Operation Safety Net: Street Medicine Manual

Definition

Street Medicine is a systematic approach to the provision of health care to the unsheltered homeless.

Mission Statement

As long as people live outdoors on our streets, along our river banks and in our abandoned buildings, Street Medicine will provide access to health care that meets their unique needs.

Philosophy

The core philosophy of Street Medicine is to create a relationship with those sleeping on the streets that will create the potential for them to live healthier lives. It is essential that all Street Medicine programs go out to where the unsheltered homeless live and engage them on their terms. The relationship with the unsheltered homeless must be grounded in respect for each individual, resulting in goal-negotiated model of care. Access to medical care is the core function of Street Medicine. Interventions which promote a healthier life are also integral to Street Medicine practice. These include safety, housing, income, psychiatric and substance abuse treatment, harm reduction and personal fulfillment.

Guiding Principles

- All persons have equal value and the right to their full potential.
- Those persons who live without shelter experience a tragic fragmentation from the larger community. This fragmentation itself must be addressed to heal all of us as a society.
- Street Medicine will have a primary commitment to those persons who are living outside of shelter. As those persons move from streets to housing, continued support will be sought either directly or through collaborative entities.
- The homeless will not be blamed for their circumstances.
- Persons living on the streets have remarkable strengths which must be identified and supported.
- The unsheltered homeless are have a right to health care access that is crafted to their reality.
- Street Medicine must maintain the highest standards of medical care possible.
- Peer based outreach and the use of the expertise of homeless and formerly homeless persons and consumers are valued and should be actively sought out.
- The homeless will contribute to how services are delivered through advisory representation.
- Engagement is the key in Outreach.
- Persons living on the streets have a right to decide how they will live their lives and the right to refuse services. Each person is responsible for the decisions they make. Street Medicine will remain fully open to them as they consider their actions.

- Services will be based on each homeless person's individual needs and goals. Actions will be negotiated with each person and forced intervention will only occur when the lives of the client or others are in imminent danger.
- Services will be delivered without discrimination on the basis of race, gender, age, income, culture, religion, ethnicity, height, weight, class, marital status, sexual orientation, family configuration, HIV/AIDS status, physical or developmental disability, ability to speak English, immigrant status, military status, or history of mental illness, and addiction.
- Street Medicine is committed to the principles and practice of harm reduction.
- All barriers to improved well being for those living on the streets must be decreased or eliminated.
- All resources that can have an impact on the lives of the unsheltered homeless should work in coordination to their benefit. Street Medicine will coordinate with all such entities as possible.
- Health care for the unsheltered homeless must have as much integration and continuity as possible.
- How we respond to those living on the streets is a witness to the greater community and all opportunities to humanize each other should be utilized though speech and action. Street Medicine will seek to promote the conditions in which all those within in the homeless and non-homeless community are respected.
- Those who seek to learn to serve the street homeless should be mentored and encouraged.
- Street Medicine practitioners will seek to work in concert with other practitioners throughout the world to support, improve and uplift each other.

Practice

A variety of services naturally emerge as the needs of the street homeless are addressed. These can be divided roughly into categories, though efforts to improve the lives of the street homeless will be, by nature, multi-layered in terms of depth and time frame. The practice of Street Medicine is truly an art form which derives from what best serves the needs of the individual street person. Street Medicine is not adequate primary care. It can be viewed as a form of intermediate "home care". In every encounter, an effort should be made to identify and refer patients to a primary care relationship. Many times Street Medicine is part of a regional Health Care for the Homeless program, but often it is a supplement to focus on the unsheltered population. As the needs of the street homeless are addressed, collaborative relationships with other agencies will naturally evolve. Anyone whose resources are relevant to the street homeless is a natural partner of Street Medicine.

<u>Outreach</u>

Outreach is the core activity in Street Medicine. Without getting out to the people who are sleeping outside, it is not possible to practice state of the art Street Medicine. Outreach can be achieved in a variety of ways and should overlap so that the different sub-populations and needs of the street population are met. The street homeless are not homogenous and a significant effort must be made to identify the demographics of the region. Typically, there will be homeless who

are eager to congregate and those who are more reclusive. Many cities have divisions within the street population along racial and other lines. Outreach response must be tailored to each of these situations. Excellent resources for Outreach are available ("To Dance with Grace" article and HCH Outreach Manual below)

Outreach workers are ideally those who have either been homeless in the past, or have a deep and productive relationship with the street population. They are the ambassadors to the street, as the clinical staff becomes the ambassadors for the homeless into the service world. Outreach workers are the team leaders in the sense of rounding patterns, safety and street etiquette. It is essential that the clinical and the outreach worker have mutual respect. Outreach workers will be responsible for an awareness of street dynamics and the location of active sites. This will involve regular explorations and staying in touch with discussions with the street population. It is also advisable to develop a rapport with all other relevant entities such as the police, store owners, bus stations, etc.

A good Street Medicine program must include walking rounds. Typically the teams consist of at least an outreach worker and a clinician. Walking rounds ensure that those who are living in remote areas are included, and it allows the program to honor the reality of those homeless clients. The outreach worker must establish with each person or camp site as to whether Street Medicine services are welcome, and adjust rounds to the changing conditions of each situation. Different teams on specific days will specialize in a particular geographic area to deepen the team/zone relationship. The outreach worker generally is the point person for all street contact, particularly with new encounters. He or she is the leader when judgment calls must be made on non-medical issues. All new team members must go through a briefing session with the outreach leader before making rounds to inform them of the rules and etiquette of walking rounds. Walking rounds may occur any time of day, though there is an advantage to evening visits when shelters are closed and the truly unsheltered homeless are identifiable. Many teams prefer driving a car to general areas, then walking to the local camps before moving on.

