Street Health Field Manual
FY 2022-2023

Alameda County
Health Care for the Homeless

TABLE OF CONTENTS

TABLE OF FIGURES

I. Introduction

The Street Health teams comprise one component of a larger service delivery system, funded by the Alameda County Health Care for the Homeless (ACHCH) program. The ACHCH program provides a continuum of clinical and social services for homeless individuals and families throughout the County's geographic regions.

The purpose of this field manual is to furnish a reference tool to assist Street Health team members in using a consistent approach to providing quality clinical care and enabling services to unsheltered residents of Alameda County. All Contractors and ACHCH staff involved in Street Health must review this field manual as part of their orientation process. ACHCH leadership expects all Street Health staff to use this manual as a guide for their daily operations and to ensure that they are using 'best practices' in each of their areas of expertise.

There are four sections in the Street Health field manual. Section I provides a brief overview of the ACHCH program --- our mission, vision, and code of ethics. Section II contains an overview of the Street Health program including definition of terms, targeted geographic areas, program design, staffing the Street Health team, key elements of the service delivery system, and quality of care. Section III focuses on general operations including community engagement, site selection and schedule maintenance, field logistics, patient confidentiality, and staff safety. Section IV covers the Street Health teams' meeting structure.

II. ACHCH Organizational Overview

ACHCH is part of Alameda County Health Care Services Agency, under the Office of the Agency Director and situated within the Office of Homeless Care and Coordination. ACHCH has provided services to homeless individuals and families since 1987. The mission and vision of ACHCH is described below.

MISSION: *Our mission is to improve the health of Alameda County residents experiencing homelessness by ensuring access to culturally informed, whole-person health care and housing services.*

VISION: *We envision a just society where all persons have access to quality health care and housing. We believe the problems of homelessness and health inequities can be solved.*

ACHCH leadership acknowledges that homelessness work can contain grey areas in professional practice as it is a significant human experience requiring service providers to frequently reassess their adherence to ethical goals/approaches that are in constant use in the field. Licensed providers have access to professional associations that have clearly articulated codes of ethics. For example, the National Association of Social Workers (https://www.socialworkers.org/) and the American Nurses Association (https://www.nursingworld.org/) each have a code of ethics on their website for review by their members. Street Health teams also adhere to a code of ethics and conduct used by their respective organizations. ACHCH staff uses its own core values and operating principles to

inform the standard of conduct. ACHCH and its Contractors are each responsible for documenting their best practices for creating professional boundaries between staff and patients.

III. Program Overview

There are several programmatic approaches and models that both government agencies and community providers have utilized to conduct outreach and deliver an array of services to homeless individuals. ACHCH leadership has reviewed the literature, interviewed experts and key stakeholders, and participated in a symposium to develop the current nurse-led model that Street Health teams implement (see Reference R-1 for a copy of Alameda County Care Connect *Street Medicine Symposium White Paper*). Figure 1 describes the Street Health program goals that all teams strive to complete. These goals frame the strategies and interventions that Street Health teams employ to carry out this important work.

Figure 1: ACHCH Street Health Program Goals

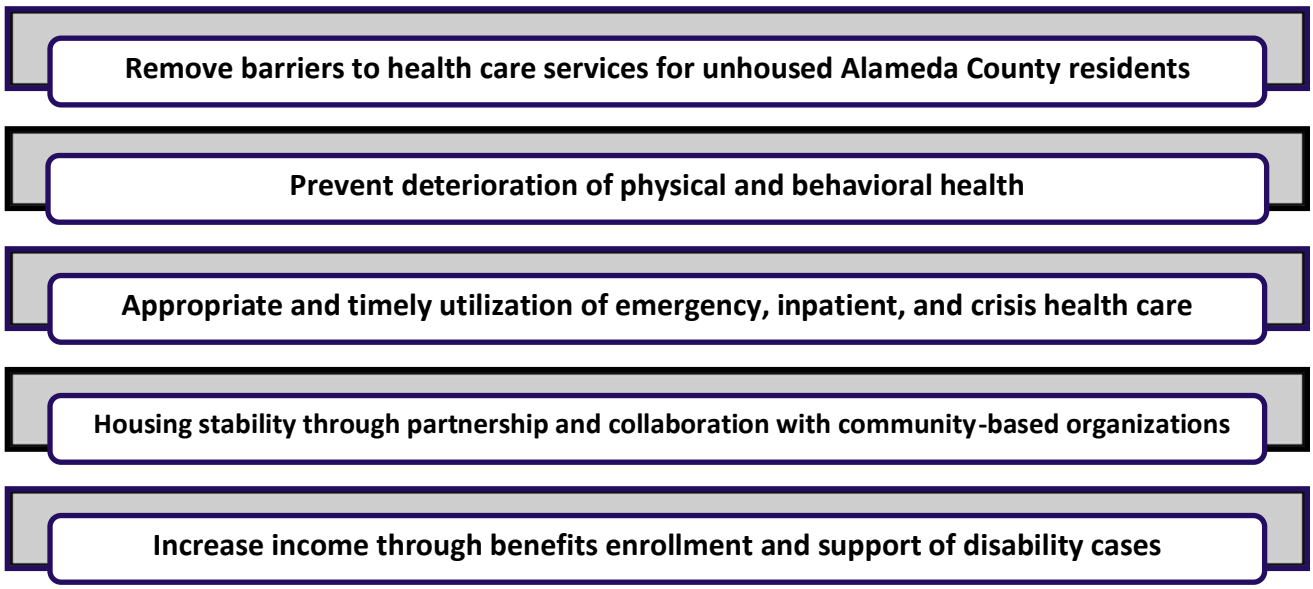

Figure 1: ACHCH Street Health Program Goals

A. Definition of Terms

This section defines key terms that affect program implementation and evaluation.

Care Plan: The Care Plan is co-developed by the patient and Street Health team member(s). The plan should include patient goals and priorities, strategies to meet identified needs, and an agreed-upon action plan. (source: Health Care for the Homeless Clinician's Network https://nhchc.org/adapted-clinical-guidelines-2/ , "Adapting Your Practice")

Enhanced Care Management (ECM) services: is **a new benefit for Medi-Cal members**. ECM is part of a five-year plan to transform Medi-Cal via California Advancing and Innovating Medi-Cal, also called CalAIM. This benefit helps Alliance members with complex needs coordinate their care.

HealthPAC: County program that provides affordable health care to uninsured Alameda County residents. Eligibility requirements include: residence in Alameda County, income up to 200% of the Federal Poverty Level (FPL), not eligible for Medi-Cal, and not enrolled in private insurance. Citizenship is not a requirement. (source: http://www.ACgov.org/health/ documents/ HealthPACbrochure-en.pdf; "What is HealthPAC?")

Health Care Service Visit Types

Clinical:

- A clinical visit is provided by a licensed medical, dental, or mental health provider, and documented in provider EHR
- Must include at least one ICD10 code
    - *Note: An ICD 10 code for a Clinical service visit is not required to be a billable diagnosis code; however, a non-billable ICD 10 code for a Clinical service visit should only be used when a patient encounters health services for some specific purpose, such as to receive limited care or service for a current condition (i.e., it cannot be a secondary Z-code like Z59.0 [homelessness]).*

Enabling Services:

- Non-clinical services provided by a credentialed provider, such as a Community Health Outreach Worker and Social Worker, that support and assist the delivery of health care services and facilitate patient access to comprehensive care, including social services.
- Must include a valid Enabling Services type descriptor. See Appendix I for Types and Definitions of Enabling Services.

Health Homes Program: The Health Homes Program (HHP) is designed to serve eligible Medi-Cal beneficiaries with complex medical needs and chronic conditions who may benefit from enhanced care management and coordination. The HHP coordinates the full range of physical health, behavioral health, and community-based long-term services and supports (LTSS) needed by eligible beneficiaries.

Housing Readiness Documentation: The documentation required to support an individual with accessing HUD funded Permanent Supportive Housing which include: Verification of Homelessness that meets program eligibility requirements (Literal or Chronic); Verification of Disability; Government Issued Identification; Social Security Card.

Housing Resource Center (HRC): Network of community agencies who provide core services to homeless individuals. HRCs provide Coordinated Entry System (CES) assessment for individuals residing within defined geographic regions.

Learning Community Meeting: Bi-monthly meeting to foster shared learning across teams, provide standard trainings, case consultation, technical assistance, and quality improvement/assurance guidance.

MAT: Medication Assisted Treatment utilizes medication to treat substance use disorders. Examples include: buprenorphine, methadone, and naltrexone.

Medi-Cal: California's Medicaid health care program for low-income individuals.

Medical Home: Clinic where a patient has been assigned or selected to receive health care services. Care is provided by a multi-disciplinary team with providers coordinating care across the health care system.

Medicare: Federal health coverage for persons 65 years of age and older and persons with permanent disability.

Basic Needs Screening/Care Plan: Standardized ACHCH form to assess patient basic needs and track patient basic need goal priorities and fulfillment.

Patient: An individual who has "consented" to receive Street Health services and has a minimum of one face-to-face encounter with a team member within the past 60 days.

Primary Care Provider (PCP): Patient's assigned medical provider at Medical Home.

Prospective Patient: Individual who has been provided information about Street Health services including engagement tools (e.g., hygiene kits, safe injection kits, snack packs, etc.) but has not consented to receive more comprehensive services.

Triage Nursing Assessment: The Triage Nursing Assessment offers a baseline RN assessment for consented patients who do not have an active medical home as identified in the Basic Needs Screening. The Triage Nursing Assessment may be completed over multiple encounters and is considered complete once all components have been assessed.

Substance Use Disorder (SUD): Recurrent use of alcohol and/or drugs that causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities.

Unsheltered: Unhoused (homeless) persons who live in places not meant for human habitation; these individuals are prioritized for Street Health services.

B. Assigned Geographic Areas

Each Street Health team is assigned a geographic area in Alameda County (see figure 2a). Geographic areas are selected based on density of homelessness by Census Tract.

Interactive map:
https://www.google.com/maps/d/edit?mid=1vA3PCKMf2uCdzBQO0JQZkc9m8VTOvwYt&usp=sharing

Figure 2: Zones and Regions of the Street Health Teams

Zone	Region
1	East County: Tri-Valley cities and unincorporated
2	South County: Fremont and Newark
3	Hayward and part of unincorporated county
4	Unincorporated county and parts of Hayward
5	San Leandro and Alameda
6	Deep East Oakland
7	East Oakland Corridor
8	East Oakland
9	Downtown Oakland
10	West Oakland
11	North Oakland
12	Emeryville and West Oakland
13	Downtown and South Berkeley, and part of North Oakland
14	North and West Berkeley and Albany

Figure 2: Zones and Regions of the Street Health Teams

Figure 3: Geographic Regions of the Street Health Teams

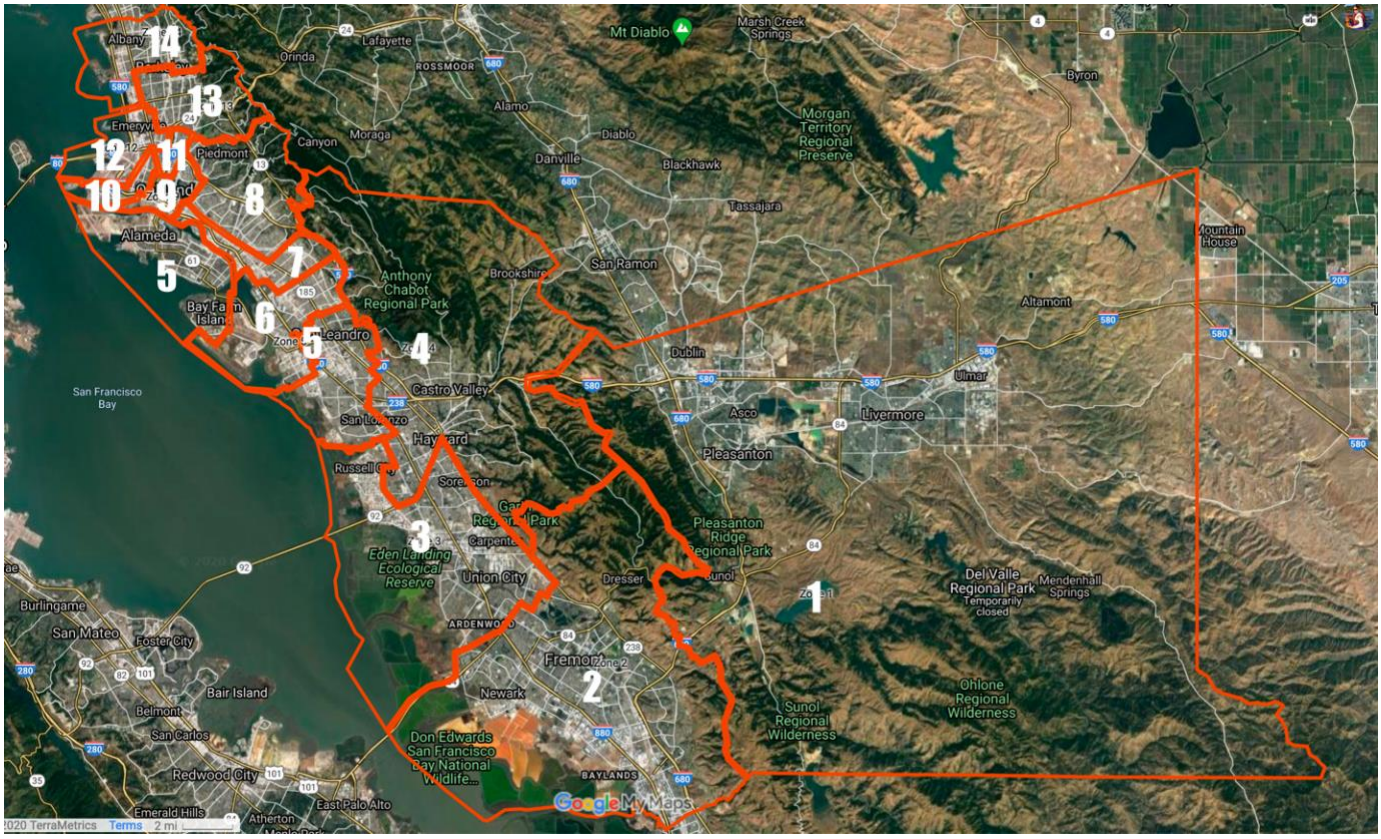

Figure 3: Geographic Regions of the Street Health Teams

C. Program Design

Alameda County's Street Health Outreach model is comprised of the following program design elements (see figure 3):

- **Development and Maintenance of a Consistent Site Schedule.** Street Health teams develop and maintain a consistent schedule for each site and submit a monthly schedule to ACHCH. Team members build trust and rapport with unsheltered homeless individuals to promote increased attendance and participation at scheduled sites.

- **Street Outreach and Patient Engagement.** Street Health teams focus outreach on the broader population within an encampment or location (e.g., Safe Parking site, Navigation Center) and work to engage and build patient trust on community and individual levels. Engagement is progressively increased as rapport is established and those identified with higher needs are connected to appropriate team members for more intensive services.

- **Assessment and Triage of Basic Medical Needs in the Field.** Initial assessment of patient health needs is conducted in the field. Street Health teams support patients to establish meaningful connection with an assigned primary care, brick-and-mortar medical home selected by the patient. Individuals with high needs are prioritized with intensive visits and services to improve health and housing opportunities. Street Health teams have access to clinic-based medical back-up.

- **Targeted Medical Provider Outreach.** Street Health teams are supported by 0.3 FTE of medical provider (MD/NP/PA/DO) time. Teams develop workflows to identify highly-vulnerable patients whose situation warrants the use of this limited resource.

- **Collaboration and Partnership.** Street Health teams support collaboration and coordination across a variety of outreach providers by sharing available information on scheduling and services with fellow providers including Street Health teams, Coordinated Entry Outreach teams, Alameda County Behavioral Health (ACBH) Mobile Outreach, and the ACHCH Mobile Medical Unit. ACHCH works with Street Health teams to foster increased communication with County and Community Based Organization partners including ACBH Crisis Response teams, Housing Resource Centers (HRCs), Substance Use Disorder treatment providers, Legal Service providers, Social Service Agencies, and Probation and Law Enforcement.

Figure 4: ACHCH Street Health Program Design Elements

Figure 4: ACHCH Street Health Program Design Elements

D. Staffing the Street Health Team

The staffing model for the Street Health team includes 1.0 FTE Registered Nurse, 1.0 FTE Community Health Outreach Worker (CHOW), 1.0 FTE Social Worker, 0.3 FTE Provider (MD/NP/PA/DO), and at least .10 FTE Program Manager. Each Street Health team member has an agency job description and should read their job description carefully so they may use it to guide their work. See below for a list of the most important tasks and responsibilities for each position (see Appendix 'A' for sample job descriptions for Street Health positions).

- **Registered Nurse**
  - Approximately 60% field-based care
  - Scope of Practice as defined in the CA Nursing Practice Act
  - Assessment, triage, and performance of patient care including wound care, medication management or titration, and other needs under direction of standardized procedures and/or prescribing provider
  - Lead co-development and execution of patient care plan including referral to social worker and/or medical provider
  - Lead daily huddle
  - Coordination and linkage: health navigation
  - Collaboration and partnership with community providers

- **Community Health Outreach Worker**
  - Approximately 60% field-based care
  - Patient outreach and engagement
  - Lead completion of the Basic Needs Screening/Care Plan
  - Transitional case management in coordination with RN to support patient care plan
  - General linkage and referral
  - Lead coordinator with housing outreach providers and housing services including completing housing readiness assessments/eligibility, housing applications, and procuring required documentation.

- **Social Worker**
    - Approximately 40% field-based care
    - Coordinate with field-based team members (CHOW and RN) for warm hand-off
    - Provide intensive transitional support and intensive case management to 20 medically and/or behaviorally complex individuals at a given time with the goal of connecting individuals to providers and agencies that will assume permanent role of support
    - Brief behavioral health interventions and counseling, including crisis and post crisis support
    - Introduce patient to new supports
    - Facilitate relationship building and mediate conflicts between patient and new supports
    - Conduct linkage and referral activities to primary care, dental, optometry, ACBH case management, SUD treatment, benefits advocacy, legal, housing resources, and mainstream services
    - Stay up-to-date with local resources
    - Link patients to needed services

- **MD/NP/PA/DO Provider**
    - 65% (3-4 hours, 2-3 days per week) field-based care providing assessment, diagnosis, and treatment of complex Street Health patients
    - 35% field or office-based care providing telemedicine to Street Health patients and consultation, technical support, and trainings regarding medical treatment of Street Health patients to Street Health staff; supporting transitioning of Street Health patients from street-based medical care to clinic-based medical care; and completion of disability/health care eligibility paperwork for Street Health patients

- **Program Manager**
    - Oversight of contract management and submission of required deliverables
    - Reporting patient-level data
    - Evaluation outcome reports
    - Liaison between team and clinic-site; creates program support structure for team including coordinating staff training needs with ACHCH
    - Supporting the Street Health team to track outcomes
    - Ensure development of protocols and procedures, including linkage of homeless patients to a brick-and-mortar clinic

ACHCH envisions that core Street Health team members allocate time in the following manner:

- **60 percent** (3 days) in the field providing outreach and engagement services, care plan development, care coordination, and case conferencing for complex patients;
- **30-40 percent** (1.5 days) of staff time in the field or office-based working with patients who require more intensive care coordination for medical, mental health, and substance use disorder conditions;

- **5-10 percent** (.5 days) of Contractor's operational hours shall be spent on data tracking, Learning Community/designated meetings, and administrative activities.

The Social Worker's time allocation may differ slightly, due to the need for carrying a caseload of high-need patients. The MD/NP/PA/DO will spend approximately 12 hours per week in the field with the team to provide targeted health care interventions to individuals with unmet medical conditions and multiple barriers accessing care in a brick-and-mortar clinic. Ideally, this time is provided in increments of at least 4 hours for efficiency.

Figure 5: Street Health Staffing Model

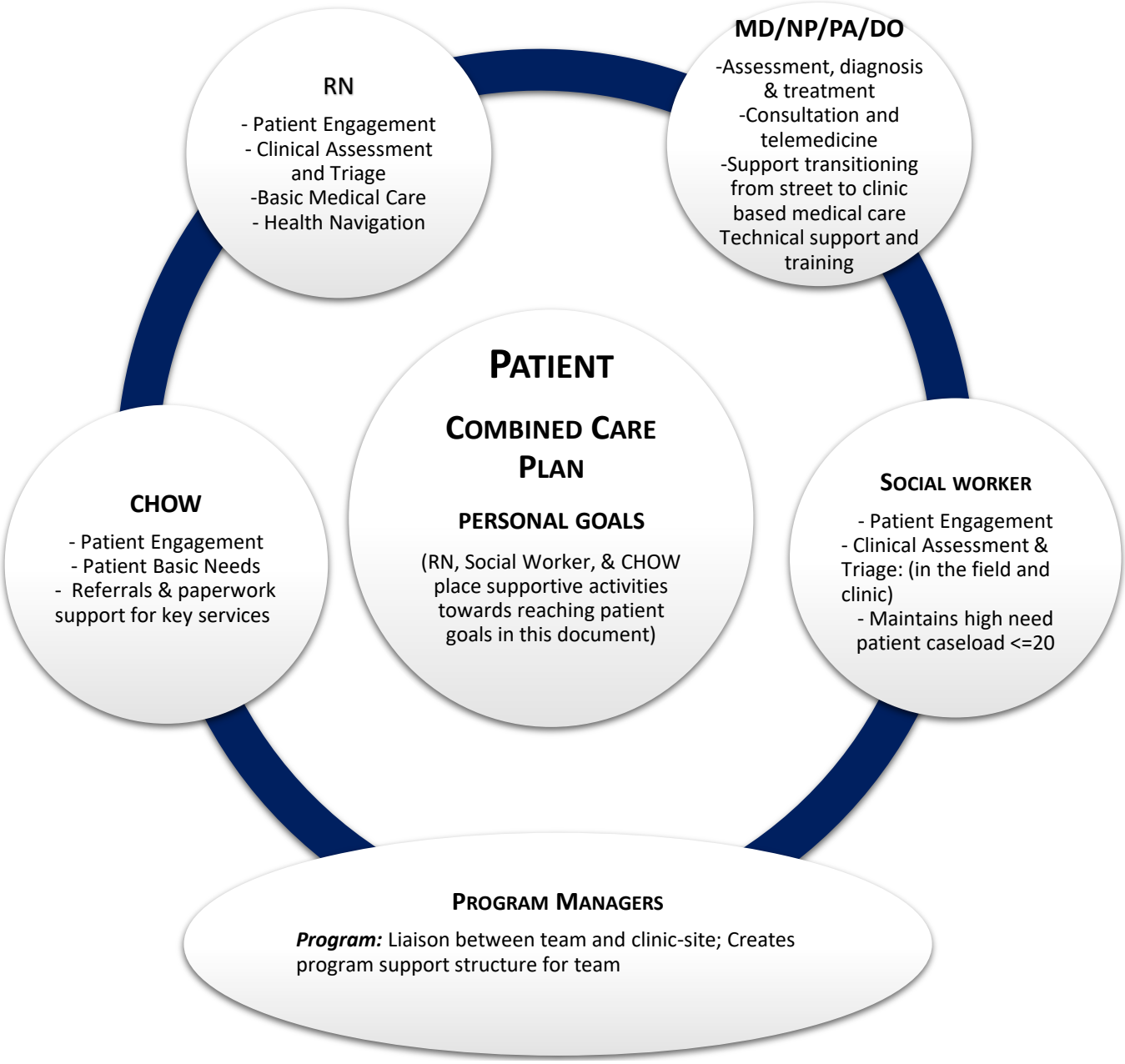

Figure 5: Street Health Staffing Model

E. Service Delivery System

ACHCH Street Health teams provide a range of street and clinic-based services throughout Alameda County. ACHCH is committed to creating a dynamic service delivery system with appropriate guidelines and resources to create greater consistency in service delivery across Street Health teams. Figure 5 shows an example of a Street Health service delivery system which tracks patient progress.

The following sections provide information and resources on outreach/patient engagement, field-based care, and coordination and linkage. Where appropriate, the sections include key principles associated with specific activities and suggested workflows, standard forms to develop and document patient access to services, as well as patient progress on care plan goals.

Figure 6: Outreach, Engagement, and Transition of Care

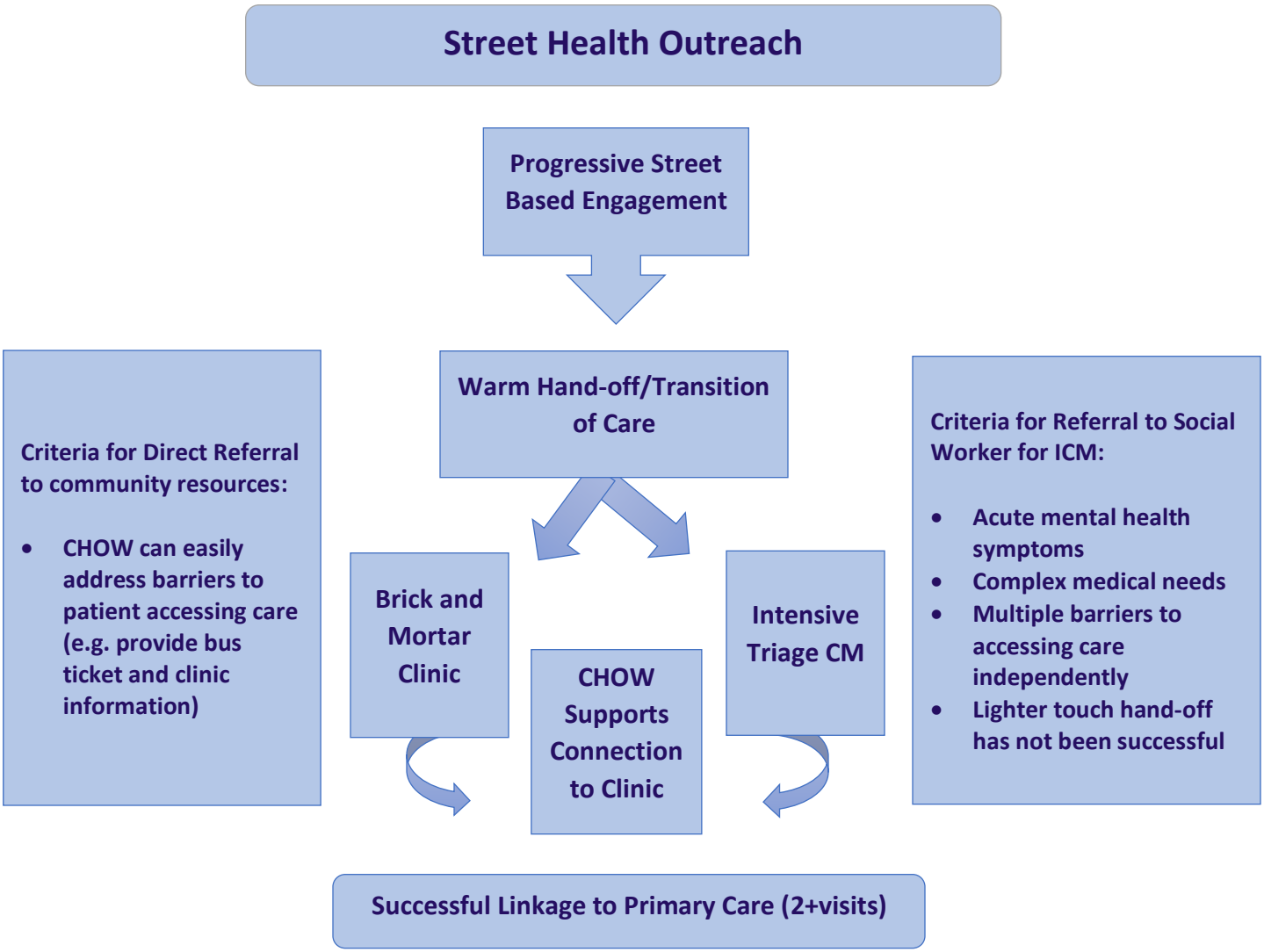

Figure 6: Outreach, Engagement, and Transition of Care

1. Outreach/Patient Engagement

The goal of Street Health Outreach is to remove barriers in accessing health services for Alameda County residents who are unhoused and would not otherwise access preventative and primary health care due to the competing pressures of daily survival, distrust of the health care system, stigma associated with being homeless, and bureaucratic and transportation navigation challenges.

Outreach Principles

- Street Health outreach is planned, strategic, and coordinated.
- Effective outreach teams include staff members with clinical training working in partnership with individuals with lived experience that helps increase empathy, understanding, and connection with homeless individuals.
- Outreach staff needs ongoing training and clinical support to utilize best practices, maintain positive impact, and prevent excessive stress and burnout.
- Engagement efforts start, but do not end, with addressing survival needs, imminent health and safety issues, and making connections with temporary shelter and longer-term housing navigation resources.

(See Reference R-2 for reference materials regarding best practices for Street Outreach)

Recommendations on Street Health Services Workflow and Associated Documentation

The service orientation should operate from a low barrier approach with limited requirements or criteria that could prohibit access to needed services. Figure 6 provides a sample workflow diagram.

Figure 7: Sample Street Health Outreach Workflow

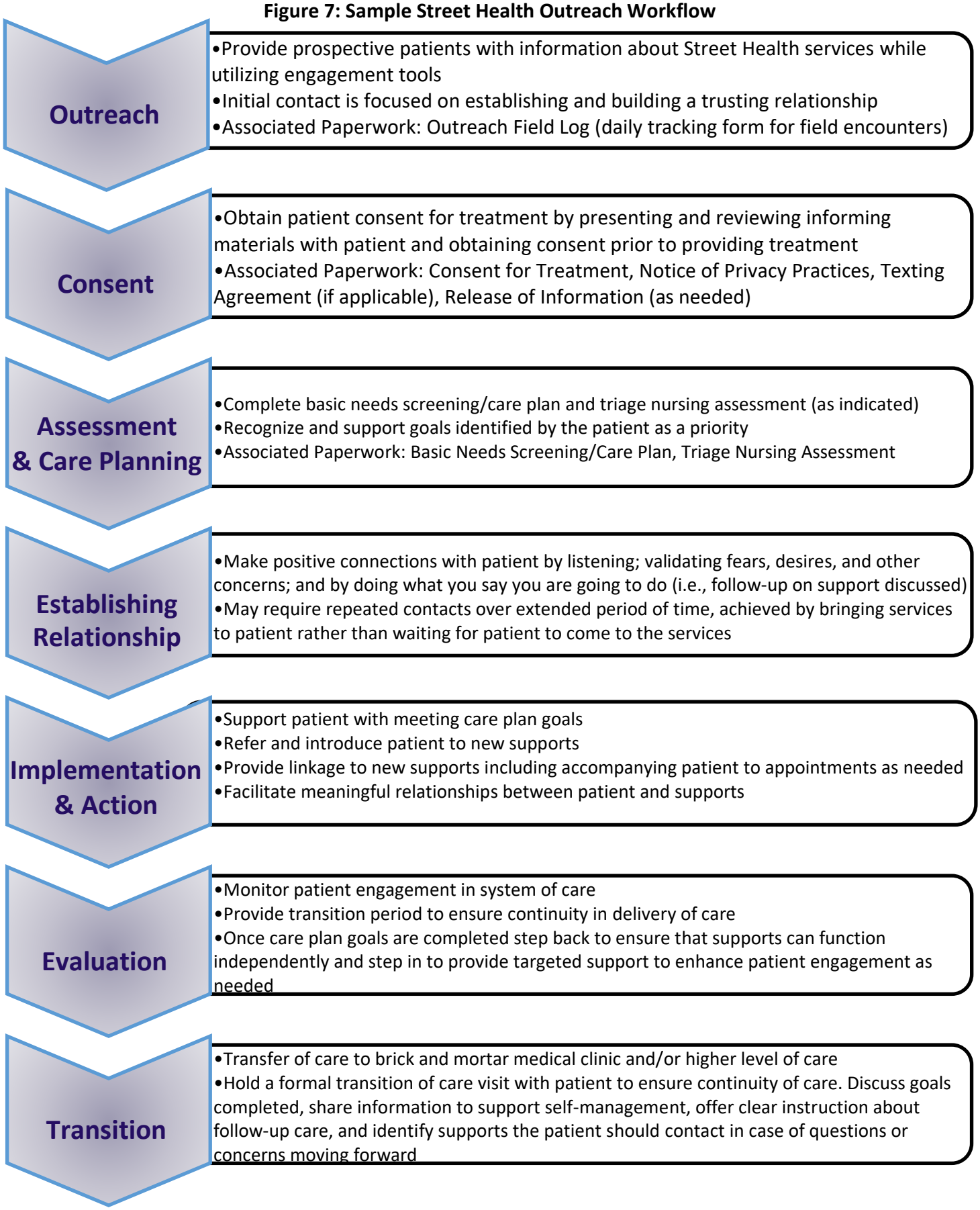

Figure 7: Sample Street Health Outreach Workflow

2. Field-based Care

Street Health teams provide field based medical and behavioral health services for unsheltered Alameda County residents, focused on addressing basic needs and fostering connections to long-term care. A primary goal of outreach is to transition patients to established brick-and-mortar clinics. Until this transition occurs, Street Health teams will need to address health needs in a bridging capacity including chronic disease management, preventative care, and addressing communicable diseases. A minority (less than 20%) of time should be spent addressing one-off acute and urgent care issues. Chronic disease management is viewed through a lens of practicality. Providing blood pressure medications to a patient whom you have met one time may not be the appropriate intervention given priorities while living on the street. However, upon continued relationship building, managing chronic conditions is within the scope and priority of field-based care until clinic-based primary care has been arranged. Finally, Street Health teams along with ACHCH will continually assess and develop plans to address preventative care and communicable diseases that are particularly important in homeless populations.

a. *Clinical Assessment, Triage, and Treatment*

Registered Nurse (RN): The full-time Street Health RN leads the team in care plan development and healthcare provided in the field.

- Scope of practice is determined by the California Board of Registered Nursing; standardized procedures provide specific field-based scope of the RN in the care of persons who are unsheltered
- Please see the following documents for additional reference
    - Triage Nursing Assessment (see Appendix K)
    - Preface to RN Standardized Procedures (Read First) (see Appendix L)
    - Registered Nurse Standardized Procedures & Clinical Protocols (see Appendix M)

Provider (MD/NP/PA/DO): The current model supports the full-time Street Health team (RN, CHOW, Social Worker) with 0.3 FTE of provider time. Given this is a limited and valuable resource, as part of their work, Street Health teams work to identify highly vulnerable individuals who are unable to make it to brick-and-mortar facilities and who may benefit from targeted and time-limited field-based assessment/care by the provider.

- Works with the Street Health team to develop a protocol and workflow for triaging high-risk patients to limited provider time for targeted medical outreach;
- Whenever possible, works to ensure that care in the field is transitioned to brick-and-mortar facilities as soon as possible to ensure a permanent and thorough medical linkage. In the ideal scenario, the patient is linked to a clinic where the Street Health provider can continue seeing them;

- Champions field medical interventions that are particularly important to a population experiencing homelessness, including screening and treatment of Hepatitis C and HIV, as well ensuring ready availability of Medication-Assisted Treatment (e.g., buprenorphine);
- Actively trains the full-time Street Health team members on medical issues so they can more confidently manage conditions in the field.

b. *Medication in the Field:*
   - Street Health teams will develop program specific medication policies that cover scenarios that will be addressed in the field. These include:
     - Dispensing over the counter medications as noted in RN protocols.
     - Picking up medications from the pharmacy and safely transporting them to patient.
     - Clinic storage of both over the counter and prescription medications, such as when a prescribed medication is unable to be delivered and must be held until a later date.
     - Establishing capacity to manage such medications as long-acting injectables and controlled substances (e.g. Suboxone).

   Pre-existing polices at your community health center regarding the above scenarios may already exist, and we defer to them. If you need any assistance in developing specific policies, please contact ACHCH.

c. *Street Team Linkage to Physical Primary Care Site*
   - Street Health teams provide field-based clinical care while working to link patients to a brick-and-mortar clinic. For some patients, successful linkage to a clinic will take more time than others.
   - While you prioritize your home clinic, all patients have the right to work with the clinic of their choice while working with a Street Health team.
   - In addition to the members of the Street Health team who go into the field, the team is also comprised of the home clinic. Each home clinic (e.g., Bay Area Community Health, Lifelong Medical Care, Roots Community Health Center, Tiburcio Vasquez Health Center) should work to implement what are considered best practices when serving the homeless population. These include:
     - Capacity for Street Health drop-in patients, as well as working to ensure the use of same day drop-in appointments.
     - Flexible and culturally-informed policies and procedures that decrease barriers to care, such as those related to no-shows or unwanted behaviors in the clinic.

d. *Transitioning High-Need Patients to the Social Worker*

Patients who are not able to navigate social services and/or connect with a primary medical home, with the standard support of Street Heath outreach services alone, may be eligible for referral to the social worker for intensive, transitional case management. To qualify for intensive, transitional case management with the social worker, a patient's presentation should demonstrate an inability to initiate and/or sustain self-directed purposeful activities that have an end goal, such as securing an I.D. or scheduling/keeping appointments. These patients require intensive support to engage in purposeful activities and obtain services. Treatment intensity (i.e., number of hours per week) and duration should be individualized and designed to meet the needs of the patient and should be adjusted according to the patient's response to intensive, transitional case management services/interventions and ability to participate effectively.

Areas of consideration for transfer of care to an external provider(s) or return of care to ongoing standard Street Health outreach services:

- *Transfer of care:*
  - Patient is assessed to be securely engaged in ongoing standard/specialty treatment and is able to participate without the support of the social worker.
- *Return to standard street health outreach services:*
  - The multidisciplinary team agrees that the patient should be transitioned back to standard Street Health outreach services due to lack of adequate, consistent progress to support continued intensive, transitional case management services, despite revisions to the treatment plan, and the patient is not yet securely engaged in ongoing standard/specialty treatment.

e. Outreach Response to Pandemic/ Epidemic Infectious Disease

The model of field-based care has been and will continue to be flexible and responsive to the needs of our unsheltered community, particularly as part of the response to diseases that present as an epidemic or pandemic. Common examples have been novel influenza A viruses including avian and swine flu, and the ongoing COVID-19 pandemic. Effective responses require a nimble, strategic approach and may involve rapidly altering protocols, countywide-coordination, frequent communication, and real-time data collection and evaluation.

In these situations, and under the direction of ACHCH, teams will collaborate and undertake a number of emergency actions to meet the needs of our most vulnerable population. As seen with the ongoing COVID-19 pandemic, targeted services may include: education related to symptoms and protective measures, distribution of hand sanitizer and masks, verbal assessment, tracking of assessment, temporal thermometer reading, COVID-19 testing, COVID-19 treatments, COVID-19 vaccination, rapid response to potential outbreaks, contact tracing support under the guidance of the Alameda County Public Health Department, and referrals to isolation and housing resources.

3. ***Coordination and Linkage****:*

Homeless individuals often face multiple barriers accessing care including transportation issues, previous negative experiences with providers and health care interactions, mental and physical health issues, stigma, and shame. As a result, many fall through gaps in traditional service delivery models and need support and advocacy to meaningfully connect to services. The foundation of developing strong coordination and linkage includes the following:

Being **Knowledgeable** about resources in your geographic region and providing linkage and referrals to homeless and mainstream resources. Linkage should include a warm hand-off when possible.

Being **Informed** of other outreach provider schedules (e.g., AHS and HOPE mobile clinics, HEPPAC, Housing Resource Center Outreach Teams, etc.), coordinating schedules when possible, and referring individuals to other provider's services as appropriate.

Establishing Partnerships in collaboration with ACHCH to work with county and city agencies including Public Works, Police Departments, Fire Departments, Code Enforcement, and Emergency Medical Services. Such collaborations must comply with all relevant laws to ensure patient privacy and confidentiality.

The specific areas to develop connections include:

Primary Care: Street Health teams have a formal pathway to refer individuals to a brick-and-mortar clinic(s) that address barriers to access, including same day visits. This connection should include assessment to determine eligibility for services including Health Homes.

Housing: Street Health teams have a formal link with the Housing Resource Center(s) in their region and coordinate with Coordinated Entry System outreach staff in the field.

Mental Health: Street Health teams have a strong partnership with Alameda County Behavioral Health (ACBH) to address urgent mental health needs (e.g., through referral/linkage to Crisis Response Team) and increase access to longer-term ACBH services through ACCESS referral/linkage and coordination with ACBH outreach teams regionally.

Substance Use Services: Street Health teams have a strong partnership with CenterPoint and Cherry Hill to increase access to Substance Use Disorder treatment services. They should work to develop knowledge of medication treatment for opioid use disorder, such as methadone clinics or community health centers that provide Medication Assisted Treatment (i.e., Suboxone, buprenorphine, naltrexone).

F. Street Health Quality of Care

ACHCH supports the principles underlying the World Health Organization's definition of quality of care, which is "the extent to which health care services provided to individuals and patient

populations improve desired health outcomes. To achieve this, health care must be safe, effective, timely, efficient, equitable, and people-centered."

- **Safe.** Delivering health care that minimizes risks and harm to service users, including avoiding preventable injuries and reducing medical errors.
- **Effective.** Providing services based on scientific knowledge and evidence-based guidelines.
- **Timely.** Reducing delays in providing and receiving health care.
- **Efficient.** Delivering health care [and enabling services] in a manner that maximizes resource use and avoids waste.
- **Equitable.** Delivering health care [and enabling services] that does not differ in quality according to personal characteristics such as gender, race, ethnicity, geographical location, or socioeconomic status.
- **People-centered.** Providing care that takes into account the preferences and aspirations of individual service users and the culture of their community.
  (source: https://www.who.int/maternal_child_adolescent/topics/quality-of-care/definition/en/)

ACHCH acknowledges that Street Health teams fall under the jurisdiction and oversight of existing quality assurance/improvement programs at each participating clinic site. ACHCH also maintains a quality management program that includes clinical and program quality of care oversight responsibilities. Results-based Accountability (RBA) is an evaluation framework that allows ACHCH to track both clinical and program process, quality, and outcome metrics. It is based on answering three basic questions:

How much did we do?

How well did we do it?

Is anyone better off?

Street Health teams will be involved in collecting/reporting data that will build a narrative of the impact of its work across Alameda County (see Reference R-3 for copies of the RBA approach and Appendix B for the Street Health RBA metrics). ACHCH staff is available for training on RBA and the Clear Impact Performance software where Street Health data will be stored.

IV. General Operations

Providing Street Health services requires the development of operations, policies and procedures that take into consideration the field-based environment in which the work is done. This section highlights critical areas for consideration.

A. Community Engagement

Outreach is often conceptualized on the patient level with limited attention given to the broader community. Community outreach and engagement requires effort and planning to create a network of contacts and resources. Building these community partnerships is essential to providing patients with a comprehensive offering of services beyond Street Health and involves:

- Identifying and fostering relationships with community supports in your region, including both formal service providers (shelters, Housing Resource Centers, Wellness Centers, etc.) and other key stakeholders that provide resources and support (churches, soup kitchens, etc.).
- Learning that those we serve are often the experts and learning from them about what community supports they are already using.
- Understanding that local businesses, composed of employers and employees, as well as families living in neighborhoods adjacent to encampments all have an important stake in how homeless individuals are either marginalized or are reincorporated into the greater community, and recognizing how Street Health teams can be an important force for 'humanizing the face of homelessness' for those individuals or businesses directly affected by the presence of homeless encampments. Being able to articulate the role of the Street Health team to local residents, business owners, and other key stakeholders can engender additional support for addressing homeless needs.

B. Site Selection and Maintaining a Consistent Schedule

The process of selecting service locations and developing a consistent schedule that is based on the unique needs of each site is the foundation of developing a service delivery model that fosters relationship building and engagement in services. See below for specific tips on how to select appropriate sites and build an effective schedule.

Site Selection

- Services may be offered at encampments, on the streets (including locations with single individual, or small group, with high needs outside of scheduled sites), in cars, at Navigation Centers, parks, shelters, and other locations homeless individuals access services.
- Site selection requires giving consideration to geographic differences across the County. For example, in Oakland and more urban areas of Alameda County, Street Health Outreach teams shall conduct most work at homeless encampments where high densities of unsheltered people reside. In Central County and suburban areas, unsheltered homeless are more dispersed and there are fewer encampments. For these geographic areas, the Street Health outreach teams shall maximize their service reach

by outreaching at encampments in combination with outreach at other homeless serving locations including Safe Parking, Navigation Centers, shelters, and drop-in centers.

