Zumbro Valley Medical Society

SERVING PATIENTS EXPERIENCING HOMELESSNESS:
A TUTORIAL FOR PHYSICIANS IN TRAINING

October 22, 2020
OVERVIEW
with
Mary O'Neil
Housing Stability Team Program Manager
Olmsted County, Minnesota

[Transcript]

Grace Johnson, Mayo medical student:

Okay guys, thank you so much for being here today. This is the first part in a series that the ZVMS is doing with the medical school on how to help patients who are experiencing homelessness. This is definitely a big issue in Rochester, but also wherever you practice. There are a lot of people who are experiencing homelessness in the United States and that number has gone up with the COVID pandemic and people losing jobs. This isn't something that we talk about very much in our medical education, but it's going to be really important. We're so happy to have Mary O'Neil here with us. Mary is a licensed mental health professional, with experience in social work and working with people who are unhoused. She is currently the housing stability team program manager for Olmsted County. Mary, maybe I'll just have you start off by telling us a little bit more about yourself, your background, and the kind of work that you do.

Mary O'Neil, Housing Stability Team Program Manager, Olmsted County, Minnesota:

Thank you for having me. I have been with Olmsted County for a little more than 20 years. Most of my experience with Olmsted County has been in adult behavioral health. That unit serves people with mental illness and substance use disorder. We were extremely involved with the civil commitment process, helping people access substance use disorder treatment, and simply case management for people with serious and persistent mental illness. I recently moved over to our housing department in February of this year to head up a new housing stability team. We are primarily focused on homelessness and addressing homelessness here in Olmsted County. It is a new team and it happened right before the pandemic hit Minnesota in March and nothing like a pandemic to build a team. It's been really a great experience for us and we're seeing lots of great successes just in the short time we've been together. So, I will go ahead and share my screen.

Mary O'Neil:

A homelessness definition, there is a little bit of difference between a federal homeless definition and state homeless definition, but for the most part, "literally homeless" means somebody who is living in a residence that is not meant for habitation. So, certainly people on the streets, in parks, camping, or living in a shelter, or people who have been homeless prior to entering an institution, a hospital, a treatment facility, places like that. People who would be deemed "imminent risk" are those who will likely lose their residence within the next 14 days and lack resources to obtain other permanent housing. And then "chronic homelessness" is really a federal definition. This is a homeless individual who has a disability and has been continuously homeless for 12 months or four separate homelessness

occasions within the past three years that total 12 months. The difference in definitions really does have to do with funding, so I won't go into detail around that, but it is really about funding and people who qualify for different types of housing programs.

Mary O'Neil:

Just a little bit of information around homelessness in Minnesota: The Wilder Foundation out of the Twin Cities does a homeless study every three years. It is a one-day study that is done throughout the entire state. The last time it was conducted was in 2018. What they found on that night is that there are 19,600 individuals across the state who are experiencing homelessness on any given night. That was an increase since the prior study was done. Children and youth represent almost 50% of that number. They did see an increase in older adults. When they did the ACEs [Adverse Childhood Experiences] questionnaire, 73% report one adverse childhood experience and 59% report multiple. So, you can gather some of the experiences that people who are experiencing homelessness have had in their childhood. 76% of the women have reported physical or sexual violence while being homeless. And, 77% of the adults have a chronic health condition. The number that did surprise me here was 24% substance use disorder. That seems a little low compared to what we're actually seeing in reality. But this also was self-reported, so it could be that they didn't want to share that information. And, 30% actually reported being employed.

Mary O'Neil:

A little bit more information around data, homelessness in Southeast Minnesota and Olmsted County: The CoC actually stands for Continuum of Care. This is a HUD-mandated regional planning group. There are CoCs across the country. If you are in Florida or Arizona, your states, as well as Minnesota, are divided up into CoCs. They're regional planning agencies to really focus on ending homelessness in that region. In Minnesota or in Olmsted County, excuse me, in Southeast Minnesota, our CoC is made up of 20 counties in Southeast Minnesota.

