

UCLA

UCLA Electronic Theses and Dissertations

Title

Street Medicine: Doctoring and Homelessness Governance in the City of Angels

Permalink

<https://escholarship.org/uc/item/7gz898wv>

ISBN

9798171607227

Author

Del Mastro Naccarato, Irene

Publication Date

2026-10-19

Peer reviewed|Thesis/dissertation

UNIVERSITY OF CALIFORNIA

Los Angeles

Street Medicine: Doctoring and Homelessness Governance in the City of Angels

A dissertation submitted in partial satisfaction of the
requirements for the degree Doctor of Philosophy in Sociology

by

Irene Del Mastro Naccarato

2026

© Copyright by

Irene Del Mastro Naccarato

2026

ABSTRACT OF THE DISSERTATION

Street Medicine: Doctoring and Homelessness Governance in the City of Angels

by

Irene Del Mastro Naccarato

Doctor of Philosophy in Sociology

University of California, Los Angeles, 2026

Professor Stefan Timmermans, Chair

What challenges and opportunities arise when providing health care to a population that is constantly policed, experiences severe illnesses driven and sustained by adverse living conditions, and distrusts service providers? Drawing on a two-year ethnography of street medicine in Los Angeles, including participant-observations of more than 355 patient-doctor interactions and 43 in-depth interviews, this dissertation analyzes the daily work of street clinicians, medical providers who deliver health care to unhoused people directly where they live. Chapter 1 explains how organizational arrangements that made street medicine feasible contributed to a distribution of care organized primarily around institutional logics rather than medical acuity. The second chapter analyzes street clinicians' struggle for continuity of care, showing that they go beyond professional mandates and domains to mitigate, and sometimes reverse, the impact of systemic factors and material constraints that make their patients unlocatable, inaccessible, and unserviceable. Chapter 3 discusses how street clinicians build and sustain trust with patients, a time-consuming, labor-intensive process that, while key to engaging those who refuse care, also creates an allocation paradox: the methods that promote patient engagement can also limit their reach and the intensity of care providers can offer. I argue that

street medicine is a care-oriented and treatment-intensive intervention that improves unhoused people's well-being by lifting substantial barriers to health care. However, structural constraints limit its reach, emotionally and physically drain providers, and make the breadth of care depend on providers' discretion and professional networks, potentially reproducing health disparities. My findings intervene in theories of poverty governance by showing how medical professional authority produces governing strategies that extend beyond the poor's physical survival. They also contribute to medical sociology debates about clinicians' role in advancing the health of the poor by showing how doing so requires navigating the criminal-legal and welfare systems and extending their work beyond professional domains and mandates through both clinical and non-clinical means. Finally, this dissertation contributes to the health disparities literature by showing that access to health care among people experiencing extreme poverty is both addressed and reproduced beyond traditional health care settings.

The dissertation of Irene Del Mastro Naccarato is approved.

Abigail C. Saguy

Christopher J. Herring

Danielle T. Raudenbush

Enrico G. Castillo

Stefan Timmermans, Committee Chair

University of California, Los Angeles

2026

DEDICATION

Para Grace, Marco e Paola.

CONTENTS

ABSTRACT OF THE DISSERTATION	ii
DEDICATION	v
LIST OF FIGURES	viii
LIST OF ABBREVIATIONS	ix
ACKNOWLEDGEMENTS	x
VITA	xiii
PUBLICATIONS	xiv
INTRODUCTION	1
CHAPTER 1	27
BECOMING A PATIENT: THE INSTITUTIONAL LOGICS OF HEALTH CARE	
DISTRIBUTION BEYOND HOSPITAL WALLS	27
INSTITUTIONAL VISIBILITY	28
MEDICAL HOMELESSNESS GOVERNANCE	45
CHAPTER 2	50
UNFINDABLE, INACCESSIBLE, AND UNSERVICEABLE: THE STRUCTURAL	
IMPAIRMENT OF CARE AND THE STRUGGLE AGAINST IT	50
STRUCTURAL IMPAIRMENTS	51
NAVIGATING STRUCTURAL IMPAIRMENTS	64
“THE BEST CARE IS THE CARE YOU ACTUALLY GET”	75
CHAPTER 3	80
CRAFTING PATIENT ENGAGEMENT: AUTONOMY, TRUST, AND THE	
ALLOCATION PARADOX	80

BUILDING AND SUSTAINING TRUST: STRATEGIES FOR PATIENT	
ENGAGEMENT	81
THE ALLOCATION PARADOX	89
FACING THE PARADOX	95
CONCLUSIONS	103
REFERENCES	114

LIST OF FIGURES

Figure 1. Text message sent by street clinician to author	58
---	----

LIST OF ABBREVIATIONS

ED	Emergency Department
HSA	Homeless Services Agency
PCP	Primary Care Provider
SM	Street Medicine

ACKNOWLEDGEMENTS

I thank every unhoused person who allowed me to observe their medical encounters and those who generously agreed to talk to me and share some of their most painful experiences, which no human being should ever have to endure. I am also incredibly thankful to the street doctors, nurses, physician assistants, case managers, peer navigators, and program directors who opened their office doors and vans so I could shadow them for hours at a time and ask countless questions. Your work is absolutely critical.

I would like to acknowledge my advisor, Stefan Timmermans, for his support all these years. He carefully read my work and gave me feedback that encouraged me to stay truthful to the data while focusing on the most interesting, sociologically relevant, and impactful aspects of it. Stefan celebrated my accomplishments and offered both personal and professional advice during the most challenging parts of this process. I was also lucky to have Chris Herring on my committee. Chris' detailed, constructive feedback and challenging questions consistently improved my work and funding applications, as did the books and articles he shared with me on numerous occasions. My journey in UCLA Sociology would not have been the same without Abigail Saguy's genuine care and thoughtful advice. It was in Abby's class that I first thought of myself as a writer and what that meant in terms of organizing my time and ideas.

I also want to thank Danielle Raudenbush and Enrico Castillo for their feedback and Randall Kuhn for bringing me into his research team, PATHS. Being part of PATHS gave me an academic community, including two amazing research assistants, financial support, and the opportunity to work more closely and collaboratively with street medicine programs. The American Sociological Association, the Center for Engaged Scholarship, the Haynes Foundation, and UCLA's Department of Sociology provided additional financial support for my dissertation.

I would also like to acknowledge the role of friendship in this process. Thanks to Lorena and Victoria for the long beach days, the movies, and all the dinners and chismes we shared. Beyond all the fun, Vic also proofread and gave feedback on some of my work, and she was always willing to help me figure out (and vent about) the administrative pieces and professional conventions of becoming a sociologist in the U.S. Lore and I navigated the emotional and bureaucratic hurdles of being international students together; she was a piece of Lima in Los Angeles I did not know I needed until she arrived. Maïlys and Priscila were also my emotional home in LA; their stories, their families, and their precious company gave me much-needed distance from grad school and reminded me of life beyond academia.

Back in Lima, I had the most amazing support system. Sharon was always a couple blocks or a video call away, ready to celebrate even my smallest accomplishments or give me her full attention and warmest comfort when I was overwhelmed. Her fieldwork stories in a women's prison and her work as a sociologist bureaucrat always sparked questions for my own work. I am forever grateful to Alix, Ana, Angélica, Cristina, Soundra, Vilma, and Ximena for not caring at all about my dissertation. Instead, they did what they have done for the past 30 years of our friendship: made fun of me, made me laugh until tears, swam in the sea with me, welcomed me into their homes, and had both the most wholesome and the most absurd conversations with me. All of that created the space I needed away from my sociologist dissertation-writer persona; a distance that let me sit more comfortably in that role and give it my best. Experiencing life by your side is an absolute gift; thank you.

Family was also essential throughout this process. My parents, Paola and Marco, hold me and inspire me every day through their brilliance as an anthropologist and sociologist and their unconditional love. Along with his ease in conversation and infinite curiosity, my dad also

instilled in me his passion for soccer, a sport that kept me sane and happy throughout the dissertation marathon. My mom's research and advocacy in a foreign country and language showed me how far love and a passion for social justice can take us. Thanks to my brothers: Francesco's perspective on mental health accompanied me on every street medicine ride I took and in every interview I conducted; without Leonardo's company, complicity, and generosity during each of my visits to Lima, I would not have been able to continue writing while also enjoying much-needed family time; and Sebastián's visit to LA was one of the most joyful and refreshing times during my fieldwork. I also want to thank Louisa and Tim for opening their gorgeous, peaceful home, where I spent a year analyzing hundreds of pages of interview transcripts and field notes, while keeping me company with daily meals and conversations they so generously shared.

Finally, this project would not have been possible without Grace. I am grateful for you coming to LA during my fieldwork—probably the most telling proof of love you can ask of a Northern Californian—for proofreading earlier versions of my dissertation and funding applications, for giving me comfort and perspective when things did not go as I expected, and for hearing me articulate my arguments out loud and challenging them. These last months of frantic writing would have been much harder, and far less joyful, without the nurturing food you grew and cooked for us, and the wonderful home and family we have built together. Thank you, Grace; you are intellect and emotion, grounding and inspiration, adventure and care, love and joy.

VITA

Education

2026	(Expected) PhD in Sociology, University of California, Los Angeles (UCLA)
2021	Master of Arts in Sociology, University of California, Los Angeles (UCLA)
2017	Master of Arts in Gender and Women's Studies, University of Wisconsin, Madison (UW Madison)
2012	Bachelor of Arts in Sociology, Pontificia Universidad Católica del Perú (PUCP)

Research Positions

2024-2025	UCLA Department of Community Health Sciences, "Periodic Assessment of Trajectories of Housing, Homelessness, and Health Study (PATHS)," <i>Graduate Research Assistant</i> , Principal Investigator: Dr. Randall Kuhn
2024	UCLA Department of Family Medicine, "LatinX/Hispanic Attitudes and Perspectives on Investigations and Studies of New Drugs," <i>Graduate Research Assistant</i> , Principal Investigator: Dr. Derjung Tarn
2023	UCLA Department of Sociology, "Perceptions and Experiences of the Formerly-Incarcerated with Ban-the-Box," <i>Graduate Research Assistant</i> , Principal Investigator: Dr. Christopher Herring
2017-2018	Universidad Peruana Cayetano Heredia, "Multi-level evaluation of Maternal and Prenatal Care at Rural Health Centers in the Peruvian Amazon," Kuskaya Global Health Research Training Fellow, Principal Investigator: Dr. Magaly Blas
2015-2016	UW Madison, "Representing Women and Indigenous Peoples in Ecuador," <i>Graduate Research Assistant</i> , Principal Investigator: Dr. Christina Ewig

Selected Fellowships, Honors, and Awards

2026	Center for Engaged Scholarship Small Grant Fellows Program
2025-2026	Haynes Lindley Doctoral Dissertation Fellowship
2024-2025	Center for Engaged Scholarship Dissertation Fellowship
2024	ASA Doctoral Dissertation Research Improvement Grant
2022	UCLA Graduate Summer Research Mentorship Program
2022	UCLA Bedari Kindness Institute Graduate Fellowship Program
2021-2022	UCLA Graduate Council Diversity Fellowship
2019-2021	UCLA Graduate Dean's Scholar Award
2017	NIH/Fogarty Kuskaya Global Health Research Training Fellowship
2017	UW Madison Worcester/Whatley/Leavitt Award
2016	UW Madison Tinker Nave Short-Term Field Research Grant
2016	UW Madison Graduate School Research Travel Award

PUBLICATIONS

Peer-Reviewed Journal Articles

Kuhn, R., Chien, J., **Del Mastro N, I.**, Saluja, S., Landrian Gonzalez, A., Cui-Naudet, G., Corletto, G., Ozuna, S., Zunner-Keating, B.P., Weaver, K. C., King, C., Robinson, C., Henwood, B.F.(In Press). Systemwide Evaluation of Field Medicine Programs in Los Angeles County: Protocol for a Mixed Methods Longitudinal Observational Study. *JMIR Research Protocols*. <https://preprints.jmir.org/preprint/94248>

Liu, R.Y., Schwartz, J.B., Renero-Haman, B, **Del Mastro N, I.**, Tarn, D.M. (2025). Attitudes about clinical trials of medications in older Hispanic/Latino adults with multimorbidity. *Journal of the American Geriatrics Society*.

Del Mastro N, I. (2022). Providing culturally competent and universal health care in the Peruvian Amazon: The role of medical authority. *Social Science & Medicine*, 315, 115556.

Del Mastro N, I. (2021). Adapting to poverty and dealing with gender: a comparative perspective on teenage pregnancy in the Peruvian Amazon. *Culture, health & sexuality*, 1-15.

Del Mastro N, I., Llaca, P, Reinders, S., Perez, R., Solis, Y., Alva, I., Blas, M. M. (2021). Home birth preference, childbirth, and newborn care practices in rural Peruvian Amazon. *PLoS ONE*, 16(5) : e0250702. <https://doi.org/10.1371/journal.pone.0250702>

Toyama, M., Diez Canseco, F., Busse, P., **Del Mastro N, I.**, Miranda, J. (2018). Design and validation of a set of SMS to promote seeking of specialized mental health care within the Allillanchu Project. *Global Health, Epidemiology and Genomics* 3, e2, 1-9 pp.

Del Mastro N, I. (2015). Entre Madres Adolescentes y Adolescentes-Madres: Un análisis de su trayectoria de vida y los factores que influyen en su configuración. ["Between Adolescent Mothers and Mothering Adolescents: A qualitative life course analysis and the factors that shape it."]. Bachelor Thesis. *Debates en Sociología* 40, 31- 60 pp.

Stuart, J., Poémape, S., & **Del Mastro N., I.** (2015). En busca del bienestar: Barreras y posibilidades percibidas por las mujeres transexuales para acceder a los servicios de salud en iquitos [Seeking well-being: Transgender women's perceived barriers and pathways to healthcare access in Iquitos]. *Argumentos*, 2(9)

Book Chapter

Del Mastro N., I. “Prefiero que seas puta a que seas leca”: El impacto de la heteronormatividad en el embarazo adolescente. ["I'd rather you be a whore than a dyke": Queer teen moms coping with stigma, maternity expectations, and the cultural intelligibility of gender]. (2018) In Hernández, W. *Género en el Perú: Nuevos Enfoques, Miradas Interdisciplinarias*. Lima: Universidad de Lima & Centros de Investigaciones Económicas y Sociales.

INTRODUCTION

It is 8:45 in the morning, and Dr. Stevenson, his medical assistant, and I arrive at the parking lot of CARE, a homeless services agency. It was a short drive from the clinic where Dr Stevenson worked, but we saw several people sleeping on the sidewalks. In the parking lot, two case managers from CARE, Joseline and Margaret, gave Dr. Stevenson an overview of the clients he would see that day. We first drove to see Shaquila, a young woman recently released from jail. Margaret stood next to her and told Dr. Stevenson, "Shaquila here is interested in the antipsychotic injectables." Shaquila interrupted her and said, "No, I don't give my consent to that." Margaret took a deep breath and reframed what she just said, "Well, her parole [officer] says she needs to be medicated."

In her conversation with Dr Stevenson, Shaquila insisted that she does not need psychiatric medications; she needed a place to live where she is not at risk of being raped and assaulted like she feels she is now. When explaining her fears, her voice cracked and Dr. Stevenson asked her, "what is going on with you right now?" Shaquila stayed silent. Margaret came back and Dr. Stevenson told her that Shaquila "is not ready for medication right now." Shaquila intervened, saying that taking the medication her parole officer wants her to take will put her at risk. She needs to be alert given "all the serious shit" that she is exposed to. Dr. Steven pushed back a little, saying that the medication is going to help her have more clarity, make better decisions, avoid getting in trouble, and not be violent. Shaquila did not change her mind about medication and eventually left.