It is common that Street Medicine walk rounds will fall into two types depending on the outreach team and the person being served. One style is to move efficiently through an area to make sure that most of the unsheltered homeless are visited and their needs addressed. This is the "greyhound style" of outreach. It ensures that emergencies are identified and that most of the homeless in that area know that they are not forgotten. This is well suited for periods of severe weather. The other general type of walking rounds is the "homecare style". With this style, time is allowed for in depth counseling and intervention. Certain teams and situations lend themselves to this strategy.

Medical vans are highly useful to meet the needs of those who are willing to use them, and provide both a community building opportunity as well as privacy for individual encounters. Natural locations for van services are those where larger numbers of homeless tend to congregate. This must be negotiated with local businesses and the city as well. Vans allow higher types of services such as dental, psychiatric, full physicals, etc. It also brings more supplies than either "car rounds" or walk rounds can provide. Van sites become a touch stone for the homeless-Street Medicine community and an excellent site for formerly homeless volunteers.

The eventual result of effective outreach is the mutual desire to seek an improved life for our clients. At this point, we join with our street friends in approaching the various resources that might help them in their healing journey. Unfortunately, this path can be tortuous and, at times, unwelcoming. We refer to this process of reaching into the system with our clients by our side as "inreach". Regardless of where this takes us, we must patiently build those bridges that will best serve our street friends. Together, amazing things can happen which transform how the greater community views their brothers and sisters on the streets – as one of us who are trying to improve their life.

Outreach Attire and behavior

Outreach attire must be appropriate for the street environment. This means that it should not only be compatible with the weather conditions, but also socially appropriate. No provocative clothing or bright colors (rather dark clothes) should be worn. Any item that would distract clients or tempt them must be avoided. Outreach teams should not give money to clients. In addition, any behavior which either distracts from effective street interactions or provokes danger will not be tolerated. The outreach leader will have final say on dress code and behavior related to street rounds.

Engagement

At its most basic, outreach is about engagement. This can be simply assessing the situation of a client from a distance, to a deep conversation exploring the person's issues. Particular attention should be given to listening to the person and validating their experience in a non-judgmental way. Plans or goals must arise from the client, but should become a negotiated, common agreement with the outreach team. As the client goals change, the team should be flexible in adjusting. One should never promise services or supplies that cannot be delivered. The correct stance with street clients is one of collaboration in a difficult situation. If one considers the street relationship as a life line to the client, care should taken not to break that life line. As clients move from the streets to housing, perhaps relapse and return to the streets, the continuity should not be broken.

Confidentiality must be maintained. Clients must be made aware that all information will be held in privacy, except as it is discussed with the professional team members to benefit the client. If clients require higher levels of privacy, this should be honored. Areas of particular concern are mental health histories, criminal records, medical conditions, location of "secret" campsites, domestic violence dynamics and personal issues that the client specifies as sensitive. All areas are to be held confidential, but highly sensitive areas require that clients are reassured of confidentiality standards. HIPPA agreements are typically signed at van, shelter and other fixed sites, with campsite agreements to the discretion of the team and clients.

Engagement on the streets will hopefully lead to the ability to refer clients to locations where higher levels of services can be provided. A close coordination between field and referral teams is necessary to "graft" the relationship to the next level. Often this requires a personal

introduction for the client from the field team to the collaborative group. In any crucial step where a street person needs guidance, a street team member can be the vital link.

Part of the engagement dynamic typically involves provision of material goods to the clients. These may be life saving items such as a sleeping bag, of useful items such as socks and hygiene kits. Philosophies vary as the extent of material support, and the provision of goods can become an escalating distraction to the deeper goals of effecting improvements in life status. A variety of guidelines can be established to monitor the dynamics of street supplies.

Acute Care

Typically this care addresses the immediate needs of the patient encountered on the streets. Examples would include small wounds, respiratory infections, foot care and blood pressure checks. Medical staff will have supplies on hand which can address these needs, but which will not create a danger to the client in the event of non-compliance or major side effects. Levels of care may vary with the degree of training and field experience. All critical situations **must** be reviewed with the medical director on call. True emergencies must be addressed through 911 and staff should stay on scene until paramedics arrive. It is often highly recommended to accompany clients through Emergency Departments to assure that things go smoothly and after care is well understood. Every acute care interaction is an opportunity to work towards true primary care and begin a case management process. It is important to craft acute care so that clients feel no barrier to care, but to balance this with an encouragement of healthier life styles.

Chronic conditions

Although clients should be seen for their chronic conditions at some sort of primary care setting, this is not always possible. Case mangers should be available to help clients establish the means to achieve primary care. In the meantime, chronic problems cannot be ignored. Counseling about chronic conditions is vital. When choosing how to intervene with chronic care, one must plan for realistic options that will not endanger the client. Medications that are started must be monitored for side effects and potential abrupt withdrawal by the client. A case management team should be included if long term care on the streets is elected. Clients that insist on destructive behavior may need to be limited if treatment is more dangerous than non-treatment (e.g. non-compliant HIV leading to resistance). Even decisions to withhold certain treatments, however, should be tempered by a message that the client is not being abandoned.