Last year in October of 2019, Olmsted County wanted to dig a little deeper into homelessness, particularly unsheltered homelessness, here in Rochester. So, we did a three-day registry, just simply, engaged people who were unsheltered, camping, people who are living in their cars, et cetera. We found 105 individuals who were unsheltered. We really did focus, because it was our first time doing it, we focused on single adults. We really did not look at families or children. We found 105 individuals were unsheltered. 35 of them were unknown to our provider network, so they were not engaged with our outreach workers. They were not engaged with our system at all.

The Coordinated Entry System is actually a database of information. We try to assess all people who are having housing crises or who are homeless. That information gets entered into this Coordinated Entry System. People are prioritized based on a number of factors. HUD-funded programs, housing programs, actually pull referrals from the system to get people housed who are most at risk or who score highest on this assessment as quickly as possible. So, 30 of those individuals were not entered into the system at all. What that evaluates to is that they are not on lists for housing referrals, so their access to housing is very limited. Seventy-five of those individuals have fallen off the list simply because they could not be reached, they could not be found. And, then, here is some data that differs from the Wilder Foundation study, 74% reported having serious mental illness and 71% with substance use disorders, which in my experience is probably better reflective of our community.

The Point in Time Count is something that HUD requires every January. It is one day, simply a snapshot of homelessness that is occurring on that day. It's done every year. What we found in our CoC, now that's the 20-county region, that 459 people were homeless on that day in January. Looking at our

coordinated entry priority list from July to September, there were 450 individuals on that list, so 450 people who are either homeless or in a housing crisis seeking housing. These are the ones that have been entered into our Coordinated Entry System, so we know there are a lot of there who have not been. Next week, October 27th through the 29th, we are actually conducting our second three-day registry. We plan to do this every year, so we can find/see some trend data. This time we really are going to expand our search to include families and youth.

Mary O'Neil:

I'm going to start out with an example of a patient that I actually accompanied and had some involvement with about a month ago and then I will reflect back on this example as I talk more about resources and tools that you can use as physicians. So, Larry, this isn't his real name, is a 68-year-old Native American. He's been in Rochester and homeless for the last four years, in and out of shelters, sleeping on the streets, basically anywhere he can find to sleep. He has a long history of substance use disorder. Alcohol is his drug of choice. I reference this just to get a sense of perhaps his background: all of his toes on both feet have been amputated. Now, I'm not entirely clear on why. He denied having diabetes and did reference at some point having some frostbite. So, I don't have a clear understanding of that.

When I met him, he had just gotten out of the hospital for a wound that he had on his foot that had been infected. He had spent a couple of days in the hospital and he was discharged with antibiotics that he was supposed to take three times per day. Then he had a follow-up appointment with family medicine to look at that wound again. The reason I had been seeking Larry, I didn't know Larry, certainly knew his name, he's well known in our community because of his alcohol use. Primarily, he has wound up in detox many, many times over the years. We were hoping to invite Larry to move into our Silver Creek Corner. It's a facility for people with chronic homelessness and alcohol use disorder, real chronic substance use. It really is a great facility that allows people to drink in their environment. It's very harm reduction focused and really designed to provide a place for people to be safe with their alcohol use and have the support that they need. I ended up meeting him at the Day Center and asked him about Silver Creek Corner if he had an interest. He talked about his recent hospitalization and said, absolutely not, I am sober. I've been sober since I got out of the hospital, I want to stay sober, and I'm going to treatment. He thought he had had a substance use disorder assessment done while in the hospital. We call it a Rule 25 here in Minnesota. But, as it turns out, as I did some digging and some calling, he did not. So, I coordinated with him to get that assessment done at an outpatient treatment center that's actually associated with Mayo Clinic and arranged for him to participate in treatment at a program that specializes in treating people who are Native. He was all on board with this plan. We also have a house called Doc's Recovery House that will take people in while they're waiting to get into treatment. It's a sober environment, very supportive, lots of peers who can support people through that initial time of being sober. They were willing to take him. They said he needed to go to detox first, for a day or two, just to ensure that there would be no complications with any kind of withdrawal that he might experience. Again, Larry was on board with that plan, but he had indicated to me that he couldn't go until after his doctor's appointment the next day. I didn't know about the appointment, but he was willing to allow me to go with him to that appointment. And, it turns out that he, in fact, did not have his medications with him and hadn't been taking them for the last seven days because he left them at Dorothy Day. When he got out of the hospital, he was staying at Dorothy Day. The walk from Dorothy Day to our Day Center was about eight blocks away. So, here he is, using a walker with a wound on his foot, and he just simply couldn't make that walk every day, so he stopped going to Dorothy Day. He left his belongings there and he was sleeping in a park.

