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## Independent Study Projects

### **Title**

Focused Clinical Multidisciplinary Independent Study Project : Healthcare for People Living on the Street (and in Shelters, Respite Centers, and other Temporary Housing).

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# **Focused Clinical Multidisciplinary Independent Study Project:**

Healthcare for People Living on the Street (and in  
Shelters, Respite Centers, and other Temporary  
Housing)

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**Background:**

Charlene<sup>1</sup> passed away from complications of an aspiration event, one that likely took place during an unwitnessed grand mal seizure. Little Mikey from hypothermia, exposure. Jim from a stroke. Old Man Bob from head and neck cancer, gone undetected until the giant mass was too hard to hide anymore. That was just the beginning, during my first year working with the people living on the street in Santa Barbara. Four lives cut too short, and so many more since I've left for medical school and beyond. Dan, heart trouble. Rick, COPD and pneumonia. Alan, his pancreas. At the time, it seemed a disproportionate amount of loss when comparing these street people to the rest of the population, and it happened earlier in life too- late forties being the norm among these individuals. And what is it they died of? Homicide, suicide, accidents? That wasn't the case. Alcoholism? Other substance abuse? Yes, some from consequences of destroying the liver or from hypothermia after a night of drinking, but not the majority. Instead, these people seemed to die from common physical health problems, often diagnosed late due to lack of access to primary care or mental health services, and accompanied by overwhelming complications stemming from lack of housing, funds, and social support. These people are gone, but the circumstances which helped lead to their deaths are still in place. It is hard to forget that in many cases these deaths were preventable, and with better access to care these people might still be adding their presence to the communities they lived in.

In order to better understand the problem of homelessness today, it might be wise to define the term. State, city, and private definitions of homelessness tend to differ, however the Federal Bureau of Primary Health Care describes homelessness using the following (Bureau of Primary Health Care, 2006):

- An individual without permanent housing who may live on the streets; stay in a shelter, mission, single-room occupancy facility, abandoned building or vehicle; or in any other unstable or nonpermanent situation.
- An individual may be considered homeless if that person is "doubled-up," a term referring to a situation in which individuals are unable to maintain their housing situation and are forced to stay with a series of friends or extended family members.
- Previously homeless individuals who are to be released from prison or a hospital may be considered homeless if they do not have a stable housing situation to return to.
- Recognition of the instability of an individual's living arrangement is critical to the definition of homelessness.

The extent of homelessness is difficult to define, with point-in-time and period prevalence counts being the most common measures. According to the National Law Center on Homelessness and Poverty, approximately 2.3 to 3.5 million people are likely to experience homelessness in a given year (2004). This translates to approximately 1% of the U.S. population experiencing homelessness each year (Urban Institute, 2000). As for a point-in-time estimate, the National Alliance to End Homelessness reported 744,313 people experiencing homelessness in January 2005.

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<sup>1</sup> Names have been changed

Being homeless is an obvious determinant of health; however, the extent of its effect is not always so evident. McMurray-Avila describe the situation well: “As a consequence of poor nutrition, lack of adequate hygiene, exposure to violence and to the elements, increased contact with communicable diseases, and fatigue accompanying the constant stress of residential instability, people without homes suffer from ill health at much higher rates than do people living in stable housing” (1997). In fact, those who experience homelessness are subject to conditions that can result in worsening of health or exacerbate existing chronic or acute illnesses, leading to rates of illness and injury from two to six times higher than for people who are housed (Wright, J. D. 1990).

Chronic medical conditions common to the general population (such as asthma, chronic obstructive pulmonary disease, diabetes, cardiovascular disease, and chronic diseases of the liver and kidneys) tend to be more prevalent among individuals experiencing homelessness and are typically more severe (Bonin E, et al, 2010). In addition, there is an increased risk for contracting and transmitting infectious diseases among those who live a transient and often communal lifestyle (Badiage, 2008). Rates of tuberculosis and MRSA are higher among the homeless, and easily spread in the shelter environment (HCH Clinicians’ Network, 2006). The prevalence of HIV/AIDS is three to nine times higher among persons with instable housing than in the general population (Song JY, 1999). Also, parasitic skin infestations such as scabies and lice, as well as dermatological conditions such as psoriasis, impetigo, seborrhea, nonspecific dermatitis, and cellulitis are frequently seen in the homeless population (O’Connell, 2004).

Most disturbingly, “although they are chronologically younger, the health and functional problems of middle-aged, homeless adults resemble those of geriatric persons in the general population” (Gelberg, 1990). In a review of the literature surrounding premature homeless mortality, J. O’Connell cites a finding that homeless persons are 3–4 times more likely to die than the general population, and that premature death is more highly associated with acute and chronic medical conditions than with either mental illness or substance abuse. Further review indicated that the average age of death in the for those on the streets is between 42 and 52 years, compared to average life expectancy of almost 80 years in the U.S. In his words, “the potential years of life lost are incalculable” (2005).

Not only are medical problems of the homeless more complex, but often there are multiple barriers in place preventing effective care. Many of these stem from the frequently nomadic lifestyle of the homeless, with practical concerns such as erratic food and water sources as well as more relational concerns such as physician discontinuity and therefore lack of follow up and lack of trust. The lifestyle of the homeless can also complicate matters such as transport, clinic access, and medication storage. Other obvious obstacles include history of mental illness, substance abuse, and physical or emotional abuse. An estimated 20–25 percent of the homeless population in the United States suffers from serious mental illness (NCH, 2009), while one in three homeless persons has an alcohol or drug problem (Burt, 1999). Disturbingly, one study reported almost 90 percent of homeless women having been violently victimized at some point in their lives (Bassuk, 1998). These and many other obstacles limit opportunities to follow an optimal treatment plan and consistently

increase homeless people's risk for complications of chronic illness and premature mortality (O'Connell, 2005).

