22nd Annual
Training Institute

CONNECTICUT COALITION to END HOMELESSNESS

Street Medicine:
Delivering Healthcare Without Walls

Connecticut Department of HOUSING

Dalio Education

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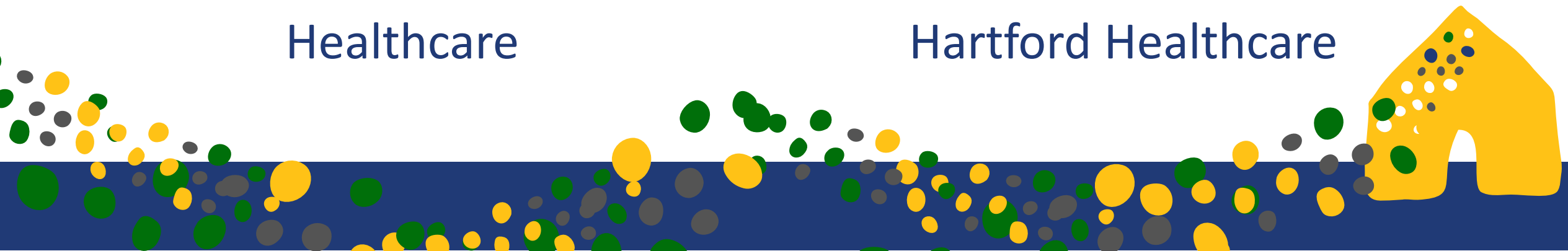
CONNECTICUT COALITION to END HOMELESSNESS

Street Medicine:
Delivering Healthcare Without Walls

- Kelly Toth, Hartford Healthcare
- Melinda Lodge, Hartford Healthcare
- Candice Rountree, Hartford Healthcare
- Dawn Filippa, Hartford Healthcare



Street Medicine: Delivering Healthcare without Walls

CT Coalition To End Homelessness ATI 2025

Presented by Hartford HealthCare Neighborhood Health & Street Medicine Team

Dawn Filippa RN & Clinical, Quality, and Safety Manager
Melinda Lodge PMP, Practice Administrator
Candice Rountree PA-C, Neighborhood Health provider
Kelly A. Toth APRN-BC & System Director of Neighborhood Health

PROUD PROGRAM MEMBER
GO TO THE PEOPLE
STREET MEDICINE INSTITUTE

Hartford HealthCare
Neighborhood Health

* We have no relevant financial relationships to disclose; Consent obtained for all patient photos *

WORKSHOP OBJECTIVES

- Introduction to Neighborhood Health & Street Medicine
- Patient Stories
- Trauma Informed Care
- Harm Reduction
- HOUSED BEDS Intake Tool
- Interagency Partnership
- Statewide Resource Review

Neighborhood Health & Street Medicine

Our mission is to empower and uplift individuals by bringing high quality medical, behavioral, and social services directly to Connecticut's most vulnerable, through harm reduction, street outreach, and neighborhood clinics. The program fosters a supportive environment promoting health, dignity, and well-being for all.

Mobile Clinics

- *Brick & mortar locations like soup kitchens, churches, and shelters on regular cadence*
- *All 5 Regions of Hartford HealthCare*
- *Services include point of care lab testing, family planning, immunizations, EKG, portable US, addiction medicine*
- *Anchor Clinics: Hartford currently; expansion to Norwich by end of FY25*

Street Medicine

- *We "Go To The People" meeting them where they are, such as encampments, parks, FastTrack*
- *Services include point of care lab testing, immunizations, portable US, addiction med, and wound care on NOVA (outreach vehicle)*
- *Currently in Hartford proper with expansion to Norwich in FY26*

Hospital Consults

- *Bridging gaps in care from inpatient to the streets by meeting them at the bedside*
- *Ensuring high risk individuals are closely followed after discharge*
- *Interagency collaboration to ensure safe discharge, coordinate shelter priority, and reduce ED and re-admission rates*

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Street Medicine Consult Service

Bridging the Gap from Inpatient to Outpatient

- Person experiencing homelessness (PEH) are some of the most complex patients in the hospital
- Chronic conditions, acute illness/injury, challenging social situations can lead to complicated discharge planning
- CT had a 13% increase in PEH since last year

