CHCF Issue Brief

JUNE 2023

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State of Street Medicine in California

Street medicine is one of several critical pieces that compose the continuum of medical outreach for California's unhoused population.[1] Defined by the Street Medicine Institute as the delivery of patient-led health and social services to people experiencing unsheltered homelessness in their own environment, street medicine comprises teams that deliver care directly to patients in riverbeds, under bridges, and on the streets, thereby removing the need for patients to transport themselves to a place of care.[2] Depending on the nature and scope of the program, direct street-based care may be offered instead of, or in addition to, care delivered in a clinic, shelter, or mobile RV (recreational vehicle) setting.

Now is a critical time for street medicine in California. The number of new street medicine programs has increased in recent years, while policy developments at the state level have opened new doors for expansion and sustainable development. Yet until now, not much has been known about the current state of street medicine programs in California.

To better understand the depth and breadth of street medicine programs operating in California, a team of researchers at Keck School of Medicine of the University of Southern California's Division of Street Medicine conducted a landscape analysis of street medicine in the state. Conducted in the spring of 2022, *The California Street Medicine Landscape Survey and Report* captures a snapshot of how these programs have been operating within a fast-changing and evolving policy environment, presents best practices for the operation of successful and sustainable street medicine programs, and draws connections to the policies that can improve care quality and accessibility for people experiencing unsheltered homelessness across the state.[3]

The California Street Medicine Landscape Survey Methodology

The landscape analysis was a mixed-methods study that consisted of the following components:

- A 41-question electronic survey that was distributed to 25 programs that met the Street Medicine Institute's definition of street medicine, which meant excluding programs strictly using mobile medicine units.
- Qualitative interviews with select programs and health system stakeholders such as community-based organizations, government entities, managed care organizations, and the California Department of Health Care Services (DHCS).
- Site visits with geographically, topographically, and organizationally diverse programs involving semi-structured interviews with street medicine program teams.[4]

Where Are Most California Street Medicine Programs Located?

Most of California's street medicine programs (64%) are based in Los Angeles County or the San Francisco Bay Area – the two regions with the largest number of people experiencing unsheltered homelessness in the state, with Los Angeles County alone accounting for 42% of California's unsheltered population. While the landscape survey found a few robust street medicine programs in rural areas, it also found that to fill

geographical service gaps, some urban-based programs travel to and care for patients outside of city centers. Since the completion of this research in 2022, several new street medicine programs have launched around the state and are beginning to provide care in previously underserved suburban and rural areas.

Street medicine programs in California are embedded within different types of organizations, which can often determine the scope of services a street medicine program may be able to offer patients. Nearly half (48%) of street medicine programs report being embedded within Federally Qualified Health Centers (FQHCs), which provide care for patients regardless of insurance status or ability to pay, have the infrastructure in place to write grant applications,[5] and may have existing clinical structures to support specialty referrals or ancillary services.[6] Other sponsoring organizations include independent nonprofits (16%), hospitals (12%), government agencies (12%), academic institutions (8%), and health plans (4%).

Street medicine programs are connected to the broader health care system and have strong relationships with traditional brick-and-mortar, mobile, and shelter-based clinics. Every program surveyed works with at least one brick-and-mortar clinic in some capacity:

- 80% of programs refer patients to a clinic.
- 60% of street medicine providers also deliver care for unsheltered patients in a traditional clinical setting part of the time.
- 72% of programs refer patients to or deliver health care from mobile clinics.

These data confirm that street medicine exists along a robust continuum of homeless health care, which includes traditional, mobile, and shelter-based clinics that are often staffed by street medicine team members who split their time between traditional clinical and street-based care.

"People experiencing unsheltered homelessness just can't access care the way the rest of us do.... It's our duty to leave our offices and to go to them.... This requires a very high level of touch."

— A street medicine program director

How Do Street Medicine Programs Operate?

Time and Energy

Providing medical care on the street is time-consuming and requires additional field-based work. Delivering effective care to people experiencing unsheltered homelessness in their own environment requires significant engagement and trust building, much of which is done by support staff like community health workers, who make up part of street medicine teams. Medical visits conducted on the street typically take longer than the average 20.8 minutes per visit in clinic settings since patients have multiple and often unmanaged physical health, mental health, and/or substance use conditions, in addition to unmet social and housing needs.[7] Visits occur more frequently, which helps providers ensure some continuity of care for patients who do not have a permanent place to stay.