After Shaquila was gone, Margaret told Dr. Stevenson that if Shaquila does not take her medication, she could get back to jail. Dr. Stevenson said that since it was the first time they had seen her, they had to wait. He added that it was particularly difficult to convince Shaquila of anything considering "how psychotic she is right now." He paused and reflected, "Some of the things are real, of course. Look at this place. But some stuff is in her mind." "It is tricky," he said to me, "is she psychotic or is it just that she's living in a terrible place?" Then he asked Margaret if she could move Shaquila to a single room.

Dr Stevenson is one of many clinicians across the nation who practice street medicine, the provision of healthcare and health-related services to unhoused people outside traditional health care settings (Withers 2011). Although their role is to simplify and expand access to healthcare for patients, delivering it remains challenging. As the vignette shows, street clinicians face at least three major challenges. First, in a city with thousands of unhoused people, they must decide whom to serve. In other words, why did Shaquila and not the dozens of people we drove by get to see Dr Stevenson? Second, as Dr. Stevenson reflected, their patients have complex health care

needs that street providers cannot address in a single visit or on their own. For instance, as much as Shaquila needed psychiatric medications, she also needed a safe place to live. Similarly, other patients might have medical conditions that require seeing a specialist or using technology not available on the streets. Third, as we saw in the interaction between Shaquila and Dr. Stevenson, just because people need health care does not mean they want it. Offering unsolicited health care may seem suspicious to anyone, regardless of housing status, but especially to a population whose interactions with front-line workers are often marked by coercion and conditional care.

This dissertation aims to understand how street clinicians navigate the challenges of providing care amid limited resources, multiple and complex health care needs, and potential distrust. In that sense, it examines whether and how street medicine transforms unhoused people's access to health care and overall well-being.

For over 30 years, street medicine teams have delivered free health and social services to unhoused people directly where they live and on their own terms (Feldman et al. 2023). In 2018, leaders of the street medicine movement sought to transform it from a fringe grassroots effort into an organized model of health care. Street medicine is now present in more than 100 U.S. cities, rapidly becoming part of government and private-sector responses to homelessness across the country (Narayan, Shah, and Hochman 2024). Although still limited, a growing body of research suggests that patients value street-based care, that it improves several health outcomes, and that it can reduce unhoused people's use of emergency services and length of hospital stays (James, Greenhill, and Sullivan 2023; Lynch et al. 2022; Perna et al. 2024). Yet this literature often overlooks or oversimplifies the challenges street medicine teams must navigate and the compromises they make in achieving these outcomes.

Street medicine teams do not operate in a vacuum; they are part of what scholars call the “institutional circuit” of poverty governance (Hopper et al. 2006). As the vignette shows, Dr. Stevenson’s work was connected to, yet independent of, that of the case managers at the homeless services agency and Shaquila’s parole officer. Poverty governance is shaped by public agencies, private entities, and nonprofit organizations whose fragmented yet interconnected work regulates the poor, typically through punishment, disciplining, and care (DiMario 2022; Soss, Fording, and Schram 2011; Stuart 2016; Wacquant 2009).

Medicine, both as a discourse and a practice, is critical in poverty governance; it is a tool within welfare and penal institutions to not only keep the poor alive but also to define their deservedness in the distribution of services, justify their involuntary displacement and containment, and control their behavior (Gowan 2010; Knight 2015; Lyon-Callo 2000; Seim and DiMario 2023; Sufrin 2017). Outside these institutions, medicine still shapes and is shaped by them; health care professionals in emergency rooms and ambulances regularly exchange caseloads with other frontline workers, such as police officers and service providers, who can both complement, expand, and complicate their work (Herring 2019; Lara-Millán 2014; Seim 2020). Situating street medicine as part of poverty governance, that is, in relation to other organizations involved in the regulation of their patients, will shed light on how street clinicians navigate the challenges of their work and its consequences beyond individual health outcomes.

Street medicine is also located within the broader context of America’s health care. This is a multi-player, financially driven, and biomedically focused system where clinicians’ power over what they can do for their patients’ health is not unrestricted (Light and Levine 1988). For instance, Dr. Stevenson considered that, in addition to antipsychotic medication, Shaquila’s health needs included moving into a single room, but he did not have full authority over that.

Countervailing powers that mediate clinicians' ability to provide care to their patients include managed care plans, government agencies, hospitals, pharmaceuticals, and other actors (Mechanic 1991; Quadagno 2004). Restrictions on the types of medications, procedures, and services clinicians can order, perform, or refer patients usually follow a financial logic of reducing costs and maximizing revenue (Light 2010).

The type of care clinicians are able to provide is also constrained by biomedical parameters, that is, focused on addressing the biological, chemical, genetic, and physiological immediate causes of sickness rather than the social factors that contribute to it (Mishler 1981; Waitzkin 1991; Whitehead 2013). This is not to say that clinicians have lost all control over their practice, that their decisions are driven primarily by profit rather than altruism and a commitment to advancing population health (Timmermans and Oh 2010), or that they remain indifferent to the social causes of illness and disease. Rather, understanding street medicine's impact on patients' health requires situating their clinical practice within a broader health care system that creates both opportunities and constraints.

Even if they had access to all health and health-related resources their patients need, clinicians cannot use them if the patient is unwilling to accept care, like Shaquille rejecting the antipsychotic Dr. Stevenson could have provided to her. Patients in the U.S. are unlikely to encounter an authoritarian doctor who imposes diagnoses and treatment plans as definitive and certain, as was once the norm (Fox 1957; Parsons 1951). A patient who unwaveringly trusts their clinician is also becoming less common (Andreassen and Trondsen 2010; Fox and Ward 2006). The patient-doctor interaction, the backbone of health care as it allows diagnoses, treatment, and prognoses to unfold, has changed drastically in the last few decades (Heritage and Maynard 2006).

The rise of malpractice lawsuits and bioethics, along with growing access to health information through the internet and alternative healing, has made the distribution of power in the medical encounter more even (Timmermans 2020). To improve patient compliance and health outcomes, providers are now expected to foster a collaborative environment in their interactions with patients, including encouraging patients to share the multiple manifestations of their symptoms and their emotions about treatment (Mead and Bower 2000; Underman and Hirshfield 2016). At the same time, clinicians expect an engaged patient who advocates for their health and actively knows and expresses their preferences (Timmermans 2020). Given that unhoused patients face significant barriers to engaging in their health care, including distrust of medicine and competing needs such as securing food and safety, to better understand street medicine, we need to closely examine how the patient-clinician interaction unfolds, especially how patient engagement is cultivated.

Considering that street medicine is actively and glowingly part of the institutional circuit of homelessness governance and America's health care system, as well as the interactive nature of their work, the research question organizing this dissertation is: ***How do street medicine teams address the health needs of a patient population facing acute and intertwined social and medical risks while respecting their autonomy and working within and alongside organizations and a regulatory system that both constrain and facilitate their provision of care?*** I addressed this question through a two-year ethnography of street medicine services in Los Angeles. My ethnographic work consisted of participant observation of more than 355 patient-clinician interactions, 85 rides with street medicine teams, 43 in-depth interviews with unhoused individuals and street medicine providers, and multiple written documents, including newspaper articles, policies, and training materials.

Meeting People Where They Are

When Mayor of Los Angeles Karen Bass was asked, “What would you love to work on to address homelessness?” the former physician assistant replied, “Health. Health is at the root of a lot of homelessness” (Noah 2023). Mayor Bass has overseen the exponential growth of municipal-funded street medicine teams (Offner and Schrank 2025). Like LA, dozens of U.S. cities, including Pittsburgh, Boston, San Francisco, and New York City, allocate municipal funds to provide health care to the unhoused directly where they live, even though municipalities in the United States are not mandated to address their constituents' medical needs. Similarly, several counties across the country are using taxpayers' dollars to contract homeless outreach teams that include a healthcare provider. At the state and federal levels, Medicaid approved reimbursement for medical services provided on the streets to unhoused individuals nationwide in 2023 and authorized several states to expand Medicaid benefits to address homelessness beyond traditional healthcare settings (Hart 2023a). Alongside the government, private and state-funded institutions like hospitals, medical schools, and community clinics are increasingly extending their services to reach unhoused people directly where they live.

These policies and programs reflect the exponential growth of street medicine (SM). For over three decades, street medicine teams have delivered clinical and social services in the spaces where unhoused individuals live, including riverbanks, highway underpasses, and public parks (Withers 2011). The scope of services provided varies across programs (Enich, Tiderington, and Ure 2023). Street medicine programs provide social services ranging from basic clothing, food, and mail services to more complex support, such as housing navigation and enrollment in health insurance and financial benefits (Feldman et al. 2023). Medical services expand from wound care and immunizations to diagnosing and treating chronic diseases,

prescribing, dispensing, and administering medications (Enich et al. 2022; Feldman et al. 2023). These social and medical services aim to reduce the multiple barriers unhoused people face in accessing health care and prevent what is considered misuse of emergency services (Gelberg et al. 2011; Han and Wells 2003; Vohra, Paudyal, and Price 2022). Overall, street medicine teams aim to improve unhoused patients' health status, which is considerably worse than that of the housed population given the unique and extreme health risks they face on the streets (Brown et al. 2022; Chilman et al. 2025; Fazel, Geddes, and Kushel 2014).

Like other low-barrier models of care, central to SM is the ethos of “meeting people where they are,” which means not only reducing spatial barriers to care but also reconfiguring the terms of clinical interaction to accommodate the patient's current emotional state and physical environment (Frankeberger et al. 2023; Medellin, Moczygemba, and Thurman 2024). In contrast to traditional, institutionally bounded encounters, SM teams claim to operate through a harm reduction and trauma-informed approach that respects patients' immediate priorities, readiness for care, and lived realities, rather than imposing standardized clinical expectations or pathways (Stefanowicz, Feldman, and Robinson 2021; Withers 2011). This approach is expected to facilitate the co-production of treatment plans between patients and providers.

Over the past decade, street medicine has shifted from a marginal, at times stigmatized, grassroots practice to an increasingly institutionalized component of homelessness governance in the U.S. Approximately 150 SM programs now operate across 17 states and are increasingly integrated into formal healthcare and policy infrastructure (Hart 2023a). In California, for example, the number of programs grew from six in 2018 to more than 70 by 2024 (Feldman 2024). This growth largely stems from the multiple funding streams created in 2022 by the California Advancing and Innovating Medi-Cal program. Several states, including Pennsylvania,

Oregon, Hawaii, and New York, are following a similar trend in expanding street medicine after the Centers for Medicaid and Medicare Services created a billing code for medical services provided to unhoused people on the streets, enabling street medicine providers nationwide to bill these public insurers for their work (Narayan, Shah, and Hochman 2024). At the same time, local governments and hospital systems have played a central role in expanding street medicine by incorporating it into crisis response systems, encampment resolution programs, hospital discharge planning for unhoused patients, and broader community health initiatives (Budnyk 2023; Hanssmann et al. 2022; NYC Health + Hospitals 2025).

Prior research has found that street medicine improves the overall quality of life and behavioral health outcomes of patients, and reduces PTSD symptoms, substance use, and other high-risk behaviors (Carter, Zevin, and Lum 2019; Perna et al. 2024). Studies have also found that unhoused patients perceived street-based care as safe, accessible, and grounded in empathetic, trusting relationships with clinicians (Paradis-Gagné et al. 2023; Strange et al. 2018). Moreover, evidence suggests street medicine can reduce the fiscal burden of homelessness by shortening hospital stays, reducing avoidable admissions, and decreasing emergency room visits (Kaufman et al. 2024; Lynch et al. 2022). Despite these findings on the impact of street medicine, it remains unclear who is likely to receive these services and why, how street providers advance their patients' health given the limitations of what can be provided on the streets and the multiple health needs their patients have, and how they engage patients who refuse care.

Independent yet Interconnected

Studying how street medicine works requires understanding the ecosystem it operates in. Poverty in the U.S. is regulated by the fragmented yet interconnected network of public agencies,

private entities, and nonprofit organizations that employ punitive, disciplinary, and palliative strategies to manage the poor (DiMario 2022; Hopper et al. 2006; Soss, Fording, and Schram 2011). These strategies respond to bureaucratic and financial mandates shaped by historically specific and sometimes contradictory ideologies about poverty, its causes, and its remedies (Gowan 2010; Stuart 2016). Frontline workers, typically within contexts of limited resources and conflicting, ambiguous expectations, implement these strategies in their everyday interactions with clients, managers, and each other (Lipsky 1980; Lara-Millán 2014; Seim 2017).

Punitive strategies seek to neutralize the poor—who are constructed as a safety threat to the rest—through punishment and punishment-like strategies that denigrate and dispossess them, such as incarceration, sanitation sweeps, arrests, and anti-homelessness architecture (Wacquant 2009). Paternalistic strategies operate under the premise that the poor are “fixable”, meaning they can engage in socially desired behaviors through the disciplining actions of frontline workers (Lipsky 1980; Soss et al. 2011; Stuart 2016). The palliative model relies on stopgap measures, minimal solutions, and frontline improvisations that keep the poor alive but do not change the conditions that generate suffering (DiMario 2022; Gong 2019; López 2020).

Medicine plays a central role in regulating poverty. Seim and DiMario (2023) define medical poverty governance as interventions by state or state-delegated institutions that are “explicitly, even if not authentically, justified in the name of advancing individual or population health” (Seim and DiMario 2023, pp.3-4). Scholars have shown how frontline workers in healthcare, criminal justice, and welfare systems have used different iterations of medicine to facilitate the punishment, disciplining, and survival of unhoused people. Medical language to define the unhoused as sick has primarily been present in studies of policing and the criminalization of homelessness. Police officers and politicians commonly label the unhoused as

mentally ill and substance users to justify arrests, property destruction, and forced hospitalization as a form of “tough love” that will eventually cure the unhoused (Gowan 2010; Mathieu 1993). More recent iterations of policing also leveraged medical diagnoses—such as labeling unhoused individuals as addicts and psychotics—to coerce people into treatment and geographic relocation (Herring 2019; Seim 2020; Stuart 2016).

Homeless service providers have also adopted medical and medically framed technologies into their day-to-day work of regulating access to and stays in publicly funded transitional and permanent housing across Housing Readiness and Housing First welfare regimes. Under Housing Readiness, shelter staff implemented pseudo-therapeutic services that were rarely overseen or provided by health care professionals, promoting self-examination and self-governance among their clients to help address the behavioral issues believed to have led to their homelessness (Gowan 2010; Lyon-Callo 2000). Although the Housing First paradigm moves away from behavioral explanations and pseudo-therapeutic solutions to homelessness, it still relies on medicine to address this social issue, but this time to stratify housing deservedness. Because publicly funded housing is limited, homeless service providers conduct health-based assessments to quantify clients' medical risk of remaining outside and therefore assign housing (Napoles 2024; Osborne 2018).

Health care is another form of medical poverty governance. Ethnographers have documented that unhoused people receive health care in jails, clinics, emergency departments, ambulances, and in permanent supportive housing (Gong 2019; Lara Millán 2014; Knight 2015; Seim 2017). Although potentially life-saving, these services are often discriminatory or delayed and typically take the form of episodic, targeted interventions rather than sustained, longitudinal care (Bourgois and Schonberg 2009). Providing care to the poor not only helps keep them alive,

but also allows government and government-funded agencies to receive financial resources they would not qualify for otherwise and protects them against lawsuits (Lara-Millán 2021). It can also enable other forms of service provision, such as making people eligible for government assistance programs for which eligibility is determined in part by medical status (Gong 2024; Hansen, Bourgois, and Drucker 2014; Knight 2015).