Preventative care

All occasions should include counseling to reduce harm. The primary tool to accomplish this is the trusting relationship with the outreach staff. Simple interventions such as sun screen, clean socks or condoms are all useful and welcome on the streets. Targeted screenings such as BP checks, arranging PAP smears or TB testing are opportunities to also add awareness and work with other agencies. Collaborations with such groups as needle exchange programs, etc are

invaluable. Street Medicine programs should regularly meet to discuss whether adequate harm reduction and preventative measures are being accomplished.

Referral and case coordination

The care of the unsheltered homeless is notoriously disjointed. Whenever possible, identify the person's medical primary care provider. If there is no PCP, but there is insurance of some sort (Medical Assistance or Veteran's Administration, for example), then the process should begin to connect the person with the assigned provider. If there is neither insurance nor a PCP, then a familiarity with local medical services that are able to take the uninsured is vital. Sometimes this can be done in the field, but other times will require counseling at the home Street Medicine office. It is a good idea to have forms for Release of Information so that, at the time of client contact, permission can be given to send for the previous records from each hospital or agency. This is a first step in establishing continuity of care.

Most Street Medicine programs have their own day time case management staff. This staff should be kept in close touch with the developments of the street clients. If referrals are made to the office, a phone call specifying the situation should be made. In turn, a mechanism for follow-up of case management progress to the client must be established. If urgent case management needs are identified in the field at night, a phone message to be reviewed in the morning is an excellent option. Regular case management meetings with all active staff are essential and should occur at least once a week. The outreach team should carry their own resource list in the field to aid in referrals.

The street encounter is often a starting point to initiate a referral to other service agencies. Outreach staff should have written lists of likely referral agencies with locations, times and phone numbers. If possible, a specific person who is familiar with the street homeless should be identified along with a note of referral. In cases of particular vulnerability, arrangements should be made to accompany clients through those referrals. Bus tickets or cab vouchers can be supplied to assure access to important meetings. Outreach staff should have a cell phone with emergency numbers.

If needed, street meetings can be arranged between clients and representatives of other agencies through the Street Medicine team. Locations should be as quiet, safe and private as possible. Care plans from all case management meetings should be made available to the Street Medicine team so that follow up can be provided. Oftentimes, there is a key person in each organization that is designated for street homeless issues. A good working relationship with that person is crucial.

Case Management Meetings

On a regular basis (perhaps weekly), the outreach and office based case managers should meet to discuss the overall street situation, specific clients and gaps in service. Typically, the outreach staff report on both the areas covered and individuals of concern, followed by office case managers updating progress on clients and follow up needs for the streets. It is desirable to have assigned case managers join the street teams in order to target specific individuals for more in

depth interventions. Some time should be reserved for a discussion of general issues affected the homeless and the program. If a larger outreach volunteer pool is part of the program, they can meet (perhaps quarterly) to discuss protocols and clinical issues. At all meetings, confidentiality and professionalism must be maintained. These meetings are an opportunity to include other agencies that work with the street homeless population.

Transportation of clients

In general, clients should either travel by bus/taxi or in the case of emergency by ambulance. There are circumstances in which it is decided to move clients by staff vehicle. This should never be undertaken if there is safety concern and only with permission from the medical director on call. In the event of client transfer, there must be at least two outreach staff, one of whom is a robust male. Transport should be limited to one client at a time and that client should be placed in the front passenger seat with an outreach person behind them. Check in with the medical director during and after transport is required.

Van care

Care delivered on the medical van is complimentary to that delivered on the streets. Many times clients will be engaged for a time on the streets before feeling comfortable with a van encounter. Van activities should be consistent and fair to all those served. A triage person and someone with the ability to maintain safety and order are required. A waiting list should be established and only violated in cases of emergency. Staff should not spit decisions regarding policy, especially in the arena of material distribution. Intake and clinical examination areas should be safe and private. Established locations and times should be posted on the van to avoid controversy. Parking permits and the safety needs of local inhabitants must be respected. It is wise to separate the major material distribution from the medical components of the van activity.

Medical records

It is essential to keep accurate medical records of all clinical activities. Clients must be advised that records are part of the legal record and, as such, are confidential. If possible, HIPPA papers should be signed. In the event that a person has not engaged in a formal agreement with the Street Medicine team (i.e. before confidential information has been shared), records should still be kept of the field assessments and impressions. Street Medicine records can be kept in a traditional paper format, but computerized data bases are highly preferred. Several products are available within the Street Medicine network and can be customized to local needs. A rigorous information management process for data gathering and entry should be established and monitored for quality. Records may be submitted as written encounter forms, tape recordings, email or FAX submissions. Each record should allow for a full documentation of insurance, primary care professional, PMHx, allergies, substance and psychiatric issues, housing status, medications, emergency contacts, and key demographic identifiers. When the reason for this information and it's confidential nature is carefully explained, most street clients will provide what is needed. Medical records should address the social as well as the medical circumstances of each encounter. Records systems should be set up so that data can accumulate over time as

clients share more specific information. This may require client identification prior to getting actual names through physical identifiers and the ability to merge records when duplicates are later discovered. Each encounter should have it's own record within the patient's chart with the date, location and specifics of the encounter. The client's verbal wishes at the time should be included. A narrative component is important to capture the dynamics of the visit and the clinicians impressions, as well as sections to record medical findings, materials and medications given (for inventory as well), referrals made and diagnoses.

