LOS ANGELES COUNTY
COMMISSION ON HIV

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HOUSING TASK FORCE

Virtual Meeting

Friday, March 28, 2025
9:00AM-10:30AM (PST)

Agenda and meeting materials will be posted on our website at https://hiv.lacounty.gov/meetings/ *Other Meetings

FEATURING A PRESENTATION ON UNDERSTANDING HEALTHCARE ACCESS AND EXPERIENCES IN SKID ROW, LOS ANGELES | HEALTH MATTERS, INC

INTERESTED? REGISTER/JOIN HERE:
https://lacountyboardofsupervisors.webex.com/lacountyboardofsupervisors/j.php?MTID=m08983179584958adb3537377fe16edb8

Meeting number: 2537 030 7041
Password: HOME (All capital letters/case sensitive)
Join by phone:
TO JOIN BY PHONE: +1-213-306-3065

For housing resources, visit:
https://www.chirpla.org/
https://housing.lacounty.gov/

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LOS ANGELES COUNTY
COMMISSION ON HIV

510 S. Vermont Ave. 14th Floor, Los Angeles, CA 90020
MAIN: 213.738.2816 EMAIL: hivcomm@lachiv.org WEBSITE: https://hiv.lacounty.gov

HOUSING TASK FORCE VIRTUAL MEETING

AGENDA

FRIDAY, MARCH 28, 2025

9:00AM-10:30AM

https://lacountyboardofsupervisors.webex.com/lacountyboardofsupervisors/j.php?MTID=m08983179584958adb3537377fe16edb8

Meeting number/Access Code: 2537 030 7041

Password: HOME (All capital letters)

Join by phone

+1-213-306-3065 United States Toll (Los Angeles)

Access code: 2537 030 7041

1. **WELCOME & INTRODUCTIONS** **9:00AM-9:05AM**

2. **CO-CHAIRS' REPORT** **9:-05AM-9:10AM**
   a. February 28, 2024 Meeting Recap (See meeting summary)

3. **DISCUSSION** **9:10AM-09:45AM**
   a. 2025 Workplan/Deliverables
   b. Review Housing and Legal Services Provider Consultations Presentation to the Commission on April 10

4. **PRESENTATION: Understanding Healthcare Access and Experiences in Skid Row, Los Angeles | Health Matters Inc** **9:45AM-10:15AM**

5. **AGENDA DEVELOPMENT FOR NEXT MEETING** **10:15A-10:20AM**

6. **ANNOUNCEMENTS & ADJOURNMENT** **10:30AM**

Upcoming Meetings (4th Friday monthly): April 25, 2025

Reports to Check Out:

Community Perspectives on the Homelessness & Affordable Housing Crisis Facing LGBTQ+ People in California

Legal Needs Assessment of People Living with HIV: Insights and Recommendations for Service Delivery

National HIV/AIDS Housing Coalition FY 2025 HOPWA Letter to Congress ($750M)

Los Angeles County Homelessness & Housing Map

LOS ANGELES COUNTY
COMMISSION ON HIV

510 S. Vermont Ave, 14th Floor • Los Angeles, CA 90020 • TEL (213) 738-2816 • FAX (213) 637-4748
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HOUSING TASK FORCE (HTF) VIRTUAL MEETING
CLICK HERE FOR MEETING PACKET
FEBRUARY 28, 2025, 2025 | 9AM-10AM
MEETING SUMMARY

Agenda Item	
Introductions	**KEY DISCUSSION POINTS**
	K. Nelson and Dr. David Hardy, HTF Co-Chairs, called the meeting to order, conducted introductions, and welcomed attendees the meeting.
CO-CHAIRS' REPORT	• K. Nelson referred attendees to the packet for the meeting summary for the January 24, 2024.
Discussion Key Takeaways	**Meeting Frequency:** • The HTF revisited the group's meeting frequency and decided by consensus to keep the HTF meeting on the 4th Friday of the month from 9am to 10am via Webex. Some meetings may be extended to accommodate discussions and presentations. **2025 Workplan/Deliverables:** Co-Chairs K. Nelson and Dr. Hardy led the HTF in reviewing its 2025 goals and deliverables. The meeting focused on addressing the housing needs of people with HIV who are homeless and exploring partnerships and strategies to improve care and support. • The group recognized the need for a needs assessment to better understand the housing needs of people with HIV who are homeless. • Dr. Green: One task that is monumental is getting a handle on what is available for housing our clients/patients as supported by various city, County and State initiatives. Somehow, we need to learn how the housing resources are actually being rolled out from the various initiatives and measures. He suggested conducting a comprehensive needs assessment focused on the issue of homelessness and HIV. • One of the HRSA requirements for planning councils is to conduct a consumer needs assessment every couple of years. Perhaps the Commission Executive Committee can be asked to consider supporting a needs assessment focused on housing. He noted the following as key

questions/areas of inquiry about housing for PLWH:

- What are the actual documentable needs of PLWH in Los Angeles County? The answer to this foundational question is key to identifying effective next steps and solutions.
- Nobody has a good sense of what resources are available and where those resources are going.

- There was a suggestion to incorporate housing assistance for seniors with HIV since the earlier genesis of the housing conversations took place in the Aging Caucus.
- The group acknowledged the challenges in obtaining accurate data on homelessness and HIV due to the way questions are asked in surveys.
- C. Barrit suggested that the HTF present the results of the provider listening sessions conducted by the HTF to the full commission in April.
- Plan dedicated conversations with housing systems providers to address deeper elements and align agencies in serving individuals with HIV experiencing homelessness. Build upon the homelessness/housing panels convened by the COH in the past. Identify and invite decision-makers overseeing housing resources to participate in the summit. Identify the right people to be involved in these conversations. Determine the actual needs of the target population and understand available resources through data collection and consultation with service providers.
- Joe Green noted the need to prioritize care for people at risk for HIV and the lack of housing services specifically for HIV-negatives.
- Lambert Talley suggested partnering with providers who offer temporary housing on Skid Row.
- Erica Robinson proposed engaging a representative from LAHSA and utilizing potential new department and funding opportunities.
- Consider offering payment or incentives to encourage participation in testing programs and incorporate surveys on identifying people who are positive. Coordinate with street medicine providers to incorporate voluntary rapid testing for unhoused individuals at risk of HIV. Explore the possibility of conducting HIV testing on the street to gather baseline information about HIV-positive individuals who may not be accessing services
- Investigate the accuracy and effectiveness of the homeless count in identifying individuals with HIV (a question for LAHSA).
- Work on establishing a centralized and frequently updated resource for available housing programs and eligibility criteria
- Consider engaging a LAHSA representative in future meetings
- Share reports on HIV self-test kits and unhoused individuals' survey with the group (E. Robinson)

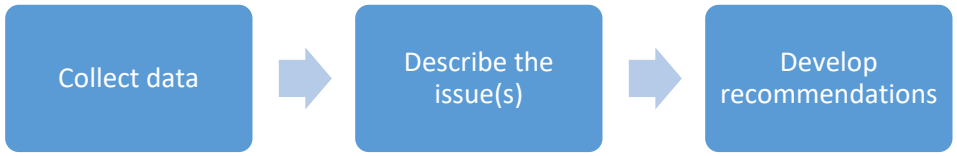
Next Steps	• Update workplan based on group discussion; focus on needs assessments, reporting back on provider listening sessions, and plan housing providers summit. • Next meeting will be held virtually on March 28, 2025 from 9amto 10:30am.
Adjournment	Meeting adjourned at 10:00am

Housing Task Force Workplan 2024 - 2025– ONGOING 06.05.24; 07.03.24; 08.07.24; 08.23.24; 01.08.25; 03.11.25

PURPOSE OF THIS DOCUMENT: To identify activities and priorities the Housing Task Force will lead and advance for 2024-2025.
CRITERIA: Select activities that are **specific and realistic and within the scope and capacity of the COH**. The Commission is Los Angeles County's integrated prevention and care planning council.
Overarching Goal: Develop specific and realistic recommendations and/or response to address the intersection of HIV/STD and housing.

2024-2025		
#	**ACTIVITY**	**TIMELINE/DUE DATE/ACTION ITEMS**
1	**Engage DHSP-funded housing and legal services agencies to understand the types of needs they see among their clients.** ○ keep people housed? How can this strategy be supported? **Status Update (02.3.25):** Completed subject matter/provider panels with DHSP-funded housing agencies; Inner Law Center completed on 1/24/25 meeting. Report back to COH 4/10.25	Invite these DHSP-funded housing and legal services agencies to the September 27 meeting and extend the time to 2 hours. Some questions to ask include: ○ How do your programs work together to foster housing-legal services and partnerships for clients? ○ When are you seeing clients in the service pipeline? What issues are they presenting with? How are your agencies mitigating their issues and needs? ○ How can your services help prevent clients from becoming homeless? What services are provided for prevention versus those who are already homeless? ○ How are clients getting to your agencies? Are they being referred by agencies? Other Ryan White-funded service providers? Self- referrals? ○ Where are the gaps and failures happening in the overall service delivery network? ○ What are legal issues are clients presenting with? ○ What strategies should we consider in using legal services as a way to keep people housed?
2	**Develop housing specific needs assessments and supplement with community listening sessions/focus groups.** • Review existing data and conduct housing-focused needs assessment. Dig deeper in the housing needs and challenges for PWH and those at risk. Identify provider needs around housing such as service/staffing and organizational capacity needs, issues, and challenges.	1. Identify and review existing data sources and needs assessments (i.e., City of LA Consolidated Plan, Housing Element Needs Assessment) March- April 2025 2. Develop needs assessment objectives, aims, questions/instruments. Develop focus group guide and survey. April 2025 3. Finalize instruments, promote, recruit participants, and administer survey. May 2025 4. Collect data analyze data. June-July 2025 **5.** Develop report and recommendations. July 2025

3	**Convene housing solutions for PLWH summit to present needs assessment and develop county wide plan of action.**	August-September 2025 or a World AIDS Day event?



PRIORITY LIST AFTER ACTIVITY 1 IS COMPLETED				
2	Use the data for service standards and/or create new service model; perhaps extend temporary housing to longer-term housing and braid RW and HOPWA funds together. Incorporate in EFA service standards the new guidance from HRSA that now allows the use of RW funds for rental deposits. ➢ Offer more legal services (such as help with eviction notices, landlord mediation, etc.) and emergency financial assistance to keep people housed.	Update service standards Review EFA and housing service standards Create program directives to DHSP		SBP is currently reviewing and updating the EFA service standards.
3	Once standards are updated, pursue advocacy efforts and use data with personal stories to advocate for more funding and/or policy changes.	Annual priority setting and resource allocations (PSRA) process.		PP&A Committee will undertake PSRA for Program Year (PY) 34 and PY 35, 36, and 37 at the July and August PP&A meetings.
4	Conduct housing resource fairs and/or housing clinics at the end of a Commission meeting (does not have to be at all Commission meetings) or have the Consumer Caucus lead this effort.	Inform, educate and disseminate information to consumers, specified target populations, providers, the general public, and HIV and health service policy makers to build knowledge and capacity for HIV prevention, care, and treatment; and actively engage individuals and entities concerned about HIV.		

****CONTRACTUAL ISSUES AND AGENCY NAMES ARE OUTSIDE OF THE PURVIEW OF THE COH. HOPWA is not under Ryan White, or DHSP or the Commission.****

	OTHER IDEAS FOR FUTURE WORKPLANS AND ACTIVITEIS			
#	**HOUSING CHALLENG/ISSUE**	**ACTION OR STRATEGY TO ADDRESS ISSUE**	**TIMELINE/ DUE DATE**	**ACTION ITEMS+NEXTSTEPS+FOLLOWUP**
1	**Lack of coordination among housing systems and providers**	• HTF should look at ways to collaborate with DHSP and other providers – agencies are not aware of what each other are doing; not much communication between HIV and housing providers; conduct a training among housing providers about the Ryan White program • Improve interagency communication; the lack of and often conflicting communication among lead agencies and subcontractor agencies lead to frustration and delays in application process; case closures are done erroneously and the burden of starting over is on the client. Submitted documents are lost when they have been submitted by the client multiple times. No one is talking to the client; often left in limbo. • Ensure Medical Care Coordination teams and benefits specialty services contractors are aware of resources; provide trauma-informed care training.		
2	**Duplicative and confusing application process**	• Improve interagency communication; the lack of and often conflicting communication among lead agencies and subcontractor agencies lead to frustration and delays in application process; case closures are done erroneously and the burden of starting over is on the client. Submitted documents are lost when they		

	OTHER IDEAS FOR FUTURE WORKPLANS AND ACTIVITEIS			
#	**HOUSING CHALLENG/ISSUE**	**ACTION OR STRATEGY TO ADDRESS ISSUE**	**TIMELINE/ DUE DATE**	**ACTION ITEMS+NEXTSTEPS+FOLLOWUP**
		have been submitted by the client multiple times. No one is talking to the client; often left in limbo.		
3	**Lack of affordable housing stock**			
4	**Current efforts are not addressing the root causes of homelessness (stagnant incomes, poverty, racism, mental health, substance use, etc.)**	• Explore service models for different populations, such as the TransLatina Coalition's employment to housing program, where graduates of the program learn to start their own business. • Intersect housing with other capacities like employment, food, mental health; some agencies just provide housing but not other services needed by the client to remain housed.		
5	**Lack of homeless prevention services**	• Explore service models for different populations, such as the TransLatina Coalition's employment to housing program, where graduates of the program learn to start their own business. • Intersect housing with other capacities like employment, food, mental health; some agencies just provide housing but not other services needed by the client to remain housed. • Universal basic income, expand		

	OTHER IDEAS FOR FUTURE WORKPLANS AND ACTIVITEIS			
#	HOUSING CHALLENG/ISSUE	ACTION OR STRATEGY TO ADDRESS ISSUE	TIMELINE/ DUE DATE	ACTION ITEMS+NEXTSTEPS+FOLLOWUP
		financial assistance, temporary and permanent supporting housing.		
6	**Lack of clarity about eligibility requirements**	• HTF should look at ways to collaborate with DHSP and other providers – agencies are not aware of what each other are doing; not much communication between HIV and housing providers; conduct a training among housing providers about the Ryan White program • Improve interagency communication; the lack of and often conflicting communication among lead agencies and subcontractor agencies lead to frustration and delays in application process; case closures are done erroneously and the burden of starting over is on the client. Submitted documents are lost when they have been submitted by the client multiple times. No one is talking to the client; often left in limbo.		
7	**Outdated and restrictive federal policies and regulations**	• Agencies are under-staffed; secure more funding to expand staffing capacity.		
8	**Unclear how/where one would access or start looking for help**	• Need effort to educate housing and HIV agencies; create a document or web page to help individuals at risk of losing housing; intervene to avert the crisis • Develop 1 hotline for housing resources and program for PLWH and those at risk? Isn't this CHIRP LA?		

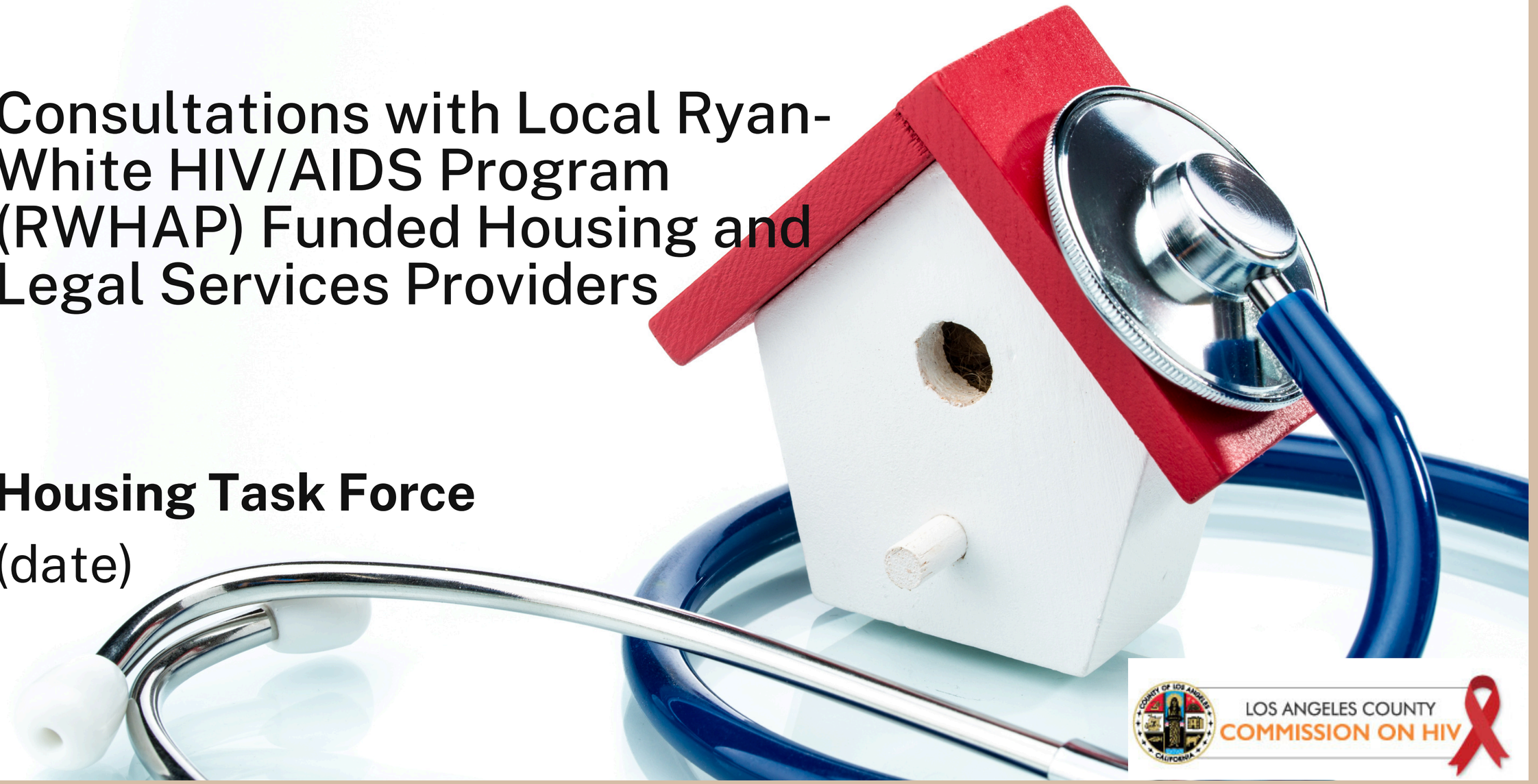
COMPREHENSIVE HIV PLAN (CHP) HOUSING RELATED ACTIVITIES:

- 7C.5b: Improve systems, strategies and proposals that prevent homelessness, expand affordable housing, as well as prioritize housing opportunities for people living with, affected by, or at risk of transmission of HIV/AIDS, especially LGBTQ people
- 7C.5c: Promote family housing and emergency financial assistance as a strategy to maintain housing
- 7C.5d: Increase coordination among housing agencies to include intergenerational housing options
- 7C.5e: Blend funding to support housing and rental assistance for seniors living with HIV

Consultations with Local Ryan-White HIV/AIDS Program (RWHAP) Funded Housing and Legal Services Providers

Housing Task Force

(date)



LOS ANGELES COUNTY
COMMISSION ON HIV

HOUSING IS A HUMAN RIGHT

HOUSING SUPPORTS BETTER HEALTH

Securing **stable housing** can help people achieve **successful HIV outcomes.**

HIV.gov

Background

The Commission on HIV formed the Housing Task Force to address the needs of people living with HIV (PLWH), with special emphasis on:

- Understanding how the local Ryan White system of HIV care can prevent and address housing as a critical piece of a person’s care.
- Conducting assessments, community listening sessions, and consultations with subject matter experts to understand service delivery gaps, barriers, and opportunities for partnerships and improvements.
- Developing recommendations to agency partners and the County to attain and maintain safe and affordable housing for PLWH.

Background

- Conducted consultations with housing and legal services agencies to learn about the service needs of their clients
- Determine how a more integrated housing and legal service delivery process to prevent homelessness among Ryan White clients (or Ryan White eligible clients).
- The consultations were held during the regularly scheduled HTF meetings from September 2024 to January 2025.

Ryan White Housing and Legal Service Providers Insights

- All housing providers reported referring clients to legal services
- Work intensively with clients to prevent eviction.
- Eviction is the last resort
- Work with clients to address behavioral or financial difficulties to avoid eviction

Primary reasons for eviction:
missed rental payments
and
poor tenant behavior

Key Themes

Comprehensive support is provided by staff:

- Agencies employ resident services coordinators who interact with clients to ensure their health, safety, and well-being.
- Staff assist with referrals and conduct personal visits to build and maintain trust with clients.
- HFH funds intensive case management to address the acute health needs of clients.

Residential Care Facility for the Chronically Il (RCFCI) and Transitional Residential Care Facility (TRCF) clients demonstrate high need for ongoing support

- RCFCI and TRCF clients are often frail, elderly, and diagnosed with significant mental health conditions; some are not receiving mental health services by choice; and require ongoing attention and support with basic skills of life, home living, and health maintenance.
- For clients who seek mental health services, securing appointments is a significant challenge.

Key Themes

Inadequate funding is straining the capacity of agencies to operate at optimal levels.

- Building repairs and maintenance are not covered by funding sources.
- Agencies are further strained when payments/reimbursements are not paid on time.
- Reimbursement rates do not match the full cost of the services.

Housing workforce capacity is under extreme pressure and stress.

- The caseload and demand for housing are not sustainable with the current workforce capacity and landscape.
- Huge turnover rate, low wage, burnout, poor treatment of staff (by clients) are systemic issues that are not being addressed.
- Difficult to attract and retain highly skilled staff for the housing services sector.
- People with lived experience are needed, however, those with subsidized housing run the risk of losing their housing if they are employed.
- Trust is a core issue. Housing providers are not trusted and not treated as equal partners by the County.

Key Themes

Poor intra and inter-agency communication and coordination.

- Due to frequent staffing changes and turnover, maintaining communication and connection with referring agencies is a challenge. This often leads to applications having to get started again, lost applications and paperwork, and inability to contact clients/applicants.

The insane amount of paperwork required for applications is detrimental to both providers and clients.

- The length of time it takes to get people housed is unacceptable but providers are hampered and powerless because of documents required by HUD-funded programs.
- Paperwork burden is duplicative and retraumatizing to clients.

Other Issues

- **Need resources and support to house undocumented clients.**
- **Some eligible clients may not seek services due to stigma.**
- **Foster a sense of compassion and understanding for people who are homeless or at risk of becoming homeless.**
- **It is important to understand the difference between subsidized vs. affordable housing. Under subsidized housing, the tenant does not pay more than 30% of their income towards rent. “Affordable” housing is subject to rent increases.**

City of Los Angeles HOPWA Partners' Insights

- Federal program administered by the U.S. Department of Housing and Urban Development (HUD) that provides housing assistance and related support services specifically to low-income individuals living with HIV/AIDS and their families.
- The only federal program dedicated to addressing the housing needs of people living with HIV/AIDS.
- HOPWA is not a Ryan White-funded program.
- Locally administered by the City of Los Angeles.

HOPWA Background

- Staffing is challenged with only 3 staff and with administrative expenses capped at 3%. In comparison, most federal grant programs cap administrative cost at 10%.
- The 3% administrative cap for the HOPWA program impacts staff capacity to respond to fiscal, programmatic, service, and community engagement efforts.
- Approximately $30 million in funding from the federal Housing and Urban Development (HUD) Department.
- This translates to 18 contracts including housing capital development service agencies, vouchers, and long-term projects to build housing.
- Most of the funding is used to work with local agencies to provide tenant-based rental assistance (TBRA) and other housing support for PLWH.
- All funds are maximized.

Major challenges

- **Need to scale up the number of people served.**
- **Agencies are not fully spending down their grant awards/contracts, possibly to due to high staff turnover rate and difficulty hiring and retaining staff**
- **Need to expand outreach more broadly to other partners.**
- **Duplication of services; e.g., some agencies are targeting the same clients and recruiting from the same hospital.**
- **Most agencies rely on word-of-mouth for promoting services which is not an effective mechanism for scaling up awareness of HOPWA services.**
- **Hiring freeze in the City of Los Angeles hampers the ability to hire staff.**
- **Large caseloads and paper work**

Strategies for Improvement

- **Increase service agreements amount with the Housing Authority of the City of Los Angeles to support housing vouchers for PLWH.**
- **Establish a process for outreach coordination to avoid duplication of services.**
- **Explore targeted social marketing, however, these efforts must demonstrate that outreach and social marketing activities reach people eligible for HOPWA services (not intended for general audience outreach).**
- **Explore leveraging street medicine to get PLWH into housing/HOPWA; currently exploring this opportunity with the USC street medicine program.**

Ryan White Legal Services Provider Insights

The common areas of assistance provided:

1. **Housing**
2. **Record clearing**
3. **Citation defense**
4. **Income maintenance**
5. **Credit/debt**

*****services are provided regardless of immigration status*****

Challenges

- **Ryan White-contracted legal services provider is not receiving enough referrals and needs agency support to promote their services and refer clients.**

- **Many Ryan White/ HIV-service agency staff are unaware they exist and that they have a legal services program for PLWH.**

- **Lack of provider awareness about ICLC and their RW-funded legal services may be partly due to confusing messaging when the funding source for the agency's legal services for PLWH moved from HOPWA to Ryan White- some agencies may have misinterpreted this as an end to the program.**

Recommendations

- Expand access to emergency financial assistance (including non-Ryan White-funded programs) to prevent homelessness.
- Explore better payment models to fund the full cost of housing services.
- Dedicate funding for ongoing training for frontline staff
- Establish more formal and frequent community and interagency outreach and coordination.
- Appeal to the federal Housing and Urban Development (HUD) Department to eliminate the burden of showing proof of income; if they are homeless and receive General Relief, SSI, or SSDI, that documentation should suffice. Eliminate the requirement to provide 3 months of bank statements. Eliminate HIV bloodwork requirement.


Thank you!


Q
&
A

Health Matters Clinic
1360 S. Figueroa St. D390
Los Angeles, CA 90015
March 5, 2025

ABOUT HMC

Health Matters (C.L.I.N.I.C. – Communities Leading Improvements Needed In Care) events are designed to improve health access and equity by addressing the social, economic, and environmental factors that influence health. Our clinic model focuses on community-led solutions that empower individuals to take control of their health and well-being.

Through outreach, engagement, and collaboration with public and private organizations, we offer a range of health screenings, education, and referrals to ensure individuals have access to essential health services. Our goal is to break down barriers and ensure that everyone has the opportunity to live a healthy, informed life.

Our clinic events are designed to meet the health needs of the community where they are, based on ongoing needs assessments. These events focus on education and connecting individuals to local resources. We offer various services and screenings that help individuals understand their health status and make informed decisions.

Some of the health-related services we offer at our clinic events include:

- Health Screenings
- Blood Pressure Screening
- Blood Glucose Screening
- Cholesterol Screening
- Vision Screening
- Hearing Screening
- STD/STI Testing and Screening
- HIV Testing
- Body Mass Index Screening

These screenings are provided by a multidisciplinary team consisting of licensed medical providers, community health workers, medical students, and other trained volunteers, all under the supervision of a licensed healthcare professional when necessary. We use these opportunities to educate individuals about their health status and empower them to seek further care if needed.

For services that require licensed healthcare providers or specialized care, we collaborate with trusted community partners to ensure individuals receive comprehensive care. For example:

> **Vaccinations (e.g., flu, COVID-19):** In partnership with the Los Angeles County Department of Public Health's Mobile Vaccine Team, licensed pharmacists are available to administer COVID-19 tests and vaccinations, as well as flu shots, at our clinic events.
>
> **Specialized Care:** For complex health needs like chronic disease management or mental health support, we connect individuals to appropriate providers or refer them to specialized services, such as the Department of Mental Health.

We take a collaborative approach to connecting individuals to the services they need. Through warm handoffs, we work directly with individuals to connect them to specialists, hospitals, and other providers in the community. We also utilize our resource maps to help individuals access services that are geographically convenient and have minimal transportation barriers.

This method ensures that individuals can seamlessly transition to the care they require while reducing the barriers they might face when accessing services outside of our clinic events. We are committed to meeting people where they are and providing the education, resources, and connections they need to improve their overall health.

