Maintaining Solidarity with the Street and with Each Other: A Guide to Street Medicine Practice in Cities with Multiple Programs

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"No one owns the streets, but we all own the responsibility for caring for those on the streets," is a street medicine maxim often repeated when organizations seek to serve people experiencing unsheltered homelessness (PEUH). When multiple organizations within a city serve the street population, this maxim can remind us of where our energy should be directed: to the people. Their well-being is a shared responsibility, not an arena for competition. Indeed, working in solidarity with those on the streets and with other organizations is inherent to the deep values of street medicine practice, the direct delivery of healthcare to PEUH in their lived environment. We are direct witnesses to the systemic violence, exclusion, and fragmented care that those living on the streets have experienced. If street-based programs cannot work in harmony to create a shared environment of trust and collaboration, we risk further traumatization of this valuable population.

This paper aims to provide guidance on how multiple street medicine programs can use the social teaching of street medicine to solve the challenges inherent to geographic coverage, continuity of care, and service optimization with more than one organization in the same space. It is written with our collective 45+ years of experience in watching the operation of over 100 street medicine programs and the observation that while some flourish, other fold and while some grow into the street, many others retreat.

The Social Teaching of Street Medicine Applied

The social teaching of street medicine guides how our common values of love, respect, and solidarity manifest in action with practical application. Love, respect, and solidarity honor the humanity and dignity of PEUH and speaks against viewing them as an object to be owned in the current healthcare culture of possession. Through assignment to a patient panel, a particular demographic, or their physical presence in a geographic region, patients are often dehumanized to represent a simple metric on a spreadsheet that can be owned or traded. Honoring our common values places PEUH as the leader of the team with us in service, rather than viewing them as tools to meet our metrics or program goals. Those we serve must be the subject, and not the object, of their own journey.

Love, respect, and solidarity uphold a person's right to choose where, how, and by whom to receive their healthcare. As with a housed patient, the decision to establish care or change care providers lies with the patient, and it is our responsibility to honor their choice by avoiding coercion, or worse, starting with the assumption they lack the ability to choose. This trust in the people, honoring their humanity, autonomy, and dignity, is necessary for their liberation from structural violence. In this way, we avoid trading one oppressive system which forces them into inaccessible brick-and-mortar clinics, with another that dictates which street medicine services they can access. While the legal classification of lacking capacity is true for some patients who suffer from mental illness, substance use or cognitive impairment, population-based assumptions that PEUH cannot be trusted to determine who, when and where to receive care is rooted in mistrust of the people and further dehumanizes them. It is contrary

to the social teaching of street medicine. It's the responsibility of organizations to clearly communicate who they represent and the scope of services they offer.

The "Continuum of Continuity"

When a street medicine program exists in a city, "continuity of care" becomes a topic of interest with the goal of preserving existing relationships with care providers in the clinic and on the street. Unlike brick-and-mortar clinics where patients willfully enter a building seeking care, street medicine providers often seek out people who may need care and will inevitably meet someone who has an established care provider. Rather than focus on "continuity of care," as expressed in a system-centered model where repeated visits are a measure of success, we advocate for continuity of a values-based relationship. PEUH deserve this not despite of, but because of, their living situation. It relies on the mutual desire to continue the relationship. The best way to gauge the existence of this relationship is to ask the PEUH, "Do you have a care provider, or someone helping you with your healthcare?" If the answer is yes, further questions should be aimed at their desire and ability to continue that relationship. When patients are in a values-based relationship, (e.g., "Yes, they come to see me every Thursday and I love them.") the human connection between patient and provider is evident and the street medicine provider should yield to the previous team. However, other times the response indicates there lacks a values-based relationship (e.g., "yes, but they're jerks,") and further inquiry about their desire to switch is appropriate. Often, PEUH will identify their primary care provider, but further discussion reveals the provider is not actually accessible due to distance or other factors. On street rounds in Rome, Italy, a PEUH said they had a care provider. Upon further questioning, the physician was in Sweden, they hadn't been seen in 25 years, and the person had no plans to return. While this is an extreme example, people have frequently relocated across the cities, or between counties, and are unsure if they will ever return. With this understanding, the primary goal is to establish if the person feels cared for and the probability of returning in a reasonable time.

