

Street Medicine Models in Other Counties: White Paper

Introduction

Alameda County invests in street medicine programs that deploy mobile teams to deliver medical care and linkage to services for unsheltered homeless community members. Currently, Alameda County has not articulated a shared model for street medicine services, relying instead on each contracted agency to define the services it delivers. Care Connect tasked Bright Research Group (BRG) with researching models and best practices for street medicine used in other counties/jurisdictions to inform Alameda County's investment in street medicine. Key research questions included:

- What are the existing models and/or best practices for delivering street medicine?
- What types of medical and/or psychiatric interventions can be offered in the street? How should these teams be staffed and deployed to the street to generate the greatest return on investment?
- How can street medicine teams support efforts to link individuals to housing or other services?
- What is the evidence base for street medicine efforts? What are the expected outcomes of this type of investment?

To answer these research questions, BRG conducted a review of the literature on street medicine interventions and interviews with the Director of Street Medicine at USC's Keck School of Medicine and key program staff from street medicine initiatives in Los Angeles County, San Mateo County, Ventura County, San Francisco County, Shasta County, and Santa Clara County. Interviews were also conducted with street medicine providers in Alameda County and other key local stakeholders. This report provides a summary of findings from this research.

Background and Review of the Literature

Street Medicine was invented in 1992 when Dr. Jim Withers started making house calls to unsheltered homeless individuals living on the street (Pittsburgh Mercy 2018). Since then, the definition has been finalized by the Street Medicine Institute as "the provision of health care directly to those living and sleeping on the streets – the unsheltered or 'rough sleeper' homeless – through mobile services such as walking teams, medical vans, and outdoor clinics" (Street Medicine Institute 2018). Although the formal definition makes no explicit mention of housing, many organizations that implement street medicine have recognized the connection between stable housing and health outcomes; as a result, some street medicine programs incorporate elements of housing support or other case management that focuses on addressing housing needs (Department of Homelessness and Supportive Housing 2018; Howe, Buck, and Withers 2009; Humphrey 2016).

With the recent growth in the size of the unsheltered population in many urban communities in California, the street medicine model is seen as a short-term population health management strategy for the thousands of individuals experiencing unsheltered homelessness (Applied Survey Research 2017). Although a growing body of evidence demonstrates a clear connection between stable housing and positive health outcomes, the sheer size of housing demand for Alameda County will not make it possible for all unsheltered homeless individuals to be placed in housing in the near future (Davidson et al. 2014; Gilmer et al. 2010; Appel et al. 2012; Tsemberis et al. 2012). Street medicine provides care for the immediate health needs of homeless individuals, while simultaneously fostering trusting relationships between homeless

patients, case workers, and housing navigators. Depending on its implementation, street medicine could also facilitate the identification and tracking of individuals for housing slots; some of the organizations Bright Research Group interviewed mentioned street medicine teams as a key method for rolling out coordinated entry and HMIS efforts.

There is limited evidence regarding the effectiveness of street medicine as an intervention to improve health outcomes. The majority of evaluations include system-centered metrics such as emergency room utilization, hospitalization rates, and cost savings (Avis 2016; Advisory Board 2017). The only two street medicine evaluations focused on patient-centered metrics found that the intervention improved patient satisfaction, strengthened provider-patient relationships, and fostered ongoing engagement with primary care and behavioral care services after the intervention (Edwards 2017; Christensen 2015). Pilot efforts in Los Angeles and San Mateo County have focused on housing placement as the key metric of success for street medicine efforts. Several studies have documented the impact of permanent supportive housing on the health outcomes of homeless individuals and have demonstrated reductions in emergency room utilization (Kushel et al 2002).

Findings

Interviews with street medicine providers and stakeholders from other counties revealed five key components to street medicine program models. The findings below address each of the fundamental design challenges with street medicine and how other counties are addressing them.

- Target Populations
- Staffing & Deployment Model
- Engagement Strategies
- Suite of Medical/Psychiatric Services
- Connection to Housing

Target Populations

Street medicine programs are primarily structured to be place-based—teams are deployed to specific target locations on some sort of regular schedule. While some programs are roaming or have large geographic regions of focus, many street medicine programs are moving towards more relationship-based models that require frequent/recurring contact with clients in order to significantly address their health conditions (instead of just providing one-time treatment in the street). As a result, street medicine programs are increasingly defining their target locations by very specific geographic boundaries (e.g. a few square blocks) and/or specific encampment communities. This type of place-based approach requires a regular schedule, location, and staff that appear consistently and aim to engage the same individuals on a recurring basis. While some individuals are immediately willing to engage with street medicine teams, others are extremely weary and distrustful of system efforts to engage them in service. Respondents shared that incorporating a consistent schedule, location, and staff into their program models resulted in an improved ability to engage the hardest-to-reach individuals.