If clients refuse recommended treatments or referrals, this should be made clear in the record. It should be clearly stated under what circumstances recommendations were explained and how they were received by the client. If the client was intoxicated or uncooperative, this should be specified. Recommendations, risks and benefits that were explained to the client should be detailed. An alternative plan to follow up and monitor the situation should be documented. This not only guides good Street Medicine practice, but also provides a legal record in case of future questions.

The computerized medical information system should allow the staff to generate reports relevant to patient care and reporting requirements. For example, an appointment list can be printed so that outreach staff can be made aware of upcoming client's appointments. The ideal record system would be a portable electronic device with either wireless or downloaded records for access in the field. All such devices must be HIPPA compliant.

Medical Backpack

Medical backpacks will vary according to the level of training and practice of each clinician. No procedures of medications should be instituted in the streets which would pose a risk under those conditions. Clinicians should be briefed as to specific dangers that street medications can pose such as Tylenol to alcoholics, medications that would be dangerous with non-compliance or poor nutrition (e.g. oral hypoglycemic).

Here is a typical "medical student backpack" which could serve as a basic version for Street Medicine practice.

Approximately day pack size and durable to include:

Individual Baggies of:

1. Tylenol, Motrin 200/400/600, naprosyn 375 (pain medicines)
2. Pen VK, Keflex, bactrim DS, doxycycline, Z Packs (antibiotics)
3. Inhalers – albuterol, combivent, advair, flovent (inhalers)
4. Sudafed, benadryl, tessalon, cepacol, Claritin (cold medicines)
5. dilantin, glucotrol or glucophage, (miscellaneous medicines)
6. antibiotic eye and ear meds (eye and ear specific antibiotics)
7. cortisone cream, antifungal ointment, antibiotic ointment, emollients (creams)

8. bandages (small and medium), 4x4's, tape, kling roll, ACE wrap (basic bandages)
9. multivitamins, iron, folate and thiamine (vitamins)
10. medical gloves and hand cleanser (sanitation)
11. norvasc, HCTZ, ASA and maybe inderal LA (antihypertensives)
12. pepcid, prevacid, tums, lomotil (GI medicines)

BP cuff, stethoscope, oto-ophthalmoscope, Tongue Blades, Glucometer, watch, flash light, saline wash, batteries, little umbrella, pencil and note pad, suture removal kit, a few plastic bags for clients to put supplies.

Business cards (*with toll free number*), encounter forms, release of information forms, laminated city map

Less experienced or non-medical participants can carry socks, food and other such supplies instead of medical supplies.

Medications

When possible, medications should be obtained from the clients' primary care physician through their own insurance. If there is no primary care physician and no insurance, vouchers from Health Care for the Homeless may be used for approved drugs. All prescriptions drugs must be cleared with the medical director on call. Either due to convenience or lack of other options, the Street Medicine program may need to distribute medications obtained through their own budget. For this purpose, a limited stock of medicines should be on hand within the program.

The distribution of medications within the Street Medicine program should be monitored by the medical director and clinical staff. Medications are typically distributed through the physician dispensary model unless a formal pharmacy is available. The choice of medicines should be based on frequency of need, affordability, safety and availability. All medicines should be packaged in appropriate amounts and clearly labeled as to drug name, dosage, amount, frequency and expiration date. Program contact information and physician should be included on the medication label.

It is highly advisable to establish an inventory system for each component of the Street Medicine program. The ordering should be uniform and well recorded. Medications distributed to each program component (back packs, medical van, severe weather shelter, etc.) should be recorded. Finally, the encounter forms should make note of medications given so that the actual point of contact distribution can be monitored. No controlled substances should be maintained in the Street Medicine stocks. Usage patterns by individuals and groups should be monitored. If certain medications have potential for street abuse (such as inhalers for crack enhancement), these must be particularly watched. If possible, narcotics and psychiatric medications should only be prescribed by the patients' primary physician. The Street Medicine program should not provide long term narcotics to clients except in exceptional circumstances.

Hospital consults

The inclusion of a hospital consult service for street homeless clients has a pivotal role in an effective Street Medicine program. When street homeless patients are admitted to a local hospital, the primary service should ideally consult the Street Medicine service to see the patient, if the patient is agreeable. Raising the awareness of this service is an ongoing challenge, but patients themselves will often prompt the medical team to do so. Meetings with medical groups, social service and nursing departments are all helpful. It is important to emphasize the benefits that a Street Medicine consult can offer to the effective and efficient care of the homeless client. Consults should be answered within one day of being received through a 24 hour phone service. It is also highly useful to find key personnel within each hospital or department who will advocate for the use of the Street Medicine consult service.

Street Medicine consults are useful on a variety of levels. Oftentimes the arrival of the Street Medicine team is a great relief to the homeless patient who feels that they are out of their element with nobody who understands them. A Street Medicine consult team can improve the trust and communication between the homeless patient and medical service. Insight and background can streamline care and improve the length of stay. Discharge plans will be reality based and follow up plans much more likely to be fulfilled. Hospital admissions are one of several "windows of opportunity" to capitalize on the street relationship and connect patients with primary care, rehabilitation and housing opportunities. Even if patients return to the streets, good aftercare on the streets can reduce complications and re-admission rates. In addition, the Street Medicine consult service is an outstanding learning opportunity for medical students and residents and can serve as a model for dealing with many vulnerable populations.