When we had gotten to the doctor's office, I actually came a bit late, I had picked up the medications for him and got into the doctor's office into the exam room, and he was meeting with the nurse. I'm assuming that the nurse had asked him, “Are you taking your medications?” And, he likely said, “Yes.” When I explained to the nurse that I'd picked up his medications, he hasn't had the antibiotics for the last seven days, she was rather surprised. So, I clarified that for her and clearly he had the majority of the bottle still full. He also proceeded to explain that he was having so much pain in his foot, that he had consumed a bottle of Extra Strength Tylenol 100 tablets within the last five days. So, obvious concerns there as well with that much Tylenol in his system. His explanation was it was either taking that Tylenol to kill the pain or I go back to drinking, and he did not want to do that. When the physician came in, he proudly announced that he was going to treatment and he had been sober. The physician was obviously very happy with that report. Larry had also requested Gabapentin for his wound and for the pain that he was experiencing on his foot and the physician was open to prescribing that to him. But, I actually explained that most treatment programs will not accept somebody who is on Gabapentin. They see that as an addictive medication and they will not allow that in their facility. So, had I not been there to explain that, the physician likely would have prescribed Gabapentin and it would have certainly derailed his opportunity to go to treatment.

Mary O'Neil:

Just some things to consider in your assessment of a patient, whether it's the first time you're seeing them, or this is a regular patient of yours that you've seen before. Just some tips and tools maybe to consider and I'll reference back to Larry's experience as well. Definitely read the medical record, definitely look at social service reports in that medical record because they're really going to ask about, certainly where somebody is living. Oftentimes with homelessness, we see a lot of substance use disorders. So, what are people coming into the ED with? It's oftentimes because of substance use overdoses or simple use or complications from their use. Reading that health history and getting a sense of what their lifestyle, I think, is very important. Health insurance is going to give you an indication of maybe some socioeconomic challenges that one might have. If somebody is on Medicaid – and that is Medical Assistance in Minnesota – but if somebody is on Medicaid, their income is going to be between 800 and a thousand dollars per month. That's just something, if you don't know that already, for you just to be aware of. When you see somebody coming in with Medicaid health insurance, they are living in poverty. So, not only consider somebody who might be homeless, but somebody who's living in poverty and some of the conditions that they are experiencing because of that.

In terms of homelessness, just consider some of the conditions that they might be living in. Food access is going to be a challenge. Yes, there are often lots of food resources in town, with free meals, et cetera, but oftentimes the quality is low. They're not going to have lean meats. They're not going to have fruits and vegetables. Oftentimes, it's high carb meals that they're given or snacks. I think of the Day Center and there's lots of snacks, cookies, and chips, and things like that. Their diet is not going to be very healthy. And, they're often not going to know when they will have their next meal. Fresh water, drinking water, is not easily come by. If they are out in parks, I know certainly during COVID, the parks shut down their water fountains, so they did not have access to water. They're often living in unsanitary conditions. They don't have access to showers or hand-washing stations. There might be free showers at the Day Center or at the shelters, but if they're not staying in those areas, they won't have access to that.