Situation

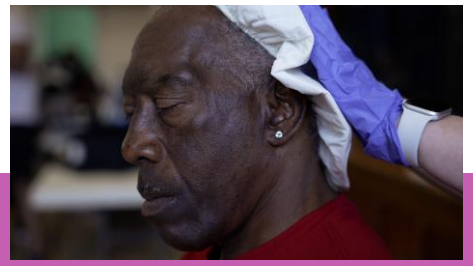
- PEH have high rates of ER use and hospital readmissions
- Inpatient medical teams are not well versed in creating care plans that match the unique barriers PEH face like access to meds or ability to make follow-up appts
- Gaps between inpatient and outpatient care are created and these pts are often lost to follow-up

Background

- Street Medicine consults provide comprehensive wrap around services reducing rates of readmission and ED use
- Consult service improves patient experience and reduces health care costs
- Lehigh Valley Health Network implemented a consult service resulting in $3.7 million in hospital savings in 2017

Assessment

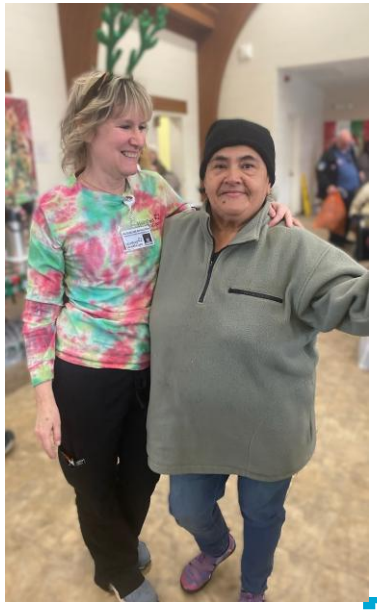
We Go To The People…And Learn Their Stories



"Nothing changes in the life of a homeless person unless you slow down and take time to earn trust and develop a lasting relationship. Consistency and presence are essential. Have coffee, play cards, share bits of yourself. Never judge.

Remember that people have lived through hell and listen carefully to their stories. With that as a bedrock, delivering health care might just be possible."

James J O'Connell, MD



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Andell: The Before

- 46 year old male with past medical history of schizophrenia, hypertension, gout, substance use disorder, and homelessness
- 1/30/25 Mercy House Homeless Outreach requested street medicine visit due to wounds on feet
- 1/31/25 Street medicine visit
  - Findings: Severe wounds with tissue necrosis and foul odor with month old dressings still in place
  - No longer mobile due to pain and swelling but declined going to the ED
- 2/1/25 Patient's friend called 911
  - Admitted at local hospital for sepsis
- 2/4/25 Patient underwent bilateral below the knee amputations
  - NH providers stayed in touch with outreach worker and hospital social worker for updates
- **Root cause of wounds --> FROSTBITE**

Wash: The Before

- 69 yo male patient with past medical history of homelessness, HIV, AUD, OUD, severe malnutrition, recent fall with left femur fracture, and depression

- Street medicine visit at hotel in February during cold weather program for medication refill

- Patient is part of Hartford CCT (complex care team) rounds
    - Hotel program ended and by April he was in the ED almost daily for OD's
    - Staff from area hospital started to notice a change in his affect – "it's like he's lost his light"
    - During CCT rounds in April, palliative care was mentioned

- 4/28 asked by CTHRA nurse to do a street med visit to discuss palliative care and EOL wishes
    - Patient also noted to have UTI requiring IV antibiotics from an ED visit a week prior as well as untreated femur fracture from a recent fall

- "How do you want your care?" conversation was had sitting with the patient at a bus stop
    - Now the patient had control of his healthcare