Due to this mix of complex medical problems and persistent impediments, the delivery of health care to people without stable living situations must be approached using a comprehensive, multidisciplinary model. An integrated system of primary care, specialty care, mental health, substance abuse and social work is essential in order to prevent emergencies and improve health outcomes for those on the street.

### **Description and Rationale of the Project:**

The aim of the Independent Study Project (ISP) was to focus on comprehensive, multidisciplinary health care for those living on the street, or those recently on the street and now in shelters, respite care centers, SRO housing, or other similar facilities. The project included rotations at three different centers for medical care of homeless persons in order to obtain the most in-depth experience and understanding of current practice and available resources.

In addition to involvement with each specified organization, the ISP allowed experience collaborating with national and worldwide programs through attendance of the International Street Medicine Symposium, held annually to gather and share current practice updates and new developments in the field of caring for people without stable housing.

Throughout the year, and especially during the two designated ISP months, time was set aside for personal study of the resources available regarding care for people on the street.

### **Objectives:**

1. Acquisition of clinical knowledge and experience caring for homeless patients
  - Hands on experience with common diseases, common treatments, and how these diseases and treatments are handled on the street
  - Understanding of common barriers to health care and possible solutions
  - Medication issues specific to those on the street
  - Emphasis on street outreach, respite care, follow up from hospitalization, women's health, home visits
  
2. Appreciation of the multidisciplinary approach to caring for homeless patients
  - Working on-site with different medical practitioners: NPs, nurses, MDs, PAs
  - Working within different specialties of medical care: Internal/family medicine, women's health, psychiatry, emergency medicine, HIV care, respite care, transgender care, addiction medicine, pharmacy
  - Exposure to non-medical areas of care: Social work, mental health (non-psychiatry)
  
3. Opportunity for national/international collaboration
  - Working with wide variety of practitioners throughout the nation while planning and carrying out the ISP
  - Attendance of the International Street Medicine Symposium VII, Salt Lake City, Sept. 27-29, 2012.

- Maintaining involvement with the newly developed Street Medicine Institute
4. Develop understanding of program structure, organization, and resource allocation
- Comparison of three comprehensive organizations caring for the homeless: One governmental (BHCHP), one under a large private health organization (OSN), and one local private, grassroots start up (DWW-SBSM).
  - Comparison of which programs offer what services, and why. How money and personnel are utilized/allocated.

### **Methods and Plan:**

ISP time was spent as follows:

1. Operation Safety Net, Pittsburgh Mercy Health System, Pittsburgh, PA. One month clinical rotation (11/26/12-12/23/12). Specifically:

- 16 nights on outreach throughout the city of Pittsburgh
- 8 half days on outreach
- 4 half days at Pittsburgh Health Care for the Homeless site at Wellspring Clinic
- 4 days total of home visits
- 8+ half days in Operation Safety Net walk in center (medical, social, housing)
- 3 hospital consults
- 1 evening at Severe Weather Shelter

2. Program for Homeless and Urban Poverty Medicine, Allegheny General Hospital, Pittsburgh, PA: 2 days in comprehensive primary care clinic specifically for homeless individuals

3. Boston Health Care for the Homeless Program, Boston, MA. Two week clinical rotation (1/14/13-1/27/13). Specifically:

- 1 day Mass General Hospital primary care clinic
- 2 days Boston Medical Center primary care clinic, one day focusing on HIV patients
- 1 day Pine Street Inn primary care clinic
- 1 day Kensington House primary care clinic focusing on addiction medicine
- 2 days at Barbara McInnis House (Respite Care Center)
- 1 day home visits with Dr. Munson
- 1 day Street Clinic at Mass General Hospital
- 1 day street outreach with Dr. O'Connell

4. Doctors Without Walls-Santa Barbara Street Medicine, Santa Barbara, CA. Two week clinical rotation (12/31/12-1/13/13). Specifically:

- Monday night meal and clinic in Isla Vista (x2)
- Tuesday Underserved Medicine Seminar lectures (x2)
- Wednesday night Pershing Park clinic and mobile clinic (x2)
- Thursday night Alameda park clinic (x2)
- Friday Women's Free Homeless Clinic (x2)

5. International Street Medicine Symposium VII, Salt Lake City, Sept. 27-29, 2012. Attended the three day conference

6. Self study of available clinical resources, as detailed in appendix below

### **Summary of Major Experiences:**

#### *Operation Safety Net, Pittsburgh, PA*

Operation Safety Net (OSN) was founded in 1992 by Dr. Jim Withers and Mike Sallows, with the intent of providing medical care to Pittsburgh's rough sleepers wherever they called home- be it in alleyways, abandoned buildings, along the riverbanks or stadium, under bridges, or beneath overpasses. OSN is one of nation's first full-time street medicine programs and is still considered a leader in its field and a driving force behind the development of the Street Medicine Institute, a non-profit dedicated to furthering the practice of medicine for those sleeping on the street. OSN consists of roughly a program director, one medical doctor, two part-time nurses, 2-3 case managers, 2-3 outreach workers, one housing program director, an AmeriCorps employee, and numerous volunteers. Together, they have housed 850 chronically homeless people over the last nine years.

