6.08 Taking it to the Streets: Bringing Healthcare to the Most Vulnerable

2025 NATIONAL CONFERENCE ON ENDING HOMELESSNESS
June 30–July 2, 2025 Washington, D.C. #NAEH2025

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Street medicine meets people where they are – literally. This session explores how street medicine breaks down barriers of the traditional delivery system. Learn how street medicine can serve as a compassionate intervention and systems-change strategy to embed it into the broader health and housing systems.

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Tamika Braveheart

Clinical Research Nurse

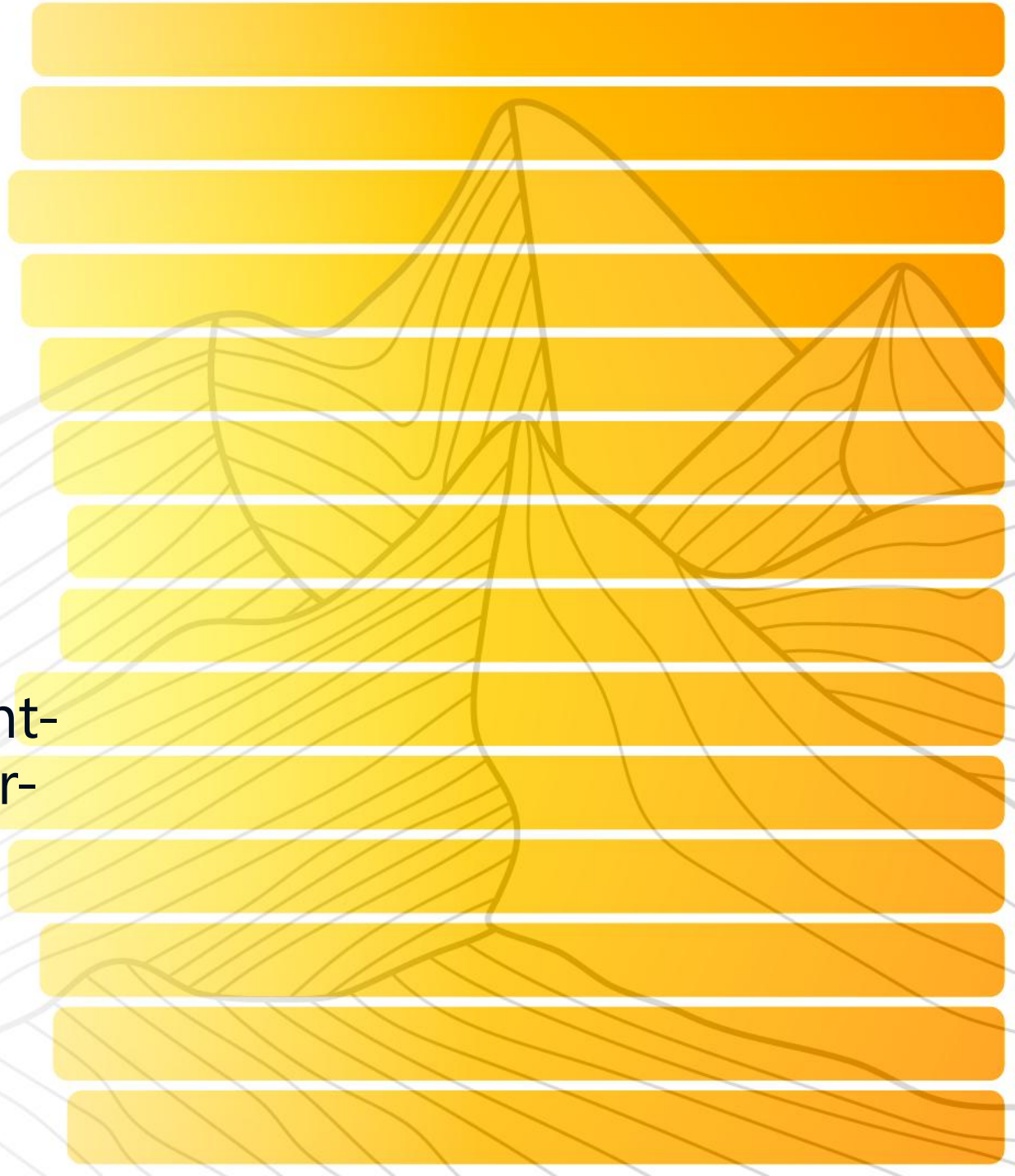
UVA, School of Medicine: Psychiatry and Neurobehavioral Sciences

The University of Virginia:

Street Medicine, Access, and Resource Team and Primary Care Clinics

Objectives:

1. Participants will understand components of UVA's Street Medicine, Access, and Resource Team (SMART)
2. Participants will understand patient-level resources required for shelter-based clinic
3. Discuss how easy it is to get fired!



