“If you wait for folks to come to your clinic, it’s too late. You have to go to them, wherever they are.”

Barbara McInnis, R.N., 1985

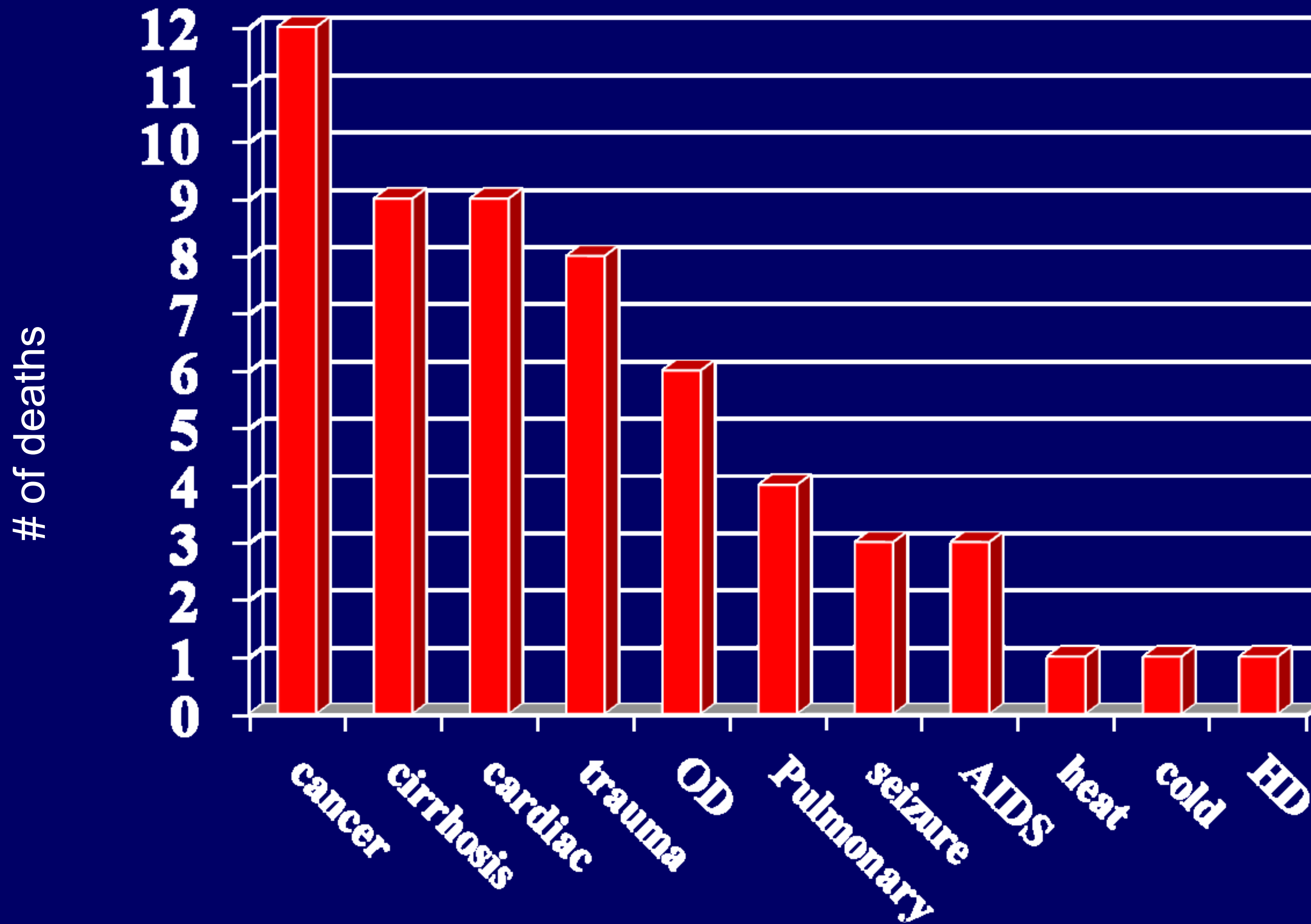
12 Years Later: Whereabouts of Original Street Cohort 01/01/2012 (N = 119)

- **Deceased** 59 (50%)
- **Nursing Home** 9 (8%)
- **Incarcerated** 1 (1%)
- **Shelter** 2 (2%)
- **Housed** 35 (29%)
- **Streets** 6 (4%)
- **Unknown/LTFU** 7 (5%)

Utilization of Medical Services by the Cohort, 1999-2003 (N = 119)

