

Healing Hands



A Publication of the HCH Clinicians' Network



**Street Medicine and Outreach:
Bringing Care to People Where
They Are**

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I. Introduction

There are many obstacles to accessing health care for people who are experiencing homelessness. It can be difficult to get to a health care clinic or a hospital without resources like reliable transportation, and it can be difficult to keep track of appointments and medications while living unhoused.

Understanding eligibility requirements and acquiring necessary documentation can be an arduous process, particularly for people with limited access to phones, computers, and physical storage space. Leaving personal possessions and pets behind may inhibit people from leaving their sleeping places, due to fears of theft or police sweeps. All of these challenges are further complicated by the fact that “this subset of the homeless population [often] has severe and co-occurring physical, mental health, substance abuse, and/or cognitive disorders, leading to difficulty navigating the relatively complex homeless services system.”¹

Moreover, “people who have been living on the streets are both emotionally and physically traumatized by the experience” and may have difficulty trusting both institutions and care providers; “One reason for that distrust may be the criminalization of homelessness, or the interference [in] ‘life-sustaining activities’ that people who are homeless engage in—sleeping, eating, camping, asking for money—by activities such as ‘sweeps’ of encampments and [prohibitions on] panhandling.”² The most vulnerable people experiencing homelessness have likely been failed by institutions many times in their lives, and their mistrust of authorities, institutions, and individual care providers may represent an attempt at self-protection that, over time, becomes a barrier to accessing care and resources that could improve their lives.

One strategy for building trusting relationships with people who are in need of medical services, while also decreasing the logistical barriers that block access for many, is for agencies to deliver health care, including medical treatment and behavioral health care, directly to the places where individuals live. This may mean delivering services on the street, in shelters or soup kitchens, in encampments, or—in more rural areas—in the woods. This approach to care provision is broadly referred to as outreach work, and in practice encompasses a variety of approaches, including street medicine.

Outreach may be defined as “the fundamental bridge between unstably housed individuals and available services and resources.”³ When working with individuals, outreach may be understood as the “front door” to an agency, which may involve “client engagement outside the traditional office setting; networking to identify clients and get in touch with them; meeting clients where they are and on their terms; and finding people, assessing their needs, and connecting them with services.”⁴ On a community level, outreach may be understood as creating a network of contacts and resources that are supportive of the well-being of clients. Combining these two levels of understanding, outreach may be conceptualized as the creation of webs of support and services linking people experiencing homelessness with each other and with a range of care providers.

This issue of *Healing Hands* is an exploration of street medicine and outreach care: what they mean, what they entail in practice, and why they matter. After considering the spectrum of services and forms of service delivery that are encompassed by the term “outreach,” attention will be given to several programs that illustrate the different forms that medical outreach can take, including: A street medicine program, an urban street outreach program, a rural outreach initiative, and outreach care delivered through emergency services personnel. Best practices and considerations for agencies hoping to develop or expand medical outreach services, through in-person on-site services as well as telehealth delivery, will also be presented.

II. Types of Outreach Services

Katie League is a COVID-19 Project Manager on the Policy Team at the National Health Care for the Homeless Council, headquartered in Nashville, Tennessee. Ms. League identifies several main types of outreach work:

- 1. Outreach work that starts with a very specific purpose—e.g., Medicaid enrollment or free phone distribution—and is oriented toward one specific transactional task that only requires one or two encounters but does not develop ongoing relationships with clients.**
- 2. Outreach work that is done by peer specialists, community health workers, and outreach workers. This work is oriented around client goals and involves frequent contact in an effort to build relationships, understand the specific needs of a given community, and help clients identify and achieve goals that may eventually lead them to pursue a connection to care. A key question asked with this kind of work is: “What do you need?”**
- 3. Outreach work that is undertaken with the goal of helping people get registered in a jurisdiction’s coordinated entry system (CES). This kind of work is more goal-specific than generalized outreach, but it builds a long-term relationship in the interest of facilitating active engagement with the region’s CES as an entry point into services.**

II. Types of Outreach Services *(cont.)*

4. Outreach work conducted by health care providers (HCPs), such as doctors, nurses, psychiatrists, behavioral health care staff, addiction care providers, etc., who conduct outreach with the goal of offering their scope of services. Many communities do this in tandem teams of outreach workers and HCPs, doing wellness checks and talking about specific physical and mental health issues, likely without the expectation of being able to bill for services.

5. Formalized street medicine work that is committed to bringing as much care and resources to the person as possible, regardless of where they live.