Our "Why":
Acute and Chronic Conditions

TABLE 6. Conditions More Likely to Affect People with a History of Homelessness			
Condition	**Homeless Cohort**	**Comparison Cohort**	**Cohen's h**
Amputation (procedure)	3.4%	1.5%	0.1
Cerebrovascular accident (i.e., stroke)	4.3%	1.0%	0.2*
Chronic diarrhea	0.4%	0.1%	0.1
Alzheimer's disease	0.8%	0.3%	0.1
Dementia**	5.7%	1.9%	0.2*
Epilepsy	10.9%	3.3%	0.3*
Viral hepatitis	17.5%	3.4%	0.5*
Chronic hepatitis C	9.1%	1.9%	0.3*
Acute hepatitis	2.6%	0.3%	0.2*
HIV infection	5.8%	1.1%	0.3*
Injury of head	33.9%	15.2%	0.4*
Cirrhosis of liver	7.2%	1.9%	0.3*
Chronic obstructive lung disease	23.0%	10.6%	0.3*
Oral infection	9.0%	3.7%	0.2*
History of pneumonia	3.4%	1.5%	0.1
Tuberculosis	3.2%	0.8%	0.2*

NOTES:
* Indicates statistically significant difference.
** Dementia includes all dementias including Alzheimer's disease.

HH

The Haven
www.thehaven.org

- Serves breakfast daily
- Showers & Laundry available
- Manages the Homeless Information Line
  - 1st step for accessing any shelter or housing resource in Cville
- Administers rehousing or homelessness prevention funds
  - Funds are very constrained and tend to run out

Clinic Overview

- Services provided every Wednesday
- UVA students and staff are guests, not employees of The Haven
- Appointments and walk-ins
- Four specialties:
  - Primary Care/Family Medicine
  - Psychiatry
  - Addiction Medicine/SMART
  - Women's Health

SMART Team Composition

Medical

- Psychiatrist
- Resident/Addiction Medicine fellow
- Registered Nurse

Social Work

- LCSW
- Patient Navigator

Work-Flow

RN and Patient Navigator (initial)

- PN does an intake assessment
- RN assesses for medical needs; provides nursing care
- Link to Primary Care same day, future appts

Follow-Up

- Initiation of treatment for substance use disorder
- Psychotherapy
- Care coordination, linkage to outpatient care (beyond clinic)
- Housing, social service support

Program Outcomes

Patients that received care through SMART alone (06/2024-05/2025)