Although it has branched out into housing and other case management programs in recent years, street medicine is what OSN is at its heart. This type of medicine is not primary care, necessarily, but outreach and basic aid provided in the hopes of bridging healthcare to other sites with available resources and trained medical and mental health doctors. Dr. Withers and his staff have written an operations manual defining street medicine, which can be found in the appendix. However, I would like to describe the nature of my involvement: We set out to cover a portion of the city by foot each night, during the time housed or sheltered persons are indoors, with a multidisciplinary team consisting of a at minimum a medical clinician and formerly homeless individual as a guide. More often than not, the team also included mental health personnel, medical students, and nurses. A regular schedule was in place: Downtown Monday night, Oakland Tuesday night, Northside Wednesday night, and Southside Thursday night. We encountered both male and female homeless individuals, most middle aged, although sometimes they were much younger. Most were African American or Caucasian. Some were obviously struggling with substance abuse, some had very prominent mental health issues. Some nights the team would walk the streets merely looking to touch base with familiar faces, or trying to make connections with those newly arrived in the city. Other times, we specifically sought certain individuals out, looking for those we knew were currently at risk for health complications or freezing. Once found, we would then assess them, examine as appropriate (or as much as they would allow in the cold), provide what medical care or medications we could, and come up with an appropriate follow up plan. I wore my feet out doing this each night, but created so many interesting and lasting impressions.

I will never forget the places we explored while trudging alongside Mike our guide. They were parts of the city that no one else focused on: the edges of Heinz stadium, under bridges and overpasses, across freeways, along the railroad tracks, and in subway stations. We always stopped and noted who was sleeping over the warm pad of concrete in front of Sally Beauty supply, created by a vent somewhere below and allowing one lucky sleeper to stay

warm even on bitter cold nights. I left with a view of the city that almost no other visitor could have. It was maybe darker and more disturbing, as some of these places showed evidence of poverty at its worst and were occupied by IV drug users, but also very realistic and not without some hope.

That hope mostly came from the realization that we were meeting people where they were. Those outreaches were home visits in a sense, of a different type than normal, but no less real. I remember campsites and sleeping areas that were sometimes very intricately set up, sometimes very messy. One had a chair and bookshelf filled with books set up neatly outside. We always treaded lightly and respectfully. I loved the continuity that came with these home visits: seeing someone in clinic, then delivering sleeping bags to them and listening to their lungs at their tent near the tracks. I believe it was effective too, as I remember talking to people in their sleeping bags at the river's edge, then seeing them in the walk-in center the next day getting some sort of medical care or getting connected into social work. Notably, we were routinely thanked for coming out at night and for caring. It was very humbling.

Home visits to recently housed individuals were a large part of my time in Pittsburgh as well. What I saw during those visits often surprised me. More often than not, the individuals were still struggling, teetering on the brink of relapse into homelessness again or whatever addiction they had picked up along the way. Or maybe still dealing with debilitating mental illnesses. There was a gentleman we visited twice. He had a lady friend whose other boyfriend, when out of jail, came and beat him up, breaking his ribs. He had several chronic medical conditions, but was confused about how to take his medications. Most notably, he was an alcoholic and continued to drink after he was placed in the small apartment. I remember visiting him in his small cramped space and noticing a tiny pill perched on the edge of his TV, near the little metal version of his favorite car. It was his emergency pill, a little benzodiazepine, placed there in that prominent spot in case he didn't drink and started getting the shakes, or worse. I'll always remember that little shrine on top of his TV.

I had many, many other interesting experiences while at OSN. I was able to accompany Dr. Withers on several hospital consults, trying to make connections with a homeless gentleman who had been stabbed. I spent many mornings in the organization's walk-in center, helping to stock the most relevant medicines and taking medical consults as they came in the door. I remember distinctly trying to help someone switch his Medicaid benefits from an outside state to Pennsylvania. I don't think I have ever felt so lost while on the phone, nor understood how difficult it is for some people to access their benefits. I am eternally grateful for social workers and case managers. I was lucky enough to visit OSN's very own housing program, which takes many street individuals who have failed other housing attempts. This program is the end of the line, so to speak, and attempts to hold onto individuals no matter how difficult their behavioral or mental health issues may be. The patience and work to accommodate people's needs was unparalleled. I remember one long-time street gentleman who had just come inside, but would only sleep on the floor of a staff member's office. They let him sleep there as long as he wanted. Later in the month, I found out just how hardy Pittsburgh residents are. The severe weather shelter of OSN opens when the temperature drops below 25 degrees (for comparison, Santa Barbara warming centers open below 40 degrees...). There is a hotline to determine whether it is open or not, and persons do not have to be clean to enter. I was able to go several nights, and see patients



with the nurse practitioner on duty. It was a great experience and I recognized many rough-sleeping individuals I had previously seen on rounds on the street or in their camps.

One main reason I chose to go to Pittsburgh during winter was the memorial service which occurs annually on December 21<sup>st</sup> (the longest night of the year) in order to honor those who have passed away on the street over the past 12 months. It is what I remember most from my time with OSN as an undergrad. Several years ago, Dr. Withers had negotiated a space under an overpass for plaques commemorating those street folk who had died. Interestingly, when we pulled up to get ready for the service this year, white lettering with the words “stop here” were sprawled after the most recent name on the wall. I do not know who the author was, but I think I agree with the sentiment: we have had enough of people dying outdoors, let’s stop here. On the night of the service, it was biting cold. We listened to several staff members recount stories about the friends they had lost, we sang Amazing Grace. Then one formerly homeless gentleman read a poem he had been asked to prepare for the occasion. I marveled at how well spoken he was, how he conveyed the emotion present in the poem. I was startled afterward though when he began a loud outburst, shouting, “I am the man who killed Osama Bin Laden!” It hit me then: We as people are so fragile. Even after being housed, after having pulled things together enough to compose a powerful poem, one may still be on the border of losing it again, teetering. I saw him later, praying over the names on the wall in the dim light. It was a powerful night, full of unpredictability and rawness despite the fact that it was a programmed event.