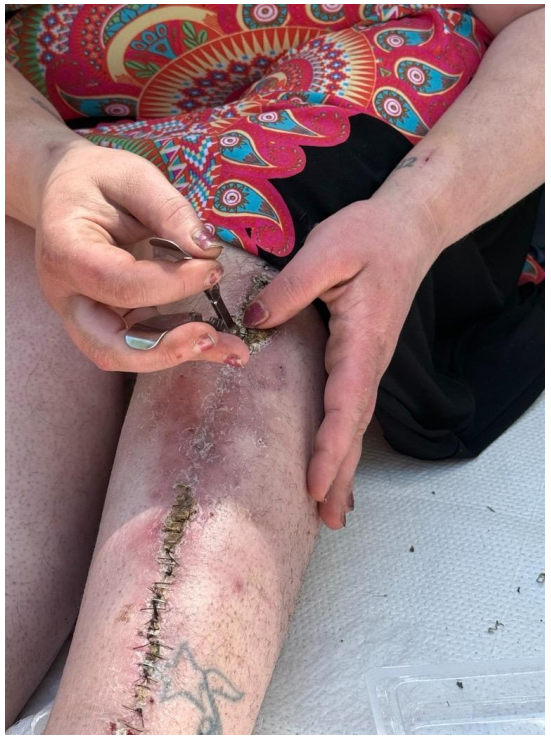
Jenna: The Before

- 33 yo female with past medical history significant for hepatitis C, SVT, preeclampsia, anxiety, depression, SUD, and surgical cut down & wash out of infected LLE wounds

- CTHRA nurse requested street medicine visit to evaluate LLE
  - Patient still had sutures and staples in place from Nov 2024 surgery at Bay State

- Patient very resistive to medical care but open to street med visit

- Four hours total spent during initial visit
  - Three surgical wounds: medial and lateral aspect of LLE, anterior aspect of left thigh
  - Roughly 100 staples removed, some sutures removed, and remaining suture loops cuts
  - Patient eventually requested to stop removal due to pain
- Plan was to return 3 days later to complete suture/staple removal
  - Instructed patient to soak crusted areas prior to next visit



What is Trauma

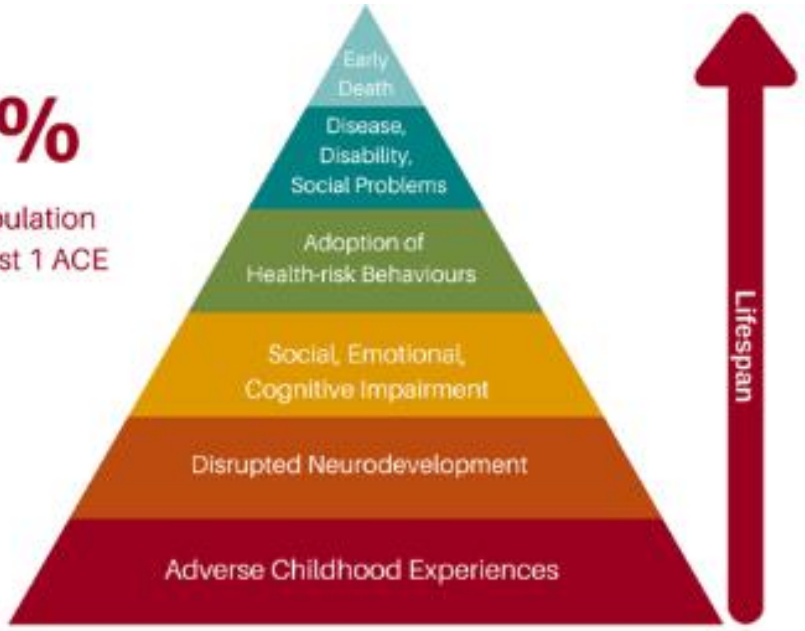
"Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects of the individual's functioning and mental, physical, social, emotional, or spiritual well-being." (SAMHSA)

- Trauma is a response to real or perceived physical, emotional, or psychological danger
  - Child abuse or neglect
  - Domestic violence
  - Sexual abuse/violence
  - Death or illness of loved one
  - Challenging family dynamics
    - Incarcerated family member
    - Parental separation
    - Exposure to violence or substance use
  - Divorce
  - Mental health crisis
  - Financial hardship
  - Loss of job or loss of home

- Trauma is heavily linked to poor health outcomes
  - 4 or more Adverse Childhood Experiences =
    - 3x more likely to smoke
    - 11x more likely to have IVDU
    - 4.5x more likely to develop depression
    - **16x more likely to experience homelessness**