People who experience homelessness don't have a lot of personal belongings. And, what I have found, is that they desert them in a heartbeat. So, if they have medications, for instance, that are in their belongings and they find a place to crash for the night, they're going to leave their belongings there. And then they're at risk of losing them or having them stolen by others. There's lots of exposure to violence.

And, you have to consider the weather extremes that one is living in, certainly in Florida and Arizona, it's going to be the extreme heat, here in Minnesota, the extreme cold.

I cannot stress enough the importance of really approaching a patient experiencing homelessness with empathy and respect and without judgment. It is so critical to establishing not only a rapport with that individual, but helping them to feel safe and comfortable and being able to be honest with you as a patient. Trust is difficult for people who are homeless. That initial interaction that you have with somebody is really going to either get them to come back and see you again, or they might give up on the medical system entirely. So, it's really critical that you approach them without judgment. Many people I've worked with over the years have reported feeling discriminated against in the medical system, whether it's the ER, whether it's a free clinic, or whether it's an outpatient primary care clinic. And, I would also say it really starts at the reception desk. So, if there's training that's taking place in your work, I would make sure you include everybody.

Always go in with providing person-centered trauma-informed care.

Ask where the patient is staying. Looks can really be deceiving. I would say with Larry, he intentionally stayed in the shelter the night before his doctor's appointment so he could shower, he could shave. He'd actually gotten a haircut, I don't know where. He got a haircut the day before so he would be presentable for his doctor. So, looks can really be deceiving. But, if you know they have a history of homelessness or if you get any sense that they might be homeless, simply asking, “Where did you stay last night?,” is a really good non-judgmental question that you can ask. This is something that we ask people all the time. So, they're used to having that question asked of them. It's a non-judgmental way of asking if you are homeless.

Think about income. Some people do not have income who are homeless, so they aren't going to have the means to maybe get their prescriptions when they have a $3 copay. Buying gauze or band-aids, things like that, will be difficult. And, even buying over-the-counter Tylenol is going to be hard. So, think about what you're recommending when it comes to income that one might have.

Consider what's most important to the patient. Now, in Larry's case, this was a simple follow-up for the wound on his foot, but I'm guessing Larry has some chronic health conditions, just based on his substance use. He appears a little bit overweight to me. So, I'm guessing there's some chronic health issues there. But, he was coming in obviously for that pain in his foot and that's what the doctor was addressing. So, he addressed that pain and this will likely get Larry to return and increases motivation to follow through.

Assume there's a history of trauma, whether it's trauma from the childhood that has led to homelessness, or whether it's trauma that has occurred since they've been homeless, I would just make that assumption.

Ask direct, specific questions. Don't make assumptions. Don't generalize. So, when that nurse asked Larry, “Are you taking your medications?,” his response was “Well, sure. I am.” A better question might have been, “When was the last time you took your antibiotic? Can I see your medication bottle to see how many pills are still there?” Be specific, be sure you're asking the question in a way that you want to elicit the correct information.

Probe about food insecurity and personal safety.

Ask them if they have anybody involved that is a support to them, whether it's a case manager or an outreach worker, or a family member. And, I would encourage you to get a release of information to speak with them right then, because you never know whether you're reaching out to them or they're reaching out to you, it's important to have that ROI in place, and that can be a huge barrier if you don't have it.

Considered dental care. Most people who are homeless just do not take care of their dental needs and don't have the ability. So, that is a real need in the community that we see.

And then of course, comorbid conditions: consider mental illness and their substance use, and really think about the capacity of the patient to follow through with recommendations dependent on how managed these illnesses are. Address immediate needs first. This is definitely going to build trust and motivation to return.

Engage the support system. I know that that is really time consuming, but it is really so important to engage the support system, even if it's a distant relative. If the patient is allowing you and willing to let you reach out, I want to encourage you to do so.