The first four types of work are fundamentally oriented around building relationships and breaking down barriers to care, but likely include the goal of helping the person go somewhere else and engage with a clinical setting—or with housing resources, or other community resources—in some way. Street medicine is a bit different, in that care is provided and available without contingencies upon visiting a physical location like a clinic. There are always limitations to the full scope of practice (as there are anywhere, including clinics). For example, in some locales it is not permitted to do blood draws on the street, and different places have different rules around the employment of various harm-reduction techniques. But the underlying philosophy of street medicine is: “I will continue to see you out here as long as possible and as long as necessary,” explains Ms. League.



Outreach team members approaching an encampment.

Photo courtesy of Pittsburgh Mercy.

Organizations may mix and match these approaches and may tailor them to specific communities being served. “Short-term engagement can be an entry into learning more about what a community needs,” says Ms. League; “You don’t stop one kind of service when you’ve picked up another. The flexibility of outreach teams is that you can build on experiences and adjust them to reflect the need of a particular community... At different times the needs will be different.” Ms. League emphasizes that ongoing and agile community needs assessments are crucial for finding the most effective approach for a given community. (“What does the community have as a need or a goal? Do folks need a doctor? Substance use treatment providers? A nurse? Help with ID and documentation? How often does this community require contact? How are the community’s needs changing over time?”)

III. Outreach Service Delivery Possibilities

These various types of outreach can also be delivered through a variety of service delivery approaches. Because different communities have different sets of needs, and different levels of resource availability, “one [approach] may be more feasible or desired in your community than another, so it is important to be thoughtful about resource allocation,” says Ms. League.

Many health centers do not provide street medicine or outreach services due to operations/administrative concerns such as: (1) a lack of clear funding options, specifically inconsistency and uncertainty of Medicaid reimbursement, (2) issues of health center scope of project, and (3) concerns about staff safety. Understanding the ways that other organizations have approached these issues and concerns can give a sense of how many potential solutions exist.⁵

According to NHCHC’s **Michael Durham**,

“Medical outreach comprises a continuum of service delivery methods. On one end is street medicine, also known as ‘backpack medicine’ (especially in communities where outdoor homelessness is hardly urban), which is direct care for people living unsheltered in the place where they reside. On the other end is an RV, some of which have multiple exam rooms, wheelchair lifts, and other bells and whistles... In between are Mobile Medical Units (MMU) of different sizes, some of which constitute the clinic itself whereas others simply transport the outreach team: but here there is a philosophical line.”⁶

Continuum of Medical Outreach



Image from Street Medicine or Mobile Medical Unit? Considerations for Expanding Medical Outreach National Health Care for the Homeless Council (nhchc.org)

III. Outreach Service Delivery Possibilities *(cont.)*

Outreach care may be delivered out of backpacks or vans; through ongoing programs or one-time outreach campaigns; and with the assistance of case managers, community health workers, emergency services workers, doctors and nurses, or behavioral health specialists—but all clinical outreach shares a common goal:

"The purpose of clinical outreach is to extend clinical services in an environment that is familiar and accessible for those who face barriers in seeking or following-up on their care. Clinical outreach seeks to address many of the most common barriers facing underserved populations, including limited or lack of transportation, lack of familiarity with the health system, and prioritization of day-to-day survival over health maintenance. Further, many clinical outreach efforts minimize the barriers of high cost or lack of health insurance by offering services for free or at very low rates."⁷

The COVID-19 pandemic has increased rates of homelessness and created additional barriers to people coming into clinics, but it has also caused some organizations to develop creative solutions, including new models in telehealth. Though traditionally technology access has been a barrier to care for unhoused populations, some agencies have begun using technological solutions, such as portable digital equipment, to use tools like telehealth and Zoom to provide care, from a distance, for people living on the streets and in encampments. Community health workers and peer support specialists can also be important sources for creative ideas on how to best reach individual communities.

According to the United States Interagency Council on Homelessness, there should be four core elements of street outreach services:

- ***Street outreach methods are systematic, coordinated, and comprehensive.*** Efforts are conducted on behalf of the community, rather than just one agency, and reflect an understanding of the community-wide network of systems, services, and resources.
- ***Street outreach efforts are housing-focused.*** Representing the understanding that housing is healthcare, street outreach represents a Housing First philosophy.
- ***Street outreach efforts are person-centered, trauma-informed, and culturally responsive,*** incorporating training that enables outreach workers to be “respectful and responsive to the beliefs and practices, sexual orientations, disability statuses, age, gender identities, cultural preferences, and linguistic needs of all individuals.”
- ***Street outreach efforts emphasize safety and reduce harm—for both outreach workers and clients/potential clients alike.***⁸

Across different regions, different communities, and different programs, care providers of all varieties work to implement these best practices of outreach care in ways that are manageable and practicable for their organizations.

IV. Street Medicine



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Visiting people where they live - in alleyways, under bridges, or within urban encampments - is a necessary strategy to facilitate trust-building with this socially marginalized and highly vulnerable population.”