It is also important to develop an awareness of how the culture of possession erodes our commitment to values-based relationships. A provider may feel that having a whole chart dedicated to a patient in the electronic medical record gives the provider, not the patient, the first right of care refusal. On the contrary, the patient should drive the continuity of the relationship. If a cognitively intact patient says they do not have a care provider, several things should be considered. First, if the provider feels they have cared for a patient, but the patient denies this relationship, there is a void of connectedness that may be better filled by another. Second, a patient my hesitate to admit to an existing primary care relationship either due to the natural instinct to protect their privacy, confusion about their status with the provider, or even a survival strategy to see if you will offer something new. Honoring the patient's answer at face value is critical and services should be offered when a patient states they do not have a care team. It is important to maintain a non-judgmental attitude about the "layers of honesty" and recognize that, as is common with all relationships, more information may unfold as the relationship deepens. Demonstrating love, respect, and solidarity as drivers of the interactions, rather than requiring the patient to fit into a pre-determined healthcare box, will ultimately create the trust needed for effective, collaborative street medicine care.

Lastly, it's important to speak to charity models of care where the system insists, and the poor begin to accept, that something is better than nothing and they should, "take what's given to them." This can be seen when volunteers, student groups, or clinics less invested in the mission, offer services a few times a month, no way to access providers between visits or after hours, or are subject to constant rotations of different providers each visit, all things which would be unacceptable for a traditional clinic. This approach creates wider healthcare inequities and patients might forgo ongoing primary care believing they are worthy of this intermittent care or will be further traumatized by the system and avoid care altogether. Organizations should aim for equity and solidarity where people who need more, like PEUH, get more. Organizations practicing intermittent medicine should become deeply introspective about the care they're providing, the true benefit to the patient, and consider teaming with those providing more consistent care on the streets.

Loaves and Fishes: Feeding the Hungry or Duplicating Services

In the famous Gospel story, Jesus and the disciples are given seven loaves of bread and a few small fish to feed the multitude of people. Would an eighth loaf be refused as a "duplication of service" since seven already existed? Similarly, the existence of more than one street medicine program in a city, or section of a city, should only be seen as a duplication if a confident statement can be made that the need is **fully** met with a similar breadth, depth, and scope of practice being delivered on the street. For example, if an organization is offering urgent care services without a concerted effort to follow over time with necessary medications and laboratory work required to treat chronic disease, this is not a duplication with an organization which is able to provide a higher level of care. Both should communicate this clearly with each other and with patients. Four main strategies are suggested as a framework to conceptualize how organizations can work together to meet the need of the people. These can, and will likely, coexist within one city. The pros, cons and suggestions for success are illustrated in Tables 1-4.

Table 1

Division by Geography	
Description	- Organizations mutually agree to divide the city by geographic regions. - Contributing factors can be brick and mortar clinical location, community partner coverage area, or other strategic partnership
Pros	- Ability to focus on smaller areas to provide a higher level of care - Less risk of duplication - Allows for fostering tight relationships with community partners on a local level
Cons	- Patients move across geography - Variation in scope of practice between organizations resulting in inequitable care across geography - Risk of turf war or "ownership" of the streets
Keys to Success	- Clear communication when patients change geography - Avoidance of desire to own territory, but work in collaboration for what is best for patients in the area - Careful consideration of what is means to "cover" an area (e.g., 2 days per month vs 2 times per week are not equal)

	- Realistic assessment of scope of practice relating to coverage (providing urgent care only vs full scope primary care) with goal of equity (e.g., if one organization only provides urgent care, another can come in for primary care) - If an area is fully covered with primary care, adding urgent care can fragment care. If co-existing, communication of scope to patients and each other is key.

Table 2

Division by Service Line	
Description	- Organizations provide different types of services. - Examples include urgent care vs. primary care; hospital-based consult service, HIV care, MAT or other unique offerings
Pros	- Maximizes level of care offered - Fosters collaboration without ownership as each play an important but different role - Optimizes skill and resources in specialty areas
Cons	- Risk of fragmenting care if services offered by different organizations with different documentation platforms - Relies on highly effective communication - Patients may be unclear that each street team is offering something different
Keys to Success	- Communication on patient level essential - Communication on administrative level for pathways to share patient information and insurance coverage