Medical providers' work in poverty governance, however, rarely occurs in isolation from other frontline workers. They exchange caseloads, collaborate, complement or co-opt each other's services, and occasionally confront one another. Seim's (2020) and Herring's (2019) ethnographies with ambulance workers and police officers, respectively, illustrate how the latter turn non-medical cases into medical ones, thus engaging in burden shuffling (Seim 2017). By doing so, police officers unilaterally shift the responsibility of having to neutralize the poor to another frontline worker, usually an emergency medical technician. From a collaborative perspective, Lara-Millán's (2014) ethnography of emergency rooms illustrates how clinicians partake in punitive governance by cooperating with police officers. Emergency nurses and doctors rushed their medical services to patients who were in police custody and delayed them when they suspected poor and racialized male patients had committed a crime. Frontline workers from different agencies also contest and supplement each other's work. For example, DiMario (2022) found that needle exchange workers serving unhoused people implemented measures to reduce the reach of criminalization, interfere with police officers' work, and connect clients with health care that had been denied or was inaccessible to them.

Street medicine is increasingly becoming part of this ecosystem of homelessness governance, bringing important implications for its study. Street medicine's participation in homelessness governance suggests that the patients they care for are already entangled with

other institutions: they are not only street medicine patients but also users of emergency services, subjects of policing, and clients of homeless service agencies. Understanding how street medicine operates therefore requires examining the relationships between street clinicians and other frontline workers in these institutions, whose actions may align with, but also differ from, their own. Doing so can illuminate how teams provide care and the constraints, opportunities, and compromises they must navigate.

However, this analysis must also consider that street clinicians enter their interactions with other frontline workers from a distinct social position. Given their complex, valuable, and specialized scientific knowledge, medical professions, unlike non-medical occupations, are granted dominance over their sphere of work by the state and the public (Freidson 1970). This dominance manifests as autonomy over medical decisions, as well as social and cultural authority. Starr (1982) defines social authority as “the control of action through the giving of commands” (p.13), and cultural authority as “the construction of reality through definitions of fact and value” (p.13). While the former belongs to the realm of conduct and social relationships, such as telling a patient or a subordinate in the medical hierarchy what to do, the latter resides in both social interactions and cultural artifacts such as books, policy, and law, where illness and health are defined (Starr 1982). Despite several studies focused on healthcare professionals, poverty scholars have understudied the role of professional authority in poverty governance, mostly focusing on how it helps access government benefits (Gong 2014; Hansen et al. 2014; Knight 2015). Studying the role of professional authority will illuminate the broader consequences of street medicine for how homelessness is governed and how people experiencing homelessness move through systems of care and support.

Multiple Complex Needs, Insufficient Power

Professional authority can only take clinicians so far when trying to advance the health of their patients, especially those who live in extreme poverty like the unhoused. There are at least two reasons for that. First, poor people have complex medical needs that a clinician alone cannot meet, especially if working outside well-resourced hospitals; they need diagnostic tests, medical equipment, and access to different specialists (Marmot 2005). Second, social factors strongly affect their health, which are not fully within the domain of medical practice, despite significant changes in the last two decades (Link and Phelan 1995; Marmot et al. 2008).

The unhoused have a life expectancy 17.5 years shorter than their housed counterparts (Richards and Kuhn 2022). This is unsurprising considering that living on the streets is associated with experiencing sexual and physical assault as well as unintentional injuries (e.g., falls, hypothermia, frostbite, burns) (Kushel et al. 2003; Kushel, Vittinghoff, and Haas 2001; Kushel and Moore 2023). People who experience homelessness also have an earlier onset of chronic conditions, including vision impairment, difficulty performing daily activities, and cognitive impairment (Brown et al. 2017; Mackelprang et al. 2014). Compared to the general population, the unhoused experience a higher prevalence of psychotic illnesses, personality disorders, and alcohol and drug dependence, leading to higher rates of hospitalization for such conditions (Adams et al. 2007; Lebrun-Harris et al. 2013; Salit et al. 1998; Fazel et al. 2008). Overall, the mental, behavioral, and chronic health conditions that disproportionately affect unhoused people tend to co-occur—something called tri-morbidity—and likely contribute to a mortality rate that is two to three times higher than the housed population (Nilsson et al. 2025; Romaszko et al. 2017).

Housing is a social determinant of health; without housing, people face risks that aggravate existing medical conditions and create new ones (Fazel et al. 2014; Stafford and Wood

2017). With homelessness being criminalized, unhoused people are constantly displaced, attacked, harassed, and dispossessed of their belongings, affecting their mental health, interrupting their access to medications, and disconnecting them from services and communities that are critical for their survival (Chang et al. 2022; Chien, Henwood, and Kuhn 2026; Goldshear et al. 2023; Herring 2019). Living outside exposes people to environmental risks such as outdoor air pollution and a lack of clean toilets, sinks, and showers, increasing their risk of multiple infectious diseases (Beijer, Wolf, and Fazel 2012; Caton et al. 2013; Kuhn et al. 2020). This population also struggles to secure nutritious food, increasing their risk of malnutrition and worsening chronic conditions (Baggett et al. 2011; Sprake, Russell, and Barker 2014).

Homelessness is also a risk factor for inadequate or lack of access to healthcare. Many unhoused people use emergency departments (EDs) as a default source of care, but these services offer little for diagnosing and managing chronic illness and infectious disease, or for preventive care (Han and Wells 2003; Vohra et al. 2022). Despite most unhoused people having health insurance, at least half report lacking a source of care outside EDs (Kushel et al. 2023). Studies suggest that unhoused people struggle to access health care beyond the EDs because they have competing needs (e.g., looking for income, shelter, food), distrust the medical system, fear being stigmatized or discriminated against, lack transportation, or are unable to pay for services—or perceive so (Brown et al. 2013; Hwang et al. 2013; White and Newman 2015).

In the context of high and intersecting sociomedical needs, a health care model that brings free, non-emergency clinical services directly to where people live represents a promising strategy for improving the health of unhoused people. Street medicine is one such model. By bringing care directly to patients, it can reduce transportation and financial barriers—whether perceived or actual—while addressing acute health concerns before they become life-threatening

or debilitating and managing, and in some cases resolving, chronic, mental health, and infectious conditions (Feldman et al. 2021; Stefanowicz et al. 2021; Withers 2011). Moreover, by helping patients address the social conditions that shape their health—such as enrolling in food and cash assistance programs and connecting them to housing services—street medicine aims to offer a comprehensive approach to addressing the intertwined health and social needs of the unhoused.

To provide this breadth of care, however, street clinicians cannot work alone. Delivering care from a van, a backpack, or a shelter imposes important material constraints on what clinicians can diagnose and treat. Although street medicine teams increasingly carry portable technologies that allow them to perform a range of diagnostic and therapeutic procedures outside conventional clinical settings, they cannot perform advanced imaging, provide several forms of treatment (e.g., chemotherapy, dialysis), or deliver many other forms of specialized care on the streets. Providing comprehensive care therefore requires street clinicians to rely on—and coordinate with—the broader health care system.

Their ability to mobilize these resources is further constrained by regulatory and institutional forces that have increasingly circumscribed clinicians' professional authority (Light and Levine 1988; Mechanic 1991; Quadagno 2004). Clinicians' authority to order tests, prescribe medications, and refer patients to specialists and other providers is not unlimited; managed care organizations, government agencies, hospitals, and pharmaceutical companies mediate it (Timmermans and Oh 2010; Light 2000). Often guided by conflicting goals of safeguarding quality of care, expanding population health, reducing costs, and increasing revenue, these organizations shape which services clinicians can bill for or authorize, for which patients, and under what circumstances. For street clinicians, whose patients often require services that extend well beyond the clinical encounter, these constraints can be particularly consequential.

Clinicians' domain of work is also constrained by biomedicine's parameters. Medical practice has historically privileged the biological, chemical, genetic, and physiological mechanisms of disease, often directing clinical attention toward the immediate causes of illness rather than the social conditions that produce and sustain it (Mishler 1981; Waitzkin 1991; Whitehead 2013). Professional expectations for assessing and considering social determinants of health when treating patients have increased over the last two decades (Betancourt 2006; Ousager and Johannessen 2010). However, scholars claim that these changes are mostly limited and superficial, failing to address power and conflict and overestimating the role of individual choices (Beagan 2003; Metzl and Hansen 2014; Olsen 2021). Moreover, although Medicaid programs have increasingly incorporated nonmedical benefits to address members' social determinants of health, these interventions remain limited in scope (Chisolm et al. 2019; Kushner and McConnell 2019). At least formally, medical professionals cannot directly determine housing availability or distribution, prevent patients from being displaced or arrested, or directly alter the policies and institutions that govern access to shelter and other basic resources.

This gap between the breadth of patients' needs and the scope of street clinicians' authority, along with the material constraints of their practice, raises an important empirical question: what are clinicians actually able to do when the conditions shaping their patients' health exceed the boundaries of medical practice? Rather than assuming that these constraints simply prevent clinicians from addressing patients' social needs, we need to examine the strategies through which they navigate, circumvent, or compensate for them—and the organizational and professional costs of doing so. This analysis also advances theories of medical professional authority by explaining how clinicians operate in a context where improving patients' health involves working outside their traditional professional domain.

Unruly Patients

Even if clinicians had unrestricted power over the health care and health-related services, interventions, and resources they could provide to their patients, they could not go too far in diagnosing or treating patients without the patients' engagement. The clinician-patient interaction remains a central component of health care despite major transformations in the organization and delivery of medical care (Heritage and Maynard 2006; Starr 1982). Trust is foundational to this relationship: patients must be confident that clinicians possess the knowledge and competence to provide appropriate care and that they are acting in the patients' best interests (Parsons 1951). Yet trust in physicians has declined since the 1970s. Although this decline stabilized during the 1990s and trust increased temporarily during the COVID-19 pandemic, evidence suggests that it has fallen again in the post-pandemic period (Alsan and Cutler 2025; Pescosolido, Tuch, and Martin 2001). Sociologists have attributed this decline in trust to a range of factors, including abuses in medical research that contributed to the emergence of bioethics, the rise of complementary and alternative medicine and patient health movements, and the increasing availability of health information and technologies that allow patients to monitor and manage their own health (Clarke et al. 2003; Epstein and Timmermans 2021; Timmermans and Oh 2010).

These transformations have also challenged the authoritarian and emotionally detached model of medical practice that characterized the clinical encounter for much of the twentieth century. Under this model, physicians presented diagnoses and treatment plans as definitive and certain while maintaining emotional distance from patients and their experiences (Fox 1957; Parsons 1951; Smith and Kleinman 1989). In recent decades, however, this model has become less feasible and acceptable, giving ground to the patient-centered and shared decision models.

Under these newer models of patient-clinician interaction, doctors seek to foster a collaborative environment in their interactions with patients, including encouraging patients to share the multiple manifestations of their symptoms, their emotions, and their preferences about treatment, and sharing with them all information related to their diagnosis and treatment (Charles, Gafni, and Whelan 1999; Halpern 2001; Underman and Hirshfield 2016).

Although they can backfire and are hard to fully implement, these models are expected to reduce the risk of malpractice lawsuits, improve satisfaction among patients, increase productivity, and smooth the clinicians' work (Institute of Medicine 2001; Mead and Bower 2000; Stivers 2007; Vinson and Underman 2020). The clinician's counterpart in patient-centered care is therefore not a passive recipient of medical expertise but an engaged patient: someone expected to articulate symptoms and preferences, participate in health care decisions, and monitor and manage their own health and treatment regimens (Rose 2001; Shim 2010; Timmermans 2020).

What, then, happens to patient-centered care when its presumed counterpart—engaged patients—are absent? How do clinicians gather information, negotiate treatments, and make clinical decisions when patients are unwilling or unable to engage in these interactions? These questions matter especially when studying street medicine. Street medicine explicitly embraces a patient-centered approach, an orientation that is especially consequential among patients, like the unhoused, who may distrust health care providers and whose competing needs and circumstances can make sustained engagement with care difficult. Yet street clinicians cannot simply impose diagnoses or treatment plans when patients do not participate in care, nor can they rely on the engaged counterpart assumed in patient-centered models. How, then, do street clinicians craft engagement among disengaged patients?

METHODS

This dissertation seeks to answer the following research question: *How do street medicine teams address the health needs of a patient population facing acute and intertwined social and medical risks while respecting their autonomy and working within and alongside organizations and a regulatory system that both constrain and facilitate their provision of care?* I approach this question by examining three aspects of the daily work of street medicine teams: (1) how they distribute their limited but highly needed services, (2) the barriers they face to provide continuity of care and the strategies they implement to overcome them, and (3) how they handle patients' rejections and treatment resistance. Ultimately, my goal is to understand *whether and how street medicine transforms unhoused people's access to health care and overall well-being.*

Fieldwork

With the second-largest unhoused population in the country and 19 street medicine programs operating there, LA is currently the epicenter of both homelessness and street medicine. These programs are increasingly part of the region's homelessness governance: they participate in the County's multidisciplinary homeless outreach teams, the city and county of Los Angeles' encampment resolution programs, private and public hospitals' discharge planning procedures, and local managed health plans' initiatives to address homelessness and housing as social determinants of health (City of Los Angeles n.d.; LA County Homeless Services & Housing n.d.; Culver City 2024; L.A. Care 2023; Los Angeles County Chief Executive Office 2019; Reynolds 2025).

My fieldwork primarily focused on the street medicine program at Parkview Community Clinic (a pseudonym). Since its early years, Parkview has sent healthcare providers into the

streets, making it one of the country’s most established street medicine programs. What began with a single physician carrying a backpack through the streets near the clinic—seeking unhoused patients who had not returned for care and engaging those who had never entered the clinic—has grown substantially. By 2024, Parkview’s street medicine teams operate in several cities within Los Angeles County, providing primary and urgent care, including immunizations, wound care, and diagnosis and treatment of sexually transmitted infections, mental illnesses, substance use disorders, and chronic diseases. They also connect patients with social service providers who help them obtain IDs, access shelters, and enroll in government benefits such as food stamps, health insurance, and cash transfers.

Like most street medicine programs in California, Parkview’s work was initially supported mainly by philanthropic funding before transitioning to a patchwork of public and private sources (Feldman et al. 2023). Local government funding has become especially significant since 2017, when Los Angeles County voters approved Measure H, a quarter-cent sales tax designed to fund the County’s “Plan to Prevent and Combat Homelessness.” This ten-year initiative—which has been replaced and expanded through Measure A since 2024—created funding streams for multidisciplinary outreach teams, requiring the inclusion of licensed healthcare professionals in them (Los Angeles County Chief Executive Office 2019). Cities across the county combine Measure H resources with municipal funds to support additional teams, further institutionalizing medical providers’ roles in street-level responses to homelessness. Parkview’s street medicine teams partner with homeless services organizations contracted to provide such multidisciplinary outreach teams.

Parkview’s street medicine program is also supported through the healthcare sector. In addition to billing for clinical services, Parkview has increasingly benefited from partnerships

with managed care plans. Since 2023, Parkview has been among the street medicine programs participating in a \$90 million initiative led by California's largest public health insurance agency to expand low-barrier healthcare services for unhoused populations.