The Street Medicine Institute defines street medicine as:

“...health and social services developed specifically to address the unique needs and circumstances of the unsheltered homeless delivered directly to them in their own environment. The fundamental approach of Street Medicine is to engage people experiencing homelessness exactly where they are and on their own terms to maximally reduce or eliminate barriers to care access and follow-through. Visiting people where they live – in alleyways, under bridges, or within urban encampments – is a necessary strategy to facilitate trust-building with this socially marginalized and highly vulnerable population. In this way, Street Medicine is the first essential step in achieving higher levels of medical, mental health, and social care through assertive, coordinated, and collaborative care management.”⁹

Street medicine, “which had only a few resolute practitioners when it got its start in the mid-1980s, has surged within the past decade,” and “advocates attribute much of the growth to organized efforts by street medicine supporters to expand awareness and create new programs. The first street medicine symposium was held in 2005 in Pittsburgh, followed by the creation of the Street Medicine Institute four years later. A 2017 symposium in Allentown, Pennsylvania, drew more than 500 international participants, compared with a handful at the Pittsburgh gathering.”¹⁰ There are now street medicine programs in over 122 cities in 29 countries on 6 continents.



Photo courtesy of Pittsburgh Mercy

IV. Street Medicine *(cont.)*

Dr. Jim Withers is the founder and Medical Director of Operation Safety Net, a street medicine program run through the Pittsburgh Mercy Health System in Pittsburgh, Pennsylvania; he also co-founded the Street Medicine Institute in 2009. Here is his story about his involvement in the development of the street medicine movement:

“This audience is aware of homeless health services and such, and many of the people and organizations that we all owe a great deal to such as Dr. Jim O’Connell and others who laid the groundwork for the NHCHC organization and movement. So I see myself contextually located within that history. And the advocacy then spills over into respite care providers’ grassroots network that became part of the network, and the street medicine movement—I didn’t invent street medicine although I coined the term. A few people were doing it when I started, notably a lot of nurses were out there doing it, sometimes without much support. So I always want to acknowledge them. But I entered the scene a little bit from the outside, as a medical educator in the very early ‘90s, without knowing anything about homeless health care. My passion was—I felt that the soul of healthcare was being lost in an arrogant system-centered dehumanizing machine. And as a teacher, I desperately wanted a new classroom where excluded people could teach us the lessons we needed to learn... I was really at a crisis in the late ‘80s about that. My passion for the unsheltered homeless probably is at the extreme edge, and so I’ve been one of the people that has really focused on that area of care. And been able to be part of a movement, first within the US and then around the world, that specifically focuses on rough sleepers.”



Photo courtesy of Pittsburgh Mercy

“... I desperately wanted a new classroom where excluded people could teach us the lessons we needed to learn” - Dr. Jim Withers

IV. Street Medicine *(cont.)*

“The philosophical underpinnings of the movement are captured pretty well in our tagline, which I saw on a wall in a hospital in Haiti... The first four words were ‘Go to the people.’ When I read it, it was one of those moments when everything kind of crystallized. It articulated a mission statement—it articulated what my heart always felt we should try to do, and where we were falling short. I feel like going to the streets and working with people in solidarity on their terms crystallizes a lesson that all of health care needs to figure out how to incorporate: Whether it’s a bank president or someone curled up next to a dumpster, we need to find a way to be present with love and respect and solidarity with people. You can do that in a clinic, you can do that in a shelter, you can do that many places. But there is something for me about crawling under a bridge and finding a way to—it’s not like you’re delivering care, you’re finding a way to join with people. Literally meeting them where they are. And it’s impossible to ever truly be one with folks that are going through so much trauma and difficulty, when you’re going to go back home to your house, but the activity of working toward that goal and then, through the grace that they show you, being able to find that common ground is really special and profound.”



Photo courtesy of Pittsburgh Mercy

IV. Street Medicine *(cont.)*

In service of this goal, practitioners of street medicine carry their supplies with them and generally do their care provision on foot. Supplies include medical supplies, of course, but also other items that may be helpful to people living on the streets. “You can never have enough clean socks in your bag,” says Dr. Withers; “the thing that someone needs right now is really important.” The needs identified by the patient may be different than the needs perceived by the provider, and street medicine is responsive to this distinction.

Other items that Dr. Withers identifies as crucial components of a street medicine bag are:

- **Pain management supplies**
- **Medical supplies for dealing with skin infections and wounds**
- **Blood pressure measurement tools**
- **Gloves and masks**
- **Flashlights**
- **Harm reduction supplies, such as Narcan, fentanyl test strips, and clean needles**
- **Feminine hygiene products**
- **Referral information downloaded to a phone**

“You are limited by how much you want to carry and how far you are going,” says Dr. Withers, “So don’t add anything that might get too heavy or lead to dynamics you don’t want.” But he also recommends fluidity and openness: “The street teaches you what you need, and you need to keep listening—because you may think you heard it, but you didn’t,” he says.