67%

of the population have at least 1 ACE



*70/30 Campaign

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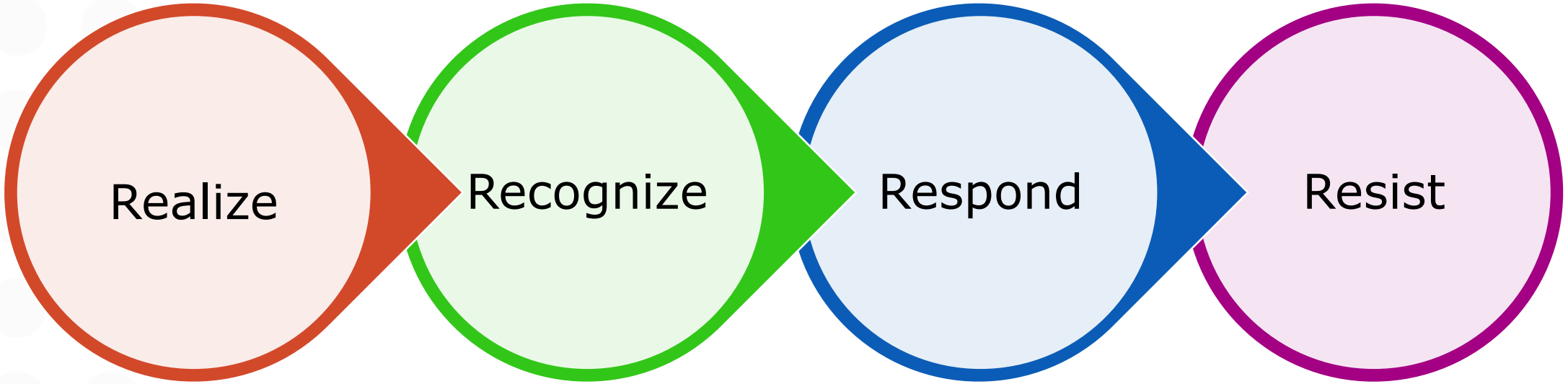
The Trauma of Homelessness

- Homelessness is not as simple as being “without housing”
  - Loss of home, community, stability, and safety
- Repetitive Trauma
  - Where do I sleep?
  - When will I eat?
  - Who will help me?
  - How will I stay safe?
- Impact of trauma
  - The world is no longer a safe place
  - Inability to trust others
  - Loss of control
  - Loss of human connection
  - More exposure to harm versus kindness
  - Hopelessness
  - Constantly in survival mode

Trauma Informed Care Delivery Model: The Four R's



- Understand the widespread impact trauma has on individuals and communities
- Acknowledge this impact
- Trauma shapes how individuals interact with the world around them

- Identify trauma in individuals
- Both overt and subtle signs & symptoms
  - anxiety, depression, fear, anger
- Recognize triggers like loud noises, small spaces, lack of privacy
- Use careful observation and active listening to create a safe and open dialogue

- Create a supportive environment with trust, choice, collaboration, and empowerment
- Shared decision making
- Provide physical and emotional safe space
- Foster recovery and growth

- Prevent further harm and re-traumatization
- Use a strengths base approach
- Address potential triggers
- Inclusive and culturally competent approach

Harm Reduction

Medical

- Patient identified health priorities
- Minimize negative health consequences
- Connect individuals to healthcare services

Examples:

Nicotine cessation therapies, Hep C and HIV testing, condoms, finger dams, oral dams, access to showers, body wipes, hygiene kits

High Protein shakes and snacks for caloric deficit

Mental Health

- Respect patient's autonomy to make decisions based on the resources provided
- Create safe and stigma free environment
- Don't require abstinence or strict adherence to treatment plans
- Low barrier access to medication management

Low Barrier Judgement Free Care

Substance Use

- Offer a safe space to obtain necessary overdose prevention and safe use supplies
- Easy access to STI testing
- Low barrier access to Medication Assisted Treatment options like buprenorphine induction

Examples:

Narcan, Fentanyl/Xylazine test strips, needle exchange, safe smoking and injection kits, safe use education