Beginning in the second year of fieldwork, I continued shadowing street medicine teams from Parkview Community Clinic while expanding my observations to include teams from other programs. Extending my research across multiple programs allowed me to better capture the range of street medicine practice in Los Angeles and identify patterns characteristic of street medicine work, rather than features specific to any single organization.

The additional teams I observed came from programs that, unlike the street medicine teams at Parkview Community Clinic, were not affiliated with a federally qualified health center. Instead, they operated within distinct institutional contexts: an independent medical group dedicated exclusively to street medicine, a hospital-affiliated program, and a university-affiliated program. These teams also served different geographic areas. While Parkview primarily operated in higher-income neighborhoods, the other programs worked across a wider socioeconomic range, including middle- and low-income areas. Finally, three programs offered very similar services (urgent and primary care on the medical side and housing navigation on the social services side), but one focused more on urgent care and humanitarian goods such as water and snacks.

By the end of my second year of participant observations, I had shadowed 11 teams, including 5 from Parkview and 6 from the additional programs. Teams were typically composed of a clinician (physician, nurse practitioner, or physician assistant), a medical assistant or licensed vocational nurse, and a case manager. It was also common for a student clinician or resident to join the team for up to a month.

I observed street medicine teams for the full duration of each shift, which ranged from 4 to 6 hours. During that time, I shadowed teams as they defined who would receive care that day and engaged patients in care. Across 355 patient-clinician interactions, I observed street clinicians assessing, coordinating, negotiating, and delivering care in public spaces, including sidewalks, homeless encampments, and parks. Additionally, I documented how local anti-homeless legislation and enforcement, as well as state-wide health insurance policies and medical guidelines, affected street medicine work. Besides street-based work, I followed clinicians into case conferences, coordination meetings with other street medicine and homeless service providers, street medicine symposia, and training sessions.

While my role was primarily observational, I occasionally participated in care delivery by facilitating communication between English-speaking clinicians and Spanish-speaking patients and by assisting clinicians with basic tasks during wound cleaning and bandaging. I also engaged in informal conversations with street medicine providers, frontline workers, and unhoused patients, which helped me clarify what I was observing and the decisions they were making. Furthermore, sometimes team members would spontaneously “brief” me on the patient, explaining their medical and social histories and the course of action the team would take.

Over the course of fieldwork, I wrote down observations on a smartphone. The level of detail varied across contexts: patient–clinician interactions were documented with a high degree of precision, often approaching verbatim transcription, whereas meetings and informal conversations during car rides or following patient encounters were captured in more abbreviated jottings. Whenever possible, I sought to document these exchanges verbatim; when permitted, I also audio-recorded conversations with providers. These materials were subsequently expanded into detailed narrative fieldnotes, typically within one day of observation.

Data analysis

I supplemented participant observation with 43 in-depth, semi-structured interviews, including 16 street medicine providers and 23 street medicine patients. Among providers, 5 were clinicians, 4 held dual roles as clinicians and program directors, and 7 were case managers. I also interviewed a health plan representative, a government consultant, and two additional street medicine program directors. These interviews enabled me both to discuss my observational data and to access perspectives not always visible in the field. In particular, they provided insight into providers' assessments of other service providers, the challenges they encounter in their work, and the external expectations for their work, as well as patients' perceptions of street medicine services and their experiences with healthcare on the streets and in other institutional settings. Interviews ranged from 30 to 120 minutes and were audio-recorded. Recordings were transcribed using Otter AI and subsequently reviewed and cleaned by research assistants.

I triangulated interview and observational data with a range of documentary and secondary sources to better situate the street medicine teams I studied within their broader institutional and policy context. These materials provided insight into the principles and goals guiding street medicine, the funding arrangements and strategies sustaining it, and the wider landscape of homelessness governance within which the teams I observed operated. Drawing on local newspaper coverage, policy and training documents, academic papers and research reports authored by street medicine providers, press releases, and recordings of webinars and symposia—which I also attended—I was able to trace how street medicine is represented, organized, and legitimized as a strategy to address homelessness.

I approached the data abductively, moving between theoretical frameworks on homelessness governance, medical professional power, and patient-doctor interactions, and the

empirical data to make sense of patterns that did not readily align with existing explanations (Tavory and Timmermans 2014). My analysis unfolded alongside fieldwork: I repeatedly returned to my notes and transcripts, refining initial interpretations and identifying points of tension or ambiguity that warranted further attention. I used NVivo to code fieldnotes, interview transcripts, and documentary materials in successive stages, beginning with close readings of the data and evolving into more focused categorizations as recurring themes emerged. Throughout this process, I wrote analytic memos to develop interpretations, interrogate relationships across cases, and clarify emerging arguments. These memos, in turn, informed subsequent engagements with the data, including revisiting earlier materials and sharpening distinctions between codes.

Overview of chapters

I have organized the dissertation into three empirical chapters and a conclusions chapter. The first chapter, *Becoming a Patient: The Institutional Logics of Health Care Distribution Beyond Hospital Walls*, describes why some unhoused people become more visible to street medicine teams than others. I show how, driven primarily by organizational pressures, local governments, homeless services agencies, and hospitals oriented street medicine teams toward people located within specific geographic spaces and institutional processes. Turning people from organizational burdens to street patients facilitated their relocation from the streets into healthcare and housing facilities, their biomedical assessment and stabilization while remaining outside, and their compassionate disciplining into efficient health care users. I conclude that, although these governing strategies risk co-optation by law enforcement, they not only help explain the distribution of street medicine but also transform how homelessness is regulated by creating care-oriented, treatment-intensive alternatives to punishment and containment.

The second chapter, *Unfindable, Inaccessible, and Unserviceable: The Structural Impairment of Care and the Struggle Against It*, examines the main barriers street medicine teams face in providing comprehensive, long-term care to their patients and how they navigate them. In the first part of the chapter, I illustrate how payment policies, the fragmentation of services, and the criminalization of homelessness make unhoused patients *unfindable, inaccessible, and unserviceable* to street medicine teams, complicating their continuity of care. I then describe the strategies street clinicians and their teams use to prevent and mitigate interruptions in care. I argue that the coexistence of these actions and structural barriers redefines standards of care on the streets, where some care is better than none and continuity of care is an achievable but heroic outcome, contingent on each team's capacity and willingness to go beyond the conventional limits of their practice.

The third and final empirical chapter, *Crafting Patient Engagement: Autonomy, Trust, and the Allocation Paradox*, analyzes how street medicine teams manage patients' reluctance to care. The chapter begins by describing how these teams develop and maintain trust with patients, and the impact of these efforts in their high-need, resource-limited environment. I argue that fostering trust with disengaged patients is a lengthy, effortful process that creates an allocation paradox for street clinicians: the methods that promote patient engagement can also limit the scope and intensity of care they can offer. Lastly, I describe the professional strategies street medicine teams use to manage this paradox and how these strategies shape the delivery of care.

Finally, in Chapter 4, I lay out my conclusions and discuss the implications of this dissertation for the sociology of medicine, the sociology of poverty, and the broader field of street medicine and homeless health care.

CHAPTER 1

BECOMING A PATIENT: THE INSTITUTIONAL LOGICS OF HEALTH CARE

DISTRIBUTION BEYOND HOSPITAL WALLS

Despite the rapid, exponential expansion of street medicine in Los Angeles and across the country, it remains a scarce resource like most homeless services. With more than 40,000 unhoused people in the city and 19 street medicine programs, only a fraction of them can receive these services. Who among the thousands of unhoused people becomes a street patient? In other words, how is street medicine distributed? One ideal course of action would be to base distribution on medical need, meaning going to the sickest patients. Addressing people who need ongoing or one-time acute care can prevent ambulance rides and emergency visits. This approach not only fulfills clinicians' professional goals, but it maximizes the clinical impact of scarce resources and supports the field's professional legitimacy as a distinctive and consequential form of medical practice, supporting its sustainability and expansion. However, there is no feasible way to identify and prioritize the sickest patients, as doing so would require assessing every unhoused person's health and ranking them by vulnerability. It would also require providers to decide who is not sick enough to receive their attention, turning scarcity into explicit exclusion.

At the other extreme, providers could adopt a random, encounter-based approach, offering care to any unhoused person they happen to encounter. This strategy requires less logistical coordination and maximizes reach, supporting the low-barrier ethos of street medicine by making care available regardless of need severity or type. Yet it also risks diluting scarce clinical capacity: providers may devote their expertise to people with relatively minor needs while those with more serious conditions remain unreached. This approach may also make street medicine less clinically distinctive, particularly when providers treat needs that lay people, such

as needle exchange workers and homeless outreach workers, could address. In this way, broadening access can come at the expense of clinical impact and make it harder for street medicine to demonstrate the distinctive contribution that supports its clinical legitimacy and further expansion.

This chapter examines the institutional need approach through which street medicine teams balance competing goals of sustainability and impact. Rather than allocating care based on medical need alone or distributing it randomly and indiscriminately, teams often found patients through government and government-funded institutions with which they collaborated. Informed by the organizational pressures they face, these institutions make some groups of unhoused more or less visible to street medicine teams. In their interactions with patients and service providers, street clinicians' professional authority—that is, their legitimacy to direct behaviors and define the contours of health and disease (Starr 1982)—helps alleviate these organizational pressures. I argue that, although it offers an imperfect proxy for medical need and may be coopted by law enforcement, this approach opens funding streams for street medicine teams and positions the field as a care-oriented, treatment-intensive alternative to the punitive and purely containment strategies that have so far dominated the medical governance of homelessness (Gong 2019; Gowan 2010; Herring 2019).

INSTITUTIONAL VISIBILITY

In the following sections, I describe the three main domains of the institutional need approach to street medicine allocation: complaint-oriented doctoring, crafting houseable clients, and managing hospital flow. In each section, I illustrate who institutions make visible to street medicine teams, and explain how and why they do it.

Complaint-Oriented Doctoring

In their day-to-day work, street medicine teams receive direct referrals from local government representatives, such as city and county officials and police departments. Some teams, especially in neighborhoods and cities with high NIMBY activity, are fully devoted to responding to local government referrals. These referrals tend to direct street clinicians to unhoused individuals residing in areas of the city with high political, symbolic, and economic value.

The team received the following message from a city official: "Encampment growing in construction area". The team lead and physician assistant, Kenji, packed medical supplies, and we left for the location referenced in the message. Construction was underway on an unoccupied one-story commercial building that was as wide as the ten empty parking spots in front of it. The building was located in an expensive residential area just feet away from the city's Chamber of Commerce and main commercial street. The three people who made up the "growing encampment" had been sleeping under one of the building's covered entrances.

As soon as we arrived, Kenji recognized one of the people—he had treated him recently at a different location—and went to speak with him about his health behind a car for greater privacy. Min (medical coordinator) and Max (peer navigator) asked the other two people whether they needed any medical services. The woman said she was fine and left the premises. The second person, Demian, was pretty high on some type of drug and stayed. He was very amicable and agreed to provide Min with his personal information so that Max could verify whether he had health insurance and enroll him as a patient. While Max was enrolling Demian, I asked him what the city's expectations were for their work. Max was very straightforward: "to move people to another location or inside". He was certain that the request to address the encampment was made by the business owner overseeing the construction, who spoke with the city, and that the city officials then called his team to "take care of it".

For \$400k a year, Kenji's street medicine team, which included six people and was part of a larger street medicine program, had to respond within an hour to the city's homeless referrals six days a week. During the first six months I spent with this program, their city referral team model expanded to three other cities in LA County. Other programs, primarily founded by

the County, have maintained a similar model since 2017. Instead of an immediate response, these other teams dedicated half-day shifts each weekday to address local governments' referrals.

My rides with teams contracted by local governments, such as Kenji's team, typically took us to see unhoused people in areas like the one depicted in the vignette: exclusive residential neighborhoods near business improvement districts. City landmarks and the vicinity of government buildings were other common locations where these teams met patients. Unhoused people living in these parts of the city were the most visible to these street medicine teams, making them more likely than people in other locations to receive these services. As peer navigator Max noted, many of the referrals his team received stemmed from business owners' complaints. Consistent with the homelessness literature, my two years in the field revealed that behind the local government's referrals were also housed neighbors, elected officials, and police officers concerned not only with the health of unhoused people and what they framed as broader public health impacts on housed people, but also with the financial impact of homelessness on businesses, municipalities, and counties (Beckett & Herbert, 2009; Gong, 2024; Herring In Press; Weaver et al., 2025).

This model of health care distribution, which I call *complaint-oriented doctoring*, has joined the local government's repertoire of responses to homelessness, which include complaint-oriented policing, homeless outreach teams, and paramedicine (Gibson 2011; Herring 2019; Seim 2020). Why are local governments relying on medical outreach teams to address complaints about homelessness? Max offered one piece of the puzzle: "to move people to another location or inside." More specifically, I found that expanding health care to the unhoused is seen as a vehicle to relocate them from public spaces to health care facilities and medically

stabilize and maintain those who stay outside. The following vignette gives us a closer look at the relocation logic.

Dr Stevenson and I arrived at an encampment behind a Whole Foods, steps from a residential area in one of LA's most famous neighborhoods. His recurrent collaborator, Officer Diaz, had asked him to come. "Oh, there is Officer Diaz, she's a good cop", the doctor told me as we approached a group of five women: a police officer, two outreach workers from the Department of Mental Health, and two case managers from a social services agency. Officer Diaz told Dr Stevenson they needed his help moving an unhoused man who was living in a parking lot that was going to be remodeled soon. "He would rather be buried in that parking lot than move," Officer Diaz said. Then she continued describing the issue, "We tried to persuade him to leave his RV. We told him we were going to tow it, even if we actually can't do that, but it didn't work. We even got a neighbor to pay for all the fees to move his RV somewhere else but the man still said no". One of the case managers chimed in, "this man is in his 70s and in pretty bad shape". Officer Diaz added, "Yeah, he's coughing very badly, could you talk him into going to the hospital, Dr Stevenson? He needs to be in a nursing home".

What Officer Diaz was trying to do, asking a doctor to persuade a patient to go to the hospital to then be routed to live in a nursing home, is substantially different from coercing people into therapeutic shelters and ambulance rides to avoid arrest (Herring 2019; Stuart 2014; Seim 2016). She could have taken the RV owner to jail or destroyed his vehicle if he did not see the doctor, but she did not. Instead, Officer Diaz appealed to the doctor's professional duty of caring for the sick ("he's coughing very badly") and professional authority ("talk him into going to the hospital") to remove him from a contested public space. She requested something that, unlike other service providers, street clinicians are uniquely equipped to do.

Recent expansions of Medi-Cal have increased coverage of inpatient healthcare facilities (e.g., nursing homes and recuperative care) for unhoused patients and given street medicine providers the authority to refer patients to them. These facilities are designed for people who are medically stable but require daily care or need to recover from a medical procedure, a mental health crisis, or a substance use problem. They are expected to be less expensive and last longer

than a hospital stay, and usually require a doctor's referral. I observed Dr. Stevenson and other street clinicians using their professional authority to emphasize the medical risks of remaining outside and successfully persuading patients to move into inpatient healthcare facilities.

In addition to redistributing unhoused people from strategic parts of the city into healthcare facilities, street clinicians provided medications that contributed to the biomedical stabilization and maintenance of patients, making those who stay outside less disruptive to the social order. Indeed, the administration of long-acting injectable antipsychotics was described as the “bread and butter” of street medicine by several street clinicians, making street psychiatry an important specialty within the field. Another common medical intervention of special interest for local governments was the assessment and management of infectious diseases such as COVID, syphilis, HIV, and hepatitis C.