Table 3

Freedom of Choice	
Description	- Includes areas where more than 1 organization wants to cover and clear divisions based on geography or service type don't exist - Patients decide which organization is the best fit for their needs
Pros	- Least restrictive - Allows provider independence to cover areas of perceived need as other medical specialties aren't restricted on where they can practice - Allows patient choice on where and by who they receive care similar to the choices we all want - Competition can inspire improvement - Over time, programs will practice where they are needed most
Cons	- Can lead to competition rather than collaboration - Risk concentrating services in some areas, while ignoring others - Risk patient confusion if organization affiliation and scope of practice not clearly communicated
Keys to Success	- Best to coordinate coverage and services offered prior to launch or expansion to avoid unnecessary competition at detriment of patients - Ego must be removed when trying to cover large or highly publicized areas - Must determine true need and realistic ability to cover area

Table 4

Join Forces	
Description	- Multiple organizations collaborate either formally with a backbone organization or through memorandum of understanding, or informally through care coordination meetings
Pros	- Allows different teams to monitor the person more often - Allows the PEUH to respond to those doing street medicine work more fluidly - Reduces the rigidity of ownership - Adds other perspectives, skills and resources
Cons	- Risk lack of coordination or care and fragmentation if communication is lacking - Risk confusion by PEUH
Keys to Success	- All must buy into collaboration - Ego and ownership must be removed or can devolve - Relationships between organizations clearly defined (union with back bone organization or confederation to foster collaboration) - Recommend meetings separated between patient level and administrative levels to allow both to have adequate attention

Coordination Strategies

In the same spirit in which we apply assertive, active engagement in the development of a values-based relationship with patients, our approach to coordination of services should be similar. For any strategy to work, it is essential that programs get to know each other. Organizations should reach out to each other to formally introduce each other's mission, philosophy, and services. Ideally, members from one organization should tour the other organization and join them on street rounds. Exchanging contact information and creating group messages will allow programs to alert others of needs on the street. However, unless patients have signed an agreement for sharing personal information, HIPAA privacy must be respected. It is also not unusual for programs to protect information such as camp location or real name if the patient is uncomfortable with that information being shared. This preference can be honored by meeting the patient in a neutral location first. Some programs will create formal relationships for information sharing, but patients must still be informed in each case. Beyond these daily, organic communications, we recommend regularly scheduled meetings that are highly effective to coordinate care and build a sense of shared values, ethics, and solidarity.

Care coordination typically takes place in two forms- one directed at coordination of individual care, and one directed at non-patient focused issues. One example of individual care coordination structure is the weekly medical meetings in Pittsburgh. Three street medicine organizations have signed HIPAA agreements and discuss the most vulnerable patients every Tuesday. A second level of coordination are weekly meetings in which all the organizations (medical and non-medical) meet every Monday to review a spreadsheet of all known PEUH. These meetings do not share any HIPAA protected information. The primary focus is to have an active list (for at least the past 6 months), to identify those who still need to register for coordinated entry housing, and anyone who has urgent needs (the details of which can be shared offline following proper privacy guidelines). Meetings to identify locations that warrant caution due to danger or sensitive issues, any recent deaths (which are recorded for patterns

and the annual memorial service), city evictions and new patterns of street drugs. In larger cities like Los Angeles, such meetings would focus on smaller geographic sections of the city.

The second type of care coordination should take place monthly to cover non-patient topics such as political issues, grant opportunities, projects, and advocacy initiatives. Meetings like this exist in both Pittsburgh and Los Angeles. It's recommended these meetings take place monthly and contain a diverse group of individuals including people with lived expertise in homelessness and active street medicine providers, as well as leadership and administrators. A host organization should be chosen to organize the group who can be trusted to further the priorities of the group rather than their own organization. Because of the diversity of attendees, time should be set aside for education. For example, administrators benefit from hearing about how policies are working during implementation, and providers from learning about new policies in development. This group should be inclusive of organizations doing street medicine, interested in street medicine, and non-medical organizations interested in furthering the mission. Important topics to cover include the authentic definition of street medicine and how it's applied, how healthcare policy is interacting with the street, such as gaps between benefit eligibility and access, and effective integration of homeless social services and healthcare. The aim of the meetings must continue to focus on the shared mission to serve PEUH and solidarity with each other.