Los Angeles' Place-Based Deployment Approach

The best example of this type of place-based deployment structure is in Los Angeles. Several years ago, Los Angeles launched the C3: City, County, and Community program to bring street medicine to the unsheltered community in Skid Row. The City divided Skid Row into four geographic zones—North, South,

West, East—with only a couple square blocks allocated in each zone. A multi-disciplinary outreach and medicine team was deployed to each of the four zones. Teams included representatives from the County’s Department of Mental Health, Health Services, Substance Abuse Prevention & Control, Los Angeles Homeless Services Authority (LAHSA) and Americorps staff. Team roles usually included an outreach worker (usually a peer specialist), a nurse, a social worker, a substance use specialist, a public housing specialist, and an Americorps volunteer. This was one of the first efforts in LA to link housing to street medicine efforts; as a result, “in 2016, the C3 team on Skid Row was able to house 158 people and connected 326 more people to housing who will be getting indoors soon” (Horvath 2017). Data on health outcomes were not available.

Target Populations

1. Target geographies to deliver place-based services
2. High utilizers of medical system/ED

As a result of the success of this model, Los Angeles—with the funding from a local measure to tackle homelessness (Measure H) and from Whole Person Care grants—is expanding this model across the County under its new “E6” program. This program is currently scaling the place-based model to the county level by delivering programs in the eight regional Service Planning Areas (SPAs) that LA uses to deploy most public services, selecting local CBO clinics in those regions to administer street medicine in specific targeted zones, and linking street medicine to housing efforts.

San Mateo County’s Focus on High Utilizers of Emergency Department Services

Aside from place-based approaches, some communities are focusing street outreach/medicine efforts to reach homeless people who are the highest utilizers of the health system. San Mateo County has contracted with LifeMoves—a longstanding local nonprofit—to locate and identify homeless people who are the highest utilizers of the emergency department (ED) at the San Mateo County Health System. San Mateo County’s hospital is utilizing Whole Person Care grant funds to conduct outreach to all high utilizers of the ED to ensure individuals are accessing preventative care and complying with aftercare plans; LifeMoves is contracted to execute this work specifically with the high utilizers of ED who are homeless (~\$250k budget). LifeMoves will deliver care/medicine on the street to those individuals (to the highest extent possible), and link the individual to Care Navigators at the hospital whose goal is to keep individuals engaged in aftercare or preemptive care. LifeMoves essentially serves as the street-based outreach arm of the health system’s Care Navigator team, linking homeless high utilizers of the ED to medical care in the street, while also providing light-touch case management and transportation to get those individuals to medical/psychiatric appointments as needed and/or as defined in their aftercare plan.

Staffing & Deployment Model

Most street medicine teams are multi-disciplinary—they include some combination of outreach workers, medical professionals, behavioral health specialists, and housing specialists. Some counties cautioned against piecemeal approaches to outreach, where several organizations or programs are providing small doses of duplicative and non-relationship-based services to homeless people. While Alameda County benefits from a rich network of nonprofits and initiatives that aim to serve this population, small doses of low-touch services could have the unintended consequence of further alienating homeless people from engaging in services. In Los Angeles, programs are being redesigned to help improve the quality and depth of interactions with homeless people in order to reverse what some homeless services providers describe as “learned helplessness”—“ a condition in which a person suffers from a sense of powerlessness arising from a traumatic event or persistent failure to succeed” (Horvath 2017).

For example, LA is aiming to remove the system's need to ask homeless people to fill out the same paperwork over and over again so that consumers can have a more seamless and less bureaucratic experience. The program theorizes that a single, unified, well-resourced street outreach/medicine team that connects homeless community members to health and housing and provides them with updates about their status will create a restorative experience for the individual's interaction with the system. This goal to transform the consumer's relationship with the system means that street outreach teams need a multi-disciplinary staff that can address the diverse and often complicated needs of unsheltered individuals that are met on the street.