Danny (director of the multidisciplinary homeless outreach program) announced to the rest of the team that the police department had requested that they double their outreach and medical efforts in the downtown area for the next couple of weeks. The reason they gave him—and he had witnessed himself—was that some streets were becoming “the new [homeless] vortex” meaning that a growing number of unhoused people were concentrating there and being loud in the middle of the night. When the meeting was over, Danny told me the police request had likely come from “the Council person who has a business on one of those streets, and wants [homeless people] all gone”.

Later that day, we parked the van just feet away from the “homeless vortex”. While Dr. Stevenson and Danny discussed the excellent sushi at the restaurant in front of us, an outreach worker brought Julian to the van. He was a 36-year-old African American man using crutches.

After asking Julian a few questions about his foot, Dr. Stevenson moved to his usual mental health and substance use assessment.

Dr. Stevenson: How's your mood? Are you sad?

Julian nodded.

Dr. Stevenson: We can probably help with that.

Julian: Yeah?

Dr. Stevenson: Yes. Do you feel like you have issues organizing your thoughts?

Julian shook his head.

Dr. Stevenson: How about getting things done? Have you had trouble finding an outpatient orthopedic for your foot?

Julian: I never found out what that was.

Dr. Stevenson: Do you want to take meds to help you be more organized?

Julian nodded.

Dr. Stevenson explained that Abilify—an antipsychotic—could help him understand better “the orthopedic stuff” and encouraged him to take it. Julian accepted. After that, Dr. Stevenson asked him about his drug use. Julian said he smoked marihuana.

Dr. Stevenson: What does it help with?

Julian: It calms me down, helps with my rage.

Dr. Stevenson: This medication that we’ll give you [referring to Abilify] could help you with that.

Dr. Stevenson’s administration of an antipsychotic to keep Julian calmer, less aggressive, and “more organized” was a recurrent strategy to subdue the effects of psychiatric disorders, but also an opportunity for local governments to reduce the cost of emergency services and to control the public disruption they and their constituents attributed to unhoused people. This operation was a larger-scale version of the common direct referrals the team received from the police and city officials. In fact, Danny learned about the operation during one of his weekly coordination meetings with the police department. These coordinated efforts focused on areas such as the location of the “homeless vortex,” the core of the city’s business improvement district.

Street medicine’s life-sustaining services, however, did not replace punitive strategies by local governments to control the visibility and social disruption attributed to homelessness. Instead, they were used in tandem. Prohibited from moving unhoused individuals from public spaces without providing shelters between September 2018 and June 2024 due to a Supreme

Court ruling, local governments across the country have tried to legitimize the forced displacement of this population by adding a service component to displacement. Scholars and journalists have widely documented how local officials in various cities justified the criminalization of unhoused people by claiming that outreach workers had previously offered services to encampment residents (see Herring 2021; Roy et al. 2022; Roy and Orendorff 2026; Human Rights Watch 2024). At best, those services were limited shelter beds for a fraction of those people being swept. At worst, it was a bottle of water and advice to cooperate with police officers and sanitation workers.

The way Julian's case evolved illustrates how street medicine has become one of those outreach services mobilized by local governments before or right after punitive measures. The "homeless vortex" operation was not only aimed at calming the city's downtown but also at clearing it by permanently removing people from those streets. The way it was organized facilitated such goals; the police arrived at 5 am to wake people up and ask them to move along. Between 9 am and noon, outreach was conducted by social and medical providers to unhoused individuals still in the area; it was during this time that the team saw Julian. In the afternoon, the police returned and conducted background checks on the individuals who had not moved. Julian was one of them, leading to his arrest.

This recurring sequence of policing, care services, and renewed policing shows how, like other forms of homeless outreach, street medicine was used by local governments as a carrot before the stick. Although street providers were usually unaware of this practice, some teams refused to collaborate with the police because their patients might misinterpret such collaboration as complicity. Other teams, like the one led by Danny, had no chance due to their contractual and

partnership obligations, and others agreed to collaborate to advocate for humane treatment and provide care to encampment members (Schwan et al. 2025).

Crafting Houseable Clients

Placing people inside interim or permanent housing has become a medicalized process that homeless services providers (HSPs) increasingly navigate with the support of street clinicians. Under the Housing First paradigm, adopted as a nationwide strategy in 2004, HSP's priority is to house people and then offer services to those who need them once they are housed. However, because there are insufficient government-supported housing units, HSPs are mandated to prioritize the most vulnerable. Besides some protected targeted groups (e.g., families with children, youth, veterans), the rest of the unhoused population is considered vulnerable based on their time being unhoused and their health status. More specifically, they need to be *chronically homeless*, which means having a physical, substance use, or mental disability *and* having experienced homelessness for at least 12 months. Therefore, unlike the previous housing paradigm—Housing Readiness—unhoused people no longer need to be sober to be eligible for permanent housing; they mostly have to be medically vulnerable (Osborne 2018). Yet, being too sick can actually complicate access to housing. Both permanent and temporary housing facilities minimize liability risks by requiring clients to be sufficiently healthy to use the facilities safely and not to pose a threat to other residents' health. When not connected to the local Department of Mental Health, these facilities can also restrict access to people whose severe mental illnesses interfere with the behavioral expectations for residents. In other words, to be housed, unhoused people have to be sick but not too sick.

Given the importance of people's health status in accessing permanent and transitional housing, street providers dedicated significant time serving HSP clients. Patients who were

referred by HSPs were usually located in the HSP's catchment zone, which typically included homeless "hot spots" (i.e., areas with high concentrations of unhoused people, such as large encampments) and parts of the city with high political and financial value (e.g., business improvement districts, tourist landmarks). While some street medicine teams were part of HSPs, others were contracted by them a few days a week. Street medicine teams without formal ties with HSP also collaborated with them: carving out time to see HSP clients was considered a mutually beneficial collaboration for street clinicians. Street providers expected that, when they needed to get one of their most vulnerable patients indoors, HSPs would assist them.

How do street clinicians facilitate HSP clients' access to and their ability to stay indoors? Street medicine's biomedical assessment and stabilization of unhoused patients contributed to making HSP clients houseable—that is, fit for housing—in two main ways. First, street clinicians certified that HSP clients were eligible for government-supported housing by assessing and attesting that their medical needs met the requirements of the facilities. Second, they made clients houseable by treating medical conditions that could hinder their access to and ability to remain in housing facilities. Consider the following common interaction between a street clinician, a patient, and a homeless services provider.

Street doctor: I don't see any evidence of active TB, so I can write a note saying that. Would that be helpful?

Case manager: Yes.

Street doctor: Ok, thanks for taking care of him.

After that, the doctor addressed the patient, "Do you need anything for your mental health today to keep things in order? Have you taken psych meds before?"

Patient: Yes, I was taking Seroquel, 300 mg.

The doctor asked how long ago that was and the patient said that last week was the last time.

Street doctor: Do you hear any voices?

The patient did not fully address the question and talked about his brother's passing away.

Street doctor: It's two weeks until your psych appointment. Do you want me to do a one-month prescription without a refill? Would you feel better with that?

Patient: Yes.

I noticed the patient had calmed down. He began the visit highly agitated, stating that he needed his paperwork ready to avoid losing a housing opportunity.

Street doctor: Do you need me to fill out more forms? You got me the physical form. Do you need me to do the disability one?

Case manager: Yes. (Then handed the doctor a disability form).

Pointing at the options in the form, the doctor asked the patient, "What do you want me to put here? Physical disability?"

Patient: Yes, that's what my SSDI is for.

Street doctor: Do you want me to put a severe mental illness too?

Patient: Yeah.

Signing disability and medical clearance forms was part of the day-to-day work of street clinicians contracted by or collaborating with HSPs. This usually happened when clients had a tangible transitional or permanent housing opportunity, either because they had maintained a consistent relationship with HSP workers (Osborne 2018) or they lived on a street that HSP workers were pressured to "clean" as soon as possible (Gong 2024). In the fieldnotes, the street clinician certified the HSP client's physical and mental health disabilities, making the client eligible for the transitional housing the case manager had found for him.

In the encounter, the street doctor also cleared the patient for tuberculosis, attesting that the patient would not be a risk for others sharing the transitional housing. This was part of a common physical assessment conducted by street clinicians, which also included assessing clients' accessibility needs and their ability to perform activities of daily living. This aspect of the evaluation assessed whether the patient could safely reside in the facility.

The medical assessment of unhoused people is an often-overlooked but key part of housing assignment. Most people referred to transitional and permanent housing needed to comply with the facilities' internal intake policies and expectations. These varied by housing facility. For instance, some facilities only admitted people who had been cleared for tuberculosis and, until not too long ago, COVID-19. Permanent supportive housing tended to be flexible regarding the deviant behavior that residents may exhibit (Gong 2019), but quite strict in admitting only as many people with ADA as ADA units available, which tended to be only one or two. Congregated settings, such as shelters and rehabilitation centers, were less tolerant of deviant behavior within the facility but more flexible regarding ADA accommodations. Nursing homes are the only facilities that accept individuals who required assistance with activities of daily living, such as bathing, eating, and using the restroom, but they were strict about residents' deviant behaviors (e.g., drug use, rage issues, etc). Street clinicians' assessments of HSP clients are key to determining the most appropriate facility and to providing guidance on what is needed to ensure the client is a good fit for available housing.

Street clinicians medically crafted houseable clients not only by assessing the immediate physical and mental health needs of HSP clients, but also by medically stabilizing them. They addressed the medical issues that could jeopardize their access to and stay in transitional and permanent housing. This included treating infectious diseases and providing people with psychiatric medications. Although unhoused people do not have to be sober or actively taking psychiatric medication to be eligible for housing like it used to be in the housing readiness paradigm (Lyon Callo 2000; Gowan 2010), street clinicians are aware that “keeping things in order” in the mental health arena can facilitate people’s access to and success (i.e., long term stay) in housing that was not run or connected to the Department of Mental Health.

While we waited for the coordination meeting to start, I asked Jack (program manager) what criteria they used to select the 26 clients who would move into a motel room today. He said they wanted clients who are consistent, who “are not too psychotic”, and who the team knows can make it inside until they are assigned to permanent housing. “What about the high utilizers?” I asked, referring to the very difficult patients they had in terms of mental and physical health. “There always has to be a few of them”, Jack answered as the meeting started.

Later that day, one of the high utilizers was dropped off by his case manager in the intake area outside of City Hall. He looked scared, holding his bag close to his chest as he sat down next to a couple of other clients. Photographers from the county began photographing him. He requested no pictures, and soon after, he stood up, spoke with his case manager, and stated that he could not do it. As he was leaving, I heard Cynthia, the HSP program director, say, “We said we were going to try with five difficult clients, and this is what we were expecting to happen and happened”.

Here, Jack, the program manager, explains how he and other case managers continue to exercise discretion in excluding certain individuals from Housing First. They do so because the acuity of some clients’ mental health conditions and associated behaviors may lead to problems in housing and, ultimately, eviction back to the streets. By contrast, clients with less acute mental and physical disabilities are viewed as having a greater likelihood of sustaining tenancy.

Only five patients out of the 20 high utilizers the team was working with were selected for this encampment resolution program, and three of them moved to the motel. In the next month, one of them, Tacker, had to exit the program because of his mental health; he had threatened the motel staff, made a hole in his room’s door, and another in the wall, and would spend hours shouting inside his room. Like Tacker, many unhoused people constantly lost their housing or were not even considered for one because they were “too psychotic”. Aware of the role that mental health could have in both accessing and staying indoors, street clinicians routinely assessed and treated people’s mental health, hoping to make them more houseable.

Managing Patient Flow Outside Hospital Walls

Like local governments and homeless services providers, hospitals have an interest in their patients becoming street patients. They have established their own street medicine teams or contracted with street medicine providers (Hansmann et al. 2022). The most prominent street medicine programs in LA began operations in collaboration with large hospitals in the region and continued to work with them, both formally and informally. In my fieldwork, all teams consistently received referrals from hospital staff, and two programs had teams dedicated almost exclusively to attending these referrals.

Hospital social worker: You said you tried [finding] William Robinson already?

Street clinician: Yeah, like 3 times, but we'll try again today. His tracker shows one place, but he's not there. Seems like he dropped his tracker.

Hospital social worker: That's not surprising.

Then the social worker asked about Leo, another referred patient who had an upcoming primary care appointment.

Street clinician: [We] encountered him yesterday. We finally found him. He doesn't have a phone number. Even if you are able to talk to him, it's going to be very hard to convey that info because he is always intoxicated.

Hospital social worker: Can you convey the [PCP] information to him?

Street clinician: Yeah, our team can try our best, but, you know, it's a matter of motivation.

The street clinician and I spent the remainder of his shift locating and treating patients referred by one of the region's largest hospitals. His team aimed to contact hospitalized patients within 24 hours and emergency department patients, such as Leo, within 4 hours. If the patient had already been discharged, as in William's case, the team approached the patient outside no later than three days after the referral. The hospital paid the street medicine program \$2,000 for each referred patient who accepted services, and the team had to provide services on the streets for at least 30 days.

The relationship with hospitals varied across teams: some, including the team in the vignette, had a formal contract with clear stipulations. Others accepted referrals from hospital staff as a professional courtesy. However, one thing remained consistent across teams: they all constantly attended to unhoused people who had been made visible by hospitals due to their presence in emergency rooms and inpatient wards.

Why are hospitals interested in turning their unhoused patients and people living near them into street patients? When I asked Javier Lopez, a street medicine program manager overseeing a hospital contract, he gave a blunt answer: the hospital wanted to avoid homeless people using its emergency department because they “misuse” these services by seeking shelter, food, and urgent care. Moreover, admitting unhoused patients to the ED or a hospital ward results in lower reimbursement rates for hospitals than admitting patients with private insurance. As we were entering a hospital to establish care with a patient, Lidia Shatz, a street nurse who had previously worked at one of the busiest emergency rooms in the county, told me that referring patients to street medicine also helped hospitals comply with state regulations requiring them to connect unhoused patients with homeless services and avoid readmission penalties.

These well-known organizational issues hospitals face regarding homelessness (Kushel et al. 2002; Whaley et al. 2024; Sabbatini et al. 2022) were also highlighted by street medicine experts at various workshops and webinars, making them part of the financial argument newer street medicine practitioners could use when seeking funding. Hospitals may be unable to turn away unhoused individuals to circumvent these organizational issues, but they can reclassify them as street patients (Lara-Millán 2014) to comply with state discharge regulations while reducing ED visits, hospital length of stay, and readmissions (Feldman et al. 2021; Kaufman et al. 2024).

How can street medicine address these organizational issues? As discussed in previous sections, street clinicians contribute to the relocation of unhoused patients to extra-hospital healthcare and housing facilities, as well as to the biomedical stabilization and maintenance of such patients directly on the streets. Additionally, street medicine helps prevent hospital readmissions and shortens people's hospital stays by coaching them to use healthcare services more efficiently.

Nurse practitioner Lidia and I looked for an unhoused man named Ronald, who spent all of yesterday in the emergency room. We went to two locations shown on his GPS tracker and called him three times. When we finally found him at a gas station, he said we should follow him to the park. It took another ten minutes until he found the perfect picnic table where he felt comfortable talking to us. I was shocked by Lidia's patience and willingness to accommodate Ronald's preferences. When we were finally settled, Lidia said:

Lidia: I would like to take your vitals and check your ulcer. Is that okay?