2024 Impact:

- 192 patient visits
- 43 emergency department visits avoided
- 12 life years saved
- $32: $1 return on investment (ROI)
- $861,926 returned to the community

***

For more information, please contact:

Erica Robinson, President of Health Matters Clinic

Email: erica.robinson@healthmatters.clinic

Cell: (404) 904-6355

Office: (213) 344-2020 ext. 200

Understanding Healthcare Access and Experiences in Skid Row, Los Angeles

Health Matters Clinic
March 28, 2025
LA County Commission on HIV
Housing Task Force Presentation

ABOUT HMC

Mission: **Improve health access and equity by addressing the social, economic, and environmental factors that influence health. To break down barriers and ensure that everyone has the opportunity to live a healthy, informed life.**

- **Outreach events, primarily in Skid Row**
  - **Multidisciplinary teams**
  - **Free health screenings, vaccinations, resource maps, and warm hand-offs to more advanced care**
  - **Partnerships with LADPH Mobile Vaccine Team and Dept. of Mental Health, as well as Harvard Medical School's Mobile Clinic Project**

Image: Team HMC providing a blood pressure check, HIV rapid test, and taking down medical history, contact information, etc. to connect a patient experiencing homelessness in Skid Row to more advanced care. March 2024.

HMC SURVEY

Understanding Healthcare Access and Experiences in Skid Row

- Direct perspectives of individuals residing in Skid Row, Los Angeles

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Understanding Healthcare Access and Experiences in Skid Row

- Direct perspectives of individuals residing in Skid Row, Los Angeles

- Participants gave their consent to participate.
    - Inclusion criteria: 18+, capable of providing informed consent, fluent in either English or Spanish, and either unhoused or living within a housing facility in Skid Row.

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- Participants were informed that their involvement in the survey was entirely voluntary with the option to skip any question or discontinue participation at any time.
    - No compensation or incentives
    - No personal identifying information was collected.
    - Surveys were conducted in an interview-based format.

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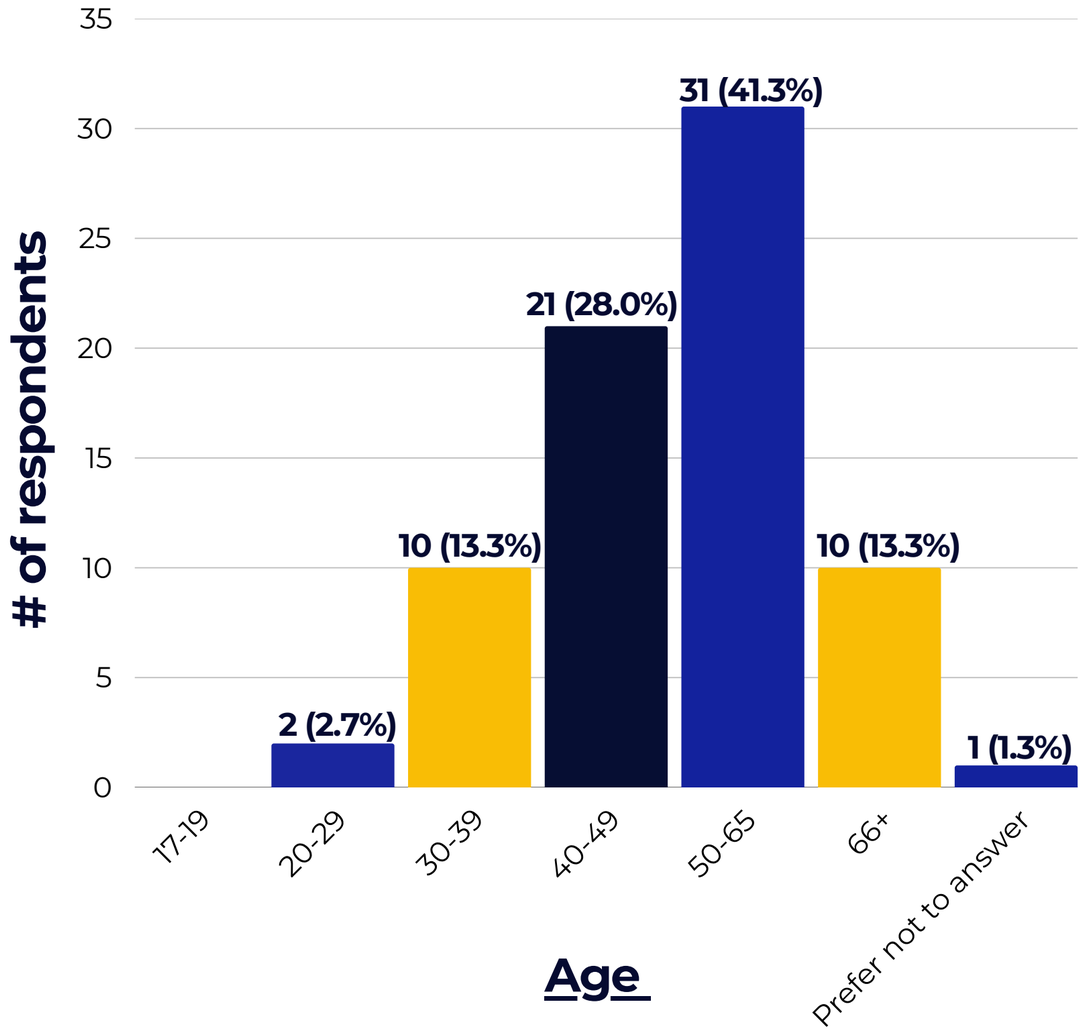
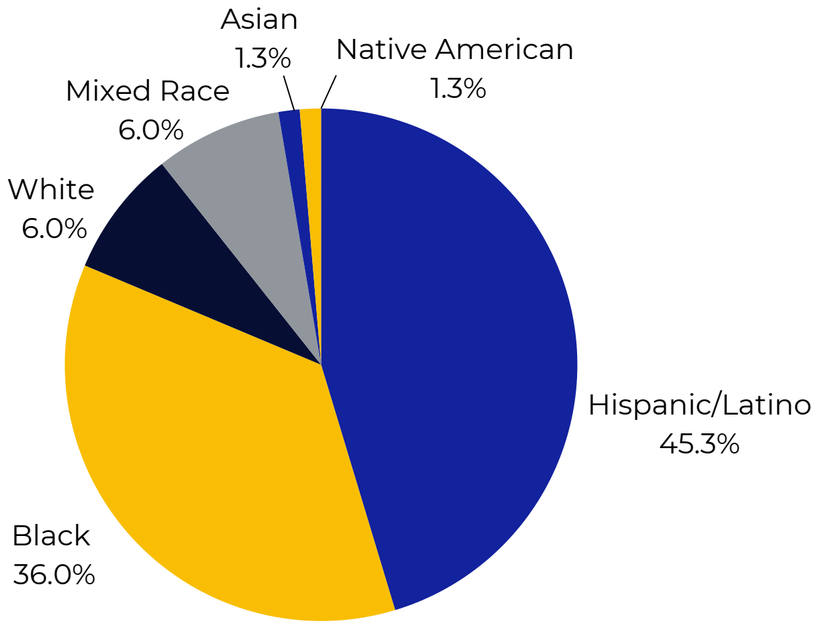
    - No personal identifying information was collected.
    - Surveys were conducted in an interview-based format.

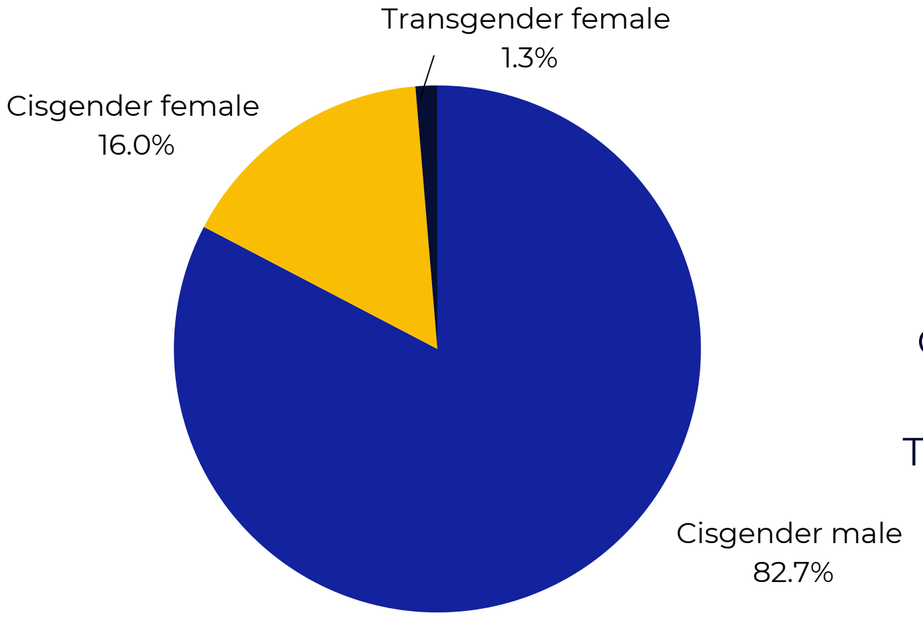
- Data was collected from **75 participants between October 2024 and February 2025.**

(This study has been certified as exempt from IRB review under 45 CFR 46.104, category 2, by the UCLA IRB, determined on October 3, 2024.)

DEMOGRAPHICS





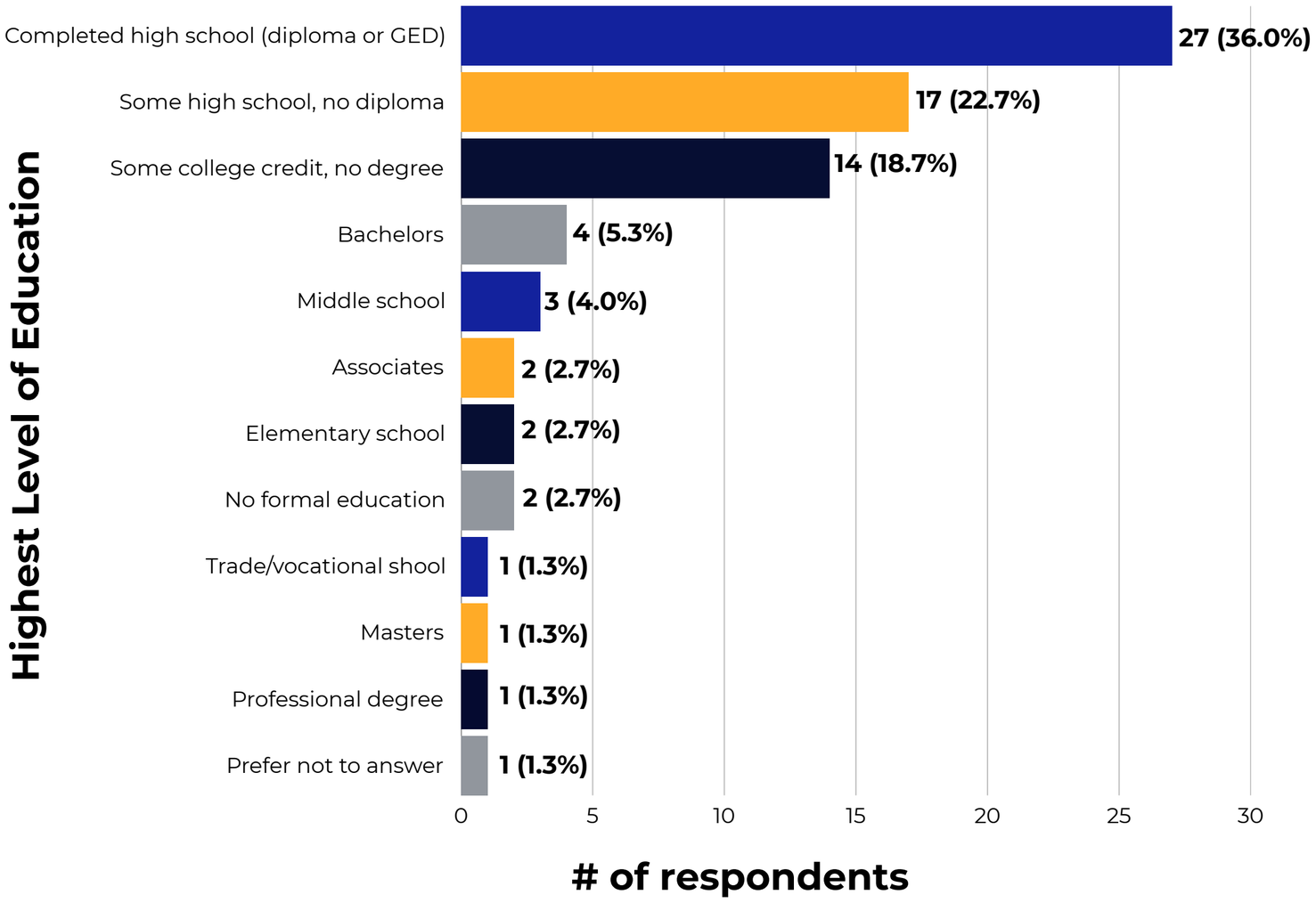


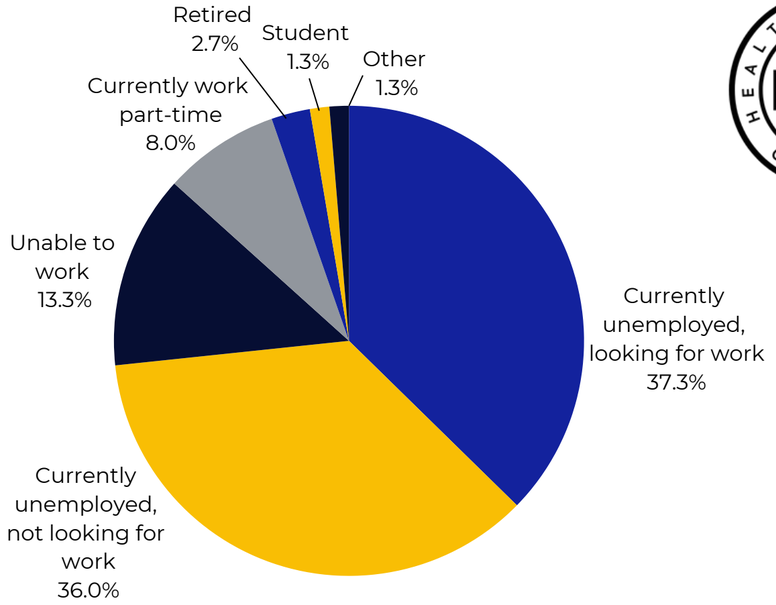
Race/Ethnicity:

34 (45.3%) Hispanic/Latine
27 (36.0%) Black
6 (8.0%) White
6 (8.0%) Mixed Race
1 (1.3%) Native American
1 (1.3%) Asian

Gender Identity:

82.7% (62) Cisgender male
16.0% (12) Cisgender female
1.3% (1) Transgender female





Employment Status:

28 (37.3%) Currently unemployed, looking for work
27 (36.0%) Currently unemployed, not looking for work
10 (13.3%) Unable to work
6 (8.0%) Currently work part-time
2 (2.7%) Retired
1 (1.3%) Student
1 (1.3%) Other

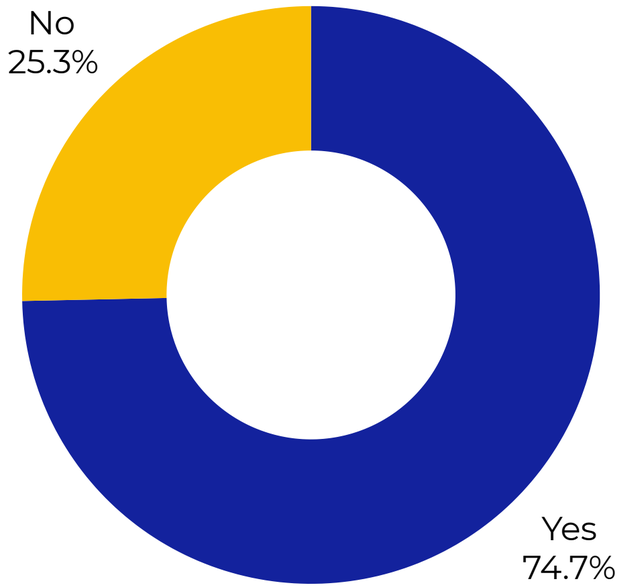
Military Status:

63 (85.1%) None
8 (10.8%) Past service
3 (4.1%) Prefer not to anser

“Are you currently experiencing homelessness?”:

Yes: 74.7% (56)

No: 25.3% (19)



"How long have you been experiencing homelessness?"

Less than 1 year: 21.4 % (9)

1-3 years: 35.7% (15)

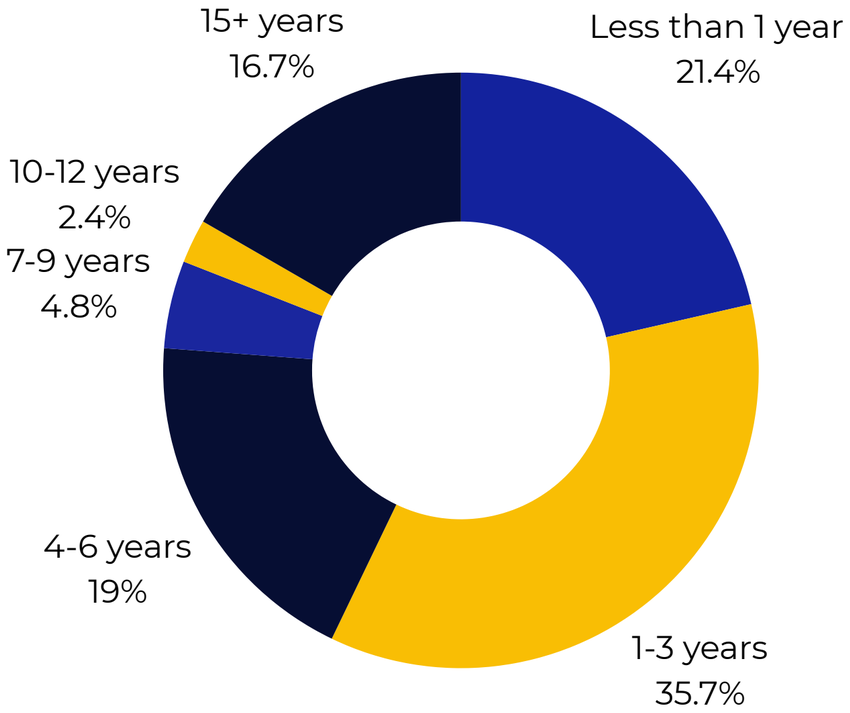
4-6 years: 19.0% (8)

7-9 years: 4.8% (2)

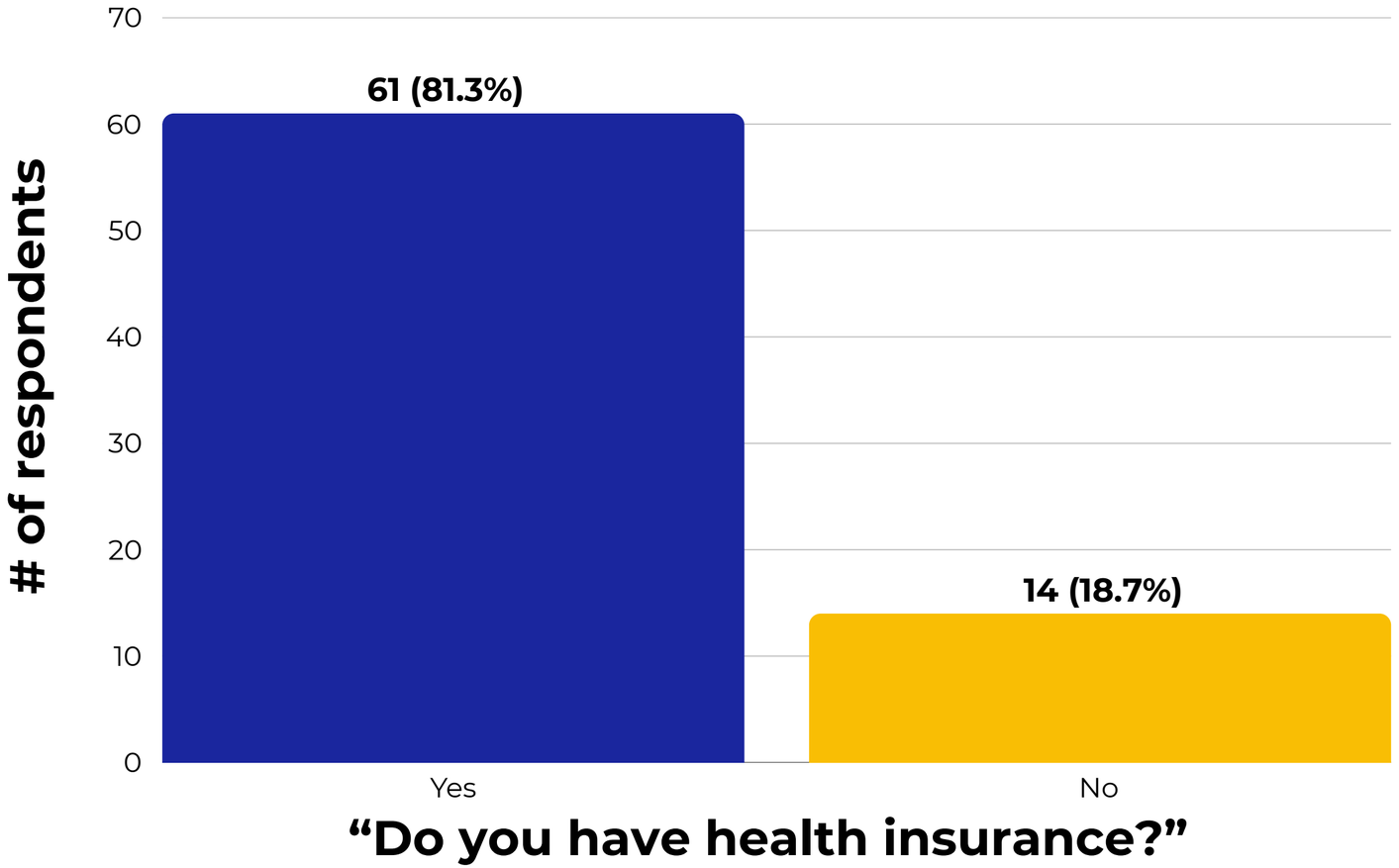
10-12 years: 2.4% (1)

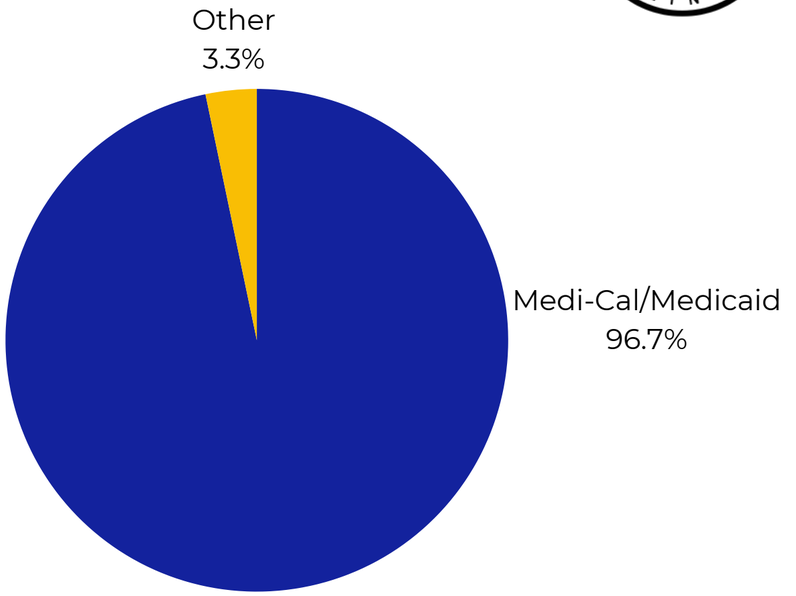
13-15 years: 0% (0)

15+ years: 16.7% (7)



HEALTHCARE ACCESS





“Who are you insured by?”:

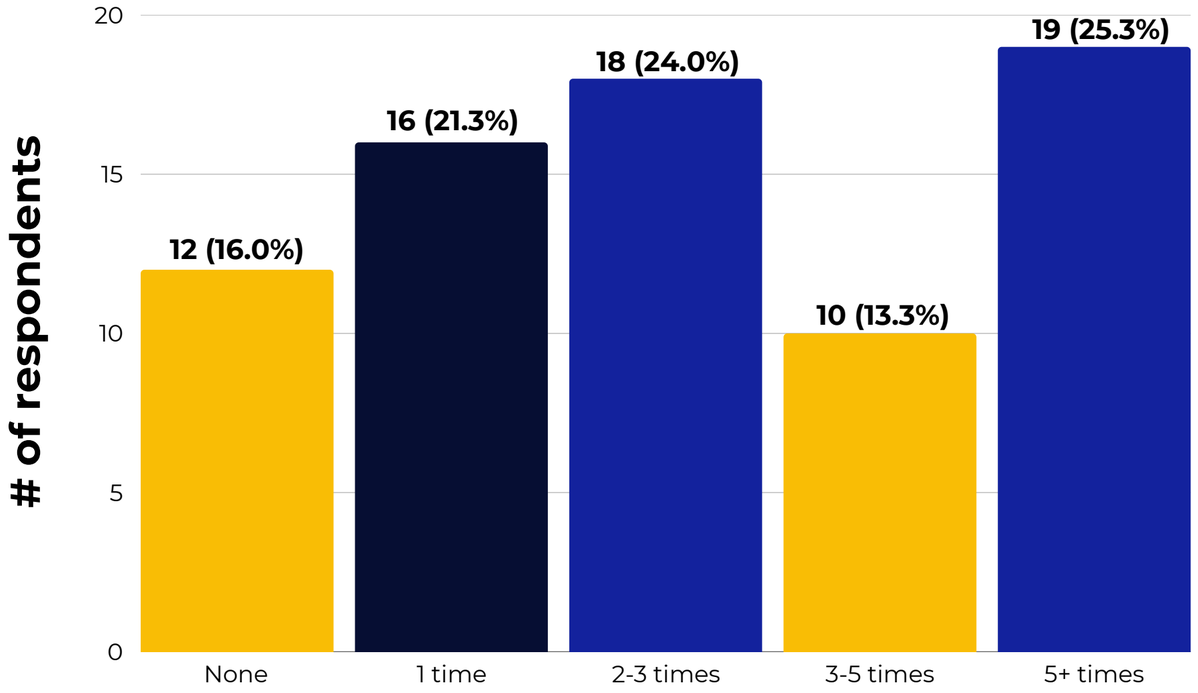
Medi-Cal/Medicaid: 59 (96.7%)

- 44 (72.1%) specified only Medi-Cal/Medicaid
- 7 (11.5%) specified LA Care
- 4 (6.5%) specified Anthem Blue Cross
- 2 (3.3%) specified HealthNet
- 2 (3.3%) specified Molina

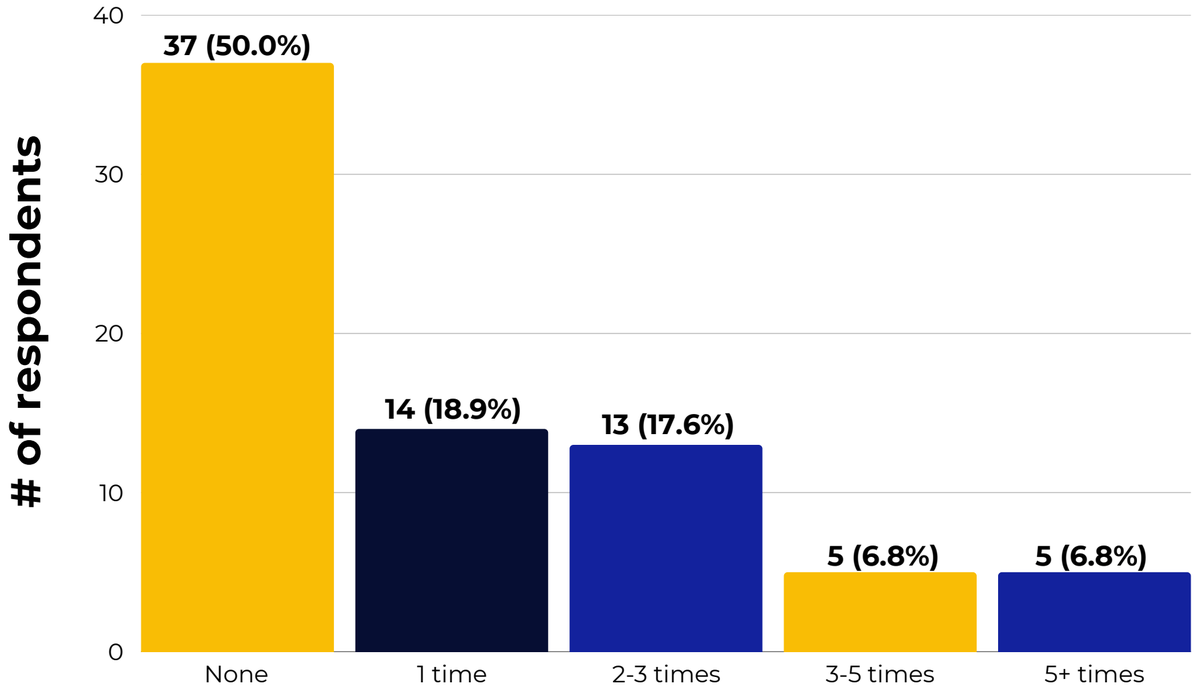
Other: 2 (3.3%)