- **Emergency Room Visits** **18,384**

Causes of Death
N = 59

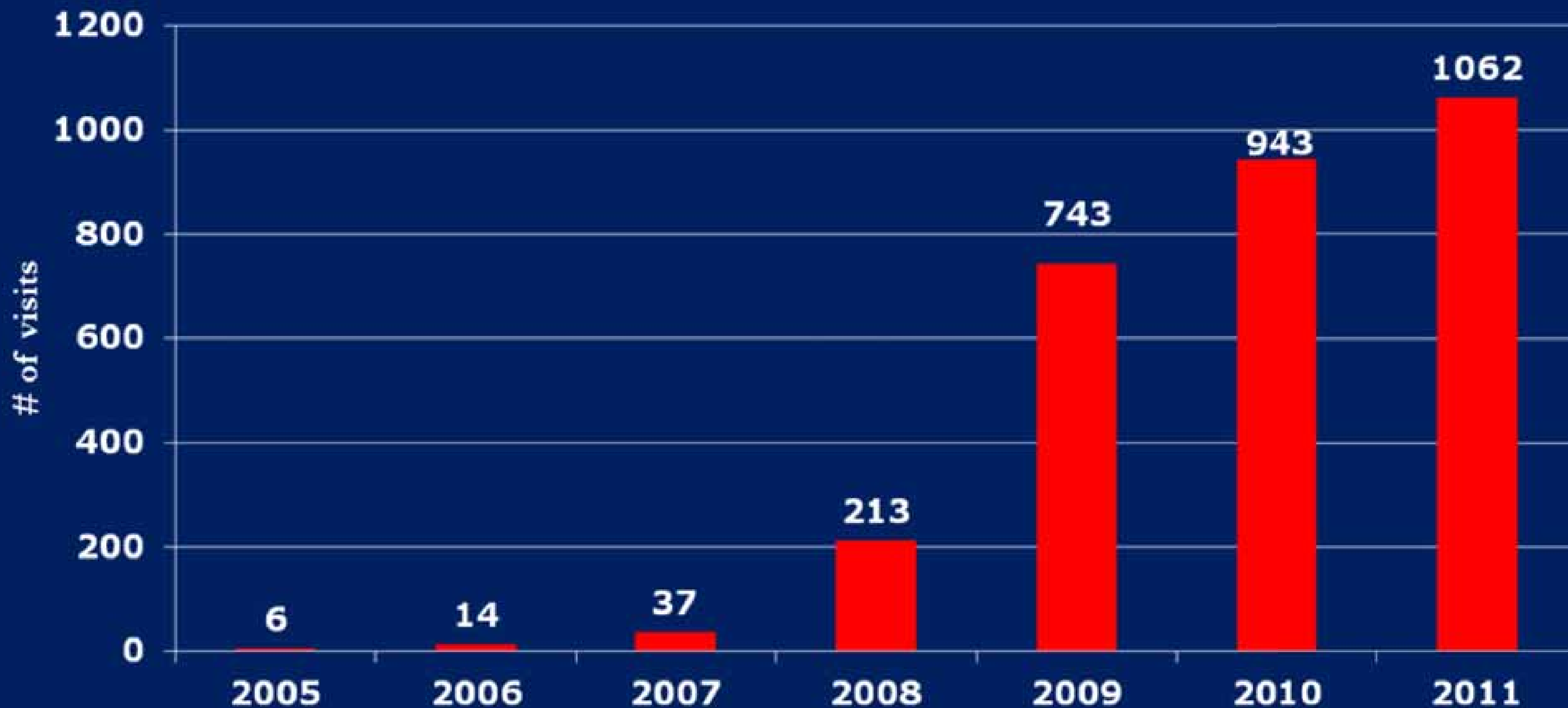


BHCHP: O’Connell/Roncarati/Swain

443
JET-
617-

Coffee mate

Street Team House Calls
2005-2011



***255 unique patients in 3,018 home visits**

House Calls:
Past as Prologue

- Regular MGH clinic visits and home visits have replaced street outreach, respite, and the ER
- 50% of all primary care and mental health interactions now occur in the home

BHCHP's Street Team

- Medical
  - 1.0 FTE Internal Medicine
  - 2.5 FTE Nurse Practitioner/Physician Asst
- Mental Health
  - 1.0 FTE Psychiatrist
  - 0.2 FTE Psychiatrist
  - 0.5 FTE PGY4 Harvard Psychiatry Resident
  - 0.2 FTE PGY2 MGH Psychiatry Residents
- Substance Abuse
  - 1.0 FTE Addictions Specialist/LICSW (planned)
- Community Support Worker
  - 2.0 FTE

Anatomy of a House Call:
The Team "Visit"

- Medical/Primary Care
  - vital signs
  - assessment and follow-up of medical problems
  - Rx refills; medication adherence
  - preventive care; quality outcomes (PPD, flu, Pneumovax, A1C)
  - specialty referrals
- Mental Health
  - Engagement and assessment
  - Connection to DMH
  - Psychopharmacology
  - Therapy
- Non-medical "stuff"
  - Housing stabilization, assessment of home surroundings
  - Case management (making appts, providing cab vouchers, picking up eyeglasses, etc.)
  - Companionship, socialization

Six Key Principles of Care

1) continuity of care (street to hospital to respite care to housing)
2) multidisciplinary team as "medical home" (medical, mental health, substance abuse, CHWs)
3) co-location of medical/mental health/addictions care
4) daily "huddles" and weekly team meeting to prioritize visits and collaborate on clinical decisions
5) collaboration with housing workers/agencies
6) consumer involvement in design of delivery model