Ronald: Yes, but you're going to be grossed out by my wound.

Lidia: I'm okay with that, I'm sure I've seen worse. How painful is it?

Ronald: Nine out of ten.

The patient rolled up his pants and showed us the ulcer. It looked very moist, and it was as big as a ping-pong ball. Lidia removed the bandages the hospital nurse had placed and started cleaning the ulcer. After that, she wrapped it again and told Ronald:

Lidia: You can leave the gauze on for a few days. If I gave you wound care supplies, would you do the cleaning and wrapping by yourself?

Ronald: Hmmmm, I could go to the ER for that.

Lidia: You don't need to go for that, but if you don't take the antibiotics they prescribed, you would have to, haha.

Ronald: Are the antibiotics for my leg?

Lidia: Yeah, they will help prevent an infection. If you need to, I can get them for you.

Ronald: I think I can go get them.

Lidia: Okay, they were sent to the pharmacy down the block. If there is an issue at the pharmacy, just let us know, okay?

Next, Lidia screened Ronald for anxiety, depression, and schizophrenia:

Lidia: You scored high for anxiety and depression, and you hear voices. Would you be interested in taking medication for that?

Ronald: Hmmm

Lidia: You also have the option to try, and if you hate the meds, we can stop them. Try the pills first, and then after a few days, if you are doing well, we can do the shot.

Ronald: Where do I have to go for that?

Lidia: Nowhere, we'll bring them to you

Near the end of the consultation, I offered Ronald water and he said he didn't drink water. I asked if he drank alcohol instead. He said he did. Lidia overheard this and said:

Lidia: Do you have withdrawal symptoms? Like, you start shaking if you don't drink?

Ronald: Yes

Lidia: Okay, if you decide to stop drinking, you need to go to the hospital, okay? You could have a stroke from that.

This interaction illustrates why hospitals find it useful to turn their patients into street patients; Lidia prevented Ronald's readmission to the ER by advancing his biomedical stabilization and maintenance outside hospital walls. She stabilized his health by caring for his wound and providing wound care supplies. Lidia explained to Ronald why it was important for him to take the antibiotics the hospital prescribed, where to find them, and offered to facilitate his access to them. A week after this interaction, nurse Lidia came back to the same spot with the antibiotics prescribed for Roland at the ER (he had not picked them up), wound care supplies to clean his ulcer again, and a 30-day supply of antipsychotics.

Nurse Lidia's care went beyond stabilizing Ronald, moving also in the direction of health maintenance; she screened Ronald for medical conditions that could take him back to the ER, such as high blood pressure, depression, and schizophrenia. Additionally, as part of their performance metrics with the hospital, Lidia and her team had to help Ronald establish or reconnect care with his primary care provider so he could access a broader range of primary care services to keep him healthy and out of hospitals.

Lidia coached Ronald to be an efficient healthcare user by explaining which medical conditions were appropriate for the emergency room (e.g., alcohol withdrawal) and which were not (e.g., wound care). She did this without coercing, scolding, or shaming Ronald, but through his *compassionate disciplining*. Nurse Lidia explained the risks of alcohol withdrawal, did not focus on what is considered an unhealthy behavior (e.g., drinking more alcohol than water), and stated that wound care was not appropriate for the ER, while offering other options such as cleaning his wound and leaving wound care supplies for him (as I said, she also came back the following week to clean the wound again in case he had not been able to). The compassionate disciplining of unhoused patients into efficient healthcare users was a recurrent feature of street medicine work.

Eduardo seems to have a broken nose; his septum is severely twisted to the left. All he remembers from last night is getting super drunk, someone asking him to move from where he was, and then he had his nose like that. He said he could not breathe, and mucus was running from his nose. Physician assistant Finn Jacobson asked me to tell the patient, who spoke only Spanish, to go to the ER. He also asked me to explain why: "I also have a deviated septum (Finn pointed at it), and even after the doctors corrected it, I still can't breathe normally. If you do not get it right in the next 5 days, it will be harder to fix and for you to breathe normally".

After that explanation, Finn asked me to ask the patient what was holding him back from going to the hospital. Eduardo said that he didn't know where the hospital was or how to get there. Finn said the team could pay for an Uber. He also asked me to give the patient some advice about the ER:

Finn: Tell the patient he'll have to wait.

Author: Like 4 hours?

Finn: Probably more. The patient needs to know that the priority is people who are about to die. Then, once he is receiving treatment, he should say he is homeless, so once they are done, they reconnect him with us.

Finally, Finn asked me to make sure Eduardo knew that the ER could and should give him a ride back to where he lives.

Compassionate disciplining is substantially different from the discriminatory treatment of unhoused patients previously reported in medical settings (Bourgois and Schonberg 2009; Knight 2015), from coercing unhoused people to change their deviant behaviors (Gowan 2010), and from criminalizing or neglecting poor patients to deal with shrinking health care budgets (Lara-Millán 2014; Gong 2024). Finn promoted the efficient use of emergency services in a compassionate manner, in part because of a series of things he said and did not say to Eduardo. He did not scold the patient for getting drunk or refrain from helping him until he got his drinking under control. Finn explained why it was important to go to the ER by using his own experience as an example, rather than coercing or manipulating the patient. He also tried to understand what barriers the patient faced and then sought to reduce them by offering a ride to the hospital.

Unsurprisingly, Finn was conflicted about sending a patient to the ER. He told me, “The hospital case workers are going to hate me for this. (...) They will think I’m clogging their ER and I’m supposed to do the opposite”. However, he was confident it was what the patient needed (he obtained a second opinion from his resident), and he tried to mitigate this by ensuring Eduardo’s use of those services was as efficient and as little-disruptive as possible. To do so, he wanted the patient to be prepared to wait, hoping that anticipation would reduce the risk of him becoming frustrated and causing trouble in the ER. He did so by explaining that he would have to wait (because people with higher needs had to be prioritized). Finally, Finn gave Eduardo instructions to reconnect him to the street medicine team so they could enroll him as a patient and prevent future ER visits and hospitalizations.

MEDICAL HOMELESSNESS GOVERNANCE

The analysis of institutional visibility, that is, how and why state and state-mandated agencies facilitate access to street medicine to people located within specific geographic locations and institutional processes, revealed three governing strategies of these services: 1) the clinical relocation of unhoused people into health care and housing facilities, (2) their compassionate disciplining into efficient health care and welfare users, and (3) their biomedical assessment, stabilization, and maintenance. These strategies are expanding and transforming the medical governance of homelessness

The state's handling of poverty "in the name of advancing individual or population health", what Seim and DiMario (2023 p. 3-4) call "medical poverty governance", has been central to regulating homelessness (Gowan 2002; Lyon-Callo 2000; Weaver et al. 2025). Unlike what scholars captured in earlier studies of medical homelessness governance (Herring 2019; Stuart 2014; Mathieu 1993), however, the clinical relocation of unhoused individuals by street medicine teams rarely entailed force or coercion. They were voluntary instead. Also, the diagnostic power of street clinicians expands the types of medical relocation documented in the literature by broadening the places to which people can be relocated and the duration of their removal from the streets: while ambulance workers primarily transport patients to emergency departments (Seim 2017, 2020), where patients typically remain for only 8 to 12 hours, street clinicians can make referrals to other longer-term medical facilities.

Street clinicians help relocate people from the streets to transitional housing and, in some cases, permanent housing. Crafting houseable clients is a multilayered, dynamic process in which doctors are not only signing disability forms (Gong 2024; Osborne 2018) but also actively make people fit for housing opportunities through medical evaluations and biomedical treatment. This shift is consistent with Seim and DiMario's (2023) characterization of a "welfarization of

medicine” (p. 8), in which medical institutions expand their scope of work to include social services. It also suggests that, even under the housing-first regime, the physical and behavioral health of unhoused people still affects their access to housing. Medicine is not only a tool for identifying who is vulnerable enough for housing, but also for medically clearing individuals to enter transitional housing and facilitating their stay there.

In line with current transformations in health care toward a more empathetic approach to the patient’s experience (Vinson and Underman 2020) in clinician-patient interactions, street clinicians had a compassionate approach to disciplining the unhoused. Their interactions with unhoused patients fell far from the coercive disciplining described in earlier homelessness governance literature (Gowan 2010; Lyon Callo 2000; Stuart 2014). Street clinicians, however, do not completely refrain from turning their patients into compliant neoliberal subjects, as has been reported in permanent supportive housing (Gong 2019). Instead, they aim to educate unhoused patients to become more efficient healthcare and welfare users by explaining how emergency and housing services function and why using them appropriately can help patients achieve their goals. In doing so, they avoid blaming their patients for what could be labeled as misuse of emergency services, deviant behavior, or failure to access care in a timely manner.

Through the biomedical assessment, stabilization, and maintenance of unhoused people, street clinicians treated health conditions usually caused or aggravated by homelessness, including wounds, hypertension, mental health disorders, substance use complications, and sexually transmitted and respiratory infections. They also performed diagnostic tests for a variety of health issues—such as HIV, diabetes, syphilis, anemia, and heart problems—and connected their patients with specialty care. This more care-oriented, treatment-intensive approach to regulating homelessness differs markedly from physically neutralizing people and thereby

impairing their access to health (Chang et al. 2022; Herring 2019), and it goes beyond merely keeping people alive (DiMario 2022; Seim 2017; Gong 2019).

Despite these positive transformations, it is important to note that street medicine's care-oriented and treatment-intensive services, although increasingly adopted by local governments, do not replace punitive interventions to control homelessness. As this chapter shows, street medicine can serve as the carrot before, or the band-aid after, the stick. This policing practice might be more common now than during my fieldwork, given the court decisions and executive orders that have intensified the criminalization of homelessness. Local governments and homeless service providers can also instrumentalize street-based medical treatment to justify a services-first approach to transitional and permanent housing over the housing-first approach. Street medicine is not only a tool for identifying the most vulnerable for housing, but street clinicians' assessments can also be used to exclude certain vulnerable individuals from housing opportunities. As shown in the chapter, street clinicians' diagnoses of the acuity of some patients' mental and physical health conditions may lead to housing problems that service providers try to avoid by keeping them on the streets to recover through medical care. Finally, distributing street medicine services on an institutional needs basis makes continuity of care vulnerable to interruption once those institutional needs are met, something I will explore in more detail in the next chapter.

CONCLUSION

This chapter has illustrated how local governments, homeless services agencies, and hospitals made certain unhoused people particularly visible to street medicine teams: those living in parts of the city with economic and symbolic value, those with opportunities for permanent or transitional housing, and those being discharged from or admitted to hospitals. This institutional

visibility not only opened funding streams that supported the financial sustainability of street medicine programs; it also expanded the impact of their work. Although institutional visibility was only an imperfect proxy for medical need, it embedded street medicine within the broader ecology of homelessness regulation, allowing its impact to extend beyond improving patients' health to alleviating three core organizational pressures: homelessness complaints, hospital costs and discharge mandates, and the allocation of scarce publicly funded permanent and transitional housing. Three governing functions associated with street clinicians' professional authority helped address these pressures while expanding the medical governance of homelessness: (1) the clinical relocation of unhoused people into healthcare and housing facilities; (2) the compassionate disciplining of patients; and (3) the biomedical assessment, stabilization, and maintenance of unhoused people.

CHAPTER 2

UNFINDABLE, INACCESSIBLE, AND UNSERVICEABLE: THE STRUCTURAL IMPAIRMENT OF CARE AND THE STRUGGLE AGAINST IT

“These avoidable barriers [to continuity of care] force delays that worsen health, increase reliance on emergency departments, prolong hospital stays, and drive up costs”
(Assembly Bill 543 Fact Sheet).

From cancer to a broken bone, the diagnosis, control, and, when possible, cure of most health issues often entails medical services that cannot be provided in a single visit or by a single provider; they require continuity of care. Continuity of care involves receiving coordinated, consistent healthcare over time. Blood samples and images that detect injuries as well as chronic and infectious diseases must be collected and processed in a lab or clinic before they are returned to their healthcare provider. Diagnoses and treatment plans are often done by a specialist who, for most people, is only accessible after referrals and appointments are scheduled. Moreover, once treatment is established, it might need to be administered, monitored, and adjusted periodically. Continuity of care both improves health outcomes and prevents health complications, making it a key component of quality of care and a common goal for healthcare professionals, health systems, and patients.

Those who live on the streets would disproportionately benefit from continuity of care due to their complex, unique, and constantly changing health needs. The severe and co-occurring health conditions that unhoused people usually experience could be at least partially controlled by accessing medical specialists and receiving adequate and uninterrupted treatment. The unhoused are also permanently exposed to health risks that worsen their health rapidly and

sometimes unexpectedly, making ongoing, accessible medical care crucial to prevent costly and life-threatening consequences of these risks. Receiving coordinated, consistent healthcare is especially important for people living on the streets, whose pressing survival needs often force them to prioritize immediate necessities over attending appointments, following treatment plans, or maintaining relationships with healthcare providers. Ultimately, as stated in the epigraph, hospitals, managed care plans, and street medicine providers see continuity of care for unhoused patients as a tool to reduce health systems costs and improve the health of the unhoused population.

Unlike ambulances and emergency rooms, which mostly focus on stabilizing a patient in a one-time intervention, and clinics that either remain hard to access or prescribe treatments that are unsuitable for the streets, street medicine has the capacity to bring care to unhoused people on a regular basis, constantly adapt medical procedures and treatment to their lived environment, and coordinate additional clinical and social services. Despite this potential, street medicine teams endured significant barriers to providing continuity of care. This chapter illustrates how the work of street medicine providers is structurally impaired by payment policies, the fragmentation of services, and the criminalization of homelessness. These systemic factors directly affected continuity of care for unhoused patients by making them *unfindable*, *inaccessible*, and *unserviceable* for street medicine providers. I define structural impairments as the policies and organizational arrangements that constrain a profession's capacity to provide services to a marginalized group. Later in the chapter, I explain the strategies deployed by street clinicians and their teams to prevent and mitigate the risks of care interruptions and discuss the implications of the coexistence of these resistance practices and structural impairment.

STRUCTURAL IMPAIRMENTS

Structural impairment manifested in three common issues that street medicine teams faced in their daily work: failing to locate their patients, knowing where they were but not being able to reach them, and reaching them but being unable to provide the services they needed.

Unfindable

Losing a patient was one of the most common challenges street medicine teams faced. Unhoused patients constantly decided to move or were forced to move across the city, making them unfindable for their street medicine providers. These relocations were often the result of local and state policies and regulations aimed at both punishing and caring for the unhoused, as well as unhoused people's responses to them.

There was like a month or two where every day we went out, it was swept. Every single part that we would go to where patients were usually located, it was swept. Honestly, I remember that first week, when everything was swept. It just felt like I felt defeated, like everything that we were trying to do for some folks—there were people that I really needed to follow up on, or I told them we would be back, and we were back. But, unfortunately, they couldn't be there, or they were removed. It really sucked. It's honestly, I think, a big struggle in SPA 5 and some of SPA 4. Some of our spots that we visit, some patients every Monday or every Thursday, they already know they come and sweep. I think sometimes it happens a little too often, where some people, we know they need a higher level of care, and sometimes we don't find them again. And then we're kind of like damn, like they needed this and this and but now we don't know where they're at. (Nicola, Street nurse)

My fieldwork revealed that arrests, encampment sweeps, and move-along orders, among other forms of forced displacement resulting from the criminalization of homelessness, affected unhoused people's health by interrupting their access to medical care. Encampment sweeps, as the street nurse explained, were incredibly disruptive to street medicine, as street medicine encounters heavily depended on patients' locations, such as the encampment where they lived or the intersection where they panhandled. The criminalization of homelessness was a recurrent barrier to providing continuity of care because it removed people from those predictable places

where their street providers usually found them. In those follow-up visits, providers delivered and adjusted patients' medications for chronic conditions, refilled prescriptions, shared test results, and cleaned complex wounds. These longitudinal services were particularly important for the sickest patients, whose chronic conditions needed to be constantly monitored, especially as they lived in an environment where they experienced persistent and acute health risks.