Nurse practitioners (NP) are seen as the most desired/valuable role on multi-disciplinary teams. While nurses and physicians assistants are the most common medical staff on multi-disciplinary teams, NPs are able to provide two key activities that are required for delivering the highest level of medical care possible in the street: 1) diagnosis, and 2) writing prescriptions. Without an NP or MD (rarely seen on street medicine teams in other jurisdictions) on the team, nurses/PAs alone can only provide basic care in the street, i.e. wound care, directions on how to manage a chronic condition or take existing prescriptions, and/or referrals to care at a brick-and-mortar clinic.

“The nurse in the street cannot do as much as they can in MedSurg or in a hospital.”

When it comes to staffing team, Counties are either contracting out services, adding county positions, or a combination of the two. In order to staff the multi-disciplinary street medicine teams, Los Angeles's E6 initiative is hiring community-based clinics/providers in each of its eight regional Service Planning Areas (SPAs) through a competitive bidding process. They expect that this initiative will result in the hiring of more than 1,000 employees at contracted provider agencies and administering public agencies (i.e. LAHSA, behavioral health, etc.). The County is hiring one full-time Outreach Coordinator in each of the eight SPAs to oversee the contracted agency in that SPA, provide strategic support on targeting geographies within the region, and to ensure coordination/linkage with housing and other regional or county-wide efforts. The contracted provider agencies deploy multi-disciplinary street outreach teams in each region. These teams include staff with mental health, physical health, substance abuse, peers with lived experience, and generalist homeless case management expertise. While the contracted provider agency is providing the medical staff on the street medicine team; the city/county will provide housing specialists, behavioral health specialists, or other case managers to deploy with the medical staff. Contracted agencies all have existing brick-and-mortar clinics in the region so that when they come across an individual in the street that needs a higher level of care, they can offer transportation and care to their nearby clinic.

While Los Angeles is contracting with clinics to provide medical staff and deploying city/county staff who are specialists in housing or case management, San Mateo County has taken the inverse approach—contracting with an external nonprofit outreach agency (LifeMoves). San Mateo County deploys the County Health System's medical team alongside LifeMoves outreach staff on the streets. Life Moves has delivered street outreach services in San Mateo County for the last decade (approximately \$1 million annually). The high utilizer outreach work with the Whole Person Care pilot mentioned above is a recent addition to their scope of work. In addition to the high utilizer outreach strategy, LifeMoves has been providing street outreach/medicine to all unsheltered individuals in the County. LifeMoves' outreach team will go to some places that are common locations for homeless people, and also serve as “rapid responders” to civilian reports/complaints of unsheltered individuals.

LifeMoves serves five key regions in San Mateo County, with multi-disciplinary teams (MDT) staffed in each of the 5 regions. The MDTs are led by a Life Moves outreach worker (FTE), and staffed by LifeMoves case managers/housing specialists and by medical staff from San Mateo County Medical Center—including a nurse practitioner (when possible), nurse, physician's aid, and psychiatrist. LifeMoves's outreach team decides where the team will go and will lead outreach, engagement, and efforts to get the individual on the housing voucher waitlist. The medical staff on the team will deliver wound care, advise on prescription use, write new prescriptions if needed, and may make a same-day or next-day clinic appointment for the individual in the case of emergency. When appointments are made, the LifeMoves outreach team is responsible for providing transportation—by any means necessary—for the individual to make their appointment. LifeMoves estimates that their clients have an 80% attendance rate at all appointments made at clinics by their street outreach team. In addition to outreach and street medicine, each of the five regional teams has a maximum caseload of 20 people who receive intensive case management—these are individuals who have been prioritized on the housing voucher waitlist.

Finally, Santa Clara County's model relies heavily on their outreach staff and the relationships that they build with the individuals they are serving through the street medicine program. While medical providers are only deployed to the street two days a week, outreach workers are deployed every day. Their primary goal is to develop relationships with consumers, notify them of opportunities to receive medical care, and to follow up with consumers who have been treated by street medicine teams to support compliance with any follow-up/aftercare. The outreach model in Santa Clara does not rely on the patient finding the provider; instead if the doctor wants a follow-up appointment with the patient, the outreach worker's role is to find that patient and to bring the medical team to wherever the patient might be in the County to ensure the connection to appropriate follow-up treatment.