Due to the time-consuming and multi-service nature of street medicine, street medicine programs often set smaller panel sizes (i.e., ratio of patients to providers). While primary care clinics typically have panel sizes of 1,200–1,900 patients, the street medicine programs surveyed report having panel sizes of 500 or fewer patients in 2021.[8]

Across California, two-thirds of street medicine programs deliver care through teams that include the following members:

- Prescribers (including physicians, physician assistants, and nurse practitioners)

- Registered nurses
- Community health workers[9]

This team-based model enables providers to address both medical and social service needs, such as care coordination, linkages to housing/shelter, and emotional support from peers, among many others. All street medicine teams surveyed manage their own safety in the field without assistance from security or law enforcement personnel. Instead, street medicine teams employ street guides (outreach workers, community health workers, or peer navigators) and trauma-informed approaches to help navigate complex social dynamics that may exist within unhoused communities.

Many street team members are present on the street for only small amounts of time per week. In addition to disrupting the continuity of care for the patient, when street team members spend less time devoted to care on the street, they limit the growth of their street medicine skill set and hamper their care coordination proficiency.

Despite similar baseline staffing structures, staffing models and team member ratios vary widely from program to program, depending on provider availability and budget. Many providers are able to allot only part of their 40-hour workweek to delivering street-based medical care. Therefore, it may take multiple part-time providers to make up a single full-time equivalent (FTE) street medicine provider.[10] The fact that all surveyed programs were composed of more staff members than FTEs indicates that street medicine teams use an array of piecemeal staffing arrangements in which patient care is split between multiple providers, and programs rely on volunteers for completing critical nonmedical outreach and trust-building work. For street medicine programs to be effective at scale, teams must be fully and adequately staffed across all roles (prescribers, registered nurses, community health workers, peer support, and other support staff) to deliver on the promise of comprehensive primary care on the street.

What Services Do Street Medicine Teams Provide?

Street medicine services both mirror and extend beyond traditional primary care practice. Nearly all (92%) of surveyed street medicine programs focus on preventive medicine, the diagnosis and management of acute and chronic conditions, and prescribing medication. California street medicine programs have developed expertise and facility in treating substance use disorders and mental health conditions. Of the teams surveyed, 60% provide medication-assisted treatment, and even though street-based psychiatric care is scarce, approximately three-quarters of survey respondents report that they routinely diagnose and treat mental and behavioral health conditions, even offering long-acting injectable antipsychotics to treat conditions such as schizophrenia and bipolar disorder.

"There are very few psychiatrists that actually go out into the streets. We don't bill.... It's all grant money.... Doing more tele-psychiatry and then also helping our primary care providers increase their knowledge of providing psychiatric care … I want to support my colleagues in that."

— A street medicine psychiatrist

Street medicine teams have also developed systems to perform vital ancillary services like dispensing medications, performing blood work and labs, and carrying out diagnostic testing on the street. Despite heavy administrative, regulatory, and financial burdens, 84% of teams directly provide medications and 40% offer

point-of-care ultrasound. Programs also help patients access basic needs like food, water, clothing, and mail services as part of their typical programming. Over half of street medicine teams report that they connect patients to housing services. Some teams also continue to provide medical care to patients once they have moved into temporary or permanent housing. As one street medicine program director explained, "[Service] longevity is really important.… If they move inside, we follow them. The care goes wherever they go."

While telemedicine became ubiquitous in the wake of COVID-19 only one-fourth (25%) of street medicine programs surveyed offer telemedicine services.[11] Telemedicine favors those with access to and familiarity with smartphones, laptops or computers, and internet and data services, which makes uptake by unsheltered people — who often lack reliable access to and use of these devices and services — much more challenging. However, there is a role street medicine teams can play in facilitating telemedicine through lending, managing, and supporting patients' use of the technology required to connect with psychiatric and other specialty services that may otherwise not be accessible in person or on the street.

Who Do Street Medicine Programs Serve?

Street medicine programs serve complex and diverse populations, and it is imperative that programs consider patient demographics to most effectively and equitably target and deliver care. Chronic homelessness and repeated exposure to trauma, weather, infection, chronic stress, and stigma lead to complex social, physical, and mental health needs, and can result in premature and high rates of mortality.[12] Survey respondents noted that 76% of patients experience chronic homelessness, and most of these experience one or more chronic physical health conditions (86%), a mental health disorder (64%), and a substance use disorder (67%). Some programs report that all their patients fell into at least one of these diagnosis groups.

Across the 25 programs surveyed, on average, 24% of street medicine patients identify as Black, although for some teams the proportion of Black patients was as high as 71%. Similarly, the average proportion of street medicine patients who identify as Latino/x across the surveyed programs is 23%, but for some teams the proportion was as high as 60%.[13] This wide range in the racial/ethnic makeup of street medicine patients by program reflects the hyperlocal demographics within different geographic areas of the state. This means that patient outreach strategies, culturally appropriate care, and the types of medical and social services offered cannot be one-size-fits-all. Rather, street medicine teams must continue to tailor their medical and nonmedical services, their delivery, and their approach to engagement so that it is responsive and patient centered.