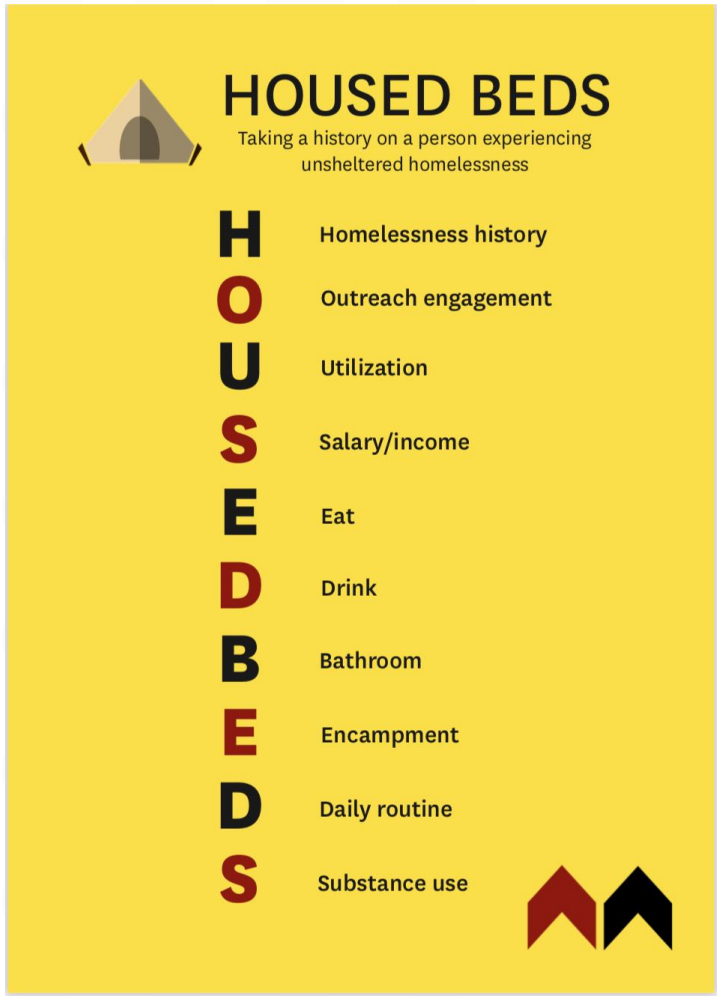
Environmental

- Minimize harm from prolonged exposure to elements
- Reduce risk of infection, dehydration, and preventable injury/harm
- Warning about impending severe weather

Examples:

Protective clothing like wide brimmed hats for sun protection or hats/gloves in winter, bug spray, sunblock, clean water with electrolyte packets, flashlights, and garbage bags to keep their space clean

HOUSED BEDS: A Clinical Listening Tool



H- Homelessness: History with homelessness and patient's definition of homelessness

O- Outreach: Other individuals/organizations engaged with the patient outside

U- Utilization: Engagement with health care (PCP vs ED use), social services, and judicial systems

S- Salary/income: Existing financial resources – SSI, food stamps, pan handle, sex work, sell things, side jobs