Volunteers

1. Volunteer Training

   All volunteers will undergo an introductory orientation as well as a more comprehensive training session that will cover issues including but not limited to:
   - Demographic profile of homelessness
   - Psychological impact of homelessness
   - The national and local response to homelessness
   - The unique needs of the unsheltered homeless
   - Physical safety and the approach to homeless clients
   - Exploring prejudices and preconceived notions of homelessness
   - Common medical and mental health problems of the homeless
   - Substance abuse and alcoholism
   - Life threatening issues in the field
   - Access to care and collaborative partnerships

2. Volunteer-Client Relationships and Medical Care

   All volunteers will sign a statement outlining the boundaries within which care and services will be rendered.

   Except for emergency situations, any medical care rendered must be supervised by healthcare professional such as a physician (M.D. or D.O.), registered nurse (R.N. or B.S.N.), Physician Assistant (P.A.), Nurse Practitioner (N.P.), Paramedic or Emergency Medical Technician (E.M.T.).

   Volunteers will be prohibited from providing clients directly with cash payments.

   Volunteers will be prohibited from accepting cash payment in return for services rendered.

   Volunteers will be prohibited from providing clients with alcohol, tobacco products or illicit drugs or products.

   Volunteers will be prohibited from engaging in personal activities and behaviors that breach the healthcare professional-client standards set by the applicable professional licensing board.

Insurance, liability and releases

Each volunteer must maintain their own malpractice insurance and sign an agreement with the Street Medicine program to waive liability for personal injury. Group insurance will be maintained by the Street Medicine program. Each participant must also read the program orientation material and operations manual. Confidentiality agreements must also be signed by all participants.

All participants must have up to date licensure as well as medical clearance. This includes a recent physical examination, TB testing and current tetanus and hepatitis vaccinations. Any medical conditions must be on record with the program administrator and medical director. Emergency contact information is also required. Minors who participate will need to be accompanied by a guardian.

Universal precautions

Universal infection control procedures are appropriate for all Street Medicine settings. Hand washing and the use of hand disinfectants in the field is mandatory. Whenever open wounds or bodily fluids are present, gloves must be available and worn. Any needle sticks should be immediately treated through standard hospital protocol and reported to the administrative staff. Eating in clinical areas is not appropriate and all work areas should be cleaned regularly with appropriate cleaning agents. Sharps containers for needles and scalpels as well as approved disposal of infectious materials must be maintained. Any clients suspected to have TB, MRSA,

VRE or other infectious disease must be appropriately entered into medical care and isolation. Street Medicine staff should be checked for tuberculosis exposure through annual PPD.

Office based case management

The Street Medicine office delivers on the promises that are implicit in the relationships developed on the streets. Information regarding street client issues is brought to the attention of appropriate case management staff who begin a case file on each client. Clients who have critical problems such as pregnancy, unstable disease or other vulnerable conditions are prioritized. Other highly motivated clients who are likely to stabilize with a few basic interventions are streamlined for rapid management. Different case workers who naturally have better rapport or resources for a certain client must be appropriately matched to that client. The progress on each case must be communicated between the office staff and the outreach clinicians for coordination.

The core components of case management with individuals are:

1. Identify common goals
2. Develop a service plan
3. Identify strengths and barriers
4. Support and motivate the client
5. Offer resources and direction
6. Advocate and collaborate with relevant agencies
7. Monitor and adapt in concert with the client
8. Celebrate the successes of each client

In addition to the cases which the outreach staff brings to the attention of the case management staff, there will be clients who arrive at the office by referral or word of mouth. Although immediate in depth case management might not be available, each client should be feel welcomed. Certain days or times (like mornings) may be particularly busy for walk-ins. These should be staffed accordingly. Some progress should be made to address their immediate needs and establish a plan for further interventions. This requires flexibility and good cooperation amongst the office staff. Standards for minimal staffing, material management and safety must be determined beforehand. Limits will be tested by some clients, so a firm, but loving atmosphere is essential.

It is essential to work together as a team in a drop-in, engagement type office. On a typical day, a tremendous diversity of forces is at work. The fact that street persons feel welcome and are willing to come for assistance represents a triumph of sorts. It is important to keep this in mind when things get stressful. However, there will usually be an element of frustration when clients first engage the office to sort out their difficult circumstances. Mixed in with the graphic needs will be disruptive and manipulative behavior. It is quite easy for Street Medicine staff to experience a splitting amongst themselves as frustration is redirected. Good communications are essential. The physical arrangement of the Street Medicine office is particularly important to assure safety, patient control and privacy. Ideally a waiting/triage area should be established

with proper security measures in place. Adequate staff should be available to see that this area does not become a bottleneck. An alternate exit for staff to come and go is an excellent idea.

In the long term, programmatic design should allow for staff renewal and bonding. Social activities as the end of major projects are an excellent way to address this issue. Time should also be created for staff to engage in continuing education and meetings. All members of the staff should receive adequate recognition for their unique area of service as well as the chance to craft better solutions for the situations they encounter. Regular evaluations of performance are essential and more frequent feedback opportunities will improve the group's overall performance. In addition to case management meetings, there should be regular office staff meetings to discuss operations.

In depth counseling should be conducted in a quiet, private setting. Case management continues to be client driven and staff facilitated. Safety and confidentiality is essential. Counseling sessions should generally be scheduled, although empty time slots for walk-ins can be filled at the discretion of the staff. Several staff members must be present in the office and able to monitor the safety of those alone with clients. A security protocol (panic button, etc) should be discussed and agreed upon by the security services of the building. Very often walk-in street clients present a cultural challenge to non-homeless agencies near the Street Medicine office, so patient flow must be carefully planned. Be aware of the potential for stealing at all times and ensure staff and other clients are adequately protected.