- Providers should foster collaboration with city, county, and community partners to help support site selection. Examples may include new changes that inform of potential future locations such as new programs including Safe Parking sites and Navigation Centers and locations with a number of calls for services.

Maintaining a Consistent Schedule

Consistent visits allow homeless individuals to have predictable access to care and repeated opportunities to engage with Street Health teams. This model increases relationship and trust building over time. Core components of an effective schedule are listed below:

- Determine frequency based on needs of encampment and number of individuals (see Appendix 'C' for a sample schedule). Reassess periodically to ensure continued alignment with encampment needs and level of engagement.
- Understand the workings of the encampment, the leaders within the site, and work to establish an alliance.
- Maintain the established schedule. Note that it is important to develop a schedule that takes into consideration travel time and emergencies to avoid any cancellations or disruptions in services.
- Communicate schedule clearly and remind individuals of the next time you will be on site before you leave each time.

Resources for mapping sites include the following:

- Census Track Data from the Point-in-Time Count
- Encampment maps from the county and respective cities
- Police beat maps

C. Street Health Field Logistics

Providing field-based services presents unique challenges that require planning, logistics, and the development of protocols, policies and procedures. Dedicating time to developing and revisiting field logistics will ensure a safe, secure, and effective service delivery model.

Supplies in the Field

All field staff should carry Street Health consent forms and clinic registration forms, the Basic Needs Screening/Care Plan form, a note pad, outreach supplies, naloxone, Overdose Prevention Education and Naloxone Distribution forms [OPEND], safer injections kits/supplies, and snacks/water for distribution (see Appendix 'D' for sample ACHCH forms).

Team member-specific contents and required tools:

- **Registered Nurse/Provider:** The medical team members should carry tools and program specific medical and nursing assessment forms that allow field-based assessment of Street Health patients. Recommended assessment tools are stethoscope, sphygmomanometer (blood pressure cuff), oral thermometer (with disposable covers), disposable tape measure(s), pulse oximeter, and a pen light. They should carry medical outreach supplies. These include items such as wound care supplies and kits, creams, and ointments such as triple antibiotic and hydrocortisone, and urine pregnancy tests. Point of care testing supplies (for hepatitis C, human immunodeficiency virus, Streptococcus, etc.) should be located in the vehicle and available for field-testing. The Street Health vehicle must have a medical emergency kit (see Appendix 'E' for a recommended inventory).
- **Community Health Outreach Worker**: The CHOW is recommended as the primary note keeper for encounter level tracking. The CHOW should carry a clip board and the Outreach Field Log (see Appendix 'F' for field log), with benefit and entitlement forms including DMV fee waiver forms, Alameda County Homeless Management Information System/Coordinated Entry System assessment forms, and Medi-Cal applications.
- **Social Worker**: The SW should carry forms related to intensive case management such as screening tools, housing resources and benefits navigation, including those noted above with the CHOW.

Patient Transport

Patient Transport in Street Health Program Vehicle:

- Prior to patient transport, the patient shall have completed all patient consents to receive services as a Street Health patient.
- Each Street Health team is encouraged to maintain a log of transported patients that documents name, preferred name, social security number (or other unique identifier), pick-up and drop-off location, and necessity of transport.
- Individual contractors develop transportation policies. Street Health staff should explicitly state policies pertaining to transportation in the company vehicle. Suggested areas of policy and procedure coverage include, though are not limited to, the following: severe intoxication, conduct within and around the vehicle, possible infestation, weapons, etc.

Patient Transport Coordination in Non-Program Vehicle (Lyft/Uber):

Ride share apps provide an effective means for patient transport. Rides need to be scheduled and coordinated by a staff member using the program account. Contractors shall develop internal policies and procedures pertaining to ride share apps if they choose to utilize this service. At minimum, patients need to be ambulatory, alert, and must have access to a cell phone for coordination. Shared rides are not advisable in most situations

due to the added coordination needed (see Appendix 'G' for list of transportation services in Alameda County).

D. Patient Confidentiality

Recommended Best Practices for Maintaining Confidentiality in the Field

Providing services outside of a traditional office setting presents unique challenges in maintaining confidentiality and ensuring proper storage of patient records.

Documentation: While out in the field, staff should take the following steps to secure patient information.

- Protected Health Information (PHI) should be treated as confidential and should be safeguarded in accordance with HIPAA, State privacy laws, and internal P&P to prevent unauthorized individuals, such as the general public, from viewing or accessing PHI at off-site locations.
- All PHI in paper or electronic form must be transported and stored in a secure manner to safeguard it against improper disclosure or loss.
- During authorized field collection and transportation of PHI, paper files and electronic portable media should be properly labeled (e.g., paper files generically labeled in non-transparent envelopes and marked with "Confidentiality Notice") and stored in a locked carrying case.
- Patient documentation containing PHI must be in the immediate personal possession of Street Health team members at all times and immediately secured once staff returns to the office. For example, from the time the PHI is collected in the field and is taken to the office; PHI should never be left unattended, including left unattended in a locked vehicle.
- Additional key considerations to secure PHI that is being transported outside of a facility to ensure confidentiality and integrity in the event of an accident, theft, or other unforeseen event are listed below.
  PHI that is transported by motor vehicle:
  - Should be transported in a secure container, such as a locked box or briefcase whenever possible; and
  - Should be transported without stops that involve leaving the vehicle unattended, if possible. If stops must be made, do not leave PHI in the vehicle. Remove and secure it so that others cannot access it.
- Mobile devices must be password-protected and encrypted.
- Electronic portable media should be encrypted whenever possible and/or password protected. Passwords or encryption keys should be disclosed through a different medium such as a separate e-mail or phone call; they should never accompany the actual media.
- If PHI is lost, stolen or improperly accessed by others, immediately notify your supervisor and organization's privacy officer or information security office; additionally, file a police report if PHI is stolen.

Creating Confidential Spaces in the Field: Staff should engage every patient in a dialogue around how to establish a confidential space.

- Inform patients of confidentiality and the right to privacy and offer office-based visits to discuss more sensitive personal information to support privacy compliance.
- Ask patient's permission to discuss PHI in the field.
- Key areas to consider:
    - Are other encampment residents in earshot?
    - Be mindful of not broadcasting conversation.
    - Ask how patient would like to be addressed in the field (i.e., do they have an alias or preferred "street name") and document legal name.
    - Is the patient comfortable with others seeing them speak with you?
    - Can you walk to a more private space while maintaining a line of sight with other Street Health team members?
- Consistent with HIPAA privacy and security provisions, PHI should never be verbally discussed/shared with any unauthorized person in the field (or elsewhere).

**** CONFIDENTIALITY NOTICE ** (Sample Notice)**
Documents contained in this package may contain confidential information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this package in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this package in error, please notify the sender immediately by calling the phone number above to arrange for destruction of these documents. Thank you.

E. Staff Safety in the Field

Field based services, particularly those in encampment settings, come with unique safety and logistical considerations. Working in environments that are often unpredictable, team members must maintain consistent adherence to established agency safety protocols. Every contractor should have written policies and procedures that outline agency standards for maintaining staff and patient safety in a street environment. ACHCH suggests Street Health teams consider the following safety tips in their policies and procedures:

- Field based care must always be provided by a minimum of two staff
- Team members wear a uniform or bright colors for easy visibility
- Team members should always maintain line of sight on each other
- Teams should have a code word indicating to others there is a risk and all team members should leave immediately
- Incident reporting/sharing important information re: safety issues at an encampment or with a particular individual

Staff safety is a necessary component of a functional Street Health team. Relationship development is a key component of Street Health service delivery. The Street Health team's familiarity with the population they serve will help maintain staff and patient safety. Always be aware of your surroundings, as the team becomes familiar with a given location, they will

become familiar with the nature and personality of each encampment and the people living there.

If one member of the team is not comfortable with something they see, hear, or feel, the entire team should leave the site without question. Consider using an easily decipherable word (or hand signal) such as a specific color, in the case of an emergency. This should be shouted loud enough for all staff to hear. If a team member is engaged with a patient and another team member sees the need to leave the site, consider stating: "We have another appointment to keep," and point to your watch. Following such an event, a debriefing should be conducted in the vehicle after the safety concern has resolved.

The vehicle should be located close to the area served. Consider parking in the same location, on return trips to sites, if possible. Have a predetermined meet-up point, should an event that requires evacuation occur.

Staff should immediately evacuate in the case of an outbreak of violence. Expect that persons who are living on the street carry a form of personal protection, approach this with respect and awareness. Always be aware of persons and vehicles travelling in and around the areas you are working.

F. Emergency Response

The expectation is that the Street Health team is prepared for the unexpected to the best of their abilities. Policies and Procedures (P&P) in this area may rely on standing clinic P&P, though adaptation for the mobile environment is advised. As an example, each clinic has an existing emergency evacuation plan for brick-and-mortar locations. Adaptations to the evacuation plan should be discussed by team members as they reach out and become familiar with new service sites. To the degree possible, location of the vehicle should remain consistent upon return visits to the same service area. Street Health staff should identify a safe meet-up location that is away from each site, though in close proximity, should an evacuation be necessary.

Possible scenarios include, though are not limited to, natural and manmade disasters such as an earthquake or fire events, medical emergencies (for patients and/or staff), mental health emergencies, overdose, and violence.

Adaptations to the mobile setting will realistically evolve as the program grows. An example of this is developing P&P pertaining to CDC recommendations for wearing face coverings to help prevent the spread COVID-19 (and N95 distribution during wildfire events that disproportionally impact persons who live outdoors).

In the event of an emergency, medical back up and in clinic staff should be notified as soon as possible.

V. Street Health Meeting Structure

Working in a framework that is both responsive to the changing needs of the homeless population, and adheres to standards, requires a commitment to team level and Street Health

meeting participation. See below for additional information on the proposed Street Health team meeting structure.

- **Daily Street Health Huddle**: Each team should have a daily huddle to debrief on site visits, exchange critical information, assign next steps by staff member, and plan for outreach the following day. It is up to the discretion of team members whether to hold the meeting in the early morning or late in the afternoon (see Appendix 'H' for sample huddle agendas).
- **Learning Community**: Key members of each Street Health team are expected to attend the bi-monthly ACHCH facilitated Street Health provider-specific Learning Community meeting. This meeting fosters shared learning across teams, and provides standard trainings, case consultation, technical assistance, and quality improvement/assurance guidance. Additional meetings may be scheduled based on emergent needs.

Appendices

References

APPENDIX A:
COMMUNITY HEALTH OUTREACH WORKER & SOCIAL WORKER JOB DESCRIPTIONS

POSITION TITLE: Street Health Community Health Outreach Worker
POSITION DESCRIPTION:

The Community Health Outreach Worker (CHOW) is a member of a multidisciplinary team that includes registered nurses, social workers, primary care providers, and possibly psychiatrists or psychiatric nurse practitioners. The position will conduct outreach and engagement activities and provide linkage and referral based services to medically and/or behaviorally complex individuals to ensure timely access to, and coordination of, fragmented medical, psychosocial, and substance use treatment services with the goal of connecting patients to resources, providers and agencies that will assume the permanent/primary role of support. The CHOW works with partner organizations to provide transitional case management until a patient has stabilized enough to transition to the conventional system of care (primary care and/or a community mental health clinic or Intensive Case Management program) or has been placed in a higher level of care.

The CHOW is an advocate, improving access to care and addressing barriers homeless individuals often experience accessing care. The CHOW is responsible for outreach, engagement, care plan development and coordination of care.

ESSENTIAL DUTIES:

The Community Health Outreach Worker's Essential duties include the following:

- Provide field-based services to individuals experiencing homelessness in encampments, on the streets and other locations. Trying out-of-the-box ways of reaching individuals who have been living on the streets for many years and who may have significant trust, mental health and substance use issues.
- Provide respectful engagement to adults experiencing homelessness, many of whom have complex physical and mental health conditions.
- Advocating on behalf patients and/or supporting them to advocate for themselves.
- Utilizes the REAL BASIC framework to inform patient-centered assessment and care planning.
- Provides patients with life skills and emotional support.
- Assists patients in building or reconnecting with social support networks.
- Collaboration and coordination of services with appropriate community agencies.
- Liaise with hospitals and community agencies.
- Develop and maintain excellent working relationships with community partners and works together to identify and improve processes that enhance services.
- Provide information and referral to community services such as mental health and housing resources.

- Assist patients with completing Coordinated Entry Assessment and obtaining housing readiness documents.
- Assist patients with accessing public benefits and assistance as appropriate.
- Facilitate transportation to appointments including accompanying patients for medical, behavioral health, social services, substance use services, and other government services such as DMV and court appointments.
- Complete all appropriate data collection, paperwork, and tracking of activities in a timely manner.
- Utilizes consultation with clinical staff when appropriate
- Make timely and accurate decisions in emergency or crisis situations with awareness of the need for safety of all patients and staff.

POSITION TITLE: Street Heath Social Worker

POSITION DESCRIPTION:

The Social Worker is a member of a multidisciplinary team providing care to individuals who are unsheltered that includes community health outreach workers, registered nurses, primary care providers, and possibly psychiatrists. The position will provide transitional intensive case management services to 20 medically and/or behaviorally complex individuals, at any given time, to ensure timely access to, and coordination of, fragmented medical, psychosocial, and substance use treatment services with the goal of connecting patients to providers and agencies that will assume the permanent/primary role of support.

Similar to Critical Time Intervention model of case management, which was originally designed for individuals experiencing homelessness and mental illness, the transitional case management model is designed to bridge the gap between homeless specific services and community-based services for individuals who are unable to independently navigate the conventional system of care (i.e., primary care and/or a community mental health clinic or Intensive Case Management program). Transitional case management services focus on building community support networks and facilitating a gradual transition to community-based service providers. The Social Worker works with partner organizations to provide transitional case management until a patient has stabilized enough to transition to the conventional system of care or has been placed in a higher level of care.

The Social Worker is an advocate for patients, working jointly with team members and partner organizations in assessing patients' health needs, treatment, and the social, emotional, and psychological consequences of social determinants of health. The Social Worker is responsible for conducting psychosocial intakes, assessment of needs, service planning, linkage to services, service

monitoring, patient advocacy, patient education, skill building, coordination of care, emotional support, crisis intervention, and discharge planning.

ESSENTIAL DUTIES:

The Social Worker's Essential duties include the following:

- Provide outreach, office/field-based intensive case management (approximately 40% field-based care), and essential enabling services/advocacy by facilitating linkage, engagement, and building of meaningful relationships that increase access to healthcare and improve long-term health outcomes through connections to primary care, dental, optometry, ACBH case management, SUD treatment, benefits advocacy, legal advocacy, housing resources, and other supportive services.
- Provide respectful engagement to adults experiencing homelessness, many of whom have complex physical and mental health conditions, utilizing trauma-informed care that is centered in harm reduction, the patient's goals and needs (often focused on housing and social services, rather than mental health symptoms or substance use disorders), and building rapport.
- Responsible for the more medically and psychiatrically complex patients.
- Functions as a member of an interdisciplinary team and collaborates with medical professionals and community partners on various social work case problems and referrals.
- Carries out, interprets, and enforces existing regulations, legal provisions, policies and procedures to Social Workers, medical vendors, and other concerned agents, organizations, and individuals.
- Introduce patients to new supports; may accompany patients to interviews/appointments with agencies and providers relative to care and treatment of individual patients.
- Determines and utilizes community resources to benefit the care of patients; facilitates and monitors planning of care of patients.
- Provide brief behavioral health interventions and counseling.
- Provide risk assessment and, when clinically indicated, crisis and post-crisis support, utilizing consultation with clinical staff as appropriate.
- Engage in collaboration and coordination of services with appropriate community agencies.
- Develop and maintain excellent working relationships with hospitals and community partners and works together to identify and improve processes that enhance services.
- Provide information and referral to community services such as mental health and housing resources.
- Assist patients with accessing public benefits and assistance as appropriate.
- Facilitate transportation to appointments including accompanying patients for medical, behavioral health, social services, substance use services, and other appropriate appointments.
- Maintain case records and complete all appropriate data collection, paperwork, and tracking of activities in a timely manner.
- Prepare correspondence and confer with supervisor regarding caseload problems.
- Stay up to date with local resources and link patients to needed services.

“REAL BASIC” Framework

“REAL BASIC” is an acronym that demonstrates the work that staff providing integrated health and housing services do with consumers. REAL represents the tasks that staff engage in and the way in which staff engage in those tasks. BASIC represents the things that consumers may need assistance with. In other words, BASIC often signifies the outcomes you and the consumer are working toward and REAL signifies how you get there. A single staff member or team of staff can support an individual through different phases of work OR staff can work in specific roles. Staff involved may be brief intervention specialists, care coordinators, health outreach workers, general outreach workers, case managers, behavioral health clinicians, social workers, housing navigators, tenancy sustaining service provider and others.

Housing Options: Increase income to afford market, share housing with others to reduce costs, strategically apply for as much affordable housing as possible, and consider moving to less expensive housing markets.

			Housing Problem Solving	Outreach	Health-Housing Services (Health & Housing Instability)	Health-Housing Services (Health & Housing Stable)
		# OF CONSUMERS PER 1.0 FTE	100-150	100-125	15-25	30-40
		FOCUS OF PHASE OR ROLE	“Brief and Impactful”	“Engage and Connect”	“Hold Hope and Care ‘Til Stably Housed”	“Keeping Home”
		SERVICE DURATION	Minutes to Month	Until connected with others	Until housed AND critical time transition to support move to housing (6-9 mos.)	Ongoing support in permanent supportive housing; taper based on need over time
STAFF ROLES	**R**	**Resources that Matter** – Your Self and True Connections. Resource Identification & Relationships, and development and care of self and team as a Resource (on-going)	Self-help housing search resources, housing education & counseling, short-term financial assistance, public benefits, mediation/conflict resolution, health services, legal assistance.	Food, clothing, shelter, transportation, health care, hygiene, drop-in centers, link with CES, overdose prevention, public benefits, obtaining ID…	Public benefits, affordable housing, move-in assistance funding, employment/education, health care, in-home supportive services, social connections….	Financial education, payee, conflict resolution, IHSS, health care services, employment, social and care connections
	E	**Engage and Empower** – Hospitality. Engaging with consumers and empowering them through respectful relationships, honoring their human dignity and personal gifts, cultural and experiential understanding and affirmation, and providing education on system resources and rights	**Long-term, hopeful, empathetic relationships** **Do with not for; join with to understand; help make real connections that do not require your ongoing involvement**			
	A	**Assessment for Action and Alignment** – Assessing consumers’ needs *<u>with</u>* intention to develop action plans that align with the consumer’s stated priorities and areas to work on together.				
	L	**Listen Deeply** – listen through your heart and spirit to truly hear someone’s spirit and inner child.				

			Housing Problem Solving	Outreach	Health-Housing Services (Health & Housing Instability)	Health-Housing Services (Health & Housing Stable)
		# OF CONSUMERS PER 1.0 FTE	100-150	100-125	15-25	30-40
		FOCUS OF PHASE OR ROLE	**“**Brief and Impactful”	“Engage and Connect”	“Hold Hope and Care ‘Til Stably Housed”	“Keeping Home”
		SERVICE DURATION	Minutes to Month	Until connected with others	Until housed AND critical time transition to support move to housing (6-9 mos.)	Ongoing support in permanent supportive housing; taper based on need over time
CONSUMER NEEDS	**B**	**Basic Needs** – dignity/humanity, safety, food, water, sanitation, shelter, air quality, clothing, communication, transportation, respite	*Help connect with priority basic needs*	*Build relationships and trust by helping to address basic needs first*	*Ensure basic needs getting met as work on housing search*	*Help support getting basic needs met in housing*
	A	**Activities of Living** – personal care, paying bills, completing multiple tasks, using transportation, meaningful activities etc.	*Help connect with priority areas of needed support*	*Address priority areas for survival in current situation*	*Identify barriers to getting and obtaining housing; work to address; consider short- and long-term support needs*	*Identify and find supports for activity needs – payee, IHSS, meal prep, etc.*
	S	**Social & Cultural Supports** – meaningful relationships, cultural and spiritual connections	*Reconnection/mediation with network to solve housing crisis*	*Identifying supports that can help resolve crisis; serve as contacts as resources become available*	*Deeper exploration of support network to help solve housing crisis, referrals to opportunities*	*Supports to get, keep and create home from housing*
	I	**Income, Insurance, & ID/Paperwork** – public benefits, health insurance, ID, applications and prep for housing	*Help connect with basic priority needs areas identified by consumer; explore benefits eligibility*	*Help get and store ID, help apply for public benefits*	*Help with more complex public benefits advocacy; help with housing applications*	*Retention of income, insurance, and key paperwork; read, respond, and review mail, e.g., inspections*
	C	**Coordinated Connections** – health, education, employment, legal, housing search info	*Connect with priority professional connections of greatest importance to consumer*	*Health and legal connections often most important*	*Connect with housing search resources, deepen useful connections; employment/education resources to increase income*	*Establish, improve, or maintain health connections; pursue personal goals with education/employment*

Results-Based Accountability (RBA) Performance Measure Development Worksheet

Organization Health Care for the Homeless Street Health **Time Period:** FY2022-23 **Date Last Revised:** 3/28/22

Program Street Health Outreach Teams: Abode Services – Zone 1; Bay Area Community Health - Zone 2; Tiburcio-Vasquez Health Center – Zones 3, 4 & 5; Lifelong Medical Care - Zones 9, 10, 12, 13 & 14; ACHCH StreetHealth – Zone 11

Goal/Result Delivery of health services and coordination/linkages to critical services for people experiencing homelessness residing in Alameda County

Process Objectives	"How Much" Performance Measure	Data Reporting Tool	Quality Objective	"How Well" Performance Measure	Data Reporting Tool	Impact Objective	"Is anyone better off?" Performance Measure	Data Reporting Tool
By June 30, 2023, a minimum of 200 patients will have a documented ACHCH Basic Needs Screening/Care Plan	# of patients who have a documented Basic Needs Screening/Care Plan	Excel Tracking Sheet EHR	By June 30, 2023, 85% of patients without active enrollment in a medical home at time of consent will receive an ACHCH Triage Nursing Assessment	% of patients without active enrollment in a medical home at time of consent who received an ACHCH Triage Nursing Assessment	Excel Tracking Sheet EHR	1a: By June 30, 2023, 80% of patients without active enrollment in a medical home at time of consent will complete a face-to-face visit with a Street Health or medical home provider (NP/PA/DO/MD) 2a: By June 30th, 2023, 80% of patients with two	1b: % of patients without active enrollment in a medical home at time of consent who completed a face-to-face visit with a Street Health or medical home provider (NP/PA/DO/MD) 2b: % of patients with two elevated	Excel Tracking Sheet EHR

Revised 3-28-22

						elevated blood pressure readings will complete a face-to-face visit with a Street Health or medical home provider (NP/PA/DO/MD)	blood pressure readings who completed a face-to-face visit with a Street Health or medical home provider (NP/PA/DO/MD)	
By June 30, 2023, 100 unduplicated prospective-patient and/or patients will be provided with substance use harm reduction supplies	# of unduplicated prospective-patient and/or patients who were provided with substance use harm reduction supplies	Excel Tracking Sheet	By June 30, 2023, 80% of patients who express a desire or need to change their pattern of substance use will have a patient-led substance use harm reduction goal(s)	% of patients who have a patient-led substance use harm reduction goal(s)	Excel Tracking Sheet EHR	By June 30, 2023, 50% of patients who have a patient-led substance use harm reduction goal(s) will achieve their goal(s)	% of patients who achieved their patient-led substance use harm reduction goal(s)	Excel Tracking Sheet EHR
By June 30, 2023, 100 unduplicated patients experiencing homelessness will receive and be enrolled in "Housing Problem-Solving" documented in HMIS including completion/update of HMIS Release of Information and HMIS Client Profile	# of unduplicated patients who received "Housing Problem Solving "	Excel Tracking Sheet HMIS report	By June 30, 2023, 90% of patients who received "Housing Problem Solving" will be screened (by asking Coordinated Entry Pre-Questions) to determine eligibility to receive a Coordinated Entry Housing Assessment	% of patients screened to determine eligibility to receive a Coordinated Entry Housing Assessment	Excel Tracking Sheet	By June 30, 2023, 90% of patients who are eligible to receive a Coordinated Entry Housing Assessment will receive a Coordinated Entry Housing Assessment	% of patients who received a Coordinated Entry Housing Assessment	Excel Tracking Sheet HMIS Report

RBA SMART GOALS AND MEASURES: DATA DEFINITIONS/ CALCULATION FORMULAS

FY2022-23

Contractor Name: HCH-funded Street Health Teams__ Date: ___3/17/22_____

RBA MEASURES	DATA DEFINITIONS	CALCULATION FORMULAS	COMMENTS
HOW MUCH DID WE DO?			
By June 30, 2023, a minimum of 200 patients will have a documented ACHCH Basic Needs Screening/Care Plan • **# of patients who have a documented Basic Needs Screening/Care Plan**	• Contractors must use the ACHCH Basic Needs Screening/Care Plan tool found in Street Health Manual or on the ACHCH website under: ACHCH Street Health Training Materials	• # of patients who have a documented Basic Needs Screening/Care Plan	• The Basic Needs Screening/Care Plan should be updated annually for patients who are rolled over into the subsequent fiscal year to count towards this SMART goal. • The Clear Impact scorecard should reflect a cumulative count.
By June 30, 2023, 100 unduplicated prospective-patients and/or patients will be provided with substance use harm reduction supplies • **# of unique prospective-patients and/or patients who were provided with substance use harm reduction supplies**	• **Examples of harm reduction supplies include but are not limited to the following:** 1. Safer Injection kits 2. NARCAN® (Naloxone) 3. Sharps containers 4. Education materials about safer drug-use practices	• # of unduplicated prospective-patients and/or patients who were provided with substance use harm reduction supplies	• The Clear Impact scorecard should reflect a cumulative count.
By June 30, 2023, 100 unique patients experiencing homelessness will receive and be enrolled in "Housing Problem-Solving" documented in HMIS including completion/update of	• **Housing problem solving in the Alameda County Coordinated Entry System**: These are "conversations that help all households identify and mobilize to safe(r) shelter and housing options within their own support networks as much as possible."	• # of patients who received "Housing Problem Solving"	• Housing problem solving conducted by an external agency/provider that is already documented in HMIS, including 'Completion/update of HMIS Release of Information and HMIS Client Profile,' should be reviewed and updated as needed by

HMIS Release of Information and HMIS Client Profile • **# of patients who received "Housing Problem Solving**	• Housing problem solving materials [e.g., HMIS ROI and Client Profile] need to be documented in HMIS.		street health teams. This counts towards the SMART goal. • The Clear Impact scorecard should reflect a cumulative count.
HOW WELL DID WE DO IT?			
By June 30, 2023, 85% of patients without active enrollment in a medical home at time of consent will receive an ACHCH Triage Nursing Assessment **% of patients without active enrollment in a medical home at time of consent who received an ACHCH Triage Nursing Assessment**	• Contractors must use ACHCH Triage Nursing Assessment template found in Street Health Manual or on the ACHCH website under: ACHCH Street Health Training Materials • Medical Home: Clinic where a patient has been assigned or selected to receive health care services. Care is provided by a multi-disciplinary team with providers coordinating care across the health care system. For patients whose medical home is not located at the Street Health team's home clinic, patients can self-report their current medical home/active enrollment status • Active enrollment: Patient has the following: 1) A designated primary care provider. 2) A minimum of one appointment in the past six months with medical home provider (NP/PA/DO/MD}. 3) The ability to schedule an appointment in a reasonable time frame o Reasonable time frame to schedule an appointment with a medical home provider: 2-weeks for non-urgent	• [# of patients without active enrollment in a medical home at time of consent who received an ACHCH Triage Nursing Assessment / # of patients without active enrollment in a medical home at time of consent] X 100	• The Clear Impact scorecard should reflect a cumulative count.

	appointment and 24 hours for urgent appointment.		

By June 30, 2023, 80% of patients who express a desire or need to change their pattern of substance use will have a patient-led substance use harm reduction goal(s)
 	
• **% of patients who develop a patient-led substance use harm reduction goal(s)**
	• Examples of substance use harm reduction goals include but are not limited to the following:
	1. Engaging
	  • Sobering/detox treatment
	  • Outpatient SUD treatment
	  • Residential SUD treatment
	  • Peer recovery program [AA, NA, etc.]
	2. Using a safer injection kit
	3. Carrying Narcan
	4. Meeting with a provider to discuss MAT
	5. MAT start
	6. Reducing substance use or changing to less harmful substance
	7. Never using alone
		• # of patients who develop a patient-led substance use harm reduction goal(s) / # of patients who express a desire or need to change their pattern of substance use X 100	• Tools/approaches to elicit patients' desire or need to change their pattern of substance use include:
			- Basic Needs Screening/Care Plan
			- Triage Nursing Assessment,
			- Ongoing street health engagement/motivational interviewing

By June 30, 2023, 90% of patients who received "Housing Problem Solving" will be screened (by asking Coordinated Entry Pre-Questions) to determine eligibility to receive a Coordinated Entry Housing Assessment • **% of patients screened to determine eligibility to receive a**		• [# of patients who were screened to determine eligibility to receive a coordinated entry housing assessment / # of patients who received "Housing Problem Solving] X 100	• Clear Impact Scorecard will calculate the percentage for this measure.

Coordinated Entry Housing Assessment			
IS ANYONE BETTER OFF?			
By June 30, 2023, 80% of patients without active enrollment in a medical home at time of consent will complete a face-to-face visit with a Street Health or medical home provider (NP/PA/DO/MD) • **% of patients without active enrollment in a medical home at time of consent who completed a face-to-face visit with a Street Health or medical home provider (NP/PA/DO/MD)**	• Medical Home: Clinic where a patient has been assigned or selected to receive health care services. Care is provided by a multi-disciplinary team with providers coordinating care across the health care system. For patients whose medical home is not located at the Street Health team's home clinic, patients can self-report their current medical home/active enrollment • Active enrollment: Patient has the following: 1) A designated primary care Provider. 2) A minimum of one appointment in the past six months with medical home provider (NP/PA/DO/MD}. 3) The ability to schedule an appointment in a reasonable time frame Reasonable time frame to schedule an appointment with a medical home provider: 2-weeks for non-urgent appointment and 24 hours for urgent appointment.	• [# of patients without an active enrollment in a medical home who completed a face-to-face visit with a Street Health or medical home provider/# of patients without a medical home at time of consent] X 100	• Patients whose medical home is not located at the Street Health team's home clinic, can self-report their current medical home/active enrollment status. • Clear Impact Scorecard will calculate the percentage for this measure. • A telehealth visit with a "medical home provider" counts as a face-to-face visit.
By June 30, 2023, 80% of Street Health patients who have two elevated blood pressure readings will complete a face-to-face visit with a Street Health or clinic-based provider **(NP/PA/DO/MD)**	• Blood pressure is defined by four blood pressure reading classifications: **- Normal BP reading**—systolic blood pressure (SBP) is <120 mm Hg; diastolic blood pressure (DPB) is < 80 mm Hg **- Pre-hypertensive BP reading:** SBP is ≥120 and ≤ 139 mm Hg; DBP is ≥80 and ≤89 mm Hg	• [# of Street Health patients with two elevated blood pressure readings who completed a face-to-face visit with a Street Health or clinic-based provider / # of	• Clear Impact Scorecard will calculate the percentage for this measure. • PQRS hypertension standard can be found at: https://www.entnet.org/sites/default/files/PQRS%20Measure%20317.pdf

• **% of Street Health patients with two elevated blood pressure readings who completed a face-to-face visit with a Street Health or clinic-based provider**	- **First hypertensive BP reading:** SBP is ≥140 mm Hg or DBP is ≥90 mm Hg - **Second hypertensive BP reading:** SBP is ≥140 mm Hg or DBP is ≥90 mm Hg. [source: American Medical Association 2012] • Elevated blood pressure includes pre-hypertensive and hypertensive readings. Possible combinations of blood pressure readings that trigger the need for a face-to-face provider visit are: Pre-Hypertensive + Pre-Hypertensive, Pre-Hypertensive + First Hypertensive, and First Hypertensive + Second Hypertensive.	Street Health patients with two elevated blood pressure readings] X 100	• A telehealth visit with a "medical home provider" counts as a face-to-face visit.
By June 30, 2023, 50% of patients who have a patient-led substance use harm reduction goal(s) will achieve their patient-led substance use harm reduction goal(s) • **% of patients who achieved their patient-led substance use harm reduction goal(s)**		• [# of patients who achieved their patient-led substance use harm reduction goal(s) / # of patients who have a patient-led substance harm reduction goal] X 100	• Clear Impact Scorecard will calculate the percentage for this measure.
By June 30, 2023, 90% of patients who are eligible to receive a Coordinated Entry Housing Assessment will receive a Coordinated Entry Housing Assessment	• Patients who received a Coordinated Entry Housing Assessment should have it documented in HMIS.	• [# of patients who received a Coordinated Entry Housing Assessment / patients who are eligible to receive a coordinated entry housing assessment] X 100	• Clear Impact Scorecard will calculate the percentage for this measure.

% of patients who received a Coordinated Entry Housing Assessment			

Appendix C:
Street Health Outreach
Zone
July 2022

	Monday	Tuesday	Wednesday	Thursday	Friday
8:00 AM	Weekly Huddle	Huddle 30min/ Admin	Huddle 30min/ Admin	Huddle 30min/ Admin	Admin
9:00 AM	Site 1 (~45)**	Targeted / follow up	ACHCH LC or Targeted Specialty Mtgs/ Internal Program Meetings	Site 8 (~30-50)	Targeted medical
10:00 AM					
11:00 AM	Site 2 (8) & Site 11 (5) (Rotating biweekly)	Site 5 (~30)	Internal meetings/ trainings		
12:00 PM	Site 3 (7) & Site 12 (11) (Rotating biweekly)		Lunch		
1:00 PM	Lunch	Lunch	Targeted medical	Lunch	Lunch
2:00 PM	Site 4 (~40-60)	Site 6 (~25)		Site 9 (~15) or Site 13 (7) (Rotating biweekly)	Huddle 30min w Provider/ Admin
3:00 PM				General Outreach	Site 10 (~8-10)
4:00 PM		Site 7 (~12)		General Outreach	General Outreach
5:00 PM	Huddle 30min/ Admin	Huddle 30min/ Admin	Huddle 30min/ Admin	Huddle 30min/ Admin	Admin

***Note Schedule includes the **Site Name** followed by the approximate **Site Census in paratheses**, e.g., "Main & 45th (~12-15)"*

Role	Staff Member	Color Coding	Event
RN/ Team Lead	Tobie RN		Admin
CHOW	Chris		Meetings/ Trainings
SW/ ICM	Taylor MSW		With Provider
Provider	Jordan NP		Set Schedule
Provider 2	Blake MD		

Site Name	Location (Address and/ or Cross Street)
Site 1 (aka "nickname1")	Street & Avenue, City
Site 2	17th Ave & Marquee Way, City
Site 3	12th Ave & Marquee Way, City
Site 4	55th-58th & Main St, City
Site 5	etc
Site 6	etc
Site 7	
Site 8	
Site 9	
Site 10	
Site 11	
Site 12	
Site 13	

Alameda County
Health Care for the Homeless

Appendix D
ALAMEDA COUNTY HEALTH CARE FOR THE HOMELESS
STREET HEALTH FORMS

ALAMEDA COUNTY HEALTH CARE FOR THE HOMELESS
1404 Franklin Street, Suite 200, Oakland, CA 94612
TEL (510) 891-8950
FAX (510) 832-2139
www.achch.org

AUTHORIZATION TO RELEASE OR OBTAIN PROTECTED HEALTH INFORMATION

PATIENT INFORMATION

Last Name | **First Name** | **Middle Initial**

Date of Birth | **Social Security No.** | **Home Phone** | **Work Phone** | **Extension**

Street Address | **City** | **State** | **Zip Code**

I HEREBY AUTHORIZE THAT MY INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION BE RELEASED FROM:

Physician Name/Clinic/Hospital/Other | **Phone Number** | **Extension**

Street Address | **City** | **State** | **Zip Code**

I HEREBY AUTHORIZE THAT MY INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION BE RELEASED TO:

ALAMEDA COUNTY HEALTH CARE FOR THE HOMELESS
Physician Name/Clinic/Hospital/Other | **Phone Number** | **Extension**

384 14TH ST | OAKLAND | CA | 94612
Street Address | **City** | **State** | **Zip Code**

INFORMATION REQUESTED

(☐) All medical records, including Mental Health and HIV treatment
(☐) Other: _____

To limit information to a specific date range, check here (☐) and fill-in the dates below:

For Dates of Service from ☐ **through** ☐

Alameda County Health Care for the Homeless

ALAMEDA COUNTY HEALTH CARE FOR THE HOMELESS
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www.achch.org

AUTHORIZATION TO RELEASE OR OBTAIN PROTECTED HEALTH INFORMATION

I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization and that I am entitled to receive a copy of this authorization after I sign it.

EXPIRATION: This Authorization expires twelve (12) months from: (☐) _____
(☐) **the date signed**

To specify a different expiration, check here (☐) and fill-in the expiration date:_____

PURPOSE OF REQUESTED USE OR DISCLOSURE OF RECORDS/PROTECTED HEALTH INFORMATION:

(☐)Purpose: _____

_____ _____ _____
Signature of Patient **Print/Type Name** **Date**

If required:

_____ _____ (☐)**Parent** _____
Signature of Parent or Guardian **Print/Type Name** (☐)**Guardian** **Date**

REVOCATION: I understand that I have a right to revoke this authorization at any time unless action has been taken in response to or in reliance on this authorization. I understand that my revocation must be in writing and presented to an Alameda County Health Care for the Homeless (HCH) representative in order to revoke the authorization granted to HCH. I further understand that I must present a separate written revocation to any other person or entity that I have authorized to receive or use my individually identifiably health information above in order to revoke the authorization granted to that person or entity.

WARNING: PROHIBITIONS ON USAGE, TRANSFER OR REDISCLOSURE OF INFORMATION, except as required by State or Federal laws, use of information released for other than the stated purpose, or redisclosure or transfer of this information to any person or entity not named herein is PROHIBITED. An additional written authorization must be obtained for any proposed new use of the information or for its redisclosure or transfer of such information. The information disclosed may be subject to redisclosure and may no longer be protected by federal privacy regulations.

MEDICAL RECORDS WILL BE RETAINED FOR SEVEN (7) YEARS FOLLOWING A PATIENT'S DISCHARGE FROM OUR AGENCY, WHEREUPON THEY WILL EITHER BE DESTROYED OR, IF REQUESTED, RETURNED.

Medical Record # or provider name (CBO Option) _____

ALAMEDA COUNTY HEALTH CARE FOR THE HOMELESS PROGRAM
Client Encounter/Intake Form

Clinic/Provider Name_____Site_____ Date of Service_____/____/____

PRINT ALL INFORMATION **LEGIBLY**

CLIENT INFORMATION

Phone #_____ (optional) SS#_____ (optional) Sex as assigned at birth: _____

First Name:_____ Last Name_____ Birthdate: _____/_____/____

Ethnicity:
- ☐ Hispanic or Latino (Spanish heritage)
- ☐ All others, including unreported

Check both *RACE* and *ETHNICITY*!!

Race:
- ☐ White
- ☐ Asian
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Black/African American
- ☐ American Indian/Alaska Native
- ☐ More than one race
- ☐ Unreported/Refuses to report

If interview/treatment is **not** conducted in English, check **Translation Needed? ☒ Y**

Translation Needed? ☐ Y ☐ N

Date HIPAA form signed:____/_____/_____

Family Status:
- ☐ Unattached to group or family
- ☐ Living in family unit with:

CHECK ALL THAT APPLY:
- ☐ Spouse/Partner
- ☐ Children [#]_____
- ☐ Siblings [#]_____
- ☐ Parents [#]_____
- ☐ Other_____ *[SPECIFY]*

Pregnant? ☐ Y ☐ N ☐ N/A

Gender Identity:
- ☐ Male
- ☐ Female
- ☐ Transgender Male (Female-to-Male)
- ☐ Transgender Female (Male-to-Female)
- ☐ Gender Queer
- ☐ Other
- ☐ Choose not to respond

Sexual Orientation
- ☐ Straight or heterosexual
- ☐ Lesbian, gay or homosexual
- ☐ Bisexual
- ☐ Something else
- ☐ Don't know
- ☐ Choose not to disclose

Medical Payment Resource:
[Check all that apply]
- ☐ No Health Insurance
- ☐ HealthPAC
- ☐ Medi-Cal Managed Care (Alliance)
- ☐ Medi-Cal Managed Care (Blue Cross)
- ☐ Medi-Cal Fee For Service
- ☐ Medicare ☐ Medi-Medi
- ☐ Private Insurance (incl. VA, Kaiser)
- ☐ Other _____ *[SPECIFY]*

Homeless Status:
- ☐ Homeless Shelter
- ☐ Transitional Housing/Program
- ☐ Recovery Program
- ☐ Doubling up (friends or relatives)
- ☐ Street, vehicle, etc
- ☐ Hotel/Motel
- ☐ Other _____

includes not currently homeless
[SPECIFY]

Monthly Income:
Total Net Amount: $_____

Financial Resources: *[Check all that apply]*
- ☐ None
- ☐ SSI/SSA
- ☐ GA (General Assistance)
- ☐ Job / Pension
- ☐ Unemployment
- ☐ Calworks
- ☐ Food Stamps/SNAP
- ☐ VA Benefits
- ☐ Other _____ *[SPECIFY]*

Is Client a Veteran?
☐Yes ☐No

ENCOUNTER INFORMATION

1. Must be face-to-face 2. Must be charted

Enabling Services Codes:
Non-Clinical Encounters Only
(Check all that apply)
- ☐ Medical Referral
- ☐ Health/Financial Benefits Counseling
- ☐ Housing assistance
- ☐ Employment assistance
- ☐ Food Assistance
- ☐ Nutrition Education
- ☐ Health Education
- ☐ Alcohol/Drug Counseling/Referral
- ☐ Mental Health Counseling/Referral
- ☐ Transportation Assistance
- ☐ Dental Referral
- ☐ Optometry Referral
- ☐ Dental Case Management
- ☐ Other:_____

Please enter Enabling Service Provider Type: →

Provider Code: (Check at least one)
- ☐ Family Physician
- ☐ Specialist Physician
- ☐ General Practitioner
- ☐ Obstetrician/Gynecologist
- ☐ Pediatricians
- ☐ Optometrist ☐Ophthalmologist
- ☐ Nurse Practitioner
- ☐ Physician Assistant
- ☐ Nurses
- ☐ Other Medical:_____
- ☐ Dentist
- ☐ Dental Hygienists

Behaviorist: ☐LCSW ☐Psychiatrist
☐ Psychologist ☐Other MH Staff

Enabling/Case Management:
- ☐ 10. Case Managers/Outreach Workers
- ☐ 11. Health Specialists ☐14. MH specialist
- ☐ 13. Alcohol/Drug Counselor

DIAGNOSIS INFORMATION

Clinical Encounters ONLY;
Complete as many as applicable.
Use ICD-10; CPT codes ONLY.
Dental providers use ADA codes ONLY.

Dx 1 _____ (Primary Diagnosis)
Dx 2 _____
Dx 3 _____
Dx 4 _____
Dx 5 _____

Alameda County Health Care for the Homeless

Basic Needs Screening/Care Plan

Name: _____ Date Care Plan Developed: _____

Date Care Plan Reviewed/Updated _____

May I ask you some questions about your health and housing needs so I can better understand how we might be able to assist you?