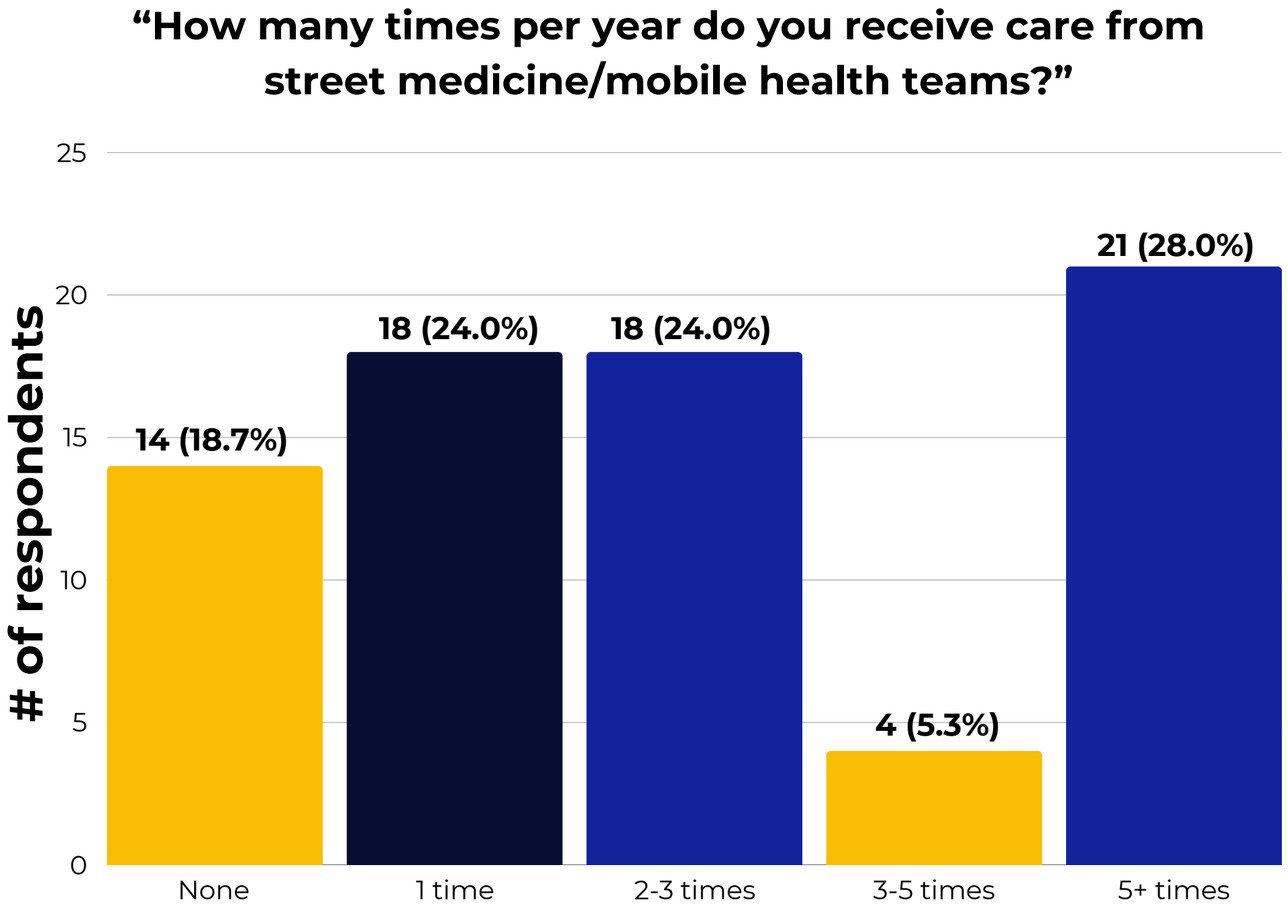
- 2 (3.3%) specified CalPERS

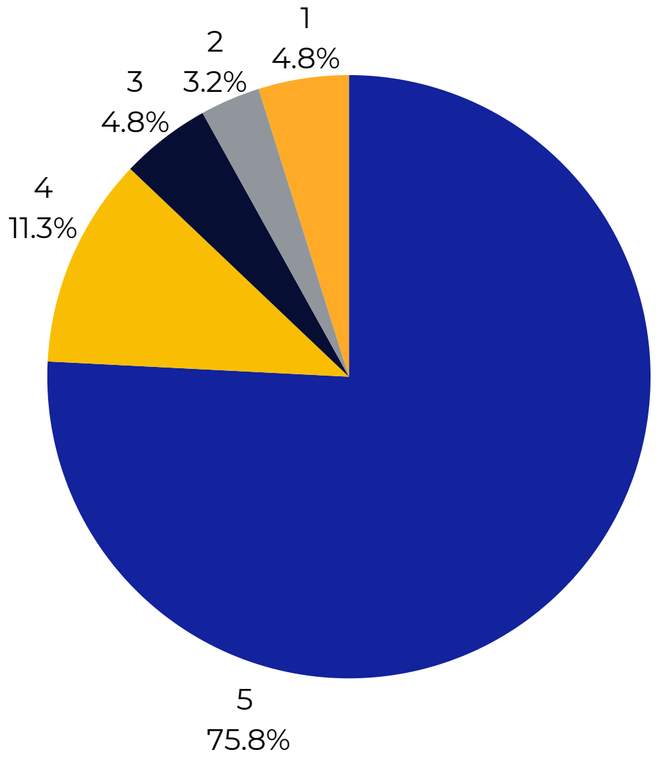
“How many times per year do you receive care in a doctor’s office?”



“How many times per year do you receive care in the emergency room?”

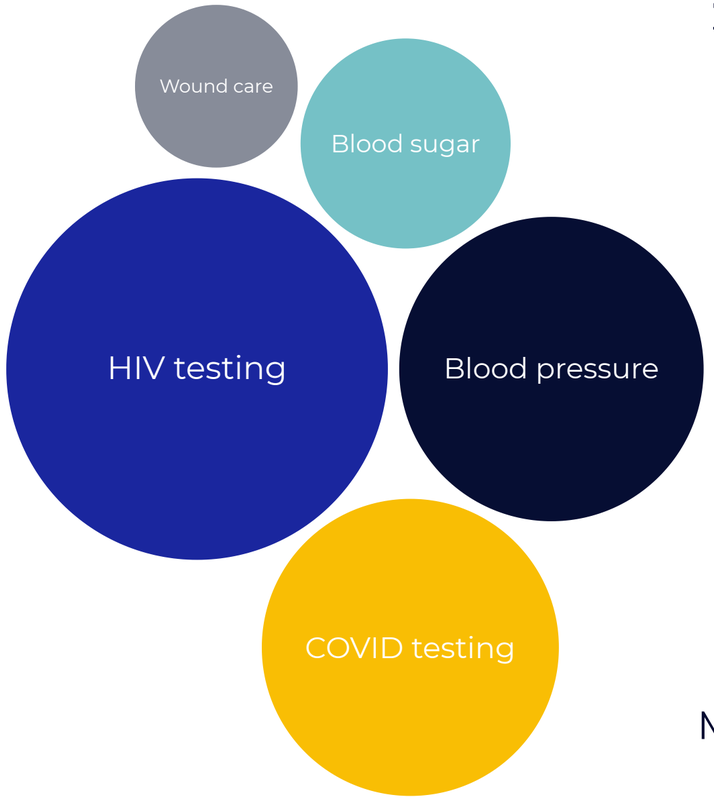






“If you have received care from mobile health/street medicine services, how likely are you to use them again?” (on a scale from 1-5)

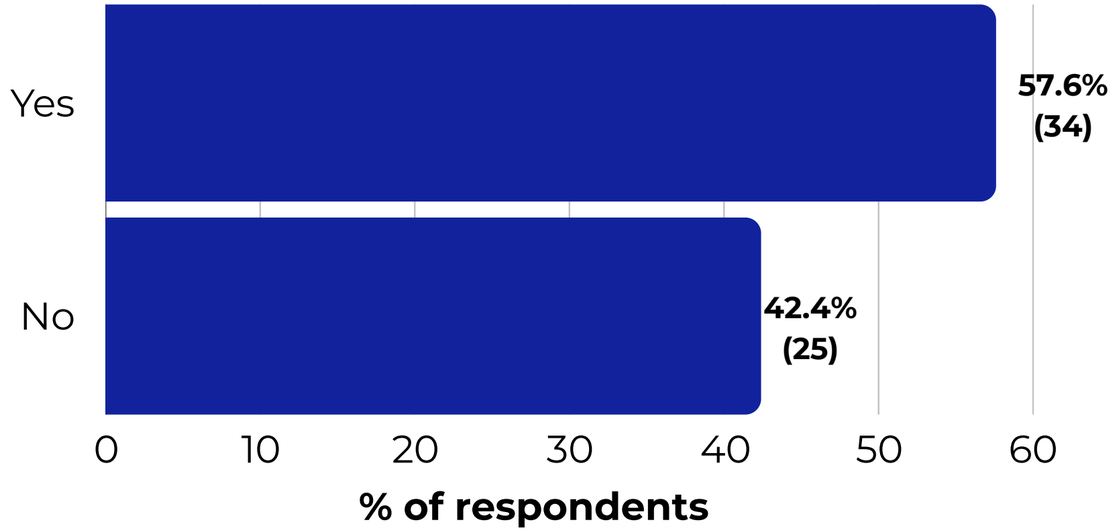
5 (very likely): 47 (75.8%)
4 (somewhat likely): 7 (11.3%)
3 (neutral): 3 (4.8%)
2 (not likely): 2 (3.2%)
1 (never): 3 (4.8%)



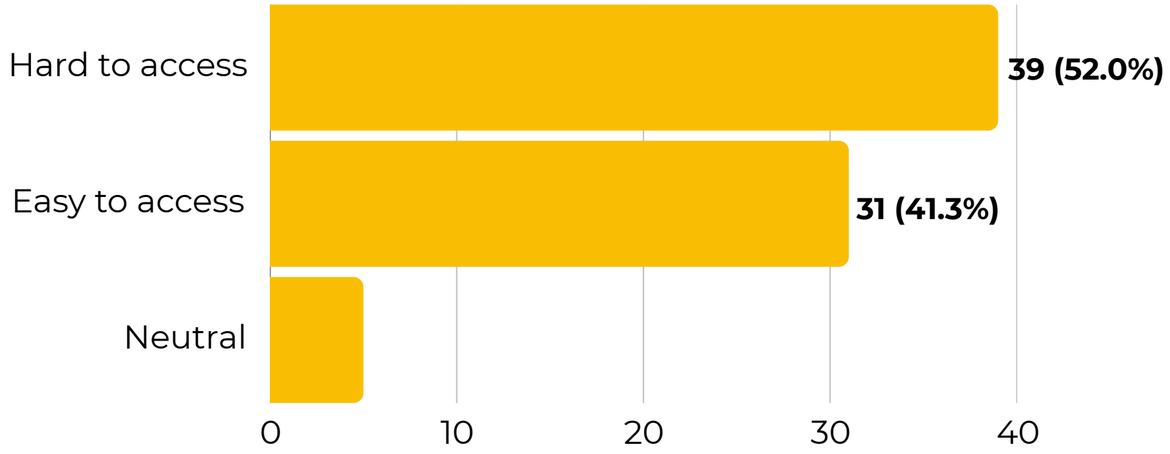
“If you have used mobile health services what health screenings, testing, or treatment have you received?”

HIV testing: 55.9% (33)
Blood pressure check: 35.6% (21)
COVID testing: 33.9% (20)
Blood sugar check: 16.9% (10)
Vaccinations: 16.9% (10)
Medications: 15.3% (9)
Other STD testing: 13.6% (8)
Physical exam: 11.9% (7)
Tuberculosis testing: 11.9% (7)
Dental care: 8.5% (5)
Wound care: 10.2% (6)
Mental health screening: 10.2% (6)
Colon/Prostate exam: 5.1% (3)
Hepatitis screening: 5.1% (3)

“Have you received this testing or treatment in a hospital, clinic, or doctor's office as well?”



“Do you feel that it is easy or hard to access the doctor’s office? Why?”



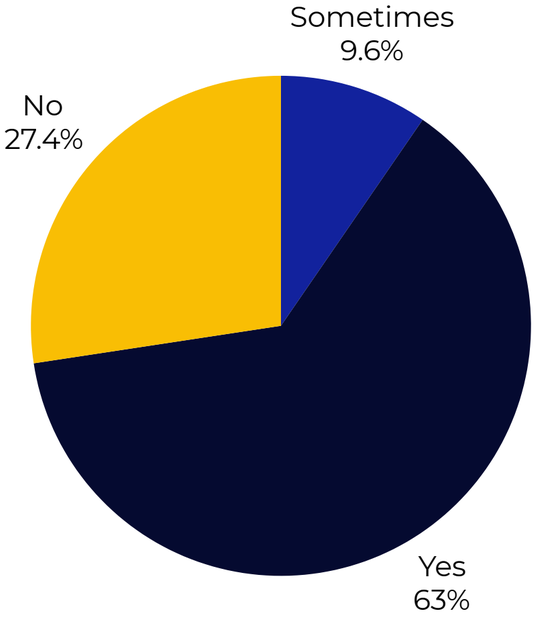
52.0% of respondents to this question (75 respondents) found it challenging to access the doctor, with the most frequently cited barriers being a lack of transportation and challenges with insurance (the latter primarily coming from those who are uninsured).

Themes	Total (38)	Representative Quotes
Difficult due to lack of transportation	28.9% (11)	“It’s hard to get transportation to the doctors' appointments, and it’s difficult to get there on time.” “I don't walk good these days so it's hard to get there. If I have a bike it's okay, but I don't want to leave my stuff in the waiting room because someone will take it.” “Hard. Got to walk and my walker got stolen.”
Challenges with insurance	28.9% (11)	“It's hard, you need insurance. If you don't have insurance you can't get help.” “It is hard because insurance makes it difficult. There’s so many different plans and when you go, you have to wait. They didn't see me last time I went for a broken tooth.”
Long wait times to receive an appointment	23.7% (9)	“It takes all day to see a doctor.” “It's hard. You have to wait so long you have a problem and you can't even see them.”
Lack of support to navigate services and paperwork	10.5% (4)	“It’s hard to know where to go around here. I need some direction.” “Honestly just filling out the paperwork is a challenge. I can’t read or write well.”
Difficult communicating with the clinic without a cell phone	7.9% (3)	“My cell phone gets stolen all the time so I cannot call for an appointment.” “If you have the right communication its easy. But my phone gets stolen all the time.”

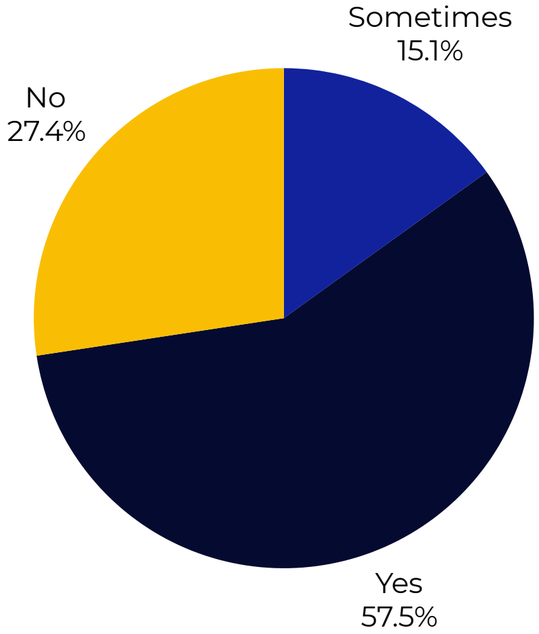
“How do you feel about visiting the doctor's office?”

Themes	Total (23)	Representative Quotes
Feelings of judgment	30.4% (7)	“Don't judge me, I'm being judged. Go meet my family. Why are you judging? Everybody out here has a background. I'm a doctor. I'm the President. So what? I'm a human, you're a human. When I sit down at the doctor I don't want medicine. I want you to understand my family. My life. Understand me. My mental health.” “I just can't deal with doctors who judge me when I tell them something is wrong. If I'm in pain, then believe me.”
Feelings of anxiety and nervousness	26.1% (6)	“It’s terrifying, I'm not sure why.” “I feel anxious and nervous. I'm 68 and in good shape now, but life happens. Anything can happen at any given time. Just like you prepare for life you prepare for death.”
Lack of trust in the doctor	21.7% (5)	“It’s terrible, I don't trust my current doctor. They’re complicit in the system and inconsistent so I study my own health. They give you wrong information.”
Discomfort due to language barrier	13.0% (3)	“La doctora es amable pero no habla español, así que realmente no me entiende.” *(English Translation: “My doctor is nice but she does not speak Spanish, so she really does not understand me.”)*
Burdened by the given diagnosis	8.7% (2)	“I don’t like it when the doctors diagnose me with something, because then I have to deal with it.” “It’s bad, it’s always something. It's good to stay up to date but I don't like to hear the news. It gives me more stress.”

Do you feel like the doctor understands you?

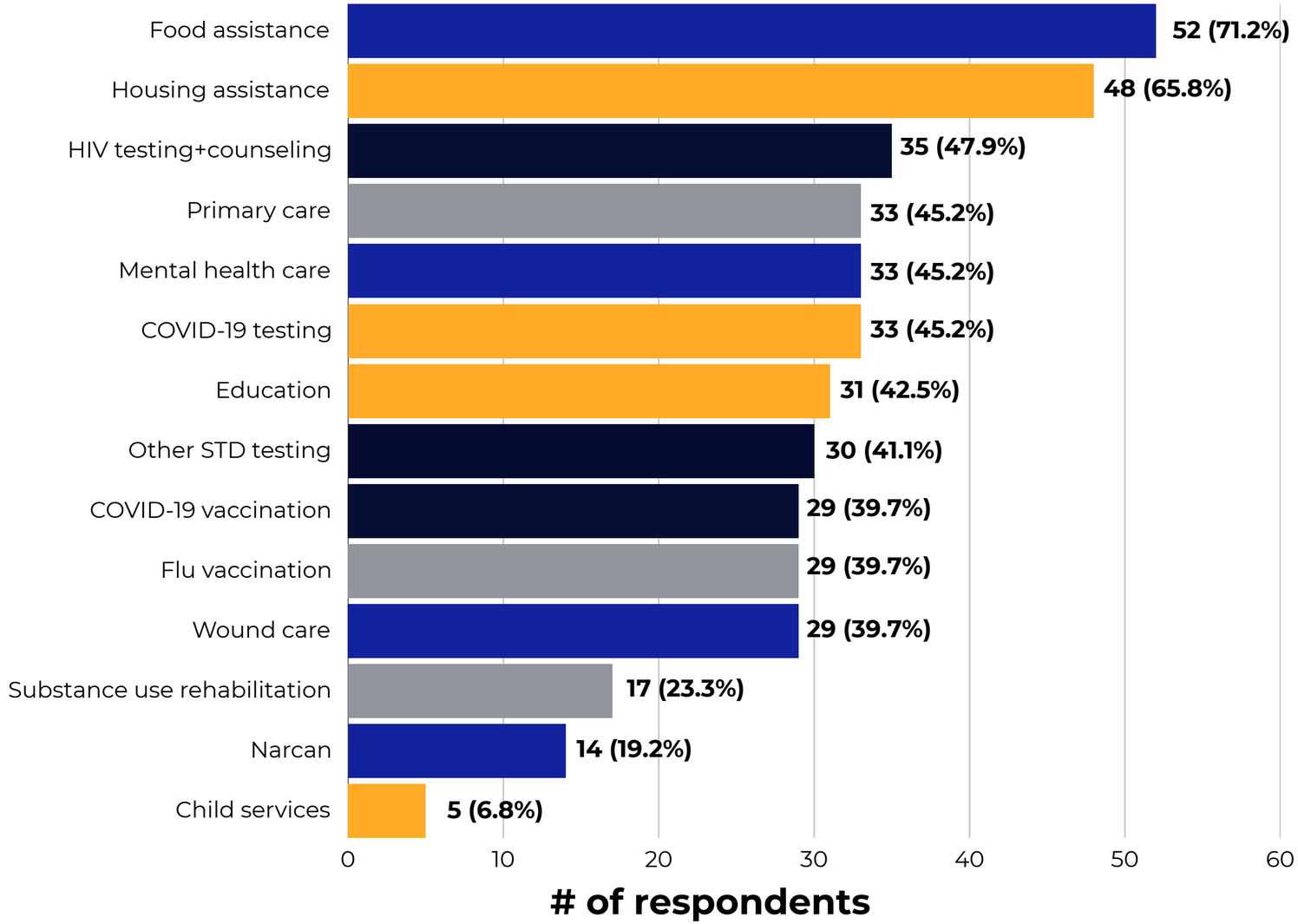


Do you feel like you can trust the doctor?



While most respondents (73) reported feeling like the doctor understood them and that they could trust the doctor, **27.4% cited sentiments of medical mistrust, in addition to 15.1% that said they can trust the doctor only "sometimes."** Responses related to medical mistrust were categorized into themes, as detailed in the table.

Themes	Total (25)	Representative Quotes
Dismissal of symptoms and perceived stereotyping and biases	48.0% (12)	"If they see that I'm homeless then they treat me different. If I tell them I'm on drugs then they also treat me with no respect." "Soy moreno. Me ven y me tratan sin respeto. Como que no soy humano." *(English translation: I'm dark-skinned. They see me and treat me without respect. Like I'm not human.)*
Poor communication	32.0% (8)	"He [The doctor] doesn't explain things well. I leave confused." "My primary doctors don't listen. I have to tell them what is wrong too many times."
New doctor at every visit	12.0% (3)	"At the free clinics around here you can see a doctor, but it's always a new one. So I feel like they don't really know me."
Language barriers	8.0% (2)	"No puedo entenderlos." *(English translation: I cannot understand them.)*



REQUESTED SERVICES

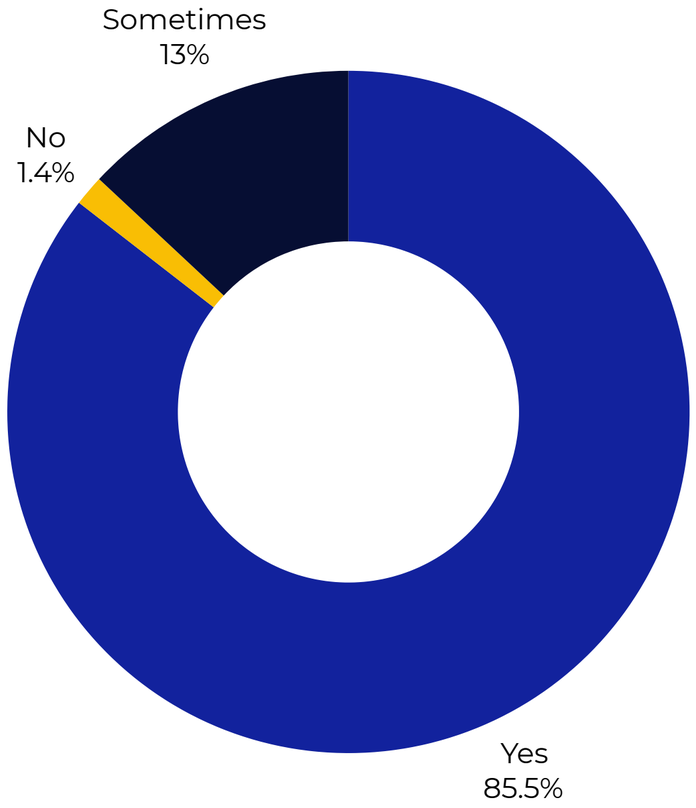
The majority of respondents indicated that they have used street medicine or mobile health services and intend to continue using them in the future. These services typically provide direct medical care and referrals to other services, such as housing.

However, many respondents still expressed a need for access to certain medical resources and social services, either because they have never received them or because they require more frequent and consistent access.

The most requested services were:

- ***Food assistance services (71.2%)***
- ***Housing assistance (65.8%)***
- ***HIV testing + counseling (47.9%)***
- ***Primary care (45.2%), Mental health care (45.2%), COVID-19 testing (45.2%)***
- ***Education services (42.5%)***

“Do you feel like street medicine and mobile health services are helpful?”



85.5% (of 75 respondents) expressed that street medicine and mobile health services were helpful. An additional 13.0% stated that they were sometimes helpful.

- **Factors: Convenience, Accessibility, Referrals to Other Resources, and Respectful Interactions**

“Why or why not?”

Quotes from respondents:

“If it were not for them many would be dead on the streets.”

“They’re helpful because a lot of people cannot get to the doctor due to lack of appointments or disabilities.”

“It’s a reminder to take care of your health. Your services are convenient, and give peace of mind especially for blood pressure checks.”

“They offer resources that I am unaware of.”

“They are respectful. Usually they don't dismiss. Would love to see them more.”

“Y'all are giving back and making sure we're taken care of. It can be more than just a health problem. It can also be drugs. You understand people's lives and living situation.”

“It helps a lot of people who aren't willing to go to doctors. You guys are the ones who listen, you're a lot of help. I don't check my blood pressure I'm too scared to do it even though it's dangerously high. I only let you guys check it.”

However...

"I've never received a follow-up. I was supposed to."

"I'd prefer if they could check in on me more often. Like come to my door. I can't walk too good so I can't really get up and go to the van [mobile health unit]."

"Well you guys can't do surgery out here. When it gets to that point then we still are kinda on our own."

"I think some people out here are still afraid to use them. It's kind of hard to know where the services are. But, I've used them, so I'd be willing to be that person to bridge the gap."

21.3%

21.3% of respondents **said that they have experienced issues with continuity of care with street medicine/mobile health teams**.

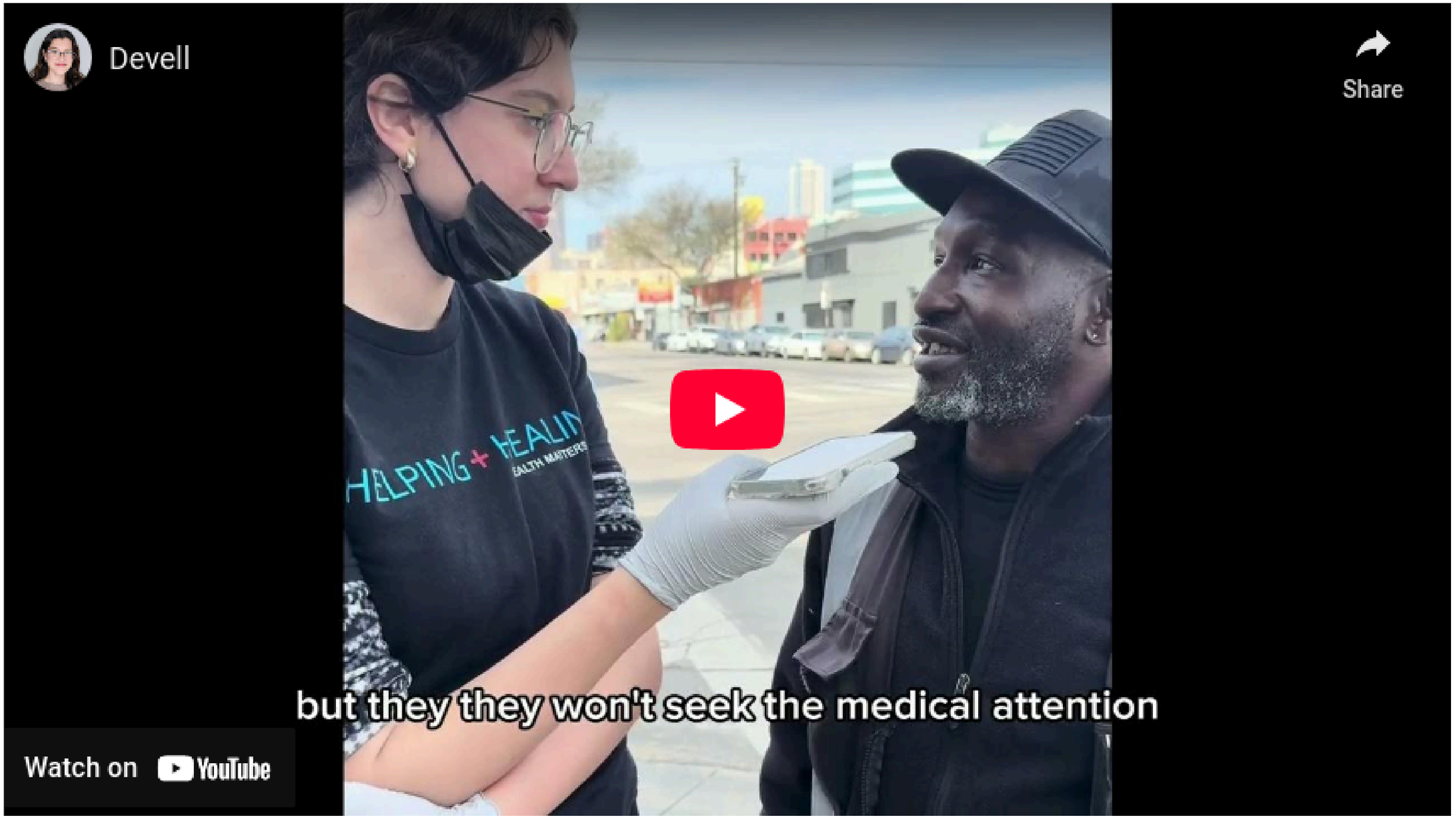
"They need to be out here posted up on the streets. Like you have the Community Refresh Spot open 24/7, but have these guys all over the place all the time so they know where it's at. Just like people know where they can get a cup of coffee. But have fellow people like us welcoming people in. Otherwise it's intimidating, you know? I'd be that [welcoming] person in a heartbeat though."

