharge
 - Will need 6 weeks of chemo/radiation
- Betty is discharged and bounces between streets, housing, ED, hospitalizations

Case 3: Betty

What is the street medicine team's role post-discharge with Betty?

What can we do to improve Betty's whole health?

Pearls from working with Betty

- Weighing risk/harm vs. benefit
- Things will fall apart
- Frequently reassess safety and treatment priorities
- Need to rely on strengths of the team; you can't do it by yourself

Self care, how do we prevent burnout?



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city of nursing

NOVEMBER 1981

AJN



ROOM AT THE INN
A guest at Boston's Pine Street shelter for the homeless.

See page 1236



The Limits of Charity

Health care as “justice not charity”

No volunteers

No students (interns, residents)

No research

No mental health services

Hale & Dorr (1984)

BHCHP Basic Goals 1984

- Establish a health services care delivery model to provide **continuity** of care from **shelter** and **street** to **hospital**;
- Provide care through multidisciplinary outreach **teams**;
- Establish the capacity to meet the needs of homeless individuals for home-type **respite care**



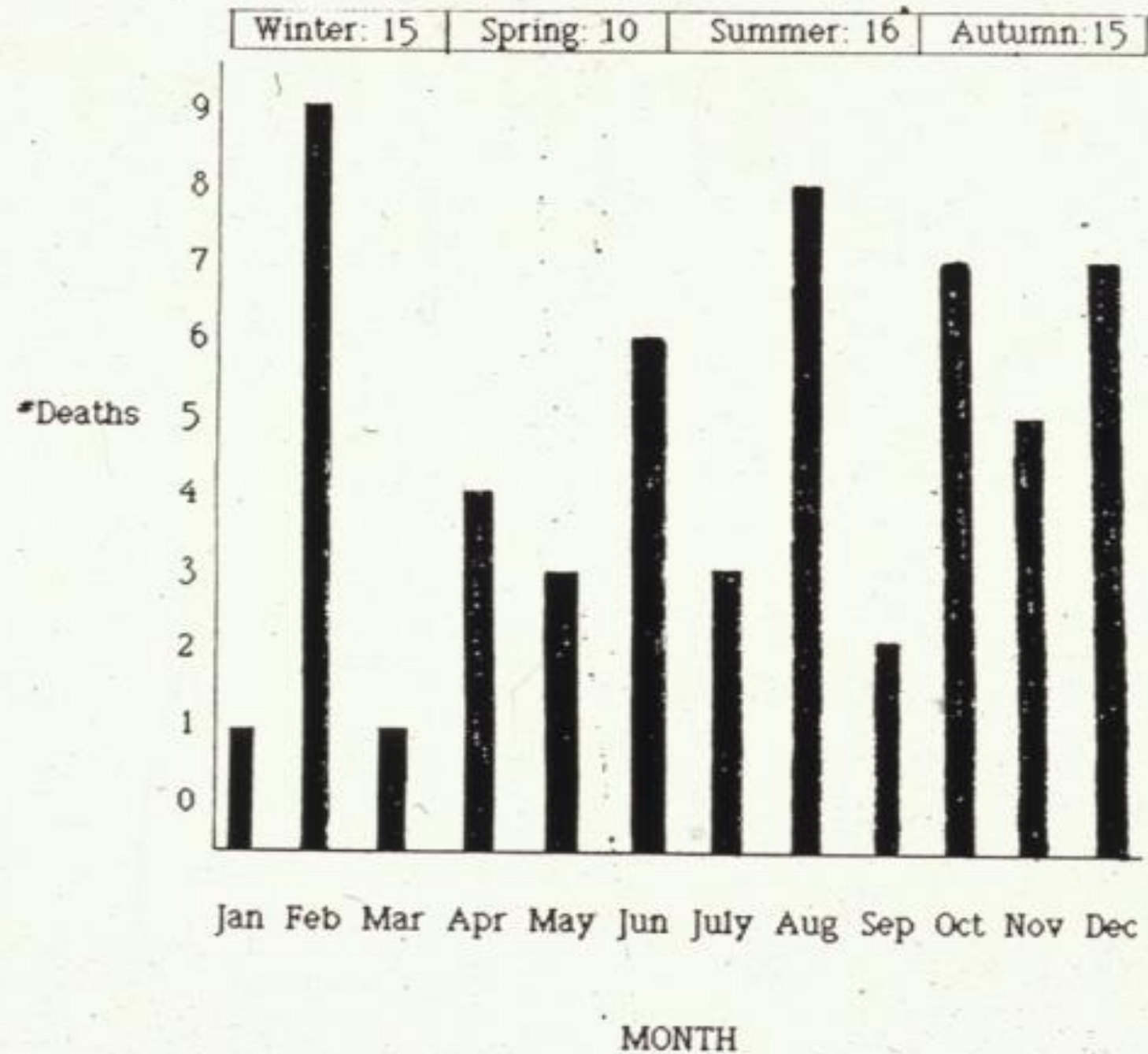
Hospitals

Family Shelters

Adult Shelters

City of BOSTON

Chart # 1. Deaths by month of the year.







Principles in the Health Care of Homeless People 1990

- **1:1 relationship, trust as foundation of care**
- **Continuity of care is bedrock**
- **Go to your patients. Don't wait for them to come to you**
- **Work in teams**
- **When in doubt, start with the feet**
- **Integration within mainstream (not alternative system)**
- **Flexible and creative approaches**
- **Involve those you are serving in designing the model**
- **Medicine and public health**
- **Town/Gown: community partnerships and coalitions**









The Commonwealth of Massachusetts

DEPARTMENT OF PUBLIC HEALTH