Basic Needs	Care Plan Goals	Completed Goal
Do you have regular access to food? ☐Yes ☐ No	Obtain CalFRESH (Food Stamps): ☐ Accepted Support ☐ Declined Support ☐ N/A (Need Met) ☐ Declined to Answer	
Do you have regular access to a toilet/shower? ☐Yes ☐ No	Obtain information on where to access hygiene resources: ☐ Accepted Support ☐ Declined Support ☐ N/A (Need Met) ☐ Declined to Answer	
Do you have regular access to transportation? ☐Yes ☐ No	Obtain Transit Pass: ☐ Accepted Support ☐ Declined Support ☐ N/A (Need Met) ☐ Declined to Answer	
Have you ever applied for any housing opportunities? ☐Yes ☐ No	If so, with what agency and when? Apply for housing opportunities/update HMIS Client Profile/CE Housing Assessment: ☐ Accepted Support ☐ Declined Support ☐ N/A (Need Met) ☐ Declined to Answer	
Do you have any safety concerns? ☐Yes ☐ No Would you like assistance obtaining a shelter bed? ☐Yes ☐ No	Safety concerns: Obtain a shelter bed, including IPV bed/support: ☐ Accepted Support ☐ Declined Support ☐ N/A (Need Met) ☐ Declined to Answer	
Health & Wellness		
<u>Physical Health</u> Do you have a PCP? ☐Yes ☐ No If yes, have you seen them in the past 6 months? ☐Yes ☐ No	Where do you receive your healthcare? Medical Home: PCP: Obtain/reconnect with (or change) medical home/PCP: ☐ Accepted Support ☐ Declined Support ☐ N/A (Need Met) ☐ Declined to Answer	
Do you have any physical health concerns? ☐Yes ☐ No	Physical health concerns: Meet with Street Health RN/Provider: ☐ Accepted ☐ Declined ☐ N/A (Need Met) ☐ Declined to Answer	
Have you had a COVID-19 vaccine? ☐ Yes ☐ No	Receive COVID-19 vaccine or booster: ☐ Accepted Support ☐ Declined Support ☐ N/A (Need Met) ☐ Declined to Answer	

Mental Health Do you have any mental health concerns? ☐Yes ☐ No Are you currently experiencing stress? ☐ Yes ☐ No (If "Yes" to either of the above): Would you like to talk to one of our providers about it? ☐ Yes ☐ No	Mental health concerns: Meet with Street Health SW/Provider: ☐ Accepted Support ☐ Declined Support ☐ N/A (Need Met) ☐ Declined to Answer	
Oral Health Do you have any oral/dental health concerns? ☐ Yes ☐ No Do you have any mouth/tooth pain? ☐ Yes ☐ No Any bleeding or abscesses in your mouth? ☐ Yes ☐ No Any cavities? ☐ Yes ☐ No Are you able to chew your food? ☐ Yes ☐ No	Oral/dental health concerns: If yes, for how long? If yes, for how long? Obtain dental care? ☐ Accepted Support ☐ Declined Support ☐ N/A (Need Met) ☐ Declined to Answer	
Substance/Alcohol Use Would it be alright if I asked you about your drug and alcohol use? ☐ Yes ☐ No Are you currently using any drugs or alcohol? ☐ Yes ☐ No Have you ever felt the desire or need to change your drug or alcohol use? ☐ Yes ☐ No	Name(s) of current/prior substance(s) used: Obtain SUD support, including MAT, detox, outpatient, or residential treatment: ☐ Accepted Support ☐ Declined Support ☐ N/A (Need Met) ☐ Declined to Answer	

Financial and Benefit Documentation		
Do you have a California ID? ☐ Yes ☐ No If no, were you born in CA? ☐ Yes ☐ No If you were not born in CA, do you have a copy of your birth certificate? ☐ Yes ☐ No	Obtain California ID: ☐ Accepted Support ☐ Declined Support ☐ N/A (Need Met) ☐ Declined to Answer Place of birth:	
Do you have a Social Security card? ☐ Yes ☐ No	Obtain Social Security Card ☐ Accepted Support ☐ Declined Support ☐ N/A (Need Met) ☐ Declined to Answer	
Do you receive any type of public benefits income? ☐ Yes ☐ No Do you have any employment or other type of income (recycling, child support, pension, etc.)? ☐ Yes ☐ No Would you like to apply for any type of public benefits income? ☐ Yes ☐ No	If so, what kind: ☐ Supplemental Security Income (SSI) ☐ General Assistance ☐ Social Security Disability Insurance (SSDI) ☐ CalWORKS ☐ Social Security (Retirement) Source: Total Monthly Amount: $_____ Apply for public benefits: ☐ Accepted Support ☐ Declined Support ☐ N/A (Need Met) ☐ Declined to Answer	
Do you have health insurance? ☐ Yes ☐ No	☐ Medi-Cal ☐ Medicare ☐ HealthPAC ☐ Private Insurance: ☐ Other: Obtain health insurance: ☐ Accepted Support ☐ Declined Support ☐ N/A (Need Met) ☐ Declined to Answer	
Other Service Connections		
Have you ever served in the armed forces? ☐ Yes ☐ No	If yes, which branch? If yes, do you know your discharge status? Connect with VA to explore potential benefit options: ☐ Accepted Support ☐ Declined Support ☐ N/A (Need Met) ☐ Declined to Answer	

Do you have any legal needs? ☐ Yes ☐ No	☐ Criminal ☐ Family ☐ Traffic ☐ Immigration Please provide details: Connect with legal support to resolve legal issues: ☐ Accepted Support ☐ Declined Support ☐ N/A (Need Met) ☐ Declined to Answer	
Are you working with any other support agencies that you would like us to know about (e.g., case manager, benefits counselor, etc.)? ☐ Yes ☐ No	Agency Name and Contact Information:	

Alameda County
Health Care for the Homeless

ALAMEDA COUNTY HEALTH CARE FOR THE HOMELESS
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TEL (510) 891-8950
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www.achch.org

Appendix D

PATIENT CONSENT FORM

CONSENT FOR TREATMENT

I hereby give my voluntarily consent to receive health care services from Alameda County Health Care for the Homeless (ACHCH) program. I further authorize any health professional working for ACHCH program to provide medical/psychiatric diagnostic assessments, tests, procedures, and treatments that are necessary or advisable for the medical/psychiatric evaluation and management of my health care.

INSURANCE AND FINANCIAL INFORMATION

I am aware of the sliding scale fee discount policy of ACHCH program. I will not be denied any health or social services provided by ACHCH program because of inability to pay. ACHCH program is permitted to seek reimbursement from third party payment sources including HMOs, Medi-Cal, Medicare, and the Health Program of Alameda County (HealthPAC).

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of ACHCH program's Notice of Privacy Practices, which explains how my treatment records and personal information are kept confidential, may be used and disclosed by ACHCH program, and how I may access this information.

My signature below gives my consent to voluntary health care services from ACHCH program. If I am the patient's legal representative, my signature gives that consent. My signature also means that the information described above was discussed with me in a language or way that I understood and that I was given copies of these materials. Further, I understand that my consent will remain fully effective until it is revoked in writing and that I have the right to discontinue services at any time.

Patient Name (Printed):	
Patient/Legal Representative Signature:	**Date:**
Witness (Signature):	**Date:**

Alameda County
Health Care for the Homeless

Appendix D:

CLIENT REQUEST AND CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS OF SMS TEXT MESSAGE

I request and consent to allow *Alameda County Health Care for the Homeless Program* to use unsecured mobile phone text messaging (i.e., unsecured SMS) to transmit to me the following protected health information:

- Information related to the scheduling of meetings or other appointments.
- Information related to billing and payment.
- Any other questions that the client may ask or information client requests via unsecured mobile phone text messaging.

Response Time
We may not be able to respond to your test messages immediately. For text messages, you can generally expect a response within *24 hours* (weekends, holidays, and time off are excepted from this timeframe). Please be aware that text messages occasionally get delayed and on rare occasions may be lost; there may be times when we are unable to receive or respond to text messages, such as when out of cellular range or out of the office.

Emergency Contact
Please note that text messaging is not designed for emergency contact. If you are ever experiencing an emergency, please call *911 or go to your closest emergency room.*

I understand that message/data rates may apply to messages sent to my cell phone.

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time and opt-out of receiving these communications from *Alameda County Health Care for the Homeless Program* by calling (510) 891-8950 or by texting "STOP" to (510) 891-8950.

Name: _____

Signature: _____

Date: _____/_____/_____

Alternatively: If a message containing PHI is received, the staff member should respond only with a brief message asking the person to call the staff member or another appropriate person in the department.

- The [agency] will respond to text messages generated by health care clients with a text message asking the client to call. The response should include the first name and phone number of the appropriate person to call.
- Messages received from subscribers or clients will be deleted from mobile devices after necessary information is documented in accordance with records retention policies.

Alameda County
Health Care for the Homeless

Appendix E
STREET HEALTH FIELD
MEDICAL EMERGENCY KIT INVENTORY LIST

Medication	Description	Strength	Form	Qty
Albuterol	Inhaler		MDI	1
Aspirin	Anticoagulant	325mg	Tablet	1 Btl
Diphenhydramine	Antihistamine	12.5mg/mL	Susp.	1
Diphenhydramine IM	Antihistamine	50mg/mL	Vial	2
Epinephrine	Epi-Pen	0.3 mg	Auto Inj.	1
Insta - Glucose	Oral	31gm	Gel	2
Naloxone HCL	Injection	0.4mg/mL	Vial	4
Naloxone HCL	Nasal	4mg	Nasal	4
Nitroglycerin			Spray or sublingual	1

Supplies	Size	Qty
ACLS Card	Card	1
Alcohol Pads		20
Ambu Bag - Adult		1
Betadine Wipes		20
Blood Pressure Cuff		1
CPR Masks		2
Emergency Anaphylaxis Procedures	Chart	1
Gloves (multiple sizes)	Box	1 each size
Glucometer Kit		1
Goggles/Eye Protection		2
Face Shield		4
Fluid Resistant Gown		2
Insta Cold Packs		8
Insta Hot Packs		8
Masks - N95 recommended		20
Masks – Surgical		100
Penlight		1
PPE: Gowns		4
PPE: Face Shield		4
Spill Kit		2
Sharps Container		1
Syringe with needle 21ga	3mL	10
Syringe with needle 21ga	5mL	10
Thermometer		2

Appendix F: Outreach Field Log

Site: Staff Completing Log:

<table>
<tr><th colspan="4">Outreach Field Log</th></tr>
<tr><th>Date</th><th>Time</th><th>Staff on Site</th><th>Partners on Site</th></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><th colspan="4">Notes</th></tr>
<tr><td colspan="3">First Name: Last Name: Alias:

☐ Updated Contact Info:</td><td>RBA Completed:
☐ Basic Needs Screening/Care Plan
☐ Triage Nursing Assess
☐ F2F Provider Visit (i.e., NP/PA/DO/MD)
☐ Subs Use Harm Reduction Supplies Distributed
☐ Subs Use Harm Reduction Goal Created
☐ Subs Use Harm Reduction Goal Achieved
☐ HPS ☐ CE Eligibility Screened ☐ CE Assess</td></tr>
<tr><td colspan="3">First Name: Last Name: Alias:

☐ Updated Contact Info:</td><td>RBA Completed:
☐ Basic Needs Screening/Care Plan
☐ Triage Nursing Assess
☐ F2F Provider Visit (i.e., NP/PA/DO/MD)
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☐ Subs Use Harm Reduction Supplies Distributed
☐ Subs Use Harm Reduction Goal Created
☐ Subs Use Harm Reduction Goal Achieved
☐ HPS ☐ CE Eligibility Screened ☐ CE Assess</td></tr>
</table>

Alameda County
Health Care for the Homeless

Appendix G: Patient Transportation Options in Alameda County

Medi-Cal Funded Transportation for Health Care Appointments

(for patients with Alameda Alliance, Anthem Blue Cross, and straight Medi-Cal)

Non-Emergency Medical Transportation (NEMT)

- ✓ Mode: Ambulance, litter van, wheelchair van, airlift
- ✓ Eligibility: Patients are eligible when normal means of transportation are contraindicated and transportation is to a medically necessary Medi-cal service
- ✓ Providers can call directly to facilitate rides
- ✓ Prior authorization (Physician's Certification Statement) and Medi-Cal required
- ✓ Must be scheduled 2-3 business days in advance
- ✓ Operator: Logisticare Phone (866) 529-2128, Fax (877) 457-3352

Non-Emergency Transportation (NET)

- ✓ Mode: Passenger car (taxi service), taxi vouchers, mileage reimbursement
- ✓ Can be used for transportation to any Medi-Cal covered service
- ✓ Providers and patients can call directly to facilitate transport
- ✓ Prior Authorization (Physician Certification Statement) and Medi-Cal required
- ✓ Schedule 1-2 days in advance for "curb-to-curb" and 7 days in advance for transportation vouchers (mailed to provider)
- ✓ Operator: Logisticare: Phone (866) 529-2128, Fax (877) 457-3352

Tips:

- ➢ Patient's name, date of birth and insurance information should be available when calling to schedule rides
- ➢ Patient should have a phone to confirm and coordinate unless staff member is with them.
- ➢ The name of the clinic and addresses needs to be provided when scheduling
- ➢ Traffic is not considered when calculating pick-up times
- ➢ Patient is allowed to bring a friend, caretaker, or pet (service certification not required)
- ➢ Alameda Alliance and Anthem Blue Cross Physician Certification Statements (PCS) are attached below

HealthPAC Funded Transportation for Health Care Appointments

(for patients with HealthPAC)

Non-Emergency Transportation (NET)

- ✓ Mode: Ambulance, passenger car, Lyft
- ✓ Eligibility: Patients of AHS with HealthPAC coverage are eligible. Level of service and mode of transport is assessed on the phone when scheduling a ride
- ✓ Solely staff members of AHS facilities and clinics can schedule rides through Royal Ambulance
- ✓ No prior authorization required (PCS form not required for NET)
- ✓ Can schedule in advance or real-time.
- ✓ Operator: Royal Ambulance: Phone (888) 510-3687

Tips:

- This is a resource that providers can request from an AHS staff member when coordinating care for an AHS patient
- Rides must be scheduled and coordinated by an AHS clinic or facility staff member
- Type of transport, eligibility for a ride, pick-up location options are case-by-case and decided during scheduling call with clinic staff

Paratransit

Wheelchair vans are available for seniors and residents with disabilities who are unable to use public transportation independently.

- ✓ Mode: ADA accessible wheelchair van
- ✓ Eligibility: A completed Paratransit Application and an in-person interview are required to determine eligibility. The application and interview must show that the patient is unable to access or use regular AC Transit and BART services independently
- ✓ Patient or provider can schedule rides
- ✓ Must schedule rides at least 1 day in advance
- ✓ Qualified attendants can ride for free, all others must pay full fair
- ✓ Patients pay a fee based on the distance traveled ($4 1-12 miles, $6 12-20 miles, $8 >20 miles, one way)
- ✓ East Bay Paratransit is the provider throughout most of Alameda County
  - **Certifications** (510) 287-5000 or 1-(800) 555-8085, press 5
  - **Reservations** (510) 287-5000 or 1-(800)-555-8085, press 1
- ✓ Wheels Dial-a-Ride is the provider for Pleasanton, Dublin, and Livermore
  - **Certifications** (925) 455-7555
  - **Reservations** (925) 455-7510

Tips:

- Provider assistance is recommended when filling out the eligibility application
- Schedule further than 1 day in advance to increase likelihood of ride time availability
- Pick-up window is ½ hour and rides may take significantly longer than taxi or passenger car
- Rides are shared with other passengers
- Applications for East Bay Paratransit can be found at https://www.eastbayparatransit.org/CMS/uploadedFiles/Combine-PT-Elig-Instruction-and-Application-Nov13.pdf
- Applications for Wheels Dial-a-Ride can be found at https://www.wheelsbus.com/wp-content/uploads/2015/10/ADA-Application-6-3-13-2.doc

Public Transportation

AC Transit Regional Transit Connect (RTC) Discount Card Program

- ✓ Approximately 50% discount on bus tickets, bus passes, and BART fares for seniors needing an attendant, minors, and eligible disabled individuals
- ✓ Eligibility
  - Seniors 65 and older who need to travel with an attendant
  - Individuals with qualifying disabilities
  - Minors
- ✓ Proof of eligibility – Basic Eligibility Form
  - Federally-issued Medi-Care card **or**
  - DMV disabled placards with DMV registration receipt **or**

- VA "Service Connected Disability ID" card and VA Certification Letter **or**
- Other California transit agency's discount card

✓ Proof of eligibility – Medical Certification Form

- If unable to provide proof of basic eligibility must submit Medical Certification Form
- Original Medical Certification Form available at AC Transit offices and other designated facilities
- Certification and signature of a licensed practitioner who is able to diagnose the applicant's disabling condition is required

Tips:

- Only original applications and supporting documents are accepted (no copies)
- License in an applicable field of practice is required to certify specific categories of disability (see Medical Eligibility Form example attached for details)
- Specific disabling conditions with moderate to severe impairments are eligible (See Medical Certification Form example attached for details)

Original Medical Certification Forms for the AC Transit Discount Program and are available at the AC Transit Customer Service Center at 1600 Franklin Street, Oakland, CA 94612. (Example for reference attached below)

Lyft

Some programs have funding and a provider account for Lyft rides to and from health care appointments (Lifelong TRUST, ACHCH, AHS)

✓ Rides need to be scheduled and coordinated by a staff member with program log-in
✓ Patients need to be ambulatory and alert
✓ Patients must have access to a cell phone for coordination (if not with provider)

Tips:

- It is advisable to have a clear, identifiable location for pick-up and drop-off
  - Cross-streets ("corner of") usually work if provider can maintain communication with the patient and driver to ensure they can find one and other
  - A specific business or address is easiest and most effective, but still my require communication with both parties
- Staff member may have to remain on the phone with the patient to ensure pick-up, as well as to contact driver to give details about the patients specific whereabouts
- Although less expensive, shared rides are not advisable in most situations due to the added coordination needed, increased restrictions on driver wait times, and limited space for medical equipment.

Alameda Health Systems

AHS clinics and hospitals have various options for patient transportation to and from health care appointments, including coordination through the Medi-Cal and HeatlhPAC transportation providers (above), bus tickets and day passes, taxi vouchers, Lyft rides, and shuttles.

✓ All modes of transportation, aside from shuttles, have to be facilitated by an AHS clinic or hospital staff member
✓ Outside programs can request transportation assistance for a patient for getting to and from AHS appointments and, in some cases, other health-related services

- ✓ The AHS staff member can assist in determining the appropriate mode of transportation assistance according to the patient's need and time restraints.
- ✓ AHS shuttles:
    - Between Lake Merritt BART station and Highland Hospital
        - 6am to 8 pm, every 15 minutes on the hour
    - Between Bay Fair BART Station and Fairmont Hospital
        - Times vary, please contact AHS for details

Tips:

- ➢ It is best to use this resource (aside from shuttles) when coordinating directly with an AHS clinic or hospital staff member to provide services to an AHS patient
- ➢ Any AHS staff member involved in coordination for the patient's care can facilitate transportation
- ➢ The staff member requesting transportation should be prepared with relevant information for logistics and assessment of transportation needs

Bike Share and E-Scooter Discounts

Most bike Share and E-Scooter companies in the Bay Area offer a deep discount for low income residents through Lyft's Bike Share for All and Lyft Access for All programs

- ✓ Lyft Bike Share for All
    - One-time $5 Annual Membership ($5/month in second year)
    - Eligibility: Bike Share for All is available to Bay Area residents ages 18 and older who qualify for Calfresh or PG&E CARE utility discount
    - Bikes available 24/7/365 in San Francisco, Oakland, Berkeley, Emeryville and San Jose
    - Membership includes first 60 minutes of each trip
    - Rides longer than 60 minutes will result in additional fees of $3 for each additional 15 minutes or potential account suspension
    - In-person enrollment at select locations
    - No credit or debit card required
    - Clipper card compatible

More information and registration/cash pay locations can be found at https://www.lyft.com/bikes/bay-wheels/bike-share-for-all

- ✓ Lyft Access for All (E-Scooters)
    - $5 monthly membership
    - Eligibility: Access for All is available to Bay Area residents ages 18 and older who are enrolled in or qualify for state or federal assistance programs, such as SNAP, Medi-Cal, or PG&E Care.
    - Scooters are available 24/7/365 in Oakland, Berkeley, and Emeryville
    - Membership includes first 30 minutes of each trip within the service area
    - Rides longer than 30 minutes may result in additional charges
    - In-person enrollment at select locations or enroll online at https://www.lyft.com/scooters/oakland-ca/community
    - No credit or debit card required

- ✓ See other E-Scooter company websites, such as Lime, to learn about and apply for their low-income discount programs.
  - https://www.li.me/community-impact

City Programs

All Alameda County cities offer shuttles for individual seniors and senior groups. These primarily serve senior centers and other locations that seniors frequent, but in some cases provide rides for shopping and appointments.

Additionally, there are volunteer organizations throughout the county that provide accompanied rides, by volunteers for seniors of various ages. Travel training for public transportation is also available in most cities for seniors and individuals with disabilities.

A comprehensive and user-friendly guide to all city-based transportation programs including AC Transit, paratransit, volunteer driver organizations, and door-to-door city programs can be found at http://accessalameda.org/.

Note: Updated transportation information may be located at: https://careconnect.elemenohealth.com/

ALAMEDA Alliance FOR HEALTH
Health care you can count on.
Service you can trust.

Physician Certification Form - Request for Transportation

Please print clearly. For NEMT only, the physician must sign this form where indicated below.
***Required fields must be completed.**
Please return form by fax to LogistiCare - Attn: Utilization Review (877) 457-3352

PATIENT INFORMATION	
*Patient's Name:	*Patient's DOB:
*Patient's ID Number/CIN#	Member's Contact Number:
DIAGNOSIS	
Diagnosis:	ICD Code:

TRANSPORTATION NEEDS (*Please check ONLY ONE level of service in *either* NEMT *or* NMT section)

Non-Emergency Medical Transportation (NEMT)
NEMT includes transportation by ambulance, wheelchair, and gurney vans for medically necessary covered services, specifically when the patient is non-ambulatory. Check the applicable level of service needed:

- ☐ Wheelchair Van
- ☐ Ambulance/Litter Van/Gurney Van (Patient bed bound)
- ☐ ALS (Patient requires ALS services/availability)
- ☐ CCT/SCT (Patient requires cardiac monitoring)
- ☐ LS (Patient requires oxygen not self-administered or regulated)
- ☐ Air Transport

Non-Medical Transportation (NMT)
NMT includes transportation provided via taxi, car or other public conveyances for medically necessary covered services. *No signature is required for NMT.* Check the applicable level of service needed:

- ☐ Public Transportation/Mass Transit
- ☐ East Bay Paratransit
- ☐ Curb-to-Curb Vehicle Transportation (Taxicab)
- ☐ Door-to-Door Vehicle Transportation
- ☐ Private Vehicle arranged by patient*

**additional verification information needed for approval*

*DURATION (based on medical necessity and continued health plan eligibility):

☐ 30 days	☐ 60 days	☐ 90 days	☐ 6 months	☐ 12 months

FUNCTION LIMITATIONS JUSTIFICATION

When transportation is requested for an ongoing basis, the chronic nature of the patient's medical, physical, or mental health condition must be indicated in the treatment plan. A diagnosis alone will not satisfy this requirement. Treatment plan should include the medical, behavioral health, or physical condition that prevents normal public or private transportation. NMT services do not require physician signature and will be approved based on the least costly method of transportation that meets the member's needs.

***PLEASE INCLUDE YOUR JUSTIFICATION BELOW:**

CERTIFICATION FOR NON-EMERGENCY MEDICAL TRANSPORTATION

The provider responsible for providing care for the member is responsible for determining medical necessity for transportation. This certificate can be completed and signed by an MD, DO, PA, or NP who is employed or supervised by the hospital, facility, or physician's office where the patient is being treated and who has knowledge of the patient's condition at the time of completion of this certificate.

Provider's Name & Credential (Print):	**Date:**
Provider's Signature:	**Phone Number:**

Questions? Call LogistiCare's California Facility Department at (866) 529-2128

Physician Certification Statement — Transportation Justification Request

This form provides ModivCare* or another authorized transportation provider with information about the appropriate level of nonmedical transportation (NMT) or nonemergency medical transportation (NEMT) needed for the member. Please return the completed form by fax to ModivCare at **877-457-3352**, Attn: Utilization Review.

Patient name (Print clearly.):	
Member ID number:	DOB:

Please check only **one** medically necessary mode of NMT. **Note:** A physician's signature **is not** required for NMT.

1. **NMT** includes transportation for medically necessary appointments and may be provided via taxi, sedan, paratransit (such as access) or fixed route transportation (such as a bus).
   - ☐ **Mass transit**: Patient/member is able to use public transportation and medically able to walk up to three-quarters of a mile to a bus stop (curb to curb).
   - ☐ **Paratransit services**: Patient/member (already certified, qualified or eligible to apply) can walk to the curb and board and exit a vehicle unassisted but cannot utilize the bus or train (curb to curb).
   - ☐ **Ambulatory (sedan, taxi)**: Patient/member can walk to the curb and board and exit the vehicle unassisted but cannot utilize the bus or train (curb to curb).

Please check only **one** medically necessary mode of NEMT. **Note:** A physician's signature **is** required for NEMT.

NEMT includes ambulances, wheelchair vans and gurney vans and is provided when medically necessary and the patient is not ambulatory. NEMT transportation under Medi-Cal Managed Care is covered only when the patient's medical and physical condition does not allow him or her to travel by bus, passenger car, taxi or another form of public/private vehicle.

- ☐ **Wheelchair van**: Patient uses a power or electric wheelchair and requires a lift-equipped vehicle and driver assistance.
- ☐ **Stretcher/gurney van**: Patient/member is confined to bed, cannot sit in a wheelchair and does not require medical attention/monitoring during transport.
- ☐ **Basic life support ambulance**: Patient/member is confined to bed; cannot sit in a wheelchair; and requires medical attention/monitoring during transport for reasons such as isolation precautions, nonself-administered oxygen or sedation.
- ☐ **Advanced life support ambulance**: Patient/member is confined to bed; cannot sit in a wheelchair; needs advanced life support; and requires medical attention/monitoring during transport for reasons such as intravenous device monitoring, cardiac monitoring or tracheotomy.
- ☐ **Air transport**: Patient/member's medical condition is such that transport by ordinary means of private or public ground transportation is medically contraindicated.

2. Please justify the mode of transportation chosen above with a medical purpose specific to visit(s), including functional limitations that preclude the patient's ability to ambulate without assistance or be transported by private/public vehicle:

* ModivCare is an independent company providing transportation services on behalf of Anthem Blue Cross.

3. Duration of services (based on continued eligibility): ☐ 30 days ☐ 60 days ☐ 90 days ☐ 12 months

   Start date: _____ End date: _____

Certification statement: The physician, dentist or podiatrist responsible for providing care for the member is responsible for determining medical necessity for transportation. This certificate can be completed and signed by the member's physician or physician extender (including Physician Assistants [PAs], Nurse Practitioners [NPs], Certified Nurse Midwives [CNMs], Physical Therapists, Speech Therapists, Occupational Therapists and Mental Health or substance use disorder providers), or discharge planner who is employed or supervised by the hospital, facility or physician's office where the patient is being treated and who has knowledge of the patient's condition at the time of completion of this certificate. A completed and approved physician certification statement form may not be modified.

Staff/physician's name:	
Staff/physician's signature:	Date:
Title:	Contact phone:

Important note: You are not permitted to use or disclose Protected Health Information about individuals who you are not treating or are not enrolled to your practice. This applies to Protected Health Information accessible in any online tool, sent in any medium including mail, email, fax or other electronic transmission.

MEDICAL ELIGIBILITY APPLICATION
REGIONAL TRANSIT CONNECTION DISCOUNT ID CARD

TO APPLICANTS:

To qualify for Medical Eligibility: Complete Section 1 of the Medical Certification form. You must also sign the application in two places to: 1) authorize your doctor to release information, and 2) indicate your acceptance of RTC Program terms. If your application is not signed in both places, it cannot be processed and will be returned to you.

Bring this form to your "Certifying Professional." The Certifying Professional must complete the application in blue ink with original signature.

Take this form to your transit agency listed on the last page, where you can submit the form and have your picture taken.

The Medical Verifier will contact your certifier to verify the information provided. If the correct contact information is missing and they are not able to contact the certifier, or the certifier is not responsive, the process will be delayed.

TO MEDICAL CERTIFIERS:

The purpose of the RTC Discount ID Card Program is to ensure that only eligible individuals receive fare discounts as mandated by state and federal law. An individual's eligibility is based on their inability to use fixed-route transit (i.e., regular accessible buses, light rail, commuter rail or BART) without special facilities, planning or design. [49 US § 1608 (c)(4), Section 99206.5, CA PUC]. We are requesting your help to ensure that recipients meet the eligibility criteria. If you have questions, please contact the Discount ID Card Program Office at 510/208-0200.

You may certify eligibility only in the categories related to the field of practice in which you are licensed in the State of California to diagnose:

- Licensed physicians with an M.D. or D.O. degree, licensed physician's assistants and nurse practitioners may certify in all categories in which they are licensed to diagnose;
- Licensed chiropractors, categories 1, 2, 3 and 4;
- Licensed podiatrists, disabilities involving the feet under categories 1, 2, 3 and 4;
- Licensed optometrists (OPT), category 9;
- Licensed audiologists (AU), category 10;
- Licensed clinical psychologists (PSY) and licensed educational psychologists (LEP), categories 12, 15, 16 and 17;
- Licensed marriage and family counselors (MFCC), licensed professional clinical counselors (LPCC), and licensed social workers (LCSW), category 17.

Your address and medical license information (required on each application form) will be verified with the state Medical License Board. Only California licenses are accepted.

Please provide telephone and fax numbers. A processing analyst will contact you to verify the information in order to ensure that your signature is not being falsified.

A description of the eligibility sections can be found on the reverse of this page. For more information, please consult the program brochure.

Thank you for helping maintain the integrity of the RTC Discount ID Card Program.

ELIGIBILITY CRITERIA GENERAL DESCRIPTIONS

Eligibility Sections: Only individuals meeting the definitions below are eligible. When completing the form, please indicate a Section Code corresponding to the descriptions. Please refer to the Program brochure for additional information.

Section 1 – Non-ambulatory Disabilities: Impairments that, regardless of cause, require individuals to use a wheelchair for mobility.

Section 2 – Mobility Aids: Impairments that cause individuals to walk with significant difficulty including requiring use of a leg brace, cane, walker or crutches.

Section 3 – Musculo-Skeletal Impairment (Including Arthritis): Musculo-skeletal impairment such as muscular dystrophy, osteogenesis imperfecta or arthritis of Functional Class III or anatomical Stage III. Individual has significant mobility impairment.

Section 4 – Amputation: Persons who suffer amputation of, or anatomical deformity of (a) Both hands; or (b) one hand and one foot; or (c) amputation of lower extremity at or above the tarsal region (one or both legs).

Section 5 - Cerebrovascular Accident (Stroke): With one of the following: (a) pseudobulbar palsy; or (b) functional motor deficit; or (c) ataxia affecting two extremities substantiated by appropriate cerebellar signs or proprioceptive loss post 4 months

Section 6 - Pulmonary Ills: Respiratory impairments of Class 3 (FVC between 51 and 59% of predicted, or FEV between 41 and 59% of predicted); or Class 4 (FVC less than or equal to 50% of predicted, or FEV less than or equal to 40% of predicted.

Section 7 - Cardiac Ills: Cardiovascular impairments of functional Class III, Cardiovascular impairments of functional Class IV. Please refer to the program brochure for additional details.

Section 8 – Dialysis: Individuals whose disability requires the use of a kidney dialysis machine.

Section 9 – Sight Disabilities: Those individuals whose vision in the better eye (after correction) is 20/200 or less; or those individuals whose visual field is contracted (tunnel vision) to 10° or less from point of fixation or widest diameter subtends an angle no greater than 20° and individuals who are unable to read information signs or symbols for other than language reasons.

Section 10 – Hearing Disabilities: Deafness or hearing incapacity that makes person unable to communicate or hear warning signals including those persons whose hearing loss is 70 dba or greater in the 500, 1000, 2000 Hz ranges.

Section 11 – Disabilities of Incoordination: Individuals suffering faulty coordination or palsy from brain spinal or peripheral nerve injury, functional motor deficit in any two limbs or manifestations which significantly reduce mobility, coordination or perceptiveness

Section 12 - Intellectual Disability: Intellectual Disability is a disorder that features concomitant deficits in intellectual functions and adaptive functioning that adversely impacts one or more aspects of daily living, such as communication, socialization, academic achievement and independent living. Please refer to the program brochure for additional details.

Section 13 – Cerebral Palsy: A neurological condition that appears in infancy or early childhood and permanently affects body movement, muscle coordination, and balance, and which primarily causes physical impairment involving limitation or loss of function and mobility. Please refer to the program brochure for additional details.

Section 14 – Epilepsy (Convulsive Disorder): A clinical disorder involving impairment of consciousness, characterized by seizures (e.g., generalized, complex partial, major motor, grand mal, petit mal or psychomotor), occurring more frequently than once a month in spite of prescribed treatment. Please refer to the program brochure for additional details.

Section 15 – Autism Spectrum Disorder: Deficits in verbal and nonverbal communication abilities and social interaction skills, coupled with the presence of restricted, repetitive patterns of behavior, interest or activities, which significantly impact the quality of social, educational, occupational, and/or adaptive functioning. Please refer to the program brochure for additional details.

Section 16 – Neurological Impairment: Disorders of an individual whose IQ is not less than two standard deviations below the norm. This section includes persons with severe gait problems who are restricted in mobility. Please refer to the program brochure for additional details.

Section 17 – Mental Disorders: A DSM-5 diagnosis in one of the following is required for eligibility: Schizophrenia Spectrum and Other Psychotic Disorders, Bipolar and Related Disorders, Depressive Disorders, Trauma- and Stressor-Related Disorders, Dissociative Disorders, Somatic Symptoms and Related Disorders, and Neurocognitive Disorders. Diagnosis must be at a Class 3 to 5 level and a moderate impairment is the minimum level of severity necessary to qualify. Not all diagnoses within these categories will qualify for eligibility. Ex. Disorders in remission and "Unspecified" diagnoses are specifically excluded from eligibility. Additionally, applicants who have a Substance-Related or Addictive Disorder as a primary disability **will not** qualify for this program.

Section 18 – Chronic Progressive Debilitating Disorders: Individuals who experience chronic and progressive debilitating diseases that are characterized by constitutional symptoms such as fatigue, weakness, weight loss, pain and changes in mental status that, taken together, interfere in the activities of daily living and significantly impair mobility. Please refer to the program brochure for additional details.

Section 19 – Multiple Impairments: This category may include, but not be limited to, persons disabled by the combined effects of more than one impairment. The individual impairments themselves may not be severe enough to qualify as a Transit Dysfunction; however, the combined effects of the disabilities may qualify the individual for the program.

MEDICAL CERTIFICATION FORM

ver. 1-2020

Section 1. APPLICANT INFORMATION (Please print legibly)

Name _____ Birth Date ☐☐ - ☐☐ - ☐☐

Mailing Address _____ Apt. _____

City _____ State _____ Zip _____

Daytime Phone # _____

M ☐ F☐ Non-Binary ☐ Email address _____

Communication preference: Via: US Mail ☐ Email ☐ Braille (via USPS) ☐

Section 2. RELEASE OF INFORMATION

I authorize the medical or other qualifying practitioner certifying this application to release the information requested to RTC personnel for use in determining my eligibility for this program, until 90 days from the date below unless I revoke this permission sooner.

Signature of Applicant (REQUIRED) _____ Date _____

Section 3. APPLICATION SIGNATURE (Signature in Section 2 and Section 3 are required)

I attest that the information I have provided on this application is true and correct. I hereby submit this application for an RTC Discount Card and understand that fraud or a misstatement of fact will disqualify me from receiving the benefits of the RTC Discount Card Program. I also agree to provide additional information that may be requested as part of this process.

Signature of Applicant (REQUIRED) _____ Date _____

Section 4. FOR MEDICAL PRACTITIONER / CERTIFIER USE ONLY

MEDICAL CERTIFIER: Please complete original in **blue ink**.

Eligibility Sect. # _____ **If Section 17 only**, please provide a required DSM code:

Is this disability permanent? ☐ Yes ☐ No, it's _____ months in duration.

Does applicant require an attendant when using public transit? ☐ Yes ☐ No If YES, please also initial here: _____

Name of Practitioner/Certifier _____ Field of Practice _____

Address _____ **Calif. State Lic.#** _____

City _____ State _____ Zip _____

Phone (_____) _____ Fax (_____) _____

I hereby certify that I have read the requirements of eligibility for the RTC Discount Card Program on the front of this form, and in my professional judgment the above named applicant is eligible to receive discount fares on transit because of a disability that limits her/his ability to use fixed route transit. Note: Any falsification of a condition or any part of a condition may be reported to the Federal Transportation Administration for prosecution to the full extent of the law.

Signature of Certifier _____ Date _____

Office Use Only

Intake Date		RTC ID #		Transit Agency	511	Other Info:	63

Bring this form in person with a valid photo ID and the application fee to a Bay Area transit agency intake location.

PLEASE CALL YOUR TRANSIT AGENCY FOR THEIR HOURS OF OPERATION AND TO FIND OUT WHAT FORM OF PAYMENT THEY ACCEPT.

If you have questions, please refer to the RTC website at www.transit.511.org/RTC.

AC Transit
1600 Franklin Street, Oakland
(510) 891-4777 TDD 711 (CRS)

BART
Lake Merritt BART Station, Oakland
(510) 464-7136 TDD (510) 839-2218

Golden Gate Transit
850 Tamalpais Avenue, San Rafael
(415) 455-2000 or 511 / 711

Tri-Delta Transit
801 Wilbur Avenue, Antioch
(925) 754-6622 TTY (925) 754-3695

SFMTA (Muni)
27A Van Ness Ave, San Francisco
(415) 252-3291 TDD (415) 701-4730

SamTrans
1250 San Carlos Avenue, San Carlos
(650) 508-6455 TDD (650) 508-6448

Sonoma-Marin Area Rail Transit (SMART)
5401 Old Redwood Hwy., Suite 200,
Petaluma
(707) 285-8182

Santa Rosa City Bus
Transit Mall (B Street and 2nd),
Santa Rosa
(707) 543-3333

County Connection (CCCTA)
2477 Arnold Industrial Way, Concord
(925) 676-1976 ext 2066/2067
TDD (800) 735-2929
VOICE (800) 735-2922

Valley Transportation Authority
55-A West Santa Clara Street,
San Jose -or-
3331 N. 1st Street, Bldg. B, San Jose
(408)321-2300 TDD (408) 321-2330

Soltrans (Vallejo Transit)
311 Sacramento Street, Vallejo
(707) 648-4666 TDD 707/649-5421

Wheels (LAVTA)
1362 Rutan Ct. #100, Livermore
(925) 455-7555

Solano Mobility Call Center
1 Harbor Center, Suisun City
(800) 535-6883

Petaluma Transit
555 N. McDowell Blvd, Petaluma
(707) 778-4460

This information is subject to change.

Appendix H:
STREET HEALTH FIELD
HUDDLE STANDING AGENDA

I. Productivity review from previous week.

II. Running client list, including action items and new folks identified to transition to Social Worker.

III. Review of any schedule changes from sites during the previous week and explanation.

IV. Review of schedule for the week:
   a. Are there any anticipated staffing issues for the week?
   b. Upcoming vacations?

V. Plan for identification and outreach to new sites.

VI. Share important reminders about practice changes and/or policy implementation.

VII. Supply review

Alameda County
Health Care for the Homeless

Appendix H:
STREET HEALTH FIELD
END-OF-DAY HUDDLE STANDING AGENDA

I. Check-in: (5 mins)

II. Urgent items: (5 mins)

III. Recurring agenda: (20 mins)

   a. Update Street Health Site Calendar (Excel): “Kept” or “Not Kept”

   b. Concurrently update Excel Tracking Sheet while reviewing field log (RN)

   c. Review field log to identify note charting responsibilities

IV. Which team members will document which client encounters?

   a. *Note: Single client encounters may require note charting by multiple team members depending on client encounter type/service provided*)

   b. Assign action items (i.e., care coordination)

V. Identify patients who need care outside of a scheduled visit

VI. Initiate identification of appropriate referrals to Social Worker for transitional intensive case management

   a. Review tomorrow’s schedule to determine patient needs and follow up.

VII. Patients identified for targeted provider (MD, NP, PA, Psychiatrist) care

VIII. Patients who require medication follow-up (i.e. prescriptions, buprenorphine)

IX. Patients who recently missed an appointment and need to be rescheduled

APPENDIX I
Enabling Services Types and Definitions

Types	Definition
Assessment	Non-medical assessment that includes the use of screening instruments to assess and evaluate needs and risks or other non-medical health status (i.e., social determinants of health). SOME EXAMPLES INCLUDE New patient Basic Needs Screening, Psychosocial Assessment, C-SSRS, PHQ9, PCL-5, Alcohol Use Disorders Identification Test (AUDIT), and other ongoing risk screening (including Coronavirus [COVID-19] screening). DOES NOT INCLUDE Cancer screening, HIV testing, spirometry, Coronavirus (COVID-19) Testing.
Case Management	An encounter with a patient in which a patient's care plan is co-developed and/or the patient is provided with activities that support the patient with achieving the goals/objectives of a care plan by a Case Manager (i.e., RN case manager, Social Worker, CHOW). A patient's care plan should incorporate referral of services to multiple providers or healthcare disciplines as needed. SOME EXAMPLES INCLUDE Co-development of patient care plan, directly assisting with activities that support the patient with achieving the goals/objectives of a care plan, directly attending a medical/social service appointment to provide patient with support/advocacy, and crisis intervention (all services).
Referral	Facilitation (i.e., referral/scheduling) of a health-related visit to a healthcare or social service provider for a patient with or without a care plan, or for services that are not part of a patient's care plan. SOME EXAMPLES INCLUDE Referral to/scheduling an appointment with a primary care, specialty care, mental health care, dental, optometry, SUD, or social service provider (including Social Security Administration, Social Services Agency, housing, food, domestic violence, employment, disability advocacy, or harm reduction services).
Dental Case Management	Facilitation of increased access to, and retention in, dental care. SOME EXAMPLES INCLUDE Educating patient about the use of dental services and keeping appointments. Identifying potential barriers to care. Scheduling and arranging patient transportation to appointments. Following up with patients regarding missed appointments. Retention services. Language translation services.
Benefits Assistance	Counseling of a patient with financial limitations as well as assessing the patient's eligibility for and providing assistance with enrollment in a health insurance program, disability program, or other benefits program.

	SOME EXAMPLES INCLUDE Enrollment in managed care plan (i.e., Medicaid, Medicare, HealthPAC), development of payment plans, eligibility determination for a pharmaceutical program, explaining a medical bill from a hospital, providing assistance with applying for General Assistance, SSI, SSDI, IHSS, payee services, ordering new EBT/Direct Express card, or obtaining a government issued ID or Social Security card. DOES NOT INCLUDE Explaining a bill from your own health center (this is part of routine health center procedures and is not considered an ES).
Food/Hygiene Assistance	Providing basic food and hygiene necessities (directly or via referral) to a patient to help reduce food insecurities, mitigate aggravation of pre-existing medical conditions, and support overall health. SOME EXAMPLES INCLUDE Providing a patient with a pre-paid food card, pre-made food parcel, list of free meal sites, or hygiene kits. Assisting a patient with registering at a food bank or applying to the Project Open Hand meal program.
Health Education/ Supportive Counseling	Provision of health education or supportive counseling to a patient in which wellness, preventive disease management, or other improved health outcomes are attempted through behavior change methodology. SOME EXAMPLES INCLUDE Providing a patient with diabetes information on nutrition, providing Coronavirus (COVID-19) education and prevention information, explaining a brochure on breast self-exams, family counseling for a patient with cancer, and domestic violence counseling.
Housing Assistance	Facilitating connecting a patient to services and supports that will lead to a patient obtaining permanent housing and stabilizing in permanent housing. SOME EXAMPLES INCLUDE Developing a housing plan with a patient, engaging a patient in housing problem-solving, competing a Coordinated Entry assessment, referring a patient to a housing resource center/housing navigation center, coordinating a respite bed placement, submitting Seasons of Sharing/Everyone Home Fund application for move-in assistance/maintaining housing stability, applying for a low income utility program, securing tenancy sustaining services for patient, and coordinating emergency shelter, Community Cabins, or safe parking placement.
Interpretation	The provision of interpreter services, including sign language, by a third party (other than the service provider) intended to reduce barriers to a limited English-proficient (LEP) patient or a patient with documented limitations in writing or speaking skills sufficient to affect the outcome of a medical visit or procedure. SOME EXAMPLES INCLUDE

	Interpreting between a patient and a health plan representative, providing sign language during a health education workshop, interpreting over the phone for a physician at a hospital and a health center patient, and translating medication instructions to primary language. DOES NOT INCLUDE Interpretation services directly provided by the service provider.
Transportation	Providing transportation assistance (directly or via referral) to a patient requiring transport to receive appropriate medical care and social services. SOME EXAMPLES INCLUDE Facilitating transport to and from appointments at the health center including providing transportation tickets, coordinating car service to off-site specialist appointments, and enrolling patients in a transportation voucher program.
Substance Use Counseling and Referrals	Providing counseling, referrals, education, interventions, and resources specific to substance use. This can include harm reduction resources, motivational interviewing, support, linkage, and education.
Other	Additional enabling/supportive services that are beyond any required case management services, do not fall into the above 11 categories, and support a health center patient's access to non-medical, social, educational, or other related services. Must input a brief (i.e., a few words) description for Other. SOME EXAMPLES INCLUDE Providing assistance with filling out financial aid forms for college or referral to Department of Rehabilitation.