"They're helpful, but the wait times can still be long. You have to get there before they do. If I see a long line, then forget it. It's not like you get a follow up after that either so for my issues it's not as helpful. For others I'm sure it is."

48.0%

48.0% of those who reported medical mistrust (25) **reported feelings of stereotyping, discrimination, and biases from medical providers.**

Please watch: https://youtu.be/XhYyK080zI8



Expanding Community Health Workers and Peer Support

Global Evidence Supporting CHW Models:

- **Haiti: 100% TB clinical cure rate with CHW support (vs. 56% and 10% mortality without).**
- **Chiapas, Mexico: Sustained improvement in diabetes and hypertension outcomes, with twice the odds of control beyond two years.**
- **Rwanda: 92.3% retention in HIV treatment programs (vs. 70% average)**

(Role of CHW included daily home visits, escorting to care, food assistance services, transportation arrangement, housing assistance, emotional support via group therapy sessions, etc.)

Palazuelos, Daniel, et al. “Community Health and Equity of Outcomes: The Partners in Health Experience.” The Lancet Global Health, vol. 6, no. 5, May 2018, pp. e491–e493, https://doi.org/10.1016/s2214-109x(18)30073-1.

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In Los Angeles:

- **Community Health Worker (CHW) Outreach Initiative**
  - **CHWs have conducted over 822,000 outreach efforts across the County.**
  - **CHWs have assisted 29,000 Angelenos with vaccine appointments.**
  - **In 2023, CHWs' roles expanded to include system navigation for food access, financial assistance, and housing services.**

- **2021 study of a nurse-led CHW intervention, that provided referrals to health and social services as well as weekly check-ins for latent tuberculosis medication completion (weekly dose, 12 doses) among unhoused adults in Skid Row, found a 91.8% treatment completion rate in comparison to the historical control group's 66%.**

Palazuelos, Daniel, et al. "Community Health and Equity of Outcomes: The Partners in Health Experience." The Lancet Global Health, vol. 6, no. 5, May 2018, pp. e491–e493, https://doi.org/10.1016/s2214-109x(18)30073-1.

Nyamathi, Adeline, et al. "Effect of a Nurse-Led Community Health Worker Intervention on Latent Tuberculosis Medication Completion among Homeless Adults." Nursing Research, vol. 70, no. 6, 11 Aug. 2021, pp. 433–442, https://doi.org/10.1097/nnr.0000000000000545. Accessed 12 Nov. 2021.

Summary of Key Findings

- **85.5% of respondents expressed that street medicine and mobile health services were helpful. An additional 13.0% stated that they were sometimes helpful. Factors cited included referrals to other resources, respectful interactions, convenience, and accessibility.**

- **42.4% of respondents who had received a service by a street medicine/mobile health team (HIV test, blood pressure check, COVID test), had only ever received those specific services on the streets.**
  - **Despite over 81.3% of respondents being insured, 52.0% still reported difficulty accessing the doctor in traditional settings, citing barriers such as access to transportation.**
  - **81.3% had used street medicine/mobile health services 1+ times in the past year; 87.1% said they're somewhat or very likely to use them again.**

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- **The most requested services were:**
  - **Food assistance services (71.2%)**
  - **Housing assistance (65.8%)**
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  - **Education services (42.5%)**

- **21.3% of respondents said that they have experienced issues with continuity of care with street medicine/mobile health teams**

Acknowledgements:

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Jenna Friedman
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Adrienne Calderon

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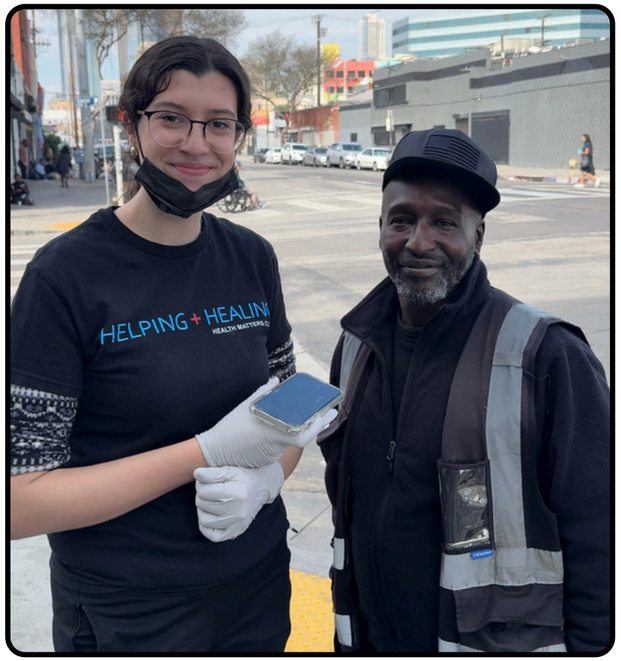

Thank You

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1360 S. Figueroa St. D390
Los Angeles, CA 90015
March 5, 2025

Los Angeles County Commission on HIV Housing Task Force
510 S. Vermont Avenue, 14th Floor
Los Angeles, CA 90020

Dear Members of the Los Angeles County Commission on HIV Housing Task Force,

On behalf of Health Matters Clinic, I would like to express our appreciation for the ongoing efforts to address HIV prevention and care within the County's most vulnerable populations. We are pleased to provide a brief summary of findings from our recent report, *Understanding Healthcare Access and Experiences in Skid Row, Los Angeles*, as well as our recommendations based on our recent evaluation of our HIV OraQuick Self-Test Kit Distribution Program in collaboration with the LA County Dept. of Public Health, particularly as it relates to individuals experiencing homelessness in Skid Row.

Our report, *Understanding Healthcare Access and Experiences in Skid Row, Los Angeles,* is based on interviews with 75 individuals residing in Skid Row. Among our findings:

- 81.3% of respondents use street medicine or mobile health services at least once per year.
- Of these individuals, 55.9% have received an HIV test through a street medicine or mobile health team.
- 42.4% of people who had received a service (ex: HIV testing, blood pressure check, COVID testing) from a mobile health/street medicine team had only received those services on the streets. This, of course, includes HIV testing services.
- 47.9% of respondents expressed a need for more frequent access to HIV testing and counseling.

These figures highlight the role that street medicine teams play in HIV testing and prevention. We understand that funding for HIV/STD programs is under threat, and we want to make clear: For many Skid Row residents, street medicine/mobile health teams are the primary point of access to rapid testing and referrals. Cutting funding for these services would be devastating to a community already suffering the consequences of gaps in HIV/STD-related public health infrastructure.

While 98% of respondents found street medicine and mobile health teams helpful or somewhat helpful, 21.3% noted challenges with follow-up services:

- One respondent shared, *"I never received a follow-up. I was supposed to."*
- Another added, *"It's not like you get a follow-up, so for my issues, it's not as helpful."*

Our own HIV OraQuick Self-Test Kit Distribution Program, in partnership with the LA County Dept. of Public Health, provides self-testing options at outreach events, with an estimated 90% completing tests on-site with our team (rather than taking their test kit "to-go"). While this program increases access to testing, there are challenges in ensuring follow-up care, particularly for individuals who may test reactive after they complete the test off-site.

Recommendations for Improving Engagement and Follow-Up Care

I would like to begin our recommendations for improving engagement and follow-up care with a video created by myself and Mr. Devell Boutte, an individual with lived experience in Skid Row with whom we have formed a relationship with since offering services in Skid Row. In this video he offers his perspective and vision for improved healthcare that addresses medical mistrust and lack of follow-up services in the Skid Row community: https://m.youtube.com/watch?v=stuXWz0_ucI&feature=youtu.be

A promising model for improving follow-up is the Community Health Worker (CHW) Outreach Initiative, launched by LA County in 2020 in response to the pandemic. CHWs—many with lived experience in vulnerable communities—have a unique position to connect individuals to care with a deeper cultural, linguistic, and social understanding that providers alone cannot offer.

Since then, according to the LA County Dept. of Public Health:

- CHWs have conducted over 822,000 outreach efforts across the County.
- CHWs have assisted 29,000 Angelenos with vaccine appointments.
- In 2023, CHWs' roles expanded to include system navigation for food access, financial assistance, and housing services.

Further, a 2021 study of a nurse-led CHW intervention, that provided referrals to health and social services as well as weekly check-ins for latent tuberculosis medication completion among unhoused adults in Skid Row, found a 91.8% treatment completion rate in comparison to the historical control group's 66%. (Nyamathi et. al, 2021).

We truly applaud these efforts, and thank the County's role in the expansion of these services. However, there is significant room for growth, particularly within the Skid Row community. Expanding these services within the Skid Row community, not just as a supplement, but as foundational to a comprehensive, community-led health system, can be the next step forward. We've seen organized systems of CHWs with government support take shape in various low-resource settings around the globe with remarkable success for decades before their implementation in Los Angeles (please read Palazuelos et. al's article on Partners in Health's CHW program outcomes since the late 1980s). A similar approach—expanding a unified and empowered force of CHWs with lived experience in Skid Row—can be the next step toward improving engagement and follow-up services, particularly for HIV/STD care in this community.

We urge the prioritization of sustainable health solutions for Skid Row, ensuring that the voices and experiences of its residents are at the center of decision-making. Our full report provides direct quotes and narratives from individuals in the community, offering insight into their needs and priorities. A healthier future for Skid Row is possible—but it requires action and community collaboration.

We look forward to continued discussion, collaboration, and welcome any questions.

Sincerely,
Ms. Sara Habibipour, Volunteer and Team Lead at Health Matters Clinic
Email: sarahabibipour@g.ucla.edu , sara@healthmatters.clinic
Phone: 760-567-5599

Report, Oct. 2024-Feb 2025 | Health Matters Clinic

Understanding Healthcare Access and Experiences in Skid Row, Los Angeles

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Important Terms:

Street Medicine is a healthcare approach that delivers medical services directly to individuals experiencing homelessness, typically on the streets, aiming to provide care where people live rather than in traditional healthcare facilities.

Mobile Health refers to healthcare services provided through mobile health units—vehicles equipped with medical equipment and staffed by healthcare professionals—that travel to various locations to offer care, screenings, and treatment, often in underserved areas.

OVERVIEW

Skid Row, Los Angeles is one of the most densely populated areas for people experiencing homelessness in the United States. With thousands lacking stable housing, health conditions become exacerbated due to poor living conditions, lack of sanitation, and limited access to healthcare services. This includes the spread of communicable diseases such as tuberculosis, hepatitis, HIV, and COVID-19, as well as the aggravation of chronic conditions such as diabetes, hypertension, substance use disorders, and mental health disorders.

Barriers to accessing healthcare in Skid Row include lack of identification, unstable living situations, transportation issues, and mistrust of the healthcare system. Several healthcare providers operate in Skid Row that offer services for free or at a low-cost, but they are often overburdened due to high demand, making it difficult for individuals to even get an appointment. Medi-Cal, California's Medicaid program, is available to many low-income and unhoused individuals, but survey results highlight that various social determinants of health, such as access to transportation and medical mistrust, create barriers to receiving healthcare in traditional settings despite being insured.

This survey seeks to gain the direct perspectives of individuals residing in Skid Row, Los Angeles regarding their healthcare access and experiences, as well as understand the types of services that individuals would find most helpful. Key findings include:

- **85.5% of respondents said that they found street medicine services helpful, with an additional 13.0% saying that they were sometimes helpful.**
- **52.0% of individuals surveyed reported that accessing medical services is challenging, with the main reasons being transportation difficulties and challenges with insurance.**
- **87.1% of respondents say they are somewhat likely or very likely to use street medicine/mobile health services again.**
- **The most sought after service in Skid Row is food assistance (71.2%), followed by housing assistance (65.8%), HIV testing+counseling (47.9%), primary care (45.2%), mental health care (45.2%), COVID testing (45.2%), and education services (42.5%).**
- **21.3% of respondents shared street medicine/mobile health teams would be more helpful if they improved continuity of care.**
- **42.4% of those who had received services from street medicine/mobile health teams had only ever received those specific services on the streets.**
- **48.0% of those who reported lack of trust in the doctor cited dismissal of symptoms and perceived discrimination/stereotyping.**

Efforts to enhance healthcare access in Skid Row continue to be notable, yet the demand greatly surpasses available resources, and **significant gaps remain in meeting basic health needs even with current street medicine/mobile health models in place.**

This report seeks to provide street medicine leaders and policymakers with insights into the healthcare challenges faced by Skid Row residents, using their direct voices and perspectives to better **shape policies aimed at improving healthcare for unhoused populations in Los Angeles.**

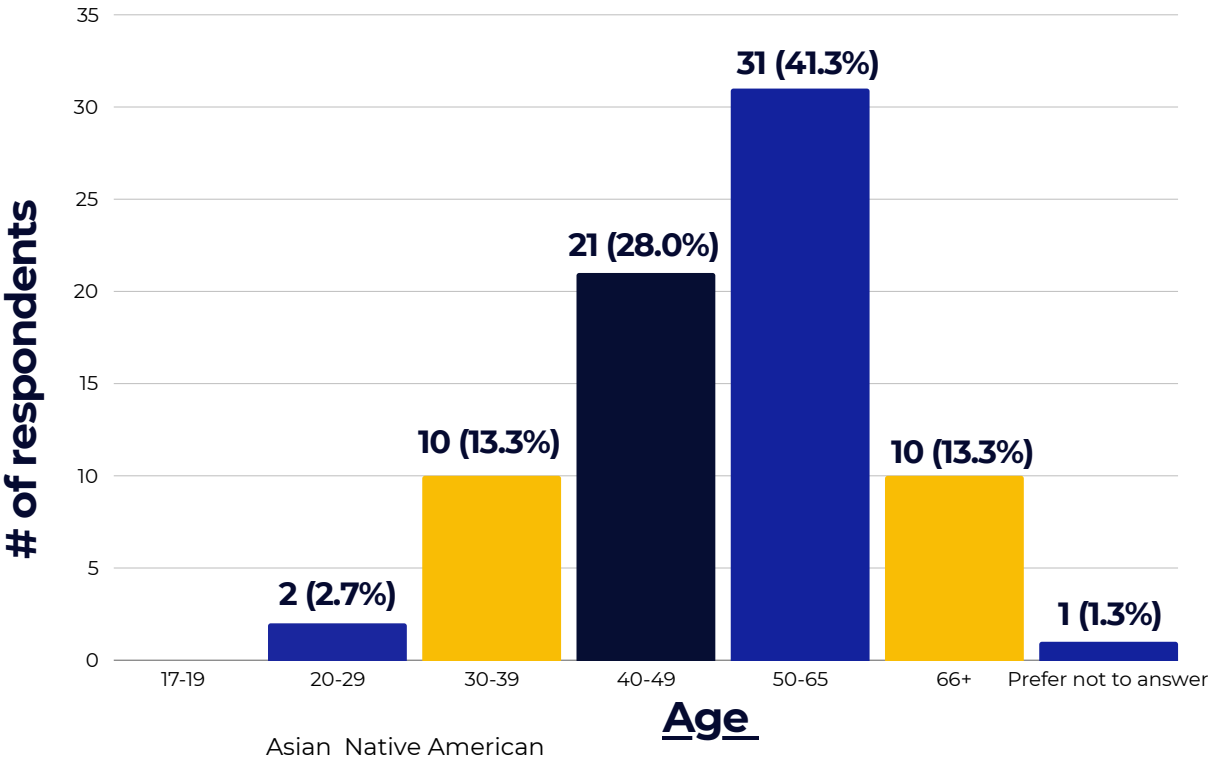
METHODOLOGY

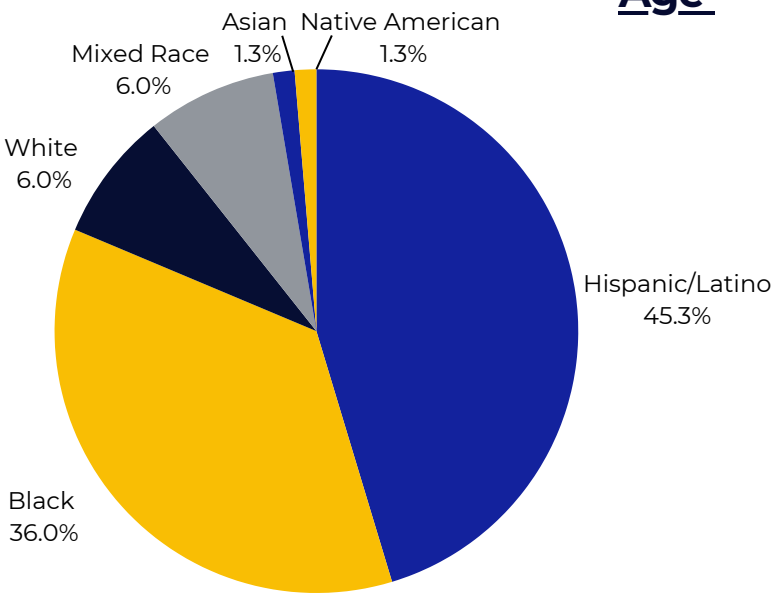
Participants for this survey were approached throughout Skid Row and asked if they would be interested in completing a survey to better understand their healthcare access and experiences. Participants gave their consent to participate orally. The inclusion criteria required that respondents be adults over the age of 18, capable of providing informed consent, fluent in either English or Spanish, and either unhoused or living within a housing facility in Skid Row.

Participants were informed that their involvement in the survey was entirely voluntary, with the option to skip any question or discontinue participation at any time. No compensation or incentives, such as gift cards or monetary rewards, were provided for participation. No personal identifying information was collected. Surveys were conducted in an interview-based format to accommodate individuals who may not be able to read, write, or navigate technology. Responses were recorded during the interviews and subsequently analyzed for themes using Survey Monkey.

This study has been certified as exempt from IRB review under 45 CFR 46.104, category 2, by the UCLA IRB, determined on October 3, 2024. Data was collected from **75 participants between October 2024 and February 2025.**

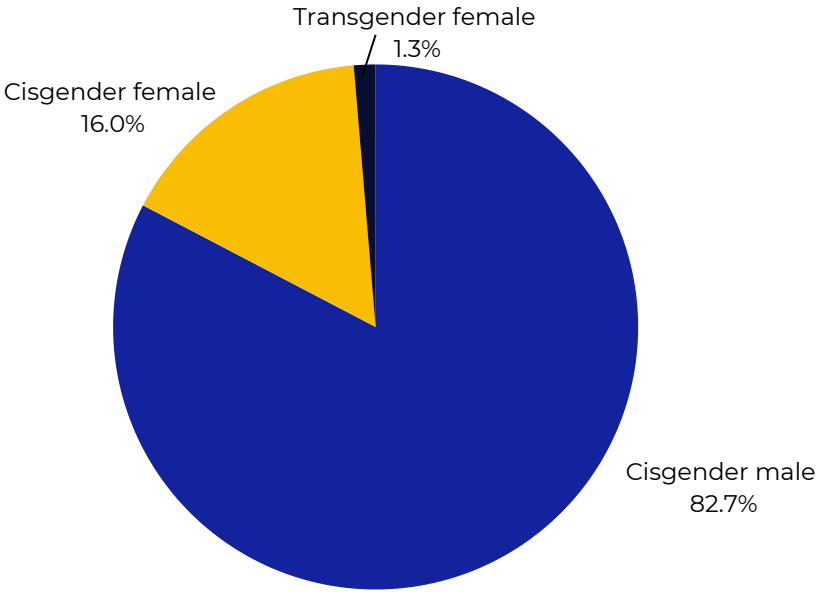
DEMOGRAPHICS





Race/Ethnicity:

34 (45.3%) Hispanic/Latino
27 (36.0%) Black
6 (8.0%) White
6 (8.0%) Mixed Race
1 (1.3%) Native American
1 (1.3%) Asian

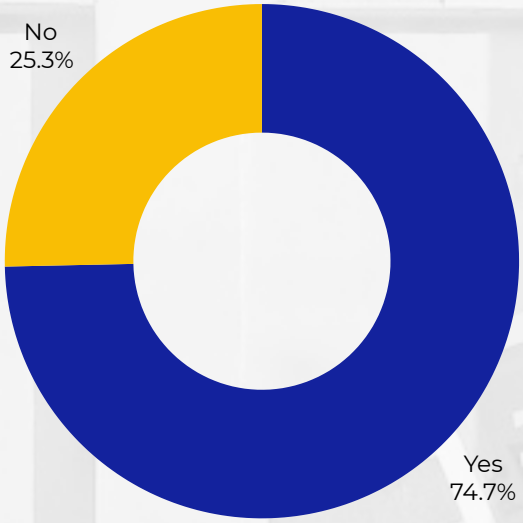


Gender Identity:

82.7% (62) Cisgender male
16.0% (12) Cisgender female
1.3% (1) Transgender female

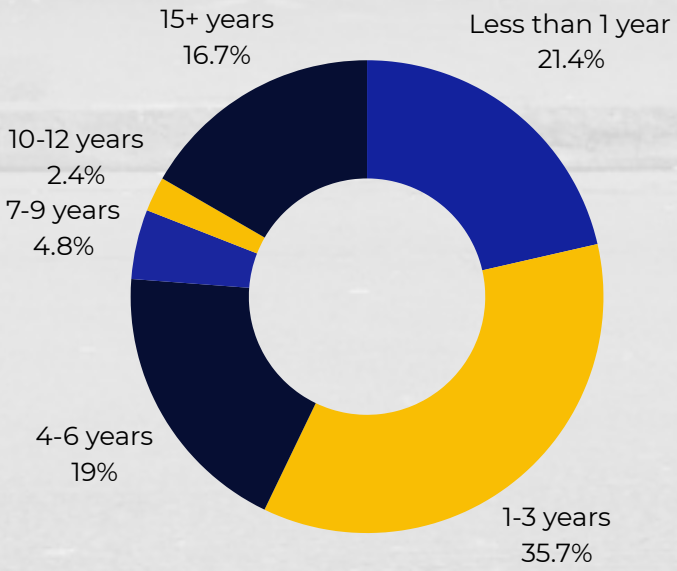
“Are you currently experiencing homelessness?”:

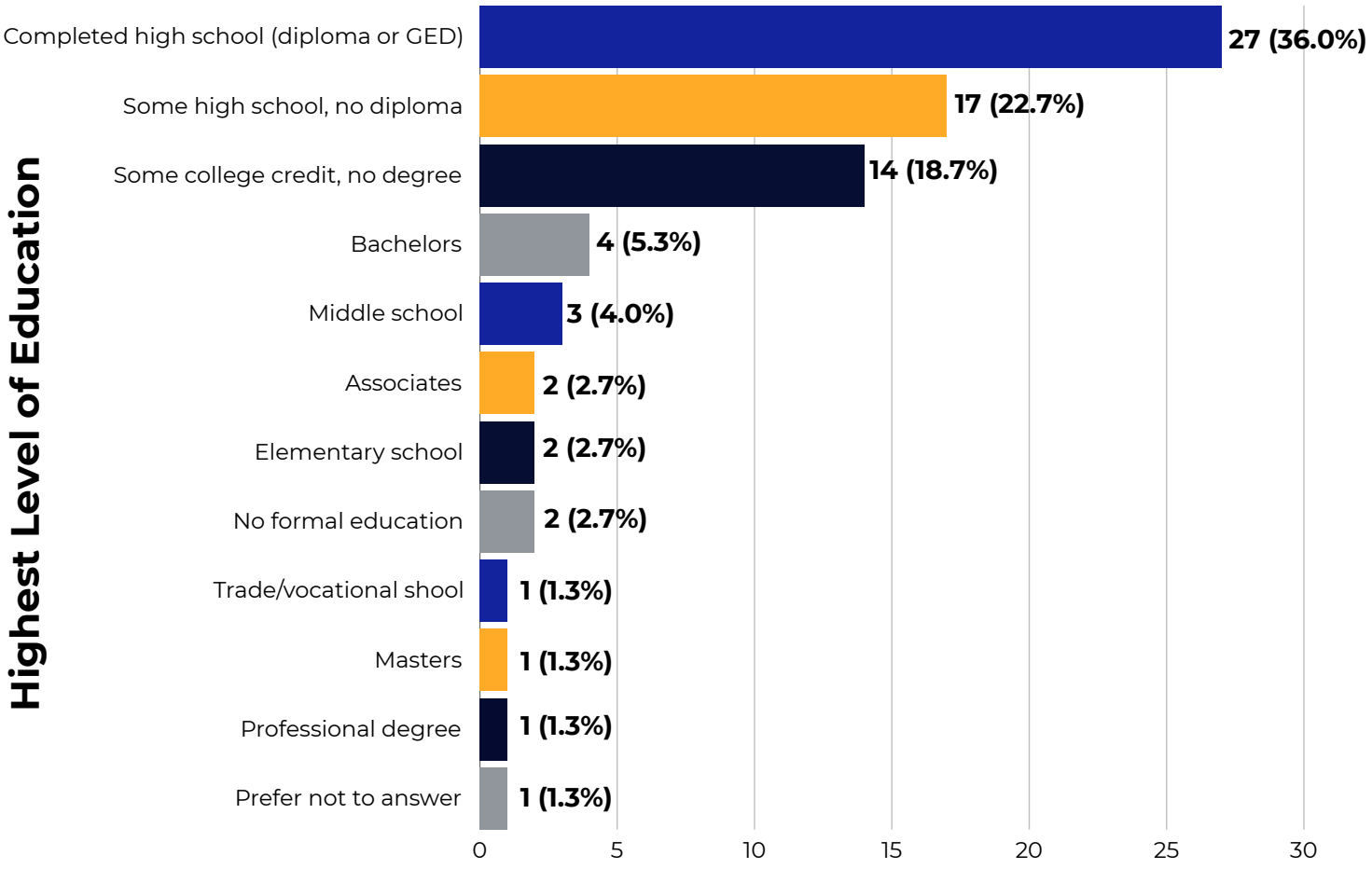
Yes: 74.7% (56)
No: 25.3% (19)

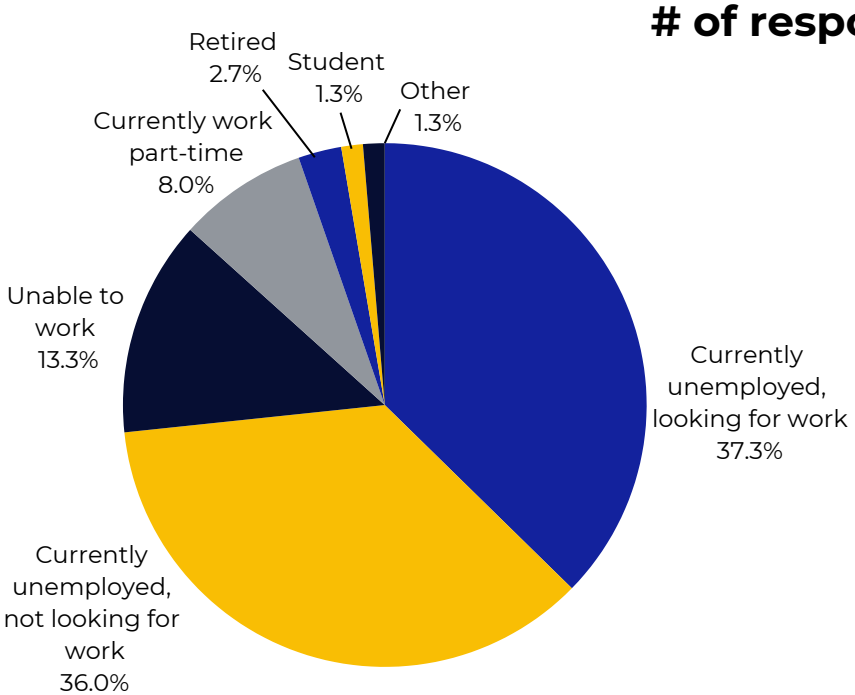


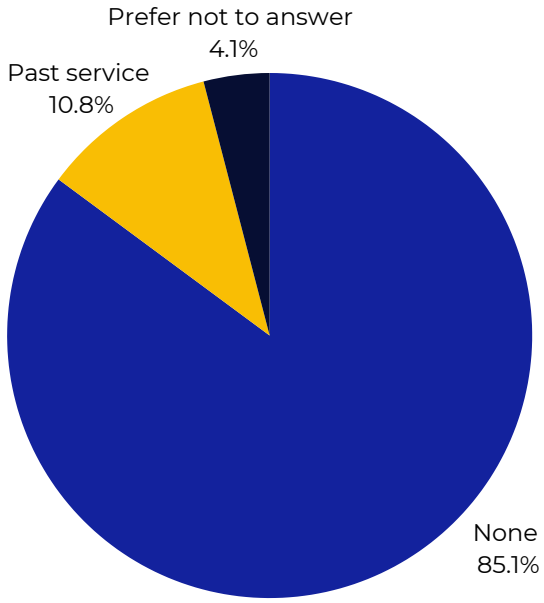
"How long have you been experiencing homelessness?"