Engagement Strategies

Respondents emphasized the importance of building in incentives for participation and engagement that meet the basic needs of unsheltered individuals living on the street. While some individuals are eager to engage with medical staff when they appear, respondents noted that some individuals are not as trusting of medical teams, and are more likely to receive medical care after some trust is developed. The most common engagement tactics used for developing trust were portable showers (LavaMae) and other problem-solving support (e.g. storage, identifying a place for a warm breakfast, pet care).

While case management is not necessarily an intentional strategy of street medicine teams, all respondents noted that a relationship-based approach is necessary. Street outreach teams try to be a consistent presence in certain areas so that people know to expect them there. Some street medicine team members effectively serve as temporary/transitional case managers whose goal is to support the health and well-being of the individual on the street until they get into a permanent supportive housing slot with intensive case management.

Respondents noted three common goals for building relationships with unsheltered individuals: 1) getting individuals "document-ready" for housing. Respondents noted that it was important not to make any promises about housing availability; 2) knowing the individuals' medical conditions/needs/preferences and being a trusting person who can help take care of those needs; 3) helping to "bridge" the time between when an individual living on the street is awaiting housing and providing continued case management once the individual has been placed in permanent supportive housing, but is awaiting connection to an intensive case manager. In San Francisco, one respondent described the Homeless Outreach team's mission as

“preventing people from dying in the street until we can get them into housing; we will do anything it takes to ensure that.”

In San Mateo County, LifeMoves convenes a monthly case conferencing meeting of the MDT street medicine teams, County behavioral health services agency staff, law enforcement, code enforcement, and other local nonprofit core agencies. The goal of these meetings is to bring a “groupthink approach” on the next steps for serving those unsheltered individuals who are connected to a LifeMoves intensive case manager (i.e. those at the top of the priority list for housing vouchers). These meetings may cover strategies for motivating compliance with prescriptions (medical and psych), connecting clients to appointments with psychiatrists or addiction treatment groups, teaching hygiene behaviors, and/or finding sheltered places for them to sleep. Code enforcement sits at the table so that they can notify outreach and medical teams about any citizen complaints or actions that will be taken to clear an encampment or relocate individuals.

In addition, the literature demonstrates the importance of connecting individuals to health insurance, and ensuring that they remain connected/enrolled in Medi-Cal and other forms of health insurance. Lack of health insurance has been identified as a key barrier to accessing healthcare for all populations, especially for homeless and transient populations; having insurance is positively associated with greater use of outpatient care, reduced barriers to accessing care, and higher medication compliance (Kushel et al. 2001). Engagement strategies should include efforts to connect individuals to health insurance. Interviews with Alameda County stakeholders revealed the need to improve policy/systems solutions that allow clinics to see and treat homeless individuals on Medi-Cal. Medi-Cal requires consumers to select a primary care provider, which may not be appropriate for homeless individuals who move frequently or who are served by multiple providers in Alameda County. One respondent noted the idea of developing an exemption for homeless individuals on Medi-Cal that allowed them to see any primary care provider in Alameda County, to avoid the administrative paperwork that is required for providers to see these patients (and bill Medi-Cal for their service).

Suite of Medical/Psychiatric Services

The suite of medical/psychiatric services that can be provided in the street depends on the staffing strategy of the street medicine team. As mentioned earlier, nurse practitioners are the most-requested staffing role for street medicine teams because they are able to diagnose and write prescriptions in the street. Otherwise, the most common services provided by these teams include supporting chronic disease management (where diagnosed), prescription refill or administration or education, wound care, and connections to primary care clinic. All respondents noted that not all medical needs can be handled in the street. Most models have some sort of effort to connect to a medical home/primary care clinic to diagnose and treat more serious medical conditions, and perform more extensive medical procedures or surgeries where needed. Key types of medical services provided in the street:

- **Wound care:** Open, infected, and festering wounds are commonly experienced by unsheltered individuals. Wound care podiatry specialist was noted as a particularly important role on these teams. Most street medicine teams noted that mobile showers were both a key engagement tactic (as described above) and also a necessary first step for allowing street medicine staff to clean and treat wounds. LavaMae shower trailers were the most commonly used service for mobile showers.
- **Prescription delivery** for people who have prescriptions to treat chronic conditions like COPD, diabetes, etc. Prescription delivery is seen as a bonding tool; when the person is feeling better,

they will engage more in other services. Due to security concerns, respondents noted that teams should only carry small amounts of prescriptions at any time. Some teams only bring prescription medication that they have already determined need to be delivered to a specific individual. Teams suggest having relationships with pharmacies near deployment locations to try to provide rapid prescription refill requests on the same day that they are identified.