Older Californians are the fastest-growing group of people experiencing homelessness. "From 2017 to 2021, California's overall older adult population grew by 7%, but the number of people 55 and over who sought homelessness services increased 84% — more than any other age group," according to a recent article in *CalMatters*.[14] Older adults (defined in the study as 55 and older) compose 42% of patients cared for by street medicine teams in California. Older patients are more likely to have multiple chronic conditions, require daily medications and disease monitoring, and experience mobility issues that may interfere with access to clinics, public bathrooms, and water sources.[15] The prevalence of geriatric conditions among people experiencing homelessness is higher than that seen in housed adults 20 years older.[16] The combination of functional impairment, medical fragility, limited access to resources, and severe social vulnerability requires a high level of support that street medicine teams may be well suited to provide.

Adults age 25–54 (49% of those receiving street medicine services) present an opportunity for preventive medicine to be performed on the street through screening, testing, and vaccination. Street medicine programs can also help young people age 18–24 — often called "transitional age youth" (8% of those receiving street medicine services) by leveraging relationships with organizations that can access youth-oriented funding streams.[17]

Street medicine creates a critical access point for those who are female, transgender, or gender nonconforming. Surveyed programs indicated that from 2020 to 2021, their teams saw more patients who identified as female, transgender, or gender nonconforming. People experiencing unsheltered homelessness who identify as female experience higher levels of victimization, trauma, and violence in their lifetime and are more likely to self-report their health as "poor" than men who are unsheltered.[18]

Nearly 60% of street medicine patients are enrolled in a Medi-Cal managed care plan (MCP) where access to the full range of managed care benefits — such as specialty care, durable medical equipment, medication, and blood work — is overseen by an MCP-assigned primary care provider (PCP). When unsheltered people opt to receive medical services from a provider who is physically present in their lived environment, street medicine teams are functionally serving as primary health care providers, but without the "PCP" label or the reimbursement that comes with it. This distinction becomes problematic under managed care policies and can present challenges to patient care when patients who need to access their managed care benefits (e.g., medical equipment, transportation, referrals to specialty care) cannot do so because their street medicine providers, not assigned PCPs, are making the referrals. As a workaround, street medicine teams report being a liaison between patients and assigned PCPs to ensure that patients can receive necessary care.

What Are the Funding and Policy Opportunities for Street Medicine Programs?

Survey respondents note that their street medicine program budgets vary widely, with expenditures averaging just over $1.3 million per year. However, 85.7% of programs surveyed indicate that current funding levels for their street medicine programs were inadequate. The greatest expense for programs is clinical personnel, followed by administrative support. Many programs note that they paid out of pocket for services that could have been covered by patients' Medi-Cal benefits, such as transportation and pharmaceuticals, due to challenges with access and with seeking reimbursement.

At the time the survey was conducted, most street medicine programs (64%) relied on a patchwork of funding that included support from government contracts, grants, donations, and some insurance reimbursement. Survey participants note that valuable staff time went to fundraising rather than patient care. They also note that a lack of sustainable funding is the greatest threat to their programs.

> *"What do we need in order to be successful? We need, of course, financial support and sustainability so that we can focus on the patients and not as much on making sure that we stay open."*
>
> — A street medicine provider

However, street medicine funding opportunities in California are evolving quickly, creating avenues for new programs to emerge and existing programs to achieve financial sustainability. At the time the survey was conducted in March and April of 2022, insurance reimbursement for street medicine was often inaccessible due to both lack of clarity and the absence of "street" as a Place of Service Code for providers to

use to bill insurance or Medi-Cal.[19] Since then, new state policy guidance and insurance reforms have expanded the possibilities of reimbursement for street medicine programs. Paired with sizable sources of one-time funding available to those providing care to California's unhoused, these developments create an environment for street medicine programs to grow and thrive with maximum impact.

New policy guidance at the state level is paving the way for street medicine programs to seek reimbursement for care. In December 2021, DHCS issued a billing clarification allowing for fee-for-service billing on the street, opening the door for managed care organizations and other insurers to contract with street medicine providers, and enabling providers to receive reimbursement for services rendered to Medi-Cal (although not Medicare) members.[20] Following this change, in November 2022, DHCS issued an All Plan Letter (APL 22-023) providing guidance to Medi-Cal MCPs that makes it easier for them to contract with organizations sponsoring street medicine programs.[21] By allowing street medicine teams to operate as assigned PCPs and making street medicine workers direct contract providers, the APL has solidified a stable revenue stream for street medicine programs, made it more financially feasible for street medicine teams to deliver whole-person care, and lowered the barriers for people experiencing homelessness to access their Medi-Cal benefits.