Alameda County
Health Care for the Homeless

Appendix J:
STREET HEALTH OUTREACH TRACKING OF PATIENTS AND PROSPECTIVE PATIENTS

Engagement and outreach for patients and prospective patients can be tracked via Microsoft Excel spreadsheets. In addition to streamlining and tracking patient care, this system allows for accurate and timely reporting of RBA Metrics. Please see the Excel Spreadsheet Template provided by ACHCH with all of these variables included.

Type of Data	Specific Data Points
Client Demographics & Contact Information	Demographics/ Contact Information • First name • Last name • Preferred name • Date of Birth • Telephone/ Email • Partner/ dependent information as appropriate
Encounter Level Details	• Engagement Level • Location of patient engagement • Original/ first encounter date • Date of most recent encounter • Consent date • Care Plan creation and initiation

Health & Wellness Information	• Medical Home
	• Primary Care Provider
	  ○ Dates of recent PCP visits x 3
	• Insurance Activity (at Consent vs. Current)
	  ○ Include date verified, CIN, expiration date
	  ○ Application date
	• Medication(s) Prescribed (including Buprenorphine)
	• Behavioral Health Referrals/ Intakes/ Connections

Social Services & Benefits	• Case manager • Alternate contact • Benefits (CalFresh, GA, SSI) • CES Status • Date of CES application • Level of documentation readiness
Other	• To-Do's • Notes • Internal referrals to team SW/ ICM, Provider

Appendix K

Street Health

Triage Nursing Assessment

I. Triage Nursing Assessment – Process and Goals

Who administers: Team RN. Team medical provider can complete if RN not available.
Which patients: All consented patients without medical home at consent as identified in Basic Needs Screening.
When complete: The Triage Nursing Assessment is considered complete once patient has been assessed by the following screenings. This may occur in a single visit or over more than one encounter.

Goals of Triage Assessment:

- Determine emergent/ urgent needs
- Determine if patient requires bridging support while awaiting connection to medical home
- Determine if patient requires street-based support in addition to care received in medical home
- Collaborate with CHOW/SW on next steps of care plan
- New PCP, insurance considerations, disability paperwork needs

II. Triage Nursing Assessment – Questions/ Sections

Confirm/ Obtain Demographics: Name, DOB, Sex at birth and gender identity

Assess for immediate medical needs

- If presence of acute emergency or related needs, proceed with emergency protocols (see Nursing Protocols)
- Urgent needs not requiring emergency response, continue/ complete Triage Assessment and transition to targeted assessment

Screen for the following conditions – Physical Health:

Condition	Negative Screening (Provide education as needed)	Brief Follow-up for Positive Screening: (*See Nurse Protocols and Clinical Recommendations for additional guidance on specific parameters and follow-up options*)
Hypertension		• Assess current blood pressure • Plan for follow-up blood pressure evaluation • Confirm current/ previous prescription(s)
Diabetes mellitus		• Assess finger stick blood glucose • Confirm current/ previous prescription(s)
HIV		• Perform point-of-care rapid test if available and acceptable • Perform labs
Hepatitis C		• Perform point-of-care rapid test if available and acceptable • Perform labs
End Stage Renal Disease		• Confirm if undergoing hemodialysis (either currently or recommended if not currently engaging in HD).
Pregnancy (as appropriate)		• Offer pregnancy test if confirmation of pregnancy is needed/ requested • Confirm patient goals concerning pregnancy. • Refer to women's health and/ or prenatal services. • Perform ultrasound as appropriate for options counseling

Physical Accessibility/Mobility:
Does patient state need for or have obvious requirements for mobility aids (wheelchair, hearing/visual impairment, etc.)? Does the patient currently have all the appropriate/ necessary DME (durable medical equipment)?

Psychiatric:

Condition	Negative Screening	Brief Follow-up for Positive Screening: (*See Nurse Protocols and Clinical Recommendations for additional guidance on specific parameters and follow-up options*)
In current/ previous psychiatric treatment	Provide education as needed	• Assess need for connection/ re-connection to services • Assess for immediate safety if needed
Hx of psychiatric hospitalizations		

Substance Use:

Substance	Negative Screening	Brief Follow-up for Positive Screening: (*See Nurse Protocols and Clinical Recommendations for additional guidance on specific parameters and follow-up options*)
Nicotine	Provide education as needed and as appropriate	• Team engagement around patient-led substance use goals, as appropriate • Depending on patient goals, follow-up may include but is not limited to: o Education of and offer of nicotine replacement therapy o Education of and provision of naloxone (Narcan) o Provision of safe use/ harm reduction supplies o Referrals to immediate care for intoxication o Referrals to substance use programs and treatment o Other
Opioids		
Stimulants		
Alcohol (beverage and non-beverage)		
Other:		
Other:		

Other Considerations:
- Safety (including IPV, trafficking)
- Sexual Health (sexual activity, birth control/ barrier use, STI history)

POLST/ DNR
- Has the patient previously completed a POLST (Physician Orders for Life-Sustaining Treatment) or DNR/DNI order? Follow-up includes education around and completing a POLST as desired.
- Note: a POLST covers a variety of end-of-life treatments. A DNR only gives instructions about CPR.

Vital Signs:

BP:	L / R arm (circle)	HR:	T: °F / °C (circle)
Repeat BP:	L / R arm (circle)	RR:	SpO2: Air vs ____% O2 (circle)

Appendices – Sample Assessment Tools

APPENDIX I	**MEDICAL HISTORY**
APPENDIX II	**PHYSICAL EXAM**
APPENDIX III	**SUICIDE RISK SCREEN**
APPENDIX IV	**OPTIONS TO ASSESS RELATIONSHIP HEALTH AND SAFETY**
APPENDIX V	**OPTIONS TO ASSESS SUBSTANCE USE AND RELATED HARMS**
APPENDIX VI	**COVID-19 SCREEN**
APPENDIX VII	**POLST (Physician Orders for Life-Sustaining Treatment)**
APPENDIX VIII	**DNR (Do Not Resuscitate) Form**

Appendices – Sample Assessment Tools

APPENDIX I: MEDICAL HISTORY

Assess for:

Past medical history

- Major illnesses and surgeries
- Prompt as needed (cardiovascular, respiratory, gastrointestinal, genitourinary, neuromuscular, integumentary, oral, ophthalmological, podiatry, etc.)
- For women, assess for current pregnancy and former reproductive history as appropriate

Prior hospitalizations or emergency department visits (medical or psychiatric)

- Prompt as needed regarding broken bones, assaults/batteries, head trauma, mental illness, psychiatric diagnosis, etc.

Allergies: Medications, foods, and environmental; nature of the reaction and seriousness; intolerances to medications

Current concerns: Any medical, psychiatric, or other conditions that the patient is concerned about or have not been identified in the previous questions?

MEDICATIONS (include supplements and over-the-counter):

List current medications: ☐ **N/A**	**Pharmacy** ☐ **N/A**
Are Refills Needed? ☐ Yes ☐ No	**OTC Medication Needs:** ☐ **N/A**

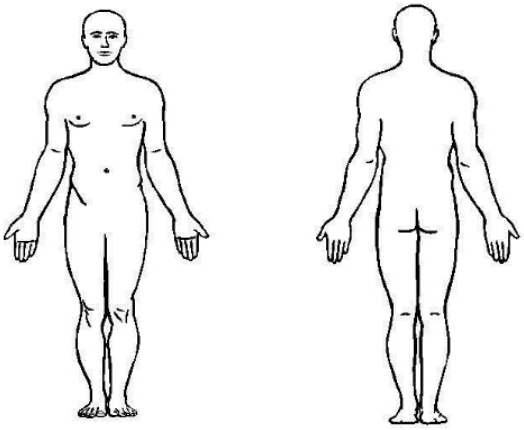
APPENDIX II: PHYSICAL EXAM

PHYSICAL EXAM:

Constitutional: (Appears well-developed, well-nourished. No acute distress.)	
Head: (Normocephalic, atraumatic.)	
Eyes: (PERRLA. Displays no redness or discharge.)	
Ears: (Displays no discharge.)	
Nose: (Displays no discharge.)	
Throat: (Displays no hoarseness.)	
Dental: (Dentulous – possessing natural teeth.)	
Respiratory: (Breath sounds clear, no crackles or wheezes. Effort normal, no accessory muscle usage. No respiratory distress.)	
Cardiovascular: (RRR, normal S1 & S2. 2+ distal pulses.)	
Gastrointestinal: (Bowel sounds normoactive. Abdomen firm, rounded, non-tender.)	
Genitourinary: (Denies dysuria, frequency, and urgency.)	
Neurological: (AOx4. Normal strength. Displays no atrophy, no tremor. Exhibits normal muscle tone. Displays no seizure activity. Gait normal.)	
Musculoskeletal: (Normal range of motion. Exhibits no edema, tenderness, or deformity.)	
Psychiatric: (Normal mood and affect. Speech is normal, non-pressured, and behavior is normal.)	
Skin & Hair: (Skin is warm, dry, and intact. No pallor, erythema, or diaphoresis. No observed hair loss.)	

REVIEW OF SYSTEMS (ROS):

General: (Denies recent weight changes, fevers, chills, sweats. Denies fatigue, difficulty sleeping, chronic pain.)	
Vision: (Denies decrease/change in vision, blurriness, pain. Denies double vision, discharge, red eye.)	

Head & Neck: (Denies pain, mouth sores, masses/growths. Denies tooth pain or problems. Denies change in hearing, ear pain, ear discharge. Denies nasal discharge, post-nasal drip. Denies change in voice/hoarseness. Denies sense of lump/mass in throat w/ swallowing.)	
Respiratory: (Denies SOB w/ rest/exertion, CP, cough, hemoptysis, wheezing, snoring.)	
Cardiovascular: (Denies CP or pressure, SOB w/ rest/exertion, orthopnea, PND, LE edema, syncope, arrhythmia, palpitations, claudication, slow healing wounds/ulcers in feet.)	
Gastrointestinal: (Denies heartburn, abdominal pain, difficulty swallowing, pain upon swallowing. Denies N/V, abdominal swelling or distention, jaundice, hematemesis. Denies black/tarry stools, bloody stools, constipation, diarrhea, change in bowel habits.)	
Genitourinary: (Denies hematuria, dysuria, nocturia. Denies incontinence, urgency, frequency, incomplete emptying, decreased force of stream, need to void soon after urinating. LMP = date)	
Neurological: (Denies abrupt loss/change in level of consciousness, seizures, numbness, weakness, dizziness, balance problems, HAs.)	
Endocrine: (Denies polyuria, polydipsia, polyphagia. Denies fatigue, weight changes.)	
Musculoskeletal: (Denies joint pain/swelling, muscle aches, LBP. Denies knee pain/swelling, hand Sx, elbow Sx, hip area Sx, shoulder Sx.)	
Psychiatric: (Denies feeling sad/depressed/anxious much of the time. Denies memory problems, confusion. Denies alcohol/substance use. Denies AH/VH.)	
Skin & Hair : (Please **ASK** the patient to indicate if they have any rashes, wounds, injuries, pain, etc.): 	Does the client have wound care orders? ☐ Yes ☐ No

APPENDIX III: SUICIDE RISK SCREEN

Wish to be Dead: *Person endorses thoughts about a wish to be dead or not alive anymore or wish to fall asleep and not wake up.*

1. Within the past 30 days, have you wished you were dead or wished you could go to sleep & not wake up?
☐ Yes ☐ No

Suicidal Thoughts: *General non-specific thoughts of wanting to end one's life/commit suicide, "I've thought about killing myself" without general thoughts of ways to kill oneself/associated methods, intent, or plan.*

2. Within the past 30 days, have you actually had any thoughts of killing yourself?
☐ Yes ☐ No

***If YES to 2**, ask all questions 3, 4, 5, and 6* ***If NO to 2**, go directly to question 6*

Suicidal Thoughts with Method (without Specific Plan or Intent to Act): *Person endorses thoughts of suicide and has thoughts of at least one method during the assessment period.*

3. Have you been thinking about how you might kill yourself?
☐ Yes ☐ No

Suicidal Intent (without Specific Plan): *Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts.*

4. Have you had these thoughts and had some intention of acting on them?
☐ Yes ☐ No

Suicide Intent with Specific Plan: *Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out.*

5. Have you started to work out or worked out the details of how to kill yourself and do you intend to carry out this plan?
☐ Yes ☐ No

Suicidal Behavior:

6. Have you done anything, started to do anything, or prepared to do anything to end your life?
☐ Yes ☐ No

If yes, how long ago did you do any of these?			
Additional comments regarding SA/SI:			
Self-Harm (without suicidal intent):	☐ Yes	☐ No	☐ Unable to assess
If yes, describe:			
SAFETY PLAN (if indicated):			

"Columbia Suicide Severity Rating Scale Screener (LACDMH Version)"

Appendices – Sample Assessment Tools

APPENDIX IV: OPTIONS TO ASSESS RELATIONSHIP HEALTH AND SAFETY

Relationship Health		
Are you sexually active (any sex in past 6 months)?	☐ Yes ☐ No	Active with: ☐ Men ☐ Women ☐ Both ☐ Other details:
Do you use barrier protection/birth control?	☐ Yes ☐ No	Methods:
Do you feel safe in your relationship(s)?	☐ Yes ☐ No	If "*No*", include discussion/interventions as part of "PLAN" below.
Are you in control of your money and personal documents?	☐ Yes ☐ No	If "*No*", include discussion/interventions as part of "PLAN" below.
Is anyone forcing you to do work/activities that make you feel uncomfortable or unsafe?	☐ Yes ☐ No	If "*Yes*", include discussion/interventions as part of "PLAN" below.
Do you have more than 1 sexual partner?	☐ Yes ☐ No	
Have you ever been told that you have a sexually transmitted infection?	☐ Yes ☐ No	List:
Have you ever been treated for a sexually transmitted infection?	☐ Yes ☐ No	List:
We recommend HIV/HCV testing for everyone. Have you tested in the last 6 months? Would you be like to be tested for HIV and/or Hepatitis C today?	☐ Yes HIV testing ☐ Yes HCV testing ☐ No (unknown status)	Previously known positive? ☐ HIV ☐ HCV In care: ☐ Yes ☐ No

Intimate Partner Violence Screening (HARK) (one point given for each Yes answer):

H (Humiliation)	Within the last year, have you been humiliated or emotionally abused in other ways by your partner or your ex-partner?
A (Afraid)	Within the last year, have you been afraid of your partner or ex-partner?
R (Rape)	Within the last year, have you been raped or forced to have any kind of sexual activity by your partner or ex-partner?
K (Kick)	Within the last year, have you been kicked, hit, slapped, or otherwise physically hurt by your partner or ex-partner?

Additional information for HARK at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2034562/

HURT, INSULT, THREATEN, and SCREAM (HITS) Tool for Intimate Partner Violence Screening

How often does your partner?	NEVER	RARELY	SOMETIMES	FAIRLY OFTEN	FREQUENTLY
Points for Yes answer	1	2	3	4	5
1. Physically hurt you?					
2. Insult or talk down to you?					
3. Threaten you with harm?					
4. Scream or curse at you?					
TOTAL SCORE:					

Each item is scored 1-5. Scores range between 4-20. A score **greater than 10** is considered positive.
Additional information for HITS at: https://www.ncbi.nlm.nih.gov/books/NBK533715/table/appf.tab1/

Appendices – Sample Assessment Tools

APPENDIX V: SUBSTANCE USE SCREENING

DRUG SCREENING QUESTIONS ("Yes" to any of the questions below indicates a positive screening)				
	Ever Used?		**Recently Used (6mo)**	
	Yes	**No**	**Yes**	**No**
Have you used nicotine products? (Cigarettes, cigars, electronic cigarettes, smokeless tobacco)	☐	☐	☐	☐
Have you used opioids? (Heroin, opium, non-prescribed pain medications)	☐	☐	☐	☐
Have you used stimulants, such as cocaine or methamphetamine?	☐	☐	☐	☐
Have you used other substances of abuse?	☐	☐	☐	☐

ALCOHOL USE SCREENING

Do you currently drink alcohol?	☐**No → Stop** ☐**Yes → Go to next question**
On average how many days per week do you drink?	
How many drinks per day do you consume? (A drink is defined as 12fl. oz. Beer, 5fl. oz. Wine, or 1.5fl. oz. Hard Alcohol)	
Have you ever had withdrawal symptoms when you stopped drinking alcohol?	☐ **Yes** ☐ **No**
Have you had seizures or "DTs" when you stopped drinking? (Delirium Tremens is severe withdrawal manifested by altered mental status and sympathetic overdrive)	☐ **Yes** ☐ **No**
If patient reports withdrawal symptoms – What kind?	

CAGE QUESTIONNAIRE

C (Cut)	Have you ever felt you should "cut" down on your substance use?
A (Annoyed)	Have people "annoyed" you by criticizing your substance use?
G (Guilty)	Have you felt bad or "guilty" about your substance use?
E (Eye)	Have you ever used a substance first thing in the morning to steady your nerves or start the day (an "eye" opener)?

Additional information for CAGE at https://www.webmd.com/mental-health/addiction/whats-the-cage-assessment

HARM REDUCTION / INTEREST IN CHANGE

Do you have access to harm reduction supplies such as syringes, safer injection supplies, cookers, cotton, condoms? ☐ Yes ☐ No ☐ N/A

Do you have naloxone, aka Narcan? ☐ Yes ☐ No ☐ Naloxone given and administration taught

Are you interested in changing your substance use patterns? ☐ Yes ☐ No ☐ N/A

Do you have a safety plan in case you overdose or stop breathing? ☐ Yes ☐ No

"If No" – Would you be willing to create an overdose/ safety plan with us? ☐ Yes ☐ No

Are you interested in medication to support reducing your substance use? ☐ Yes ☐ No

Appendices – Sample Assessment Tools

APPENDIX VI: COVID-19 SCREENING

CURRENT SYMPTOMS, INTENSITY, DURATION, ONSET, FREQUENCY:

FEVER	☐ None	☐ New	☐ Worsening	☐ Unchanged	Date of onset or worsening:
COUGH	☐ None	☐ New	☐ Worsening	☐ Unchanged	Date of onset or worsening:
DIFFICULTY BREATHING	☐ None	☐ New	☐ Worsening	☐ Unchanged	Date of onset or worsening:
DIARRHEA	☐ None	☐ New	☐ Worsening	☐ Unchanged	Date of onset or worsening:
SORE THROAT	☐ None	☐ New	☐ Worsening	☐ Unchanged	Date of onset or worsening:
MUSCLE FATIGUE/ BODY ACHES	☐ None	☐ New	☐ Worsening	☐ Unchanged	Date of onset or worsening:
LOSS OF SMELL OR TASTE	☐ None	☐ New	☐ Worsening	☐ Unchanged	Date of onset or worsening:
CHILLS/ SHAKING WITH CHILLS	☐ None	☐ New	☐ Worsening	☐ Unchanged	Date of onset or worsening:
HEADACHE	☐ None	☐ New	☐ Worsening	☐ Unchanged	Date of onset or worsening:

Other Symptoms:_____

Have you previously been diagnosed with COVID-19?	☐ Yes ☐ No Date(s) if known: Were you hospitalized? ☐ Yes ☐ No
Have you received the SARS-CoV-2 ("COVID-19") vaccine?	☐ Yes ☐ No
If "Yes" – What type(s)? When?	Type: Date(s) if known:
Have you received a Booster?	☐ Yes ☐ No
If "Yes" – What type(s)? When?	Type: Date(s) if known:
If "No" – Would you like to be vaccinated against COVID-19?	☐ Yes ☐ No
Do you know where to get free COVID treatment if you get sick?	☐ Yes ☐ No

EMERGENCY MEDICAL SERVICES
PREHOSPITAL DO NOT RESUSCITATE (DNR) FORM

California Medical Association
Physicians dedicated to the health of Californians

Purpose

The Prehospital Do Not Resuscitate (DNR) Form has been developed by the California Emergency Medical Services Authority, in concert with the California Medical Association and emergency medical services (EMS) providers, for the purpose of instructing EMS personnel to forgo resuscitation attempts in the event of a patient's cardiopulmonary arrest. Resuscitative measures to be withheld include chest compression, assisted ventilation, endotracheal intubation, defibrillation, and cardiotonic drugs. The form does **not** affect the provision of other emergency medical care, including palliative treatment for pain, dyspnea, major hemorrhage, or other medical conditions.

Applicability

This form was designed for use in **prehospital settings** – i.e., in a patient's home, in a long-term care facility, during transport to or from a health care facility, and in other locations outside acute care hospitals. However, hospitals are encouraged to honor the form when a patient is transported to an emergency room. California law protects any health care provider (including emergency response personnel) who honors a properly completed Prehospital Do Not Resuscitate Form (or an approved wrist or neck medallion) from criminal prosecution, civil liability, discipline for unprofessional conduct, administrative sanction, or any other sanction, if the provider believes in good faith that the action or decision is consistent with the law and the provider has no knowledge that the action or decision would be inconsistent with a health care decision that the individual signing the request would have made on his or her own behalf under like circumstances. This form does not replace other DNR orders that may be required pursuant to a health care facility's own policies and procedures governing resuscitation attempts by facility personnel. Patients should be advised that their prehospital DNR instruction may not be honored in other states or jurisdictions.

Instructions

The Prehospital Do Not Resuscitate (DNR) Form must be signed by the patient or by an appropriate surrogate decisionmaker if the patient is unable to make or communicate informed health care decisions. The surrogate should be the patient's legal representative (e.g., a health care agent, a court-appointed conservator, a spouse or other family member) if one exists. The patient's physician must also sign the form, affirming that the patient/surrogate has given informed consent to the DNR instruction.

The **first copy** of the form should be retained by the patient. *The completed form (or the approved wrist or neck medallion – see below) must be readily available to EMS personnel in order for the DNR instruction to be honored.* Resuscitation attempts may be initiated until the form (or medallion) is presented and the identity of the patient is confirmed.

The **second copy** of the form should be retained by the physician and made part of the patient's permanent medical record.

The third copy of the form may be used by the patient to order an optional wrist or neck medallion inscribed with the words "DO NOT RESUSCITATE-EMS." The Medic Alert Foundation (1-888-755-1448, 2323 Colorado Avenue, Turlock, CA 95381) is an EMS Authority-approved supplier of medallions, which will be issued only upon receipt of a properly completed Prehospital Do Not Resuscitate (DNR) Form (together with an enrollment form and the appropriate fee). Although optional, use of a wrist or neck medallion facilitates prompt identification of a patient, avoids the problem of lost or misplaced forms, and is strongly encouraged.

Revocation

If a decision is made to revoke the DNR instruction, the patient's physician should be notified immediately and all copies of the form should be destroyed, including any copies on file with the Medic Alert Foundation or other EMS Authority-approved supplier. Medallions and associated wallet cards should also be destroyed or returned to the supplier.

Questions about implementation of the Prehospital Do Not Resuscitate (DNR) form should be directed to the local EMS agency.

EMERGENCY MEDICAL SERVICES
PREHOSPITAL DO NOT RESUSCITATE (DNR) FORM

California Medical Association
Physicians dedicated to the health of Californians

An Advance Request to Limit the Scope of Emergency Medical Care

I, _____ , request limited emergency care as herein described.
(print patient's name)

I understand DNR means that if my heart stops beating or if I stop breathing, no medical procedure to restart breathing or heart functioning will be instituted.

I understand this decision will not prevent me from obtaining other emergency medical care by prehospital emergency medical care personnel and/or medical care directed by a physician prior to my death.

I understand that I may revoke this directive at any time by destroying this form and removing any "DNR" medallions.

I give permission for this information to be given to the prehospital emergency care personnel, doctors, nurses or other health personnel as necessary to implement this directive.

I hereby agree to the "Do Not Resuscitate" (DNR) order.

_____ _____
Patient/Surrogate Signature Date

_____
Surrogate's Relationship to Patient

By signing this form, the surrogate acknowledges that this request to forgo resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of this form.

I affirm that this patient/surrogate is making an informed decision and that this directive is the expressed wish of the patient/surrogate. A copy of this form is in the patient's permanent medical record.

In the event of cardiac or respiratory arrest, no chest compressions, assisted ventilations, intubation, defibrillation, or cardiotonic medications are to be initiated.

_____ _____
Physician Signature Date

_____ _____
Print Name Telephone

THIS FORM WILL NOT BE ACCEPTED IF IT HAS BEEN AMENDED OR ALTERED IN ANY WAY

PREHOSPITAL DNR REQUEST FORM

Copy 1 – To be kept by patient

EMERGENCY MEDICAL SERVICES
PREHOSPITAL DO NOT RESUSCITATE (DNR) FORM

California Medical Association
Physicians dedicated to the health of Californians

An Advance Request to Limit the Scope of Emergency Medical Care

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I understand this decision will not prevent me from obtaining other emergency medical care by prehospital emergency medical care personnel and/or medical care directed by a physician prior to my death.

I understand that I may revoke this directive at any time by destroying this form and removing any "DNR" medallions.

I give permission for this information to be given to the prehospital emergency care personnel, doctors, nurses or other health personnel as necessary to implement this directive.

I hereby agree to the "Do Not Resuscitate" (DNR) order.

_____ _____
Patient/Surrogate Signature Date

_____
Surrogate's Relationship to Patient

By signing this form, the surrogate acknowledges that this request to forgo resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of this form.

I affirm that this patient/surrogate is making an informed decision and that this directive is the expressed wish of the patient/surrogate. A copy of this form is in the patient's permanent medical record.

In the event of cardiac or respiratory arrest, no chest compressions, assisted ventilations, intubation, defibrillation, or cardiotonic medications are to be initiated.

_____ _____
Physician Signature Date

_____ _____
Print Name Telephone

THIS FORM WILL NOT BE ACCEPTED IF IT HAS BEEN AMENDED OR ALTERED IN ANY WAY

PREHOSPITAL DNR REQUEST FORM

Copy 2 – To be kept in patient's permanent medical record

EMERGENCY MEDICAL SERVICES
PREHOSPITAL DO NOT RESUSCITATE (DNR) FORM

California Medical Association
Physicians dedicated to the health of Californians

An Advance Request to Limit the Scope of Emergency Medical Care

I, _____ , request limited emergency care as herein described.
(print patient's name)

I understand DNR means that if my heart stops beating or if I stop breathing, no medical procedure to restart breathing or heart functioning will be instituted.

I understand this decision will not prevent me from obtaining other emergency medical care by prehospital emergency medical care personnel and/or medical care directed by a physician prior to my death.

I understand that I may revoke this directive at any time by destroying this form and removing any "DNR" medallions.

I give permission for this information to be given to the prehospital emergency care personnel, doctors, nurses or other health personnel as necessary to implement this directive.

I hereby agree to the "Do Not Resuscitate" (DNR) order.

_____ _____
Patient/Surrogate Signature Date

_____
Surrogate's Relationship to Patient

By signing this form, the surrogate acknowledges that this request to forgo resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of this form.

I affirm that this patient/surrogate is making an informed decision and that this directive is the expressed wish of the patient/surrogate. A copy of this form is in the patient's permanent medical record.

In the event of cardiac or respiratory arrest, no chest compressions, assisted ventilations, intubation, defibrillation, or cardiotonic medications are to be initiated.

_____ _____
Physician Signature Date

_____ _____
Print Name Telephone

THIS FORM WILL NOT BE ACCEPTED IF IT HAS BEEN AMENDED OR ALTERED IN ANY WAY

PREHOSPITAL DNR REQUEST FORM

Copy 3 – If authorized DNR medallion desired, submit this form with Medic Alert enrollment form to: Medic Alert Foundation, Turlock CA 95381

What is a POLST?

Key Facts About POLST for Individuals and Family Members

Physician Orders for Life Sustaining Treatment (POLST) is a medical order that helps give people with serious illness more control over their care during a medical emergency. POLST can help make sure you get the care you want, and also protect you from getting medical treatments you DO NOT want.

- **POLST is voluntary.** Nursing homes and assisted living facilities may include POLST in their admission papers, but can't require you to complete a POLST if you do not wish to.

- **POLST is for people who are seriously ill or have advanced frailty**. If you are healthy, an advance directive is for you.

- **A POLST does NOT replace an advance directive,** which is still the best way to appoint someone you trust to act as your medical decisionmaker. A POLST works together with your advance directive, providing more specific detail regarding medical wishes and goals of care during a serious illness or at the end of life.

- **The POLST form should be completed by your doctor or another trained medical provider** after you've had a good conversation about the form's medical terms and options. This conversation is very important and should cover your overall health, your personal values, goals for your care, and treatment wishes. It can be helpful to include your family in the talk so they know and understand your treatment wishes.

- **The POLST form is not valid until it is signed by both you (or your designated decisionmaker) *AND* your physician, nurse practitioner, or physician assistant.**

- **Once completed and signed, a copy goes in your medical record and you keep the original bright pink POLST**. Wherever you go for medical care, the signed pink form should go with you. At home, keep your POLST in an easy to find place, like on your refrigerator, in case of a medical emergency.

- **POLST does not expire, but it should be reviewed regularly to make sure your wishes haven't changed.** You do not need to fill out a new POLST if you move from one facility to another, or change doctors. You only have to complete a new POLST if your treatment wishes change.

- **POLST is a medical order, which means licensed medical providers are required to follow its instructions** regarding CPR and other emergency medical care. The POLST form is printed on bright pink paper so it is easy to recognize, but photocopies are also considered valid.

- **You can void your POLST form at any time, verbally or in writing.** If you have changes, it is best to complete a new POLST. To void a POLST form, draw a line through sections A through D, write "VOID" in large letters, then sign and date the line.

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

EMSA #111 B
(Effective 4/1/2017)*

First follow these orders, then contact Physician / NP / PA. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. **POLST complements an Advance Directive and is not intended to replace that document**.

Patient Last Name:	Date Form Prepared:
Patient First Name:	Patient Date of Birth:
Patient Middle Name:	Medical Record #: *(optional)*

A — CARDIOPULMONARY RESUSCITATION (CPR): *If patient has no pulse and is not breathing.*

If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.

Check One

☐ **Attempt Resuscitation/CPR** (Selecting CPR in Section A **requires** selecting Full Treatment in Section B)

☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)

B — MEDICAL INTERVENTIONS: *If patient is found with a pulse and/or is breathing.*

Check One

☐ **Full Treatment – primary goal of prolonging life by all medically effective means.**
In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.

☐ ***Trial Period of Full Treatment.***

☐ **Selective Treatment – goal of treating medical conditions while avoiding burdensome measures.**
In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.

☐ ***Request transfer to hospital only if comfort needs cannot be met in current location.***

☐ **Comfort-Focused Treatment – primary goal of maximizing comfort.**
Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. ***Request transfer to hospital only if comfort needs cannot be met in current location.***

Additional Orders: _____

_____

C — ARTIFICIALLY ADMINISTERED NUTRITION: *Offer food by mouth if feasible and desired.*

Check One

☐ Long-term artificial nutrition, including feeding tubes. Additional Orders: _____

☐ Trial period of artificial nutrition, including feeding tubes. _____

☐ No artificial means of nutrition, including feeding tubes. _____

D — INFORMATION AND SIGNATURES:

Discussed with: ☐ Patient (Patient Has Capacity) ☐ Legally Recognized Decisionmaker

☐ Advance Directive dated _____, available and reviewed →
☐ Advance Directive not available
☐ No Advance Directive

Health Care Agent if named in Advance Directive:
Name: _____
Phone: _____

Signature of Physician / Nurse Practitioner / Physician Assistant (Physician/NP/PA)
My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences.

Print Physician/NP/PA Name:	Physician/NP/PA Phone #:	Physician/PA License #, NP Cert. #:
Physician/NP/PA Signature: *(required)*		Date:

Signature of Patient or Legally Recognized Decisionmaker
I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

Print Name:		Relationship: *(write self if patient)*
Signature: *(required)*	Date:	Your POLST may be added to a secure electronic registry to be accessible by health providers, as permitted by HIPAA.
Mailing Address (street/city/state/zip):	Phone Number:	

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

*Form versions with effective dates of 1/1/2009, 4/1/2011,10/1/2014 or 01/01/2016 are also valid

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Patient Information

Name (last, first, middle):	Date of Birth:	Gender: **M F**

NP/PA's Supervising Physician	**Preparer Name** (if other than signing Physician/NP/PA)	
Name:	Name/Title:	Phone #:

Additional Contact ☐ None

Name:	Relationship to Patient:	Phone #:

Directions for Health Care Provider

Completing POLST

- **Completing a POLST form is voluntary**. California law requires that a POLST form be followed by healthcare providers, and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by a physician, or a nurse practitioner (NP) or a physician assistant (PA) acting under the supervision of the physician, who will issue appropriate orders that are consistent with the patient's preferences.
- **POLST does not replace the Advance Directive**. When available, review the Advance Directive and POLST form to ensure consistency, and update forms appropriately to resolve any conflicts.
- POLST must be completed by a health care provider based on patient preferences and medical indications.
- A legally recognized decisionmaker may include a court-appointed conservator or guardian, agent designated in an Advance Directive, orally designated surrogate, spouse, registered domestic partner, parent of a minor, closest available relative, or person whom the patient's physician/NP/PA believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known.
- A legally recognized decisionmaker may execute the POLST form only if the patient lacks capacity or has designated that the decisionmaker's authority is effective immediately.
- To be valid a POLST form must be signed by (1) a physician, or by a nurse practitioner or a physician assistant acting under the supervision of a physician and within the scope of practice authorized by law and (2) the patient or decisionmaker. Verbal orders are acceptable with follow-up signature by physician/NP/PA in accordance with facility/community policy.
- If a translated form is used with patient or decisionmaker, attach it to the signed English POLST form.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid. A copy should be retained in patient's medical record, on Ultra Pink paper when possible.

Using POLST

- Any incomplete section of POLST implies full treatment for that section.

Section A:

- If found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressions should be used on a patient who has chosen "Do Not Attempt Resuscitation."

Section B:

- When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort-Focused Treatment," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- IV antibiotics and hydration generally are not "Comfort-Focused Treatment."
- Treatment of dehydration prolongs life. If a patient desires IV fluids, indicate "Selective Treatment" or "Full Treatment."
- Depending on local EMS protocol, "Additional Orders" written in Section B may not be implemented by EMS personnel.

Reviewing POLST

It is recommended that POLST be reviewed periodically. Review is recommended when:

- The patient is transferred from one care setting or care level to another, or
- There is a substantial change in the patient's health status, or
- The patient's treatment preferences change.

Modifying and Voiding POLST

- A patient with capacity can, at any time, request alternative treatment or revoke a POLST by any means that indicates intent to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writing "VOID" in large letters, and signing and dating this line.
- A legally recognized decisionmaker may request to modify the orders, in collaboration with the physician/NP/PA, based on the known desires of the patient or, if unknown, the patient's best interests.

This form is approved by the California Emergency Medical Services Authority in cooperation with the statewide POLST Task Force.
For more information or a copy of the form, visit **www.caPOLST.org**.

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

Street-Based Engagement & Outreach
Registered Nurse Standardized Procedures
Updated July 2021

REGISTERED NURSE STANDARDIZED PROCEDURES

FOR STREET-BASED OUTREACH AND ENGAGEMENT

NOTICE

These standardized procedures were developed as a tool to guide care and assessment by registered nurses working in Street-Based Engagement Services and Outreach providing care to persons who are unsheltered. The primary goal of this work is to help us all offer high-value assessment and coordination to our neighbors who are unsheltered.

These protocols are intended to assist agencies including county healthcare systems, community clinics, or healthcare-based homeless outreach teams in establishing protocols for their outreach nursing staff and/ or volunteers. Please modify at will!

These standardized procedures for registered nurses were originally drafted in 2018. I would like to thank the following organizations who shared medical protocols and guidance: the *California Board of Registered Nursing*; *Lehigh Valley Health Network Street Medicine*; *Los Angeles Housing for Health*; *San Mateo Mobile Health Clinic*; *San Francisco Sobering Center*; and the *San Francisco Street Medicine Team*.

Share, edit, and feel free to send me questions or comments anytime.

Thank you!
Shannon

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https://www.linkedin.com/in/shannonsmithbernardin/

Please note: *These procedures are based on nursing practice within the state of California. These protocols do not supersede local, regional, or state laws and the expectation is that – prior to adoption – your agency will assure any adopted procedures conform to legal and other related regulations. Additionally, as with any medical and nursing intervention, new information and evidence-based research since these were updated may offer alternative options to those listed here. Any discrepancy or errors are not intentional – if you do find anything or have comments, please let me know!*

1.0	Functions to be performed: The specified functions may be performed in street-based engagement and street medicine teams where services are offered by the: Registered Nurse (RN)
2.0	Specific circumstances: Staff will review and implement these Standardized Procedures for RNs when a patient is being examined during street-based engagement including in out-of-doors locations for acute or ongoing care.
3.0	Procedure and Requirements: 3.1 Confirm patient identity/ demographics. 3.2 Perform initial assessment, either focused based on patient complaint or a general assessment including blood pressure, pulse, oxygen saturation, temperature, blood glucose as indicated, wound assessments, and psychosocial needs as appropriate. 3.3 Nursing staff must contact 911 immediately when assessing a patient or potential patient who presents with: 1. Unresponsiveness 2. Signs of recent head trauma 3. Cardiac Arrest 4. Chest Pain 5. Grand mal seizure > 2 minutes or multiple seizures 6. Abdominal and/or chest wounds 7. Vomiting frank red blood or coffee ground emesis 8. Black tarry stools or bright red bloody stools 9. Hemoptysis 10. Violent Behavior 11. Actively suicidal and/or homicidal 12. Systolic blood pressure < 80 or < 90 and unable to take POs 13. Systolic blood pressure > 180 with headache or confusion 14. Diastolic blood pressure > 110 with headache or confusion 15. Heart rate < 60 with dizziness, syncope or altered mental status 16. Heart rate > 140 17. Blood glucose < 60 and stuporous or obtunded 18. Respiration less than 8 or greater than 24 per minute 19. Audible wheezing and respiratory distress 20. Oxygen saturation less than 90% 21. Temperature < 93º F (33.9º C) tympanic

GENERAL STATEMENT OF PROCEDURE

The following guidelines describe the steps to follow for all Standardized Protocols for Registered Nurses who are working in the community as part of street-based outreach and engagement teams. The registered nurse role oversees patient health and wellness, including the assessment, management and care coordination for chronic disease and acute medical complaints. Nursing care provided in street-based outreach and engagement offers a general level of assessment and care within the RN scope of practice, such as vital sign monitoring, obtaining health history, providing education, care coordination, and medication procurement and management.

For patients without regular care in a clinic-based or primary care setting, the registered nurse offers, in collaboration with medical provider guidance, a comprehensive level of care in the field in order to support health and wellness.

1. Document encounter in S.O.A.P. format, including protocol followed under assessment, time seen, completion/ discharge time, and name with title.

2. Collect data thoroughly and consistently.

3. For acute health conditions or complaints, perform physical exam pertinent to presenting problem(s). See procedural guideline *Triage and Treatment of Illness by Registered Nurse* for additional support on managing acute conditions.

4. Consult regularly with assigned provider and/or medical back-up that oversees your team utilizing verbal orders or telemedicine when appropriate.

5. To ensure collaboration and communication within the healthcare system, document assessment and related notes within the electronic health record as close to the assessment day as possible, ideally same-day or within one business day.

Primary Care Connection
Connecting the patient with a regular clinic is a priority of the engagement process. Ideally, medical and nursing care should be transitioned from street-based to clinic-based care as soon as feasible for the respective patient.

1. Provide every patient with next primary care clinic appointment and encourage appointment adherence through support as appropriate. If patient is not scheduled, team can assist in scheduling patient for clinic appointment in appropriate timeline.

2. Refer patient to medical home if not yet assigned. Consult with your team administration and/ or regional coordinators to assist with complications in this process.

3. As able and appropriate, continue to provide care to the patient until health care needs have been transitioned to a clinic.

TABLE OF CONTENTS

CALL 911/ EMERGENCY RESPONSE

Nursing staff must call 911 when assessing a patient or potential patient who presents with:

1. Unresponsiveness
2. Signs of recent head trauma
3. Cardiac Arrest
4. Chest Pain
5. Grand mal seizure > 2 minutes or multiple seizures
6. Abdominal and/or chest wounds
7. Vomiting frank red blood or coffee ground emesis
8. Black tarry stools or bright red bloody stools
9. Hemoptysis
10. Violent Behavior
11. Actively suicidal and/or homicidal
12. Systolic blood pressure < 80 or < 90 and unable to take POs
13. Systolic blood pressure > 180 with headache or confusion
14. Diastolic blood pressure > 110 with headache or confusion
15. Heart rate < 60 with dizziness, syncope or altered mental status
16. Heart rate > 140
17. Blood glucose < 60 and stuporous or obtunded
18. Respiration less than 8 or greater than 24 per minute
19. Audible wheezing and respiratory distress
20. Oxygen saturation less than 90%
21. Temperature < 93º F (33.9º C) tympanic

Street health outreach team management should be alerted immediately of all critical emergencies involving cardiopulmonary resuscitation (CPR), administration of naloxone, AED/ defibrillator use, and/or resulting in patient disability or death.

Staff may contact management at any time with questions regarding patient care, staff safety, or operations.

CONTACT MEDICAL BACK-UP

What is Medical Back-up:

During street engagement encounters, a patient or other individual may present with a clinical scenario necessitating medical assessment or evaluation. Medical back-up may include team providers (NPs, PAs, MDs), emergency department attending-on-duty, contracted medical providers (i.e., HIV consulting physician), and 911. The particular clinical scenario and team on the scene will often dictate which medical back-up is appropriate as stated in the protocols.

How to Contact Medical Back-Up:

During outreach hours, consult with the assigned provider on duty, typically referred to as 'medical back-up'.

If unavailable and situation does not necessarily warrant a 911 call, contact the local ED and ask for attending on duty (AOD).

Procedure:
Nursing staff states their affiliation *"I am calling from the _____ [Street-Health Outreach Team]"* and be prepared to give the following information as able:

- Patient age
- Gender
- Current presentation and reason for calling
- Current level of consciousness
- Orientation
- Ability to ambulate
- Ability to take PO fluids
- Relevant medical history

If on scene staff feel the patient should be transferred to an ED or clinic, nursing staff should state *that: "According to our protocols, this patient requires urgent evaluation. Should this patient be sent by 911, transport (code 2) ambulance, or our non-clinical transport?"*

At times medical back-up is not available and there is concern for patient safety, **err on the side of the higher level of care and/ or transportation**.

Please see individual protocols for indications to contact the Medical Back Up.

CLIENT REFUSAL OF MEDICAL SERVICES

Scenario:

A patient may present with a clinical need requiring assessment or medical attention at the emergency department. This may be determined via the attached protocols and/or clinical judgment of staff.

During certain encounters, a patient may verbally state they are not in need of additional medical services. This can happen with either a current or prospective patient. Examples may include (but are not limited to): decreasing oxygen saturation, symptoms of cardiac instability, suspected systemic infections, post-fall confusion, or severe undertreated wounds.

If staff feel the patient is at risk of decompensation or worsening condition, and the patient is still refusing care, medical back-up should be contacted for assessment and consultation. Emergency medical staff (paramedics, EMTs, supervisors/captains) can offer additional support in negotiating a plan of care with the patient.

Procedure:
Contact medical back-up or 911 directly as indicated in the related protocol. Depending on the situation, you may or may not need immediate response to engage with the patient and this can be determined on a case-by-case basis.

- Provide information as appropriate for medical back-up call
- Inform dispatch that the patient is at risk for worsening condition (be specific to the scenario), but is currently refusing treatment.
- Upon arrival of EMS, provide your report and indicate your clinical concerns regarding the patient.
- EMS should assess patient at this time. If patient still refuses transport to further care, determine with EMS if:
    1. Additional support is needed to encourage/order participation (supervisors, law enforcement, crisis outreach team). In this case, EMS or Outreach staff should contact 911 dispatch or the appropriate agency for further support. Or,
    2. Patient has capacity to refuse transport. If it is determined the patient can refuse transport:
        - Have EMS complete an AMA form. Keep a copy.
        - Document specifically how capacity was determined.
            - Reference in the Appendix: *"Evaluating Patients' Decision Making Capability"* by Thom Dunn.
        - As able, educate patient to signs and symptoms that indicate a more critical or worsening condition, including steps to contact emergency services. If available, include a friend or family in this education (i.e., encampment mates for which the patient verbally consents to involve in this specific conversation).
        - Plan follow-up with the patient to check-in as soon as feasible.