Less than 1 year: 21.4 % (9)
1-3 years: 35.7% (15)
4-6 years: 19.0% (8)
7-9 years: 4.8% (2)
10-12 years: 2.4% (1)
13-15 years: 0% (0)
15+ years: 16.7% (7)









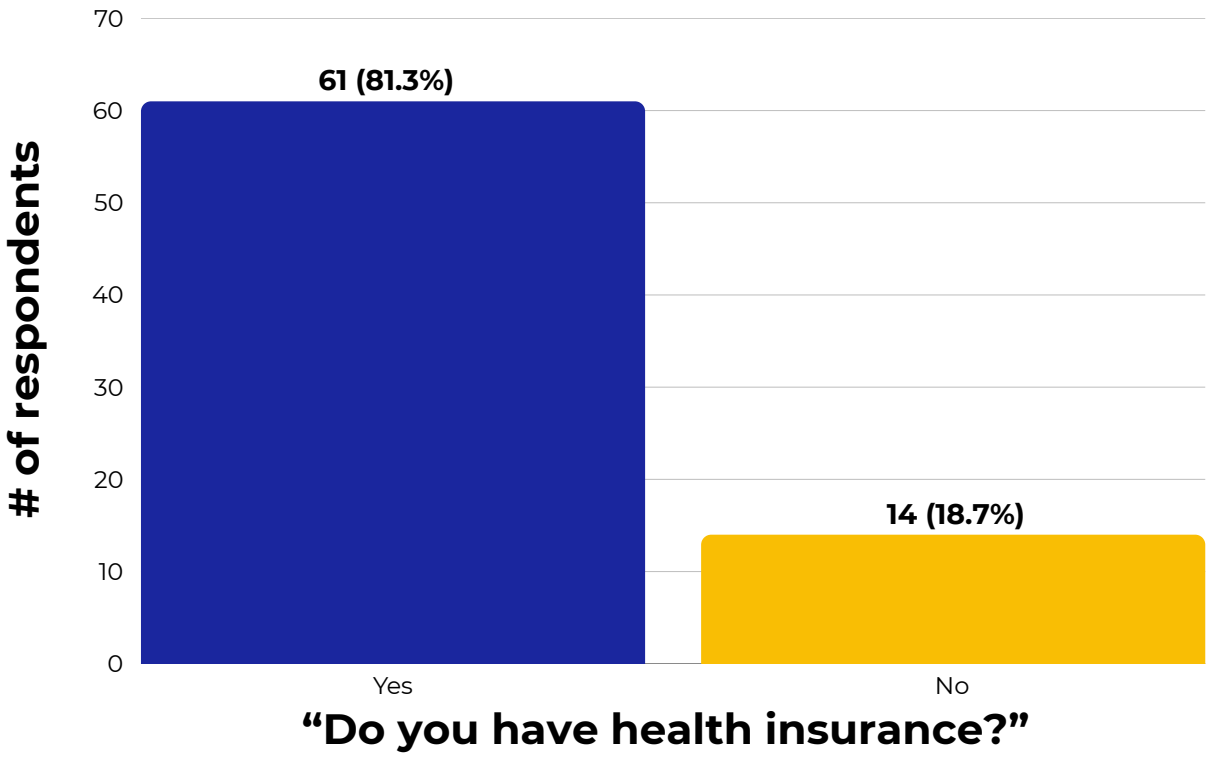
Employment Status:

28 (37.3%) Currently unemployed, looking for work
27 (36.0%) Currently unemployed, not looking for work
10 (13.3%) Unable to work
6 (8.0%) Currently work part-time
2 (2.7%) Retired
1 (1.3%) Student
1 (1.3%) Other

Military Status:

63 (85.1%) None
8 (10.8%) Past service
3 (4.1%) Prefer not to anser

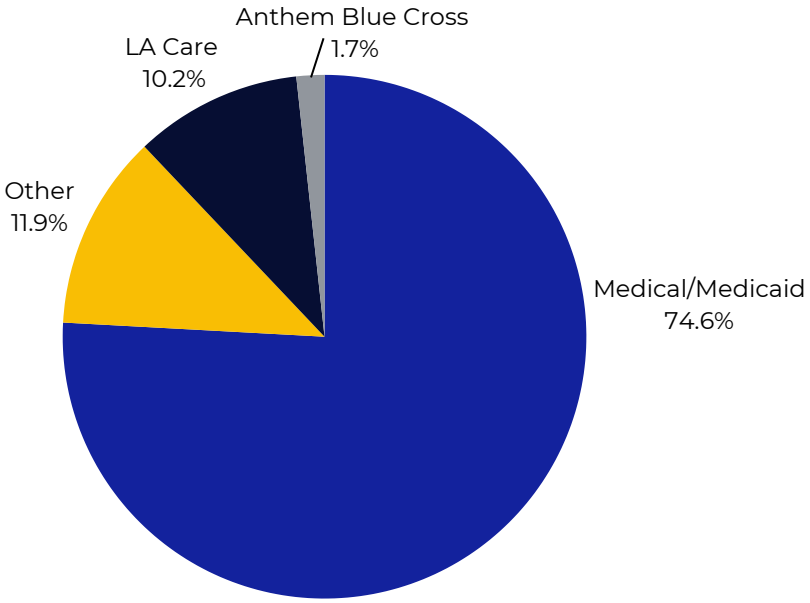
HEALTHCARE ACCESS



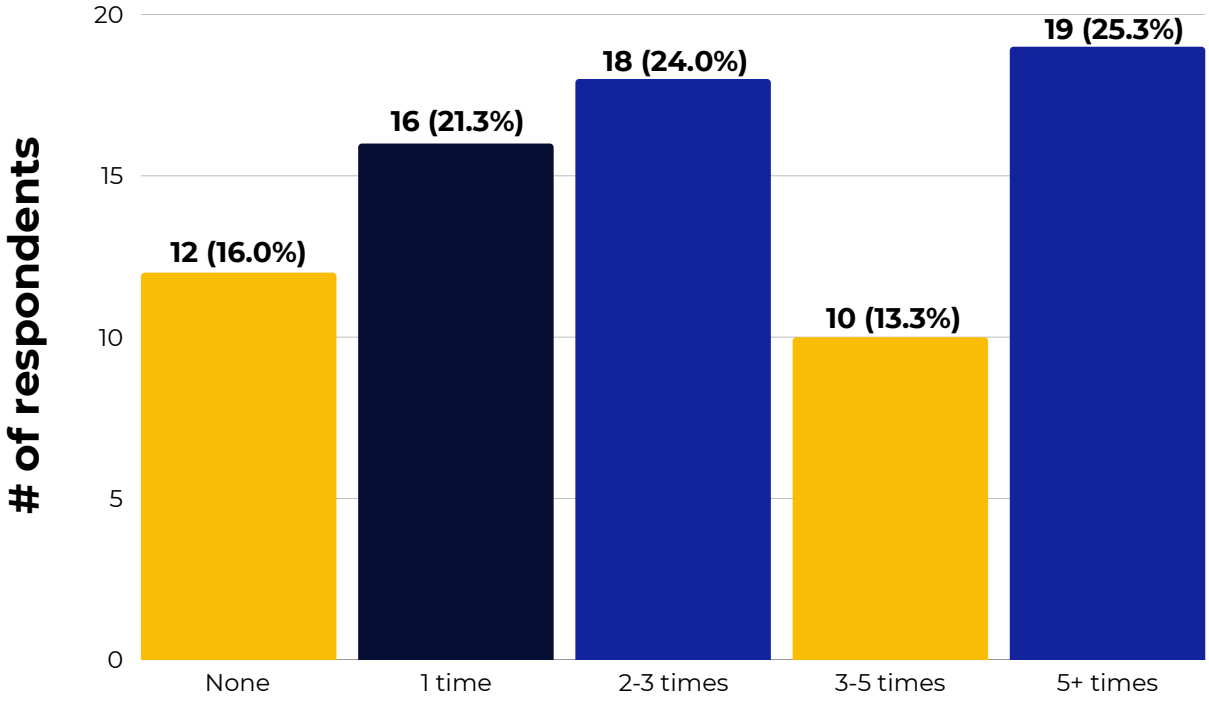
"Who are you insured by?":

Medical/Medicaid: 44 (74.6%)
Other*: 7 (11.9%)
LA Care: 6 (10.2%)
Anthem Blue Cross: 1 (1.7%)

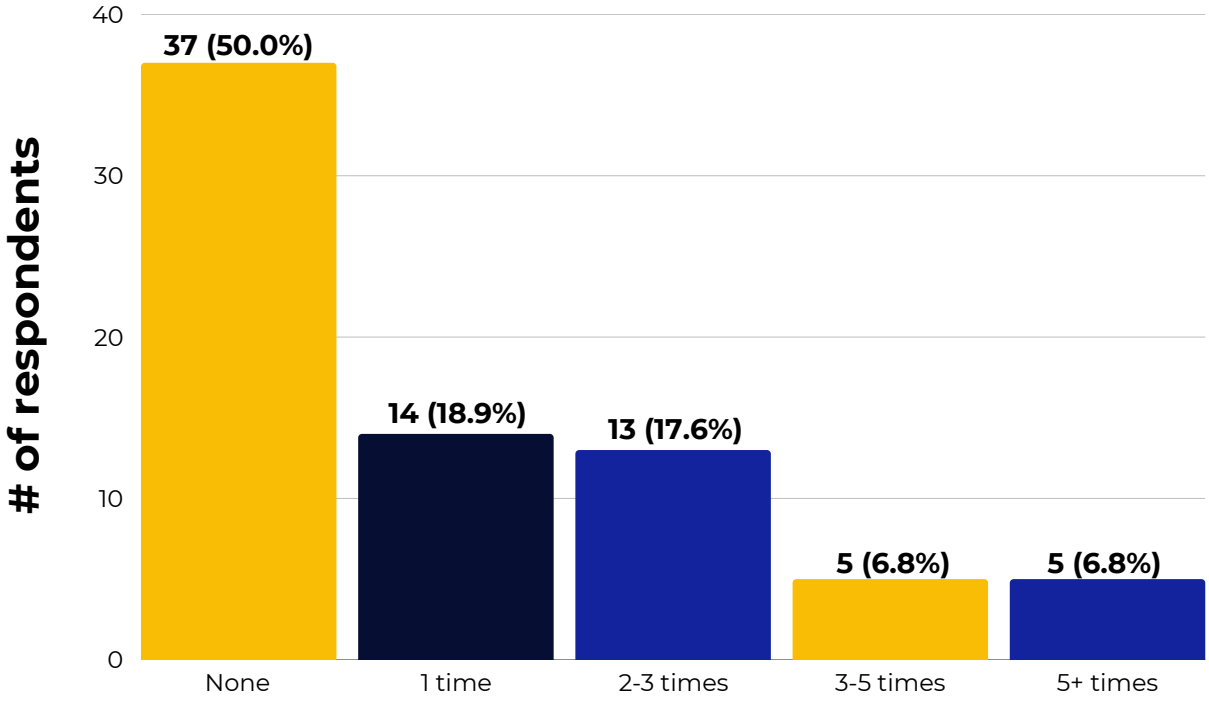
**Other responses include HealthNet, CalPERS, Blue Cross Blue Shield, and Molina*



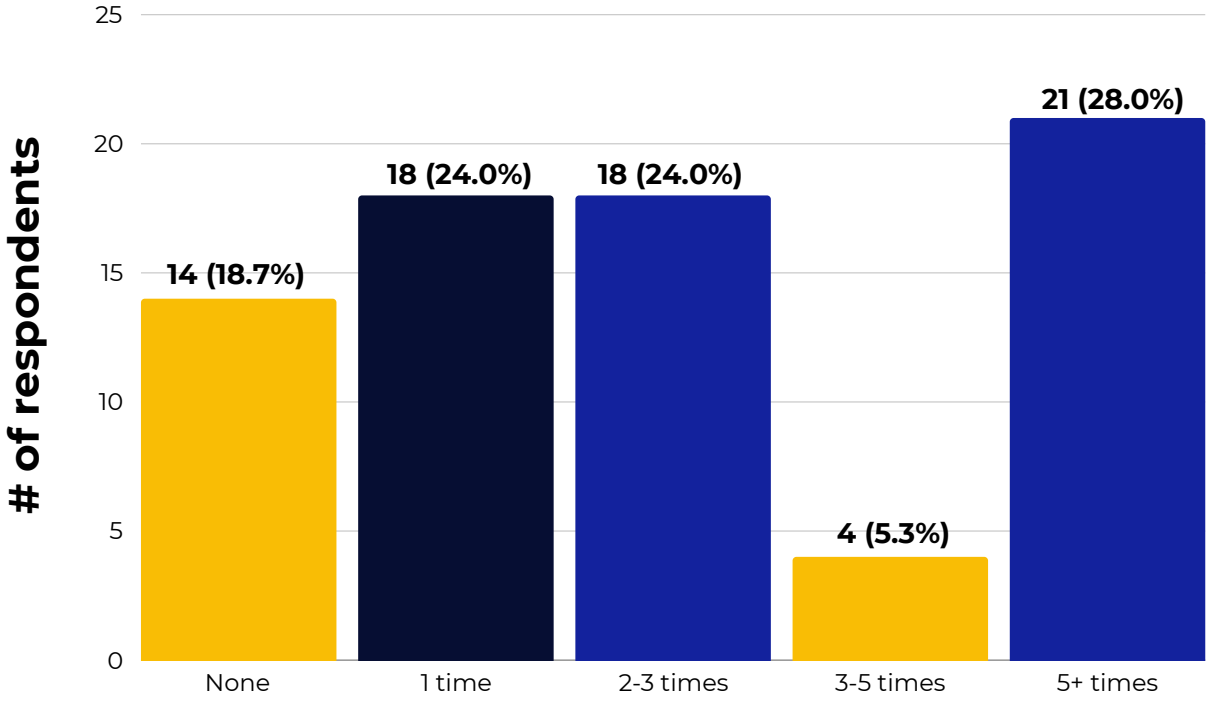
“How many times per year do you receive care in a doctor’s office?”



“How many times per year do you receive care in the emergency room?”



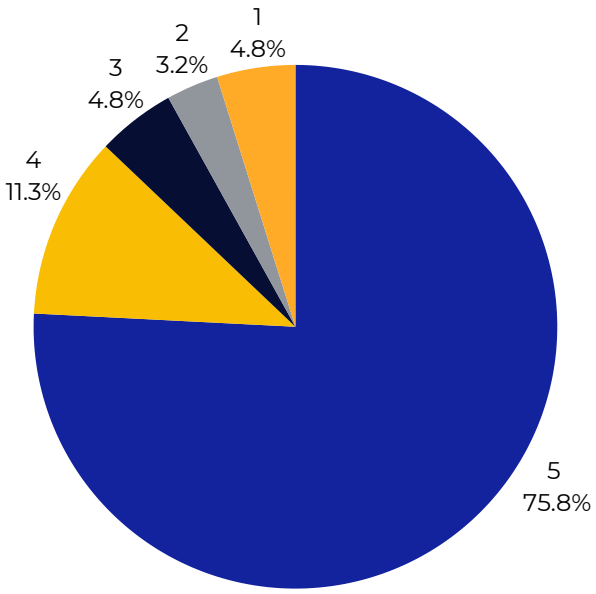
“How many times per year do you receive care from street medicine/mobile health teams?”



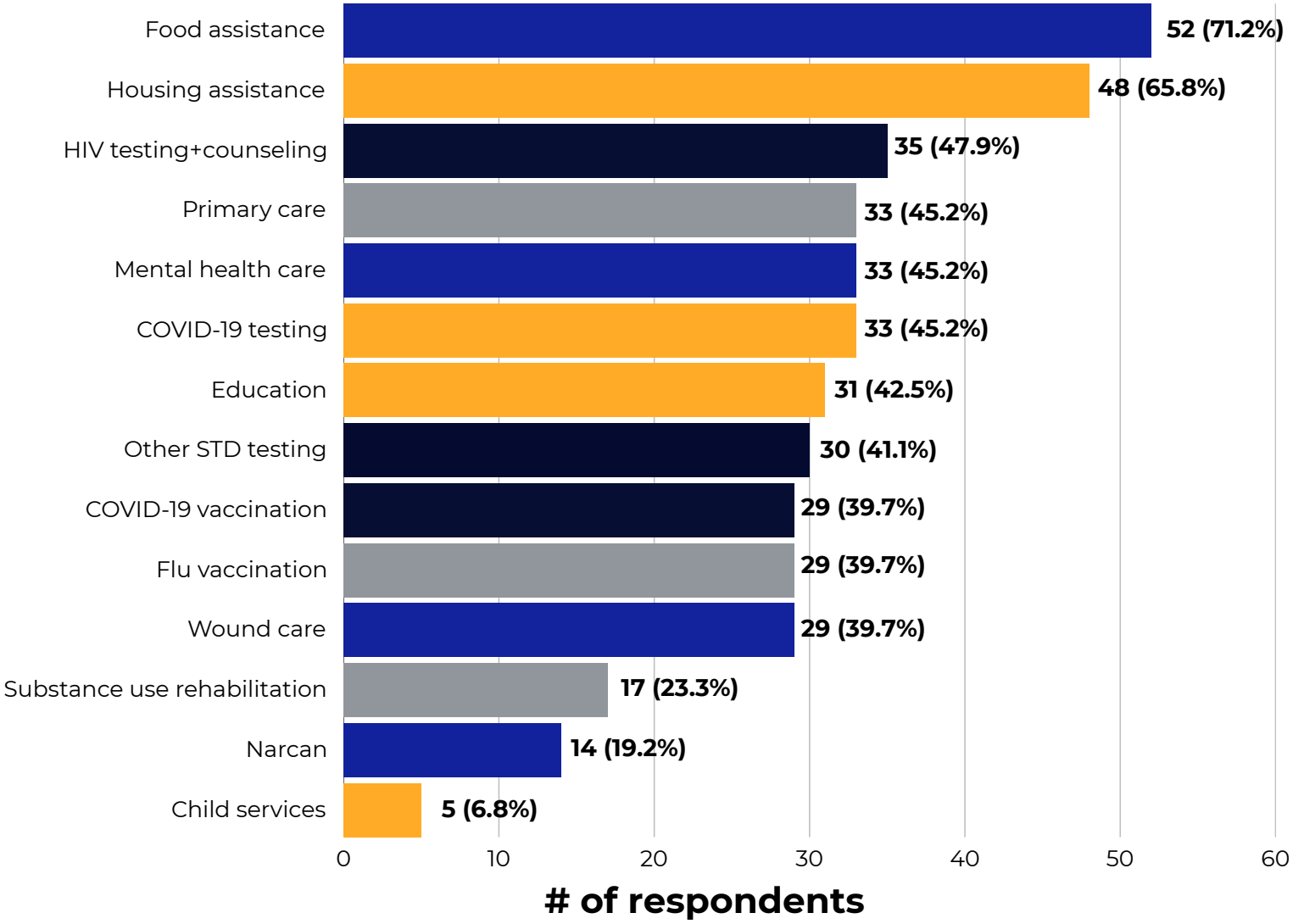
Among those who reported using mobile health/street medicine services more than once a year (62 respondents), 87.1% reported being likely to use these services again, with 75.8% saying “very likely” and 11.2% saying “somewhat likely.” **It is evident that mobile health/street medicine services fulfill a critical need within the Skid Row population.** This strong inclination toward future utilization suggests that mobile health services are not only providing immediate medical assistance but also fostering trust and accessibility among users, which is vital for improving health outcomes.

“If you have received care from mobile health/street medicine services, how likely are you to use them again?” (on a scale from 1-5)

5 (very likely): 47 (75.8%)
4 (somewhat likely): 7 (11.3%)
3 (neutral): 3 (4.8%)
2 (not likely): 2 (3.2%)
1 (never): 3 (4.8%)



REQUESTED SERVICES



The most frequently reported services that respondents requested needing access to were food assistance services (71.2%), housing assistance (65.8%), HIV testing + counseling (47.9%), primary care (45.2%), mental health care (45.2%), COVID-19 testing (45.2%), and education services (42.5%). These findings highlight the need for comprehensive medical and social support that address the multifaceted challenges faced by the Skid Row population.

"Other services" requested included legal services, carpool services, blood sugar checks, footwear donations, assistance filing for documentation, and self-defense lessons.

Note that respondents were allowed to select multiple options

HEALTHCARE EXPERIENCES

- Despite over 80% of respondents reporting some form of health insurance, **a disconnect persists between coverage and actual care received by respondents in Skid Row.**

- Alarmingly, ~20% of respondents reported not visiting a doctor at all in any given year (whether in a traditional doctor's office, emergency room, or mobile health service), particularly those experiencing homelessness for 10 years or longer.

- This, coupled with nearly half of the population reporting unmet needs for crucial services like food assistance services (71.2%), housing assistance (65.8%), HIV testing + counseling (47.9%), primary care (45.2%), mental health care (45.2%), COVID-19 testing (45.2%), and education services (42.5%) **suggests that insurance alone is not enough to bridge the gap in healthcare access**.

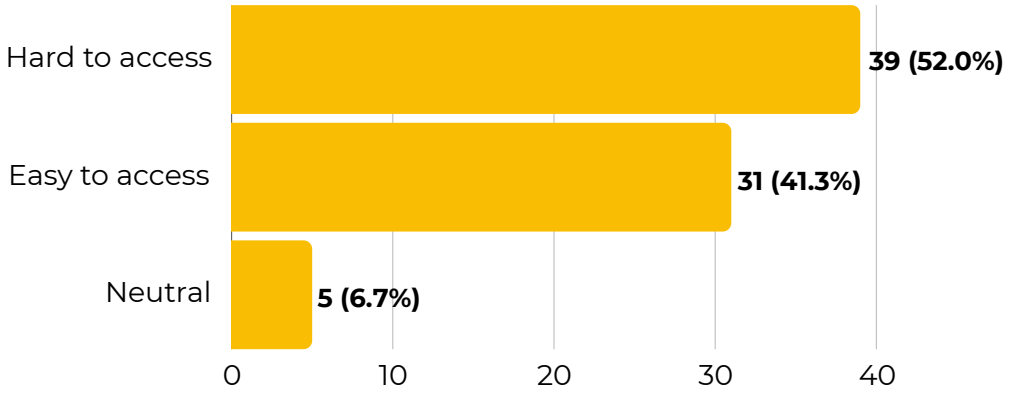
The **subsequent interview-based questions** are designed to explore in more detail the barriers in access to healthcare in traditional settings (ex: the doctor's office) that respondents face, as well as their experiences in traditional healthcare settings and street medicine/mobile health services.

“How do you feel about visiting the doctor's office?”

While 45.3% of respondents to this question (72 respondents) reported generally positive feelings about visiting the doctor’s office—most commonly stating "I feel comfortable"—**a notable portion expressed less favorable sentiments**. Specifically, 33.3% of respondents shared negative emotions about visiting the doctor, **citing a range of concerns that were categorized into themes related to healthcare access challenges and medical mistrust, as detailed in the table below.** An additional 20.8% of respondents expressed neutral attitudes, with responses such as "I don’t have a problem with it" or "it’s alright," suggesting indifference or detachment from the experience.

Themes	Total (23)	Representative Quotes
Feelings of judgment	30.4% (7)	“Don't judge me, I'm being judged. Go meet my family. Why are you judging? Everybody out here has a background. I'm a doctor. I'm the President. So what? I'm a human, you're a human. When I sit down at the doctor I don't want medicine. I want you to understand my family. My life. Understand me. My mental health.” “I just can't deal with doctors who judge me when I tell them something is wrong. If I'm in pain, then believe me.”
Feelings of anxiety and nervousness	26.1% (6)	“It’s terrifying, I'm not sure why.” “I feel anxious and nervous. I'm 68 and in good shape now, but life happens. Anything can happen at any given time. Just like you prepare for life you prepare for death.”
Lack of trust in the doctor	21.7% (5)	“It’s terrible, I don't trust my current doctor. They’re complicit in the system and inconsistent so I study my own health. They give you wrong information.”
Discomfort due to language barrier	13.0% (3)	“La doctora es amable pero no habla español, así que realmente no me entiende.” *(English Translation: “My doctor is nice but she does not speak Spanish, so she really does not understand me.”)*
Burdened by the given diagnosis	8.7% (2)	“I don’t like it when the doctors diagnose me with something, because then I have to deal with it.” “It’s bad, it’s always something. It's good to stay up to date but I don't like to hear the news. It gives me more stress.”

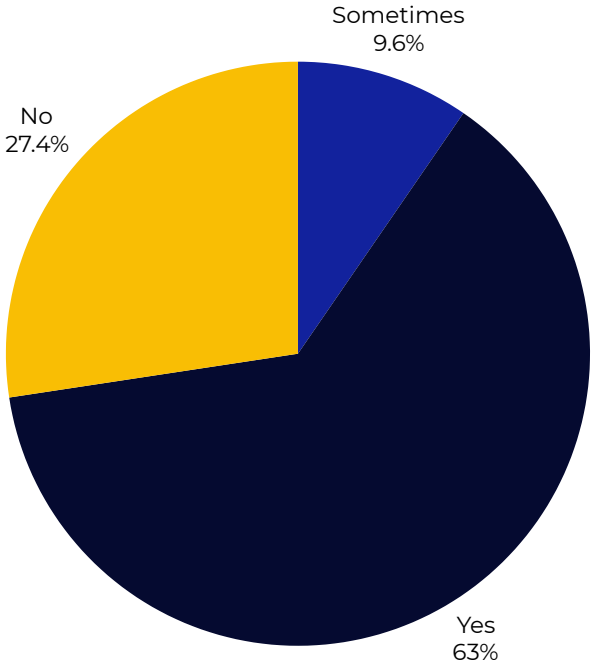
“Do you feel that it is easy or hard to access the doctor? Why?”



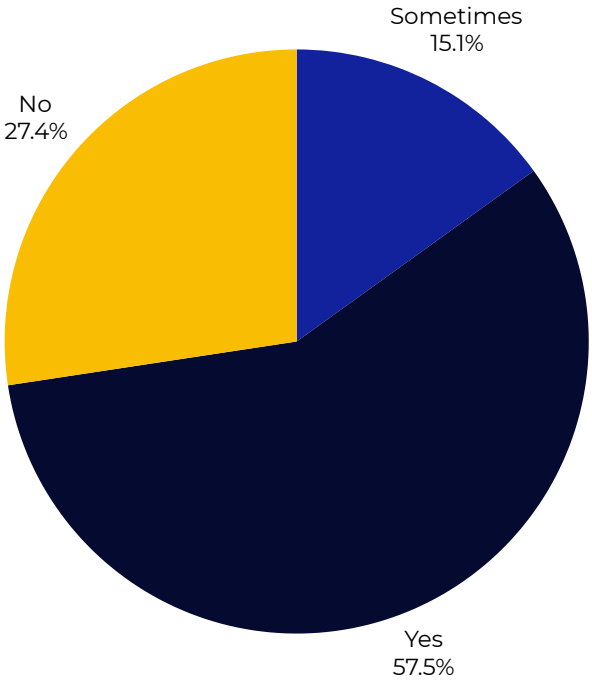
52.0% of respondents to this question (75 respondents) found it challenging to access the doctor, with the most frequently cited barriers being a lack of transportation and challenges with insurance (the latter primarily coming from those who are uninsured).

Themes	Total (38)	Representative Quotes
Difficult due to lack of transportation	28.9% (11)	“It’s hard to get transportation to the doctors' appointments, and it’s difficult to get there on time.” “I don't walk good these days so it's hard to get there. If I have a bike it's okay, but I don't want to leave my stuff in the waiting room because someone will take it.” “Hard. Got to walk and my walker got stolen.”
Challenges with insurance	28.9% (11)	“It's hard, you need insurance. If you don't have insurance you can't get help.” “It is hard because insurance makes it difficult. There’s so many different plans and when you go, you have to wait. They didn't see me last time I went for a broken tooth.”
Long wait times to receive an appointment	23.7% (9)	“It takes all day to see a doctor.” “It's hard. You have to wait so long you have a problem and you can't even see them.”
Lack of support to navigate services and paperwork	10.5% (4)	“It’s hard to know where to go around here. I need some direction.” “Honestly just filling out the paperwork is a challenge. I can’t read or write well.”
Difficult communicating with the clinic without a cell phone	7.9% (3)	“My cell phone gets stolen all the time so I cannot call for an appointment.” “If you have the right communication its easy. But my phone gets stolen all the time.”