*Program for Homeless and Urban Poverty Medicine, Allegheny General Hospital, Pittsburgh, PA*

While in Pittsburgh, I was lucky enough to get to work with Pat Perri, former Street Team doctor for BHCHP and Liz Cuevas, former internist for BHCHP. They are a husband and wife power duo, working to create a new, comprehensive health system for the city’s Northside poor. Specifically, they are building a primary care medical home exclusively serving homeless patients, focusing on the high utilizers of the health system in the area.

One man they followed had 13 ER visits and 6 long hospitalizations in the span of a year and a half. He spent much of that time admitted. On chart review, the cost was astronomical. At his initial intake visit, he spoke of a pulled muscle, difficulty catching breath, bright red blood with his stool, and itching on his stomach and legs. He had a medical history including HTN, atypical angina, syncope, and osteomyelitis. He was staying in a transitional shelter at the time, but two years ago had missed getting his bed, and so stayed out all night resulting in frostbite that required amputations. He was out of his medications and out of a job. Previously he was a cook, but had started drinking in 1995 and had since been consistently struggling with alcoholism, his longest period of sobriety being 4-5 months. Out of touch with his family, without housing, in the throes of a long-term addiction, and in poor medical health, this patient was a recipe for disaster and frustration and neglect. This is the type of patient though that Pat, Liz and AGH are seeking out, whose needs they are trying to encompass with comprehensive care and a team approach. And with persistence and patience, this is the type of patient they are starting to make progress with. How do they do it? They call people as their appointment times approach, helping them access free phones so they have no excuse to be out of contact. They wait for them if they are late. The nurses talk with the patients extensively upon arrival, then speak with the doctor regarding what issues might arise and be most pertinent to address. The doctor listens, and is allowed an hour to see a patient. Motivational interviewing is used effectively to help the patients

themselves come up with a plan. They refuse to use the word “non-compliant” but chose to look further and ask “why?” instead. When finished, the doctor returns to brief the nurses on what was discussed and what future steps were decided upon. And then the nurse, for sake of understanding and further reinforcement, goes back in and reviews the plan with the patient. Then the team pursues the follow up plan, with phone calls and petitions to the hospital or whatever agency they are working with, in order to achieve the decided upon goals and keep the patient in and out of the hospital. Most notably, Allegheny General Hospital actually funds this medical home, because they can *see* it saves money (this is not without a great amount of work beforehand to *make* them see, however...). I loved this clinic, and learned more in two days than I thought would be possible. I hope to be able to emulate the model someday.

*Doctors Without Walls-Santa Barbara Street Medicine, Santa Barbara, CA*

Santa Barbara Street Medicine–Doctors Without Walls (SBSM-DWW) is a non-profit organization founded in 2005 by three family physicians dedicated to providing free, volunteer medical care to the most vulnerable of Santa Barbara County. I was lucky enough to be present at the organization’s inception, and have watched it grow from a small grassroots movement into a powerful force in the community, providing consistent health care for those living on the street and pushing for progress toward a social justice model of care for those they serve.

Practices have changed drastically since I was a UCSB student volunteer for the organization. Previously, there was only one clinic per week accompanying a church dinner and street rounds in the surrounding Isla Vista town. Now, there are three outdoor clinics per week, comprehensive and reliable street outreach in the downtown area once per week, a full-fledged women’s clinic three times per month, and an annual seminar on underserved medicine run by DWW-SBSM director Jason Prystowsky. The team of student volunteers is numerous and strong, handling multiple facets of the organization, including public relations and monthly newsletter, Companion Care (partnering with homeless individuals to get them to connected into appropriate care), volunteer coordination, program coordination, and scribe services. I was amazed by the work they do, and felt privileged to be able to spend time with them again.

Some of the most interesting parts of their program are the clinics they run in the city parks of Santa Barbara at night. I have seen nothing quite like them, and was extremely impressed with the efficiency and sophistication in which they carry out medical services for the homeless. Students arrive early, setting up 3-4 portable tables- one for triage, one for vitals, one for MD care and treatment. On the last table sits the pharmacy- the most well organized backpack of medications I have ever seen. It is carefully labeled, with laminated sheets detailing where everything lies. Medications are mostly funded by the monetary donations received by DWW-SBSM, and a list of each backpack’s contents can be found in the appendix, as I find it interesting to see what each street medicine organization considers worth carrying.

Seeing patients in this environment was remarkably easy, and was striking in how much it reminded me of providing primary care services in a normal clinic with four walls. We were present at the same time each week, with opportunity for patient continuity (as much as possible with a more transient, mobile population). We had adequate lighting, space to exam patients if needed, nursing, physician and mental health staff, and access to the most

commonly needed medications. The only differences were the fact that we were operating in a park, in the dark.