In Pittsburgh, Dr. Withers explains, street medicine teams are made up of 4 to 5 people that include dedicated full-time outreach workers (many of whom have lived experience with homelessness), clinicians who are able to work at a doctor or nurse practitioner levels, plus a peer navigator or support person who can take on the navigation of social issues. Teams also include learners: medical students, occupational therapists, nursing students, or medical residents.

“We are limited in the number of learners we can take out,” says Dr. Withers, “because we don’t want to overwhelm people, but over the years, maybe one of the most important things we’ve done is to have that classroom in the streets. So many street medicine programs that exist now were started by former students that became passionate about it and went on to start their own programs and educate other people.”

V. Urban Street Outreach



“

... when someone can just come in and see us a few times and test things out—assessing whether we are sincere, coming back, and treating them with respect—we can help them with one issue which gives them courage to tackle a bigger issue”

- Dr. Hugh Silk

Outreach services can also be folded into other programs; for instance, some health care clinics may offer outreach services as well as on-site services, or they may use a care delivery model that is a hybrid of traditional clinic-based care and outreach care.

In Worcester, Massachusetts, **Dr. Hugh Silk** is a physician with the Homeless Outreach and Advocacy Program (HOAP), and he also teaches in the medical school at the University of Massachusetts. HOAP is affiliated with the Family Health Center of Worcester, a health center that provides primary care, psychiatrists and therapists, and caseworkers. Dr. Silk also work with Road to Care (RTC), a clinical outreach program that currently employs on-foot outreach and is in the process of acquiring a mobile medical unit. The RTC team provides medical care in encampments, food pantries, shelters, and other settings. The work is funded by the Bureau of Substance Addiction Services (BSAS) and the Kraft Foundation.

The RTC program started last spring, growing out of the realization of how many people were not being reached in the clinic. Dr. Silk saw how difficult it was for many people experiencing homelessness to make and keep a clinic appointment: “The person may not have a phone to receive the reminder. If the weather is bad, they may have physical difficulties. Transportation is hard. There is fear of engagement... So for us to just show up at a place that people are going for food, and they don’t have to make an appointment because they can just write their name down, eat breakfast, then come see us when it is their turn... This low-barrier care is huge.” And the outreach approach is also responsive to other barriers around trust and mental health issues. Dr. Silk says that “when someone can just come in and see us a few times and test things out—assessing whether we are sincere, coming back, and treating them with respect—we can help them with one issue which gives them courage to tackle a bigger issue.”

A key strategy for the program has been going to the same places every week and on a reliable schedule, because the consistency helps people know where to find them. In encampments, the team engages people around wound care or mental health medications,

V. Urban Street Outreach *(cont.)*

and they ask about substance use. (Provision of Suboxone is a key offering for harm reduction and engaging people in care.) “As we get to know people and talk to them about [their interest level in] trying to get off substances, we keep showing up, and people decide to work with us,” explains Dr. Silk.

“Anecdotally,” he adds, they are seeing impacts: “We are seeing the same faces, having the same people come back and talk about how they are making progress. We have some people who are coming weekly for Suboxone who just look better. People are more alert, bright-eyed, talking to us about goals, having conversations. It’s enough people that it keeps us excited about the program. There are people we have seen with serious wounds who we’ve been able to help before they became serious infections... [for instance], a man whose thumb was in such bad condition that it...fell off in the office as we were providing care, but we were able to contain the infection. He didn’t lose his hand and he keeps coming back and is now thinking about addressing his substance use.”