It is highly desirable to have an answering service for the Street Medicine program. This will allow other agencies to contact the program at any time to coordinate care of clients. In addition, a medical director should be on call 24 hours a day to field questions and respond to emergencies. Internet access to the Street Medicine database is desirable at all times. There should also be protocols for non-medical emergencies and critical communications.

Housing

Housing is clearly one of the highest goals for a Street Medicine program. Once people living on the streets are able to obtain housing, their overall well being can improve dramatically. Most current Street Medicine programs do not have an integrated housing program, but all will eventually face the opportunity of helping street clients access the available housing options. As such, the case managers should become familiar with the resources and partner organizations that can be of assistance. However, almost by definition existing resources have not been successful for those living on the streets. The depth of the relationship that the Street Medicine staff/volunteers have with the chronically homeless on the streets is a powerful tool for connecting them with housing. Although government funded public housing, shelters and SRO (single room occupancy) facilities are viable options, most Street Medicine associated housing initiatives have used the "Housing First" model. In this model, street homeless individuals are placed directly into apartments located throughout the community and then case managers work intensively with them to make the transition successful. Typically, HUD funds are used for Housing First projects. The challenge is to help individuals replace one life style with another and to interface with the landlords and general community involved. The advantage is that there is a basis of trust and insight with the Street Medicine case managers that helps the clients

navigate these challenges. Flexibility and a sense of humor are critical. It is crucial that case managers regularly visit clients in their new homes, especially early in the transition period. As the client situation stabilizes, visits can become less frequent. Street Medicine programs should be prepared to include specialty follow up visits to housed clients such as medical, psychiatric and legal. Housing is only half the battle, but a very important step towards a better life.

Additional Services

Depending on the local conditions, a number of other services can be added to the existing Street Medicine program either through paid staff, volunteers, or collaborative projects. Examples would be a legal counseling service, specialists to assist in medical benefits, domestic violence experts, etc. By listening to the needs and responding, much of the service spectrum will define itself.

Consumer Advisory Board

Ideally, the entire Street Medicine program should evolve in direct response to the realities and needs of the streets. Remaining responsive to the street reality is a philosophical commitment that requires constant attention. In addition to regular feedback from outreach workers, homeless clients and others, a formal Consumer Advisory Board (CAB) is highly desirable. Unfortunately, those clients who are still living under bridges can be a challenge in terms of access and stability. A CAB can be composed of both currently and formerly homeless individuals. Most existing CAB's do not have governance authority, but there are exceptions. Many programs provide compensation to CAB members. Their input should be reviewed by both the Board of Directors and the administrative staff of the Street Medicine program, with formal responses to the suggestions of the CAB.

Special circumstances

A number of special circumstances in the practice of Street Medicine warrant further discussion. These are situations which have a high potential for either clinical or programmatic risk. There are undoubtedly many other such circumstances, but the discussion of these will underscore the need to design policies for areas of high risk.

Abuse – The occurrence of physical abuse within the street homeless population is common and complex. Paradigms for intervention within the general health care arena are useful as guidelines, but fall short of addressing the needs of abused persons in the street setting. For example, the dynamics of an abuser – abused couple may involve other persons and activities which complicate the problem. Also, a standard PFA has little meaning in an environment without walls. The basic principles of gaining trust, maintaining confidentiality and creating opportunities for safety apply. If a client chooses to flee an abusive relationship, a clear plan of escape and safety must be planned ahead of time. Good communications with the local DV center is critical.

Emergency Housing – There are occasions when immediate housing must be available for certain clients. Contact information for emergency shelters, domestic violence shelters and severe weather shelters should be carried with each outreach team. When these options are not

successful, clients should not be taken home! A credit account and fund to provide housing at a local hotel is the best option. Usually this will require an outreach worker to check the client into the hotel, and provide staff with a care plan and a credit card for liability.
Violence – Violence is a reality of street life. With proper precautions and avoidance, most Street Medicine programs have not experienced staff or volunteer injury. When threats of violence to staff are encountered, immediate action must be taken to remove the team from the setting. If appropriate, the police should be summoned by cell phone. When violence to another person is either witnessed or feared, the police should be notified. All such incidents must be also reported to the medical director on call. In the event of injury due to any cause, immediate attention at the nearest Emergency Department followed by contact with the medical director on call is required.
Suicidal or homicidal threat – Street Medicine teams will inevitably encounter threats by the street homeless of both suicide and homicidal ideation. The interpretation of these threats is complicated by intoxication and the need to emphasize their emotional needs. When there is serious concern, either the police or local mental health emergency response team (ACES) should be notified. In less clear circumstances, the most skilled outreach person should take time to talk to the client in depth to explore the issues with the client in a safe, but private setting. If safety cannot be guaranteed, the police should be notified. Many times the ability to articulate emotional needs will result in the client "contracting" to not harm themselves or others. If this cannot happen, emergency services should be summoned.
Pregnancy – Every pregnancy in a street homeless woman is a high risk situation. When suspected, every effort must be made to verify the pregnancy and get the client into prenatal care. Many times this does not immediately happen. A trusted female staff member should be paired with the pregnant woman and the most skilled male team member should work to gain the trust of the male partner. Team members should institute harm reduction and nutritional intervention. A plan to respond to any care opportunity should be discussed and established beforehand.
Police encounters – Street Medicine teams encounter many community entities such as the police. If possible, these relationships should be established formally before the street encounter. At all times, Street Medicine teams must show respectful, professional behavior towards such groups. Proper identification and appropriate permits should be on hand. If inappropriate behavior is noted from other groups, those actions should be documented by the group and reported to the Street Medicine program for follow up.