While working here, I saw patients with scabies, and was able to give the one time 200mcg per kg Ivermectin treatment becoming more popular among providers for homeless patients. Dr. Prystowsky introduced me to articles on the topic, showing slightly less rates of efficacy as Permethrin, but without some of the compliance issues surrounding covering oneself neck to toes in ointment for 12 hrs while on the street. I also saw patients with very common issues such as hypertension. One gentleman was given a new diagnosis and started on diuretic treatment while in the park. Other patients returned for the next dose of their prednisone taper, dealing with chronic lung disease and coming off of a burst of steroids. Even other patients came with abscesses, which Dr. Prystowsky was willing to drain if need be. As an ER doctor with significant prior experience working with MSF in disaster ridden areas, his comfort level was obviously higher than most doctors working with limited resources outside a clinic, and he and DWW-SBSM could be seen pushing the limits of what is possible on the street.

One other very notable aspect of the DWW-SBSM program is their Women's Free Homeless Clinic. Women sleeping on the street are the most vulnerable of homeless populations, and are difficult to provide with places of trust and continuity for their medical care. This particular clinic is held three times per month, and is almost entirely female staffed. Ladies come inside early morning, with access to laundry and dryer, showers, new clothes, and basic toiletry supplies. They are provided with lunch, cooked by a group of organic soup kitchen workers who create healthy meals, more delicious than anything I had tasted myself in some time. During the rest of the day, the women are invited to stay and rest. Basic medical appointments are available with a nurse practitioner, as are GYN appointments and mental health care. Each medical case is reviewed by the overseeing MD. Other modalities of care are also available, including acupuncture, Qi Gong, and Yoga.

I was amazed at the popularity of the program among the homeless women of Santa Barbara, and the progress that was being made with some of their care. I remember the medical director pointing out each lady individually and telling me how long it had taken them to come inside, be comfortable, and access care. Some of these women had severe mental health issues, and had taken years to trust the staff enough to enter, not to mention to talk and interact. These were the city's most vulnerable population, and the volunteers at DWW were patiently creating a space for them to feel safe, be cared for, and move toward improving their health in mind and body.

#### *Boston Health Care for the Homeless Program, Boston, MA*

The Boston Health Care for the Homeless Program (BHCHP) began in 1984 as one of the first Health Care for the Homeless programs in the country, with primary care and dental services offered at several local hospitals and shelters. In the years since, it has continued to expand, now providing services to homeless people at over 80 sites. BHCHP employs a staff of nearly 300 people, focusing on an integrated model with collaboration among health professionals and throughout the different care sites.

It was the continuity between providers and patients which was most impressive by far. BHCHP has organized their delivery of care so that providers are often placed on a multidisciplinary team, each in charge of a certain subset of patients. They are also required to work at a multitude of sites throughout the week. It was easy to see why this arrangement

is so beneficial. Patients see the same faces at the Mass General and Boston Medical Center primary care clinics, at the city's shelter based clinics, at Barbara McInnis House, on home visits, and during street outreach. They build strong relationships with their provider, or team of providers, and have a sense of ownership in their health care. When discussed among their advisory board, BHCHP was notified that this is the aspect of care most important to their patients. This set up also allows patients to have 24 hour access to competent, informed care without unduly burdening the providers. Someone who knows the patients and their history is on call daily from each team, allowing them to respond efficiently, maintain consistency and provide better care without sacrificing personal time or becoming overwhelmed. This continuity was my favorite part of the program: doctors providing primary care through the spectrum of locations, meeting people where they are at to provide better care.

Although the program's scope is too broad to adequately sample in two weeks, I was able to spend time in an arrangement of very diverse care sites. I spent several days in the Mass General and Boston Medical Center primary care clinics. There I saw common yet still complex cases of patients with type two diabetes, chronic ulcers, multiple admissions to the hospital, and with re-infection with new osteomyelitis. One gentleman I saw, with history of HIV and diabetes, had spent 270 days out of the last year in the hospital. There are no easy solutions for patients such as these, and even a comprehensive program like BHCHP has trouble keeping them out of the emergency department recurrently.

Barbara McInnis House, BHCHP's 104 bed respite care facility, is paramount to the program as a whole. It provides short-term medical and recuperative services for homeless people who are too sick for life in shelters or on the street, but not sick enough to occupy an acute care hospital bed. There are four teams of doctors, caring for 13 patients each. I was able to spend several mornings rounding with the respective teams, and was impressed with the complexity of cases they handled. These cases ranged from treatment for C. difficile, recovery post CABG operation, chemotherapy, detoxification (although not an official reason for admission), episodes of flu, and assaults. It was an indispensable resource to have, resulting in better care for the patient at much cheaper cost than would have been possible in a hospital setting.

As mentioned earlier, many care providers at BHCHP are placed on teams. One of those teams is the Street Team, consisting of two MDs, a nurse practitioner, and several nurses and social workers. These are the people primarily in charge of Boston's rough sleepers. They carry out home visits and street outreach, hold their own Walk-in Clinic at Mass General Hospital, and are one of the teams managing patients at the Barbara McInnis House (any one sleeping on the street usually gets admitted to their care). I spent one day visiting the apartments of formerly homeless individuals with Dr. Munson, the newest doctor on the team. Together we were welcomed into people's homes, performing what could be considered a normal medical visit complete with vitals, check up on symptoms, focused exam, and new prescriptions as needed. During the fall, they gave flu shots at these visits, and plans are in place for introducing blood draws and iPads for medication reconciliation and record keeping in the near future (for now, notes are written upon returning to the office). These visits are billed appropriately and the program is reimbursed for them. Street Outreach with Dr. O'Connell was remarkably similar to the home visits, except that the people's homes happened to be located on the side-walk or in the train station. Less medical attention was given, obviously, but connections were strengthened and new contacts made.