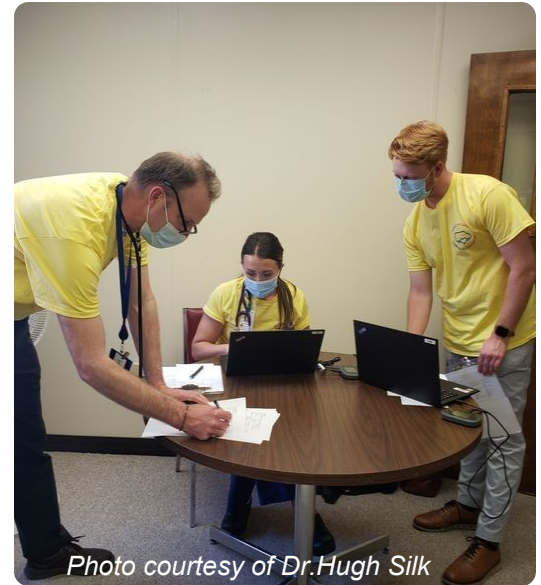


Photo courtesy of Dr. Hugh Silk

Dr. Silk has many hopes and plans for the future of RTC as well as community collaborations. “In our van,” he says, “we’ll have all the supplies for primary care. We’ll have a mobile care unit with an exam room and an exam table where we can do PAP smears and procedures like draining abscesses, and there will be more privacy.” Dr. Silk would also like to see more multi-faceted services added to the services available in the mobile medical unit: “In my ideal world we’d have a therapist with us who could telehealth to a psychiatrist. We may figure this piece out before too long—how to involve telehealth. The pandemic has shown us that ability....And to have this van have the capabilities of having half being medical and other half being dental. We really need an oral surgeon who can remove teeth, help people get dentures.” In the meantime, RTC is also working with community partners on some key service provision efforts—with AIDS Project Worcester on sexually transmitted infection (STI) testing and a clean needle initiative and assisting with a grant for a collaborative mobile methadone unit in the city.



Photo courtesy of Dr. Hugh Silk

“Partnerships take us all further.”

- Dr. Hugh Silk

VI. Rural Outreach



“

For the low-income population, transportation is a real issue because things are so far apart...and there is one existing bus system that is challenging and intermittent and doesn't reach most smaller rural communities. So for many of the patients we serve from those demographics, we have to go to them where they are.”

- Alysa Lavoie

Outreach services are often referred to as “street outreach,” representing the fact that urban agencies often have more resources available to allocate to outreach services. But outreach also happens in places where there are no streets! In Kailua-Kona, Hawaii, outreach workers with the West Hawaii Community Health Center (WHCHC) travel across lava fields and through jungles to reach people who are living unsheltered. **Alysa Lavoie** is the Behavioral Health Programs Manager, **Emily Crabill** is the Marketing and Development Manager, and **Nate Hakeem** is a Behavioral Health Case Manager at WHCHC.

Ms. Lavoie explains that WHCHC services the west side of the Big Island, “an area about the size of all the other Hawaiian Islands put together, times two.” The organization includes five clinics with a combined service area of about 150 miles and serves 20,000 patients. “The area is incredibly large and rural,” says Ms. Lavoie, “with two population hubs on the island...no cities, and a couple

of towns up and down the coast that aren't really even considered towns... For the low-income population, transportation is a real issue because things are so far apart...and there is one existing bus system that is challenging and intermittent and doesn't reach most smaller rural communities. So for many of the patients we serve from those demographics, we have to go to them where they are.”

The island has an extremely high unhoused population, owing largely to the housing crisis in Hawaii. Rent is unaffordable for many Hawaiian residents, particularly those with fixed incomes. Mr. Hakeem says, “I suspect we'll see that in numbers in coming years because even with a solid income, people can't afford rent. There are new populations of families living in vehicles, which may be going unreported for now because people still see their situation as



Photo courtesy of West Hawaii Community Health Center

VI. Rural Outreach *(cont.)*

temporary. People will have to move off island or something will have to give."

According to Ms. Crabill, WHCHC has been running a clinical outreach program for seven years. Outreach is conducted once a month, with the knowledge that there is a need for more. Outreach teams typically consist of about 10 people: a health care provider, one or two case managers, someone who can help with insurance, a care coordinator, and community volunteers. Ms. Crabill says that their outreach program "is similar to what you see on the mainland with street medicine, with a few exceptions. Our populations are dealing with different needs; we don't have to worry about cold weather illnesses, but infections run rampant year-round. There is a lot of staph and MRSA. People get scratches while living in encampments with sharp, thorny trees. Areas with trees are easier places to find a safe encampment, but that means cuts and risk of infections."

Ms. Lavoie adds that in addition to caring for emergent needs, such as wounds and infections, outreach teams also provide emergency behavioral health care, and seek to connect people living unhoused to other services, such as substance use disorder treatment and medications, emergency dental services, a crisis hotline, housing programs, and food banks.



Photo courtesy of West Hawaii Community Health Center

However, referrals pose a difficulty in these rural areas, both because of transportation challenges and a scarcity of community resources. Mr. Hakeem explains that "One of the biggest challenges for case management is connecting people with resources. You want to point people toward community resources, but there are so few. We can do street medicine and provide wound care, emergency mental health care, etc., but trying to connect them with case management and ongoing services is difficult because they are short staffed and overworked... We had somebody yesterday with a fentanyl crisis, and it's difficult to connect people with detox or other services. Sending people off-island during COVID (e.g., to Maui) became impossible. Travel has been limited. There is always a wait list for services... In a big city, there are numerous options for food and clothing; here, we have maybe one or two options

VI. Rural Outreach *(cont.)*

for each thing... The wait list to get housing (even if you qualify) is long, and then finding housing is nearly impossible. We feel like we're always working with bare minimum scraps to offer people. We can only do so much."