Do you feel like the doctor understands you?

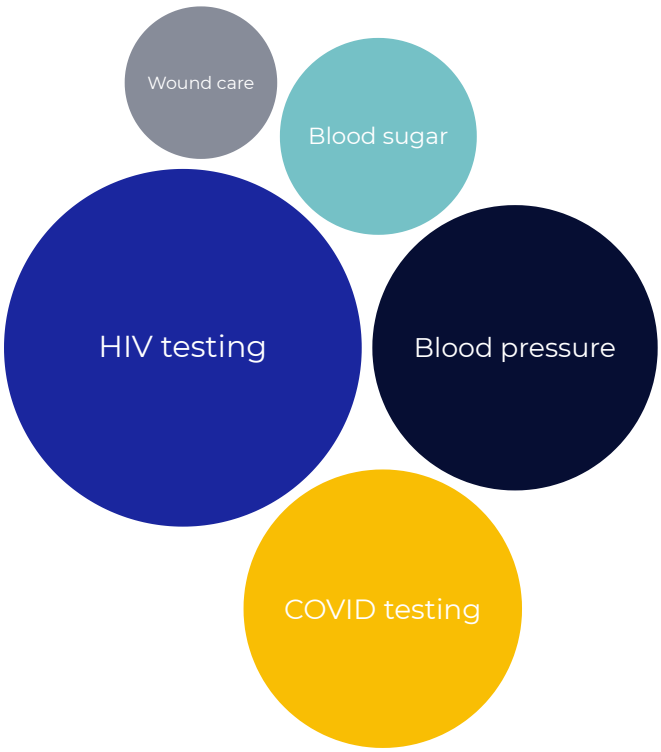


Do you feel like you can trust the doctor?



While most respondents (73) reported feeling like the doctor understood them and that they could trust the doctor, **27.4% cited sentiments of medical mistrust, in addition to 15.1% that said they can trust the doctor only "sometimes."** Responses related to medical mistrust were categorized into themes, as detailed in the table below.

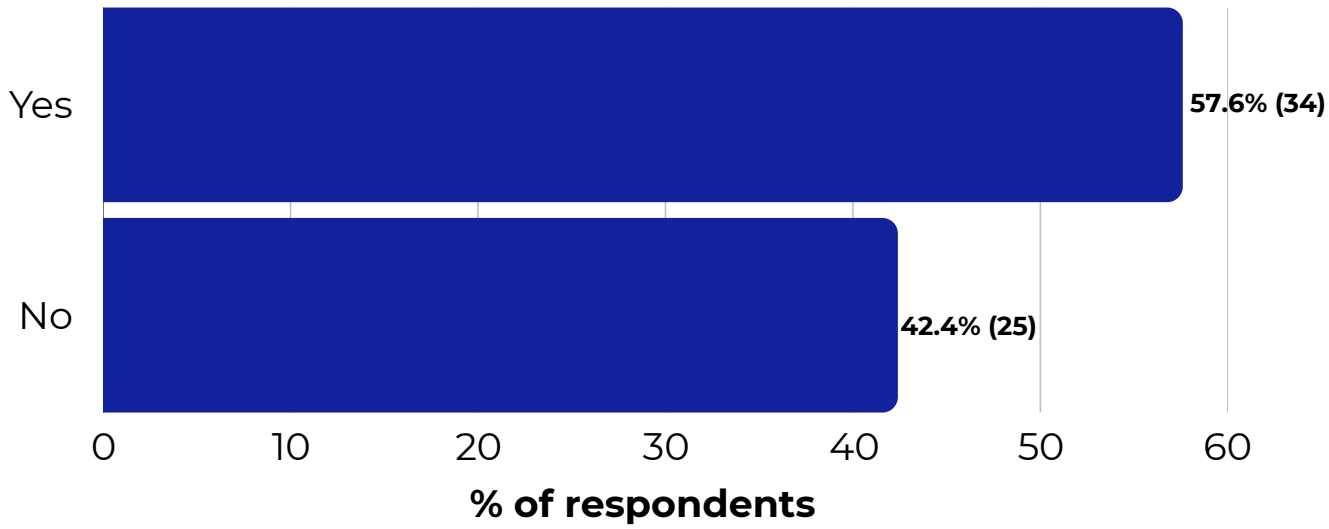
Themes	Total (25)	Representative Quotes
Dismissal of symptoms and perceived stereotyping and biases	48.0% (12)	"If they see that I'm homeless then they treat me different. If I tell them I'm on drugs then they also treat me with no respect." "Soy moreno. Me ven y me tratan sin respeto. Como que no soy humano." *(English translation: I'm dark-skinned. They see me and treat me without respect. Like I'm not human.)*
Poor communication	32.0% (8)	"He [The doctor] doesn't explain things well. I leave confused." "My primary doctors don't listen. I have to tell them what is wrong too many times."
New doctor at every visit	12.0% (3)	"At the free clinics around here you can see a doctor, but it's always a new one. So I feel like they don't really know me."
Language barriers	8.0% (2)	"No puedo entenderlos." *(English translation: I cannot understand them.)*



“If you have used mobile health services what health screenings, testing, or treatment have you received?”

HIV testing: 55.9% (33)
Blood pressure check: 35.6% (21)
COVID testing: 33.9% (20)
Blood sugar check: 16.9% (10)
Vaccinations: 16.9% (10)
Medications: 15.3% (9)
Other STD testing: 13.6% (8)
Physical exam: 11.9% (7)
Tuberculosis testing: 11.9% (7)
Dental care: 8.5% (5)
Wound care: 10.2% (6)
Mental health screening: 10.2% (6)
Colon/Prostate exam: 5.1% (3)
Hepatitis screening: 5.1% (3)

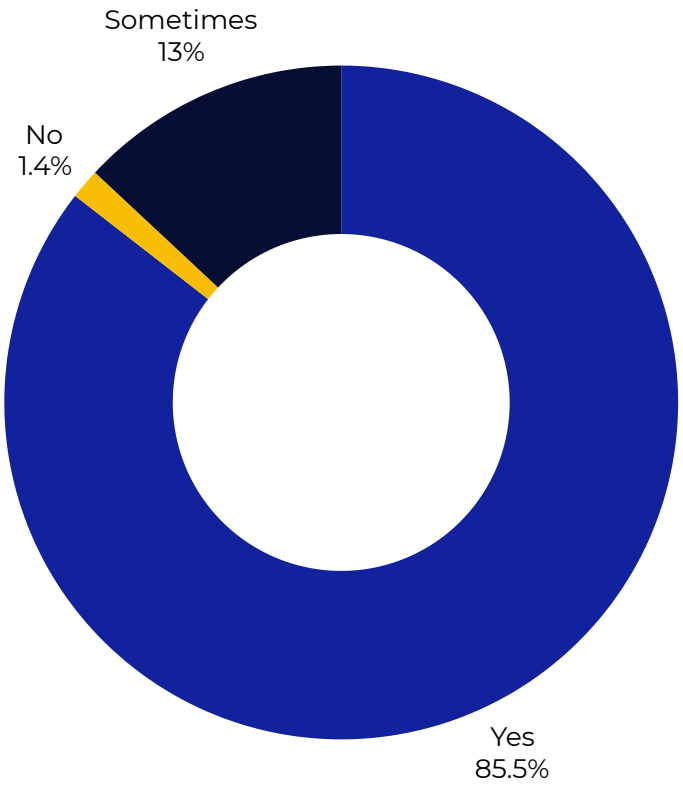
“Have you received this testing or treatment in a hospital, clinic, or doctor's office as well?”



42.4% of individuals who had previously received health services via street medicine or mobile health teams **had only ever accessed these services on the streets**, rather than in a traditional doctor’s office.

For these individuals in Skid Row, street medicine and mobile health services often serve as their primary, and sometimes only, access to healthcare, highlighting the importance of investing further into these programs.

“Do you feel like street medicine and mobile health services are helpful? Why or why not?”



85.5% (of 75 respondents) expressed that street medicine and mobile health services were helpful. An additional 13.0% stated that they were sometimes helpful. This overwhelming approval speaks volumes about the necessary role that these services play in Skid Row Key themes that emerged from respondents included:

- **Convenience**: The ability to receive care without the barriers typically associated with traditional healthcare settings, such as long wait times or complex appointment processes.
- **Accessibility:** Mobile health teams bring services directly to individuals where they live, reducing the logistical hurdles that can prevent people from seeking help, including physical disabilities.
- **Referrals to Other Resources:** Street medicine teams often provide not just medical care but also connections to housing, legal assistance, and other support services, addressing the holistic needs of individuals experiencing homelessness.
- **Respectful Interactions:** Respondents noted a distinct sense of respect and friendliness from healthcare workers involved in street medicine and mobile health, fostering a supportive environment that encourages individuals to seek care.

Quotes from respondents:

“If it were not for them many would be dead on the streets.”

“They’re helpful because a lot of people cannot get to the doctor due to lack of appointments or disabilities.”

“It’s a reminder to take care of your health. Your services are convenient, and give peace of mind especially for blood pressure checks.”

“They offer resources that I am unaware of.”

“They are respectful. Usually they don't dismiss. Would love to see them more.”

“Y'all are giving back and making sure we're taken care of. It can be more than just a health problem. It can also be drugs. You understand people's lives and living situation.”

“It helps a lot of people who aren't willing to go to doctors. You guys are the ones who listen, you're a lot of help. I don't check my blood pressure I'm too scared to do it even though it's dangerously high. I only let you guys check it.”

However...

"I've never received a follow-up. I was supposed to."

"I'd prefer if they could check in on me more often. Like come to my door. I can't walk too good so I can't really get up and go to the van [mobile health unit]."

"Well you guys can't do surgery out here. When it gets to that point then we still are kinda on our own."

"I think some people out here are still afraid to use them. If the services aren't right in front of you then it's still hard to have the hope and motivation to use them. I know because I've been out here. I'd be willing to be that person to bridge the gap. Since I've been out here and people know me, it would make a bigger difference coming from me. I'd be involved in any way I can."

"They need to be out here posted up on the streets. Like you have the Community Refresh Spot open 24/7, but have these guys all over the place all the time so they know where it's at. Just like people know where they can get a cup of coffee. But have fellow people like us welcoming people in. Otherwise it's intimidating, you know? I'd be that [welcoming] person in a heartbeat though."

"They're helpful, but the wait times can still be long. You have to get there before they do. If I see a long line, then forget it. It's not like you get a follow up after that either so for my issues it's not as helpful. For others I'm sure it is."

21.3%

21.3% of respondents who responded to "Do you feel like street medicine and mobile health services are helpful? Why or why not?" (75 respondents) **said that they have experienced issues with continuity of care with street medicine/mobile health teams**. In other words, they do not feel that they are receiving adequate follow-up and believe these services would be more helpful if they provided more continuous, longitudinal care.

48.0%

48.0% of those who reported medical mistrust (25) **reported feelings of stereotyping, discrimination, and biases from medical providers.** It's evident that these sentiments surrounding healthcare services persist in the Skid Row community.

CALL TO ACTION

Message to LA officials, policy makers, and healthcare workers:

Street medicine and mobile health services play a clear role in improving healthcare within the Skid Row community. About 98% of respondents found these services helpful or somewhat helpful, reinforcing their importance, especially as 52.0% of respondents reported difficulties accessing healthcare, primarily due to transportation and insurance barriers. Notably, 42.4% of individuals who had received services via street medicine or mobile health teams had only ever accessed those specific services through these programs, particularly HIV testing.

But, progress still needs to be made.

It's clear that **significant gaps remain** in meeting basic health needs even with current street medicine/mobile health models in place, as 71.2% of respondents requested food assistance, housing assistance (65.8%), HIV testing + counseling (47.9%), primary care (45.2%), mental health care (45.2%), COVID-19 testing (45.2%), and education services (42.5%).

Further, 21.3% of respondents shared that they felt street medicine/mobile health teams would be more helpful if they provided more consistent follow-up care. 48.0% of those who reported medical mistrust stated that these sentiments came from perceived discrimination and stereotyping by medical professionals.

Interestingly, some community members in Skid Row have suggested **involving individuals with lived experience in Skid Row (even volunteering themselves)** to address feelings of intimidation surrounding the use of street medicine/mobile health services that they feel are present in the community due to underlying medical mistrust. They could also certainly be involved to fill gaps in continuity of care.

This aligns with the **Community Health Worker (CHW) model**, which has proven effective worldwide. In these contexts, we've seen CHWs take a more involved role in providing daily patient visits, escorting people to care, providing food assistance services, arranging transportation, and providing housing assistance as well as emotional support via group therapy sessions. With these systems in place, Partners in Health has reported remarkable results. For example, in Haiti, they reported a 100% clinical cure in all patients receiving CHW support in addition to free care, versus only 56% cure and 10% mortality in patients receiving free care alone, among many other cases worldwide which can be found here:
DOI: 10.1016/S2214-109X(18)30073-1.

Amplifying and unifying such programs in Skid Row not just as a supplementary intervention—but as foundational to a comprehensive healthcare system—could be the **next step forward**. While street medicine/mobile health teams have filled a critical need with overwhelming community support, challenges such as lack of follow-ups and long wait times often stem from limited capacity and high demand on street medicine/mobile health teams themselves.

By expanding street medicine/mobile health efforts through a robust, unified CHW initiative—led by those with lived experience in Skid Row—we can build a more **sustainable and equitable healthcare system** for this community.

We are eager to engage in further discussion and encourage you to reach out to Erica Robinson (contact@healthmatters.clinic) and Sara Habibipour (sarahabibipour@g.ucla.edu).

ACKNOWLEDGEMENTS

We would like to extend our deepest gratitude to the Health Matters Clinic Helping and Healing Team for their diligent efforts in conducting these surveys and interviewing individuals in Skid Row, which have provided invaluable insights for this report.

Special thanks to the Health Matters Clinic Education and Training Committee for their thoughtful work in developing the survey questions that guided our research.

Lastly, we would like to acknowledge Erica Robinson, President of Health Matters Clinic, for providing the time and resources for this initiative. We would like to acknowledge Sara Habibipour for analyzing the surveys, writing, and creating the report.

Health Matters Clinic

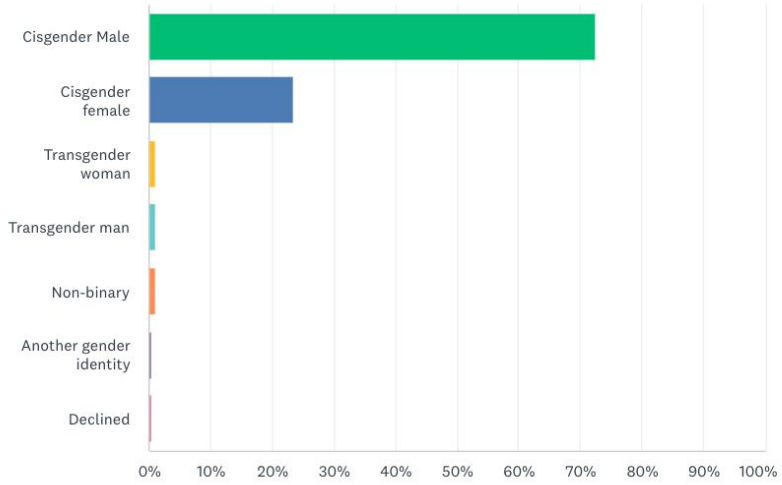
OraQuick HIV Self-Test Kit Distribution Data
Skid Row, Los Angeles, January 2024–February 2025

HIV OraQuick Test Kit Distribution

- Through partnership with the LA County Dept. of Public Health, we offer HIV OraQuick test kits at our outreach events in Skid Row, Los Angeles.
- The option to take the test is voluntary; we simply offer it as a part of our routine health screening services.
- No compensation or incentives are given for taking a test.
- The program is designed for individuals to take the test with them, to complete on their own time. But, the grand majority complete the test on site with our outreach team. We would estimate that 90% complete the test on-site.
- This data includes distribution data for those who complete the test both on and off site.
- Of those that completed the test with the team on-site, 4 tested reactive for HIV. However, these individuals already knew that they were HIV+. We do not have follow-up data from those who completed the test off-site.

Gender Identity

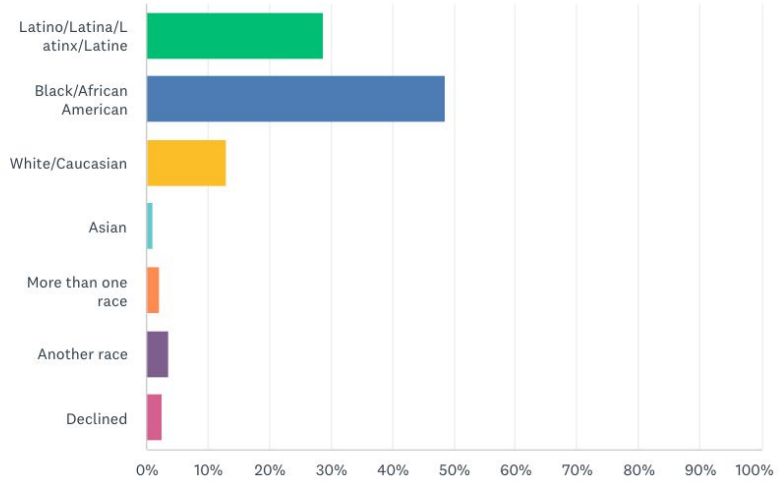
Answered: 192 Skipped: 0



ANSWER CHOICES	RESPONSES	
Cisgender Male	72.40%	139
Cisgender female	23.44%	45
Transgender woman	1.04%	2
Transgender man	1.04%	2
Non-binary	1.04%	2
Another gender identity	0.52%	1
Declined	0.52%	1
TOTAL		192

Race/Ethnicity

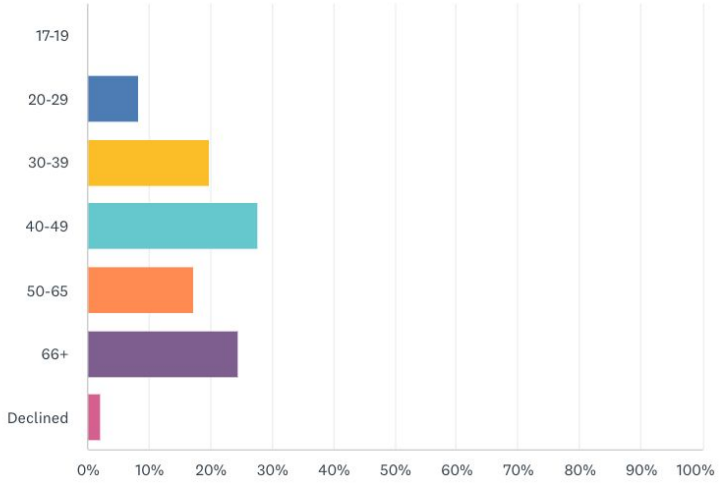
Answered: 191 Skipped: 1



ANSWER CHOICES	RESPONSES	
Latino/Latina/Latinx/Latine	28.80%	55
Black/African American	48.69%	93
White/Caucasian	13.09%	25
Asian	1.05%	2
More than one race	2.09%	4
Another race	3.66%	7
Declined	2.62%	5
TOTAL		191

Age

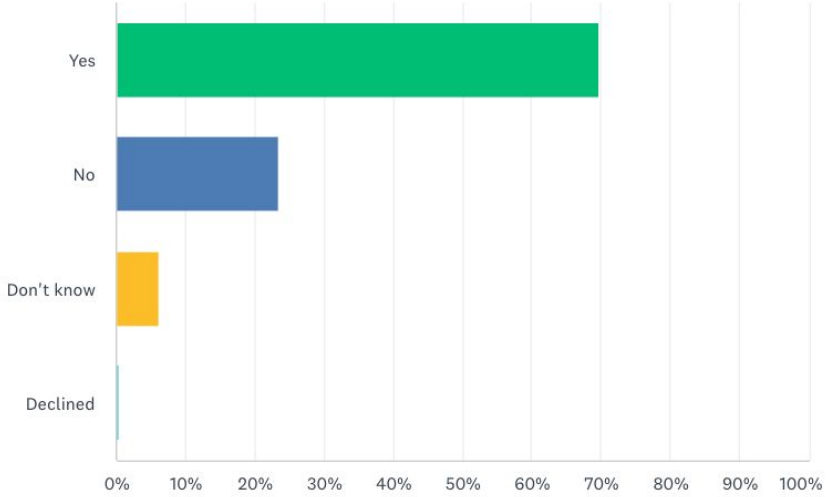
Answered: 191 Skipped: 1



ANSWER CHOICES	RESPONSES	
17-19	0.00%	0
20-29	8.38%	16
30-39	19.90%	38
40-49	27.75%	53
50-65	17.28%	33
66+	24.61%	47
Declined	2.09%	4
TOTAL		191

Has the client ever tested for HIV before?

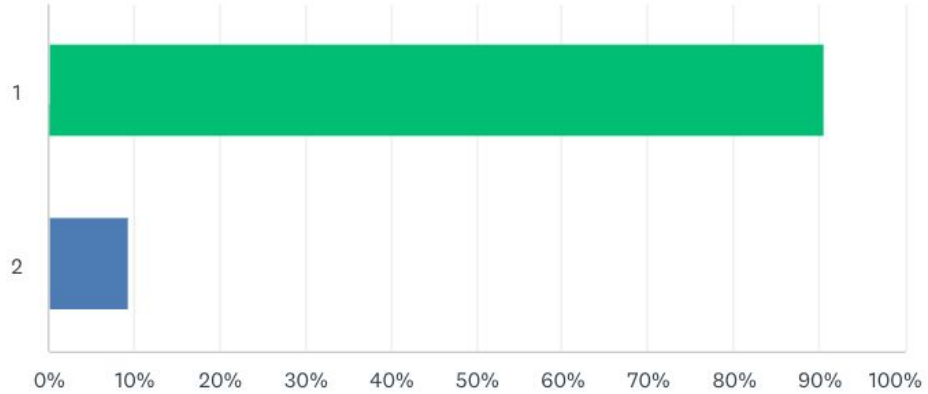
Answered: 192 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	69.79%	134
No	23.44%	45
Don't know	6.25%	12
Declined	0.52%	1
TOTAL		**192**

Number of HIV Self Test kits given

Answered: 192 Skipped: 0



ANSWER CHOICES	RESPONSES	
1	90.63%	174
2	9.38%	18
TOTAL		192

Street Medicine Pocket Guide

Protecting health during encampment sweeps

CALIFORNIA STREET MEDICINE COLLABORATIVE

USC Street Medicine

Before Sweeps

1. Educate patients about street sweeps, what they can expect, & their rights.

2. Proactively develop a relocation plan with patients.

3. Plan for loss of communication.

4. Provide tools to protect critical documents, medications, & other essential resources.

5. Develop “sweep-resilient” medical treatment plans.

6. Increase harm reduction efforts.

7. Provide more basic necessities.

8. Establish communication with relevant authorities to stay informed & advocate for trauma-informed approaches.

During Sweeps - Key Considerations

1. Presence or non-presence during sweeps

2. Engaging (or not) with law enforcement and officials

3. Advocacy for patients: when and how?

4. Providing medical & mental health support

5. Logistical support: to what extent?

After Sweeps

1. Locate displaced patients as quickly as possible.

2. Replenish critical survival supplies, including food, water, & harm reduction supplies.

3. Reestablish medical treatment plans & replace lost medications.

4. Re-establish trust & support patients to process trauma and grief.

MITIGATING THE HEALTH IMPACTS OF ENCAMPMENT SWEEPS IN CALIFORNIA:

A PRACTICE GUIDE FOR STREET MEDICINE

FEBRUARY 2025

Kaitlin Schwan, PhD; Kyle Patton, M.D.; Catherine Weaver, M.D.; Brian Zunner-Keating, MS, RN; Brett Feldman, PA-C; Daphne Achilles; M.K. Orsulak, M.D.; Matthew Beare, M.D.; Corinne T. Feldman, PA-C & Katherine Pocock, MHS, PA-C

CALIFORNIA STREET MEDICINE COLLABORATIVE

USC Street Medicine

street medicine institute

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Table of Contents

Executive Summary

Street sweeps – also known as “encampment resolutions,” "encampment clearings,” or "displacements" – are increasingly common across the United States. These actions involve the forced removal of unsheltered individuals and their belongings from public spaces, often on the grounds of public health, public safety, or improving the aesthetic appearance of an area.[1] In California, the legal and policy landscape surrounding street sweeps shifted significantly in the summer of 2024, following the Supreme Court's ruling in *Johnson v. Grants Pass* and Governor Gavin Newsom's Executive Order N-1-24. These developments have contributed to more aggressive enforcement of anti-camping ordinances and heightened sweeps activity, creating new challenges for people experiencing homelessness and those who support them.

As encampment sweeps have intensified across the state, the role of street medicine has evolved. The increased frequency and scale of sweeps have transformed street medicine practice, requiring teams to not only provide immediate care, but also address the compounded health risks that encampment sweeps create. In response to these challenges, this Practice Guide aims to provide street medicine providers with practical tools to reduce the harms of encampment sweeps and protect the health of those they serve.

This Guide seeks to:

- Highlight the health impacts of encampment sweeps on individuals experiencing homelessness.

- Provide practical strategies to minimize the harm of sweeps and protect the health of impacted individuals – before, during, and after sweeps.

The intent of this Practice Guide is not to endorse encampment sweeps or assume their inevitability, but to acknowledge their ongoing occurrence and equip street medicine practitioners with reality-based strategies to mitigate their harm. By equipping providers with actionable strategies, this Guide seeks to empower street medicine teams to navigate the evolving landscape of encampment sweeps while prioritizing the dignity, rights, and wellbeing of those they serve.

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[1] In alignment with the National Healthcare for the Homeless Council, this report defines “sweeps” as “the forced disbanding of homeless encampments on public property and the removal of both homeless individuals and their property from that area. This could be through an explicit or implied threat of enforcement of criminal ordinances, or use of public health, sanitation, parking enforcement, park or other public space regulations.”

Methodology

This report draws on three research methods: a scoping literature review, a community consultation with 250 street medicine practitioners and allied professionals, and 11 key informant interviews. The literature review synthesized academic research, policy papers, and media reports on the health impacts of encampment sweeps. The community consultation, held at the *6th Annual California Street Medicine Symposium*, used an adapted World Café methodology to explore two core questions:

1. What are the consequences of encampment sweeps on people experiencing unsheltered homelessness, from a street medicine perspective?
2. How have you and your patients mitigated the harms and consequences of these sweeps?

Additionally, interviews with 11 California-based street medicine practitioners provided deeper insight into care during displacement and patient experiences.

The Health Consequences of Encampment Sweeps

Encampment sweeps have significant negative health consequences, including the loss of essential belongings, increased health risks, care disruptions, heightened vulnerability to violence, and trauma that worsens mental health and substance use challenges. These harms also undermine efforts to secure stable housing by disrupting connections to services and support systems. Research identifies five key consequences of sweeps:

1. Loss of Personal Belongings Critical to Survival

Sweeps result in the loss of essential items like medications, identification, hygiene supplies, and survival gear. Losing medications for conditions like opioid use disorder, HIV, and hepatitis C increases risks of disease transmission and medication resistance. The loss of mobility aids and critical documents further restricts access to healthcare and social services, while the destruction of tents and blankets exposes individuals to greater physical health risks.

2. Increased Health Risks & Disruption of Care

Forced displacement can expose individuals to extreme weather, disease, and violence, worsening existing health conditions. Disruptions to regular care—missed appointments and lack of communication about relocations—complicate management of chronic conditions, mental health, and substance use disorders. Displacement often sends individuals to more hazardous areas, increasing risks like hypothermia and dehydration.

3. Disruption of Community and Vulnerability to Violence

Encampments provide vital social support networks, which sweeps dismantle, leaving individuals more vulnerable to violence. Women and transgender individuals face higher risks of robbery, physical violence, and sexual assault when displaced. Additionally, pets—key sources of emotional support and protection—are often lost, deepening feelings of isolation and increasing vulnerability.

4. Trauma and Escalation of Mental Health and Substance Use Challenges

Sweeps cause significant psychological trauma, commonly worsening issues like anxiety, depression, and PTSD. The constant fear of displacement and loss of belongings fosters feelings of demoralization and hopelessness. Substance use often escalates as individuals cope with trauma, increasing the risk of fatal overdoses, especially with disruptions to harm reduction services. These compounded challenges undermine efforts to exit homelessness by destabilizing individuals' mental health and access to essential support systems.