- Injectable anti-psychotics and other Street Psychiatry:**
 Respondents in Los Angeles and San Mateo County are working to strengthen their ability to deliver injectable anti-psychotics in the street. In San Mateo County, the psychiatrist on street medicine engages with individuals with psychiatric needs and aims to connect them to a clinic to receive further treatment. The psychiatrist has both done assessment and referral in the field, but if the patient has a history of not following through for appointments, the psychiatrist may develop a treatment plan and weekly check-in regimen with the patient in the field.
- Chronic disease management:** Chronic diseases cannot be managed on the street alone. This is where a relationship-based approach is essential, with the end goal of linking individuals to a brick and mortar clinic. Supporting individuals with managing chronic disease is within the scope of these teams; however, a common challenge is finding people on a regular basis and building enough trust so that they go to a clinic periodically to get higher levels of treatment as needed.
- Connection to Medical Shelters/Recuperative Beds:** If an unsheltered person ends up in the hospital because of chronic illnesses, Los Angeles County develops a discharge plan with that individual so that they can go to recuperative care and get into short-term medical shelters until they can stabilize their chronic medical disorders. Los Angeles has seven medical shelter locations, with 400+beds available. Traditionally, medical shelter beds are reserved for individuals who are referred after receiving inpatient services. Los Angeles is now opening up these beds for referrals from the E6 street outreach teams. This strategy was developed because street outreach teams were coming into contact with individuals on the street who were facing imminent death on the street. By allowing street outreach teams to refer these individuals to medical shelters, Los Angeles hopes to try to stabilize the sickest and hardest-to-reach individuals living on the street and prevent death.

The Los Angeles Department of Health Services recently developed standardized procedures for registered nurses who are deployed in street-based engagement teams (these pilot protocols—launched in March 2018—are provided in attachment). Los Angeles developed their protocols based on protocols from the San Francisco Sobering Centers, Los Angeles Sobering Centers, San Francisco Homeless Outreach Team clinic, and the San Mateo mobile clinic. These protocols dictate the conditions that can be treated on the street, and what nurses are

LA's Street Medicine Clinical Treatment Protocols

Nursing procedures have been developed for treating the following conditions in the street:

Abdominal Pain
 Allergic Reaction
 Altered Mental Status
 Animal Bites
 Athlete's Foot
 Bradycardia
 Chest pain
 Cold/ Upper
 Respiratory Infection
 Constipation
 Cough
 Dental Pain
 Dermatitis, Atopic
 (Eczema)
 Dermatitis, Contact
 Diarrhea/ Loose Stools
 Hay fever / Allergic
 Rhinitis
 Headache
 Heat Related Illnesses/
 Hyperthermia
 Hypertension
 Hypoglycemia/
 Hyperglycemia
 Hypotension
 Hypothermia
 Menstrual Cramps /
 Dysmenorrhea
 Musculoskeletal Pain
 Nausea & Vomiting
 Opiate Overdose/
 Depressed Respirations
 Scabies
 Seizure
 Shortness of Breath
 Sore Throat
 Suicidal Client
 Suture Removal
 Tinea Corporis/ Tinea
 Pedis (Ring worm)
 Wounds

supposed to do if they can't treat a condition on the street, but the person either requires a higher level of care or is experiencing an imminent life threatening emergency. Los Angeles is also training its street medicine teams in protocols for assessing clients' decision-making capacity and utilizing shared decision-making models due to the commonality of interacting with individuals in the street who may be declining potentially life-saving care. The shared decision-making model that is informing Los Angeles' approach and training on these situations is provided in attachment to this memo.

Excerpt from Los Angeles' Street-Based Engagement Registered Nurse Standardized Procedures (March 2018)

“General Statement of Procedure: The following guidelines describe the steps to follow for all Standardized Protocols for Registered Nurses who are working in the community as part of street-based outreach and engagement teams.