Despite these challenges, WHCHC's outreach teams go to great lengths to find people and encampments, often covering up to six miles of shoreline and forested territory per day, says Ms. Crabill. "We're cautious about how we enter the communities," emphasizes Ms. Lavoie, "because we don't want the police to know where they are and do sweeps. We are trying to help communities while protecting them from surveillance, but finding encampments is hard. It's literally hiking through lava fields and forests to try to find people. We have good relationships with folks who will keep us updated on where friends have moved... and recently, a helicopter company in town took us up in a helicopter to fly around Kona and spot where the encampments were. So we were able to do mapping of specific spots where people were gathering."



Photo courtesy of West Hawaii Community Health Center

These maps will help WHCHC's outreach workers as they continue building relationships—with partner organizations, community volunteers, donors, and patients. "The number one thing," says Ms. Lavoie, "is the concept of *aloha*—rapport. Making sure we build trust with folks is the foundation of everything... consistently coming back, bringing hygiene packs and food and water and whatever else we can bring, and developing the relationship. Everything is based on this: If you show someone that you care for them, they can care for themselves, too."

“ The number one thing is the concept of *aloha*—rapport. ”

- Alysa Lavoie

VII. Emergency Services

Another innovative model for providing outreach services to people living unhoused is through collaboration with emergency services. In Durham, North Carolina, **Capt. Helen Tripp** is the Program Manager of the EMS Community Paramedics program. “We have a team of community paramedics who work with patients in the community to help them with health care needs, housing, food, finances, etc.,” she explains. Capt. Tripp estimates that around 25 percent of her team’s service provision is medical care. The team is equipped for critical responses, but their primary goal is to respond to the calls of frequent utilizers of EMS and attempt to help them connect to community resources.”

“If someone has called 911 several times in a week,” says Capt. Tripp, “we’ll get involved and try to find out what is going on, what their needs are. We ask if they need a PCP and whether we can help them get connected... A lot of our frequent callers are uninsured or underinsured, so we want to get them connected to homeless services and clinics that take referrals.” These high utilizers of the EMS system are often people experiencing homelessness, living with substance use disorder, and/or experiencing mental health emergencies, so the outreach model is a way of responding not only to emergent situations, but to longer-term needs as well.

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[The key is] making sure that you do understand the needs of the community, and not just thinking that you know what they are. ”

- Capt. Helen Tripp

The key to doing this work effectively, says Capt. Tripp, is to “know your resources. Know the community resources that are available... In Durham, we have a lot of resources that we have discovered in working with different people in the community. Sometimes Person A doesn’t realize that there is already a resource available. One thing I’ve been able to do is connect people together—they’re doing what you need to do, and you didn’t even know they existed! Take advantage of committees, do resource mapping, get contact information for them. And understand the needs of your community. It’s one thing to get an idea—we did this early on, we had an idea that we were going to help one group or another but once we started to look at what that group needed, we find out there were already a lot of people working on that very problem, so we didn’t need to do it after all. We didn’t need to be reinventing that wheel. [The key is] making sure that you do understand the needs of the community, and not just thinking that you know what they are.”

The community paramedics model is also an example of how collaboration between different agencies can help meet community needs. Last year, Capt. Tripp’s program worked with community health and public health agencies on a COVID vaccine distribution initiative. Though vaccine clinics may be considered a single-visit/one-time initiative, they can also open the door to relationships of trust with patients, and to longer-term collaboration between agencies and organizations.

VIII. Best Practices in Street Medicine & Outreach Programs



“

A lot of folks living in the streets don't have the trust that sheltered people have with institutions and professionals, like doctors, the police, etc. That trust is shattered when living on streets.”

- David Peery

David Peery is Executive Director of the Housing Justice Campaign of the Miami Coalition to Advance Racial Equity, a housing justice campaign that is fighting Miami's criminalization of homelessness and advocating for constructive alternatives to end homelessness in Miami. Based on his experience as a lawyer, advocate, and person with previous experience living unsheltered, he states that the two most important pillars of outreach work are trauma-informed care and peer support.

Trauma-informed care means that providers “stop focusing on what is wrong with a person and focus instead on the systemic issues that have brought a person where they are,” he says. Trauma-informed care requires that providers have a systems-level analysis of the lived reality of the people they meet and understand the pipelines that exist that funnel people toward poverty, homelessness, incarceration, substance use, and other interrelated realities.¹¹ “Instead of forcing human beings to do things,” says Mr. Peery, “people have to be open and willing to be changed—nudged along, rather than forced.”