5. Loss of Life

The combined effects of sweeps increase mortality rates among people experiencing homelessness. Studies show individuals in shelters have 10x higher mortality rates than housed individuals, with unsheltered individuals facing even greater risks. Displacement, care disruptions, and the emotional toll of sweeps heighten health crises, contributing to fatalities, including suicides or accidents during a sweep.

Mitigating the Health Impacts of Encampment Sweeps in California:

A Practice Guide for Street Medicine

Street medicine practitioners play a vital role in mitigating the harms caused by encampment sweeps, addressing immediate healthcare needs, and advocating for the rights and well-being of individuals living in encampments. This guide offers strategies to reduce the impact of sweeps on patients before, during, and after the event.

BEFORE SWEEPS

1. Educate patients about street sweeps, what they can expect, and what their rights are.

Provide clear information on the types of sweeps occurring, what patients can expect, and the role of different stakeholders, such as law enforcement or sanitation workers. Offer concise materials like postcard-sized handouts that explain patients' rights during sweeps and how to advocate for them.

2. Proactively develop a relocation plan with patients.

Work with patients to identify alternative locations for meeting and support during displacement, considering risks such as exposure to violence. Plan for transportation needs, including helping those with disabilities or large belongings, and coordinate with RV residents for necessary services (e.g., vehicle registration).

3. Plan for loss of communication.

Provide durable contact cards and ensure patients have updated contact information. Establish backup contacts like street vendors or local store owners for reconnection. Organize interagency meetings for care coordination and update systems such as the Homeless Management Information System (HMIS).

4. Provide tools to protect critical documents, medications, and other essential resources.

Distribute waterproof document bags, brightly colored "do-not-touch" pouches or bags, or lockable containers for IDs, medications, medical records, valuables, and other vital paperwork. Ensure law enforcement and security personnel are informed about these strategies and agree not to destroy these containers. Digitize documents when possible. Advise patients to use secure storage options, such as trusted friends or family, to safeguard medications and important papers.

5. Develop "sweep-resilient" medical treatment plans and prescribing practices.

Prescribe medications in shorter increments or use long-acting medications to ensure continuity of care during displacement. Account for environmental risks and advocate for refill flexibility with pharmacies.

6. Increase harm reduction efforts.

Educate patients about the increased risks of overdose after a sweep and provide increased harm reduction supplies like syringes and Naloxone. Encourage safer substance use practices and overdose prevention.

7. Increase the provision of basic necessities.

Supply food, water, hygiene products, clothing, and harm reduction materials to address immediate needs post-sweep. Distribute phones or prepaid SIM cards to maintain communication with patients after they've been displaced.

8. Establish communication channels with relevant authorities to stay informed about upcoming sweeps and advocate for trauma-informed approaches.

Open lines of communication with local authorities responsible for sweeps, and advocate for trauma-informed approaches to their actions. Maintain ethical boundaries between healthcare providers and law enforcement to protect patient trust.

DURING SWEEPS – KEY CONSIDERATIONS

1. Presence or non-presence during sweeps

Teams must assess whether being physically present during a sweep aligns with their mission and patients' needs, and does not compromise patient trust or team safety.

2. Engaging (or not) with law enforcement and officials

Some teams engage with law enforcement to advocate for patients, while others may avoid confrontation to maintain long-term working relationships. The approach should align with the team's broader goals and patient needs.

3. Advocacy for patients: when and how?

Advocacy during sweeps may involve negotiating for patient needs or working behind the scenes on policy changes. Teams should balance on-the-ground intervention with long-term advocacy efforts.

4. Providing medical and mental health support

Street medicine teams must balance their capacity to provide immediate care during the event without compromising their ability to provide ongoing support afterward. Some teams may want to be present to respond to medical issues that arise; others may feel that the trauma and logistics of a sweep make it an unsuitable setting for a healthcare visit.

5. Logistical support: to what extent?

While patients may require assistance with transportation or storing belongings, teams must be realistic about their capacity to provide these services. When direct support isn't feasible, connecting patients to trusted resources is crucial.

AFTER SWEEPS

1. Locate displaced patients as quickly as possible.

Leverage community networks and outreach efforts to track displaced individuals. Use shared case management systems, such as HMIS, to find patients and collaborate with other service providers.

2. Replenish critical survival supplies, including food, water, and harm reduction supplies.

Distribute hygiene kits, food, blankets, and water, and work with pharmacies to ensure patients can access refills. Provide cell phones or chargers to help patients reconnect with essential services.

3. Reestablish medical treatment plans and replace lost medications.

Re-administer the HOUSED BEDS Assessment Tool to evaluate access to basic needs and supportive services in the new environment, and reassess treatment plans based on changes in living conditions. Leverage prescription assistance programs with pharmacist support to replace lost medications, reschedule missed appointments, and provide information on local services like healthcare and housing.

4. Re-establish trust and support patients to process trauma and grief.

Create spaces for patients and team members to reflect and process emotions. Demonstrate unconditional positive regard, reaffirming patients' dignity and your commitment through consistent follow-up and care.

Introduction

Street sweeps – also known as “encampment resolutions,” "encampment clearings,” or "displacements" – are increasingly common across the United States. These actions involve the forced removal of unsheltered individuals and their belongings from public spaces, often on the grounds of public health, public safety, or improving the aesthetic appearance of an area.[2] In California, the legal and policy landscape surrounding street sweeps shifted significantly in the summer of 2024, following the Supreme Court's ruling in *Johnson v. Grants Pass* and Governor Gavin Newsom's Executive Order N-1-24. These developments have contributed to more aggressive enforcement of anti-camping ordinances and heightened sweeps activity, creating new challenges for people experiencing homelessness and those who support them.

As encampment sweeps have intensified across the state, the role of street medicine has evolved. The increased frequency and scale of sweeps have transformed street medicine practice, requiring teams to not only provide immediate care, but also address the compounded health risks that encampment sweeps create. In response to these challenges, this Practice Guide aims to provide street medicine providers with practical tools to reduce the harms of encampment sweeps and protect the health of those they serve. Specifically, this Guide seeks to:

- Highlight the health impacts of encampment sweeps on individuals experiencing homelessness.

- Provide practical strategies to minimize the harm of sweeps and protect the health of impacted individuals – before, during, and after sweeps.

The intent of this Practice Guide is not to endorse encampment sweeps or assume their inevitability, but to acknowledge their ongoing occurrence and equip street medicine practitioners with reality-based strategies to mitigate their harm. Decades of research have shown that street sweeps are harmful to the health and well-being of individuals experiencing homelessness, exacerbating existing vulnerabilities and hindering access to necessary care [1, 2, 12-18]. Rather than improving public health outcomes, these sweeps contribute to worsened health, increased morbidity, and higher mortality among the unhoused population [1, 2, 12-18]. Studies show that when governments conduct sweeps without the provision of meaningful supports and adequate housing,

[2] In alignment with the National Healthcare for the Homeless Council, this report defines “sweeps” as “the forced disbanding of homeless encampments on public property and the removal of both homeless individuals and their property from that area. This could be through an explicit or implied threat of enforcement of criminal ordinances, or use of public health, sanitation, parking enforcement, park or other public space regulations.”

these actions often deepen homelessness rather than resolve it [2,3]. Paradoxically, these actions often undermine the investments governments are making to reduce homelessness in their communities.

Given the urgent need for actionable guidance, this Practice Guide draws on multiple sources to develop practical recommendations for street medicine teams. To ensure its relevance and grounding in both research and lived experience, it was informed by three key research methods: a scoping literature review, a statewide community consultation with 250+ street medicine practitioners and allied professionals, and 11 key informant interviews. By integrating research, community insights, and practitioner expertise, this guide offers evidence-based strategies to help street medicine teams mitigate the health harms of encampment sweeps.

POLICY BACKGROUND

The Changing Landscape of Encampment Laws and Policies in California

Recent legal decisions and executive actions in the United States and California have reshaped the landscape of homelessness policy, with profound implications for those living in encampments. The Supreme Court's ruling in *Johnson v. Grants Pass* and Governor Gavin Newsom's Executive Order N-1-24 (July 2024) signal a new era of enforcement authority, overturning prior legal precedents and expanding municipal discretion to conduct encampment sweeps, regardless of shelter availability. While many communities in California and other states have previously implemented similar laws or bylaws, enforcement against encampments is becoming more prominent and widespread at both state and national levels [32, 33].

Johnson v. Grants Pass (June 2024)

On June 28, 2024, the Supreme Court reversed the U.S. 9th Circuit Court of Appeals decision in *Johnson v. Grants Pass* (2022) 50 F.4th 787. This landmark ruling permits public agencies to enforce local laws prohibiting sleeping or camping in public spaces, even if no shelter options are available. The Court determined that such enforcement does not violate the Eighth Amendment's prohibition against "cruel and unusual punishment." This decision marks a significant shift, overturning the precedent set by *Martin v. Boise* (2019) 920 F.3d 584. Under *Martin v. Boise*, local governments were barred from enforcing anti-camping ordinances unless adequate and accessible shelter was available, as failure to provide such shelter was deemed unconstitutional. The Supreme Court's ruling does not mandate new actions by local governments, nor does it allocate additional resources for addressing homelessness, but it does restore full authority to municipalities to decide how and when to enforce anti-camping regulations.

This ruling gives municipalities the discretion to enforce anti-camping laws without being legally required to ensure the availability of shelter. However, both the majority and dissenting opinions highlighted that this does not automatically make all such ordinances constitutional. They warned that certain regulations might still be vulnerable to legal challenges under the due process clauses of the Fifth and Fourteenth Amendments (*City of Grants Pass v. Johnson* (2024) 144 S.Ct. 2202, 2221 (majority) and 2242 (dissent)).

Governor Newsom's Executive Order N-1-24 (July 2024)

Governor Gavin Newsom issued Executive Order N-1-24 in July 2024, aimed at addressing homelessness and encampments on state-owned property in California. Executive Order N-1-24 articulates that California is experiencing a "homelessness crisis decades in the making" and calls for urgent action to address encampments that "pose threats to life,

health, and safety" and "undermine the cleanliness and usability of parks, water supplies, and other public resources." The order requires state agencies under the Governor's authority to adopt policies aligned with the California Department of Transportation's Maintenance Policy Directive 1001-R1, including advance site assessments, providing notice to vacate where feasible, engaging service providers for outreach, and storing personal property for at least 60 days unless it presents a health or safety hazard. Local governments are encouraged to implement similar policies and utilize state resources to prioritize the removal of encampments, particularly those posing immediate risks.

The order also highlights the significance of a recent Supreme Court decision overturning restrictive Ninth Circuit precedent, noting that "there is no longer any barrier to local governments utilizing the substantial resources provided by the State" to resolve encampments "with both urgency and humanity." Agencies outside the Governor's authority are requested to align their policies with these directives, while the California Interagency Council on Homelessness is tasked with offering technical assistance to local jurisdictions. The Governor underscores that solutions should "prioritize offers of shelter and services as a first step."

California Intensifies Enforcement of Encampment Bans Post-*Grants Pass*

By September 2024, over 14 cities and one county in California had either enacted new camping prohibitions or amended existing ones to increase penalties, while another dozen were contemplating similar measures. Additionally, at least four areas had revived previously unenforced camping bans. Here are some examples:

- **San Joaquin County, CA**: A new ordinance in the county prohibits sleeping in a tent, sleeping bag, or car for more than 60 minutes and restricts individuals from sleeping within 300 feet of a previously occupied sleeping area. The county has also adopted a policy of offering jail as an alternative for those refusing shelter.

- **Vista, CA**: The city resumed enforcement of a 1968 ordinance banning encampments citywide. The law prohibits sleeping in any public space and bans tents or other camping gear. The city has adopted a "zero tolerance" approach, issuing citations or making arrests for non-compliance, even though shelters frequently lack available beds.

- **Newport Beach, CA**: A law that started in October 2024 makes it illegal to camp in the city, even without a tent. This includes sleeping on sidewalks or in cars, and using a sleeping bag in public spaces can result in citation.

- **Fresno, CA**: In September 2024, Fresno adopted a new illegal camping ordinance. The ordinance bans anyone from sitting, lying, sleeping, or camping in public spaces, including sidewalks, streets, and alleyways, at any time. People in violation of the law face a $1,000 fine and one year in jail, or both. As of winter 2024, the City of Fresno continues to enforce the anti-encampment ordinance, despite the persistent lack of available shelter beds.

Methodology

This report draws on three iterative research methods to explore the health consequences of encampment sweeps and the role of street medicine in mitigating harm. These methods—a scoping literature review, an action-oriented World Café, and key informant interviews—were chosen to gather diverse perspectives and insights, combining evidence from existing research, collective community discussions, and practitioner experiences.

Scoping Literature Review

The authors conducted a scoping literature review on the health consequences of encampment sweeps in the United States. Scoping reviews serve multiple purposes, such as: exploring the scope and diversity of a research question, assessing the potential value of conducting a systematic review, summarizing and sharing findings with specific audiences, and pinpointing gaps in the existing literature [5]. Given the limited research on this issue, and the absence of systemic reviews on this topic, a scoping review was chosen because it enabled us to both broadly map available evidence on the topic and strategically summarize findings for targeted policy and practice audiences [5]. Further, a scoping review enabled us to include various types of relevant information and literature – including scholarly literature, public reports, policy documents, government publications, and media coverage [5]. The inclusion criteria restricted sources to those published in English after 2010. Sources were gathered by conducting searches on academic scholarly databases, alongside manual searches of government websites, media websites, and other reputable sources (e.g., National Healthcare for the Homeless Council website).

Action-Oriented World Café at the *California Street Medicine Symposium*

In August 2024, the California Street Medicine Collaborative hosted an action-oriented World Café session at the 6th *Annual California Street Medicine Symposium*, hosted by University of Southern California's Street Medicine Division. The workshop utilized an adapted World Café methodology to engage approximately 250 participants in a collective community consultation on the health consequences of encampment sweeps and the role of street medicine in mitigating the associated harms.

The World Café method is a collaborative way to bring people together for meaningful discussions and shared problem-solving. It usually involves small groups talking about specific questions, with participants moving between tables to share ideas and build on each other's insights. This approach helps gather a wide range of perspectives, encourages teamwork, and creates a sense of shared purpose in finding solutions. The purpose of this adapted World Café session was to better understand the consequences of street sweeps on patients and outline avenues for clinical and advocacy action. By the session's conclusion, participants collectively identified movement-wide priorities for addressing the issue both clinically and through advocacy.

Participants represented diverse health care professions from across California, including medical providers (e.g., physicians, physician assistants, nurse practitioners, registered nurses, licensed vocational nurses, medical assistants), community health workers, outreach workers, social workers, researchers, first responders, harm reduction workers, hospital staff, and other allied healthcare professionals. These participants serve urban, rural, and suburban unhoused populations in diverse communities across California. The session also included people with lived experiences of homelessness and encampment sweeps, as well as a small number of participants serve people experiencing homelessness in other states across the country.

The session was structured around two core questions:

1. What are the consequences of encampment sweeps on people experiencing unsheltered homelessness, from a street medicine perspective?
2. How have you and your patients mitigated the harms and consequences of these sweeps?

Participants were organized into small groups, with a volunteer facilitator and notetaker at each table to guide discussions and document insights. Rather than rotating tables as in a traditional World Café, groups remained stationary to allow for deeper exploration of their assigned questions. This adapted World Café method preserved the collaborative ethos of the approach while emphasizing actionable insights and community-driven priorities, aligning with the workshop's goal of advancing both clinical and advocacy efforts within the street medicine movement.

At the end of the session, all notes were collected and analyzed by the principal author (Schwan). Key themes and practices were identified, categorized, and cross-referenced with findings from the literature review and consultations with key informants.

Key Informant Interviews

In fall 2024, the principal author conducted informal key informant interviews with eleven street medicine practitioners across California to deepen our understanding of themes identified through the World Café method. These interviews focused on the impacts of street sweeps on their patients and the challenges of delivering care during widespread displacement. Practitioners provided detailed accounts of their experiences providing care in different contexts across the state, sharing compelling patient stories and insights into clinical strategies for mitigating harm. Several of these practitioners reviewed and critiqued the report in its draft stages, contributing verbatim accounts of patient experiences and providing further details and nuance to the findings.

Next Steps

This document is intended to be iterative, recognizing that the contexts and political realities surrounding encampments and encampment sweeps will continue to evolve in California and across the United States. Phase two of this project will focus on widespread

consultation with people with lived and living experiences of homelessness to further examine the role of street medicine in addressing the consequences of encampment sweeps. These consultations aim to ensure that future iterations of this report are guided by the voices and expertise of those most directly impacted.

The Impact of Encampment Sweeps on Health

Top 5 Health Consequences of Encampment Sweeps

1. Loss of personal belongings critical for survival.
2. Increased health risks & disruption of care.
3. Disruption of community & vulnerability to violence.
4. Trauma and escalation of mental health and substance use challenges.
5. Loss of life.

1. Loss of Personal Belongings Critical to Survival

Encampment sweeps often result in the loss of essential personal property in ways that undermine individuals' health and wellbeing [2, 4, 7-9]. Personal belongings such as medications, government issued identification, hygiene supplies, survival materials, phones, and vital documents like proof of income or insurance are frequently confiscated or destroyed. In San Francisco, a recent survey found that 46% of respondents experiencing homelessness had belongings confiscated and 38% had belongings destroyed by city officials during sweeps [11].

Many medications lost during sweeps are expensive and difficult to replace, including medication-assisted treatment for opioid use disorder, hepatitis C, and HIV medications [12]. Given that consistent access to medication and care is crucial for managing conditions like HIV and hepatitis C, disruptions can increase the risk of disease transmission and medication resistance within communities [12]. Insurance plans typically do not cover early refills, which are often necessary when medications are destroyed during a sweep. This creates a substantial financial burden for patients and street medicine teams, who often struggle tremendously to cover the cost of replacing these vital medications. Loss of mobility equipment, such as walkers and wheelchairs, is also common during sweeps and can make it challenging for individuals to maintain their physical well-being and access healthcare services or other services [12,14].

The loss of these materials often leaves patients in even more vulnerable conditions and disrupts their ability to access care or benefits [1, 15-16]. The loss of government issued

identification and critical documents also poses significant barriers to accessing housing and employment. For instance, replacing lost identification is often a prerequisite for accessing social services or opening a bank account, both crucial steps towards stable housing [17].

Street medicine practitioners across California report that sweeps often destroy critical survival materials like blankets, tents, tarps, clothing, and other materials used to protect against the elements. Studies indicate the loss of critical survival gear can contribute to a decline in physical health and increase the risk of infectious diseases [18]. Encampment residents may also be displaced from locations where they have established access to food, water, hygiene supplies, bathrooms, and means of making money – all of which they may struggle to reestablish.

Insights from the Streets

Across California, street medicine teams report observing:

- Encampment sweeps occurring while a patient was actively having a medical crisis, including during a miscarriage, forcing the patient to choose between getting medical attention and losing their possessions.
- Loss of irreplaceable personal possessions, including: the ashes of family members, family heirlooms and photographs, tools and materials used to generate income (e.g., carts for transporting cans), and cultural items and artwork.
- Patients' possessions being stolen by security and law enforcement for personal use.

Insights from the Streets – Case Study in Patient Care

"We once had a patient who asked to enter his tent to retrieve his medications and ID/documents during a sweep. They wouldn't allow him to enter his tent and instead threw out everything. We had spent many weeks gaining his trust and working with him on his medication regimen and getting his documents - all of which were destroyed. We saw him later that day and he was so distraught that wouldn't even engage with us for about a week, despite having a long-standing relationship with him."

- *Brian Zunner-Keating, MS, RN, UCLA Homeless Healthcare Collaborative (Los Angeles, CA)*

Insights from the Streets – Case Study in Patient Care

"One morning, I visited a patient and found he wasn't in his usual spot but around the corner, drenched in sweat and looking exhausted. He explained that early that morning, police had cleared his area, forcing him to move his belongings, including several dogs, to a nearby warehouse. Shortly after settling there, two armed guards emerged and threatened to harm him unless he moved immediately. By the time we arrived, he had moved his belongings twice and was visibly drained. He hadn't eaten in two days and had no water. One of his pets, frightened, had fled, adding to his distress. The pet has not returned.

These sweeps are not only emotionally taxing but also physically exhausting, especially when there is a lack of access to food and water. Given that a significant portion of our unsheltered population is over 50 and managing multiple medical conditions, I can see how people lose everything they own because they simply don't have the strength and stamina to preserve them."

- *Corinne Feldman, MMS, PA-C, USC Street Medicine (Los Angeles, CA)*

2. Increased Health Risks & Disruption of Care

Displacement caused by street sweeps significantly increases health risks and disrupts medical care routines. Forced relocations can expose individuals to extreme weather, disease, and violence, exacerbating existing health conditions and increasing reliance on costly emergency medical services [19-21].

- **Exacerbation of Health Challenges:** Losing access to regular medications and healthcare can lead to more frequent and severe health crises, requiring emergency interventions and increasing the burden on emergency healthcare systems (particularly EDs) [12]. Street medicine providers across California report seeing patients experience preventable medical crises, in some cases with irreversible consequences, because their medication was destroyed during sweeps. Sweeps often interrupt access to food and water and worsen sleep disruption, all of which create or exacerbate existing health challenges.

> "If you want to design an epidemic, repeatedly taking medications away from an entire vulnerable population would be an ideal way to start."
>
> *– Dr. Ricky Bluthenthal, 2024 6th Annual California Street Medicine Symposium*

- **Disrupted Care Continuity:** Research demonstrates that patients frequently miss critical appointments, treatments, and even court dates because outreach teams struggle to locate them post-displacement [1]. This is particularly problematic for managing chronic illnesses, mental health conditions, and substance use disorders [1].

  Street medicine teams across California report continuously losing patients after encampment sweeps, sometimes for months or indefinitely. Often, street teams are not informed about upcoming sweeps and are unable to help their patients prepare. In sweeps that involve moving patients into interim housing, there is often a significant lack of communication about where patients are being relocated, making it difficult for teams to follow up. In some cases, these patients miss specialty appointments that took their street medicine team months to arrange. In other cases, sweeps disrupt ongoing wound care provided by the street medicine team, sometimes resulting in serious medical complications. Loss of phones often means street medicine practitioners can't reach their patients to arrange follow up care.

- **Environmental Hazards:** After being displaced, individuals are often pushed into unfamiliar or more dangerous areas with less access to shelter, food, or healthcare, increasing their risk of harm and injury. They may be displaced to areas with less protection from the elements, such as those lacking tree cover, which heightens their risk of environmental exposure and leads to conditions like hypothermia, frostbite, trench foot, and heat-related illnesses [22]. The risk of these conditions is further heightened when individuals must navigate these new environments without the survival resources they previously relied on before the sweep. For example, a Denver, CO study found that amongst those who had stopped using items for personal shelter (e.g., blankets, tents) at the direction of police, there was a "71% higher rate of frostbite, a 39% higher rate of dehydration, and twice the rate of heat stroke" [22]. In some cases, individuals displaced by sweeps are also forced to reside in contaminated areas or areas with hazardous waste, increasing risks of respiratory illness and other health issues [14].

A Denver, CO study found that amongst those who had stopped using items for personal shelter (e.g., blankets, tents) at the direction of police, there was a "71% higher rate of frostbite, a 39% higher rate of dehydration, and twice the rate of heat stroke."

Street medicine teams in California report that displacement to more isolated areas create significant challenges in reaching patients for medical care and coordinating transportation to specialty appointments or hospitals. For example, many teams across the state note that sweeps drive patients to seek shelter in abandoned buildings, both for personal protection and to avoid encounters with law enforcement. However, abandoned buildings present substantial risks to situational awareness and challenges for ensuring the street medicine team's safety, leading many to avoid entering these spaces, further limiting their ability to locate and care for patients.

Climate adaptation in Los Angeles (credit: Corinne Feldman, USC Street Medicine)

• **Street Sweeps & Extreme Weather:** Extreme weather patterns, combined with the disruptions of encampment sweeps, pose significant risks to people experiencing unsheltered homelessness [2]. Local authorities often fail to account for severe weather forecasts when conducting sweeps, displacing individuals from areas that provide relief from extreme conditions [22]. In summer, many seek shade or camp near

waterways to escape the heat, yet these locations are frequently targeted for sweeps, leaving individuals exposed to dangerous temperatures. Similarly, winter brings freezing conditions, atmospheric rivers, and bomb cyclones, further endangering unhoused populations [34-35]. Prolonged heatwaves and increasingly severe storms have made survival even more challenging, forcing individuals to prioritize basic needs over medical care [33, 35].

International public health guidance identifies socially vulnerable groups at high risk for poor health outcomes from extreme weather, including unsheltered individuals [23]. The National Institutes of Health (NIH) highlights three key factors that heighten climate-related risks: adaptive capacity (coping ability), exposure (degree of impact), and sensitivity (capacity to adjust). Unsheltered individuals face heightened vulnerability across all three, with encampment sweeps further exacerbating these risks [24].

According to street medicine teams across the state, extreme weather intensifies the challenges posed by encampment sweeps, compounding health risks for unhoused individuals and disrupting the care provided by street medicine teams and other outreach efforts. This forced displacement often interrupts continuity of care, as street medicine teams lose track of patients or must redirect their focus from ongoing medical treatment to addressing immediate survival needs.

Insights from the Streets – Case Study in Patient Care

"One of my patients had a skin mass on his nose that I biopsied on the street, and it was diagnosed as skin cancer. We were in the process of coordinating his care with a dermatologist for a straightforward removal when his camp was dismantled during a sweep. We lost track of him for about six months. When he resurfaced, the mass had grown significantly and was now threatening his right eye, as well as obstructing his sinuses, nasal passage, and lacrimal duct. He required several months of radiation therapy and eventually had to undergo surgical removal of his nose, leaving him with an exposed nasal cavity. He's now housed and has completed his full treatment, but we're still working on getting him a nasal prosthesis, which has proven difficult.

The impact of missing appointments or interrupted treatment is far more severe for our patients than most people realize. The outcomes of encampment sweeps are often life-altering and can directly affect people's health in devastating ways."

- *Kyle Patton, MD, Medical Director of HOPE Program, Shasta Community Health Center (Redding, CA)*

Insights from the Streets – Case Study in Patient Care

"Our team is currently providing medical care to a young woman who suffers from cardiomyopathy with congestive heart failure with a markedly reduced ejection fraction. She has required frequent hospitalizations in the past, however, as of late, we have been able to medically optimize her on all her appropriate medications and keep her out of the hospital. She has been an amazing collaborator, working hard to fill her pill boxes regularly and stay on top of a demanding regimen of medications to keep her out of the hospital.

However, in the past few weeks, she has been swept multiple times, with her medications all going into the trash with each displacement. The pharmacy has been kind enough to give us multiple early refills, however, upon the third request, they declined the request. The patient was without her required medications for approximately four days and ended up in the hospital with an acute exacerbation of congestive heart failure; she required three days of inpatient services. This was a preventable hospitalization that proved costly and was clearly disheartening to a patient who has been working incredibly hard to take her medications accurately to improve her health and situation."

- *Kate Pocock, PA-C, USC Street Medicine (Los Angeles, CA)*

3. Disruption of Community and Vulnerability to Violence

Encampments often provide individuals with a sense of community and social support that is vital for their well-being [1, 10]. These connections are vital for emotional well-being, safety, and survival, providing mutual aid, shared resources, and companionship. Encampment sweeps frequently break up communities, leading to isolation and a loss of protective networks that help ensure safety and emotional support for individuals [1, 18, 25-26]. The destruction of these protective factors often has a deleterious impact on health and mental health [1, 4, 25].

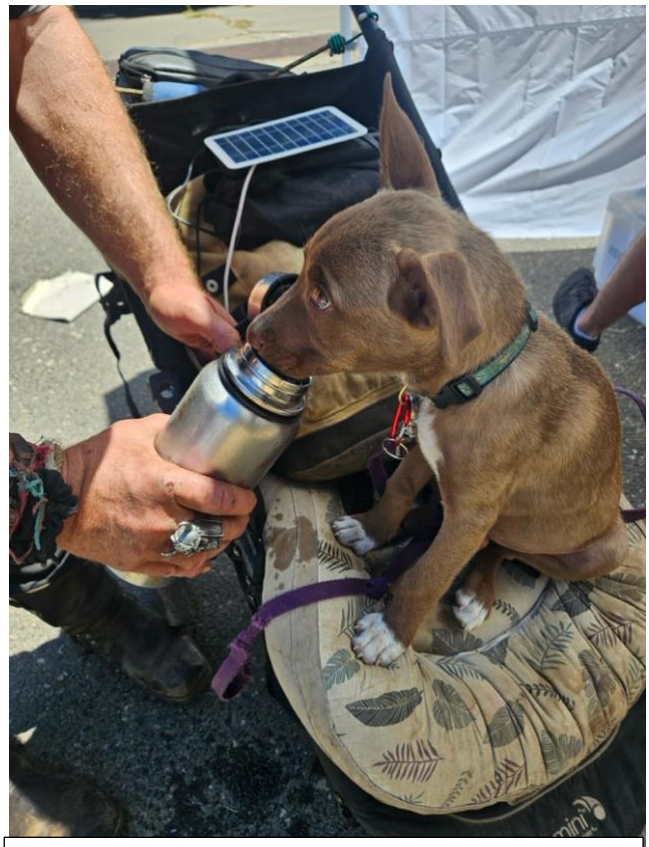
A study in Denver, CO, found that when women slept in more remote or hidden locations to avoid police interactions, they experienced a 50% higher rate of robbery, a 60% higher rate of sexual assault, and over three times the rate of physical assault.