Most importantly, encouragement was given to come to the Mass General Hospital Walk-in Clinic, held every Thursday morning by the Street Team. At the Walk-in Clinic, they welcomed people with breakfast and took care of many of the needs unable to be addressed outdoors- refilling medications, checking lab results, or dealing with complicated social work issues. Dr. O'Connell, Dr. Munson, and Suzanne the nurse practitioner saw patients who had been coming to this clinic for years, each of whom considered the team to be their primary medical caregivers. One couple came in specifically to say goodbye to the team, as they were leaving Boston for good and traveling to warmer weather. They had been with the program since it's beginnings, and I am not sure who was more saddened by the move- the couple or the team. I saw Dr. O'Connell sneak out in between clinic visits in order to take a photo with them and say goodbye. My time in Boston and with the Street Team was incredibly informative and fun, and I left wanting to be BHCHP's newest hire.

### **Discussion:**

These past several months working in Pittsburgh, Santa Barbara, and Boston have certainly provided me with knowledge and experience; however, they have also given me reason and ample time to consider certain issues and questions surrounding the way we care for the underserved, specifically those living in poverty on the streets. Some of these are more philosophical, some very practical, and others quite personal.

What exactly is the best way to care for homeless persons? More specifically, as providers concerned over the health and well-being of these people, is our most important job bridging people to normal primary care centers from the street, or providing them with special primary care services in clinics, or providing them with primary care while on the street? Of all questions, this one was most persistent for me. It is an important question, too, since it determines how we use our personnel, our money, and our limited resources. I was lucky enough to work with several types of programs, each exemplifying positive aspects of their respective type of care. I consider OSN to be a bridging program. They have a very focused, direct approach to identifying rough sleepers, providing immediate needs, and setting them up with longer term medical and social resources. They have been extremely successful in getting people off the street this way, and their program remains relatively sustainable with the available funding. The medical providers on the street also carry a certain protection in this type of bridging role. They are able to maintain their position of encouragement and understanding, without having to deliver some of the stern decisions regarding pain management or other issues in treating someone's chronic illnesses. It is a way to separate oneself from the establishment and maintain invaluable connections with vulnerable patients. However, it does not come without a cost. In that separation, there is a gap between providers into which some of the homeless patients fall. Miscommunications- including confusion over prescriptions, confusion over who is providing what service, and confusion over where to go even- are all more prone to occur. The end result is people falling through the cracks.

So are we to work instead toward a model like that of Pat Perri at Allegheny General Hospital, focusing on primary care services specifically tailored to homeless individuals? In articles on premature mortality of the homeless population, Dr. Jim O'Connell has frequently described homelessness as a co-morbidity, not merely a circumstance in their lives. I believe this is worth noting, and that traditional health care providers are ill equipped to respond to

it as such. Dr. Perri's clinic is based off of the Positive Health Clinic, a comprehensive medical home model for HIV patients located in the same building. This clinic is highly successful, with visible cost saving and effectiveness. Limitations apply to this model too, however. Significant backing must be available, and until resources can catch up to demand, there will always be limits on how many can be accommodated. Dr. Perri's clinic operated one half day a week while I was present, with 4 patients being seen per half day. Although providers saw patients outside in clinic shelters, no outreach was set up as of yet.

Maybe the best answer for now is a mixed model, with comprehensive primary care specifically for homeless persons across the spectrum of care settings, including street outreach. I do believe this is where most organizations are heading; however, resources are slim and the cost of carrying out this type of program on a large scale is high. BHCHP is one model that is succeeding, and many others are following in its wake. For now though, we are left with providers in different cities, working with different homeless populations, different amounts of time available, and different amounts of funding. The answer of how best to care for the homeless population will likely be best answered individually after investigating the needs of one's community and the resources available. We will likely need both programs focused on outreach to the street, and programs focused on providing primary care to those living on the street. I am simply glad I had an opportunity to work with both.

One other more philosophical issue deserves attention, and that is the ethics of treating people on the street. This issue is relevant to all the organizations that I worked with, but maybe applies more so to those attempting to provide primary care outside of a traditional clinic. There are positives to this approach, definitely. Remember, for example, several of the patients seen by DWW-SBSM in the park. One man was started on a diuretic for newly diagnosed hypertension, one man was maintained on a prednisone taper, and one was offered an incision and drainage for his abscess. The benefits offering these treatments in the park can be great- access to care is completely eliminated, and the patient probably gets treated much sooner than he would have otherwise. However, what happens if something goes wrong? What happens if that man does not follow up and get his electrolytes and renal function checked? We were leaving much to chance. What happens if the other man runs out of his taper, or takes too much? What happens if the other man gets a worse infection, or never comes back to have the packing removed? Probably nothing, or at least nothing worse than would happen if that individual were treated in a normal clinic. It is worth remembering though that we are treating people with primary care issues, without the support or follow up structure of a primary care clinic. Sometimes I look at the confidence of our providers pushing the limits, and wonder whether or not this level of service is sustainable. What is acceptable to do in this field of medicine? What is appropriate to prescribe? And how much of that should depend on who the leader of the program is? Street medicine is about removing barriers, but there will always be shortcomings in the quality of care. Should we accept this standard because we are treating people living in poverty? Is this an ethical position to take? Or should we withhold from attempting primary care until we can bridge someone into a clinic? I understand the difficulty in providing care to those on the street, and think the attempt at managing disease wherever possible, even in a park, is worth it. However, we must be careful to be striving to improve our shortcomings and minimize those risks.