Severe Weather Response

Many cities have severe weather emergencies in which the street homeless are at grave risk from exposure. The Street Medicine program is ideally positioned to understand and respond to these emergencies. The program should be involved in the planning and activation of the local severe weather response. At a minimum, the Street Medicine program can patrol the streets to alert the homeless and direct clients to a severe weather shelter. Ideally, the Street Medicine team would also provide medical evaluation and treatment within the severe weather shelter, building on the trust that was established with the homeless over time. An agreement with the National Weather Service can provide early warning of severe events. A phone message which clarifies the status of the shelter allows all relevant agencies to be sure of whether the shelter will be open. The severe weather shelter is another opportunity to heighten case management for the hard core

street homeless and to include psychiatric and other vital services. The Street Medicine team can also advise the severe weather shelter on sanitary conditions and health screening of clients.

Administration of Street Medicine program

Proper administration of a successful Street Medicine program requires skill and flexibility. A good Street Medicine program must be sensitive to the view of health from the street level up. There should be a dedicated administrator who is fully aware of the reality of street work and able to balance the requirements of clinical work with regulations, funding, personnel and resource management. There should be a clear delineation of staff responsibilities and job descriptions. An accountability process should be established in advance. The administrator must work in concert with the medical director to both plan program development and assess program effectiveness.

The medical director is another essential part of a successful Street Medicine program. That person must oversee all clinical issues to assure that quality medical care is delivered. A designated medical director provides backup for medical-legal issues. The medical director should attend all case management meetings. Ideally, the medical director should participate directly and regularly in street care. All significant clinical decisions by volunteers and staff must be reviewed by the medical director as well as the health delivery policies of the program. The medical director or qualified designate must be on call at all times.

Valuable staff positions for a Street Medicine program include a secretary and receptionist. This may be one position if conditions are appropriate. This person must be able to handle the remarkable spectrum of visitors to the Street Medicine office with equanimity and patience. It is helpful to have at least two persons to greet and manage those clients, students and donors who typically pass through the office each day. The secretary is the natural person to coordinate the schedules of outreach staff, students and others with updated information.

A reliable, skilled data entry person is highly desirable, especially if volunteer clinicians are utilized. Clinicians should experience their own data entry to understand the process, but a consistent data entry person will prove to be invaluable. The medical director and administrator should review the quality of data entry and management.

A full time nurse case manager is also vital to an effective Street Medicine program. The nurse should address the immediate needs of walk in clients and assist in getting those persons into primary care relationships. The nurse case manager will have a case load of clients with priority needs and opportunities which should be scheduled in advance. It is helpful to have the nurse review the distribution of medicines and assist in the consult service. This person must work closely with the medical director.

Perhaps no position is more important than the Street Medicine social worker. This person will be very busy working directly with clients and networking with other agencies. It is a job that requires determination, good humor and patience. It is natural for the social worker to assist in housing. This is a time consuming transition process and work time must be allowed for

successful monitoring of newly housed clients. A second social worker will be a good investment when possible.

If a van is part of the Street Medicine program, a dedicated van driver should be assigned to this task. This person should also oversee the required maintenance of the vehicle. Since many people are depending on the van service, the van driver should be highly reliable.

Outreach workers should have a strong street credibility and good judgment. Formerly homeless persons are ideal if their lives have stabilized for at least 6 months to a year. Attention must be given to their personal needs so that helping others does not their ability to achieve their own recovery. Not all, or even most, formerly homeless persons are suited to be outreach workers. Individuals with extensive experience on the streets are also good outreach workers. Typically cities may have social workers or others who have shown a natural ability in this direction. Building on their street relationships is highly effective.

Public Relations

Public relations are another important area of concern for a Street Medicine program. Street Medicine specifically targets a population that is controversial to the general public. As such, the program will find itself in a position of attention by many entities. This includes, but is not limited to, city government, business partnerships, the media, advocacy groups, medical societies, church and social organizations. As a trusted medical delivery system, the confidentiality and dignity of the homeless clients must be maintained. There is adequate room to argue that a Street Medicine program should not become involved in the "politics" of homelessness. However, experience indicates that the positive influence that a reasoned witness to the plight of the homeless by a medical program is nearly a moral obligation. It is how to deliver that message that becomes crucial.

Certain activities such as public speaking to colleagues and community groups are excellent venues to raise awareness. One or two designated spokespersons should be groomed for this task. With practice, and perhaps photographic documentation (with signed release of clients), such talks can become powerful vehicles for social change. Donations and volunteers are typical immediate results, but the long term humanization of the homeless community is more important. The vision of a community in which all members of society are valued becomes a compelling force to those who are responsive. It is wonderful if members of the homeless community can be included in these presentations, but care must be taken to avoid the potential emotional distress such testimonials can inflict.

A careful media relations protocol should be developed *before* any potential media frenzy is encountered. If a media relations department exists in your organization, discuss your vision and goals ahead of time. A balance between total avoidance and complete openness should be achieved. Speak to other partners in the area who can handle the more controversial, non-medical aspects of homeless public relations. Often the less a medical program generally says, the more weight it will carry when the need arises to make a statement. Review the legal issues with an attorney and always err on the side of protecting your clients from harm.