Think about prescribing practices. So, he was required to take antibiotics three times a day, which that might have been really the only dosing that could have occurred to clear up that infection. But, I would say if you can minimize dosing to one time a day, or if somebody has a psychotic disorder who could benefit from an injectable, think about how you can minimize dosing. People can't remember to take those medications that often, and they're likely going to miss. If you're prescribing a medication that's required to be taken with food, think about, again, if somebody is homeless, they don't know where their next meal is coming from, so if they take the medicine without food and they have some side effects, the likelihood of them taking that medication is slim.

Obviously, consider their dependence history and potential for misuse or selling of that medication. Talk to them about how they're going to store their meds, keeping in mind that people will desert their belongings at any given moment. How can you come up with a plan with the patient to store the medications on their person, whether it's a backpack that never leaves their sight or if it's a pocket that they have, however they can keep their medications with them at all times would be a nice plan to develop.

Offer medical supplies that they can't purchase themselves. So, like I said, the band-aids, the gauze, over-the-counter medications, things like that. Offer immunizations at the time of the appointment. You have a captive audience right there in your office or in the hospital, offer the immunizations. People are certainly susceptible to illnesses that some of the general public is less likely to get, so offer those immunizations when you have them in your office.

Offer written instructions on a wallet-size card they can put that in their pocket. Be careful about their reading ability and be careful about their healthcare literacy as well. Just something to be mindful of as you think about written instructions.

Consider the prescriptions you're going to be prescribing. Benzodiazepines certainly have street value, so it's something that you may want to consider when you're prescribing. Drugs metabolized in the liver is likely probably not the best for somebody who has alcohol use disorder. Some medications can be used to get high, some that you wouldn't even think people could use for that purpose, or they're used to enhance effects of other drugs. Just be knowledgeable about some of that. If somebody is seeking substance use disorder treatment, do not prescribe anything that can be considered addictive. Either they won't be successful, or they won't even be allowed in treatment with that kind of prescription. Diuretics is another thing to consider, particularly in the extreme weather and temperatures where a diarrhetic could exacerbate dehydration.

Schedule more follow-up frequent visits to build trust with that person. Anticipate unscheduled office visits and phone calls from them. Their sense of time in general is quite poor. So, if you schedule an appointment for one, they might show up at four o'clock in the afternoon. So, don't be surprised if you get some unscheduled phone calls and visits. Make referrals as best you can to social services and other community resources. Update the emergency contact information while they're there in the office; their

phone numbers change all the time. It's amazing how disposable cell phones are. Get them to sign releases while they're there. And also, be able to provide some resources in the moment. Become aware of simple resources in your community. In Rochester here, we have a green book; it's a pocket-sized book that we have all of the community resources listed. It was intentionally made the size that it is so they can put it in their pocket. Have those available and have those handy to hand out. Be knowledgeable about other resources in town, so that you could offer that up to somebody if they're saying they don't have enough food to eat.

Coordinated Entry System: As I mentioned before, that is a HUD-mandated system and it's everywhere in the country, so become familiar with it. You certainly don't need to know details, but have a general understanding of how that system works.

I would suggest having bags available, a zip-lock bag to offer a patient, socks critical in extreme weather like we have in Minnesota, personal hygiene products, hand sanitizer, bus passes, just have these handy to be able to hand to somebody that you know might be homeless. Offer cab coupons, or Uber gift cards, bus passes, for return visits. Definitely reach out to case managers or shelter staff. I am amazed at how compassionate our shelter staff is here in town, and they will definitely do what they can to help, outreach workers as well. Connect with a social worker within your clinic to make referrals and apply for health insurance. And, even have a coat rack in your lobby for donated coats, hats, and gloves during the winter months. Some simple things that could be done within your own clinic.

Grace Johnson:

Great. Well, thank you so much, Mary, for your talk. That was incredibly eye-opening and very helpful for us, too, as future providers for how we can navigate those clinical situations and support patients. We really appreciate your time and your insights.