Some issues I encountered were very practical, such as those surrounding billing. Consider the efficiency of the Boston Health Care for the Homeless Program. The program

derives approximately 80% of its budget from Medicaid/Medicare and the other 20% from federal grants, private grants, and philanthropy. The program itself was built a little differently than most, dictated primarily by the surrounding community and the unique political and healthcare climate in Massachusetts. After the initial round of grant funding provided by the government, most sites became Federally Qualified Health Centers. Rather than sending nurses on outreach and home visits, BHCHP sent doctors and nurse practitioners to do the care, per the communities' request. Unlike nursing visits, BHCHP could bill for these MD and NP visits, therefore generating an income. Factor in the presence of the Massachusetts health care system (MassHealth had full expansion through the state in 1996), whom BHCHP can bill for the majority of their patients, and it becomes even more evident how BHCHP can operate sustainably. In addition, Barbara McInnis House is a very consistent source of income. Through a special Medicaid project, BHCHP can bill the government for up to 5 visits per day, per person admitted. With these considerations in mind, the size of BHCHP makes more sense, and it is easier to comprehend their vast resources. Most other programs serving the homeless are simply not set up this way, and we have lots to learn from them in terms of creatively searching for other sources of funding.

Other practical issues include specific treatment conundrums. The most vexing for me personally was diabetic patients with lower extremity ulcers. How are we to keep people living on the street with diabetes healthy? How are we to treat infected ulcers, or osteomyelitis, with long term IV antibiotics if the patient does not have a home? Why are there not more respite centers like Barbara McInnis House for cost-effective treatments of this kind? Will we resort to letting people revolve through the doors of the emergency department until it becomes worse enough to need amputation?

One other practical realization hit me particularly hard during the past several months: The homeless street culture has a significant problem with illegal drugs and prescription narcotics. This is a simple observation, of course, but never have I been so well aware of the issue. I know the difference between Suboxone and Methadone. I am aware of the drug trafficking outside in the methadone maintenance clinic lines, with the "Trifecta" of Methadone, Clonidine, and Klonopin being in high demand. If Neurontin is added (a drug I'd previously considered benign without a street value), it creates a mild, sustained high. I now know that cold urine warrants a urine analysis to make sure it is actually urine, not grapefruit juice. Most saddening, I have seen heard the pattern of progression to IV drug use repeated again and again: They began with Percocet 30s; then moved to oxycontin and started crushing it. When that wasn't enough, they progressed again to heroin (only sniffing), then eventually found themselves injecting heroin into their veins. I know it has made me more wary of opioids, and highly desirous of developing ways to best combat the issue.

Occasionally, in treating homeless patients over the past several months, I have come across situations that are hard to handle personally. One in particular involved a patient in Pittsburgh by the name of KS. She was a middle aged Caucasian woman, often found sitting on the bench with her belongings at a bus stop near OSN. She stayed the nights in a women's shelter, but often came to the Wellspring Health Care for the Homeless Clinic staffed by Dr. Withers every Thursday. KS was a very well spoken woman, very pleasant to talk to. She had mild hypertension, for which she came to clinic and was well controlled. She also, however, had a very large right facial mass. It was ill defined and covered the majority of her right face, distorting features and preventing her from opening her right eye. There was an ulceration in the center, which I could tell had been present for some time and was

continuing to grow. A workup had been done at one point, with a biopsy that was inconclusive. Obviously a significant problem for her, and also potentially a malignancy, it was important to have her seen again by specialists in the hospital. However, she refused to go, stating at each clinical visit, "It's shrinking little by little every day." Sound in mind otherwise and very clear in her denial, we were unable to force her to seek care, despite trying repeatedly. And so, all we could do was walk by and said hello, as she sat with her things in the bus stop. I do not know what has happened to her since, but hope that she has changed her mind. That situation was difficult for me, as it would be for anybody. There have been many others- a homeless schizophrenic lady in the hospital clearly denying treatment for ovarian cancer, the white haired older lady with bad congestive heart failure and leg edema, sitting in the Boston South End Station refusing for years to come inside. It is never easy to have a medical treatment available for someone in need, only to have them deny it for some unfathomable reason to us. We are not trained in how to handle this as physicians and although I know these will not be the last situations of their kind, I still sometimes feel at a loss in how to deal with them.

### **Future Directions:**

As I assess how to proceed in my pursuit of a career in homeless medicine, I realize that as doctors we must re-evaluate what we are doing constantly. There was a paper published this year in JAMA (Baggett et al), detailing the shifts in cause of death over a 15 year period in Boston. This study compared BHCHP data from 1988-1993 and newly collected BHCHP data from 2003-2008. Most notably, the all cause mortality rate among homeless adults in Boston remains high (9 fold higher in 25-44yr olds, and 4.5 fold higher in 45-64 yr olds) and not statistically changed since 1988-1993, despite a major expansion of clinical services in the interim. This is huge. When Dr. Jim O'Connell spoke at UCSB's Underserved Medicine course this March, he placed a photo on the screen of a group of his patients: young homeless individuals under the Longfellow Bridge, about 10 years ago. They looked happy and healthy, vibrant and colorful, glad to be together. He then proceeded to explain that only one of those individuals remains living today. The rest have gone on and left us, the end result of abject poverty and its effect on health.