TRIAGE & TREATMENT OF ILLNESS BY THE REGISTERED NURSE

The Registered Nurse (RN) may complete nursing assessments and provide nursing care in accordance with the State Nurse Practice Act and the County or partner agency's specific nursing protocols. Additionally, the RN may dispense medications and complete procedures following standing nursing protocols, written orders, verbal or phone orders. Providers on scene with the RN (including NP, PA, MD, DO staff) will act as medical back-up. If no providers on-site, a designated provider off site should be available for phone consultation.

PROCEDURE

1. The RN will collect a history of present illness and complete a nursing assessment that is appropriate to the specific complaint.
    a. Both Subjective (History/ Symptoms) and Objective (Physical Assessment) exam should be completed
    b. This may be a limited assessment for minor complaints.
    c. The RN will use sound nursing judgment in observing for signs of more serious illness and will expand her/his assessment as indicated.

2. After the assessment, the RN will decide on the level of severity of the patient's condition and choose appropriate actions. Decision-making will fall into one of the following categories.
    a. Mild Complaint/Illness
        i. Appropriate nursing care
        ii. May medicate prn per orders/protocols

    b. Complaint that needs referral to Medical Back-up
        i. Immediate nursing actions based on nursing judgment, protocols, and orders
        ii. Either immediate referral to provider or evaluate need for referral to Urgent Care Clinic if provider not available for on site evaluation

    c. Complaint that requires phone consult or possible referral to outside provider

    d. Emergent Situations/Serious Illness
        i. Based on her/his judgment, the RN may make a decision for immediate referral to the Emergency Department. The RN will determine the most appropriate method of transport (by car/ van, non-emergent EMS ambulance, versus 911 transport).

3. After appropriate assessment including drug allergies, medication reactions, and medical contraindications to receiving medications, the RN may administer appropriate doses of medications which are either over the counter or as listed in the nursing protocols.
    a. The RN should contact medical back-up to request any medication order beyond over the counter or standing orders.

4. The RN will document all nurse visits on the appropriate forms and corresponding electronic health record.

5. The RN will monitor for frequent/repetitive clinical needs that may indicate the need for additional medical workup, counseling or referral; identified problems will be addressed with medical back-up.

PHLEBOTOMY aka VENIPUNCTURE

Purpose:
To obtain a venous specimen for testing and treatment using proper technique and equipment to prevent infection, sustain viability of the vein and produce the highest quality specimen.

Policy:
Applies to registered nurses in Street Health Outreach Teams and intended for field- or mobile-based phlebotomy.

Recommended Equipment:
Tape or Band-Aid
Appropriate size needle
Dry gauze pad or cotton ball
Gloves
Isopropyl alcohol pads
Disposable tourniquet
Tubes for tests ordered (including extras for required discard/ wasting or need to redraw)
Disposable vacutainer adapter
Sharps container and Biohazard container/tote
Documentation paperwork
Writing supplies

Procedure:

1. Explain procedure to patient. Confirm patient understands process and purpose of venipuncture.
2. Confirm patient's identity via two patient identifiers (e.g., having patient state full name and date of birth)
3. Gather all supplies and identify all tubes required for ordered labs
    a. Choose needle size and type related to vein size and amount of blood needed.
    b. Confirm the order of draw based on tube type (available through your contracted laboratory)
        i. Typical order for drawing blood specimens is: 1) Blood cultures; 2) Non-additive tubes; 3) Coagulation tubes; 4) Other additive tubes
        ii. When drawing all additive specimens, coagulation and CBC are drawn first
4. Perform hand hygiene and don gloves.
5. Check for restrictions on available venipuncture sites
    a. **Venipuncture is not to be performed:** on an artery, an extremity with an active shunt or fistula, or central vascular access device or on the same side as axillary lymph node surgery
    b. If presence of hematoma on the extremity, perform venipuncture above hematoma (proximal) to avoid hemoconcentration of the blood sample.
    c. **Venipuncture of the legs or feet may predispose the patient to phlebitis.** Use of a lower extremity requires provider consultation (verbal or telemedicine ok) prior to venipuncture.
6. Apply tourniquet to appropriate site and assess for appropriate vein for venipuncture
    a. The vein ideally should be visible without applying the tourniquet.
    b. In case of no obvious appropriate sites, consult with patient to help identify particular veins or locations at which phlebotomy has been previously successful.
7. Cleanse area of skin with minimum 70% alcohol preparation swab in a circular motion and allow to dry. Use multiple alcohol swabs as needed to ensure clean site. Do not fan or blow on site to speed rate of drying.
8. Perform venipuncture to assessed vein, in order of proper collection

   a. If there is no blood flow, gently reposition the needle in the vein and insert a new tube into the vacutainer adapter. Do not remove the needle from the skin. If another venipuncture is necessary, prepare a new site and use a clean needle.
   b. After two unsuccessful attempts at venipuncture by a nurse, reassess and consider using another resource (e.g., another RN or staff member certified in phlebotomy, provide oral hydration and wait at least 15mins, urgent care clinic).
   c. Consult with provider as needed.
9. Release the tourniquet while needle still in patient
   a. Note: the tourniquet is typically released as soon as blood enters the first tube. You may leave the tourniquet on during the entire procedure if needed.
   b. Remove tourniquet before withdrawing needle.
10. Retract the needle from the patient while applying gauze or cotton ball to the area of collection for approximately 2 minutes, or until bleeding has ceased. As able, patient may apply pressure instead of the nurse.
   a. Do not bend the arm at the puncture site as this may increase chance of hematoma.
   b. If bleeding does not cease, apply bandage and additional pressure on top of existing gauze or cotton ball. Do not remove original dressing.
   c. Notify health care provider if bleeding continues for five minutes.
11. Discard needle/ vacutainer adapter and any discard lab tubes in the sharps container.
   a. After drawing tubes with additives, invert the tube gently ten times. Do not shake any tubes.
12. Remove gloves and perform hand hygiene.
13. Unless soaked with blood or bodily fluids, the gloves, gauze, alcohol pads, and tourniquet may be disposed of in double-bagged system within regular trash.
14. Document in patient chart including:
   a. Number of attempts
   b. Patient's tolerance
   c. Venipuncture site
   d. Lab test(s) obtained
   e. Receiving lab
   f. Other details as appropriate
15. Apply appropriate labels to specimens and complete the specimen requisition. Documentation on each tube must include:
   a. Patient name, DOB
   b. Collection date and time
   c. Identification of collector (nurse initials)
   d. Completion of the lab slip including venipuncture location
   e. Any additional information as required by processing laboratory
16. Place collection tubes in clear biohazard bag and place in specimen delivery bag for laboratory. Ensure labs are delivered within acceptable window of time for processing (confirm with laboratory).
17. In follow-up visit, assess venipuncture site as able to ensure no signs or symptoms of infection are present.

References:

Perry, A., Potter, P. & Ostendorf, W. (2019) Nursing Interventions & Clinical Skills, 7th Edition. Mosby. Available at: https://www.elsevier.com/books/nursing-interventions-and-clinical-skills/perry/978-0-323-54701-7

World Health Organization Guidelines on Drawing Blood: Best Practices in Phlebotomy. Accessed July 2021 at https://www.ncbi.nlm.nih.gov/books/NBK138665/.

ABDOMINAL PAIN

Abdominal pain can be caused by something simple such as gas or indigestion, or may be a serious life threatening condition like internal bleeding. Careful assessment and observation must be done.

See related protocols *Nausea & Vomiting, Constipation,* and/or *Diarrhea* as appropriate.

Subjective information

- Patient complains of abdominal pain, nausea, vomiting, diarrhea, blood in emesis or stool, constipation
- History of ulcers, constipation, gallbladder problems, recent abdominal trauma, pancreatitis, HIV/AIDS, GI bleeding
- Menstruating or pregnant, abnormal vaginal discharge, unprotected sexual intercourse
- Poor intake over past few days
- Medications (particularly ASA, NSAIDS)

Objective information

- Vital Signs
- Abdominal guarding, absent bowel sounds, abdominal distention or rigidity

Plan

1. Evaluate vitals signs. Assess for shock related to internal bleeding, including hypotension (BP <100/60) or tachycardia (HR >110).
2. Call 911 if vomiting frank blood or coffee grounds, passing black tarry stools (melena), or bright red bloody stools (hematochezia).
3. Abdominal pain: If patient complains of abdominal pain offer fluids and reassess in 30 minutes. If pain is persistent and not improving, and vital signs are within normal limits, send patient to ED via non-emergent transport.
4. Abdominal pain: If pain persists and vital signs are abnormal (see #1), call 911.
5. Pregnancy: Any pregnant women with abdominal pain send via non-emergent transport to ED.

ALLERGIC REACTION

An allergic reaction is a hypersensitive state caused by an antigen-antibody reaction that releases histamine from the body's storage sites and results in a complex of characteristic conditions, which may include eczema, allergic rhinitis, bronchial asthma or urticarial/ hives. Anaphylaxis is a life-threatening allergic reaction which may occur within seconds or minutes following exposure to a specific allergen.

Subjective (History/Symptoms):

- History of exposure to known allergen
- Recent injection/ oral medication
- Itching/ rash/ hives
- Shortness of breath/ wheezing/ chest tightness
- Swelling of hands, lips, tongue
- Dizziness
- Palpitations
- Abdominal pain/ nausea/ diarrhea

Objective (Physical Assessment)

- Document onset, duration, overall general appearance, note distress
- Vital Signs: paying particular attention to respiratory rate and quality/rate/depth
- Note: Rash/Hives, swelling of hands/lips/tongue, Stridor/ Hoarseness (indicative of laryngeal edema), wheezing, hypotension, weak thread pulse, pallor

Plan

As able for topical exposures, remove allergen from proximity of patient. For other exposures, such as respiratory or ingestion, advise patient to cease intake as able. If the allergen may be a medication, contact the prescribing provider for additional recommendations and order.

An allergic reaction with mild systems may or may not require medication management, based on the patient preference and level of discomfort.

Mild symptoms:
(Hives, Rash, Allergic Rhinitis)

- Contact medical back-up for medication orders, such as diphenhydramine (Benadryl) PO.
- Monitor Symptoms. If symptoms unresolved within 2 days, recommend patient visit urgent care or primary care clinic. Notify Medical back-up or Primary Care Provider for additional orders.
- Update patient's allergy record

Moderate to Severe symptoms:
(Brochospasm, Altered Mental Status, Hypotension SBP<90, swelling of hands/ lips/ tongue, severe SOB, stridor/ hoarseness)

- Activate EMS/ call 911.
- If patient has an existing prescription and available medication, Epinephrine 0.3 mg IM x 1 may be administered.
- Protect the airway, and be prepared to initiate CPR
- Continue to monitor VS
- Notify Medical Back-up
- Update patient's allergy record
- If able to follow-up: Evaluate signs/ symptoms, refer to primary or urgent care clinic if condition does not respond to treatment in 2 days

ALTERED MENTAL STATUS

Alterations in mental status reflects a disturbance in cerebral functioning can be presented by a change in level of consciousness, agitation, impaired attention/concentration/ thinking, incoherent speech, and or hallucinations. Changes in mental status can be a result of but not limited to medical conditions, substance intoxication, medication side effect, infections or head injury. The condition typically develops over a short period of time. An acute mental condition such as delirium which presents with confusion, disorientation and restlessness can be reversed if the underlying cause is treated. This can be associated with central nervous system, metabolic, and/or cardiopulmonary disorders, systemic illnesses, and sensory deprivation or overload.

Assessment:

Subjective Information (If Possible):

1. (Patients) Person, place, thing- Is the information accurate?
2. Able to answer yes or no questions- can they answer simple questions?
3. Patient Hx:
  a. chronic illnesses (seizures, diabetes, hypertension, liver, kidney, or cardiac disease), alcohol or drug use, trauma

Objective Information:

1. Confusion and disorientation:
  a. Glasgow Coma Scale <13 (see Appendix)
  b. AVPU (Alert, Verbal, Pain, Unresponsive)
2. Focused exam to include:
  a. PERRLA (Pupils Equal Round & Reactive (to) Light & Accommodation)
    i. Pupils dilated: may indicate cardiac arrest, stimulants, hallucinogens, etc.
    ii. Constricted: may indicate CNS disorder or opiate ingestion
    iii. Unequal: may indicate stroke or head trauma
  b. Vitals: RR, BP, Pulse, Temp and O2
  c. Glucose Finger Stick (See *Hypo/ Hyperglycemia Protocol*)
  d. Assess for head trauma such as contusions or abrasions
  e. Hydration status

Plan:

1. Obtain a finger stick blood glucose *(see related Hypo-Hyperglycemia Protocol)*
  a. If AMS accompanied with weakness, sweating, rapid pulse, anger, or anxiety, consider hypoglycemia
  b. If AMS accompanied with weakness, lethargy, abdominal pain, nausea, consider hyperglycemia
2. Pupils unequal upon exam, with signs of altered mental status without prior documentation indicating unequal at baseline (*Anisocoria*), should be treated as a medical emergency. Contact 911.
3. If patient does not have history of mental illness or similar behaviors in past, and has a blood glucose within normal limits (>70 and <400), **evaluate orientation.**
  a. If the patient cannot answer simple yes or no questions about him or herself, is totally unresponsive, unable to follow simple commands, or severely disoriented, **call 911.**
4. If patient has head trauma and presents with red or purple bruises anywhere above the clavicles, lacerations, dried blood or with unequal pupils, paralyzed limbs, **call 911. See Head Trauma protocol.**
5. Suicidal or violent threats must be taken seriously, **call 911.**

ANIMAL BITES

Many wounds are often ignored until signs of pain swelling or drainage appear. Clinical manifestations of infections usually occur after 24 hrs. and consist of fever, erythema, swelling, tenderness, purulent drainage. Common animal bites include:

Dog- cause minor wounds such as scratches or abrasions or complicated wounds such as deep lacerations, deep puncture wounds, tissue avulsions, and crush injuries. Lethal wounds involve head, neck or direct penetration of vital organs and require extra precautions with ABC's and immobilization.

Cat- cause wounds with their teeth or claws usually in the upper extremities or the face. They can result in deep puncture wounds because of long, slender, and shaper teeth, with wounds more susceptible to bacteria below the periosteum. Cat bites can often transmit the highly pathogenic Pasteurella bacteria.

Rodent- bites of most small animals such as squirrels, rodents, and rabbits are treated the same as cat bites.

Human- Occlusive wounds are made by teeth closing over and breaking the skin. **Clenched fist or fight bites** occur when skin over a joint strikes a tooth which may damage the skin and the underlying structures. They are not bites but assessed similar to bite wounds. Skin that brakes over the bite wounds are prone to infection because of the proximity of the skin over the knuckles to the joint capsule. These types of wounds place people at risk for deep soft tissue infection, septic arthritis, and osteomyelitis.

Subjective Information:

- What caused the bite or injury?
- Type and size of the animal? Possibility of rabies (animals with fur)?
- How did it happen?
- When did it happen?
- How has the patient treated the injury thus far?
- Preexisting conditions which may have weakened the immune system or altered healing

Objective Information

- Assess wound site:
    - Note the structures involved
        - Damage may include fractures, lacerated tendons, blood vessels, nerve damage to the joint space or body cavity
    - Examine for foreign bodies such as teeth or broken bone.
    - Assess distal neurovascular function including circulation and palpable pulses

Plan:

1. **Immediate injuries:**
    a. **Safety is the first priority. If the animal is on site,** call for support to remove patient to a safer environment or to secure the animal. Appropriate entities to assist include:
        a. Animal control
        b. Law enforcement
        c. Fire department
    b. Do not attempt to make contact with offending animal

2. **Bites (<24hrs)**

All bite injuries should be referred to urgent care or other clinic. If unable to refer patient to clinic or other medical setting, proceed with the following care.

a. Clean thoroughly with irrigated water, soap and water, or sterile saline.
b. Utilizing clean technique, cover wound with non-adherent dry dressing, and advise patient to keep dry and clean for 24-48 hours.
c. If there is bleeding, a clean towel or non–adherent dressing should be used to press the wound to slow or stop the bleeding.
d. If bleeding does not stop after applying pressure for 15 minutes, **call 911.**
e. Red, painful, swollen, and warm injury sites indicate possible infection. Contact medical back-up for further instruction.
f. All bites to the hands must be referred to a higher level of care, either clinic or ED. Contact medical back-up for instruction.
g. For puncture wounds:
    i. Superficially irrigate the wound avoiding high pressure irrigation.
    ii. Remove gross wound contaminants (such as teeth or broken bones). Place large items in biohazard bag and do not immediately dispose. Provide to medical teams providing care. These items may be also secondarily provided to law enforcement officers in case of human-to-human bite.
    iii. Avoid removal of deep tissue.

3. Bites (after 24hrs)

a. Any damage to circulation or lack of distal pulses requires immediate medical intervention. Contact 911 or an emergency department immediately.
b. Red, painful, swollen, and warm injury sites indicate possible infection. Irrigate with normal saline and cleanse wound site. Re-evaluate once wound is clean.
    a. Refer to *Wound Protocol* as appropriate.
c. If infection is complicated: cellulitis, soft tissue abscess, septic arthritis, necrotizing soft tissue infection, and osteomyelitis, refer to medical back-up.

ATHLETE'S FOOT

A superficial infection of the feet caused by fungi of the dermatophyte group. The fungi invade dead tissues of the skin, usually producing mild or no inflammation and creating scaly lesions with raised borders or maceration. A stronger immunologic reaction to the fungus causes itching, redness and/or erosion. The condition may be acute or chronic, usually affecting the interdigital web space and soles of the feet.

Contributing factors include tight, ill-fitting shoes, nonporous socks, sweaty feet, and walking barefoot in public showers or on damp floors.

Cellulitis and lymphangitis may be seen if bacterial superinfection occurs.

Subjective:

- Document onset duration, frequency of occurrences, and the nature of symptoms
- Contact with or sharing shoes/ socks with person with athlete's foot
- Self-care history including access to hygiene facilities and ability to wash/ dry feet on a regular basis

Objective (Wear gloves for examination):

- Maceration between toes
- Mild erythema in affected areas
- Scaling and cracking of the skin
- Edema and erythema
- Difficulty walking
- Scaling thickening and cracking on the sole and heel that may extend over the side of the feet in a "moccasin" distribution
- Toenails may be brittle, discolored, and abnormally shaped.

Plan

1. Mild Symptoms:

    - Foot soak/wash with soap and warm water.
    - If any symptoms of secondary infection or if interdigital blistering – refer to Medical back-up
    - Provide supplies as needed – foot soak basin and clean socks.
    - As able, patient should wash feet daily and dry thoroughly. Vinegar soaks for 20-30mins (one cup vinegar to 2 quarts water) can be recommended as appropriate.
    - Management with over-the-counter medications may be appropriate. Contact medical back-up for orders, including clotrimazole cream 1% or anti-fungal foot powder.
    - Severe symptoms or those that are difficult to resolve may be treated with oral medications including itraconazole (Sporanox), fluconazole (Diflucan), or terbinafine (Lamisil). Refer to urgent care or contact medical back-up for additional assessment and medication orders.

2. Signs/ Symptoms of Infection:

    - Any indication of infection, including red streaks on limb, co-occurrence of fever, or wounds that are red, hot, swollen, or purulent should be seen in urgent care or the ED. Non-emergent transport can be used as available.

BRADYCARDIA

Low pulse or bradycardia may be due to a drug effect, heart problem, syncope, or may be normal in athletic persons.

Subjective information

- Current cardiac and/ or other medications (e.g. atenolol, metoprolol, clonidine)
- Past history of pulse abnormalities
- Fatigue, dizziness

Objective information

- Pulse rate <60
- Regular or irregular pulse
- Abnormal characteristics i.e. weak, thready or bounding pulse

Plan

1. Any patient with a pulse <60 should be referred to medical back-up and/ or the emergency department. Contact medical back-up for advice on transport method and location.
2. Patients with a pulse <60 accompanied with dizziness, syncope, or other signs of altered mental status (see Altered Mental Status protocol) should be referred to the ED via 911.
3. Refer to medical provider for evaluation during working hours.

CHEST PAIN

Complaints of chest pain must be taken seriously. The patient who describes chest pain represents an immediate challenge, as the symptom is often of benign etiology, but it may indicate imminent catastrophe. Try to gather as much information as possible including patient history.

Subjective and Objective information

- The patient with myocardial ischemia may feel chest "pain." Other descriptions include squeezing, tightness, pressure, constriction, strangling, burning, heart burn, fullness in chest, band-like sensation, knot in the center of chest, lump in the throat, ache, heavy weight on chest, and toothache (with radiation to lower jaw).
- Acute chest pain with a classically ripping or tearing quality may indicate acute aortic dissection. This is a significant medical emergency with a high risk of death. Symptoms typically include severe, sharp or "tearing" posterior chest or back pain or anterior chest pain which can radiate in the thorax or abdomen. It is most commonly seen in patients with severe hypertension or recent cocaine use.
    - Note: **If dissection suspected, provide oxygen** but **do not administer other medications**.
- History – Has patient had this symptom before, if so what was cause and resolution.

"PQRST" Assessment

Nurse should assess the subjective information for presence of Pain; Quality of Pain; Region/Radiation; Severity; and Temporal characteristics.

Other information to obtain:

- Past Medical History
- Associated Symptoms– diaphoresis, shortness of breath, dizziness, anxiety/feeling of doom
- Medications
- Vital Signs
- Skin signs

Assessment and Plan

1. The patient complaining of chest pain requires an emergency medical assessment and 911 should be called – unless the chest pain is clearly benign such as a documented muscle sprain or heartburn consistent with patient's typical heartburn.

2. Place patient in a comfortable seated or lying position as able. Be prepared to initiate CPR.

3. Medications may be administered only under direct orders of a prescribing provider. If provider and medications are available, patients with active chest pain may be provided (prioritizing in order listed):
    a. **Oxygen** via nasal cannula *(if at location with access to oxygen)*
    b. **Aspirin** PO *except* when primary complaint is "tearing chest pain"
    c. **Nitroglycerin**: *except* when primary complaint is "tearing chest pain". Must have SBP >110mmHg to administer.
        i. For patients with an **existing prescription of nitroglycerin**, the nurse may recommend self-administration as appropriate.

4. Upon EMS arrival, report medications provided and hand off further treatment when directed.
5. Document

COLD/ UPPER RESPIRATORY INFECTION

An acute respiratory tract infection, with major involvement in any of the airways, including the nose, paranasal passages, throat, larynx, and often the trachea and bronchi. A self-limited viral syndrome caused by any of the over 200 viruses which is managed symptomatically.

Subjective

- Assess onset, duration and nature of symptoms (sore throat, nasal congestion, rhinorrhea, sneezing, cough, nature of sputum, aches, pains, fever, chills, fatigue, headache, ear pain, shortness of breath).
- Document pertinent past medical history including chronic obstructive disease, pneumonia or flu
- Self-care history

Objective

- Document overall general appearance, vital signs. Note distress as applicable.

ASSESSMENT: Note the absence or presence of the following symptoms to guide intervention options. • Red eyes • Tearing, discharge • Runny nose • Nasal congestion • Sneezing • Throat redness, swelling • Quality of cough • Auscultate chest • Palpate sinuses for pain	EXCLUSIONARY CRITERIA: **If any of these are present, consult medical back-up and/or the relevant additional protocols**. • Fever >100° F (38° C) • Elevated blood pressure • Elevated heart rate • RR >24 and/ or O2 sat. on RA <94% • Neck stiffness • Exudate in throat and/or on tongue • Abnormal breath sounds • Swollen glands • Ear Pain • Sinus pain with purulent drainage • Shortness of breath • Uncontrolled asthma • Cold symptoms for >7 days • Untreated +PPD or +QFT • Exposure to person with COVID-19

Plan

1. If patient presents with any listed Exclusionary Criteria, contact medical back-up and/or the relevant protocols for further guidance.
    a. As able for patients with active cough or untreated tuberculosis or COVID-19, place mask on patient and encourage staff to wear masks.

2. Assure that patients with Asthma/ COPD have access to prescribed medications and refills

3. Assess if patient may require medication management of the URI symptoms, and contact medical back-up for further assessment and consultation.

4. Over-the-county medications often recommended for URI-related symptoms may include:
    a. For nasal congestion/ sinus pressure:
        i. **Pseudoephedrine hydrochloride**
        ii. Caution may be used in patients with HTN, and contra-indicated for patients also taking MAOIs
    b. For chest congestion/ cough:
        i. Expectorant/ Suppressant cough syrup: Guaifenesin / Dextromethorphan syrup (Robitussin DM, Mucinex DM).

    c. For non-hacking coughs with thick mucus:
        i. Expectorant syrup: Plain Guaifenisen cough syrup.

    d. For fever/ pain:
        i. Ibuprofen or Acetaminophen (typically not recommended in patients with liver disease)

    e. Sore throat: Cepacol throat lozenges

    f. Depending on symptoms: Saline nasal spray; multi-vitamins; Vitamin C

CONSTIPATION

An abnormal infrequency of bowel movement, or the passage of hard, dry fecal matter. The normal frequency of bowel movements varies from 3/day to 2/week. Contributing factors to constipation are variable and include: lack of privacy, mobility impairment, inactivity, poor nutrition, dehydration, opioid use, anxiety, painful hemorrhoids, anal fissures, and recent anesthesia.

Subjective (History/Symptoms):

- Document frequency and consistency of stools, last bowel movement, abdominal pain, rectal pain and/ or bleeding, abdominal fullness (bloating), flatulence, indigestion, vomiting.
- History of constipation
- Medical history including current medications, such as antacids, antidepressants, opiate pain medications, some cold medications including antihistamines, or cardiac medications (including some cholesterol or blood pressure medications).

Objective (Physical Assessment):

- Document general appearance, vital signs. Note areas of distress.
- Perform abdominal exam as able:
  - Symmetry
  - Abdominal distension
  - Presence or absence of bowel sounds in all four quadrants
  - Rigidity or tenderness
- Prescription for opiate medications

Intervention:

Mild Symptoms (complaints of constipation lasting < 2 days, normal VS, mild abdominal discomfort, no vomiting).

- Contact medical back-up for further assessment and orders, which may include Metamucil, docusate sodium (Colace), senna, or suppository.
  - Educate patient to not attempt all four interventions at one time.
  - Advise patient to increase water intake as appropriate.
- Monitor symptoms. If symptoms remain unresolved or worsen in 2 days, notify primary care or medical back-up.

Moderate- Severe Symptoms (severe abdominal pain with cramping, nausea, vomiting, and/or distention, no BM x 24 hours after enema, fever, heart palpitations, vomiting with sediment of feces, absence of bowel sounds, history of Crohn's Disease or Ulcerative Colitis)

- Refer to Urgent Care, Primary Care, or EMS as appropriate

- Notify medical back-up or patient's primary care provider if frequent symptoms (recurrence of constipation every 2-3 weeks)

- Confirm patients that are prescribed opiate pain medication or other medication affecting constipation are also prescribed stool softeners

COUGH

A cough can result from numerous conditions such as the common cold, allergies, gastroesophageal reflux (GERD), chronic bronchitis, COVID-19, or tuberculosis. Cough without additional symptoms may indicate exposure to tuberculosis, particularly as individuals without homes are at risk of contracting tuberculosis and exposing others if they have active disease. Persons with active substance use disorders, poor nutrition and/ or immuno-suppression (e.g. HIV infection) are susceptible to reactivation of latent TB. Though presence of a cough is likely due to another condition than tuberculosis, take relevant precautions to decrease risk of exposure to others. All persons who are homeless and outreach staff should have screening for tuberculosis regularly.

Subjective Information

- History of tuberculosis (TB) exposure
- History of COVID-19 exposure (see *Coronavirus Disease 2019* protocol)
- Complaints of cough > 2-3 weeks, unexplained weight loss, night sweats, weakness/ fatigue
- Stated history of +PPD (TB skin test) or +QFT (QuantiFeron)
- Incomplete TB treatment
- Unvaccinated status (COVID-19)

Objective Information

- Persistent coughing
- +PPD or +QFT (QuantiFeron)
- Hemoptysis (bloody cough)
- Clinical alert stating exposure to tuberculosis

Plan

1. Patients with **intermittent cough**: place a mask over patient nose and mouth and alert medical back-up for evaluation (See also *Cold/ URI* protocol). If no provider available, refer patient to primary care or urgent care.

2. Patients with **persistent cough** and/or additional signs or symptoms of infectious condition (i.e., active TB, COVID-19 – *see related protocol*) require urgent evaluation and testing. Place mask on patient. Alert medical back-up and/or transport patient to urgent care or primary care. If no provider or clinic available, consider transport to emergency department via non-emergent transportation. See "Patient Refusal of Medical Services" as appropriate, if a higher level of care is needed and refused. Additionally, if TB is suspected, follow clinic guidelines to contact the Public Health Department for further instruction.

3. If available, conduct onsite swab and test for COVID-19. In case of positive results, follow protocols to promote self-quarantine or refer patient to appropriate shelter setting.

4. Patients with **hemoptysis**, cough with **fever**, or **difficulty breathing** (see *Shortness of Breath* protocol) require urgent evaluation. Contact 911 for transportation.

5. Staff has the option of wearing a mask as appropriate. Mask use is encouraged when caring for individuals with a cough.

CORONAVIRUS DISEASE 2019 (COVID-19)

Coronaviruses are a large family of viruses that can cause illness in animals and humans. COVID-19 is caused by the virus "severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)". This is a respiratory illness spread person-to-person primarily through respiratory droplets when someone with COVID-19 sneezes, coughs, or talks. Though apparently rare, persons can be infected with COVID-19 from touching hands, objects, or services with droplets and then touching their own eyes, nose, or mouth. Persons with mild or no symptoms are still able to transfer the virus to another individual. Though vaccination does offer a substantial amount of protection, it does not offer full immunity; persons who are vaccinated for COVID-19 may still acquire and transmit COVID-19 to other individuals.

Symptoms may present both as a respiratory condition and more broadly. As of June 2021, these include: fever or chills, cough, shortness of breath, fatigue, headache, nasal congestion, muscle or body aches, sore throat, new loss of smell or taste, nausea or vomiting, and/ or diarrhea. Estimated incubation period is 2 to 14 days. Updated information may be found at the Centers for Disease Control and Prevention at http://www.cdc.gov/coronavirus/.

Priorities for assessment of COVID-19 is to rapidly identify suspect cases early to reduce transmission within the public and initiate monitoring or treatment to reduce negative health complications including death.

Subjective Information

- History of COVID-19 exposure
- Symptoms consistent with those listed above, including new emerging symptoms
- Vaccination status for COVID-19
- Vaccination status for flu, pneumonia

Objective Information

- Persistent coughing, congestion, shortness of breath
- Fever
- Clinical alert indicating exposure to COVID-19 case
- Cases of COVID-19 in neighboring persons within same or nearby encampments

Plan

1. Due to the emerging process of SARS-CoV-2, specific methods of testing and treatment are not being included here in these procedures. Refer to latest CDC and county guidelines for testing, medical back-up, transport, and treatment of patients with positive or suspected COVID-19.
2. General guidelines:
    a. Mask use is encouraged when working with any patient with a cough. Staff should don a medical or cloth face mask prior to performing additional assessment. Additional PPE may be warranted depending on staff preference and clinical scenario, including eye protection (goggles or face shield) or gloves.
    b. Place a mask over patient nose and mouth.
    c. As available, perform onsite rapid COVID-19 test.
    d. Refer to medical back-up for suspected and positive cases. If no provider available, refer patient to primary care or urgent care.
    e. Report suspected or positive cases of COVID-19 to team management or public health department as specified by local or state guidelines.

DENTAL PAIN

Toothache - A painful tooth or an acute suppurative process (of pus) of the tissues encompassing or surrounding the root of a tooth that can often be the result of dental abscess or trauma. Dental abscess may be dental or periodontal in origin. Pain level can vary: a normal appearing tooth may be the source of much pain, and a broken rotted tooth may be painless. Teeth with acute abscesses are generally extremely sensitive to the tap of an instrument. Complications of chronic abscess may include fistulas, cellulitis, and osteomyelitis.

Subjective (History/Symptoms):

- Duration and severity of symptoms
- Quality of pain (i.e., dull, throbbing continuous)
- Gingival or facial swelling
- Fever and/or chills
- Difficulty eating with sensitivity to hot/cold/sweet/pressure
- Bad taste in mouth
- Difficulty swallowing

Objective (Physical Assessment):

- Localized inflammation, intra-oral or facial swelling
- Loose teeth, broken teeth, or dental caries
- Foul breath
- Tenderness with percussion (tap tooth with a tongue blade)
- Drooling
- Note presence of fever, facial or jaw swelling, or enlarged lymph nodes

Intervention (Based on signs and/or symptoms):

1. No facial swelling, minimal discomfort and no elevated temperature:
    - Refer patient to dentist or dental clinic
    - Contact medical back-up for pain medication (such as acetaminophen or oil of clove) as appropriate while awaiting dental examination.
2. ANY facial swelling and/or moderate pain:
    - Consult with medical back-up
    - Assist patient in obtaining an urgent dental appointment/plan.

3. Facial swelling, difficulty swallowing or drooling, moderate to severe pain, or fever:
    - Consult with medical back-up or refer patient to urgent care or ED as appropriate. Facial swelling can increase rapidly and may require IV antibiotics.

Patient Education:

- Advise warm water mouth rinses prn.
- As able, avoid extremes of hot and cold foods and liquids.

DERMATITIS, (ATOPIC) ECZEMA

Atopic dermatitis is a chronic, pruritic, inflammatory skin disease that affects the epidermis, the first line of defense between the body and the environment. It causes dry, itchy, scaly, red skin, erythema, oozing and crusting, and lichenification. It occurs most often in infants and children, but can also be found in adults. The skin may become thickened and darkened, or even scarred from repeated scratching. There is no known cause or cure. The focus is on **controlling the symptoms** by restoration of skin barrier function and hydration of the skin, patient education, Rx treatment for inflammation and itching, reducing or eliminating exacerbating factors.

Subjective

- Med Hx: particularly asthma, allergic rhinitis, hay fever, family history of eczema
- Scratching: Is there intense scratching throughout the day? Is it worse at night? Does it impact daily activities?
- Assess what triggers or exacerbates patient symptoms: emotional distress, hot or cold climate, food allergies, tobacco smoke, soaps, detergents

Objective

- Distribution of lesions: Neck and/ face, flexor surfaces (folds), hands feet, upper chest, genital areas, axilla
    - **Infants:** red scaly, and crusted areas are found on the front of the arms, legs, cheeks, or scalp (diaper area usually not affected).
    - **Children and adults:** commonly affects the back of the neck, elbow creases, and back of the knees, and can sometimes include the face, wrist, and forearms.
- Skin Assessment can be evaluated and monitored with specific tools: SCORAD index (incorporates objective and subjective data), or EASI (utilizes objective information estimates of disease extent and severity).
    a. Mild
        i. areas of dry skin, **infrequen**t itching (with/without small areas of redness)
        ii. little impact on everyday activities, sleep, and psychosocial well being
    b. Moderate
        i. Areas of dry skin, **frequen**t itching, redness (with or without excoriation and localized skin thickening.
        ii. Moderate impact on everyday activities, psychosocial wellbeing, frequently disturbed sleep
    c. Severe (20% general skin involvement; 10% skin involvement affecting eyelids, hands, and intertriginous areas that do not respond to therapy).
        i. Widespread areas of dry skin, incessant itching, redness (with or without excoriation, extensive skin thickening, bleeding, oozing, cracking, and alteration of pigmentation)
        ii. Severe limitation of everyday activities and psychosocial functioning, nightly loss of sleep
    d. I**nfected** (at risk for cutaneous bacterial, viral, and fungal infections)
        i. Superinfection: weeping, pustules, honey colored crusting, worsening of dermatitis, or failure to respond to therapy
        ii. Presence of vesicles and punched-out erosions may be a sign of eczema herpeticum, a life-threatening condition which can affect, eyes, lungs, brain, liver

Plan:

1. **Restoration of Skin Barrier Functions and Skin Hydration**

a. Bathing (arrange access to bathing, if possible)
    i. Lukewarm baths can hydrate, cool the skin, and relieve itching
    ii. Use unscented mild soap

b. Wound care may alleviate symptoms and help to restore the skin barrier. Contact medical back-up for further assessment and prescription ointment orders.
    i. Advanced practice registered nurses with an active, accredited Wound Certification may practice to the scope of their credentialing in wound care management.
        1. Accreditation should be from either Accreditation Board for Specialty Nursing Certification (ABSNC) or National Commission for Certifying Agencies (NCCA).

c. Contact medical back-up to obtain over-the-counter or prescription medication orders.
    i. Mild:
        1. Medications typically recommended include emollients (thick creams) such as Eucerin or Cetaphil or ointments such as petroleum jelly, Aquaphor, and Vaseline.
        2. If a low potency topical corticosteroid cream or ointment (hydrocortisone) is prescribed, advise the patient it should be applied after bath or cleansing.
    ii. Moderate
        1. A medium to high potency corticosteroid creams (flucoinolone, triamacinolone, betamethasone) may be appropriate.
    iii. Severe
        1. May require referral for phototherapy or systemic immunosuppressant. Consult with medical back-up or primary care for a referral.

2. Skin Irritation

a. Topical or Oral steroids may be prescribed to prevent thinning and/or irritation of the skin. Contact medical back-up, urgent care, or primary care for assessment and orders.

3. Control Itching

a. Topical or Oral antihistamines may be prescribed to alleviate itching. Contact medical back-up or primary care for assessment and orders.

b. Wet dressing may be applied to temporarily sooth and hydrate the skin to reduce itching, redness, loosen crusted areas, and prevent injury from scratching.
    i. A clean dampened cotton garment can be worn over the affected area and covered with a dry garment. It can be worn overnight and changed twice daily
    ii. Wet dressing may be applied utilizing the clean technique at minimum. If a clean technique is not achievable in the field, patient should be transferred to a location where a clean technique may be achieved.

4. Eliminate Aggravating factors

a. Heat, perspiration, dry environments, emotional stress or anxiety, rapid temperature changes, exposure to certain chemicals or cleaning solutions, wool or synthetic fibers, dust, sand, and cigarette smoke aggravate the symptoms and should be avoided or eliminated whenever possible.

DERMATITIS, CONTACT

Allergic contact dermatitis (ACD) is immune mediated inflammatory skin rash. The inflammation of the skin presents itself by different degrees of edema, erythema, and vesiculation. It affects people who have been previously sensitized to a contact such as poison ivy, latex, or topical antibiotics. It is an inflammation of the skin that is manifested in differed degrees of edema, erythema, and vesiculation.

Irritant contact dermatitis (ICD) is a localized inflammatory skin response to a chemical or physical agent that increases skin permeability and trans-epidermal water loss. It is considered the most frequent cause of hand eczema and the most at risk are those with "wet work" exposures such as food handlers, healthcare workers, cleaners, and house keepers. The face, hands, and finger webs are areas more prone to irritation. Environmental factors such as temperature, air flow, humidity, and occlusion affect the skins response to the irritant.

Subjective

1. Review patient's contact with chemicals, activities including hobbies and or occupation, products used, or a change or addition of a chemical (such as a soap)
2. Medical Hx: does patient know of allergies? Have they symptoms happened before? When? How long do symptoms occur after exposure? What is usually seen or felt? What has helped resolve the issue?
   a. Itching, burning, stinging or pain
3. History of irritant exposure
   a. Onset of symptoms within minutes or hours? Or within weeks?
   b. Pain, burning, stinging, or discomfort exceeding itching
   c. Investigate if other persons were affected by the same irritant
   d. Exposure to multiple irritants

Objective

1. **Allergic CD**
   a. Erythema and edema
   b. Bullae and vesicles, with distinct borders
   c. Appears to spread with time
2. **Irritant CD**
   a. Erythema, hyperkeratosis, or fissuring with no distinct borders.
   b. Glazed, parched, or scalded appearance of the skin.
   c. Healing process proceeds without plateau when irritant is removed.
   d. Affects only point of contact.

Plan:

1. **Identify and create plan to reduce or eliminate contact with irritants or allergies**

2. **Goal is restoration of skin barrier and hydration**
   a. Mild
      i. Over-the-counter emollients (thick creams such as Eucerin or Cetaphil) or ointments (such as petroleum jelly, Aquaphor, or Vaseline) may be recommended. Contact medical back-up for additional assessments and orders.
      ii. Low potency topical corticosteroid cream or ointment (i.e. hydrocortisone) may be indicated, and should be applied after bath or cleansing. Contact medical back-up for additional assessments and orders.

b. Moderate or Severe symptoms with skin inflammation
  i. Medium to high potency corticosteroid creams (flucoinolone, triamacinolone, betamethasone) or other prescription medications may be indicated. Contact medical back-up for orders.
  ii. If there is a lot of swelling or a rash covering much of the body, consult with medical back-up or refer patient to urgent care/ ED.

3. Control Itching

a. Over the counter oral antihistamines such as Zyrtec or Claritin (non-drowsy) or Benadryl or Atarax (may cause drowsiness) may address itching not controlled by topical medications. Contact medical back-up for orders.
  i. Recommend patients follow dispensing guidelines as indicated on the package or as prescribed by a provider.

b. Wet dressing may be applied to temporarily sooth and hydrate the skin to reduce itching, redness, loosen crusted areas, and prevent injury from scratching.
  i. A clean dampened cotton garment can be worn over the affected area and covered with a dry garment.
  ii. It can be worn overnight and changed BID.
  iii. Wet dressing may be applied utilizing the clean technique at minimum. If a clean technique is not achievable in the field, patient should be transferred to a location where a clean technique may be achieved.
  iv. Registered nurses with an active, accredited Wound Certification may practice to the scope of their credentialing in wound care management.
    1. Accreditation should be from either Accreditation Board for Specialty Nursing Certification (ABSNC) or National Commission for Certifying Agencies (NCCA).

DIARRHEA

Diarrhea is oftentimes viral in cause, though both bacterial and viral conditions can be severe. The most important goal of therapy is to prevent dehydration. Co-occurring symptoms, such as abdominal pain, can be caused by benign conditions such as gas or indigestion, or may be a serious life threatening condition such as internal bleeding. Careful assessment and observation must be done.

See related protocols *Nausea & Vomiting* and/or *Abdominal Pain* as appropriate.

Subjective

- Patient complains of abdominal pain, nausea, vomiting, diarrhea, blood in emesis or stool, constipation
- Nature of stools (watery, bloody, fatty, etc.), frequency, onset/ duration
- History of constipation, gallbladder problems, pancreatitis, HIV/AIDS, GI bleeding
- Menstruating or pregnant, abnormal vaginal discharge, unprotected sexual intercourse
- Patient report of recent diagnosis of shigella, c-diff (clostridium difficile)
- Rectal pain
- Stimulant use

Objective

- Vital Signs (obtain orthostatic BP if any signs/ symptoms of dehydration)
- Assess for shock related to internal bleeding, including hypotension (BP <100/60) or tachycardia (HR >110).
- Bloody stool or melena
- Signs of Dehydration (low blood pressure, sunken eyes, decreased skin turgor, infrequent or dark urine)
- Assess for history of transmissible disorder such as c-diff or shigella. If any recent history of un- or undertreated infectious process, contact medical back-up for likely transport to ED or urgent care for further evaluation.
- Assess for diarrhea related to recent antibiotic treatment (within last 4 weeks)

Plan

1. Mild Symptoms: *(diarrhea lasting < 2 days, no observed blood in stool, normal vital signs, no vomiting)*
    a. Encourage increased PO fluid intake.
    b. Over-the-counter oral medications may alleviate mild symptoms, such as bismuth subsalicylate (Pepto Bismol) or loperamide (Immodium). Contact medical back-up for further assessment and orders.
        i. Note: Pepto Bismol can darken stool
        ii. If possible cause of diarrhea is recent antibiotic treatment, consider clostridium difficile (C-Diff). Alert medical back-up to antibiotic history, as treatment with loperamide may worsen condition.
    c. Monitor Symptoms x 2 days. If symptoms unresolved, notify medical back-up for additional assessment.