Fluidity and the healing journey: autonomy

Street medicine practitioners quickly learn that every person living on the streets is a unique and sacred human being. One could argue that their uniqueness - and the characteristics of a rigid society – have interacted so that the streets are the only immediate option. The PEUH is one of the most diverse one will ever encounter. Each will have their own survival strategies and healing journey that must be respected. What works for one person will not necessarily work for another. Within a specific street medicine program, it is essential to develop diverse staff and services to offer opportunities for the most PEUH to find their preferred relationships and options. In a city with multiple street medicine programs, each will have their own character and staff variety. Ideally, when multiple programs work fluidly together, this maximizes the autonomy of PEUH to choose what suits them best. Such preferences can change over time and PEUH are then able to switch to another person or program without a sense of abandonment, mirroring freedoms held by a housed population in choosing their own healthcare.

Politics and motivations explored

It is worthwhile to frankly discuss some of the real and sometimes less pleasant factors one will likely encounter when multiple agencies serve the same PEUH. A full discussion is beyond the scope of this paper but acknowledging how the political forces can shape the landscape is important.

Street medicine is difficult, but street medicine is also very sexy. Many who enter the work initially do not have a fully developed sense of balance and are seeking something in the work that has been lacking in their previous lives. This is natural but needs to be tempered with the

fact that this work is not about us but about those who are suffering and dying on the streets. The intensity of the work can sweep people up like a drug. New street medicine practitioners should be mentored and counseled by experienced street medicine team members who may be inside or outside of the sponsoring organization. One of the recognized side effects of the intoxication of street medicine is a sense of ownership and jealousy for the relationships on the streets. When someone begins to use such phrases as "my people", it can be a red flag. Such street medicine initiatives require care and patience for collaboration as there is also danger for experienced programs to take a similar ownership stance in protection of "their people." There is also the "Robin Hood" phenomenon, in which (usually newer) street medicine practitioners process the injustice they witness and galvanize their vision behind an oppositional, avenging stance towards any other group who is already established but not responding adequately to the plight of those on the streets. Deficits, inadequacies, and injustice must be brought to the light and addressed, but a constant divisive attitude towards all other agencies is contrary to solidarity. Fortunately, many practitioners usually develop a more functional and mature attitude over time but erosion of the collaborative spirit between teams can have long term effects for the patients we ultimately serve. When working with such individuals and programs, it is worth not responding negatively, but focusing on positive opportunities. The grace we model is another core value for the healing of not just our relationships with PEUH but also for the healing of the larger community.

One prevalent driver of divisiveness between street medicine teams is the struggle for financial survival. Unlike paramedic and fire departments, we are generally competing for sources of funding. This can lead to friction, paranoia, and conflict. While such competition is a reality, there are still meaningful ways to work together. Shared grants that improve and expand services are a good example. Once this precedent is established, it can generate a positive reputation within the funder community with street medicine organizations working for better collaboration. Presenting together to the public and giving credit for each other's work establishes a unified vision and can encourage funders to give more. Street medicine has the advantage of being a compelling example of service if we work together to raise awareness.

Parent organizations may not necessarily share the same warm feelings for each other that their street medicine programs share with other street medicine programs. Being mindful of such dynamics is important when protecting our street medicine relationships.

When reflecting on the power of being recognized within the larger community as the program that "really walks the walk" and "goes to the people" (the Mother Theresa effect if you will), we must be mindful of that power. Many have likened it to the One True Ring in the Lord of the Rings Trilogy. The public recognition, financial support and political clout can be intoxicating. We must resist the temptation once again to make it about ourselves but direct the focus on those we serve – and the vision of a collaborative healing community.

Applying the Social Teaching of Street Medicine to Each other: Love, Respect and Solidarity Among those in the Movement

Street medicine is a small global movement and the same love, respect and solidarity we show our patients is applied to each other. The act of street medicine is subversive of oppressive systems. We are working against powerful social, financial, and political forces that would

perpetuate that oppression. If we are in conflict with each other, we undermine the hope of justice for those we serve. Cities with more than one organization operating have an opportunity to synergize their work for the benefit of PEUH. Indeed, our unity itself can be a challenge to the rest of the community that we reject the forces that lead to exclusion, apathy, hate and selfishness. Wherever street medicine is practiced in the world, we have seen how it activates the imagination of those who believe in its underlying values. It is a challenge to those who do not follow the path of love, respect and solidarity with our sisters and brothers on the streets. We MUST remain united, treating each other as we treat those we have the privilege of serving on the streets.

The purpose of the Street Medicine Institute is to support unity and meaningful connections within the movement. We are available to help if needed. Remember, no one owns the streets, but we all own the responsibility for care for those on the streets.

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