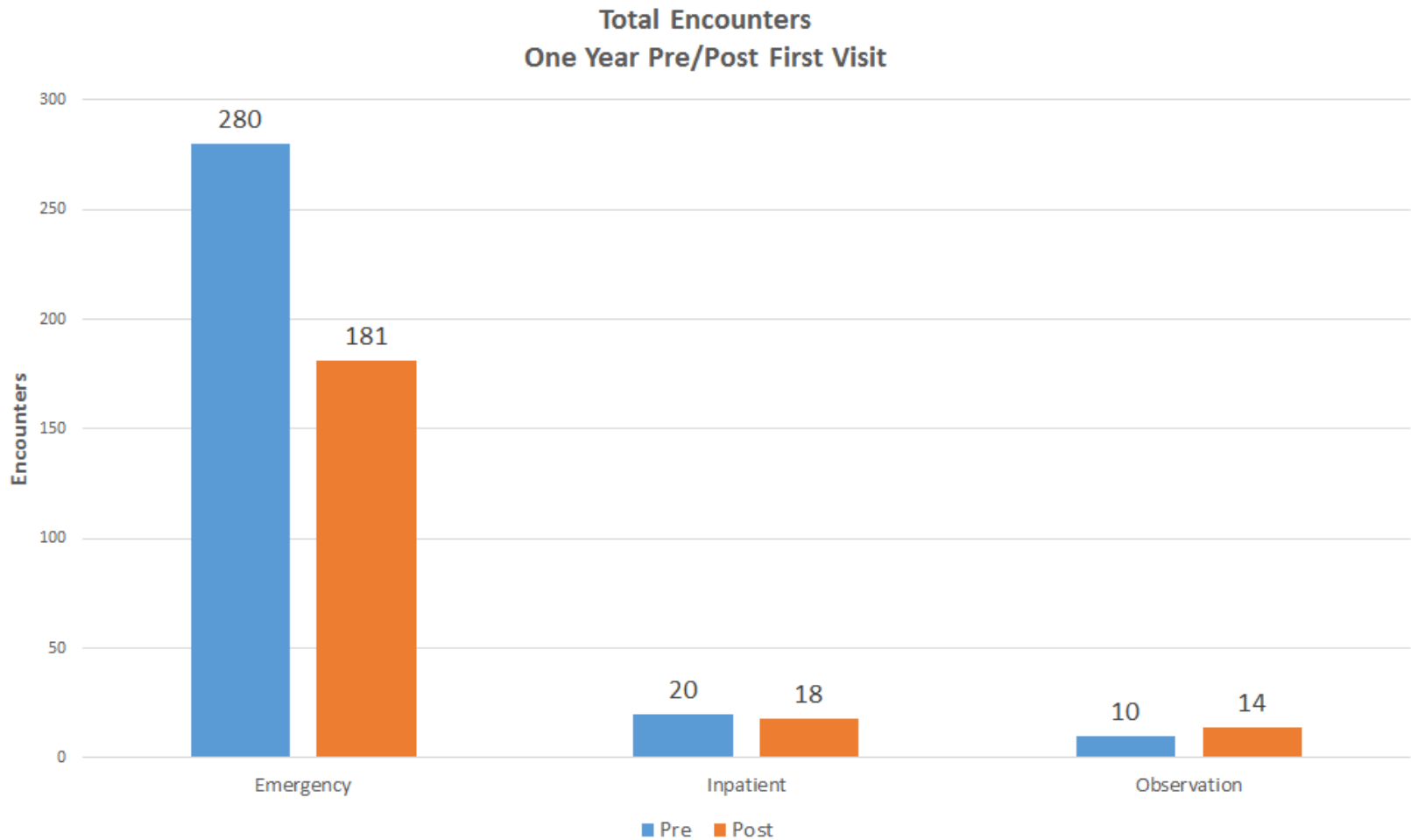
29	15	30*
Screened for Opioid Use Disorder	Treatment Initiated	Care Coordination

Ending Homelessness is Possible.

Program Outcomes

Patients seen on average on a clinic day

- Patient Navigation--17 (4 unique)
- RN services—12 (3 unique)
- Psychotherapy-- 2
- Medication Management—5 (at the shelter and hospital site)
- Initial appointment and intake for initiation of treatment--2


Total Encounters
One Year Pre/Post First Visit
Encounters
300
250
200
150
100
50
0
280
181
20
18
10
14
Emergency
Inpatient
Observation
Pre
Post

Case Study

Demographics

- Age range 25-60
- Unhoused
- Meth/Alcohol/Cannabis Use
- Undiagnosed psych disorder
- Symptomatic for sexually transmitted infections
- Symptomatic for chronic disease

Initial Visit

- Presenting problem discussed
- Disclosures, confidentiality, access to records discussed
- Care Coordination initiated:
  - Appointments w/provider
  - Financial screen
  - Patient education

Case Study

Input from SMART

- Attend outpatient appointments
- Education on medication
- Weekly sessions with pt
- Goal setting: health, social
- Challenges to navigate
  - Loss medicine monthly
  - Arrests
  - Inpatient psych, rehab

Other Resources

- Housing Coordinator
- Case Manager
- Psychiatrist
- Addiction med counselor
- School counselor

Case Study: Outcomes

Outcomes

- Guest is housed
- Started benefitted job
- Regular attendance at appointments→ more independence in care plan
- Not completely abstinent but decreased substance use