2. Moderate-Severe Symptoms: *(watery stools lasting more than 2 days, altered mental status, vomiting, fever, blood in stool, evidence of severe dehydration: hypotensive, orthostatic hypotension, tachycardia, oliguria/ anuria, dry mucous membranes, decreased skin turgor)*
    a. Refer to medical back-up and/or urgent care, primary care, or EMS as appropriate

HAYFEVER / ALLERGIC RHINITIS

Allergic rhinitis is the inflammation of the mucous membranes due to inhaled allergen causing edema, nasal obstruction, rhinorrhea, cough, sore throat, sinus pressure, itchy/ watery eyes, itchy nose/ mouth/ throat, swollen/ blue color under eyes. Symptoms often present without a fever, will persist as long as exposure to allergen, and can be chronic, depending on cause. An allergic reaction may become more severe, including signs of an upper respiratory infection or cardiac compromise.

Subjective:

- Onset/ duration/ severity of symptoms
- Past history of seasonal rhinitis
- Sinus pressure, sore throat, headache

Objective:

- General appearance/ distress, including: difficulty breathing, tearing/ affected eyes, rhinitis, sneezing, nasal congestion, throat redness
- Lung Sounds (including wheezing, stridor or diminished lung sounds)
- Presence of a fever

Plan

Mild symptoms:

- Over-the-counter antihistamines, such as diphenhydramine, loratadine, or cetirizine, may help alleviate symptoms. Contact medical back-up for further assessment and orders.
    - Advise patient to avoid alcohol while taking diphenhydramine

Moderate/ Severe symptoms:

- May indicate a worsening condition or more systemic allergic reaction. Symptoms may include presence of a fever, significant exudate, significantly low blood pressure, congestion, or chest tightness.
- If any cardiac or advanced respiratory symptoms are present (hypotension; palpitations; chest pain; difficulty breathing; bronchospasm, wheezing), contact medical back-up.
- If airway is compromised (rapid respiratory rate, low oxygen saturation, tripod positioning), contact EMS via 911.

HEADACHE

Headache is one of the most common medical complaints. Primary headaches include migraines, tension-type headaches, cluster headaches. Secondary headaches may be due to neurologic or systemic conditions, including mild (dehydration, mild alcohol or drug withdrawal, bruxism) or severe (hemorrhage, stroke, increasing blood pressure) conditions.

Subjective

1. Frequency, duration, severity of pain
    a. Does anything aggravate or worsen the headache?
2. Pain location: is it unilateral, bilateral, periorbital, occipital?
    a. Does it radiate? Is there neck stiffness associated with it?
3. Associated symptoms:
    a. Nausea/ Vomiting
    b. Visual disturbances
    c. Weakness/ numbness
    d. Fever
    e. Dizziness
4. Med Hx: Hx of headaches, migraines, presence of co-existing conditions (hypertension, asthma, depression, anxiety, hx of heart disease or stroke)
5. Evaluate nutrition: last meal or non-alcohol fluid intake

Objective

1. Vital sign assessment, particularly elevated BP or pulse
2. Neuroexam:
    a. Mental status: alert, oriented
    b. Eyes: Tearing, watery, red
    c. Pupils: PERRLA
    d. Facial symmetry and weakness
3. Neck, head, and shoulder exam: Trauma? Tenderness? Stiffness?
    a. Posture, range of motion
    b. Hand grips: equal in strength?
4. Gait, balance, coordination: Normal, weak, uncoordinated

Plan:

1. **Mild symptoms**
    a. Many over-the-counter pain relievers are available and may be recommended including aspirin, acetaminophen, NSAIDS. Contact medical back-up for further assessment and orders.
        i. Do not provide these medications for patients with gastritis, active or chronic alcohol consumption, ulcers, liver disease, kidney disease, and bleeding conditions. Consult with medical back-up regarding options.
        ii. Avoid alcohol while taking acetaminophen or ibuprofen

    b. Provide oral fluids in cases of dehydration

2. **Patients with the following symptoms indicate a condition requiring consultation with medical back-up. If medical back-up or urgent care is not available, consider transfer to ED.**
    a. New onset or major change in pattern and systemic illness (cancer, HIV, etc.)

    b. New, throbbing headache in patients over 50 years of age (temporal arteritis, an inflammation of the arteries providing blood to the head and brain)
        i. Co-occurring symptoms in temporal arteritis include jaw claudication, visual loss, double vision, shoulder or hip pain and stiffness

    c. Papilledema (optic disc swelling) without alteration in LOC and no focal neurological signs

3. **Patients with the following symptoms indicate a possible emergency. Contact 911.**
    a. Patients with a sudden or severe headache (thunderclap headache)
    b. Headache with fever and neck stiffness (Meningismus)
    c. Papilledema (optic disc swelling) with altered level of consciousness and/or focal signs
    d. Non-reactive, mild dilated pupil, acutely inflamed eye, visual disturbance with pain and nausea (acute angle-closure glaucoma)

HEAT-RELATED ILLNESS

During extreme heat, sweating itself may not be enough for the body to cool itself. A person's body temperature rises faster than it can cool down. Heat related illnesses can affect anyone but is common among athletes, elderly, people with pre-disposing medical conditions (diabetes), and people who take a variety of medications. Levels of high humidity and dehydration are other risk factors. **HEAT STROKE and HEAT EXHAUSTION** are two of the common illnesses associated with extreme heat.

HEAT STROKE
Classic heat stroke (non-exertional) affects older individuals typically with an underlying condition (cardiovascular disease, neurologic/psychiatric disorders, obesity, physical disability, extremes of age, use of alcohol or cocaine, diuretics or beta blockers). **Exertional heat stroke** usually occurs with youthful healthy individuals who exercise in extreme heat conditions.

Subjective

- Medical history
  - Preexisting conditions
  - Drug use (Rx and Illicit)
  - Muscle cramps
- History of symptoms
  - Neurological changes: Dizziness or weakness, confusion loss of consciousness (often goes un-noticed and patient collapses)
  - Loss of consciousness (passing out)
  - Muscle weakness

Objective

- Vitals: HR (may be tachycardic), BP (may be hypotensive/ normotensive), High body temperature, 104 ◦F or higher, RR (may be tachypneic)
  - Note some temperature readings with heat stroke may not exceed 40-degree C, especially if cooling measures were initiated.
- Hot, dry or damp skin often with lack of sweating (especially in classic heat stroke)
- Confusion, altered mental status or seizures
- Decorticate posturing (stiff with legs out straight, fists clenched, arms bent to hold hands on chest)
- Crackles due to pulmonary edema, excessive bleeding, slurred speech, irritability, agitation

Plan

1. See related protocols as appropriate including *Altered Mental Status*, *Headache,* or *Musculoskeletal pain*
2. If physical assessment indicates heat stroke, contact 911.
   a. If safe and possible, move person to a cooler place
   b. Maintain airways, breathing, and circulation
   c. Help lower the person's temperature with cool cloths or a cool bath
   d. Apply ice packs to axillae, neck, and groin
   e. Do not give the person anything to drink if they are altered

HEAT EXHAUSTION

Inability to maintain adequate cardiac output due to strenuous physical exercise and environmental heat stress. Acute dehydration may be present.

Subjective

- Tired
- Headache
- Losing consciousness ("I feel like I am passing out")

Objective

- Vitals: HR (tachycardia, weak pulse), RR, BP, T (usually 101°F to 104°F)
- Heavy sweating, "prickly heat" sensations
- Cool, pale, and clammy skin
- Headache, nausea and/or vomiting
- Muscle cramps and/or abdominal cramps
- Weakness

PLAN

1. If safe and possible, move to a cool place
2. Loosen clothing
3. Place patient supine with feet elevated above the level of their head
4. Place cool wet clothes on body
5. Allow for a sip of water
6. If rapid improvement does not occur, **call 911.**

HYPERTENSION

Elevated blood pressure may be due to essential hypertension, stress, pain, agitation, effect of drugs, or various medical conditions. Often hypertensive persons are asymptomatic. The constellation of headache, confusion, and/or chest pain with SBP>180 and DBP>110 may represent **malignant hypertension**, a medical emergency.

Subjective information

- Co-occurring symptoms including: headache, chest pain, confusion, dizziness, irritability, blurry vision
- Past history of elevated blood pressure, myocardial infarction, or stroke/ transient ischemic attack
- Current antihypertensive/cardiac medications (confirm date/ time last taken)

Objective information

- Systolic blood pressure greater than 160
- Diastolic blood pressure greater than 90
- Note: recheck blood pressure on both arms as able for abnormal blood pressure.

Plan – Assessing Acute Hypertension

- If patient presents with Systolic BP greater than 180 and/or Diastolic BP greater than 110 **with a complaint of headache, chest pain, confusion, dizziness, blurry vision, diaphoresis or irritability**, contact 911 for assessment and transport to ED.

- If patient's SBP is 160-189 or DBP is 90-109 and is asymptomatic, discuss patient history of elevated blood pressure including typical range. Offer rehydration with 1 liter of water.

- Confirm if patient has medication prescribed for hypertension and available on person. If patient has not yet taken their medication, evaluate prescription and encourage patient to take as directed. Consult medical back-up for follow-up evaluation.

- Encourage patient to visit urgent care or primary care provider for follow-up and bring in all medications for review, as appropriate.

Plan - Repeat Measures of Hypertension

- For ongoing assessment and care of elevated blood pressure, repeat assessments with provider follow-up is recommended. Blood pressure is defined by blood pressure reading classifications (American Heart Association guidelines, 2012):
    - **Normal** BP reading—systolic blood pressure (SBP) is <120 mm Hg; diastolic blood pressure (DPB) is < 80 mm Hg
    - **Pre-hypertensive** BP reading: SBP is ≥120 and ≤ 139 mm Hg; DBP is ≥80 and ≤89 mm Hg
    - **Hypertensive** BP reading: SBP is ≥140 mm Hg or DBP is ≥90 mm Hg

- Assess blood pressure on two repeat engagements with the patient at least one day apart. Recheck elevated blood pressures on both arms.

- If BP is elevated in the pre-hypertensive or hypertensive range for each repeat assessment, schedule a face-to-face appointment with a street- or clinic-based medical provider for further evaluation.

HYPO/ HYPERGLYCEMIA

Identification of diabetes and prevention of hypoglycemia are the main objectives of care. Hypoglycemia in general is less well tolerated and more rapid in onset than hyperglycemia. Persons with frequently higher blood sugars are prone to dehydration due to excessive diuresis. Persons with alcohol use disorders tend to deplete their sugar stores and the lack of sufficient gluconeogenesis leaves persons prone to hypoglycemia.

Subjective (as able)

- **Medical history:** individual or family history of diabetes
- Previous occurrences of hypo- or hyperglycemia: primary cause if known and resolution
- Any medications for diabetes prescribed including insulin or oral medications
- Last time patient checked their FSBG or took insulin
- Confirm when and what the patient last consumed for food or drink (may affect FSBG results if <2hrs)
- Specific **symptoms:**
    - **Hyperglycemia -** Has the patient experienced any polyuria, polydipsia, dry mouth, or weight loss? Is their stomach pain? Has the patient felt weak, loss of focus, or blurred vision?
    - **Hypoglycemia -** Has the patient experienced hunger, restless sleep, fatigue, headache, confusion irritability?

Objective

- **Level of consciousness, ability** to answer simple yes or no questions
- Finger stick blood glucose.
    - **Hypoglycemia,** FSBG < 70 mg/dl
        - Typical symptoms include: weakness, sweating, rapid pulse, anger, anxiety, tremor, decrease in level of consciousness.
    - **Hyperglycemia,** FSBG >250. Blood glucose levels stay higher than 140 mg/dl (before meals), some can be > 400 and accompanied with dehydration
        - Typical symptoms include: frequent urination, thirst, abdominal pain, nausea, vomiting; decreased skin turgor, tachycardia; hypotension (severe)

Plan

1. **Hypoglycemia (FSBG <70)**
    a. **FSBG <60** and **stuporous/ obtunded**, **call 911**
        i. If available as existing patient prescription, use glucagon pen while waiting. If glucagon is available in emergency kit, obtain verbal orders and administer as indicated.
        ii. Additionally, a small amount of glucose gel, if available and with orders, may be administered orally. Administer directly or put on gloved finger and rub inside cheeks and on gums.
    b. FSBG 50-69 and oriented with ability to swallow, give nutritional or high sugar snack.
        i. Recheck at 20 minutes and 60 minutes.
        ii. **If FSBG does not elevate above 69, contact medical back-up** for orders
    c. **All persons stuporous/obtunded or unable to comply with consuming snack shall be referred to the ED via 911 for evaluation** (also see *Altered mental status* protocol).
        i. Administer **glucagon pen** per orders indicated above while awaiting 911.

2. **Hyperglycemia (FSBG >250).**
    a. Encourage fluids and use of medications and insulin as directed. Assist patient to self-administer medications as appropriate. As able, confirm with patient their typical FSBG reading.
    b. For FSBG >400 and alert/ oriented, contact medical back-up.
    c. For FSBG "High", >500, or any signs of altered mental status, contact 911.

HYPOTENSION

A systolic blood pressure less than 90 is not a normal finding; however, in some individuals a reading of 90 can be typical and not abnormal. Hypotension is most often a result of dehydration in this setting; it may also be due to blood loss, drug effect, opiate use, cardiac disorders, or hypothermia.

Subjective

- Dizziness, especially when standing or getting up quickly
- Use of any antihypertensive medication
- Use of diuretics
- Recent illness, PO intake

Objective

- Systolic blood pressure less than 100
- Diastolic blood pressure less than 60
- Evidence of blood or fluid loss (N/V/D, tarry stools, quality of emesis)
- Note: recheck blood pressure on both arms as able for abnormal blood pressure.
- Check orthostatic blood pressure.

Plan

- Manually recheck blood pressure immediately if SBP less than 100 or DBP less than 60. Confirm with patient their typical blood pressure.
- Interventions depend on systolic blood pressure:
    - SBP < 80 without alteration to mental status, contact medical back-up
    - SBP < 90, and patient is unresponsive or unable to take PO fluids, call 911.
    - If SBP is 80-99 and patient is alert and able to take PO fluids, give oral rehydration of 1 liter or more and recheck in 30 minutes. If SBP less than 90 after 30 minutes, contact medical backup.

- Though patients on medications should be encouraged to comply with their prescription medication regimen, a patient with symptomatic hypotension on anti-hypertensive medications should not take these medications until provider evaluation. Check with primary care as able or medical back-up for further instructions

HYPOTHERMIA

A subnormal temperature in those who are living outside without adequate shelter is most often as a result of exposure. Though rare, it may also be a sign of other conditions such as sepsis or hypothyroidism. Consider these alternate conditions if patient presentation is not consistent with environment.

Subjective information

- Complaints of feeling cold
- Exposure to cold, especially wet weather
- Inadequate clothing

Objective information

- Temperature less than 97º F (36.1 º C) oral or 96.5º (35.8 º C) tympanic bilaterally
- Shivering
- Lethargic
- Damp or inadequate clothing
- Body is cold to touch
- Diminished level of consciousness

Plan

1. As able, bring patient indoors. Provide radiant heat, dry clothes, blankets, warm liquids (note: never force fluids on a patient with diminished level of consciousness).
2. Recheck temperature every 1 hour until 97º F (36.1 º C) oral or greater.
3. If temperature does not improve over 2 hours, and patient is alert and oriented, send to emergency department via non-emergent transportation. For altered level of consciousness, refer to *Altered Mental Status* protocol.
4. Call 911 if temperature is less than 93º F (33.9 º C) and patient has a diminished level of consciousness.
5. If temperature < 93º F (33.9 º C) and patient is fully alert and oriented however you are unable to place patient indoors, call medical back-up.

LICE, *Head or Body*

Lice infestation most commonly occurs in hairy parts of the body. There are two forms, head lice and body lice, which can be observed by visual assessment. Head lice are extremely contagious and difficult to successfully treat.

Body lice saliva can produce an intensely irritating small red popular rash in sensitized persons and later wheals. In addition to other conditions, body lice can infect their host with Bartonella quintana, also known as Trench Fever. Early signs of infection are fever, fatigue, headache, poor appetite, and an unusual, streaked rash. Swollen glands are typical, especially around the head, neck and arms. Other symptoms may include lymph node enlargement, gastritis, abdominal pain, sore throat, sore soles, and tender subcutaneous nodules along the extremities.

Subjective:

- Itching or report of rash on head, neck, axilla, waist, hands, genital area, etc.
- History of allergies

Objective (Wear gloves for examination):

- Live lice on body or in seams of clothing
- Nits and lice in hair
- Excoriations
- Cannot stop scratching
- Diagnosis from medical provider indicating active scabies or lice

Plan:

- In patients with possible symptoms of Trench fever or other infection, refer to medical back-up.
- Intervention removing bugs depends upon the ability of the patient to find or be placed in a clean environment. A treated patient, who then returns to an infected area, will likely be immediately re-infected with lice. Thus, treatment should be reserved primarily for patients once able to transition to a clean environment.
    - If patient warrants treatment, use best judgment regarding safety of fellow staff and risk for infection.
- Lice treatment:
    - Remove all clothing and belongings from patient.
    - Wash all clothes with hot water and dry at least 30 minutes in high heat dryer.
        - Do not dry in dryer prior to washing.
- Body lice: Have patient shower and wash thoroughly with staff supervision. Body lice require no further treatment than a shower and removal of infected clothing/ belongings.
- Head lice: Treat all patients with head lice with **1% permethrin** shampoo.
    - Note: Do **not** treat with permethrin unless a staff member will complete the combing process. Shampoo alone is not effective and has resulted in large-scale permethrin resistance.
    - Leave lotion on for minimum 10 minutes. After ten minutes, comb through all hair with comb provided in permethrin packet.
    - After combing, wash hair and body thoroughly with soap and water.
    - Inform patient that treatment should be repeated in 7-10 days. Patient should follow-up with primary care or urgent care.
- Permethrin may exacerbate pruritus, edema, and erythema. Consider medical assessment if possible infection is present.
    - Patient should be returned to clean bedding. Any bedding used by patient before shower should be washed or disposed of immediately.

MENSTRUAL CRAMPS (DYSMENORRHEA)

Painful menstruation is classified as primary (excess prostaglandin production on ovulatory cycle) or secondary (associated with other conditions including endometriosis, fibroids, adenomyosis, PID, and IUDs). Often described as a dull ache or a sense of pressure in the lower abdomen that can be constant or intermittent. Ache may radiate to hips, lower back, and thighs.

Subjective:

- Onset/ duration/ severity of symptoms
- Date of last menstrual period and past history of dysmenorrhea, fibroids, or other gynecological conditions
- Confirm if current menstrual bleeding is typical for patient
- Concomitant symptoms including nausea, vomiting, diarrhea, headache, dizziness
- Confirm recent pregnancy (<7 days ago), or induced or spontaneous abortion

Objective:

- Evaluate vital signs, in particular evaluate for signs of excessive bleeding or dehydration, including hypotension, orthostatic hypotension, or tachycardia.
- Document general appearance/ distress
- Fever (risk for infection)

Plan:

For patients without recent pregnancy or abortion, without fever or signs of excessive bleeding:

- Contact medical back-up for further assessment and orders for analgesic medication, such as ibuprofen.
- Advise patient to present to urgent care or primary care provider if there is an increase from normal bleeding, or the symptoms do not improve in three days.

For patients **with** recent pregnancy or abortion, **without** fever or signs of excessive bleeding:

- Confirm any complications experienced during birth or abortion, such as birth outside medical facility, departure against medical advice, incomplete evacuation of tissue
- Consult with medical back-up

For patients **with** fever or signs of excessive bleeding:

- Confirm any complications experienced during birth or abortion, such as birth outside medical facility, departure against medical advice, incomplete evacuation of tissue
- Consult medical back-up

MUSCULOSKELETAL PAIN/ Non-traumatic

Muscle or joint pain sometimes with accompanying swelling, stiffness, inflammation, with no known precipitating traumatic cause. Pain may be due to osteoarthritis, undiagnosed infection, degenerative joint disease, obesity, positioning during sleep, gait, posture, and more.

Subjective

- Describe the pain in detail including characteristics of symptoms
  Provoking factors: what improves the condition? What makes it worse?
  Quality: Sharp, dull, cramping, etc.
  Region/ **R**adiation: Where is the pain? Is it radiating? Where?
  Severity: Mild, Moderate, Severe? Use Pain Scale (1-10)
  Time: When did it start? Consistent or intermittent? Getting worse or better with time?
- Other concomitant symptoms, illness, or injury during past several weeks (e.g. sore throat, constipation, fall, etc.)
- Document systemic symptoms such as fever, chills, malaise, insomnia, etc.
- Review current medications and adherence

Objective

- Vital Signs, particular respiration rate/ depth/ quality and any fever
- Note: posturing, guarding, disuse of affected area, tenderness, swelling, redness, pain with movement, impaired range of motion, numbness, weakness

Plan

1. Mild-Moderate Symptoms: (Extremity, joint, back pain and/ or stiffness, normal vital signs, and no other symptoms of illness or distress)
   - As feasible, recommend rest, elevation, heat and/ or ice to affected extremity
   - Over-the-counter analgesics may be effective, such as acetaminophen, ibuprofen, or NSAIDs. Contact medical back-up for further assessment and orders.

2. Severe Symptoms (Sudden onset, co-occurring nausea/ vomiting, tachycardia, HTN, fever, debilitating pain, recent trauma resulting in possible fracture/ head injury)
   - Refer to Medical back-up and/or urgent care, primary care, or EMS as appropriate

3. Low Back Pain:
   a. Requires UA chemstrip to rule out acute kidney process or infection
   b. Contact medical back-up or bring patient to urgent care or primary care
      - Encourage patient to increase PO fluids

NAUSEA and VOMITING

Abdominal pain can be caused by a benign condition such as gas or indigestion, or may be a serious life threatening condition including internal bleeding or alcohol poisoning. Careful assessment and observation must be done.

Subjective:

- Patient complains of abdominal pain, nausea, vomiting, diarrhea, blood in emesis or stool, constipation
- History of ulcers, constipation, gallbladder problems, recent abdominal trauma, pancreatitis, HIV/AIDS, GI bleeding
- Poor intake over past few days
- Medications (particularly ASA, NSAIDS)

Objective:

- Vital Signs (particularly low or orthostatic BP)
- Abdominal guarding, absent bowel sounds, abdominal distention or rigidity
- Signs of Dehydration (low blood pressure, sunken eyes, decreased skin turgor)
- Bloody or coffee ground emesis, bloody stool or melena

Plan

1. Evaluate vitals signs. Assess for shock related to internal bleeding, including hypotension (BP <100/60) or tachycardia (HR >110).
2. Call 911 if vomiting frank blood or coffee grounds, passing black tarry stools (melena), or bright red bloody stools (hematochezia)
3. Nausea: If nausea persists have patient take slow sips of water; reassess in 30 minutes. If it persists, contact medical back-up or recommend patient be evaluated in urgent care or primary care clinic.
4. Emesis: If patient vomits, assess for nausea and have patient sip fluids and reassess in 30 minutes. If emesis persists longer than 60 minutes or if patient is unable to hold down any fluids, consult with medical back-up and/or send to ED via non-emergent transport.

OPIATE OVERDOSE/ DEPRESSED RESPIRATIONS

The exposure to opioids falls under several categories: therapeutic use, recreational use, intended self-harm, and "body stuffing" in attempt to conceal drugs. Opiates are usually prescribed for their analgesic properties and to reduce pain such as oxycodone, morphine, and hydrocodone. They also include non-prescribed drugs such as heroin or fentanyl. Persons released from incarceration or with a long period of sobriety are often at higher risk of opioid overdose because of lost tolerance related to cessation.

Subjective

- Patient states they taken oral, inhaled, or injected opiates

Report by witnesses or other persons familiar with patient who indicate prior or current history of drug use

Objective

- Difficult or unable to arouse
- Not oriented, inability to answer questions
- Pinpoint pupils
- Vital sign abnormalities may include:
    - Respirations < 8 bpm and decreased tidal volume. Crackles may indicate aspiration or acute respiratory distress.
    - Low to normal HR
    - Mild hypotension
    - Hypothermia (often due to exposure)
- Decreased bowel sounds
- Look for signs of trauma, particularly on the head
- Possession of used syringes, opiate medication, empty medication bottles

Plan

1. Attempt to arouse patient using pain (sternal rub, trapezius pinch). Check ABCs and provide CPR / rescue breathing as warranted. Utilize team members to obtain medications and/or provide CPR.
2. If no provider is immediately available onsite and patient remains unarousable, call 911 for a possible overdose.

3. Medications:
    a. **Naloxone**:
        i. **IM**: Provide naloxone 0.4mg IM. May repeat x 1 after 5 minutes for total of 0.8mg IM. IM injections can be administered via needles or automated injector as available.
        ii. **Nasal**: Administer 1mg/1ml per nostril (total 2mg/2ml). May repeat x 1 after 5 minutes for total 4mg/4ml.
        iii. **If team does not have naloxone on site, team members may ask other parties in the area if they have naloxone. New, unused naloxone may be administered to patient.**
    b. **Oxygenation**:
        i. For nonresponsive patients or patients with respirations < 4 bpm, provide rescue breathing every 4-5 seconds. Utilize an ambu bag as available.
        ii. If oxygen is available, obtain orders from a prescribing provider and apply nasal cannula at 4 L/min.

4. Patients receiving naloxone **should** be encouraged to continue to the ED via EMS, due to the risk of overdose after the naloxone effect diminishes (30-45 minutes).

a. If patient unable or unwilling to continue to ED, provide education to risk of overdose in next 1 to 3 hours even in absence of additional drug use.
b. Team members who can provide training, may provide a training in real-time to patient and other interested parties in naloxone use and administration. Provide naloxone kits to patient and interested parties for emergency use.

5. Contact medical backup after calling 911 for additional verbal orders.

SCABIES

An infestation of the skin by mites that burrow into the skin. It often presents in the sides and webs of fingers, wrists, axillae, areolae, and genitalia. It causes visible lesions 2-15 mm, thin gray, red, or brown lines. These lesions are often not visible because of excoriation or secondary infection. Scabies can be spread from direct and prolonged skin-to-skin contact. It is possible for contamination from wearing or handling heavily infected clothing, belongings, or sleeping in unchanged bedding. Itching begins three to six weeks after primary infestation or within one to three days after re-infestation.

Crusted (Norwegian) Scabies is characterized by hyperkeratosis and may occur in people who are immunocompromised, with HIV/AIDS, older adults, and patients with Down syndrome. They are poorly-defined, crusty red patches or bumps on the skin. If untreated, scales become warty, crusts and fissures appear, and lesions become odorous, nails are thickened and discolored. Norwegian scabies are easily spread.

Subjective

- Medical History:
    - Contact with anyone with scabies
    - Older adult, or person with compromised immune system, cognitive impairment, or inability to scratch (due to physical disability, amputation, etc.)
- Is itching widespread and worse at night?
- Itching may be reported as out of proportion to visible changes in the skin
- Any previous diagnosis and/or treatment for scabies

Objective (Wear gloves for examination)

- Assess skin, looking for:
    - Gray skin color
    - Wavy lines in skin 2-15 mm in length ending in pearly blebs or blisters. These are often found in interdigital webs of hands, wrists, shaft of penis, elbows, feet, genitalia, buttocks, waist and axilla.
    - Assess for crusted scabies, which are thick crusted fissures
- Any secondary infection:
    - Signs of general rash, urticaria, eczema, excoriation, impetigo, fever.

Plan

1. **In addition to suspected scabies infection, alert medical back-up when there is:**
    a. Suspicion of crusted scabies, signs of further infection, or if patient is pregnant.
2. **Treat mites:** Obtain orders from medical back-up for Permethrin/ Elimite 5% cream. Approved for ages 2+, Pregnancy Category B (clearly indicated to treat obvious infestation). Apply to all areas of the skin from neck and feet and is washed off in shower or bath after 8-14 hrs.
    a. A second full-body treatment should be repeated in 8-10 days.
    b. Note: Confirm if patient has been recently treated for scabies. Itching and rash are often present up to 4 weeks after successful treatment; medication does not need to be repeated.
3. **Treat family members/ living mates:** Close contacts of a person with symptoms also need to be treated for scabies. Confer with medical back-up to help decide if it is necessary.
4. **Wash Items:** that have come in contact with infected person (bedding, clothes, towels, even stuffed animals). Place items in plastic bags for at least three days, then machine wash and dry. Ideally, dispose of and replace infested items.
5. **Relieve itching:** antihistamines such a Benadryl or Claritin can be recommended to help control itching and improve sleep. Contact medical back-up for orders as indicated.
    a. Patients will not be contagious after one treatment if directions are followed
    b. Rash and itching may continue for 2-4 weeks after treatment

SEIZURE

Seizures are common in persons with idiopathic epilepsy, brain scarring due to previous head trauma, or severe alcohol use disorder that may be due to alcohol use or withdrawal. Seizures can be dangerous if prolonged or recurrent and can be associated with risk for injury.

Subjective

- Past history of seizures
- Feeling of imminent seizure
- History of taking anti-epileptic medications

Objective

- Witnessed seizure
- Loss of consciousness, urinary incontinence, buccal damage

Plan

1. In the event of a seizure, protect the patient against injury. Place patient in side-lying position.
    a. Note: do not place anything in the patient's mouth. This is dangerous and does not protect patient.
2. Obtain vital signs and blood glucose when safe. Refer to appropriate protocols as needed.
    a. Monitor ABCs. If any decompensation, initiate CPR as appropriate and contact 911.
3. Continue to monitor the patient while emergency transport is notified. Code 2 (non-urgent) transportation is generally sufficient. Note time, length, and type of seizure.
4. In the event of a seizure lasting longer than 2 minutes or the occurrence of multiple seizures: protect patient against injury and call 911. A staff member must be present with patient at all times until ambulance arrives.
5. For any seizure resulting in head injury, please call 911 and refer to *Altered Mental Status* protocol .

SHORTNESS OF BREATH

Respiratory rate outside acceptable parameters may be due to a number of conditions including pre-existing pulmonary disease, upper respiratory infection, anxiety or panic disorders, or intoxication from drugs or alcohol. Evaluation is critical to determining if the SOB may be controlled, such as reducing anxiety or utilizing previously prescribed inhalers.

Subjective

- Complaint of shortness of breath or difficulty breathing
- History of Asthma, COPD
    - With a history of chronic obstructive pulmonary disease, an oxygen saturation between 88-92% may be appropriate.
- Current medications
- Presence of chest pain or pressure (also refer to *Chest Pain* protocol)
- Use of tobacco products or other inhaled drugs (crack-cocaine, heroin, meth)

Objective

- Audible wheezing or stridor (high pitched wheezing from upper airway obstruction)
- Gasping for breath
- Oxygen saturation less than 90%
- Respiration greater than 24 or less than 8 per minute
- Slow, shallow breathing or noisy respirations
- Signs of opiate/barbiturate/sedative/hypnotic use (excessive sedation, respiration rate < 8, pinpoint pupils)
- Respiratory symptoms and signs associated with fever

Plan

1. If patient is responsive and able to engage, confirm if they have any previously prescribed inhalers, particularly albuterol. If able, secure inhaler and have patient use as directed.
    a. Re-evaluate oxygen saturation and respiratory rate after 10 minutes. Contact medical back-up for further instruction.
    b. If you are at or able to bring patient to a clinic setting, treatment may be initiated via provider orders and upon securing medication, and may include albuterol inhaler, or albuterol nebulizer and prednisone provided within a clinic setting.

2. If no provider on site or patient unable to go to nearby clinic, call 911 if:
    a. Respirations are less than 8 with altered mental status, or greater than 24 per minute;
    b. Patient has oxygen saturation less than 90%; or
    c. If patient has audible wheezing or gasping for breath.
    d. Refer to *Altered Mental Status* protocol as appropriate.

3. If patient is alert and oriented with an oxygen saturation between 90-93% and/or respirations between 8-12 per minute, consult with medical back-up.

SORE THROAT

Sore throat, a symptom of acute pharyngitis (inflammation of throat), may be described as discomfort, pain, burning, scratchiness in back of throat, worse when swallowing. Sore throat can be caused by multiple pathogens including viruses (most common, including Influenza, infectious mononucleosis, and herpes simplex) and bacteria (least common, including Group A Strep), as well as non-infectious causes (i.e., allergies and smoking).

Sore throat is often accompanied with symptoms of fever, headache, malaise, lymphadenopathy ("swollen glands"), and other signs/ symptoms associated with upper respiratory infection (nasal congestion, cough, sinus pain).

Subjective

- Onset, nature, severity, and duration of symptoms
- Associated symptoms such as: presence or absence of cough, fever, malaise, nasal congestion, sinus pain, difficulty swallowing

Objective

- Fever >100 F
- Presence or absence of tonsillar exudate (white or yellow coating on tonsils)
- Cervical adenopathy (swelling of lymph nodes around head/ neck)
- Medical history including increased risk for severe infection (poorly controlled diabetes, HIV+, cancer)
- Swelling of throat, drooling, or secretions

Plan

1. **Low-risk symptoms:** (sore throat without tonsillar exudate, may or may not be accompanied by signs or symptoms of upper respiratory or influenza infection)
    a. Over-the-counter medications may be indicated with low-risk symptoms, such as benzocaine/ menthol throat lozenges or acetaminophen.
        - Be sure to alert medical provider if patient has liver disease or a substance use disorder, particularly avoiding alcohol while taking acetaminophen
    b. Monitor Symptoms. If symptoms unresolved within 2 days, notify medical back-up or primary care provider.

2. **Moderate to Severe symptoms**: (Difficulty/ inability swallowing, respiratory distress, secretions, drooling, dysphonia (muffled voice), neck swelling, tonsillar exudate)
    1. Contact medical back-up and/ or refer to urgent care, primary care, or EMS as appropriate
    - As available, perform a Rapid Antigen Detection Test and/ or throat culture indicated to rule in/out Group A Strep when 2 or more of following symptoms present:
        - Tonsillar exudate
        - Tender anterior cervical adenopathy
        - Fever
        - Absence of cough

SUICIDAL CLIENT

Suicidal behavior is associated with many different types of events, illnesses, and life circumstances. Patients who are currently homeless may have one or more risk factors for suicide, including prior suicide attempt, physical illness, chronic pain, major mental health disorders, history of trauma or abuse, family history of suicide, lack of social support, or barriers to care. We must be alert and always assess for potential suicidality, especially if any history of mental illness or previous attempts is known.

Subjective information/ Risk Factors

- Verbal expressions of suicide
- History of past suicide attempts
- History of mental illness, bipolar, schizophrenia, depression, psychiatric medications
- Verbalizes a plan for suicide and has the means to carry it out
- Ability to contract to not harm self

Objective information

- Active attempt at harming self
- New wounds including lacerations, bruising, signs of ingestion
- Presence of weapon or

Plan

1. If patient is attempting suicide or unable to contract for safety, call 911 for 5150 (danger to self) evaluation. Observe patient at all times and obtain additional staff support as needed. If safe for staff and other nearby persons, intervene to keep patient from self-harm.
2. If patient is able to verbally contract to not harm self, engage with patient to remove any potentially harmful belongings from area. If one or more team members are 5150 certified, the team member may perform a suicide risk evaluation. Assist in coordinating with emergency response for 5150 transfer and placement as appropriate.
    - 911 should be called for any patient attempting suicide or attempting to leave the location while actively suicidal. A staff member should keep visual contact on patient at all times, including if 911 has been contacted but not yet arrived.
3. Notify medical back-up and/or social work team members of any suicidal patient.
4. You may refer patient to crisis intervention services at any time before or instead of 911.

    Mobile Crisis Team - Countywide
    510-891-5600
5. Please note: Safety is the priority. If the person has a weapon or item that may cause harm to self or others, all team members should be safely out of range (i.e., well distanced from knife or razor; out of sight or behind available barrier in case of gun). 911 may be the best option if there is a weapon present. Notify dispatch of 911 or mobile crisis for the presence of a weapon.
    - If the patient is engageable and you can communicate from a safe distance, you may recommend they place the weapon down and out of reach. Ideally, they are willing to move themselves away from the item or weapon.
    - Do not at any time attempt to remove a weapon from a person.

SUTURE REMOVAL

Sutures are often appropriate when the depth of the wound extends through the dermis. The amount of time sutures are necessary depends on the type of wound, where it is located, and the healing process of the wound.

Subjective

- Determining the mechanism of injury
- When did the injury happen? When were the sutures placed?
- Why were sutures placed
- How many were placed

Objective

- Assess for signs and symptoms of infection (redness, swelling, exudate, opening wound, tenderness, fever)
- Adequacy of healing (closed, clean edges, no exudate, no bleeding)
- Assess sutures: Can they easily be removed? Are they broken, hard to visualize, embedded?

Plan:

- **If the following conditions apply, do not remove sutures and refer to medical back-up or clinic:**
  a. Signs of infection present (redness, swelling, fever, drainage, tenderness)
  b. Inadequate healing, patient request of premature suture removal, embedded sutures
  c. Post-surgical sutures when surgical or clinic follow up has been recommended or is warranted
- Length of time appropriate for the removal of sutures:
  - Eyelids: 3 days
  - Neck: 3–4 days
  - Face: 5 days
  - Scalp: 7-14 days
  - Trunk and upper extremities: 7 days
  - Lower extremities 8-10 days

To remove sutures:

- Clean wound with warm water or saline and gauze to remove encrusted blood and loosen scar tissue.
- Use suture removal kit: Tweezers are used to pick up the knot of each suture, and then the surgical scissors are used to cut the suture. Tweezers are then used again to remove the loosened suture and pull the thread from the skin.
- If wound is closed appropriately then continue until the sutures have all been removed.
- Cleanse wound again using warm water/mild soap, and allow wound to dry thoroughly
- Apply adhesive strips (Steri-Strips, butterfly adhesives) to allow the wound to continue strengthening.
  - Keep the adhesive strips on 5 days. Soak in warm water for removal. Do not peel off.
  - Remind the patient that suture removal does not mean the wound is completely healed. Continued care is necessary for healing and reduction of scarring.
    - Keep wound clean and dry, and keep out of sunlight
- If the wound dehisces during or after suture removal, apply butterfly adhesive strips or steri-strips to approximate and support the edges. Refer to clinic and/ or medical back-up for evaluation.
- If unsure if all sutures have been removed or if unable to remove all, refer to clinic or medical back-up.

TINEA CORPORIS ("RING WORM")

Dermatophytes are the prevailing cause of fungal infection of the skin, hair, and nails. Tinea Corporis is the infection of body surfaces other than feet, groin, face, scalp hair, or beard hair. It is commonly and incorrectly known as "ringworm", as there is no worm. Rather, it represents a skin infection caused by fungus. It begins with a pruritic, circular or oval, erythematous, scaling patch or plaque that spreads from the center outwards. The center clears, and an active, advancing, raised border remains creating a ring-shaped plaque. It can be contracted by animals (kittens and puppies), who then infect humans. Tinea corporis is more prevalent in warm, humid climates and may also result from the spread of infection from other sites on the body. Extensive tinea corporis should raise concern for an underlying immune disorder.

Subjective

- Itching or burning at site
- Immunocompromised condition which may increase risk for infection or exacerbate

Objective

- Annular, erythematous, scaling plaques commonly found on neck, arms, legs, chest, abdomen, or back,
    - Active border on the outside and clear in center
    - Can develop papules, vesicles, and crusting.
- Lichenification may appear (can change the shape) from scratching.
- Plaques can cover large areas in patients who are immunocompromised or have diabetes.

Plan:

1. Limited, localized disease should be treated topically, applied at 2cm outside border of lesions. Topical over-the-counter antifungals may be used for 1 to 6 weeks depending on clinical response.
    a. Contact medical back-up for further assessment and orders. Over-the-counter topical medications typically indicated for tinea corporis include:
        i. Clotrimazole 1%
        ii. Miconazole cream or lotion (cover after treatment)
        iii. Tolnaftate powder
    b. Note: Topical corticosteroids by themselves or in combination with antifungals are contraindicated in immunosuppressed patients. In certain cases, this may lead to persistent fungal infections.

2. Prescription products may be warranted. Contact medical back-up for further assessment and orders.
    a. Prescribed medications typically include Ketoconazole 2% cream or Econazole 1% cream.
3. Teach patient with chronic tinea pedis (athlete's foot) to put socks on before their pants to not spread infection to the legs. See *Athlete's Foot* protocol as appropriate.
    a. Recommend patient avoid occlusive and tight clothing and if possible to wear cotton or synthetic materials. Provide clothing as able and appropriate.

4. Educate patient that ringworm is very contagious until lesions have been treated for a minimum of 48 hours. Do not share towels, hats, or clothing until lesions are healed.

5. Refer to medical back-up if patient does not respond to treatment or if swelling and pain occur.

WOUNDS

Wounds are disruptions of the normal structure and function for the skin and skin architecture. An acute wound is anticipated to progress through the normal stages of wound healing. A chronic wound is physiologically impaired and often requires intervention to heal appropriately. Due to poor hygiene, lack of access to hygiene facilities, poor nutritional status, and immune-suppression, wound infections are common.

Subjective

- History of wound:
  - When/ how did wound occur
  - Change in size or drainage over time
  - Previously recommended treatment(s), what has been done, and response
  - Reports of pain. Does pain radiate?
  - Other wounds and history of healing
- Related medical/ personal history:
  - Any medical conditions that may prevent wound from healing (obesity, diabetes, CHF, peripheral artery disease, chronic kidney disease)
  - Does the patient smoke or have a history of smoking tobacco?
  - Nutritional intake

Objective

1. Age of injury:
   a. Less than 24 hrs may be primarily closed in treatment unless other conditions exist.
   b. Greater than 24 hrs should not be closed
2. Location of wound:
   a. Facial wounds can be closed up to 24 hrs after injury. For all facial wounds, refer to medical back-up or a clinic for evaluation.
   b. Hands and feet: can close within 6hrs. All hand wounds should be evaluated by a provider. Refer to medical back-up or clinic.
   c. Scalp: can close up to 24 hrs.
3. Characteristics of wound
   a. Length, width and depth of wound in cm. and color
      i. Has the wound penetrated other layers of the skin or structures?
   b. The presence and position of undermining
   c. Dried necrotic wound surface
   d. Drainage- amount, type, color, odor
   e. Active bleeding
4. Signs of infection may include:
   a. Fever (refer to protocol), wound odor, increasing redness and tenderness and swelling around the surrounding skin, striations, large amount of drainage. Refer to medical back-up..
5. Vascular Assessment – presence of the following may indicate a poorer prognosis for healing:
   a. Slow capillary refill in distal areas to the wound, thread or light pulse, or a lack of hair on feet and lower leg, and hypertrophic deformed nails.

Wound Plan:

1. If there is active bleeding, a clean towel or a non- adherent dressing should be used to press on the wound to slow or stop the bleeding.
    - **a.** If wound has not stopped active bleeding after applying pressure for 15 min**, refer to medical back-up immediately and/ or urgent care or 911 as appropriate.**
    - b. In cases of active bleeding with co-occurring altered mental status, refer to the *Altered Mental Status* protocol.

2. Wounds which have not been previously assessed or treated:
    - a. Any stab wound, refer to medical back-up and/ or urgent care, ED as appropriate.
    - b. All lacerations <6 hours old, refer to medical back-up as the separation may need suturing.