CLINIC LICENSE

In accordance with the provisions of the General Laws, Chapter 111, Sections 51-56 inclusive, and the regulations promulgated thereunder, a license is hereby granted to:

Boston Health Care for the Homeless Program, Inc.

Name of Applicant

for the maintenance of

Boston Health Care for the Homeless Program, 780 Albany Street, Lobby, 1st and 2nd Floor, Boston, MA 02118

Name and Address of Clinic

and Satellites as listed below.

The license is valid until July 7, 2020, subject to revocation or suspension, either wholly or with respect to a specific service or specific services, or a part or parts thereof.

SERVICE(S):

- Medical
- Surgical
- Dental
- Mental Health
- Physical Rehabilitation
- Substance Abuse
- Birth Center
- Mobile Medical
- Transfusion
- Pharmacy
- Limited Services

SATELLITE(S)

McInnis House Clinic
 780 Albany Street, 3rd and 4th Floor
 Boston, MA 02118
 Services: Medical, Dental, Pharmacy & Mental Health

Boston Health Care for the Homeless
 at Pine Street Inn Women's Clinic
 363 Albany Street, Boston, MA 02118
 Services: Medical, Dental & Mental Health

Boston Health Care for the Homeless
 at Pine Street Inn Men's Clinic
 444 Harrison Avenue, Boston, MA 02118
 Services: Medical & Mental Health

Boston Health Care for the Homeless
 at Pine Street Inn at the Shattuck
 170 Morton Street, Boston, MA 02130
 Services: Medical & Mental Health

Commissioner of Public Health

July 8, 2018

Date Issued

LICENSE No 4LQX

POST CONSPICUOUSLY

SATELLITE(S)

(continued)

Boston Health Care for the Homeless @ Father Bill's Place
38 Broad Street
Quincy, MA 02171
Services: Mental Health & Medical

Boston Health Care for the Homeless @ St. Francis House
39 Boylston Street
Boston, MA 02118
Services: Mental Health & Medical

Boston Health Care for the Homeless @ Mass General Hospital
55 Fruit Street
Boston, MA 02114
Services: Mental Health & Medical