E- Eat: Access to and frequency of food intake

D- Drink: Access to and frequency of clean water intake

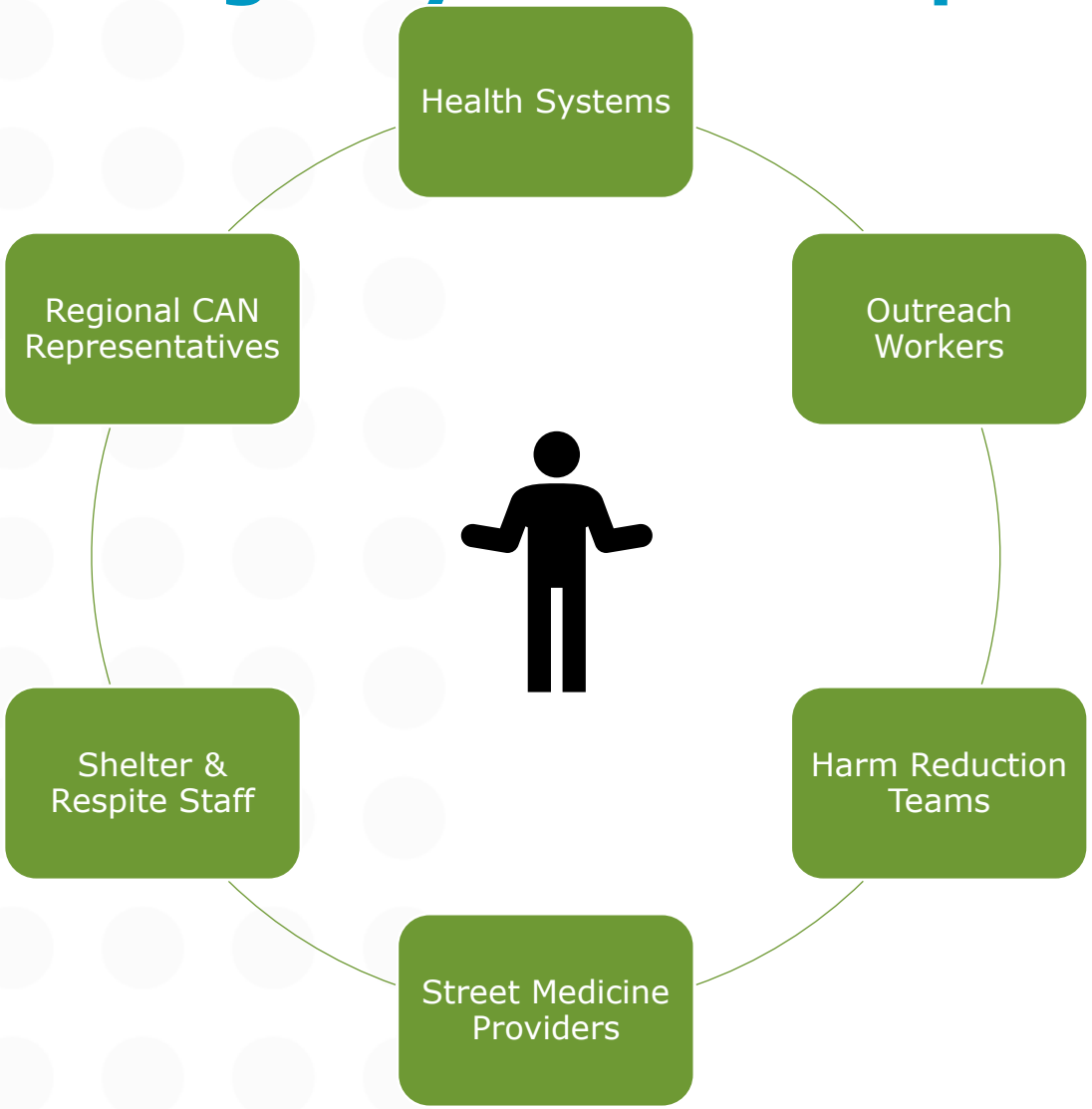
B- Bathroom: Access to toilet/showers

E- Encampment: Sleeping environment – tent, bus stop, alone, with others

D- Daily routine: Patient's daily routine (to support provider care and outreach)

S- Substance use: History and current use of substances, including overdose

Interagency Partnership for Patient Centered Care



- Cannot work in silos
- Bidirectional communication is key
- We are treating the person, not the problem so the plan has to make sense for the individual
- Remember it takes a village!