1. Document encounter in S.O.A.P. format, including protocol followed under assessment, time seen, completion/ discharge time, and name with title.
2. Collect data thoroughly and consistently.
3. Perform physical exam pertinent to presenting problem.
4. Consult medical back-up as necessary.
5. Connecting the client with a regular clinic is a priority of the engagement process. Ideally, medical and nursing care should be transitioned from street-based to clinic-based care as soon as feasible for the respective client.
6. Provide every client with next primary care clinic appointment and encourage appointment adherence. If client is not scheduled, assist in scheduling client for clinic appointment in appropriate timeline.
7. Refer client to medical home if not yet assigned.
8. Consult regularly with assigned provider and/or medical back-up that oversees your team utilizing verbal orders when appropriate.”

Connection to Housing

In most other jurisdictions, the overall mission for street medicine teams is to support the health and well-being of individuals until they are connected to housing. Street outreach/medicine teams are seen as a key strategy for rolling out Coordinated Entry and HMIS in Los Angeles and San Mateo County. Key goals include assessing the vulnerability of individuals (high to low), getting them on housing lists in order of priority from highest risk to lowest, connecting them to social service benefits and health care services while they are still living in the street, and getting them “document-ready” for housing (i.e. all the paperwork they need to have in place in order to move into that housing unit once its available).

Street Medicine & Housing First in Los Angeles

In 2017, Los Angeles voters passed Measure H—the County's most comprehensive effort to end homelessness in the region. The County released a detailed funding and implementation plan for all homelessness prevention and intervention strategies funded by Measure H, including the E6 street medicine initiative described in this memo (see link in textbox to the right). Under the new E6 initiative, the ultimate goal of the countywide network of multidisciplinary street medicine teams is housing, but supporting the health and well-being of those patients through the delivery of street medicine helps the county: 1) identify, track, and assess the vulnerability of homeless individuals to support the execution of coordinated entry and HMIS, and 2) build trust with the homeless clients by providing them with health care services

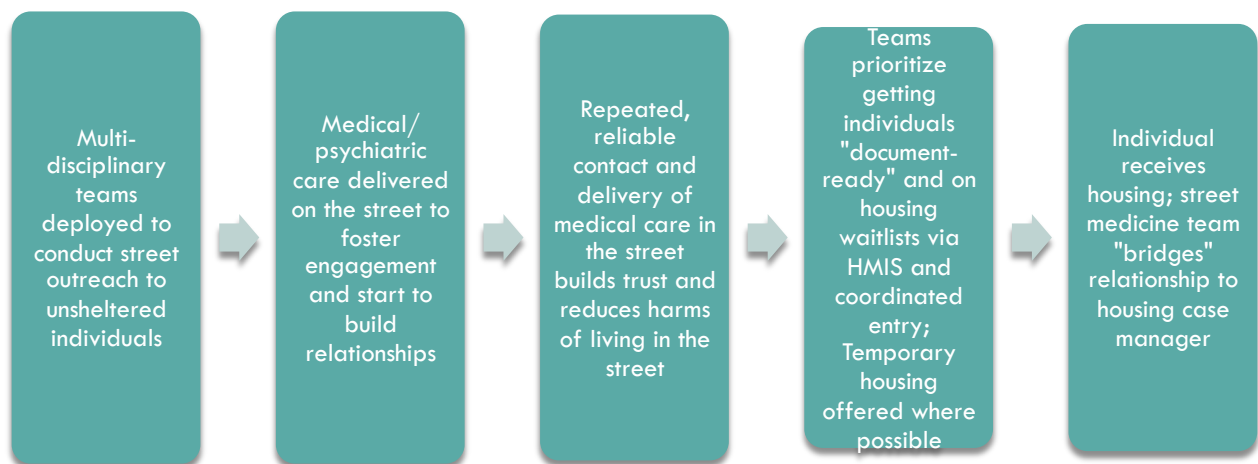
and treatment that supports their well-being. These individuals have a history of negative, distrustful experiences with public systems, and the street outreach teams are seen as an opportunity to meet the individuals where they are (literally and figuratively) and do anything they can to support the well-being of that individual.

Coordinated Entry in San Mateo County

In San Mateo County, a key goal is to assess the vulnerability of the individual in order to prioritize their placement in the coordinated entry system. LifeMoves' street medicine team has connected 40 unsheltered individuals to housing because of the prioritization of vouchers through recent coordinated entry efforts. They also have 35 people who are presumptively matched with vouchers, and who the LifeMoves team is supporting to get "document-ready". These individuals are matched with a LifeMoves intensive case manager, who will remain assigned to the client for an additional 60-90 days after they move into permanent supportive housing. A key strategy for Life Moves intensive case managers is to provide warm hand-offs to housing case managers that come with the housing voucher placement.