3. Wounds previously treated and/or with existing dressing:
    - a. Remove existing dressings if dirty, and clean wound area. If able, have patient shower with soap and water. Do not remove intact, clean, secure dressings.
        - i. Cleaning superficial wounds can be done with saline or tap water.
        - ii. To irrigate wounds, remove visible debris, excess slough, and irrigate with tap water or saline under pressure (utilizing a syringe)
        - iii. Pat surface dry with soft moist gauze (Do not disrupt visible granulation tissue)

4. Clean and dress wounds according to standard nursing procedure utilizing clean technique.
    - **a.** Dressings should extend 1-2 cm beyond margin of laceration.
    - **b.** Be attentive to the possibility of foreign bodies
    - **c.** A primary goal of wound care is to provide a moist but not wet wound bed, while not allowing the wound to become dry.
    - **d.** Dressing is influenced by type and location of wound, amount of exudate, skin condition, condition of wound and available dressing.
        - i. If medications are not indicated, apply a moist saline, wet-to-dry dressing.
        - **ii.** Medicated dressings require provider orders. Contact medical back-up for further assessment and orders as appropriate.
    - e. Prescribed, medicated dressings specific to particular wounds may include:
        - i. Wounds neither dry or exudative: utilize a polyvinyl dressing (i.e.tegaderm)
        - ii. Dry wounds utilize hydrocolloid dressing (i.e. DuoDerm)
        - iii. Exudative wounds: an absortive dressing, such as calcium alginate or hydrofiber (ie. Aquacel)
        - iv. Infected wounds: ideally silver sulfadiazine (Silvadene) or bacitracin-zinc ointment (if patient is allergic to sulfa drugs)
        - v. Long term, chronic wounds: products with Manuka honey may improve wound closure
        - vi. Fragile skin: hydrogel sheets to secure dressing

5. The following conditions indicate a need for in-person assessment by medical back-up, clinic, or ED:
    - a. Wounds that appear infected (red, swollen, hot to touch, purulent)
    - b. Any hand and foot wound that is red, hot, swollen, and purulent must be seen in a clinic or ED
    - c. Any wound accompanied by fever

6. Evaluate nutrition status and provide support as needed:
    - a. Increase protein intake (consult medical back-up for patients with kidney disease)
    - **b.** Consult medical back-up for vitamins which may improve wound healing: Vitamin A, Vitamin E, Vitamin C, Zinc

Glasgow Coma Scale

The Glasgow Coma Scale provides a score in the range 3-15; patients with scores of 3-8 are usually said to be in a coma. The total score is the sum of the scores in three categories. For adults, the scores follow:

Activity Score

Eye opening

None	1 = Even to supraorbital pressure
To pain	2 = Pain from sternum/limb/supraorbital pressure
To speech	3 = Nonspecific response, not necessarily to command
Spontaneous	4 = Eyes open, not necessarily aware

Motor response

None	1 = To any pain; limbs remain flaccid
Extension	2 = Shoulder adducted, and shoulder and forearm rotated internally
Flexor response	3 = Withdrawal response or assumption of hemiplegic posture
Withdrawal	4 = Arm withdraws to pain, shoulder abducts
Localizes pain	5 = Arm attempts to remove supraorbital/chest pressure
Obeys commands	6 = Follows simple commands

Verbal response

None	1 = No verbalization of any type
Incomprehensible	2 = Moans/groans, no speech
Inappropriate	3 = Intelligible, no sustained sentences
Confused	4 = Converses but confused, disoriented
Oriented	5 = Converses and oriented

TOTAL (3–15): _____

Reference

Teasdale G, Jennett B. Assessment of coma and impaired consciousness. A practical scale. Lancet 1974;2(7872):81-4.

Evaluating Patients' Decision-Making Capacity

Available at: https://www.emsworld.com/contact/19816/thom-dunn-nrp-phd

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EMS is called to a local drinking establishment for a report of a bar fight with injuries. After arriving on scene and checking in with the police, the crew is directed to a 22-year-old male standing outside, holding a bloody bar towel to the upper left quadrant of his abdomen. "I've been stabbed in the gut!" he shouts. The attending paramedic finds a strong radial pulse of 124 and directs the man to start walking toward the ambulance. "I'm not going to the hospital, and you can't kidnap me!" he shouts even louder. The paramedic calls medical direction, which asks, "Is he sober and competent?"

EMS providers are regularly challenged with ethical issues during the course of their work. Ethical dilemmas are situations that present with no clear right answer and where more than one course of action can be defended. In the case above, there is a patient with penetrating trauma to the abdomen. In any EMS system, this is a priority patient. But wait: He is objecting to treatment and transport. The ethical dilemma is created due to our value of patient autonomy and shared decision-making between provider and patient. However, many would argue this patient is at high risk for a bad outcome if he doesn't seek medical care.

I started thinking about these issues long after I started working in EMS in the 1980s. I'm an active paramedic field instructor for an urban EMS system, but I'm also a clinical psychologist in an academic medical center. As a psychologist, I am regularly called upon to assess the decision-making capacity of patients who refuse lifesaving care. After several years of this, I was invited to sit on the hospital's ethics committee, where many issues are similar to the case above: Someone refuses care or cannot voice their wishes, and others make decisions for them. What struck me most was how many EMS providers face the same ethical dilemmas as physicians, but without the support often found in hospitals (such as on-call specialists like psychologists, an ethics committee, risk managers, legal department, etc.). This article is intended to help guide EMS providers through an ethical dilemma they encounter often: the patient who needs treatment but declines help.

The Shared Decision-Making Model

EMS providers and physicians share many parallels. Both meet their patients and ascertain a chief complaint, then form a clinical impression after taking a history and performing a physical exam and using other diagnostics. Options are discussed, and a treatment plan is decided upon. This model, "shared decision-making" (SDM), came about in the early 1990s and honors the patient's right to autonomy over their own body. This is the bedrock of informed consent. The patient is given options, risks and benefits are explained, and the patient makes an informed choice. Conflict arises when the provider and patient are unable to reach a decision together about the best course of action, typically when the patient decides differently than what the clinician believes to be the best.

EMS providers regularly meet patients who decline ambulance transport. For example, there are individuals who are injured in motor vehicle collisions, but not sufficiently that they believe they need prehospital care and transport. Similarly, diabetics who have become hypoglycemic and recovered after the administration of glucose often decline transport. In most EMS systems, the patient and provider complete paperwork documenting the patient's decision not to be transported by ambulance. Often this paperwork documents the risks to declining care and that the patient has been informed of such risks in deciding against transport.

Less common but far more risky are the patients who would likely benefit from transport and treatment who decide against it. In some instances these patient may be making decisions that will lead to death or disability. It's a fine line for the paramedic or EMT to walk: Respect the patient's right to autonomy to refuse care, while knowing such a decision may lead to that patient's death. In these instances, most EMS systems require the EMT or paramedic to assess the patient's capacity to decline transport and make contact with medical control. The case at the beginning is an extreme one, but exploring it can help frame how to approach such situations.

Evaluating Capacity
While the word competent is often used when discussing decision-making ability, such a term is typically reserved for use only by judges making legal decisions. Our discussion concerns medical decision-making ability (as opposed to the capacity to make other decisions, such as financial ones). The physician's question, "Is he sober and competent?" speaks directly to this. It means, "Are there features about this patient that impair his ability to make decisions?" including intoxication. It's important that EMS providers are able to evaluate medical decision-making capacity.

There are several different approaches to assessing decision-making capacity. I am partial to this one and use a modified version of it when working as a paramedic and or assessing patients as a psychologist.

1. Is the patient an adult without a guardian? In the prehospital arena, children may not refuse transport. Some adults also have guardians who make their decisions. In these instances the EMS providers deal with the patient's parent or guardian.
2. Can the patient communicate a choice about his or her care? For obvious reasons, if the patient cannot communicate their wishes, decisions have to be made by someone else. I also believe patients who refuse to cooperate with an evaluation regarding their decision-making capacity fall into this category. By refusing to communicate with me, these patients are deemed as lacking decision-making capacity.

Steps 3 and 4 are incumbent on the patient being able to process information. Inherent in these steps is whether the patient is free from an altered mental status and not under the influence of an intoxicating substance. I also worry about patients with possible head injuries or other disease processes known to impair cognition (such as hypoglycemia, seizure/postictal phase, dementia, CVA, etc.). Be very careful about leaving patients behind who have central nervous system impairment and who you believe would otherwise benefit from ambulance transport. EMS providers need to be able to perform a thorough mental status exam (beyond "alert and oriented") and be aware of different signs of intoxication.

3. Does the patient have a factual understanding of their medical condition? It need only be a layperson's level of understanding, as evidenced by statements like, "You're worried a blood vessel in my heart is blocked," or "This pain in my stomach might mean I have internal bleeding after my car accident," or "Since I'm taking a blood thinner, there might be bleeding in my brain after I fell." Can the patient understand the risks and benefits of ambulance transport? Can they describe the risks of not being transported? Have the patient articulate them. Common risks are a condition that worsens and there's no provider to intervene or that without intervention they are likely to die. There are no risks to ambulance transport. (Getting into a crash is not a risk; medical risks are things like bleeding during an operation, not that the hospital might catch fire.)
4. Can the patient reason and come to a decision with a certain degree of logic? Perhaps the patient can talk about a medical condition and its possible consequences, but is still making an illogical decision—e.g., "I know you're worried I'm going to bleed to death, but bad things don't happen to me, so I don't need to go." This is an illogical conclusion. Finally, does the patient's decision present as rational and stable across time? This may be the hardest for a field provider to assess, but when it comes to whether the decision is rational, I ask, "What makes you decide this way?" When the rationale for the

decision is odd—like "I'm not going to the doctor because the mind control beams tell me not to!"—question whether it's a rational decision.

In a hospital setting, the more serious the decision being made, the more scrutiny is placed on the process that leads to that decision. For example, a patient making a decision that might lead to their death has to demonstrate an extraordinary capacity for making such decisions. In the field, there may not be time to perform a thorough decision-making capacity evaluation that rises to this level. Further, many EMS providers may not feel comfortable documenting that they let a person die instead of transporting because they documented the patient had sufficient capacity to make such a decision.

EMS systems do not typically have ethics committees or attorneys on speed dial because in an emergency, there is considerable leeway given to simply doing what seems to be in the patient's best interest. If the EMS provider believes the patient has impaired decision-making capacity and a bad outcome will happen if that patient is not transported, most EMS systems will permit an intervention over the patient's objections. That is, the patient's autonomy takes second place to intervening in a life- or limb-threatening emergency. A patient with impaired decision-making capacity and a serious medical condition needs a capable person to start making decisions on their behalf. That may be the EMS provider or a family member in conjunction with the EMT or paramedic. This should never be seen as "kidnapping." While some patients are transported over their objections, this is a medical intervention to go the hospital. Ransom demands aren't made, and there is no ill intent. In the case of the person stabbed in the abdomen, it is unlikely he has enough decision-making capacity to let him decline care.

Conclusion

In summary, I believe patients have a right to make informed decisions I don't necessarily agree with. As EMS providers, we have to be careful about thoroughly assessing decision-making capacity and mental status, following protocols for patients who refuse transport, and documenting every encounter. Many systems also mandate discussing such cases with online medical control. Savvy EMTs and paramedics develop methods for resolving patients' concerns about being transported. Sometimes it's as easy as making sure a pet will be cared for or a loved one is contacted.

Street Medicine Models in Other Counties: White Paper

Introduction

Alameda County invests in street medicine programs that deploy mobile teams to deliver medical care and linkage to services for unsheltered homeless community members. Currently, Alameda County has not articulated a shared model for street medicine services, relying instead on each contracted agency to define the services it delivers. Care Connect tasked Bright Research Group (BRG) with researching models and best practices for street medicine used in other counties/jurisdictions to inform Alameda County's investment in street medicine. Key research questions included:

- What are the existing models and/or best practices for delivering street medicine?
- What types of medical and/or psychiatric interventions can be offered in the street? How should these teams be staffed and deployed to the street to generate the greatest return on investment?
- How can street medicine teams support efforts to link individuals to housing or other services?
- What is the evidence base for street medicine efforts? What are the expected outcomes of this type of investment?

To answer these research questions, BRG conducted a review of the literature on street medicine interventions and interviews with the Director of Street Medicine at USC's Keck School of Medicine and key program staff from street medicine initiatives in Los Angeles County, San Mateo County, Ventura County, San Francisco County, Shasta County, and Santa Clara County. Interviews were also conducted with street medicine providers in Alameda County and other key local stakeholders. This report provides a summary of findings from this research.

Background and Review of the Literature

Street Medicine was invented in 1992 when Dr. Jim Withers started making house calls to unsheltered homeless individuals living on the street (Pittsburgh Mercy 2018). Since then, the definition has been finalized by the Street Medicine Institute as "the provision of health care directly to those living and sleeping on the streets – the unsheltered or 'rough sleeper' homeless – through mobile services such as walking teams, medical vans, and outdoor clinics" (Street Medicine Institute 2018). Although the formal definition makes no explicit mention of housing, many organizations that implement street medicine have recognized the connection between stable housing and health outcomes; as a result, some street medicine programs incorporate elements of housing support or other case management that focuses on addressing housing needs (Department of Homelessness and Supportive Housing 2018; Howe, Buck, and Withers 2009; Humphrey 2016).

With the recent growth in the size of the unsheltered population in many urban communities in California, the street medicine model is seen as a short-term population health management strategy for the thousands of individuals experiencing unsheltered homelessness (Applied Survey Research 2017). Although a growing body of evidence demonstrates a clear connection between stable housing and positive health outcomes, the sheer size of housing demand for Alameda County will not make it possible for all unsheltered homeless individuals to be placed in housing in the near future (Davidson et al. 2014; Gilmer et al. 2010; Appel et al. 2012; Tsemberis et al. 2012). Street medicine provides care for the immediate health needs of homeless individuals, while simultaneously fostering trusting relationships between homeless

patients, case workers, and housing navigators. Depending on its implementation, street medicine could also facilitate the identification and tracking of individuals for housing slots; some of the organizations Bright Research Group interviewed mentioned street medicine teams as a key method for rolling out coordinated entry and HMIS efforts.

There is limited evidence regarding the effectiveness of street medicine as an intervention to improve health outcomes. The majority of evaluations include system-centered metrics such as emergency room utilization, hospitalization rates, and cost savings (Avis 2016; Advisory Board 2017). The only two street medicine evaluations focused on patient-centered metrics found that the intervention improved patient satisfaction, strengthened provider-patient relationships, and fostered ongoing engagement with primary care and behavioral care services after the intervention (Edwards 2017; Christensen 2015). Pilot efforts in Los Angeles and San Mateo County have focused on housing placement as the key metric of success for street medicine efforts. Several studies have documented the impact of permanent supportive housing on the health outcomes of homeless individuals and have demonstrated reductions in emergency room utilization (Kushel et al 2002).

Findings

Interviews with street medicine providers and stakeholders from other counties revealed five key components to street medicine program models. The findings below address each of the fundamental design challenges with street medicine and how other counties are addressing them.

- Target Populations
- Staffing & Deployment Model
- Engagement Strategies
- Suite of Medical/Psychiatric Services
- Connection to Housing

Target Populations

Street medicine programs are primarily structured to be place-based—teams are deployed to specific target locations on some sort of regular schedule. While some programs are roaming or have large geographic regions of focus, many street medicine programs are moving towards more relationship-based models that require frequent/recurring contact with clients in order to significantly address their health conditions(instead of just providing one-time treatment in the street). As a result, street medicine programs are increasingly defining their target locations by very specific geographic boundaries (e.g. a few square blocks) and/or specific encampment communities. This type of place-based approach requires a regular schedule, location, and staff that appear consistently and aim to engage the same individuals on a recurring basis. While some individuals are immediately willing to engage with street medicine teams, others are extremely weary and distrustful of system efforts to engage them in service. Respondents shared that incorporating a consistent schedule, location, and staff into their program models resulted in an improved ability to engage the hardest-to-reach individuals.

Los Angeles' Place-Based Deployment Approach

The best example of this type of place-based deployment structure is in Los Angeles. Several years ago, Los Angeles launched the C3: City, County, and Community program to bring street medicine to the unsheltered community in Skid Row. The City divided Skid Row into four geographic zones—North, South,

West, East—with only a couple square blocks allocated in each zone. A multi-disciplinary outreach and medicine team was deployed to each of the four zones. Teams included representatives from the County's Department of Mental Health, Health Services, Substance Abuse Prevention & Control, Los Angeles Homeless Services Authority (LAHSA) and Americorps staff. Team roles usually included an outreach worker (usually a peer specialist), a nurse, a social worker, a substance use specialist, a public housing specialist, and an Americorps volunteer. This was one of the first efforts in LA to link housing to street medicine efforts; as a result, "in 2016, the C3 team on Skid Row was able to house 158 people and connected 326 more people to housing who will be getting indoors soon" (Horvath 2017). Data on health outcomes were not available.

Target Populations

1. Target geographies to deliver place-based services
2. High utilizers of medical system/ED

As a result of the success of this model, Los Angeles—with the funding from a local measure to tackle homelessness (Measure H) and from Whole Person Care grants—is expanding this model across the County under its new "E6" program. This program is currently scaling the place-based model to the county level by delivering programs in the eight regional Service Planning Areas (SPAs) that LA uses to deploy most public services, selecting local CBO clinics in those regions to administer street medicine in specific targeted zones, and linking street medicine to housing efforts.

San Mateo County's Focus on High Utilizers of Emergency Department Services

Aside from place-based approaches, some communities are focusing street outreach/medicine efforts to reach homeless people who are the highest utilizers of the health system. San Mateo County has contracted with LifeMoves—a longstanding local nonprofit—to locate and identify homeless people who are the highest utilizers of the emergency department (ED) at the San Mateo County Health System. San Mateo County's hospital is utilizing Whole Person Care grant funds to conduct outreach to all high utilizers of the ED to ensure individuals are accessing preventative care and complying with aftercare plans; LifeMoves is contracted to execute this work specifically with the high utilizers of ED who are homeless (~$250k budget). LifeMoves will deliver care/medicine on the street to those individuals (to the highest extent possible), and link the individual to Care Navigators at the hospital whose goal is to keep individuals engaged in aftercare or preemptive care. LifeMoves essentially serves as the street-based outreach arm of the health system's Care Navigator team, linking homeless high utilizers of the ED to medical care in the street, while also providing light-touch case management and transportation to get those individuals to medical/psychiatric appointments as needed and/or as defined in their aftercare plan.

Staffing & Deployment Model

Most street medicine teams are multi-disciplinary—they include some combination of outreach workers, medical professionals, behavioral health specialists, and housing specialists. Some counties cautioned against piecemeal approaches to outreach, where several organizations or programs are providing small doses of duplicative and non-relationship-based services to homeless people. While Alameda County benefits from a rich network of nonprofits and initiatives that aim to serve this population, small doses of low-touch services could have the unintended consequence of further alienating homeless people from engaging in services. In Los Angeles, programs are being redesigned to help improve the quality and depth of interactions with homeless people in order to reverse what some homeless services providers describe as "learned helplessness"—" a condition in which a person suffers from a sense of powerlessness arising from a traumatic event or persistent failure to succeed" (Horvath 2017).

For example, LA is aiming to remove the system's need to ask homeless people to fill out the same paperwork over and over again so that consumers can have a more seamless and less bureaucratic experience. The program theorizes that a single, unified, well-resourced street outreach/medicine team that connects homeless community members to health and housing and provides them with updates about their status will create a restorative experience for the individual's interaction with the system. This goal to transform the consumer's relationship with the system means that street outreach teams need a multi-disciplinary staff that can address the diverse and often complicated needs of unsheltered individuals that are met on the street.

Nurse practitioners (NP) are seen as the most desired/valuable role on multi-disciplinary teams. While nurses and physicians assistants are the most common medical staff on multi-disciplinary teams, NPs are able to provide two key activities that are required for delivering the highest level of medical care possible in the street: 1) diagnosis, and 2) writing prescriptions. Without an NP or MD (rarely seen on street medicine teams in other jurisdictions) on the team, nurses/PAs alone can only provide basic care in the street, i.e. wound care, directions on how to manage a chronic condition or take existing prescriptions, and/or referrals to care at a brick-and-mortar clinic.

> "The nurse in the street cannot do as much as they can in MedSurg or in a hospital."

When it comes to staffing team, Counties are either contracting out services, adding county positions, or a combination of the two. In order to staff the multi-disciplinary street medicine teams, Los Angeles's E6 initiative is hiring community-based clinics/providers in each of its eight regional Service Planning Areas (SPAs) through a competitive bidding process. They expect that this initiative will result in the hiring of more than 1,000 employees at contracted provider agenices and administering public agencies (i.e. LAHSA, behavioral health, etc.). The County is hiring one full-time Outreach Coordinator in each of the eight SPAs to oversee the contracted agency in that SPA, provide strategic support on targeting geographies within the region, and to ensure coordination/linkage with housing and other regional or county-wide efforts. The contracted provider agencies deploy multi-disciplinary street outreach teams in each region. These teams include staff with mental health, physical health, substance abuse, peers with lived experience, and generalist homeless case management expertise. While the contracted provider agency is providing the medical staff on the street medicine team; the city/county will provide housing specialists, behavioral health specialists, or other case managers to deploy with the medical staff. Contracted agencies all have existing brick-and-mortar clinics in the region so that when they come across an individual in the street that needs a higher level of care, they can offer transportation and care to their nearby clinic.

While Los Angeles is contracting with clinics to provide medical staff and deploying city/county staff who are specialists in housing or case management, San Mateo County has taken the inverse approach—contracting with an external nonprofit outreach agency (LifeMoves). San Mateo County deploys the County Health System's medical team alongside LifeMoves outreach staff on the streets. Life Moves has delivered street outreach services in San Mateo County for the last decade (approximately $1 million annually). The high utilizer outreach work with the Whole Person Care pilot mentioned above is a recent addition to their scope of work. In addition to the high utilizer outreach strategy, LifeMoves has been providing street outreach/medicine to all unsheltered individuals in the County. LifeMoves' outreach team will go to some places that are common locations for homeless people, and also serve as "rapid responders" to civilian reports/complaints of unsheltered individuals.

LifeMoves serves five key regions in San Mateo County, with multi-disciplinary teams (MDT) staffed in each of the 5 regions. The MDTs are led by a Life Moves outreach worker (FTE), and staffed by LifeMoves case managers/housing specialists and by medical staff from San Mateo County Medical Center—including a nurse practitioner (when possible), nurse, physicians aid, and psychiatrist. LifeMoves's outreach team decides where the team will go and will lead outreach, engagement, and efforts to get the individual on the housing voucher waitlist. The medical staff on the team will deliver wound care, advise on prescription use, write new prescriptions if needed, and may make a same-day or next-day clinic appointment for the individual in the case of emergency. When appointments are made, the LifeMoves outreach team is responsible for providing transportation—by any means necessary—for the individual to make their appointment. LifeMoves estimates that their clients have an 80% attendance rate at all appointments made at clinics by their street outreach team. In addition to outreach and street medicine, each of the five regional teams has a maximum caseload of 20 people who receive intensive case management—these are individuals who have been prioritized on the housing voucher waitlist.

Finally, Santa Clara County's model relies heavily on their outreach staff and the relationships that they build with the individuals they are serving through the street medicine program. While medical providers are only deployed to the street two days a week, outreach workers are deployed every day. Their primary goal is to develop relationships with consumers, notify them of opportuniites to receive medical care, and to follow up with consumers who have been treated by street medicine teams to support compliance with any follow-up/aftercare. The outreach model in Santa Clara does not rely on the patient finding the provider; instead if the doctor wants a follow-up appointment with the patient, the outreach worker's role is to find that patient and to bring the medical team to wherever the patient might be in the County to ensure the connection to appropriate follow-up treatment.

Engagement Strategies

Respondents emphasized the importance of building in incentives for participation and engagement that meet the basic needs of unsheltered individuals living on the street. While some individuals are eager to engage with medical staff when they appear, respondents noted that some individuals are not as trusting of medical teams, and are more likely to receive medical care after some trust is developed. The most common engagement tactics used for developing trust were portable showers (LavaMae) and other problem-solving support (e.g. storage, identifying a place for a warm breakfast, pet care).

While case management is not necessarily an intentional strategy of street medicine teams, all respondents noted that a relationship-based approach is necessary. Street outreach teams try to be a consistent presence in certain areas so that people know to expect them there. Some street medicine team members effectively serve as temporary/transitional case managers whose goal is to support the health and well-being of the individual on the street until they get into a permanent supportive housing slot with intensive case management.

Respondents noted three common goals for building relationships with unsheltered individuals: 1) getting individuals "document-ready" for housing. Respondents noted that it was important not to make any promises about housing availability; 2) knowing the individuals' medical conditions/needs/preferences and being a trusting person who can help take care of those needs; 3) helping to "bridge" the time between when an individual living on the street is awaiting housing and providing continued case management one the individual has been placed in permanent supportive housing, but is awaiting connection to an intensive case manager. In San Francisco, one respondent described the Homeless Outreach team's mission as

"preventing people from dying in the street until we can get them into housing; we will do anything it takes to ensure that."

In San Mateo County, LifeMoves convenes a monthly case conferencing meeting of the MDT street medicine teams, County behavioral health services agency staff, law enforcement, code enforcement, and other local nonprofit core agencies. The goal of these meetings is to bring a "groupthink approach" on the next steps for serving those unsheltered individuals who are connected to a LifeMoves intensive case manager (i.e. those at the top of the priority list for housing vouchers). These meetings may cover strategies for motivating compliance with prescriptions (medical and psych), connecting clients to appointments with psychiatrists or addiction treatment groups, teaching hygiene behaviors, and/or finding sheltered places for them to sleep. Code enforcement sits at the table so that they can notify outreach and medical teams about any citizen complaints or actions that will be taken to clear an encampment or relocate individuals.

In addition, the literature demonstrates the importance of connecting individuals to health insurance, and ensuring that they remain connected/enrolled in Medi-Cal and other forms of health insurance. Lack of health insurance has been identified as a key barrier to accessing healthcare for all populations, especially for homeless and transient populations; having insurance is positively associated with greater use of outpatient care, reduced barriers to accessing care, and higher medication compliance (Kushel et al. 2001). Engagement strategies should include efforts to connect individuals to health insurance. Interviews with Alameda County stakeholders revealed the need to improve policy/systems solutions that allow clinics to see and treat homeless individuals on Medi-Cal. Medi-Cal requires consumers to select a primary care provider, which may not be appropriate for homeless individuals who move frequently or who are served by multiple providers in Alameda County. One respondent noted the idea of developing an exemption for homeless individuals on Medi-Cal that allowed them to see any primary care provider in Alameda County, to avoid the administrative paperwork that is required for providers to see these patients (and bill Medi-Cal for their service).

Suite of Medical/Psychiatric Services

The suite of medical/psychiatric services that can be provided in the street depends on the staffing strategy of the street medicine team. As mentioned earlier, nurse practitioners are the most-requested staffing role for street medicine teams because they are able to diagnose and write prescriptions in the street. Otherwise, the most common services provided by these teams include supporting chronic disease management (where diagnosed), prescription refill or administration or education, wound care, and connections to primary care clinic. All respondents noted that not all medical needs can be handled in the street. Most models have some sort of effort to connect to a medical home/primary care clinic to diagnose and treat more serious medical conditions, and perform more extensive medical procedures or surgeries where needed. Key types of medical services provided in the street:

- **Wound care:** Open, infected, and festering wounds are commonly experienced by unsheltered individuals. Wound care podiatry specialist was noted as a particularly important role on these teams. Most street medicine teams noted that mobile showers were both a key engagement tactic (as described above) and also a necessary first step for allowing street medicine staff to clean and treat wounds. LavaMae shower trailers were the most commonly used service for mobile showers.
- **Prescription delivery** for people who have prescriptions to treat chronic conditions like COPD, diabetes, etc. Prescription delivery is seen as a bonding tool; when the person is feeling better,

they will engage more in other services. Due to security concerns, respondents noted that teams should only carry small amounts of prescriptions at any time. Some teams only bring prescription medication that they have already determined need to be delivered to a specific individual. Teams suggest having relationships with pharmacies near deployment locations to try to provide rapid prescription refill requests on the same day that they are identified.

- **Injectable anti-psychotics and other Street Psychiatry**: Respondents in Los Angeles and San Mateo County are working to strengthen their ability to deliver injectable anti-psychotics in the street. In San Mateo County, the psychiatrist on street medicine engages with individuals with psychiatric needs and aims to connect them to a clinic to receive further treatment. The psychiatrist has both done assessment and referral in the field, but if the patient has a history of not following through for appointments, the psychiatrist may develop a treatment plan and weekly check-in regimen with the patient in the field.
- **Chronic disease management**: Chronic diseases cannot be managed on the street alone. This is where a relationship-based approach is essential, with the end goal of linking individuals to a brick and mortar clinic. Supporting individuals with managing chronic disease is within the scope of these teams; however, a common challenge is finding people on a regular basis and building enough trust so that they go to a clinic periodically to get higher levels of treatment as needed.
- **Connection to Medical Shelters/Recuperative Beds**: If an unsheltered person ends up in the hospital because of chronic illnesses, Los Angeles County develops a discharge plan with that individual so that they can go to recuperative care and get into short-term medical shelters until they can stabilize their chronic medical disorders. Los Angeles has seven medical shelter locations, with 400+beds available. Traditionally, medical shelter beds are reserved for individuals who are referred after receiving inpatient services. Los Angeles is now opening up these beds for referrals from the E6 street outreach teams. This strategy was developed because street oureach teams were coming into contact with individuals on the street who were facing imminent death on the street. By allowing street outreach teams to refer these individuals to medical shelters, Los Angeles hopes to try to stabilize the sickest and hardest-to-reach individuals living on the street and prevent death.

The Los Angeles Department of Health Services recently developed standardized procedures for registered nurses who are deployed in street-based engagement teams (these pilot protocols—launched in March 2018—are provided in attachment). Los Angeles developed their protocols based on protocols from the San Francisco Sobering Centers, Los Angeles Sobering Centers, San Francisco Homeless Outreach Team clinic, and the San Mateo mobile clinic. These protocols dictate the conditions that can be treated on the street, and what nurses are

LA's Street Medicine Clinical Treatment Protocols

Nursing procedures have been developed for treating the following conditions in the street:

Abdominal Pain
Allergic Reaction
Altered Mental Status
Animal Bites
Athlete's Foot
Bradycardia
Chest pain
Cold/ Upper Respiratory Infection
Constipation
Cough
Dental Pain
Dermatitis, Atopic (Eczema)
Dermatitis, Contact
Diarrhea/ Loose Stools
Hay fever / Allergic Rhinitis
Headache
Heat Related Illnesses/ Hyperthermia
Hypertension
Hypoglycemia/ Hyperglycemia
Hypotension
Hypothermia
Menstrual Cramps / Dysmenorrhea
Musculoskeletal Pain
Nausea & Vomiting
Opiate Overdose/ Depressed Respirations
Scabies
Seizure
Shortness of Breath
Sore Throat
Suicidal Client
Suture Removal
Tinea Corporis/ Tinea Pedis (Ring worm)
Wounds

supposed to do if they can't treat a condition on the street, but the person either requires a higher level of care or is experiencing an imminent life threatening emergency. Los Angeles is also training its street medicine teams in protocols for assessing clients' decision-making capacity and utilizing shared decision-making models due to the commonality of interacting with individuals in the street who may be declining potentially life-saving care. The shared decision-making model that is informing Los Angeles' approach and training on these sitautions is provided in attachment to this memo.

Excerpt from Los Angeles' Street-Based Engagement Registered Nurse Standardized Procedures (March 2018)

"*General Statement of Procedure:* The following guidelines describe the steps to follow for all Standardized Protocols for Registered Nurses who are working in the community as part of street-based outreach and engagement teams.

1. Document encounter in S.O.A.P. format, including protocol followed under assessment, time seen, completion/ discharge time, and name with title.
2. Collect data thoroughly and consistently.
3. Perform physical exam pertinent to presenting problem.
4. Consult medical back-up as necessary.
5. Connecting the client with a regular clinic is a priority of the engagement process. Ideally, medical and nursing care should be transitioned from street-based to clinic-based care as soon as feasible for the respective client.
6. Provide every client with next primary care clinic appointment and encourage appointment adherence. If client is not scheduled, assist in scheduling client for clinic appointment in appropriate timeline.
7. Refer client to medical home if not yet assigned.
8. Consult regularly with assigned provider and/or medical back-up that oversees your team utilizing verbal orders when appropriate."

Connection to Housing

In most other jurisdictions, the overall mission for street medicine teams is to support the health and well-being of individuals until they are connected to housing. Street outreach/medicine teams are seen as a key strategy for rolling out Coordinated Entry and HMIS in Los Angeles and San Mateo County. Key goals include assessing the vulnerability of individuals (high to low), getting them on housing lists in order of priority from highest risk to lowest, connecting them to social service benefits and health care services while they are still living in the street, and getting them "document-ready" for housing (i.e. all the paperwork they need to have in place in order to move into that housing unit once its available).

Street Medicine & Housing First in Los Angeles

In 2017, Los Angeles voters passed Measure H—the County's most comprehensive effort to end homelessnessness in the region. The County released a detailed funding and implementation plan for all homelessness prevention and intervention strategies funded by Measure H, including the E6 street medicine initiative described in this memo (see link in textbox to the right). Under the new E6 initiative, the ultimate goal of the countywide network of multidisciplinary street medicine teams is housing, but supporting the health and well-being of those patients through the delivery of street medicine helps the county: 1) identify, track, and assess the vulnerability of homeless individuals to support the execution of coordinated entry and HMIS, and 2) build trust with the homeless clients by providing them with health care services

and treatment that supports their well-being. These individuals have a history of negative, distrustful experiences with public systems, and the street outreach teams are seen as an opportunity to meet the individuals where they are (literally and figuratively) and do anything they can to support the well-being of that individual.

Coordinated Entry in San Mateo County

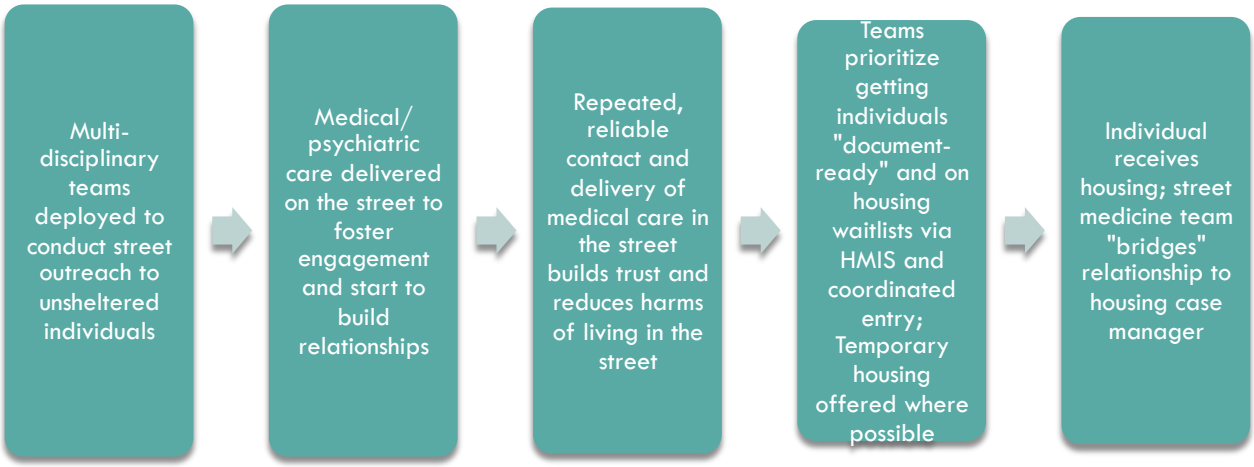
In San Mateo County, a key goal is to assess the vulnerability of the individual in order to prioritize their placement in the coordinated entry system. LifeMoves' street medicine team has connected 40 unsheltered individuals to housing because of the prioritization of vouchers through recent coordinated entry efforts. They also have 35 people who are presumptively matched with vouchers, and who the LifeMoves team is supporting to get "document-ready". These individuals are matched with a LifeMoves intensive case manager, who will remain assigned to the client for an additional 60-90 days after they move into permanent supportive housing. A key strategy for Life Moves intensive case managers is to provide warm hand-offs to housing case managers that come with the housing voucher placement.

Los Angeles' Measure H Strategy Implementation Plans (September 2017)
See p. 48-53 for the E6 implementation plan
http://homeless.lacounty.gov/wp-content/uploads/2017/03/Measure-H-Strategy-Cover-Sheets.pdf

Measure H Strategies At-A-Glance (November 2017)
See p. 26 – 27 for E6
http://homeless.lacounty.gov/wp-content/uploads/2017/03/Measure-H-Strategy-Cover-Sheets.pdf

Even with the improvements in housing prioritization due to coordinated entry, all counties report that wait lists can still be 2-3 years long. In the interim, there is a shared recognition that unsheltered individuals are going to continue living on the street or in large (and often, growing) encampments. Because of the health and safety hazards of encampments, many jurisdictions are grappling with how to manage and clear encampments given the unfortunate reality of low supply of permanent supportive housing slots. In San Mateo County, Life Moves partners with code enforcement, planning departments, law enfocement, and city managers to coordinate efforts and notification around encampment evictions or closures. LifeMoves has asked these departments to contact them when they are planning to evict or clear encampments, and LifeMoves will prioritize deploying to those locations to notify residents, offer services, and try to support a more humane eviction/clearing process. They are not part of the encampment closure team and do not post eviction notices; their primary goal is to ensure that clients are aware and supported with moving.

A common, unifying theory of change for street medicine efforts that incorporate a housing first approach may be depicted as follows:



Considerations for Alameda County

Compared to other counties, Alameda County has not sufficiently defined its program model for street medicine and would benefit from a model that is more integrated and directive. In strengthening its street medicine investments, Alameda County should consider the following options:

Program Model Element	Options & Considerations
Target Population	• Specify targeted geographies for deploying place-based street medicine. Geographies should be narrower than large neighborhoods (i.e. East Oakland, West Oakland), and can be as specific as a few square blocks or specific encampments/ areas of critical mass. • Require consistent, recurring schedules, locations, and staff • Prioritize/support a relationship-based approach to engaging with patients on the street (i.e. move-away from high-volumes of low-touch engagemnets with patients) • Consider piloting a team whose goal is to partner with Alameda Health System to locate and provide targeted support to high utilizers of medical services who are unsheltered
Staffing & Deployment	• Establish multi-disciplinary teams, staffed by outreach workers (ideally, peer professionals), medical professionals, behavioral health specialists, and housing specialists • Staff teams with nurse practitioners • Deploy city or county staff with housing or social service expertise with medical/outreach teams on the street • Ensure contracted provider agencies have a brick-and-mortar clinic that can serve as the medical home for the individuals who are met on the street
Engagement Strategies	• Allow contracted agencies to use portable showers (LavaMae), meals, and other problem-solving strategies as key engagement/trust building tactics • Encourage relationship-based approach to street medicine, i.e. light-touch case management model and/or intensive case management for those who are next in the queue for permanent supportive housing vouchers. Consider developing a multi-agency case conferencing model for supporting these high-priority individuals.
Suite of Medical/Psych Services	• Encourage teams to deliver care in the street and, when necessary, connect individuals served on the street to a higher level of care in a clinic • Require teams to provide transportation to appointments at clinics • Develop clinical treatment protocols for specific conditions that should be treated in the street (see above for details) • Allow street medicine teams to refer individuals to any available medical shelters/recuperative beds
Connection to Housing	• Emphasize getting individuals “document-ready” for housing • Utilize street medicine as a key strategy for supporting roll out of

	coordinated entry and HMIS
Other Policy/Systems Change Work	• Develop shared outcomes/RBA metrics for this program • Research portable care exemption for homeless individuals on MediCal • Develop funding model that addresses billing/payment via MediCal • Expand access to pharmacy-dispensing licenses and buprenorphine/suboxone • Identify and fund shared resources that support street medicine providers' ability to adapt this model (i.e. mobile exam rooms, staff with housing or social service expertise, etc.)

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San Diego
Homeless Outreach Worker (HOW)
Best Practices

Introduction

Homeless outreach is an essential step towards meeting people experiencing long-term or multiple episode homelessness and developing the critical relationships necessary for supporting transition to affordable housing and/or needed treatment. At a discussion among outreach workers in Washington, DC, one participant described the reasons for providing outreach to people experiencing homelessness: "Waiting for people to come to us didn't work…so what we're doing is going to where people are comfortable, to where they are right now, because that's probably most effective." This description highlights three essential aspects of outreach. First, outreach and engagement means "going to where people are," rather than waiting for them to seek services at a specific place. Second, traditional approaches to site-based social services may not be accessible for people who are marginalized, such as homeless individuals and families. Finally, workers (HOWs) provide outreach because it is "probably most effective." (Olivet et al., 2010)

Homeless service providers, advocates, and consumers have viewed the process of outreach and engagement as critical components of homeless service delivery. Although there is no single definition of outreach, experts agree that outreach is a process designed to contact individuals in non-traditional settings who might otherwise be ignored or underserved. Its purpose is to improve physical and mental health and social functioning, increase use of human services, and re-integrate people into the community. For homeless outreach to occur, HOWs frequently must attempt to establish a relationship with people who are often mistrustful of service providers and who are often reluctant to engage. To meet the difficult challenge of engaging homeless clients, effective HOWs must be flexible, empathetic, respectful, non-judgmental, committed, and persistent and should have specialized knowledge of the issues facing the people they serve, be aware of the availability of services and systems of care such as housing, medical, behavioral health, and substance use disorder treatment. (Olivet et al., 2010)

Outreach: Definitions, Principles, & Roles

Outreach is the fundamental bridge between unstably housed individuals and available services and resources. Most Outreach experts agree that Homeless Outreach comes in a variety of forms, is approached through several key principles and practices and requires HOWs to play numerous roles for their clients and agencies. (NHCHC, 2014)

Defining Homeless Outreach

Homeless outreach is face-to-fact interaction with people experiencing homelessness. Homeless outreach takes place on the streets, in camps, under bridges, in temporary motels, shelters, meal sites, libraries, public facilities, and wherever else people might be located. In active outreach, HOWs seek out and connect with individuals and families who are homeless.

On a client level, outreach has been described as the "front door" to an agency. Past and current outreach workers have defined outreach with a few key phrases: client engagement outside the traditional office

setting; networking to identify clients and get in touch with them; meeting clients where they are and on their terms; and finding people, assessing their needs and connecting them with services. (NHCHC, 2014)

Principles of Outreach

Experienced frontline staffs, including HOWs, base their outreach work on a number of principles. Many of these principles relate to the importance of the human connection and how to create it, including building trust, developing a sense of community, dignity and respect, and honesty. Other principles involve relationship dynamics such as giving individuals the choice of whether or not to engage, the need for a give-and-take relationship between the HOW and client, letting the client lead, appearing visible and approachable, taking small steps toward progress, not making promises, ensuring consistent follow-up, and not pushing an agenda. Some other principles of importance include serving as a patient advocate, reducing barriers to services, follow evidence based-models of care, motivational interviewing, harm reduction, and trauma-informed care. However, core outreach principles should always include the following: (NHCHC, 2014)

- Meet people where they are-geographically, emotionally, and physically.
- Meet basic needs.
- Be respectful and treat everyone with dignity.
- Recognize that the relationship is central to outreach and engagement
- Create a safe, open, friendly space, regardless of the setting. (Olivet et al., 2010)

Roles of Outreach

The roles of outreach include parts of many positions. Aside from the typical outreach positions such as HOWs, homeless outreach can also be done by community health workers, case managers, hospital liaisons, and disability assistance staff. As frontline staff, HOWs often serve as agency ambassadors in their communities, establishing first impressions of their agencies to both prospective clients and community partners and stakeholders. Second, HOWs serve as a bridge to agency services, establishing contact in the field and facilitating referrals. Third, once HOWs engage clients, they can serve as navigators, helping clients overcome system complexities and access appropriate services in the community. Finally, HOWs can provide support to other teams, namely clinical and behavioral health staff, often through multidisciplinary outreach teams. (NHCHC, 2014)

Community Homeless Outreach: Building Networks & Raising Awareness

Beyond engaging with potential clients, homeless outreach to other community agencies is essential for building a referral network to complement the services available within one's agency. Most homeless experts agree that outreach and collaboration with community agencies is an important part of a HOWs work. Agency partners can span many sectors, including faith-based organizations and churches, hospitals, jails, mental health providers, free clinics, police and sheriff departments, meal sites, homeless shelters, libraries, and community and day centers. (NHCHC, 2014)

There can be several strategies to promote coordination among outreach agencies. Online central referral systems (i.e. Homeless Management Information System (HMIS), Coordinated Entry System (CES) and Services Point) often created to facilitate countywide placements in permanent supportive housing based on a vulnerability index (i.e. vispdat.pdf), have become strong tools for agency collaboration. Most current and past HOWs have expressed that a central referral system was the central point of contact that helped put outreach workers at various agencies on the same page regarding the status of mutual clients. Another collaborative approach can be to perform outreach in zones or coverage areas so that agencies are not duplicating efforts by performing homeless outreach in the same areas. This type of coordinated outreach can be organized through regularly scheduled meetings involving staff from different homeless service agencies. (NHCHC, 2014)

Another component of community outreach is raising awareness of homelessness among community organizations and residents. Presentations to churches, schools, and other community groups should and can be an important part of a HOW's job. (NHCHC, 2014)

Homeless Client Outreach: Who & Where

With the assumption that community partnerships locally are in place for collaboration and referrals, HOWs can focus much of their efforts on engaging clients in the community.