Peer support means that peers—people with lived experience of homelessness—are the vehicle for outreach. Mr. Peery explains: “Data shows that peers are effective in reaching folks in the street... especially those who are trained as peer support specialists, perhaps even certified, and trained in trauma-informed practice.” He emphasizes that peer support can be a crucial tool in developing trust among consumers: “A lot of folks living in the streets don't have the trust that sheltered people have with institutions and professionals (like doctors, the police, etc.). That trust is shattered when living on streets. So you'll see that many street medicine folks often find barriers to connecting with folks who need medical care, because of that lack of trust. And peer support can help to bridge those barriers. When you combine street medicine with peer support specialists on the frontline, they can help to pull folks into the system and help to engage people into primary care, wound care, and harm reduction services that providers offer.”

VIII. Best Practices in Street Medicine & Outreach Programs *(cont.)*

One concept that may be useful for outreach workers is the “three homes” theory, developed by **Ken Kraybill**, which emphasizes that one must respect the three homes of a person experiencing homelessness—the individual’s personal space, the physical space where they live, and the community in which they live. Since outreach workers are coming into other people’s spaces, it is important to cultivate an atmosphere of respect and dignity:

“What implications does this notion of “three homes” have for outreach workers? People on the streets often do not feel “at home” in their own bodies, minds, and souls, have no housing to call home, and are disaffiliated from a meaningful role and purpose in the larger community... As the saying goes, a house is not a home. We must assist [people experiencing homelessness] in making their housing into a home. In addition, we must also help them be more attuned to their own personal conditions, needs and care. And we must help them find their “place” in the larger community. Helping others move towards a greater sense of being “at home” in their lives begins with the very first outreach encounter. For example, by offering a hospitable presence – “creating a free and friendly space for the stranger” (Nouwen) – one makes it possible for the other person to experience a taste of being “at home.”¹²

“

Those who sleep outside are often most mistrustful of institutions for valid reasons, not least of which is the trauma they have experienced in medical settings. So going to where clients reside is to meet them on their own territory on their own terms, altering the power differential; we are guests in their space just as we would be in someone’s house.”¹³

- Michael Durham

VIII. Best Practices in Street Medicine & Outreach Programs *(cont.)*

The National Health Care for the Homeless Council has published a guide to approaching and enrolling clients in outreach care.¹⁴ This guide acknowledges that there are many challenges to connecting clients with resources, including:

- **Unmanaged mental illness, particularly when clients cannot provide informed consent**
- **Lack of client readiness, including lack of trust and fear of committing to program requirements/requests**
- **Difficulty in reaching clients without phones or fixed addresses**
- **Lack of transportation options**
- **Lack of language/interpretation services**
- **Resource scarcity, particularly with regard to housing resources**
- **Staff safety and risk of burnout**

Understanding that these barriers exist, first impressions are essential for outreach workers; an outreach worker's initial approach and treatment of a person may be a key factor in whether the person declines care, or agrees to begin establishing a relationship and accepting services:

- **Never sneak up on someone or corner them**
- **Respect the individual's "three homes"**
- **Clearly identify yourself and your agency**
- **Get to know the person without pushing an agenda**
- **Carry hygiene packs to distribute**
- **Describe available resources and allow the individual to decide how to proceed**
- **Cultivate a demeanor that is laid-back, open-minded, and puts the person at ease**
- **If possible, make a "soft hand-off" and personally recommend clients to new providers, benefits staff, or outside agencies that are able to provide needed resources**
- **Repeat visits are often necessary to build trust**

VIII. Best Practices in Street Medicine & Outreach Programs *(cont.)*

Dr. Hugh Silk notes that one of the best lessons he has learned about street outreach is to always have something in hand and ready to share—socks, hand warmers, water, tents, sleeping bags. “By showing some good will,” he explains, “making some little wins can contribute to bigger wins. Plenty of people really just want their mental health medications filled because no one else will do it. For us to do that again is another little win where someone feels helped, and then might be prepared to ask for more help. That is the key above all else—being nice, building trust, helping people with immediate needs then looking for longer-term things.”

Strategies for Building Client Engagement in Outreach Work, from the National Health Care for the Homeless Council:

- 1. Get to know the individual’s personal story.**
- 2. Build a consistent presence in the community.**
- 3. Follow up and follow through.**
- 4. Support people as they set personal goals.**
- 5. Let the client lead.**
- 6. Celebrate small steps.**
- 7. Move at the client’s pace.**

For more explanation of these strategies, see National Health Care for the Homeless Council. (December 2013). *Tip Sheet: Strategies for Building Client Engagement*. [Author: Sarah Knopf-Amelung, Research Associate.] Nashville, TN: Available at: Improving Quality of Care: Clinician Tip Sheet (nhchc.org)

IX. Conclusion

Across the country, in urban and rural areas alike, outreach workers and street medicine practitioners are creatively and tenaciously providing health care to people experiencing homelessness. By taking the care to the places where people are, many of the common barriers to health care, both logistical and attitudinal, can be overcome. The most effective outreach care is built on showing up consistently and kindly, and intentionally building a relationship of trust with patients.