- **Heightened Vulnerability to Violence:** Encampments, while imperfect, often provide a sense of community and relative safety in numbers. Sweeps often force people to move to more isolated, hazardous, and less visible spaces, further away from support systems [15, 25]. This makes displaced individuals easier targets for violence and limits their ability to seek help or support from others [15, 26-29]. Certain groups, such as women and transgender individuals, face disproportionate risks of violence [14-15, 30]. Women experiencing unsheltered homelessness often rely on men in encampments for protection, but forced displacement can disrupt these relationships, increasing their risk of violence and abuse [30].

  A study in Denver, CO, highlighted that when individuals seek more hidden or isolated sleeping locations to avoid police contact, both men and women experience higher rates of robbery, physical violence, and sexual assault for both men and women [22]. Women who relocated to a more hidden or remote location to avoid law enforcement reported a 50% higher rate of robbery, a 60% higher rate of sexual assault, and more than three times the rate of physical assault [22]. Street medicine practitioners also report that the extreme stress of displacement can also erode leadership structures within encampments, as well as increase tension within and between encampments, resulting in increased conflicts and violence.

- **Loss of Pets:** Pets provide crucial emotional support and companionship, yet they are often lost during sweeps, deepening distress and isolation [15]. Street medicine teams report that losing a pet is profoundly traumatic for their patients, with many equating it to losing a family member. Beyond emotional support, pets also offer protection, and their loss leaves individuals more vulnerable to violence and theft [15]. A major concern is that pets are frequently taken to the pound during sweeps, forcing owners to navigate bureaucratic and financial barriers to retrieve them. If they cannot pay quickly enough, their animals risk euthanasia.

  Many shelters and transitional housing facilities do not allow pets, forcing people to choose between shelter and their animals. This restriction not only limits access to safe housing but also makes it harder to engage with healthcare services, including street medicine teams. The emotional toll is



Pup on the streets of Sacramento, CA (credit: Kaitlin Schwan, California Street Medicine Collaborative)

immense, as individuals face the heartbreaking decision of leaving behind a beloved companion or accessing shelter.

Recognizing this issue, one animal rescue group in Bakersfield (CA) has launched a campaign to chip pets and create an "emergency contact" system, allowing animals to be transferred to trusted individuals rather than being sent to the pound during a sweep. This initiative seeks to mitigate some of the trauma caused by the separation and ensure that animals are cared for while their owners work to reclaim them.

Insights from the Streets

"From what we're seeing, our patients—and I'd bet this holds true for other street medicine teams—have a really unique relationship with their animals. For them, their dogs aren't just pets; they're companions, protectors, and a critical mental health lifeline. Most of our patients prioritize their animals' well-being above their own, almost every time.

What's troubling is that we're seeing more and more instances where these animals are being separated from their owners. Just last week on the riverbed, one of our patients told us that dozens of people were arrested for illegal camping. Their dogs were taken to the pound for 12 hours while the patients were in custody. When released, they had to find their way back to their camps, then figure out how to get to the pound, and then somehow scrape together enough money to pay for their dogs' release. One man I spoke to had to pay $500 to get his momma dog and her six puppies out.

On top of that, there's a daily cost for keeping animals at the pound, and if owners can't pay quickly enough, the animals are euthanized. This isn't just happening on the river—it's standard practice across town for unhoused individuals with pets.

- *Matthew Beare, MD, Program Director - Addiction Medicine Fellowship, Clinica Sierra Vista (Bakersfield, CA)*

- **Alienation & Dehumanization:** Studies suggest that the destruction of communities within encampments often fosters a sense of instability, alienation, and dehumanization, undermining individuals' sense of belonging and trust in authority [1, 4, 11]. This distrust can also hinder housing efforts, as individuals may be reluctant to engage with outreach providers affiliated with county or city organizations.

- **Greater Difficulty Engaging in Health Care and Housing Services:** Street medicine teams report that encampment displacements disrupt the community support systems that help individuals access healthcare and housing services. For many, these communities provide a safety net, watching over belongings, tents, and pets while individuals seek care. Without this support, individuals may be hesitant to attend medical appointments or meet with housing workers, fearing the loss of possessions or the well-being of their pets. The breakdown of these communal arrangements creates significant barriers to healthcare and housing interventions.

4. Trauma and Escalation of Mental Health and Substance Use Challenges

Encampment sweeps inflict profound psychological and emotional harm, worsening existing mental health conditions and increasing the risk of substance use and overdose. The repeated displacement caused by these actions creates a cycle of instability, making it very difficult for individuals to establish safety or stability, let alone access services or improve their circumstances.

Insights from the Streets

"In all of my medical training, sweeps are at the top, if not the very top, of the most traumatic things I witness. We certainly play a role as providers, but sweeps also take a toll on us."

- *M.K. Orsulak, MD, UC Davis Department of Family & Community Medicine (Sacramento, CA)*

Psychological Trauma and Mental Health Decline

The fear of losing personal belongings, the dehumanization of being forcibly removed, and the constant threat of citation or arrest inflict psychological trauma on individuals experiencing homelessness [1, 17, 26]. These stressors exacerbate pre-existing mental health challenges such as anxiety, depression, and post-traumatic stress disorder (PTSD) [4, 17]. Research indicates that homelessness itself is often a form of psychological

trauma [18], and sweeps compound this harm, leaving people feeling demoralized, dehumanized, and hopeless [1]. Studies show the ongoing need to relocate undermines individuals' efforts to regain stability, furthering feelings of despair and hopelessness [1]. Street medicine teams across California report that in the wake of a sweep, their patients often feel disrespected, ashamed, abandoned, and that they don't belong anywhere. They report that patients frequently become disoriented or confused, lose their sense of routine and purpose, and feel that their very humanity has been violated.

Insights from the Streets

Street medicine teams across California report that in the wake of a sweep, their patients often feel disrespected, ashamed, abandoned, and that they don't belong anywhere. They report that patients frequently become disoriented or confused, lose their sense of routine and purpose, and feel that their very humanity has been violated.

Exacerbation of Substance Use

Street medicine teams observe that substance use often increases following encampment sweeps, a trend linked to both the trauma caused by displacement and the disruption of care. Trauma from sweeps can drive individuals to use substances as a coping mechanism, heightening the risk of dependency, relapse, and overdose [12, 15, 17]. Additionally, the disruption of access to essential services, such as methadone clinics or harm reduction supplies, can exacerbate or alter substance use. Providers report that patients are more likely to use substances in isolation or engage in unsafe practices after losing access to harm reduction supplies. Additionally, some patients increase their use to stay awake for safety reasons or to guard their belongings in a new and unfamiliar environment.

Research indicates that the disruption caused by sweeps directly impacts access to harm reduction services, including naloxone (Narcan), clean supplies, and overdose prevention programs. In some cases, critical life-saving items, such as naloxone kits, are confiscated or discarded, increasing the likelihood of fatal overdoses [1]. Studies show that the confiscation or destruction of naloxone—a medication that reverses opioid overdoses—during sweeps has led to overdose deaths by depriving individuals of this critical, life-saving treatment [4, 11]. A modeling study estimated that continual displacement could lead to a 56% decrease in initiations of medications for opioid use disorder and contribute to a 16% to 24% increase in deaths among people experiencing unsheltered homelessness who inject drugs [26]. Similarly, a study of sweeps in L.A. and San Francisco found that individuals who experienced displacement were more likely to report an overdose in the past 3 months [11].

Undermining Housing and Service Efforts

Street medicine providers report that trauma associated with being displaced by government officials is easily transferred to other government agencies, like housing and social service authorities. When one branch of an institution inflicts harm while another simultaneously offers assistance—sometimes at the very moment the harm occurs—individuals may refuse help due to a loss of trust. For example, when a city's Department of

Sanitation and Police Department clear an encampment, and a housing agency later offers assistance, individuals often see these agencies as part of the same system rather than distinct entities with separate roles. This perception reinforces distrust and complicates efforts to provide support. As a result, encampment clearings can inadvertently undermine broader governmental efforts to house and assist people experiencing homelessness.

Insights from the Streets – Case Study in Patient Care

"One of our patients had multiple medical conditions alongside significant post-traumatic stress disorder. It took us over a year to help her stabilize through weekly street medicine visits, medication adjustments, and support with basic needs. She was doing well and starting to set both short- and long-term goals beyond just survival. However, one day we arrived to find her encampment had been swept away. When we located her a few days later, she was in the midst of an acute mental health crisis and expressed thoughts of ending her life. Our team responded by increasing the frequency of our visits and support. After a few weeks, she began to find a new sense of stability. Then, one evening, a pick-up truck arrived with several men who claimed they were hired to clear the area. They removed all her belongings, leaving only a few recently purchased items still in sealed boxes, which they placed in the front seat of the truck—presumably for their personal use. Soon after, she experienced another acute mental health crisis. It has now been six months since her initial displacement, during which she has been forced to move three more times, and she has not yet returned to her emotional baseline."

- *Corinne Feldman, PA-C, USC Street Medicine (Los Angeles, CA)*

Distress on the streets of Los Angeles (credit: Ara Oshagan, UCLA Health)

5. Loss of Life

Encampment sweeps contribute to increased mortality among people experiencing homelessness, a population already facing significantly higher death rates than housed individuals [1]. Research shows that mortality rates for people living in shelters are ten times higher than those of housed individuals in the same city, while unsheltered individuals face an even greater risk, with mortality rates three times higher than those in shelters [37]. Sweeps exacerbate these dangers by removing vital harm reduction resources, increasing vulnerability to overdose and other life-threatening conditions. A simulation modeling study across 23 U.S. cities estimated that continual involuntary displacement could lead to a 15.6% to 24.4% increase in deaths among unhoused individuals over a decade [31]. The trauma of eviction and displacement has also led some individuals to take their own lives rather than endure repeated upheaval [4], and in at least one documented case, an unhoused woman was killed by a bulldozer while sleeping in her tent during a sweep [4].

Research highlights the disproportionate impact of encampment sweeps on people who use drugs (PWUD). A 2023 study by Barocas and colleagues found that sweeps significantly increase the likelihood of overdoses and hospitalizations while reducing access to medication-assisted treatment [31]. Additionally, Fleming et al. describe sweeps as part of an "institutional circuit" that perpetuates cycles of instability, forcing PWUD to oscillate between fleeting stability and heightened insecurity in both social and material contexts [37].

Insights from the Streets

Street medicine teams report bearing significant burden associated with street sweeps, including:

- Vicarious trauma resulting in burnout and staff turnover, further disrupting patient care.
- Significant financial costs when having to re-prescribe and dispense medications from their backpacks after sweeps, which often relies on out-of-pocket spending from limited funding pools.
- Additional financial costs related to uncompensated labor (e.g., time looking for displaced patients).
- Loss of trust from patients due to perceived association/collusion with law enforcement or other authorities.
- Increased challenges meeting quotas and metrics for patient panel sizes due to displaced patients.
- Environmental waste produced by the circular destruction and replacement of survival materials.

Mitigating the Health Impacts of Encampment Sweeps in California:

A Practice Guide for Street Medicine

Street medicine practitioners occupy a critical role during sweeps, serving as both care providers and advocates. This Practice Guide outlines reality-based strategies for mitigating harm at three key stages—before, during, and after sweeps—while centering the health, dignity, and rights of patients.

Foundational Principles for Action

The following foundational principles should guide all areas of practice—before, during, and after sweeps—ensuring that interventions are rights-based, trauma-informed, and patient-centered:

- **Autonomy and Agency**: Ensure all interventions respect the rights of individuals experiencing homelessness to make informed choices about their own lives.
- **Dignity and Respect**: Treat all patients with humanity and compassion, recognizing their inherent worth and human rights.
- **Coordination**: Strengthen collaboration among service providers, outreach teams, law enforcement, and community organizations to ensure seamless support for displaced individuals.
- **Harm Reduction**: Focus on minimizing the immediate and long-term impacts of sweeps through practical, patient-centered strategies.
- **Inclusive Engagement**: Work directly with patients in encampments to ensure their lived experiences are reflected in the response and action planning. Prioritize their voices in decision-making processes to ensure interventions are relevant, effective, and responsive to their unique needs.

SUMMARY
17 Strategies for Protecting Health & Reducing Harm

BEFORE SWEEPS

1. Educate patients about street sweeps, what they can expert, and what their rights are.
2. Proactively develop a relocation plan with patients.
3. Plan for loss of communication.
4. Provide tools to protect critical documents, medications, and other essential resources.
5. Develop “sweep-resilient” medical treatment plans and prescribing practices.
6. Increase harm reduction efforts.
7. Increase the provision of basic necessities.
8. Establish communication channels with relevant authorities to stay informed about upcoming sweeps and advocate for trauma-informed approaches.

DURING SWEEPS – KEY CONSIDERATIONS

1. Presence of non-presence during sweeps.
2. Engaging (or not) with law enforcement and officials.
3. Advocacy for patients: when and how?
4. Providing medical and mental health support
5. Logistical support: to what extent?

AFTER SWEEPS

1. Locate displaced patients as quickly as possible.
2. Replenish critical survival supplies, including food, water, and harm reduction tools.
3. Reestablish medical treatment plans and replace lost medications.
4. Re-establish trust and support patients to process trauma and grief.

BEFORE SWEEPS

Being proactive prior to encampment sweeps is critical for minimizing harm, ensuring continuity of care, and supporting individuals living in encampments. By anticipating the challenges that may arise from displacement and disruption, teams can help patients navigate these obstacles more effectively.

1. Educate patients about street sweeps, what they can expect, and what their rights are.

- Proactively educate your patients about different kinds of sweeps being conducted in their area, and what they can expect during each type of sweep. Be transparent about the probability of a sweep, sharing any available information.

- Clearly communicate the distinct role of street medicine teams and other stakeholders, such as law enforcement and sanitation workers, during sweeps to define responsibilities and delineate spheres of influence.

- Educate patients on their rights during sweeps, how they can advocate for their rights, what to do if their rights are violated, and what role your street medicine team will play in relation to rights violations (if any). Some organizations have effectively provided this information through concise, postcard-sized handouts, making it easily accessible for those affected.

Street Medicine Visit in South LA (credit: Corinne Feldman, USC Street Medicine)

2. Proactively develop a relocation plan with patients.

- Ask patients how they would like to be supported during a sweep and clearly communicate what is and isn't feasible within the scope of your role.

- Discuss where patients might go in the event of a sweep (e.g., 'If there was an encampment sweep, where are two other places I could find you?') and other locations they are likely to visit. Work with patients to establish their daily

routines and identify specific places where you could meet them if they're displaced, such as a local soup kitchen or a favorite panhandling spot.

- Support patients in assessing options for relocation and the relative risks of those locations (e.g., risk of sexual violence, exposure to environmental hazards).

- Work with patients to develop relocation preparedness plans, ensuring there is plan in place for: emergencies, document and medication storage, options for access to basic necessities (e.g., food, water), pets, communication, harm reduction, and information about where to access shelters, healthcare, or other services after losing their usual support network.

- Plan for transportation needs during a sweep, including options for moving pets or larger belongings. Develop detailed transportation plans for patients with disabilities or mobility challenges, seeking to ensure that critical resources like wheelchairs and canes are not lost. Where possible, provide materials that can support with transportation (e.g., carts, luggage).

- Develop strategies to assist RV residents before sweeps, such as connecting them with services to renew vehicle registration or making necessary repairs to ensure vehicles are drivable.

Insights from the Streets

"We have a weekly multidisciplinary team meeting where we discuss vulnerable patients, during which we come up with support plans with our non-medical staff and review the list of our patients needing to be found. As the chaos of the streets increases, so too does our need for communication amongst our various team members. We have found this meeting to be essential."

- *Kyle Patton, MD, Shasta Community Health Center (Redding, CA)*

3. Plan for loss of communication.

- Ensure patients have your contact information written on durable materials and stored in multiple locations (not just their phone). Consider providing water-proof contact cards.

- Publish a public phone number that provides a direct line to street medicine services. Ensure this number is prominently displayed on a website and posted in common public areas, such as drop-in centers or other services where patients may have access to a phone. This ensures patients can reconnect with their street medicine teams even if their phone with stored numbers is lost.

- Update contact information for your patient each time you see them and check to ensure they still have your contact information.

- Maintain a list of alternative and emergency contacts, such as family, friends, or community members, who can help locate the patient post-sweep. Ask patients who they would like you to contact if the team can't locate them. If possible, share your contact information with patient-approved persons in advance of a sweep. For some, this might be a street vendor or a local store or service.

- Identify key figures within encampments, including informal leaders or "street moms" and build relationships with them to help maintain communication with patients post-sweep. These leaders may have critical information about where to find your patient after a sweep. Share your contact information with these persons in advance of a sweep.

- Establish regular interagency team meetings to enhance communication, especially for larger teams conducting outreach. Use these meetings to coordinate care, plan for upcoming sweeps, develop support plans, and review lists of patients requiring follow-up. Update the Homeless Management Information System (HMIS) to include street medicine as part of the care team, and the most recent location where the person was found.

4. Provide tools to protect critical documents, medications, and other essential resources.

- Distribute waterproof document bags, brightly colored "do-not-touch" pouches or bags, or lockable containers for IDs, medications, medical records, valuables, and other vital paperwork.
    - Whenever possible, ensure that law enforcement and security personnel are informed about these strategies and agree not to destroy or confiscate the designated 'do-not-touch' bags.

- With patient consent, digitize or photocopy critical documents and store them securely to ensure they are accessible if originals are lost.

- Strategize with patients to identify secure alternatives for storing critical documents or medications, such as with trusted housed friends or family members.

Insights from the Streets

"We recently set up a PO box that our patients can have critical documents sent to. Our staff go and collect the mail regularly, and our case managers store the documents securely at our office. This allows us to hang on to their newly sent documents until they have a greater degree of stability."

- *Kyle Patton, MD, Shasta Community Health Center (Redding, CA)*

5. Develop "sweep-resilient" medical treatment plans and prescribing practices.

- **Administer the HOUSED BEDS Assessment Tool**: Getting a vivid picture of the person's current access to basic survival needs, daily routine, existing relationships with other agencies, and community connections will serve as a critical harm-mitigation tool.

- **Prescribe Shorter Durations**: Prescribing medications in shorter increments (e.g., weekly instead of monthly) can help ensure patients can maintain access to their medications if they are confiscated or discarded during sweeps.

- **Use Long-Acting Medications**: Consider administering long-acting medications (e.g., long-acting buprenorphine injections for opioid use disorder, long-acting antiretroviral therapy (ART) for HIV) to reduce the need for frequent refills, prevent medication loss during displacement, and help prevent the possible exacerbation of medical conditions due to treatment interruption.

- **Plan for Environmental Risks**: Account for environmental conditions (e.g., heat, cold, or moisture) when prescribing medications and provide guidance on storage solutions.

- **Increase Refills and Advocate for Refill Flexibility**: Consider including multiple refills on prescriptions to minimize barriers to access for patients who may experience frequent displacement. Teams might also consider prescribing smaller quantities of medication per refill, as larger supplies can lead to significant challenges with insurance and pharmacies when early refills are requested. Where possible, work with pharmacies to ensure patients can easily access refills.

Street Medicine Visit in Redding, CA (credit: Kyle Patton, Shasta Community Health Centre)

6. Increase harm reduction efforts.

- Increase education on harm reduction, such as the importance of not using substances alone, how to identify overdose warning signs, how to respond to an overdose, and the benefits of beginning with a smaller dose when using new batches of unknown potency.

- Educate patients who use substances on the increased risk of overdose they (or others around them) may experience post-sweep.

- Increase the provision of harm reduction materials (e.g., syringes, pipes, fentanyl strips).

- Increase the provision of Naloxone/Narcan and educate patients and community members on how to use these medications.

7. Increase the provision of basic necessities.

- **Expand Supply Distribution**: Provide larger quantities of essential items, including food, water, hygiene supplies, clothing, sheltering supplies (e.g., tarps), supplies to weather the elements (e.g., sunscreen), and harm reduction materials, recognizing that sweeps frequently remove access to these necessities and displace individuals from locations where they currently have strategies for generating income. This must be balanced by the understanding that during a sweep, large quantities of items must be left behind, but the choice of what to take should remain with the patient.

- **Improve Access to Phones**: When possible, distribute cell phones, including prepaid or "burner" phones, to help individuals maintain access to critical services and contacts after being displaced. If this is not feasible, work with patients to plan for how they could access a phone if displacement were to occur.

8. Establish communication channels with relevant authorities to stay informed about upcoming sweeps and advocate for trauma-informed approaches.

- Determine which authorities are responsible for policing the community and/or land where your patients reside. Open lines of communication with these authorities, including when you encounter their staff out on street rounds. Share contact information and ask authorities to alert you in advance of sweeps (as early as possible).

- Advocate for trauma-informed approaches to encampment sweeps, including associated training for law enforcement, paramedics, parks and recreation departments, and other authorities.

- Maintain clear boundaries between healthcare providers and law enforcement to protect patient trust and ensure ethical practices.

Insights from the Streets

"When offers of shelter or temporary housing are made during a sweep, one strategy we use is to ask how beds are prioritized and how providers can advocate for patients who are shelter-ready or could benefit most from being indoors. We also inquire about the locations of the shelters so we can begin planning follow-up care. For instance, we may establish a relationship with the shelter before the sweep, ensuring we can immediately support our patients once they are relocated to the shelter. If we're unable to go to that area, we can coordinate with another medical team to continue patient care."

- *Brian Zunner-Keating, MS, RN, UCLA Homeless Healthcare Collaborative (Los Angeles, CA)*

DURING SWEEPS – Key Considerations

Encampment sweeps are highly disruptive events, often creating crisis situations for individuals experiencing homelessness. Street medicine teams must carefully weigh their role during these events, ensuring that their engagement does not inadvertently harm their relationships with patients or undermine their broader mission. There is no singular "right way" to engage during a sweep—teams must assess multiple factors in real time to determine how to best support their patients while preserving trust and safety. Below are key considerations for street medicine teams when deciding whether and how to engage on the day of a sweep.

1. Presence or Non-Presence During Sweeps

- Some teams choose to be present at sweeps, providing visible support, medical care, or de-escalation. Others find that their presence can be misinterpreted by patients as complicity with the sweep or may create tensions with law enforcement that could jeopardize future work.
- Consider whether being physically present aligns with your team's mission and your patients' needs.

2. Engaging (or Not) with Law Enforcement and Officials

- Law enforcement and city officials play key roles in sweeps, and interactions with them require careful consideration.
- Some teams engage directly, advocating for additional time or ensuring humane treatment. Others avoid direct confrontation to maintain long-term working relationships and protect their ability to continue serving patients.
- Consider how engaging with officials may impact your credibility with both patients and decision-makers in your community.

3. Advocacy for Patients: When and How?

- Advocacy can take many forms, from directly negotiating for patient needs during a sweep to working behind the scenes on policy change.
- Consider whether on-the-ground advocacy—such as requesting time for patients to pack belongings—is feasible and safe, or if it might inadvertently escalate tensions.
- Some teams prefer to focus on long-term advocacy by engaging with city officials, submitting reports, or influencing policy without directly intervening in sweeps.

4. Providing Medical and Mental Health Support

- Many patients experience acute medical and psychological distress during sweeps, requiring rapid assessment and intervention.
- Consider whether your team has the capacity to provide immediate care during the event without compromising your ability to provide ongoing support afterward. Some teams may want to be present to respond to medical issues that arise; others may feel that the trauma and logistics of a sweep make it an unsuitable setting for a healthcare visit.
- If present, teams should be prepared to address trauma responses, provide emotional support, and assist with medical needs while respecting the patient's autonomy and priorities in the moment.

5. Logistical Support: To What Extent?

- Patients may need help with transportation, storage, or relocation assistance. However, unless a team has the infrastructure to offer meaningful logistical support, making promises that cannot be fulfilled may cause harm.
- If unable to assist directly, consider connecting patients with trusted resources and documenting where relocated belongings can be retrieved.

Ultimately, each street medicine team must develop its own approach to engagement during sweeps, balancing patient care, advocacy, and long-term program sustainability. A thoughtful, case-by-case approach ensures that teams provide meaningful support while maintaining trust and effectiveness.

Insights from the Streets

During encampment sweeps, street medicine teams, harm reduction workers, and other outreach services are sometimes misunderstood to be collaborating with law enforcement, particularly when they are present during enforcement actions. This perceived (or real) connection can generate mistrust among individuals experiencing homelessness, who may conflate these services with punitive and violent systems. As a result, some patients may become hesitant to engage with street medicine teams or outreach workers, even when in dire need of medical treatment or essential resources (e.g., water, harm reduction supplies). This experience can further isolate individuals living outdoors, heightening feelings of mistrust and increasing the risk that health and mental health needs will go unaddressed. Given this, it is critical that clear boundaries between healthcare providers and law enforcement are established and communicated to patients – before, during, and after a sweep.

AFTER SWEEPS

The aftermath of a sweep often leaves individuals disconnected, resource-deprived, and struggling to reestablish routines. For street medicine teams, this is a critical period to rebuild lost connections, provide necessary supplies, and restore disrupted care.

1. Locate displaced patients as quickly as possible.

- **Leverage Social Networks**: Work with known community leaders, peers, and informal networks to track the whereabouts of displaced individuals. Leave contact information and supplies with trusted figures in the community for those you cannot locate immediately.

- **Expand Outreach Efforts**: Conduct increased scouting rounds in possible relocation areas, including spaces that are more remote or isolated. Consider shifting schedules to do outreach at different times of day or night to find patients who have new habits or schedules.

    - Consider establishing "pop-up" service locations at predictable times and places where individuals know they can reconnect with your team. Spread the word about these services.

Searching for patients in Redding, CA (credit: Kyle Patton, Shasta Community Health Centre)

- **Use Integrated Databases**: Collaborate with other service providers, hospitals, law enforcement, and emergency shelters to locate displaced individuals using shared records, case management systems (e.g., Homelessness Management Information System), and/or by-name lists.

Insights from the Streets

"We are changing our schedules and doing more nighttime outreach as more people are now without set camps and looking for different places to lay down at night, which could change regularly. I think changing that changing the times you do outreach can be an effective strategy for finding people as they change their camping habits in response to pressure."

- *Kyle Patton, MD, Shasta Community Health Center (Redding, CA)*

2. Replenish critical survival supplies, including food, water, and harm reduction tools.

- Distribute survival supplies to patients, including hygiene kits, food, blankets, clothing, and harm reduction materials.
- Re-prescribe medications and work with pharmacies to address refills and insurance issues caused by displacement.
- Leave supplies at trusted community organizations or shelters for individuals to access if they cannot be located directly.
- Offer cell phones, SIM cards, or chargers to ensure individuals can reconnect with support networks and services. If this is not possible, allow individuals to use your phone to make critical calls to family, shelters, or employers.

3. Reestablish medical treatment plans and replace lost medications.

- Re-administer the HOUSED BEDS Assessment Tool based on the patient's new lived environment to assess for varied access to food, clean water, sanitation and supportive services.

- Reassess treatment plans to account for any changes in patients' living conditions or routines.

- With the support from pharmacists, leverage patient prescription assistance programs to cover specific medications that may have been lost during sweeps. For instance, individuals living with HIV may qualify for a one-month supply of free medications in emergencies involving the loss of their prescriptions. Proactively request this assistance from the pharmacist rather than wait for it to be offered.

- Contact individuals to reschedule missed medical appointments and provide transportation assistance if necessary.

- Provide information on the location of healthcare facilities, food, housing agencies, and other services near their new locations.

Insights from the Streets

"Having a relationship with a medical respite program can be particularly helpful during widespread encampment sweeps. We utilize admits into our medical respite program a lot during these times, as our patients' chronic illnesses commonly deteriorate, and they develop acute complications. This allows us to get them off the street for a period of time and stabilize them medically, while also trouble-shooting their relocation to a new camp location. This means we can maintain continuity of care, while also preventing hospitalizations and further truncated care."

- *Kyle Patton, MD, Shasta Community Health Center (Redding, CA)*

4. Re-establish trust and support patients to process trauma and grief.

- Create safe spaces for reflection and emotional processing, both for patients and team members.

- Demonstrate unconditional positive regard for patients, showing that their value and dignity remain intact despite the harm caused by the sweep. Reaffirm your commitment to patients through consistent follow-up care and presence.

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