In addition to interrupting the care people received on the streets, the criminalization of the unhoused interfered with the services street medicine teams had arranged—sometimes for weeks—with external medical providers. This included appointments with specialists and diagnostic tests that could only be performed in clinics and hospitals, such as MRIs and X-Rays. Visits to the patient's primary care provider, which would provide patients with access to medical equipment such as walkers and wheelchairs, were also thwarted by encampment sweeps. Consider what Rocio, a 60-year-old street patient from Mexico, told me after she reunited with her street medicine team:

The [street medicine] team could not find me. They just did because I came to sweep this street where I used to live before the police asked me to move. She [nurse] just told me they were looking for me to check if I still wanted to see the doctor because they made an appointment for me like two months ago, but I was moved from this street, so I didn't make it. I just told them I do want to see the doctor, I'm running out of pills, and they give me my pills. (Rocio, Street Patient)

Rocio missed her appointment with a cardiologist that the street medicine team had scheduled for her. When the team came to take her to the doctor's office, she was not at her regular spot. As she mentioned, she was asked to move to another location by police officers and, like most unhoused people, she did not have a phone to communicate with the team. The two months she stayed disconnected from the team also resulted in her not receiving a refill for

her hypertension pills. Had she run out of them before reuniting with the team, it could have put her at risk of a heart attack.

Continuity of care for street patients was also affected by their relocation by homeless services agencies (HSAs) and hospitals. Street patients' constant voluntary and involuntary movement in and out of the streets, healthcare institutions, and housing facilities across the city disconnected them from the street medicine services they were receiving. These types of relocations were primarily the result of care- and finance-oriented regulations at the organizational and state levels. Hospitals, for instance, were mandated to connect unhoused patients with homeless services and available shelter beds upon discharge. However, they could choose, as an organization, not to take Medi-Cal patients beyond emergency services, which usually resulted in patients being transferred to safety-net hospitals if additional medical services were needed and they agreed to those services¹.

Although unhoused people's relocations were sometimes coordinated with street medicine teams, as described in Chapter 1, they also occurred without coordination, further complicating the continuity of care for unhoused people.

I have lost Gary a few times, usually because of the hospital. This happened twice, actually, at Pacific Horizon Hospital. So the first time he was outside, he went to Pacific Horizon Hospital. He got sent somewhere. Don't know what happened to him. A few months later, he popped back up. "Oh, okay, great." Same thing happened. He was at the Buck Inn. He had a room there. He got sick again, and then Pacific Horizon Hospital, sent him to another hospital, but they didn't say where. And then we lost him for another few months, and he lost his room at the Buck Inn, and then [we] just randomly found him again, we saw him walking down the street. I'm glad we found him because he doesn't look good. He's losing a lot of weight; he's wasting away, and I think a lot of that is because his HIV is uncontrolled. So, you know, the interruptions and care for him are

¹ During psychiatric holds or under conservatorships, patient's consent was not required, which made some of these relocations involuntary.

really dire in the sense that we're the only ones giving him his HIV meds. Could he get them somewhere else? Yeah, but he's not with it, not enough to go to a clinic. Honestly, his mentation waxes and wanes in the sense that he'll be more or less psychotic, depending on when you talk to him, and what his substance use patterns look like. (Finn Jacobson, Street Physician Assistant)

Gary's HIV treatment was interrupted multiple times following his admission to a hospital, severely affecting his health. Physician assistant Finn attributed Gary's interruption of care to the hospital relocating him to an unknown institution first and then to another hospital, making Gary unfindable to the street medicine team led by Finn. Even though Finn and his street medicine team worked with Pacific Horizon (pseudonym), which gave him access to Gary's hospital medical records, he could not find where Gary was sent. For teams without an institutional relationship with hospitals, this type of care interruption was more common.

The hospital that treated Gary last might have sent him back to the street with his HIV medication, momentarily mitigating the interruption of care. However, once he did not have access to that batch of medication anymore, either because it ran out, got lost, or was discarded by law enforcement, Gary's health started to wane. Unhoused patients were unlikely to walk into a clinic to get their medication due to competing needs such as safety, food, and leisure, or mental health conditions, as Finn mentioned was the case with Gary. Because of those barriers and individual decisions, street medicine teams like Finn's were the primary means by which patients received their medications. Thus, when these teams could not find their patients, chronic conditions like HIV that required longitudinal care were compromised.

It could be argued that hospitals relocate street patients into institutions that would take care of their medical needs, meaning that disconnecting them from their street team did not translate into an interruption in care. Yet, this was not always the case. Hospitals also transferred unhoused patients to shelters and rehabilitation centers that did not offer health care, or at least

not to the level that street medicine was capable of. Even if patients were transferred to another hospital, the street clinician's medical records were not accessible to those institutions, so many of the health issues they were working on with the patient were not necessarily continued there.

Similar to hospitals, HSAs relocated street patients to shelters and motels and sometimes to permanent housing. When doing so, they had to follow state and local regulations aimed at protecting their clients' privacy, which were occasionally interpreted as not sharing their new location with their clients' street doctors. Not sharing relocation information with street medicine was also an organizational strategy to manage the operation's limited resources. For instance, at the beginning of the Inside Safe encampment resolution program, in which people living in selected homeless encampments were relocated to motel rooms, the Los Angeles Homeless Services Authority (LAHSA) decided not to inform street medicine teams and other community-based organizations about its operations. They did so because they feared street clinics and other service providers would let their clients who were not living in the targeted encampment know about the operation, and then there would not be enough motel rooms for them. On other occasions, HSA workers simply did not know their clients had a street medicine team that they could have informed about the relocation.

Inaccessible

Even if the street medicine team knew where patients were, relocations could still interrupt street medicine care by making patients inaccessible to the team. In these cases, hospitals, HSAs, and even the patients informed the street medicine teams of their relocations, but the relocations were to places the street medicine teams lacked access to. Consider the following fieldnotes from a street medicine team's daily coordination meeting:

The team has to follow up with two patients who were sent to a rehab center through the hospital. Tiffany (street nurse and team coordinator) told Mike (case manager): "If

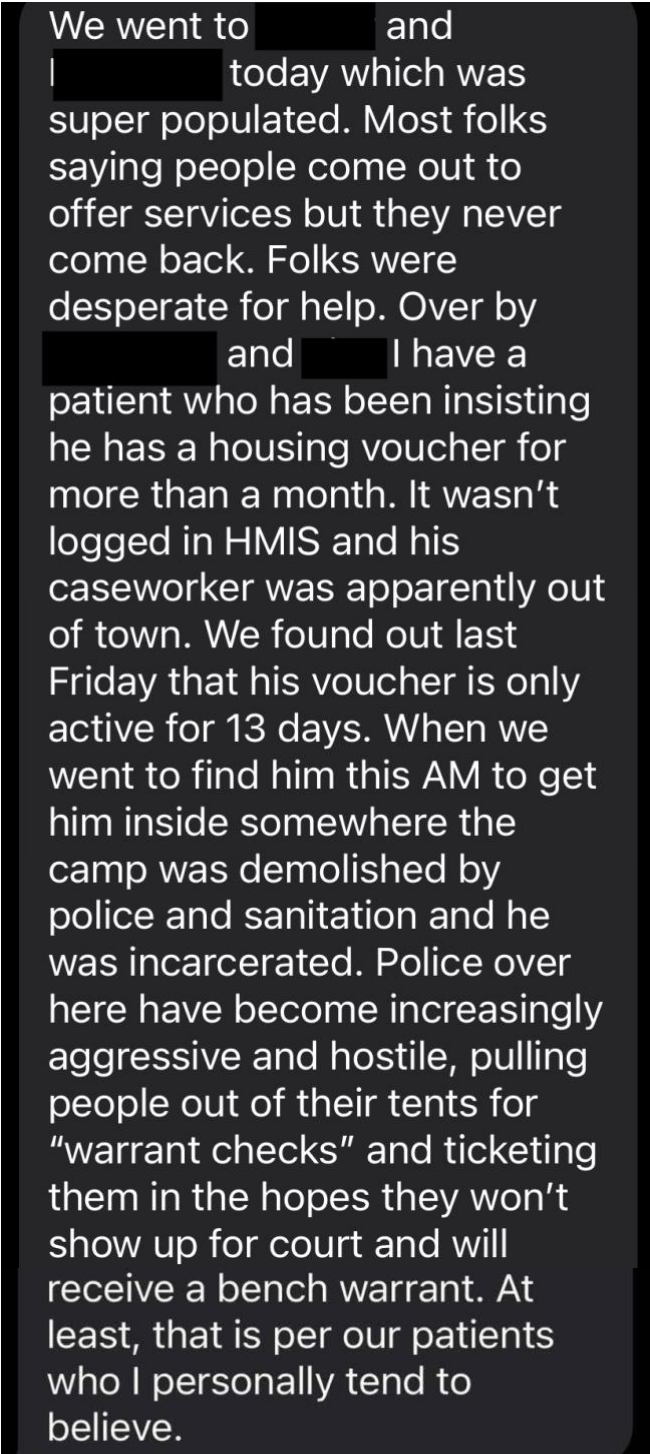
[New Beginnings] let you in, good; if they don't, we will count it as a cancel because if we can't talk to the patient, we can't treat them." Mike responded, saying he was almost 100% sure that New Beginnings won't let the team talk to the patient. Noticing my confusion, physician assistant Kenji, who was sitting next to me, told me New Beginnings was a rehabilitation center where patients were not supposed to lose focus, so they did not allow anyone from outside to interact with the patients.

Hospitals and HSAs sent patients to rehabilitation centers, hospitals, nursing homes, and shelters where street medicine teams could not enter. Without access to the patient, the teams were unable to resume care. For instance, teams like Tiffany's and Keji's had to wait 90 days for the rehabilitation program at New Beginnings (pseudonym) to conclude before they could speak with their patient. This translated into missed appointments with specialists or diagnostic tests that patients had been waiting for weeks—or even months—for, and that the team had put a lot of effort into scheduling.

The relocation of patients also made them inaccessible to street medicine teams because the institutions or housing facilities to which they were relocated were outside the team's area of operation. Street medicine teams tended to be geographically bound, allowing them to optimize their time and see more patients. The downside of this approach was that when hospitals and HSAs relocated their patients outside those geographical boundaries, continuity of care was at risk. Teams that operated on the west side of LA, for instance, lost contact with several patients who moved Downtown because there were more shelters and single-room occupancy facilities there. Similarly, when the city and county conducted encampment resolution programs such as Inside Safe and Pathway Home to relocate people into motels across Los Angeles, the care of several street patients was interrupted because the motels were outside the team's area of work.

The criminalization of homelessness also resulted in a lack of access to the patient, especially when patients were arrested. Street medicine teams were rarely able to follow their

patients in jails. The following text message I received from a street clinician illustrates how encampment sweeps disrupt the longitudinal care provided by street medicine teams.



We went to [REDACTED] and
I [REDACTED] today which was
super populated. Most folks
saying people come out to
offer services but they never
come back. Folks were
desperate for help. Over by
[REDACTED] and [REDACTED] I have a
patient who has been insisting
he has a housing voucher for
more than a month. It wasn't
logged in HMIS and his
caseworker was apparently out
of town. We found out last
Friday that his voucher is only
active for 13 days. When we
went to find him this AM to get
him inside somewhere the
camp was demolished by
police and sanitation and he
was incarcerated. Police over
here have become increasingly
aggressive and hostile, pulling
people out of their tents for
"warrant checks" and ticketing
them in the hopes they won't
show up for court and will
receive a bench warrant. At
least, that is per our patients
who I personally tend to
believe.

Figure 1. Text message sent by street clinician to author

The street medicine team was able to reconnect their patient with a housing voucher that had been assigned to him and would have allowed him to move into an apartment and likely improve his congestive heart failure. However, the patient's incarceration after his encampment was demolished was likely going to cost him the opportunity to move off the streets. As the street clinician pointed out in the text message exchange, this was far from an isolated case and was more of a routine practice that his patients and his team had to deal with. The arrest also interrupted the team's ability to provide medical care to the patient, as he could not see him or transfer his medical notes to the health providers at the jail.

Unserviceable

I can eat the cost of an antibiotic here or there. I will even eat the cost of contraceptives. My hands are a little tied because I can provide a measure of acute care, but at some point, because it is still a business model, even if it's a nonprofit business, I have to say, "Look, I've told you before, you have to get your insurance fixed because I can't continue to eat the cost of these meds". If I do it, I am affecting my institution, which translates into our ability to continue to operate long-term. (Finn Jacobson, Street Physician Assistant)

Even if they could locate patients and access them, an additional recurrent challenge that street medicine teams faced in providing continuity of care was the financial coverage of services. Although they would "eat the cost" of some medications and initial visits on a daily basis, continuity of care—that is, subsequent visits by street medicine teams, specialty care, and medically necessary services such as medical equipment and diagnostic tests—depended heavily on having serviceable patients. Those were patients with health insurance that covered both street medicine and the cost of continuity of care. Conversely, *unserviceable* patients were those who were uninsured or had insurance that did not contract with street medicine services.

Street medicine teams, like any health care providers in the U.S., could choose to do charity work, meaning they would not charge the state or the patient for their services. This

meant operating mostly or exclusively with volunteers and donations, or relying on a parent institution that covered the costs of staff and medication. Some teams certainly did that, while others opted for a mixed model in which they collect grants and philanthropic donations but also rely on Medicaid billing for financial sustainability and independence. Still, teams with mixed funding models reserved 20-30% of their patient panel for unserviceable patients. However, offering their services for free and “eating the cost” of some medications for some or all of their uninsured patients only addressed part of the continuity-of-care issue. Unhoused patients usually needed more services than what street medicine providers could offer. Medical specialists, pharmacies, medical laboratories, and diagnostic clinics all charge for their services and products. It was financially impossible for street medicine teams to pay for those services themselves. Health insurance, then, was critical for the continuity of care.

There were three main factors that made people *unserviceable*: (re)enrollment red tape, coverage hurdles, and low reimbursement rates. Although unhoused people were eligible for health insurance through the state’s Medicaid program (Medi-Cal) during my fieldwork, their enrollment in it was not automatic. Due mainly to the means-tested nature of the U.S. healthcare system, enrolling in Medi-Cal was a bureaucratic process that required proof of eligibility (e.g., CA residency, homelessness) and the completion of lengthy application forms. Obtaining proof of eligibility documents was particularly hard if the person was undocumented, a resident of another state, or did not remember their personal information. Moreover, once enrollment was achieved, it was not permanent; patients—or service providers on their behalf—had to resubmit proof of eligibility annually, or they could be disenrolled from Medi-Cal. This red tape around enrollment, which partially explains why 20-30% of unhoused people lack health insurance

(Kushel et al., 2022), has worsened since the passage of HR1 (also known as the “Big Beautiful Bill”).