What are we doing wrong? The data from the study is interesting. There actually was a significant 15% decrease in deaths due to natural causes when compared to the prior study, much of which may be attributed to the introduction of HIV therapy and reduced instances of death from AIDS. However, this decrease in natural cause mortality was offset by a 3 fold increase in deaths due to drug overdose (16.8% of total cohort), 80% of which involved opioids, and a 2 fold increase in deaths due to suicide. This has changed the way homeless health care providers think, obviously, and in the words of the authors, "Drug overdose has replaced HIV as the emerging epidemic." This warrants increasing interventions to prevent and reverse drug overdose, and as the paper suggests, we need to work harder to promote integration of psychiatric and substance abuse services in to primary care. However, it remains that cancer and heart disease prove to be major causes of death, accounting for about 16% of total mortality in the cohort apiece. This is important too, and we must not overlook it. Malignancies of the trachea, bronchus, and lung made up almost one third of the cancers. With nearly 80% of the homeless population smoking cigarettes, compared to only 20% of the general population, we may need to begin concentrating our efforts and



interventions in the area of smoking cessation, too. Overall, we must not lose hope and think our work is futile, but we must re-evaluate, constantly, always asking ourselves which of our methods are ineffective and what we can do better.

## **Conclusions**

If I have learned anything, it is that a multidisciplinary approach to caring for people on the street is paramount. It truly does take a village. We had students, nurses, medical assistants, doctors, mental health workers, and a chaplain in Santa Barbara. In Pittsburgh, we had Mike Sallows as guide, case management, nurses, students, and AmeriCorps workers. Boston has its comprehensive teams. I cannot imagine it functioning otherwise. Even with this approach, the work is often tedious, and not always easy. Productivity is not up to what health systems would consider the norm for this day and age. Some may not view caring for these homeless as an “efficient” use of time and training. However, we are dealing with people, often ones who are forgotten and neglected. What else are we here for as doctors? I know I will use the knowledge gleaned in the last several months wisely, with the goal of eventually being able to care for homeless persons across the whole spectrum of locations, from hospital and clinic to the home and the street. I would love that continuity. Many of the providers I worked with had heard of this quote from Lao Tzu, and had posted on their walls or other practice sites. I found it relevant:

Go  
to the People;

Live among them,  
Love them;  
Learn from them;

Start from where they are;  
Work with them;  
Build on what they have.

This how I have been taught that we should care for those on the street, and I was privileged to witness it in action.

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## Appendix:

### Homeless Healthcare and Street Medicine Read List

#### Books:

1. O'Connell JJ (Editor). *The Health Care of Homeless Persons: A Manual of Communicable Diseases and Common Problems in Shelters and on the Streets*. Boston Health Care for the Homeless Program; 2004.
2. McMurray-Avila, M. *Organizing Health Services for Homeless People*. Nashville, TN: National Health Care for the Homeless Council; 1997.
3. Not All of Us are Saints by David Hilfiker
4. Souls in the Hands of a Tender God by Craig Rennebohm
5. The People of the Abyss by Jack London
6. Nickel and Dimed by Barbara Ehrenreich
7. Urban Injustice: How Ghettos Are Formed by David Hilfiker
8. Housecalls: How We Can All Heal The World One Visit At A Time by Patch Adams
9. Pain, the Gift that Nobody Wants by Paul Brand and Phil Yancey
10. The Pedagogy of the Oppressed by Paulo Freire
11. Addictive Thinking by Abraham Twerski
12. Pathologies of Power by Paul Farmer

#### Articles:

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12. To Dance with Grace: Outreach and Engagement To Persons on the Street by Sally Erickson, M.S.W. and Jaimie Page, L.S.W
13. From the Streets, to the Emergency Department, and Back: A Model of Emergency Care for the Homeless by Susan O'Toole, RN and James Withers, MD, *Topics in Emergency Medicine, 1998; 20(4): 12- 20*.
14. Delivering Health Care on the Streets: Challenges and Opportunities for Management by Evan Howe PhD MPH, David Buck, MD MPH and James Withers, MD *Q Manage Health Care; Vol. 18: No. 4, pp 239 – 246*.

Still to read...

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### **Street Outreach Backpack Inventory Lists**

Operation Safety Net in Pittsburgh, PA:

*Pain Meds*  
Tylenol 500

Motrin 200/400/600  
Naprosyn 375

*Antibiotics*

Pen VK  
Keflex  
Bactrim DS  
Doxycycline  
Z Packs  
E-mycin

*Inhalers*

Albuterol  
Combivent  
Advair  
Flovent

*Cold Rx*

Sudafed  
Benadryl  
Tessalon  
Cepacol  
Claritin

*Miscellaneous*

Dilantin  
Glucotrol

*Eye/Ear*

Antibiotics, eye  
Ear meds

*Potions/Lotions*

Cortisone cream  
Antifungal ointment  
Antibiotic ointment

*Bandages*

Small and medium  
4x4s  
Tape  
Kling roll  
ACE wrap

*Vitamins*

MVI  
Iron  
Folate  
Thiamine

*Cardiac*

Norvasc

HCTZ

ASA

*GI*

Pepcid

Prevacid/Prilosec

Tums

Lomotil

*Other Supplies*

BP cuff, stethoscope, oto-ophthalmoscope, suture removal kit, gloves, hand sanitizer

Health Care for the Homeless Program in Boston, MA:

Wrist BP cuff

Thermometer

Portable finger pulse oximeter

Prescription pad

Cab vouchers

Bus passes

Gift cards to Dunkin Donuts

Dressings

Epi-pen

Narcan nasal spray