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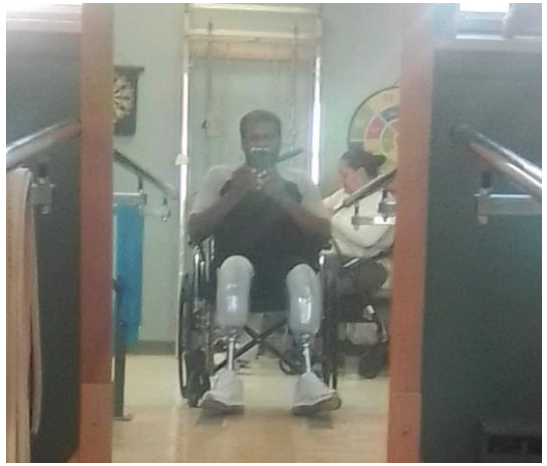
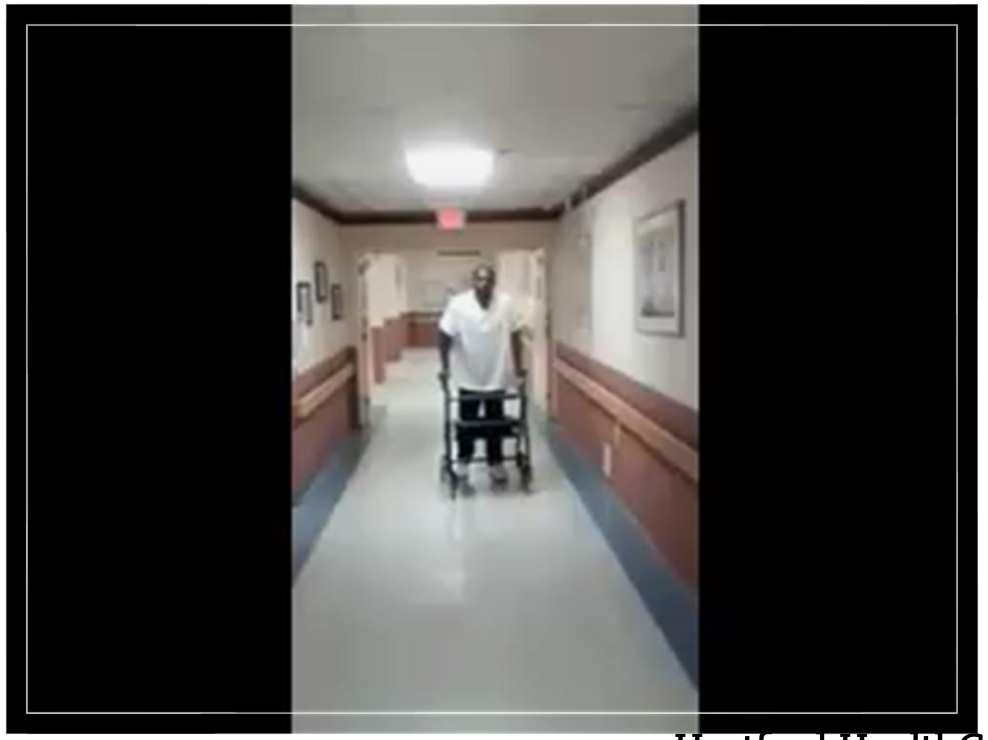
Andell: The After

- 2/13/25: Outreach worker voiced concern about plan to discharge to the street
  - Denied at STR facilities because he "did not meet level of care requirements" and because of unhoused status
- Over the next 24 hours nearly a dozen individuals from various organizations advocated and worked together for a safe discharge plan
  - Neighborhood Health, Hartford Hospital, Mercy House, Journey Home, Hands On Hartford, and St. Francis
- 2/14/25: Tentative plan was dc to Travel Inn motel with Hands On Hartford ensuring a handicap accessible room, but home health services denied the case due to no common area to treat the patient
  - Urgent meeting with NH director, St. Francis CM team, and Director of HH CM resulted in ICare SNF VP being contacted
  - Accepted at Westside Care Center in Manchester where he was met on arrival by his outreach worker
- Present Day: Andell remains at Westside. He has been sober since admission, improving with physical therapy, and WALKING with his new prosthetic legs! ***We are all working to ensure he has a safe place to go when he is discharged from STR.***





Wash: The After

- Wash was agreeable to be admitted for IV antibiotics, restart HIV meds, and addiction medicine support
- Patient was accepted at Leeway in New Haven
  - Residential care facility for AIDS patients
  - They do not discharge back to the street
- CTHRA nurse visited him on 5/9 and reported: *"Wash sends his love from New Haven! He is doing well. He was very grateful and humbled by all the care and love the collective group provided him. He said 'I didn't think anyone care. But a lot of people care about me. I got a whole team behind me.'"*