SMART Input One Year Later

- Meet twice monthly for coffee
- Guest reaches out for troubleshooting, only
- Continue goal setting and working on milestones

Lessons Learned

Community-Facing

- It takes TIME to build relationships with this community
- Health is one need of many
- Housing presents challenges for case management

Institutional

- Managing therapeutic relationship vis a vis clinical care can be labor intensive
- Students run primary care
- Takes time to gather evidence of "impact"
- Internal coordination is key

Taking it to the Streets: Bringing Healthcare to the Most Vulnerable

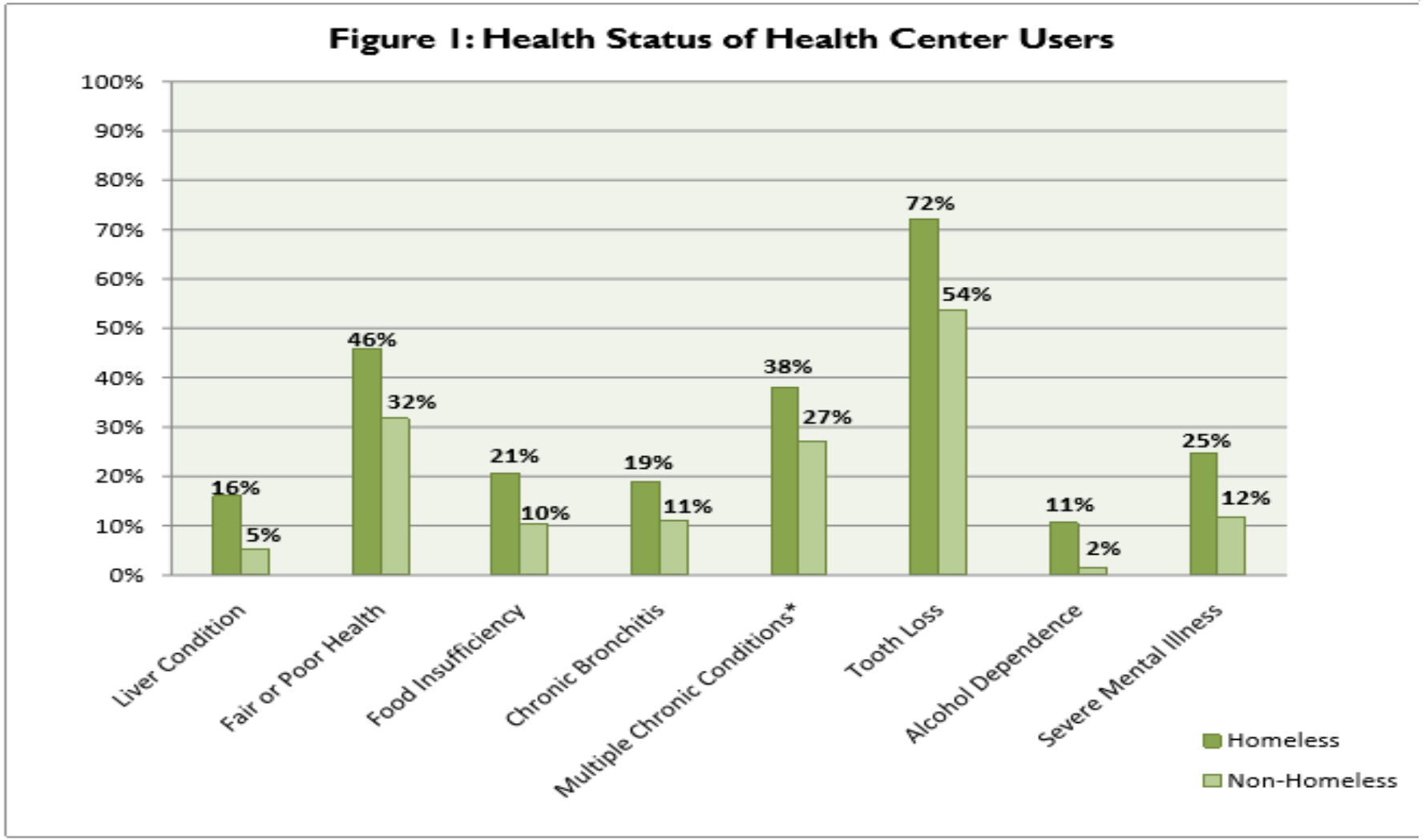
Brendyn Richards
Siouxland Community Health Center
Board Member at The Warming Shelter
Sioux City, Iowa/South Sioux City, Nebraska

Purpose:

Provide an overview of the unique health-related challenges of persons who are homeless and highlight opportunities to improve health care and health outcomes for this population.