Even with the improvements in housing prioritization due to coordinated entry, all counties report that wait lists can still be 2-3 years long. In the interim, there is a shared recognition that unsheltered individuals are going to continue living on the street or in large (and often, growing) encampments. Because of the health and safety hazards of encampments, many jurisdictions are grappling with how to manage and clear encampments given the unfortunate reality of low supply of permanent supportive housing slots. In San Mateo County, Life Moves partners with code enforcement, planning departments, law enforcement, and city managers to coordinate efforts and notification around encampment evictions or closures. LifeMoves has asked these departments to contact them when they are planning to evict or clear encampments, and LifeMoves will prioritize deploying to those locations to notify residents, offer services, and try to support a more humane eviction/clearing process. They are not part of the encampment closure team and do not post eviction notices; their primary goal is to ensure that clients are aware and supported with moving.

A common, unifying theory of change for street medicine efforts that incorporate a housing first approach may be depicted as follows:



Los Angeles' Measure H Strategy Implementation Plans (September 2017)

See p. 48-53 for the E6 implementation plan
<http://homeless.lacounty.gov/wp-content/uploads/2017/03/Measure-H-Strategy-Cover-Sheets.pdf>

Measure H Strategies At-A-Glance (November 2017)

See p. 26 – 27 for E6
<http://homeless.lacounty.gov/wp-content/uploads/2017/03/Measure-H-Strategy-Cover-Sheets.pdf>

Considerations for Alameda County

Compared to other counties, Alameda County has not sufficiently defined its program model for street medicine and would benefit from a model that is more integrated and directive. In strengthening its street medicine investments, Alameda County should consider the following options:

Program Model Element	Options & Considerations
Target Population	<ul style="list-style-type: none"> • Specify targeted geographies for deploying place-based street medicine. Geographies should be narrower than large neighborhoods (i.e. East Oakland, West Oakland), and can be as specific as a few square blocks or specific encampments/ areas of critical mass. • Require consistent, recurring schedules, locations, and staff • Prioritize/support a relationship-based approach to engaging with patients on the street (i.e. move-away from high-volumes of low-touch engagements with patients) • Consider piloting a team whose goal is to partner with Alameda Health System to locate and provide targeted support to high utilizers of medical services who are unsheltered
Staffing & Deployment	<ul style="list-style-type: none"> • Establish multi-disciplinary teams, staffed by outreach workers (ideally, peer professionals), medical professionals, behavioral health specialists, and housing specialists • Staff teams with nurse practitioners • Deploy city or county staff with housing or social service expertise with medical/outreach teams on the street • Ensure contracted provider agencies have a brick-and-mortar clinic that can serve as the medical home for the individuals who are met on the street
Engagement Strategies	<ul style="list-style-type: none"> • Allow contracted agencies to use portable showers (LavaMae), meals, and other problem-solving strategies as key engagement/trust building tactics • Encourage relationship-based approach to street medicine, i.e. light-touch case management model and/or intensive case management for those who are next in the queue for permanent supportive housing vouchers. Consider developing a multi-agency case conferencing model for supporting these high-priority individuals.
Suite of Medical/Psych Services	<ul style="list-style-type: none"> • Encourage teams to deliver care in the street and, when necessary, connect individuals served on the street to a higher level of care in a clinic • Require teams to provide transportation to appointments at clinics • Develop clinical treatment protocols for specific conditions that should be treated in the street (see above for details) • Allow street medicine teams to refer individuals to any available medical shelters/recuperative beds
Connection to Housing	<ul style="list-style-type: none"> • Emphasize getting individuals “document-ready” for housing • Utilize street medicine as a key strategy for supporting roll out of

	coordinated entry and HMIS
Other Policy/Systems Change Work	<ul style="list-style-type: none"> • Develop shared outcomes/RBA metrics for this program • Research portable care exemption for homeless individuals on MediCal • Develop funding model that addresses billing/payment via MediCal • Expand access to pharmacy-dispensing licenses and buprenorphine/suboxone • Identify and fund shared resources that support street medicine providers' ability to adapt this model (i.e. mobile exam rooms, staff with housing or social service expertise, etc.)

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