Street Medicine in and of itself is a challenge to the rest of the community. It is a test of how we will treat those who have fallen. Many are threatened by the implications of working with those whom society often blames for their own misery. Care should be taken not to become embroiled in fear or anger based controversies. The strongest argument (to paraphrase Albert Schweitzer) will be how you conduct your lives of service. If you are given the opportunity to hold up a vision of hope and healing, this opportunity is the fulfillment of our medical calling.

Fund raising

Street Medicine is not a fund generating activity per se. If it were, there would be more Street Medicine programs. But money is essential to the complete development of a successful Street Medicine program. The budget can be extended immensely by the use of volunteers and donations, but a core staff of professionals is needed to assure accountability. Many models exist to support Street Medicine delivery, but even within established hospital, community or Health Care for the Homeless programs, complimentary funding is essential. Typically the Street Medicine administrator will dedicate significant time to grant writing and report preparation. Collaborations with other agencies and foundations can leverage both funding and staff. Being a recognized community collaborator is highly valuable, but one must reflect on the program's mission to avoid "mission drift". Be careful (as with you homeless clients) not to promise anything you cannot deliver. Your track record of reliability will be one of your greatest assets. Programs should avoid simply "following the money". Develop the skills within your daily record keeping to meet both the reporting needs of funding agencies as well as those of the clients.

In addition to local foundations and federal grants, local fund raising activities can generate visibility to your cause. Sometimes these events become true celebrations of unity for the community – a value in and of itself. An unrecognized majority of the greater community is seeking a positive vision such as Street Medicine embodies. Student involvement greatly enhances this vision and develops future leaders. Ultimately, a patchwork quilt of funding will likely be needed to meet the needs of a Street Medicine program. With practice, this quilting skill becomes more manageable.

Medical Education

Leaders of Street Medicine agree that the inclusion of idealistic, creative students in their programs is crucial. Although supervision and management can be initially daunting, partnerships with educational institutions can also greatly benefit the Street Medicine effort. Teaching faculty are an ideal resources for volunteers or staff. The renewing energy of medical, nursing, dental and other students has been proven to transform many Street Medicine programs. Special projects by students and their faculty are opportunities to expand services. In addition, teaching institutions are often the gateway for higher levels of care that our street homeless clients need. Volunteers from within these systems are natural and powerful advocates for our

clients. In time, many students are encouraged to join the ranks of service oriented health care professionals.

It is still essential to have an organized system for the inclusion of students in the Street Medicine program. Each student must undergo proper orientation and be supervised within the experience. Goals should be clearly stated and complete schedules, contact numbers, and supportive staff specified. The medical director must be in close contact with the students to assure appropriate care and safety. A regular debriefing must be conducted to identify problems and explore the experience. Students should be allowed to have supervised responsibility for several clients during the rotation. A journal and background readings are advisable. If different student groups are involved at different levels, a coordinator for all activities should be assigned. No student should ever work with clients alone. A written evaluation with mutual feedback must occur at the end of each rotation.

Networking

Networking is the process of connecting the strengths of one program with other entities to enhance the benefit of the unsheltered homeless. This is vital at a local level. Many times these connections follow the natural path of inreach for each client. When key partners are identified, it is best to take a pro-active approach and seek out a meeting in advance. Every encounter is an opportunity to acknowledge the good work of other agencies and seek ways to enhance the combined resources of both groups. By presenting a respectful, open and helpful face to new relationships, the common goals usually reduce any potential conflicts. For the sake of our homeless clients, no important bridges should ever be burned. Those who truly care about the street homeless will find a way to work together. As mentioned earlier, shared projects (such as a severe weather project or TB screening program) can build the collaborative vision for the community and lead to new possibilities for our clients.

In the decade leading up to 2005, a movement began to connect Street Medicine programs throughout the United States and abroad. Mutual visits and the exchange of expertise revealed that a new field of "Street Medicine" warranted a venue to learn between experts in different cities. The first International Street Medicine Symposium was held in Pittsburgh, Pennsylvania in October of 2005. Expert pioneers from India, Chile, Puerto Rico, Honolulu as well as 12 mainland US cities met to discuss the shared experiences of their programs. This was the first meeting of its' kind and was a great success. Subsequently, numerous other partners in Europe, Asia and the US have joined the Street Medicine Network. Activities are coordinated between cities as well as such organizations as Health Care for the Homeless in the US and FEANTSA in Europe. This explosion of networking has resulted in the delineation of Best Practices in Street Medicine, a Street Medicine Student Fellowship fund and commitment to inter-city collaboration. The Street Medicine Network (www.streetmedicine.net) is an unprecedented resource for all those who would like to establish or improve services for the street homeless of our communities.

Appendix

Bibliography

The Health Care of Homeless Persons, James J. O'Connell, MD Editor, 2004.

To Dance with Grace: Outreach and Engagement to Persons on the Street,
Sally Erickson, M.S.W. and Jaimie Page, M.S.W., L.S.W. 1998.
http://aspe.hhs.gov/homeless/symposium/6-Outreach.htm

Outreach to People Experiencing Homelessness, Ken Kraybill, MSW National Health Care for the Homeless, June 2002.

O'Toole, S., Withers, J., "From the Streets to the Emergency Room and Back: A Model of Emergency Care for the Homeless", Topics in Emergency Medicine, volume 20/number 4, December 1998, pp12-20.

Psychology on the Street, Thomas L. Kuhlman, 1994.

Outreach to People Experiencing Homelessness, A Curriculum for Training Health Care for the Homeless Outreach Workers, Craig Rennebohm, http://www.nhchc.org/Curriculum/preface.htm