Reforms in the insurance sector are expanding access to whole-person care for people experiencing unsheltered homelessness. According to the DHCS APL, street medicine teams can now contract to be Enhanced Care Management (ECM) providers under CalAIM (California Advancing and Innovating Medi-Cal), a multi-year initiative to improve health outcomes for Medi-Cal enrollees and the most comprehensive health care program designed to serve people experiencing homelessness in California history.[22] ECM provides a funding mechanism to support care coordination activities and the high ratios of nonbillable staff that street medicine requires, such as community health workers, peer support staff, and patient navigation workers, who are responsible for much of the time-consuming nonclinical work that the practice of street medicine requires. The combination of CalAIM and the billing guidance from the DHCS APL means that street medicine teams will be able to reliably access flexible and sustainable funding streams that can cover the costs of their core staff and services.

One-time sources of dedicated funding have the potential to create an environment in which street medicine programs will be able to thrive, especially when coupled with the policy and insurance developments that have simplified billing processes for street medicine providers:

- CalAIM Providing Access and Transforming Health Initiative (PATH), a five-year, $1.85 billion initiative designed to support ECM as well as Community Supports, is well positioned to fund new or expanding street medicine programs.[23]
- PATH Capacity and Infrastructure Transition, Expansion and Development (CITED) provides funding to enable the transition, expansion, and development of ECM and Community Supports capacity and infrastructure.[24]
- The Housing & Homelessness Incentive Program (HHIP) provides $1.3 billion in one-time funds to encourage and support MCPs in developing capacity and partnerships that will help connect members with housing services in order to prevent or resolve homelessness.[25] To receive HHIP funds, MCPs must meet certain metrics, many of which are directly related to street medicine, such as contracting with street medicine organizations, increasing the number of members who receive street medicine services, enabling members to receive services through CalAIM, and screening for homelessness or placing members into the Homeless Management Information System.[26] The relevance of these metrics to

street medicine is encouraging for the financial sustainability, as well as the potential impact, of existing and emerging street medicine initiatives across the state.

Looking Ahead

Street medicine programs lower the barriers to health care for people experiencing unsheltered homelessness through the direct delivery of whole-person care to patients in their lived environments. Recent changes in health care policy, insurance billing practices, and one-time funding opportunities indicate a promising future for street medicine programs in California. To maximize the potential impact of recent developments and optimize care delivery for unsheltered communities across the state, it is important for MCPs and other stakeholders to do the following:

- **Capitalize on momentum to scale and expand these programs.** Establish new street medicine programs, scale and optimize existing programs, and invest in the recruitment and development of core staff roles. HHIP and PATH-CITED offer a time-limited opportunity to fund organizational and programmatic capacity building and service expansion (both in service scope and geographical reach); however, sustained support beyond these one-time resources is needed to ensure continuous improvement in the practice and field of street medicine. MCPs and street medicine programs should negotiate new and flexible contracting arrangements and workflows that provide appropriate reimbursement for the time- and energy-intensive provision of street medicine services, inclusive of the patient outreach and trust-building work. Intentional investments to support the start of new street medicine programs — via start-up, seed, or capacity-building grants — can provide critical support for organizations sponsoring street medicine programs. These investments should consider organizational and programmatic infrastructure needs and operational ramp-up periods, which are costs not recoverable through MCP contracts or billing.
- **Evaluate the impact of these programs.** Develop consistent practices around collecting and regularly reviewing and assessing patient data, with a particular focus on race and ethnicity, to ensure that both access to services and patient outcomes are equitable across all patient groups. Local Homeless Management Information System (HMIS) data along with other data sets can be leveraged to help set benchmarks and to better inform the deployment of limited resources. Additionally, the impact of street medicine and other models of care, including mobile and traditional clinic-based models, for people experiencing unsheltered homelessness must be evaluated to establish best practices and inform decisions on where to direct limited resources.
- **Consider demographic needs.** Support subpopulations that are not well served through conventional care delivery models, such as transitional age youth, older adults, and people with behavioral health needs, through a health and racial equity lens. Policies governing street medicine programs should aim to increase access to psychiatric services and specialty consultations and should explore how using telemedicine can facilitate increased access. Nonpsychiatric providers working as part of street medicine teams should be trained to diagnose, treat, and manage mental illness and substance use disorder to shore up shortages in the mental health field at large.

About the Authors

Robin Buller, PhD, is an independent consultant.

USC Street Medicine is a collaboration of interdisciplinary health care professionals that aims to improve care for people experiencing homelessness while advocating for health care justice in Los Angeles through medical and social service outreach and research. This paper is based on research conducted by USC Street Medicine and previously published in a longer format.

About the Foundation

The **California Health Care Foundation** (CHCF) is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

Endnotes

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