Boston Health Care for the Homeless @ South Hampton Street Shelter
112 South Hampton Street
Boston Harbor, MA 02118
Services: Mental Health & Medical

Boston Health Care for the Homeless at New England Center and Home Veterans
17 Court Street, Second Floor
Boston, MA 02108
Services: Mental Health & Medical

Boston Healthcare for the Homeless at Stacy Kirkpatrick House
461 Walnut Avenue, First Floor
Jamaica Plain, MA 02130
Services: Medical & Mental Health

MOBILE UNIT

Boston Health Care for the Homeless
780 Albany Street
Boston, MA 02118
Services: Medical and Mental Health

SPECIAL PROJECT LOCATIONS

Providing Mental Health & Medical Services

Kingston House 39 Kingston Street Boston, MA 02111	Transitions 201 River Street Mattapan, MA 02126	The Night Center 31 Bowker Street Boston, MA 02114	Woods Mullen Shelter 794 Massachusetts Avenue Boston, MA 02118	Rosie's Place 889 Harrison Avenue Boston, MA 02118
Crossroads Family Shelter 56 Havre Street Boston, MA 02128	Lindemann Mental Health Center 25 Staniford Street Boston, MA 02111	Casa Esperanza 245 Eustis Street Roxbury, MA 02119	Medeiros Center 1960 Washington Street Boston, MA 02118	St. Ambrose Family Shelter 25 Leonard Street Dorchester, MA 02122
Nazareth Residence 91 Regent Street Roxbury, MA 02119	Finex House P.O. Box 1154 Jamaica Plain, MA 02130	Asian Task Forces Against Domestic Violence P.O. Box 120108 Boston, MA 02111	Casa Nueva Vida 53 Glen Road Jamaica Plain, MA 02130	
Crittenton Women's Union 10 Perthshire Road Brighton, MA 02135	Entre Familia 209 River Street Mattapan, MA 02126	Home Suites Inn 455 Totten Pond Road Waltham, MA 02451	St. Anthony's Shrine 100 Arch Street Boston, MA 02110	Sojourner House 85 Rockland Street Roxbury, MA 02119
Friends of the Unborn 38 Edgemere Road Quincy, MA 02269	St. Mary's Center for Women and Children 90 Cushing Avenue, 4th Floor Dorchester, MA 02125	Bridge Over Troubled Waters 47 West Street, 4th Floor Boston, MA 02111		
Street Team	Engagement Center	Hildebrand Family Self Help Center	EVA Center	









JAMES J. O'CONNELL, M.D.
MASSACHUSETTS GENERAL HOSPITAL
BOSTON, MASSACHUSETTS 02114
MEDICAL WALK-IN UNIT
617-726-2707

PATIENT'S FULL NAME	PHONE NUMBER	AGE	SEX
JOHN DOE	N/A	50	M

ADDRESS	DATE
STORROW DRIVE BRIDGES	9 / 4 / 2005

R_x

1 STUDIO APARTMENT

SIG: USE EVERY DAY PRN

: 30 DAYS

Dr. J O'Connell M.D.

Refills 1 2 3 4 11

No Refills Void After _____

DEA #: _____

VALID FOR CONTROLLED SUBSTANCES

Interchange is mandated unless the practitioner writes the words, "No Substitution" in this space.

Standard Register Scrip Plus™

ANTI-FRAUD PROTECTION - PATENTS 5,197,765; 5,340,198; 5,039,92







Round Table Discussions

- Table 1: Street-based substance use treatment - Kevin Sullivan
- Table 2: Packing your backpack - Joel Hunt
- Table 3: Quality Improvement and Risk Management – Brett Feldman
- Table 4: FQHC-specific questions – Jim O’Connell
- Table 5: Street-based physical health treatment – Pat Perri
- Table 6: Street-based psychiatric treatment – Liz Frye
- Table 7: Program development – Jim Withers

Adjourn

- Please complete your evaluations!
- Get help when you go home: www.nhchc.org/ta