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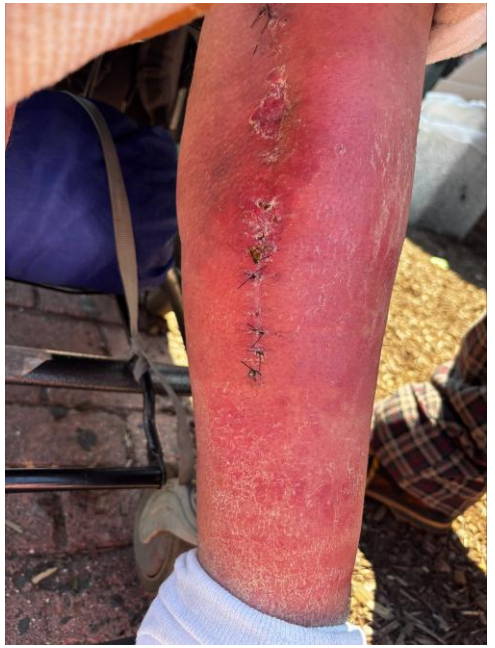
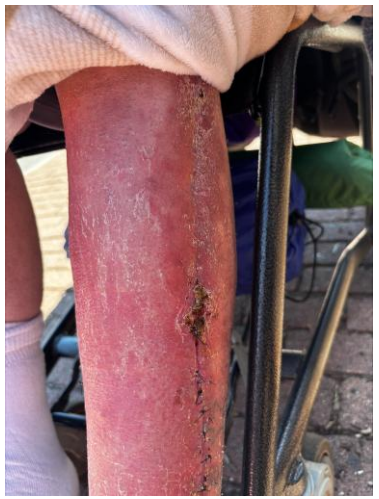
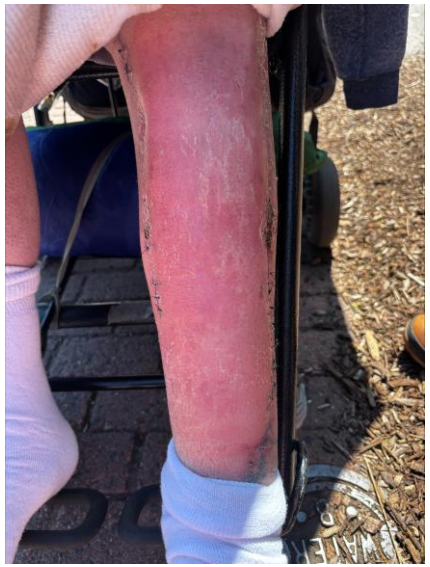
Jenna: The After

- Day of return visit patient had experience clearing of camp site by the city
- Patient was upset about the clearing, dope sick, and not in frame of mind for further removal of sutures/staples
- Discussion had about further removal being done in ED for pain control
  - Facetime with trauma surgeon who would help coordinate care in ED
  - Patient was agreeable to this plan however "not today"
  - Risks such as sepsis, loss of limb, and loss of life discussed
- Two weeks later patient now with evidence of significant soft tissue infection
  - Street med visit on 5/16 with increasingly edematous leg, pus like drainage from lateral wound, and hot to touch
  - 11 sutures successfully removed with several still in place
- Patient continues to have competing priorities and is not ready to go to the hospital despite risks to life and limb
- CTHRA and HHC Street Medicine will continue to follow & support







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Statewide Resource Review

Not all inclusive list but a starting point. Google your area, find out who is providing healthcare to the clients in your region! Network and develop partnerships!

Hartford area	Hartford Healthcare Neighborhood Health	NeighborhoodHealth@hhchealth.org 860-986-3078
Hartford area	CT Harm Reduction	860-263-8720
New Haven area	Cornell Scott Hill	203-503-3000
New Haven area	Community Health Care Van	203-764-9995
Central Area: New Britain, Wallingford, Middletown, Meriden	Community Health Clinic Mobile Health Units	860-622-1517
Bridgeport area	Southwest: La Guagua	203-330-6000
New London area	Generations: Mobile Health Unit	mobilehealth@genhealth.org 860-450-7471, option 2
Winsted/Torrington area	CHW: BETTY (Bringing Exceptional Treatment To You)	860-489-0931

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Thank You!

For any questions email info@cceh.org

Visit our website cceh.org