2022 Nationwide Health Center Patient Survey

Conducted by the Health Resources and Services Administration



*Note: Multiple chronic conditions include (2 or more of the following): hypertension, diabetes, asthma, emphysema, chronic bronchitis, heart problems, stroke, liver condition, weak/failing kidneys, cancer, and HIV/AIDS.

Effects of Homelessness on Health

1

Homeless individuals are twice as likely to have had an Emergency Room visit within the last year than their housed counterparts.

2

More than 1 in 3 people experiencing homelessness report multiple chronic health conditions.

3

Average life span of a person who is chronically homeless is 15 years less than their housed counterparts.

Chronic Medical Conditions

Poorly controlled hypertension

Poorly controlled diabetes

Chronic pain

Emphysema / bronchitis

Seizures

Infectious Diseases

Pneumonia

Infestations (body lice, scabies, bed bugs)

Tuberculosis

Hepatitis C

HIV / AIDS

Sexually Transmitted Infections

Homelessness and the Health Care System

Emergency Department Use by Homeless Individuals

Emergency Room Visits (Unity Point and Mercy One hospitals in Sioux City, IA (2020-2024)

0 visits:	189 (35%)	
1 visit:	102 (19%)	
2-3 visits:	109 (20%)	
4-5 visits:	89 (16%)	
25-50 visits:	36 (6%)	= 1,016
51-75 visits:	10 (1.8%)	= 475
76-100 visits:	5 (0.09%)	= 364
101-125 visits:	2 (0.03%)	= 250
44 individuals (7%) = 2,105 visits		

Principles of Clinical Care for Patients who are Homeless

- Patient-centered care
  - Trust & listening
  - The patient's top concern, not yours
- Acute vs. Chronic (unmanaged) vs. Chronic (managed) conditions
- Collateral history from clinicians and pharmacists
- Promote continuity of care
- Understand the person's life situation

Mobile Showers

- 2024 Final Statistics:
  - 55 shower dates
  - 27.74 average attendees per session
  - **1,526 total**, 1,123 male, 403 female
- Showers were on Monday, Wednesday, and Friday from 1-4 pm
  - *Highest previous year: 803 (596 men, 207 women) 18.6 average per session*
  - *2022 in the last year of use: 443 total, 345 men, 98 women, 11.97 average per session*

Mobile Showers-2025

- 2025 Statistics (to date):
  - 5 shower dates
  - 29.2 average attendees per session
  - 146 total, 113 male, 33 female
  - 23 tested for HIV/HepC by Team 8 staff
  - We started this year's Mobile Health Services at shower sessions on 6/16. We will have services on Monday's shower dates

- Schedule: We hold showers on Monday and Thursday from 1-4 pm
  - In 2024 we provided 1,526 total with an average of 27.74 per session

Services at the Mobile Shower—

Monday and Thursday's, 1-4:30 pm, May 1st-October 20th

- Three Shower unit
  --We provide all toiletries--
- New clothing provided by our Foundation
- Meal and water
- Medical Tent for those that aren't comfortable in the Mobile Clinic/HIV & HepC testing provided
- Mobile Clinic

City of Sioux City-Neighborhood Services

- Check individuals/intakes for Coordinated Entry
- Vital document assistance

U.S. Department of Veterans Affairs

Veterans Affairs Homeless Program

- Conducting coordinated outreach to proactively seek out Veterans in need of assistance.

SAVE THE DATE

Virtual Capitol Hill Day:
September 17

National Alliance to
End Homelessness

ENDHOMELESSNESS.ORG

TAKE ACTION TODAY

Prepare to take action and sign up for our Advocacy Alerts.

National Alliance to End Homelessness

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