Who: Homeless Outreach Staffing

HOWs in larger cities most often perform street outreach in teams of a least two staff, while those in smaller cities and areas tended to do individual outreach. In some cities and areas, a combination of individual and team outreach was performed depending upon the situation. However, homeless and medical outreach is frequently combined and a multidisciplinary team is often used in these situations. These teams are often composed of outreach workers (HOWs), social workers, case managers, medical assistants, physicians and/or nurses. Rounding out the multidisciplinary team, consumers and peers can play significant outreach roles in both formal and informal capacities. Some agencies have positions staffed by a peer or a former consumer as part of their outreach teams, which many outreach experts believe strengthens engagement with clients. Consumers frequently can provide HOWs with referrals to other consumers who are in need of services. (NHCHC, 2014)

Tips For Staying Safe

- Always let your supervisor(s) know your location.
- Go in pairs whenever possible.
- Don't approach people who are "giving signs" that they don't want to be approached.
- Don't interrupt sales of drugs or sex-trust your gut

(*SAMHSA*)

The team approach generally is said to be safer, particularly when working outside fixed homeless outreach sites such as shelters and day centers or entering unknown areas. A team approach also provides the support necessary to navigate an

often challenging job. Even in areas where homeless outreach was done individually, staff often will have team meetings to share their experiences and gain insight from each other. In other situations, complex case management committees work together to formulate plans for mutual clients, creating additional ways for interdisciplinary support and collaboration. (NHCHC, 2014)

Where: Homeless Outreach Locations

The guiding principle determining location is to go where clients naturally congregate. Clinic lobbies are natural starting points for homeless outreach and HOWs can often connect with new clients in waiting areas to assess their needs and facilitate referrals and benefits enrollment. Experienced HOWs frequently have regular schedules for fixed sites, which include churches, shelters, drop-in and day centers, free clinics, hospitals and emergency departments, jails, libraries, community centers, and meal sites. Due to the regular necessity of meals, sites offering meal programs often anchor the fixed outreach schedules of HOWs or other outreach staff, determining appropriate times to visit meal sites (during meal times) and other fixed and mobile sites (during off times). Beyond lobbies and fixed sites, mobile and street outreach is important for reaching disengaged populations. HOWs can frequent public transportation stops (bus and trolley stations), areas under bridges and overpasses, homeless encampments, wooded and covered areas, river beds, and other street locations known as meeting spots. In many areas and cities HOWs are often notified by police or local government agencies regarding individuals who should be targeted for outreach. (NHCHC, 2014)

Tips for Approaching Potential Clients and the "Dos" of effective Homeless Outreach

- Never sneak up or corner someone
- Respect the Individual's "three homes"
- Clearly identify yourself and your agency
- Be yourself
- Listen
- Use Motivational Interviewing
- Respond, don't react
- Dress for the street
- Be Culturally competent
- Trauma-informed
- Describe available resources and allow individual to decide how to proceed
- Repeat visits are often necessary to build trust

(SAMHSA, National Health Care for the Homeless Council)

Homeless Client Outreach: Challenges, Strategies & HOW Best Practices

Homeless outreach is demanding work that requires unique problem-solving strategies to mitigate a host of barriers. The following provides an overview of the common challenges faced by HOWs and the strategies and best practices they can employ to build client engagement to overcome these issues.

Outreach Challenges

Most homeless experts would agree there are many challenges that impede outreach staff's (HOWs) ability to connect homeless clients with available resources. On a

client level, the biggest challenge usually identified is unmanaged mental illness, which makes client engagement very difficult, particularly when individuals have a lack of insight to their symptoms or cannot provide informed consent. Other major challenges relate to a lack of client readiness, including fear of committing to a program or service requirements and lack of trust. On the systems level, most challenges revolve around limited resources, including difficulty contacting patients without phones or fixed addresses, distance and lack of transportation options, lack of language and interpretation services, and most importantly lack of readily available housing resources to offer clients (e.g. temporary or permanent housing). From the staff perspective, other challenges include burnout and safety. (NHCHC, 2014)

Strategies: Initial Approach

To mitigate some of these challenges, HOWs should emphasize the importance of first impressions and how they should approach potential clients. Underscoring the significance, a HOW's initial approach and treatment of individuals is a major factor in the individual accepting or refusing services. Although styles vary, all share several key principles. In terms of demeanor, HOWs should never sneak up or corner someone; instead, they should be undemanding, ask open-ended, and get to know the individual without pushing your agenda. One homeless expert operates by the "three homes" theory, which emphasized that one must respect the three homes of a person experiencing homelessness: the individual's personal space, the physical space where they live, and the community in which they live. When HOWs or any outreach staff first approach someone, they should identify themselves and their organization. Next, they should try to get to know the individual and identify any needs that could be met. This should be followed by describing the resources and service possibilities available and potentially facilitating referrals. For many individuals, repeat engagements are necessary to build relationships and trust before referrals are possible. HOWs and outreach workers can emphasize the role a strong agency reputation can play in successfully engaging individuals. Another strategy may include having agency vehicles emblazoned with logos which can work well to attract individuals and build trust. HOWs can also carry hygiene packets and other supplies to distribute, particularly to individuals who are more hesitant to engage. (NHCHC, 2014)

Strategies: Building Engagement

Once HOWs or other outreach workers have made initial contact with potential clients, they must build engagement so these individuals are comfortable and well-equipped to access services and resources. Homeless experts define client engagement by a few key concepts: a client's willingness to speak with the HOW on an ongoing basis, the client successfully showing up to appointments, and establishing a collaborative relationship in which the HOW and client both contribute to mutual goals. Experts also recommend several strategies to build client engagement. Relationship-building is said to be key, particularly through building trust, getting to know the personal narrative of individuals, demonstrating empathy and understanding, and establishing an equal, collaborative relationship between clients and HOWs. Experts further recommend building these relationships by creating a consistent presence at various sites on a regular schedule and always following up and following through with promises. Having a common background, such as a history of addiction or homelessness, is also beneficial to forging these relationships. In terms of an action plan, it's expected to let the client lead. Encouraging the client to set

Characteristics of Effective HOWs

- Flexible
- Non-judgmental
- Relaxed
- Resourceful
- Patient
- Calm and clear
- Assertive
- Independent
- Team player
- Tactful
- Cautious and alert
- Assertive (takes initiative)
- Centered
- Focused

(*SAMHSA*)

goals, both short- and long-term, is an effective means of increasing engagement. Setting small steps and achieving them build a sense of accomplishment and further inspires client involvement. Experts emphasize that engagement should be built at the pace and desires of the client, pursuing his or her goals, as opposed to those of the HOW or outreach staff. (NHCHC, 2014)

HOW Best Practices

Based on literature review and the general consensus of homeless outreach experts the following are critical HOW best practices in providing effective homeless outreach and engagement:

Person-Centered Practice promotes a person's right to have choice and control over the process of exiting homelessness and is an effective strategy to empowering people. Involving the person in all decision-making process supports a person's right to autonomy, develops their living skills and capacity to live independently. (Homelessness NSW, 2016)

Harm Reduction is a critically important principle of effective homeless outreach. It is a means through which HOWs can establish trusting relationships with homeless individuals promote safety and continuously monitor safety issues while intervening as needed. A harm reduction approach aims to provide a quality service by reducing the adverse effects of homelessness. The primary goal of outreach when with people who are "sleeping rough" is to assist people to improve their health and housing outcomes. (Homelessness NSW, 2016)

Consistent and Trusting Relationships – Assertive homeless outreach is often described as a process. In recognition of the outreach process, effective practice should be centered on the development and maintenance of a trusting relationship between a HOW and the person. The building of such relationships can begin to rectify mistrust of services and the trauma of demeaning behaviors and attitudes. (Homelessness NSW, 2016)

Honest Communication – The process of effective engagement involves the development of a common language between HOWs and clients to enable the full consideration and exploration of possibilities for health changes from a common frame of reference. When HOWs pay attention to subtle meanings in a person's language they can learn to use this understanding to form meaningful connections with the person. As part of this process, workers attempt to genuinely comprehend and respond to the words and gestures communicated. (Homelessness NSW, 2016)

Persistent Approach to Homeless Outreach – A persistent approach to requires repeated contact with individuals unwilling to engage. To provide a persistent approach the following support systems should be required.

- An awareness by management of the issues involved in supporting persistence, such as caseload size and capacity issues to prevent HOW burnout.
- Ensuring assertive homeless outreach attracts employees (HOWs) with the necessary skills and personal attributes to successfully engage with people.
- Providing appropriate training to HOWs throughout the process of recruitment
- Frequent contact between HOWs and individuals is a central component of homeless outreach and can increase the likelihood of successful engagement. (Homelessness NSW, 2016)

Trauma Informed Care and Practice – HOWs need to understand a person's previous exposure to trauma and how these experiences have shaped their life trajectory. To reduce the likelihood of re-traumatization all interactions and engagement with a person should be based on trauma informed care principles. (Homelessness NSW, 2016)

Culturally Sensitive Practice – The above principle of trauma informed care facilitates the provision of various outreach services to people whose unique needs may differ widely. It is particularly important to be mindful of trauma informed care when providing homeless outreach services to culturally diverse people as a slightly different approach may be more culturally relevant and appropriate. It is imperative that all HOWs receive training in culturally sensitive practice. A lack of awareness about the needs and issues affecting culturally diverse people can result in re-traumatization and perpetuate damaging stereotypes. (Homelessness NSW, 2016)

Homeless Outreach Worker
"Don'ts"

- Don't "space invade".
- Don't promise what can't be delivered.
- Don't "case manage."
- Don't go alone.
- Don't preach, pry, and prod.
- Don't go at 4 a.m.

(*SAMHSA*)

Strategies: Referral Management

After achieving client engagement, HOWs often facilitate referrals within their agencies and with other community organizations. This step is pivotal to helping clients successfully access homeless services and resources, but it requires thoughtful strategies to ease potential missteps. Experts recommend approaching referral management in a number of ways, often dictated by the size of their agencies and the needs of clients. If possible, HOWs should make a "warm hand-off," in which they personally introduce clients to their new providers, benefits staff, or outside community agencies/providers. In many cases, it is also recommended to communicate with fellow staff about referrals in person, on the phone, or through electronic medical records (EMRs). For more complex

situations, case conferences with multidisciplinary teams to coordinate referrals are also recommended. For example, an agency can provide an outreach leads dedicated to operating an outreach call center (e.g. 211 San Diego), which potential clients can contact for assistance. Referrals are either made on the phone or clients can visit the office for an in-person meeting. However, homeless experts also emphasize that although HOWs or outreach staff help facilitate referrals, clients have to exercise personal initiative as well, upholding the equal, collaborative relationship between HOWs and clients. (NHCHC, 2014)

Conclusion: Why do Homeless Outreach? Findings & Outcomes

As discussed throughout this paper, homeless people have multiple service needs. The provision of available services is complicated by the state of being homeless. Although there are occasional reports of homeless people refusing services, data from multiple homeless studies indicate that, when properly approached, the homeless welcome services. The fact remains, demand for homeless and supportive services both locally and nationwide exceed current availability. However, successful homeless outreach conducted by HOWs do make a difference. For example, placing the homeless in stable housing plus accompanying supportive services makes a difference. Consistent findings include:

- Over 80 percent of supportive housing tenants are able to maintain housing for at least 12 months.
- Most supportive housing tenants engage in services, even when participation is not a condition of tenancy.
- The use of costly (and restrictive) services declines in homeless, health care, and criminal justice systems.
- Nearly any combination of housing and services is more effective that services alone.
- "Housing First" models with adequate support services can be effective for people who don't met conventional criteria for "housing readiness." (CSH, www.csh.org)

Aggressive homeless outreach efforts led by HOWs and coordinated case management are crucial to successful service provision to homeless people, HOWs serve as a conduit to supplying these efforts to homeless populations in need. Intensive efforts to identify homeless people who are in need of stable housing, health care, substance use disorder and other services, to determine eligibility for benefits, to encourage acceptance of appropriate treatment, and to facilitate receipt of services are always in demand.

Resources, Links:

Homeless Resources on the Web

Government

- United States Interagency Council on Homelessness (USICH)—Members of the Interagency Council on Homelessness develop innovative $35 million-funding opportunities to improve the delivery of federal resources to help end chronic homelessness.
- Bureau of Primary Health Care (BPHC)—An agency of the Health Resources and Services Administration (HRSA), Department of Health and Human Services, whose mission is to increase

access to comprehensive primary and preventive health care and to improve the health status of underserved and vulnerable populations. The bureau administers Health Care for the Homeless (HCH), authorized in Section 330(h) of the Public Health Service Act, which makes grants to community-based organizations to assist them in planning and delivering high-quality, accessible health care to people experiencing homelessness.

- Centers for Disease Control & Prevention (CDC)—An agency of the Department of Health and Human Services located in Atlanta. This site includes health data standards, scientific and surveillance data, health statistics, laboratory information, and information about grant and cooperative agreement funding opportunities.
- Substance Abuse and Mental Health Services Administration (SAMHSA)—A HRSA agency that administers two targeted homeless grant programs: Projects for Assistance in Transition from Homelessness (PATH), a formula grant program created under the McKinney Act that provides funding to support service delivery to individuals with serious mental illnesses and/or substance use disorders, including those who are homeless or at risk of homelessness; and the Center for Substance Abuse Treatment, which enables communities to expand and strengthen their treatment services for homeless individuals with substance abuse disorders, mental illness, or co-occurring substance abuse disorders and mental illness.
- U.S. Department of Housing and Urban Development (HUD)—Provides information about HUD programs, community and marketplace issues, housing options, and research on housing and community-related materials.
- U.S. Department of Veterans Affairs (VA)—Provides information about veterans' benefits and services including an online directory of veterans service organizations.

Housing

- 100,000 Homes Campaign—The 100,000 Homes Campaign, parented by Community Solutions, brings together change agents from across the country to find homes for 100,000 of the most vulnerable and long-term homeless individuals and families by July 2013.
- OneCPD Resource Exchange—Provides information for the HUD office of Community Planning & Development, including consolidated work plan summaries and funding information.
- National Housing Institute—Covers housing and community development issues, includes articles from Shelterforce, and provides links to other housing development sites.
- National Housing Law Project—Works to advance housing justice for the poor by increasing and preserving the supply of decent affordable housing. This site contains helpful information on public housing, Section 8, and other housing resources.
- National Housing Trust Fund Campaign—A growing national campaign for a trust fund to support the construction or rehabilitation of 1.5 million units of affordable housing over the next 10 years. This site directs you to legislative advocacy opportunities to support the fund and to increase the availability of housing that is affordable for low-income people.
- National Low Income Housing Coalition—A national advocacy organization for affordable housing. This site contains background information on housing issues, policy updates, and NLIHC activities.

Homelessness

- European Federation of National Organisations Working with the Homeless—FEANTSA, the European Federation of National Organisations Working with the Homeless, was established in 1989 as a European non-governmental organization (in French, FEANTSA stands for la Fédération Européenne d'Associations Nationales Travaillant avec les Sans-Abri). The some 100 member organizations come from 30 European countries. Members are non-governmental organizations that provide a wide range of services to homeless people including accommodation and social support. Most FEANTSA members are national or regional umbrella organizations of service providers. They often work in close co-operation with public authorities, social housing providers, and other relevant actors. FEANTSA, the only major European network that focuses exclusively on homelessness at the European level, receives financial support from the European Commission for the implementation of its activities. FEANTSA works closely with EU institutions and has consultative status at the Council of Europe and at the United Nations.
- The Weingart Center—A non-partisan research organization focusing on homelessness and poverty, especially in Southern California. The Institute serves as a resource for the media, academics, policy makers and social service organizations. Resources include their free, weekly listserve alerting subscribers to the latest cutting-edge academic and policy research reports regarding homelessness and poverty.
- Homelessness Marathon—A radio broadcast that enables homeless people speak to the nation from an overnight program that has originated from a different city each year. Host "Nobody" broadcasts from outdoors to dramatize the plight of people with nowhere to go to get out of the cold. For 14 hours, he interviews experts on various aspects of poverty in America (e.g., health care, hunger, public housing, etc.) and takes calls from around the country while talking with homeless people.
- Institute for Children and Poverty—An independent research and policy think tank based in New York City that conducts national research on the causes of family homelessness, the demographics of this growing population, and the programs most effective in assisting homeless families to transition to stability and self-sufficiency. This site contains information for policymakers, the non-profit community, education institutions, and the private sector.
- National Center for Homeless Education—Provides numerous resources on homelessness and education for homeless children and youth, the Stewart B. McKinney legislation, fact sheets on homelessness, resources for advocates, links to other organizations that work with homelessness issues, a monthly feature of a model program, listings of upcoming events, and a variety of other information and resources on homeless children and youth.
- National Center on Family Homelessness—A non-profit organization working towards long-term solutions that help homeless families become self-supporting and active participants in community life. Its mission is to translate research findings and field experience into innovative programs benefiting homeless families across the country.

- National Student Campaign against Hunger & Homelessness—A coalition of students and community members across the country to end hunger and homelessness through service projects and action. NSCAHH trains students on strategies to improve or create service projects that meet their community's needs.
- North American Street Newspaper Association—Supports a street newspaper movement that creates and upholds journalistic and ethical standards while promoting self-help and empowerment among people living in poverty.

Health

- Association of Clinicians for the Underserved—Provides information relevant to clinical practice, research, and training for clinicians and organizations serving uninsured or medically underserved populations.
- Balancing Act: Clinical Practices that Respond to the Needs of Homeless People—A paper by Marsha McMurray-Avila, Lillian Gelberg, and William R. Breakey, describing special adaptations to clinical practice that are necessary to address the most common health problems experienced by homeless people.
- The Children's Health Fund (CHF) works nationally to develop health care programs for the nation's most medically underserved population—homeless and disadvantaged children. CHF brings medical care and essential services directly to underserved children in rural and urban communities via Mobile Medical clinics (doctor's offices on wheels) and fixed site clinics. Moreover, CHF has become a major national advocacy voice on behalf of all children and has inspired special federal legislation designed to help create innovative children's health projects throughout the United States.
- Fact Sheets on Health Care & Homelessness—Compiled by the National Coalition for the Homeless, these documents examine the relationship between poor health and homelessness and specify chronic and acute health problems frequently experienced by homeless people.
- Homeless Veterans: A Resource Guide for Providers—Compiles current information about health care issues and resources for veterans, explicates the complex array of services provided by the Veterans' Administration, explores barriers that exist, and describes helpful collaboration between the VA and homeless service providers in some communities.
- Identifying and Responding to Domestic Violence among Poor and Homeless Women—Guidance for health care providers in identifying, assessing, documenting, and treating the medical and psychological effects of domestic violence; published by the Better Homes Fund in collaboration with the HCH Clinicians' Network.
- Migrant Clinicians' Network—Information and resources for clinicians serving migrant farm workers.

Policy & Advocacy

- National Alliance to End Homelessness (NAEH) – a nonprofit membership organization dedicated to solving the problems of homelessness and to preventing its continued growth. The Alliance web page contains information on programs, practices, legislation, and NAEH activities.

- National Coalition for the Homeless (NCH) – a national advocacy network of homeless persons, activities, service providers and others committed to ending homelessness through public education, policy advocacy, grassroots organizing, and technical assistance. The site includes a searchable bibliographic database with reference to research on homelessness, housing, and poverty; calendar of events; legislative alerts, and links to local state and national homeless/housing organizations.
- National Coalition for Homeless Veterans (NCHV) – provides legislative advocacy, public education and technical assistance for service providers of homeless veterans.
- National Law Center on Homelessness & Poverty – advocates to protect the rights of homeless people and to implement solutions to end homelessness in America. To achieve this mission, the Law Center pursues three main strategies: impact litigation, policy advocacy, and public education. This site provides information on homelessness and describes current projects, publications, and activities.

Links

http://www.nationalhomeless.org/

https://www.hud.gov/program_offices/comm_planning/homeless

https://www.samhsa.gov/homelessness-programs-resources

http://www.epath.org/site/main.html

https://www.nhchc.org/resources/general-information/web-resources/

https://www.va.gov/homeless/resources.asp

https://www.alphaproject.org/

https://endhomelessness.org/homelessness-in-america/who-experiences-homelessness/children-and-families/

https://www.sandiego.gov/homeless-services

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THE
THE RESULTS-BASED ACCOUNTABILITY™ GUIDE

The *Results-Based Accountability™ Guide* uses and is based upon concepts and materials developed by Mark Friedman, author of *Trying Hard is Not Good Enough* (Trafford 2005) and founder and director of the Fiscal Policy Studies Institute.

TABLE OF CONTENTS

I. INTRODUCTION

What is Results-Based Accountability™?

Results-Based Accountability™ ("RBA") is a *disciplined way of thinking and taking action* used by communities to improve the lives of children, families and the community as a whole. RBA is also used by agencies to improve the performance of their programs.

How does RBA work?

RBA *starts with ends and works backward, step by step, towards means*. For communities, the ends are conditions of well-being for children, families and the community as a whole. For example: "Residents with good jobs," "Children ready for school," or "A safe and clean neighborhood" or even more specific conditions such as "Public spaces without graffiti," or "A place where neighbors know each other." For programs, the ends are how customers are better off when the program works the way it should. For example: The percentage of people in the job training program who get and keep good paying jobs.

Why use RBA?

RBA improves the lives of children, families, and communities and the performance of programs because RBA:

- gets from talk to action quickly;
- is a simple, common sense process that everyone can understand;
- helps groups to surface and challenge assumptions that can be barriers to innovation;
- builds collaboration and consensus; and
- uses data and transparency to ensure accountability for both the well being of children, families and communities and the performance of programs.

What is the RBA Guide?

The RBA Guide is a tool for leading or facilitating a group in the use of RBA in decision making. The RBA Guide is designed to be used as a roadmap with which to navigate the complete RBA decision-making process, step-by-step.

II. THE RBA "TURN-THE-CURVE" TEMPLATE

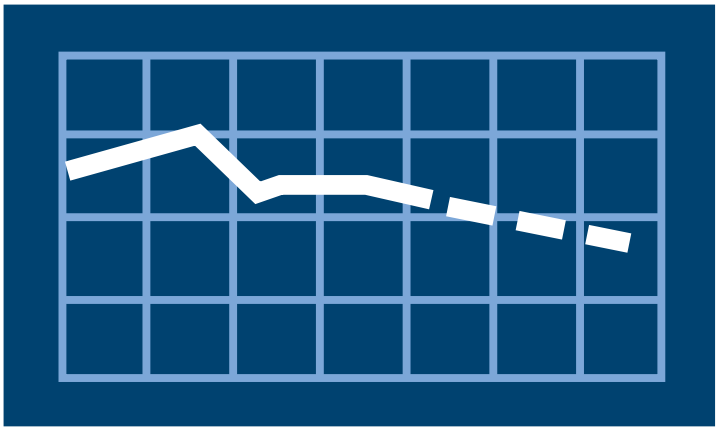
This template is an overview of the step-by-step RBA "turn-the-curve" decision-making process.

1 What is the "end"?

Choose either a result and indicator or a performance measure.

2 How are we doing?

Graph the historic baseline and forecast for the indicator or performance measure.



3 What is the story behind the curve of the baseline?

Briefly explain the story behind the baseline: the factors (positive and negative, internal and external) that are most strongly influencing the curve of the baseline.

4 Who are partners who have a role to play in turning the curve?

Identify partners who might have a role to play in turning the curve of the baseline.

5 What works to turn the curve?

Determine what would work to turn the curve of the baseline.
Include no-cost/low-cost strategies.

6 What do we propose to do to turn the curve?

Determine what you and your partners propose to do to turn the curve of the baseline.

III. STEP-BY-STEP RBA TURN-THE-CURVE PROCESS

The following is a step-by-step guide for conducting an RBA decision-making process to get from talk to action.

1. What is the end?

The starting point in "turn-the-curve" decision making is to identify the desired "end." Is it to improve the quality of life for a population (population accountability) or does it concern how well a program, agency or service system is performing (performance accountability)?[1]

If the focus is Population Accountability:

- Begin by identifying a *population* (e.g., all children in a county).
- Next ask what quality of life or condition is desired for that population (e.g., entering school fully ready) - which is called a "*result*."
- Then ask how will the extent to which that result is being achieved be gauged (e.g., a developmental assessment of kindergartners), which is called an "*indicator*."

To select an indicator (2 or 3 at the most) for a result, use the following criteria:

■ **Communication Power:** Does this indicator communicate to a broad range of audiences? Would those who pay attention to your work (*e.g.,* voters, legislators, agency program officers) understand what this measure means?

■ **Proxy Power:** Does this indicator say something of central importance about the result? Is this indicator a good proxy for other indicators? Data tend to run in a "herd" - in the same direction. Pick an indicator that will tend to run with the herd of all of the other indicators that could be used (so it is possible to use only 1 to 3 indicators).

■ **Data Power:** Is there quality data for this indicator on a timely basis? To be credible, the data must be consistent and reliable. And timeliness is necessary to track progress.[2]

If you are focused on Performance Accountability:

- Begin by identifying the program, agency, or service system.
- Next select a performance measure. There are three kinds of performance measures:
  - How much are we doing?
  - How well are we doing it?
  - Is anyone better off?

Appendix A describes the process for developing and selecting performance measures.

2. How are we doing?

After you have selected your indicator or performance measure, present the corresponding data on a graph with:

1 This distinction between population and performance accountability allows two different assessments: first, what efforts and programs should be undertaken to achieve a desired quality of life or "result" and, second, how well are those efforts and programs performing. This distinction also recognizes that a single program, agency or service system cannot take sole responsibility (or credit) for achieving a desired result.

2 Note: If an indicator is strong on the first two criteria but data is not available, consider putting that indicator onto a "data development agenda."

(a) an historic baseline (at least 5 years of data, if available) and

(b) a forecast *assuming no change in your current level of effort* (for 3 - 5 years, if possible).

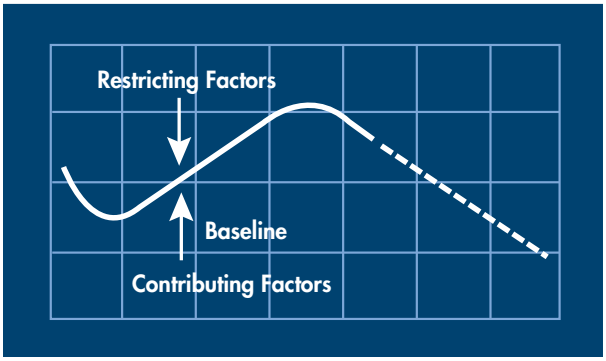
To provide the forecast, you will need to complete step 3, the "Story Behind the Curve." Turn-the-curve decision making is systematically determining the best actions to take to improve on the forecasted trend for the baseline - to "turn the curve."

3. What is the story behind the curve?

In this section, list the key factors underlying the historic baseline and forecast for the indicator or performance measure. Identify: (1) contributing factors that are supporting progress and (2) restricting factors that are hindering progress. Progress is defined as turning the curve of the baseline (or accelerating the curve if it is already headed in the right direction).

This "force field analysis," below, illustrates how factors may be viewed according to their contributing and restricting influences on the curve of the baseline.

Force Field Analysis



It is important to identify not just the most immediate and easily observed factors impacting the baseline (i.e., the "proximate causes"), but to engage in the kind of rigorous analysis that will identify the underlying or more systemic factors (i.e., the "root causes"). It is also important to conduct additional research where necessary and feasible.

Once the root causes have been identified, prioritize those root causes according to which have the greatest influence on progress and, therefore, are the most critical to address to improve progress.

The best format is a "bullet" for each root cause with a brief header that is underlined and a brief description of the root cause.

4. Who are partners who have a role to play in turning the curve?

Identify potential partners who may have a role to play in improving progress. The identification of root causes impacting progress will often point the way to the types of partners who should be engaged.

5. What works to turn the curve?

Before selecting a strategy to undertake to turn the curve of the baseline, it is necessary to determine whether what would work to turn the curve is known. And it is important to be sure to explore the full range of options for strategies. A strategy may, of course, involve the discontinuation of existing activities as well as the implementation of new ones. And a strategy should be multi-year and integrated. The following are criteria to consider in developing options:

- *Does the option address one or more of the root causes you have identified?*

  The alignment of a proposed option with a root cause provides the rationale for selecting that particular option: it is the link between the "end" (as measured by the indicator or performance measure and the "means" (the strategy).

- *Is the proposed option evidence-based?*

  What research or other evidence is available to demonstrate that the strategy has a reasonable chance of turning the curve of the baseline? There may, of course, be times that data are limited and you must move forward with the best judgment of experienced professionals; however, in most cases a strategy should be supported by research or evidence.

- *Have "no-cost/low-cost" options been developed?*

  Funding is often a critical need and careful thought must be given to ways to increase funding where needed. However, it is equally important to explore "no-cost/low-cost" options (*i.e.,* options that may be pursued with existing resources). This line of inquiry, in turn, can help to surface outdated assumptions that stand in the way of innovation.

- Is additional research necessary to determine what would work or to identify other options?

6. What do we propose to do to turn the curve?

Selecting the proposed strategy involves applying four criteria to each of the options: leverage, feasibility (or reach), specificity, and values.

■ **Leverage:** *How strongly will the proposed strategy impact progress as measured by the baselines?*

Given that resources are finite, decisions with respect to the dedication of resources to a proposed strategy must be based on the expected impact of those resources on progress. One way to gauge impact is to assess the importance of the underlying root cause(s) an option is designed to address. In other words, the strategy that is proposed should address the most important root causes identified and, therefore, be geared to having the greatest potential impact on the trend for the corresponding baseline. This concept is sometimes referred to as "leverage."

■ **Feasibility (or reach).** *Is the proposed strategy feasible?*

Can it be done? This question is the necessary counterpart to the question of leverage. Questions of feasibility should be handled so as not to limit innovation. Sometimes the consideration of an apparently infeasible option will be the catalyst in the thinking process that leads to a highly creative and feasible option. Once ways to improve feasibility have been adequately explored, however, then leverage and feasibility must be weighed and balanced in choosing the strategy. A strategy that has high leverage and high feasibility will, of course, be a prime candidate for action. The choice among other options, however, will likely involve trade-offs between leverage and feasibility and will need to be weighed accordingly.

■ **Specificity.** *Is the strategy specific enough to be implemented?*

Is there a timeline with deliverables that answers the questions: *Who? What? When? Where? How?* There should be budget detail for the strategy, including implications for future budgets.

■ **Values.** *Is the strategy consistent with the values of the community and/or agency?*

Once the proposed strategies are selected, list them in order of priority. The best format is a "bullet" for each strategy which provides a brief header that is underlined and a brief description of the strategy.

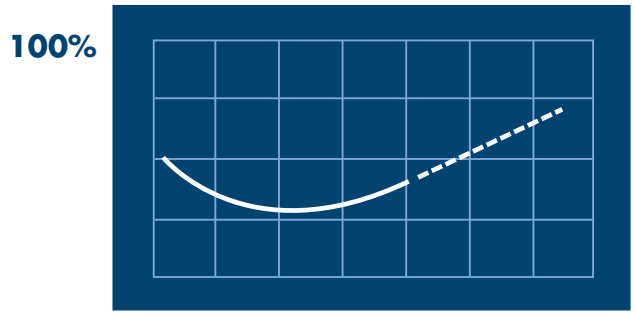
IV. AN ACCOUNTABILITY TOOL

The "Turn-the-Curve" template is not meant to be used to produce a static document; rather, it is intended to be used as a tool. On an ongoing basis, in consultation with key partners, stakeholders should use the data to assess progress and systematically adjust strategies where necessary to improve progress. The following schematic, a succinct RBA reporting format, demonstrates the nature of this ongoing process.

Results-Based Accountability™

Result and Indicator or Performance Measure

Data presented as a graph, with both an historic baseline and a forecast.



Story behind the curve

Key factors (positive and negative, internal and external) impacting progress (*i.e.,* impacting the curve of the baseline).

What we propose to do to improve progress

Feasible, high-impact actions/strategies with specific timelines and deliverables. Partners with roles to play in improving progress.

Monitor both implementation and the baseline for improvement and, as new data are obtained, repeat the process.

APPENDIX A

Performance Measures

Introduction

The selection of performance measures is the first and most essential step in the performance planning process for each element of the Population Accountability strategy. The following directions will assist you in choosing your headline performance measures.

What are Performance Measures?

Your agency/division/program provides services that improve, in some way, the quality of life of its customers/clients. Performance measures simply give you the means to know how well the agency/division/program is doing at providing those services and improving those lives.
A good performance measure gives you and your staff the ability to make changes and see whether those changes improve the agency/division/program's performance, that is, its ability to improve customers/clients' quality of life.

Importantly, performance measures are data - they quantitatively measure the agency/division/program's performance.

The following Data Quadrant, Figure 1, is a useful tool for sorting and categorizing performance measures.

Sorting Performance Measures: The Data Quadrant

All performance measures fit into one of four categories. The categories, the four quadrants, are derived from the intersection of *quantity* and *quality* and *effort* and *effect*.

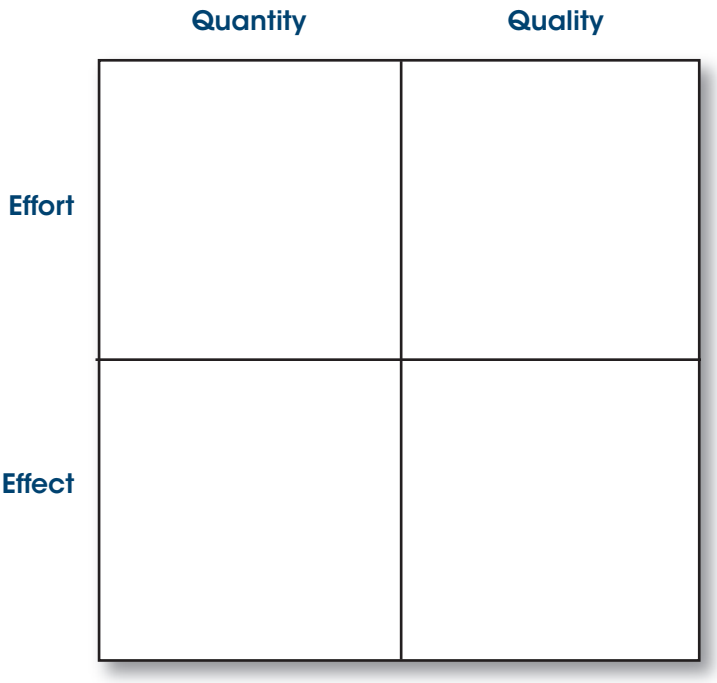


Figure 1

The rows separate measures about effort (what is done and how well) from measures about effect (the change or impact that resulted), the columns separate measures about quantity (of the effort or effect) from measures about quality (of the effort or effect).

Figure 2 shows how these combinations lead to three universal performance measures: *How much did we do? How well did we do it? Is anyone better off?* The most important performance measures are those that tell us whether our clients or customers are better off as a consequence of receiving the services ("client results," the lower left and right quadrants). The second most important measures are those that tell us whether the service or activity is done well (upper right quadrant). The least important measures are those that tell us what and how much we do. To answer the two most important questions, that is, to identify candidate for the most important performance measures, follow the following steps, using the Data Quadrant.

Step 1: How much did we do? *Upper Left Quadrant*

First, list the number of clients served. Distinguish different sets of clients as appropriate. Next, list the activities or services the department/division/program performs for its clients. Each activity or service should be listed as a measure. For example, "child welfare casework" becomes "# of child welfare cases" or "# of FTEs conducting child welfare case work." "Road maintenance" becomes "# of miles of road maintained." "Stream monitoring" becomes "# of stream sites monitored." "Provide health care" become "number of patients treated."

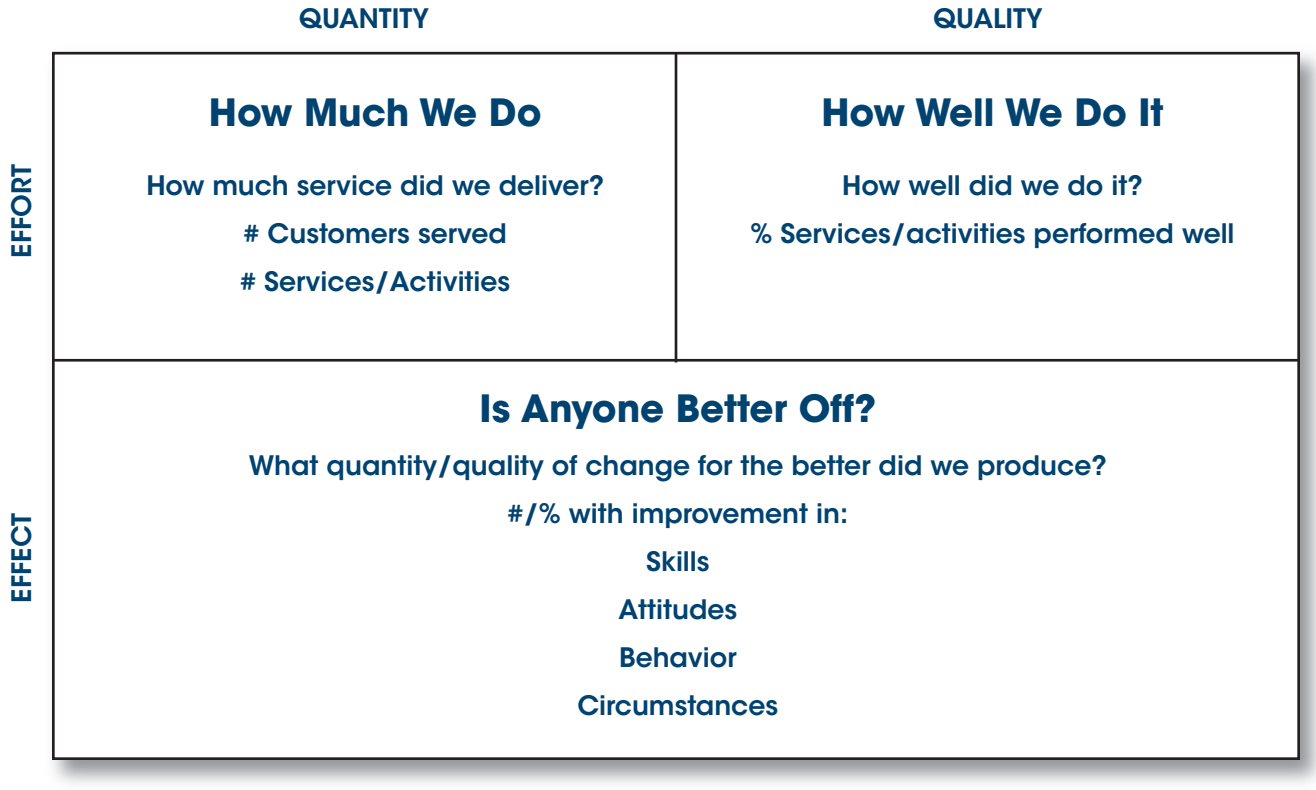


Figure 2

Step 2: How well did we do it? *Upper Right Quadrant*

This quadrant is where most traditional performance measures are found. For each service or activity listed in the upper left quadrant, choose those measures that will tell you if that activity was performed well (or poorly). The measures should be specific. For example, ratio of workers to child abuse/neglect cases; percent of maintenance conducted on time; average number of sites monitored per month; percent of invoices paid in 30 days; percent of patients treated in less than an hour; percent of training staff with training certification.

Step 3: Is anyone better off? *Lower Left and Lower Right Quadrants*

Ask "In what ways are your clients better off as a result of getting the service in question? How would we know, in measurable terms, if they were better off?" Create pairs of measures (# and %) for each answer. Four categories cover most of this territory: skills/knowledge, attitude, behavior, and circumstances (e.g., a child succeeding in first grade or a parent fully employed). Consider all of these categories in developing measures of whether clients are better off. Examples are: #/% of child abuse/neglect cases that have repeat child abuse/neglect; #/% of road miles in top-rated condition; #/% of cited water quality offenders who fully comply; #/% of repeat audit findings;

Selecting Headline Performance Measures

Key to ensuring the usefulness of performance measures is to limit the number used. In most cases, select from the list of candidate measures 3 to 5 "headline measures" (in total, from both the upper right and lower right quadrants). To select these headline measures, rate each candidate measure using the following three criteria (similar to the criteria for selecting indicators):

Communication Power: Does this measure communicate to a broad range of audiences? Would those who pay attention to your work (*e.g.,* voters, legislators, agency program officers) understand what this measure means?

Proxy Power: Does this measure say something of central importance about your department/division/program? Is this measure a good proxy for other measures? For example, reading on grade level might be considered a proxy for other measures such as attendance, quality of the curriculum, quality of the teachers, etc.

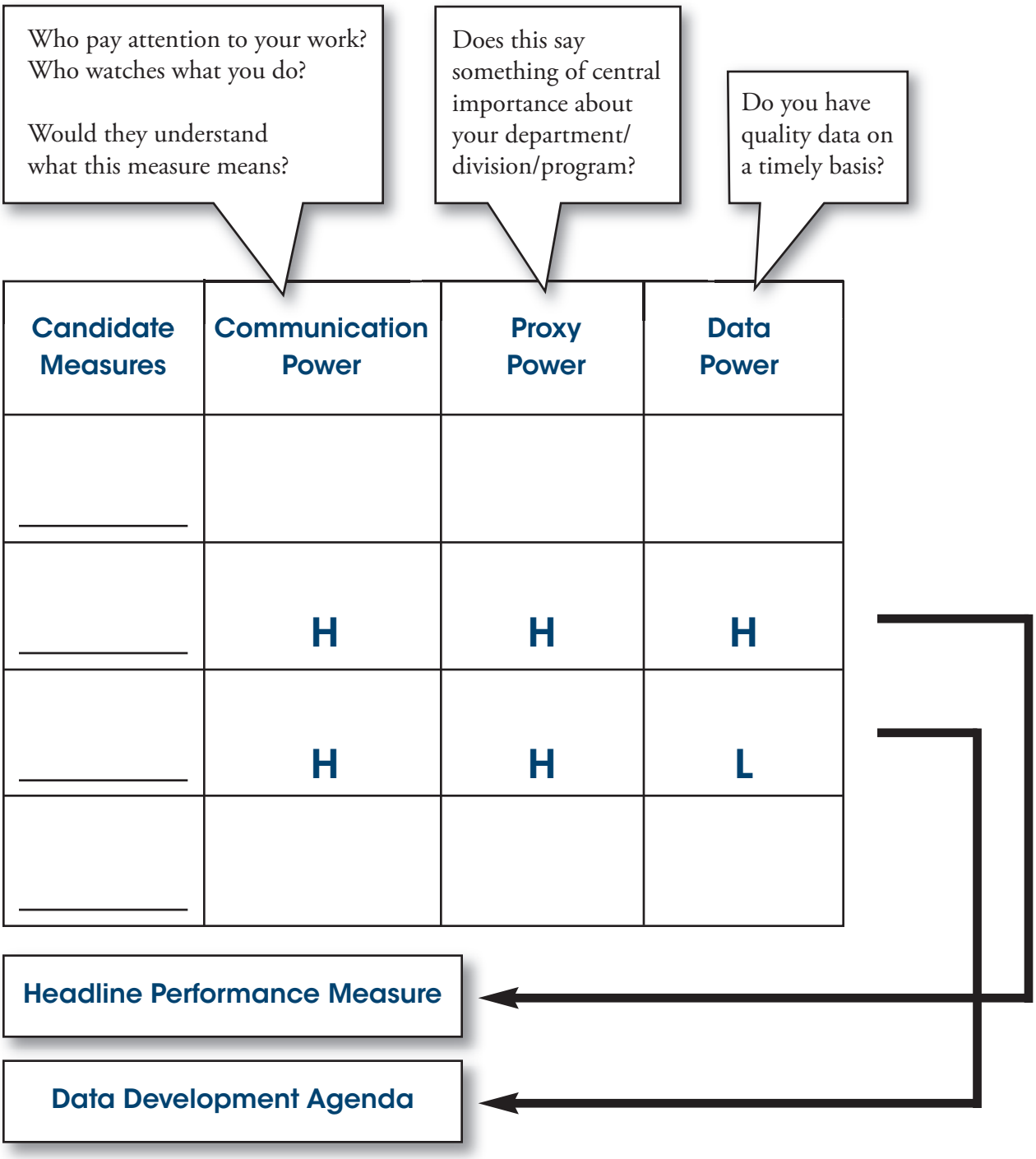
Data Power: Do you have quality data for this measure on a timely basis? To be credible, the data must be consistent and reliable. And timeliness is necessary to track progress.

Rate each candidate measure "high," "medium," or "low" for each criterion. Use a chart, like the one shown below, "Selecting Headline Performance Measures." The candidate measures that have high ratings for all three criteria are good choices for headline measures.

For those measures that are rated high for communication and proxy power, but medium or low for data power, start a data development agenda. These are measures for which you might want to invest resources to develop quality data that would be available on a timely basis.

Selecting Headline Performance Measures

Directions: List candidate performance measures and rate each as **H**igh, **M**edium, or **L**ow on each criterion: Communication Power, Proxy Power, and Data Power.



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