“Everybody that reads this article has learned the same things,” says Dr. Jim Withers: “That each person is also a story. And their story is really important. You need to respect it and understand it and celebrate their own ability to write their story as it unfolds. You can’t just look at a person as a snapshot, ever. It takes time, and trust.”

Photo courtesy of West Hawaii Community Health Center



Please share your thoughts about this issue and fill out our evaluation. We appreciate your feedback!

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References

- ¹ National Health Care for the Homeless Council (July 2012). *Within Reach: Perspectives of Hard-to-Reach Consumers Experiencing Homelessness: Findings from a Consumer Participation Outreach Survey*. [Authors: Darlene Jenkins, Director of Research and Evaluation; Daniel Rabbitt, Health Policy Organizer; Molly Meinbresse, Program and Research Specialist; Patrina Tilley, Research Assistant and Sarah Knopf, Research Assistant, and Barbara DiPietro, Director of Policy.] Nashville, TN: Available at: [The Readiness for Meaningful Use \(MU\) of HIT and Patient Centered Medical Home \(PCMH\) \(nhchc.org\)](https://www.nhchc.org)
- ² Firth, Shannon (November 19, 2021). *How Can We Improve Medical Care for Homeless People?* Medpage Today. Available at: [How Can We Improve Medical Care for Homeless People? | MedPage Today](https://www.medpagetoday.com)
- ³ National Health Care for the Homeless Council. (December 2013). *Outreach & Enrollment Quick Guide: Promising Strategies for Engaging the Homeless Population*. [Authors: Sarah Knopf-Amelung, Research Associate; Patrina Twilley, Evaluation and Quality Improvement Specialist.] Nashville, TN: Available at: [outreach-enrollment-quick-guide.pdf \(nhchc.org\)](https://www.nhchc.org)
- ⁴ Ibid.
- ⁵ Recent resources from NHCHC about staff safety in outreach can be found here: <https://nhchc.org/the-hch-helpdesk/tips-to-ensure-safety-in-street-outreach/> and here: <https://nhchc.org/webinars/promoting-safety-in-street-outreach/>
- ⁶ Durham, Michael. (February 10, 2022). *Street Medicine or Mobile Medical Unit? Considerations for Expanding Medical Outreach*. Available at: [Street Medicine or Mobile Medical Unit? Considerations for Expanding Medical Outreach | National Health Care for the Homeless Council \(nhchc.org\)](https://www.nhchc.org)
- ⁷ Health Outreach Partners (HOP). (2015). *Clinical Outreach: Outreach Reference Manual*. Available at: http://outreach-partners.org/clientportal/wp-content/uploads/2017/02/ORM_CO.pdf
- ⁸ United States Interagency Council on Homelessness. (June 2019). *Core Elements of Effective Street Outreach to People Experiencing Homelessness*. Available at: [Core-Components-of-Outreach-2019.pdf \(usich.gov\)](https://www.usich.gov)
- ⁹ Street Medicine Institute. (2021). *About Us*. Available at: <https://www.streetmedicine.org/about-us-article>
- ¹⁰ Montgomery, David. (September 18, 2018). *The Homeless Get Sick: 'Street Medicine' is There for Them*. Stateline. Available at: [The Homeless Get Sick; 'Street Medicine' Is There for Them | The Pew Charitable Trusts.pdf](https://www.pewcharitabletrusts.org)

References (cont.)

¹¹ For more on trauma-informed care, visit this NHCHC webinar: <https://nhchc.org/online-courses/trauma-informed-care-webinar-series/being-trauma-informed-and-its-role-in-ending-homelessness/>

¹² National Health Care for the Homeless Council. (n.d.). *Three Homes*. [Author: Ken Kraybill.] Nashville, TN. Available at: [H1- Three Homes \(nhchc.org\)](#)

¹³ Durham, Michael. (February 10, 2022). *Street Medicine or Mobile Medical Unit? Considerations for Expanding Medical Outreach*. Available at: [Street Medicine or Mobile Medical Unit? Considerations for Expanding Medical Outreach | National Health Care for the Homeless Council \(nhchc.org\)](#)

¹⁴ National Health Care for the Homeless Council. (December 2013). *Outreach & Enrollment Quick Guide: Promising Strategies for Engaging the Homeless Population*. [Authors: Sarah Knopf-Amelung, Research Associate; Patrina Twilley, Evaluation and Quality Improvement Specialist.] Nashville, TN: Available at: [outreach-enrollment-quick-guide.pdf \(nhchc.org\)](#)

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Credits

Melissa Jean, PhD, writer
Lily Catalano, MSSW, clinical manager

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