HR1 has reversed years of Medi-Cal eligibility expansion. Homelessness is no longer a condition that qualifies people for health insurance; people must present proof of disability or comply with work requirements to qualify while homeless. Similarly, since January 2026, undocumented people are no longer eligible for Medi-Cal regardless of disability or work status. This has left thousands of people without insurance, further complicating their access to continuity of care. Additionally, starting in 2027, the redetermination process—that is, resubmitting proof of eligibility—will occur every 6 months rather than every 12 months. Shorter redetermination periods mean that proof of eligibility must be presented more often, creating an additional administrative burden and causing more frequent interruptions to care.

As insurance eligibility did not translate into health insurance enrollment, enrollment did not guarantee coverage of street medicine services. It was not enough for patients to be enrolled in Medi-Cal. The patient’s managed care plan (MCP) had to include an active contract with the street medicine team that would provide care to them. When, in the opening vignette, PA Finn recalls telling his patient to get his insurance “fixed”, he meant switching to an MCP that had a contract with Finn’s street medicine team so they would be reimbursed for their services. In other words, patients needed to have the right type of insurance; otherwise, the team would not be reimbursed for its services. Switching MCPs required the patient’s consent first, which could be challenging if the patient believed they could only receive certain benefits through their current MCP. After the patient had decided to switch, they had to request it by calling Medi-Cal, a process that usually took a couple of weeks to take effect, leaving people without access to comprehensive care during that time.

Enrollment also did not ensure access to prescription medication, durable medical equipment (e.g., wheelchairs), diagnostic tests, and specialty care visits. For medically necessary services to be covered by health insurance, enrollment was not enough; they had to be ordered by the patient's assigned PCP.

If somebody needs more major care, it really is a barrier for us to be able to do it. (...) Paul needs...he's had fractured bones. He has prostate cancer, which has spread to different parts of the body. So he needs a cancer doctor. He needed an orthopedic doctor because he's having surgery on broken bones. Needed a urologist who has to do specifically with the prostate, who works with cancer doctors. So he was getting that, and he was [going] through a different system, but it seems like he hasn't been getting follow up in a while. And so I wanted to reconnect him. "Hey, you need to, you know, get these appointments. Let me see if I can refer you urgently to get the ball rolling", and then we could help him get there and manage [the rest], but unless he switches to say that we're the primary clinic, which he hasn't done, or he's got another clinic, so we need to get him from that other clinic, or else. So we're a little bit limited in what we can assist with. (...) Usually, [switching PCPs] takes till the first of the next month. Sometimes, if it's late in the month, it's not till the following month. So you have a one to two month, you know, two weeks to two months delay until that's active, and then we can do that. So it's a lot of navigating a system that is complex, and sometimes it just doesn't make sense. But that's the way it is. [A] referral can't be sent. It won't be approved, and then you won't be able to schedule. The office will say, "Oh, no, the referral is not approved. We can't see you." Which means we will not get paid to see you. That's what it is. We will not get reimbursed to see you. Anybody can see anybody, you know, you can walk in a doctor's office and the doctor could say, like, "Sure, let me see and review and do this". But they don't. (Dr. Williams, street physician)

Through Paul's case, Dr. Williams illustrated one of the most common constraints in the everyday practice of street medicine: being unable to refer patients to medically necessary care. PCPs had full control over the patient's access to these services; without an order or referral from them, the providers of those other services, in this case, the urologist, orthopedic, and oncologist, would not get paid. Paul was assigned to a PCP who did not practice street medicine, which likely contributed to the interruption of his initial care. To "get the ball rolling" and reconnect Paul with life-saving care, such as seeing a urologist and oncologist for his prostate cancer, Dr.

Williams had to become Paul's PCP. To switch PCPs, the patient had to call their insurance and request the change, which required a phone with active service and the patience and motivation to spend hours on the phone. As Dr. Williams noted, the reassignment could take several weeks to take effect, further delaying care. During that time, some patients lost interest in seeking specialty care, and others lost contact with the street medicine team due to forced or voluntary relocation.

Sometimes, however, reassignment was not a feasible option for addressing PCPs' power over comprehensive care. This was usually the case for street medicine providers who could not serve as the patient's PCP due to contractual restrictions imposed by MCPs. In other cases, the patient did not want to switch PCPs, or the street provider determined it would not be in the patient's best interest to do so. In those situations, patients needed to see their PCP and obtain a referral or medical order, depending on their medical needs. Such PCP reassignment took several weeks, a similar time frame, if not worse, applied for a PCP visit. In addition to affecting patients' health, these delays frustrated patients and sometimes jeopardized their relationships with the street medicine team, as they felt they were not receiving adequate care.

Finally, being enrolled and covered by Medi-Cal was not a golden ticket to continuity of care either. Street medicine teams then had to find a provider (e.g., a laboratory or medical specialist) that accepted Medi-Cal. This was not always an easy task since Medi-Cal reimbursement rates were significantly lower than those of other insurers. With few providers to refer patients to, especially rheumatologists and dermatologists, wait times were long, further complicating continuity of care. In the weeks and even months that it took to see a specialist, the patient could lose interest in the appointment or become inaccessible or unfindable for the team, resulting in missed appointments. Moreover, conditions could get worse during the wait time.

NAVIGATING STRUCTURAL IMPAIRMENTS

Street medicine teams navigated structural impairment through *streetwise doctoring*, a top-down strategy to adapt clinical work, in coordination with patients and their support system, to the cultural, social, and material reality of homelessness; *network mobilization*, a lateral strategy to overcome barriers to continuity of care in coordination with other service providers; and *clinical advocacy*, a bottom-up strategy in which they appealed to authorities for structural change.

Streetwise doctoring

Streetwise doctoring is the adaptation of clinical work to unhoused patients' cultural, social, and material realities. Understanding the streets as both a living and a working environment enabled street medicine teams to, in coordination with their patients and their patients' support systems, implement field-based strategies to prevent and mitigate the risks of health care disruption. More specifically, these field-based efforts were informed by street clinicians and their team's awareness of unhoused people's constant movement, the frequent discard and theft of their belongings by third parties, as well as their survival strategies and their social networks.

If you have a good rapport with your patients, or whatever, you can ask, "Hey, what happened to such and such like I've been looking for them". When you have a great relationship with not just the community partners, but the community itself, it allows you to, like, gain folks' trust and to be able to continue to help people when you lose contact with them. I lost contact with another patient that I got matched up at Jasmine [street], where all those RVs used to be. I couldn't find her for like six, seven months, until I ran into another patient who stayed near her. I was like, "Where is such-and-such?" "Oh, she's, oh, she's been right there, on, on, such and such [street]". Then we found her. So if you have a good relationship with the people and the players, like the agencies, it makes it a bit easier. (Kevin, Case Manager)

Kevin described a common strategy for finding a missing patient and resuming care: building rapport not only with community partners but also with people close to the patient, such as neighbors, friends, romantic partners, and relatives. Street clinicians learned about the culture of homeless encampments and participated in the social world of their patients; they identified and built relationships with people who ran the encampments, those who tended to have good relationships with most people in the encampment, and those—usually women—who adopted a caring role. Those connections often led to valuable information for finding patients.

Other strategies to prevent care interruptions or to resume care when they occurred included learning about their patients' survival tactics and leisure practices. For instance, street medicine teams were aware of their patients' recurring panhandling locations, so they would look for them there when they could not find them at their regular living spaces. They tried to be informed of their patients' favorite stores, as well as public spaces where they would meet with friends to drink, use drugs, or simply hang out. As encampment sweeps became more frequent, some mapped, in coordination with their patients, three locations where they could meet if their patients' encampments were swept.

Street medicine teams also adapted treatment aspects of their work to prevent care interruptions. Consider the following intervention by a street doctor during the presentation of a practice guide for street clinicians on dealing with encampment sweeps at a webinar.

We stock various medications, prescribed medications, and we also have the ability to store our patients' medications securely. If we know that there's an encampment sweep coming up, then we can essentially hang on to their medications, if it makes sense medically. That way, our patients aren't necessarily at risk of losing those during the encampment sweep and then following up later on, once they land somewhere and have a little more stability, and then we can go out and take those to them. That's been helpful. [Also] developing street-resilient treatment plans, like considering a long-acting injectable versus an oral medication, such as our anti psychotic meds, hepatitis C medications. We do a lot of hep C treatment up here. We do Hep C treatment on the

street, but as we know, that's like an eight to 12 week course of medications that we really want them to be taking daily without a lot of missed doses. It could be something that you consider delaying treatment until they've gotten to kind of a place of a little more stability, or figuring out a way to, like, store their medications, like a little bit of the course at a time, and taking that out to them, you know, on a weekly or every two week frequency (Dr. Phillips, Street Doctor)

Dr. Phillips described two strategies to the audience for preventing and mitigating treatment disruptions: storing patients' medications and developing street-resilient treatment plans. Street teams tried to ensure they had the right equipment and space to store patients' medications before a potential loss of communication, such as after an encampment sweep. The gold standard of street-resilient treatments—a common practice in street medicine—was to administer long-acting injectables rather than dispense oral medications. Unlike oral medications, which usually have to be taken daily by the patient, long-acting injectables are not only administered by the street medicine team, ensuring that the patient has the medication, but they also last for weeks, giving the team and the patient more time to restore communication before the patient needs another dose. As Dr. Phillips said, when it was not medically possible to use a long-acting injectable, dispensing the medication gradually over time was a preferred alternative. Another common practice for street-resilient treatments was prescribing lower medication quantities so that patients could more easily obtain a refill at their pharmacy if their medication was confiscated or discarded, thereby mitigating the risk of treatment interruptions.

Networks Mobilization

Street clinicians were inserted into professional networks to improve their ability to provide continuity of care. They built an *intra-professional* network of street medicine providers across LA that exchanged best practices, addressed insurance challenges, shared information about encampment sweeps, and coordinated care for missing and moving patients.

This network proved particularly handy when the city and county of LA each implemented encampment-resolution programs that moved all or part of the encampment residents to motel rooms without always informing the street medicine team providing care there. To avoid interruptions in care, street medicine providers shared the approximate date and location of future encampment-resolution operations with one another as they learned of them. For instance, when physician assistant Finn Jacobson received a tip from his colleague that one of the encampments where he worked would be part of the operation, he reached out to the city to ask to participate with his team. Participating in the operation gave Finn the opportunity to know his patients' new locations: those who stayed outside, those who were placed in a motel near the encampment, those who were placed too far away for his team to reach. With the first group, he stayed in contact as much as he could, given that they were not allowed to return to the street where the encampment used to be located. The biggest achievement in terms of continuity of care, however, was that Finn and his team were able to provide weekly care to his patients at the motel where most of them had been relocated.

The intra-professional network also helped street clinicians exchange patients with one another when patients moved from one team's geographic area to another's, and when their patients needed care outside the team's scope of practice. Physician Assistant Kimberly, for instance, asked Dr. Watson's team to cast one of her patients because they had those supplies, as their scope of practice was closer to urgent care. Conversely, Dr. Watson's team connected patients to Kimberly's team when they needed primary care, usually for chronic conditions such as diabetes and hypertension. By exchanging patients with one another to meet their needs, street providers avoided sending them to the hospital or a clinic, which, as discussed previously in the chapter, could interrupt care. Finally, the intra-professional network helped street medicine

providers find missing patients: they let other teams know about a missing patient they urgently needed to locate and asked whether other teams had recently seen the patient or knew where the patient was.

Street clinicians also built an *inter-professional* network that contributed to continuity of care. Their colleagues who did not formally work as street clinicians served as volunteers, providing specialty care directly on the streets or seeing street patients at their clinics through pro bono work. They also facilitate continuity of care for street patients within the hospital by fast-tracking them through the Emergency Department (ED) where they worked, or by ensuring they were referred to a specialist or long-term health care facility that the street medicine team. When the street clinician knew the patient's assigned PCP or had colleagues in common, they tried to leverage those professional relationships to save time in obtaining referrals for medically necessary services for their patients. These inter-professional connections also helped street clinicians determine a patient's whereabouts. For instance, doctors working at the ED alerted street clinicians when their patients were admitted to the hospital where they worked, so the team would know where to find them.

Finally, street clinicians had an *extra-professional* network that helped them navigate the challenges of continuity of care. They collaborated closely with homeless service providers to facilitate their patients' enrollment and re-enrollment in Medi-Cal, learn about future encampment sweeps, and locate missing patients.

We just began to partner and work together more, not just with [John from LAHSA], but with other people. We keep each other in the loop, like when they're traveling, you know, leaving, or because, you know, folks living on the streets move from area to area, especially in the same town. So that's how I'm able to keep up with the patients or the clients. And then, perhaps I'm like, "Hey, do you think you can submit a housing referral for this person?" And then most times they'll say, "Yeah". (...) The way that I see it is, you know, they call us and they lean on us for, like, medical and things like that, so. A

favor-for-a-favor type of thing. I call it leveraging. You have to leverage your resources because that's how we get any work done. No one agency can take care of everything by themselves, you know? So yes, they've called plenty of times. Like just yesterday, [they] had a patient with a dog bite, and they called us, that's pretty much the gist of our partnership: "Hey Mario, are you out with the [street medicine] team today? We're on Cotner. We've got such and such right here". Or I can put an APB out on some of my clients through these different agencies. I call it APB, but it's like a, it's like a be on the lookout, kind of like, just like, a "hey, hey, like, heads up. I'm looking for this person. I haven't seen them in a few weeks. Do you know where they're now staying at?" (Mario, Case Manager)

Mario was a case manager for a street medicine team who constantly had to deal with patients going missing. "Being on the lookout" was such a recurring part of his job that he had an acronym for it and a strategy to deal with it. As he mentioned, he partnered with other service providers working in the area to find the team's patients. This resulted from what was seen as a mutually beneficial relationship, in which social service providers asked the street medicine team to provide clinical services to their clients when needed. In exchange, the street medicine team relied on their relationship with social service providers to locate their patients and facilitate their access to services that helped ensure continuity of care. For instance, they secured a bed in a shelter or a motel room for a few days before a clinical procedure, so the patient would be easier to find and the chances of missing the appointment would be lower. Homeless service providers also occasionally informed street medicine teams about upcoming street cleanings so they could plan ahead and try to mitigate disruptions to care.

Case management positions like Mario's were part of the design of several street medicine teams. People in positions like his were expected to be the closest person on the team to the patient and to directly manage the patient's access to social and medical services. In terms of continuity of care, they enrolled and re-enrolled patients in Medi-Cal and, when possible, helped patients switch PCPs to a street clinician. They were also the point of contact when the

patient needed to see the street clinician, their PCP, or medical specialists, and the ones in charge of making the encounter happen.

A more controversial extraprofessional relationship that street medicine teams cultivated to prevent discontinuity of care was with law enforcement.

So one thing that we have found helpful in order to stay ahead of the sweeps and to do some of that prep work, it is good to know, like when sweeps are going to happen. And so we have tried to build some bridges with our local law enforcement agency. That way we can have some of that information ahead of time, and we can go out as teams and sort of triage our folks that are, you know, more vulnerable than most, try to come up with alternative shelter solutions, and then think through some of those, like, maybe coming up with a sweep resilient treatment plan, or really just thinking through the details of, like, what would happen to my patient medically, were they to be displaced from their regular spot and also to lose contact with me? So, you know, on the flip side, we're also very careful, like, we're very clear with our patients that the information only flows one way. We are receiving information from law enforcement about when they are doing sweeps and where, that way we can be more effective in navigating this. But we never disclose to our police department where camps are, or, you know, we just try to be very sensitive to our patients' privacy. (Dr. Phillips, Street Doctor)

Dr. Phillips explained that professional relationships with law enforcement were a tool for navigating the harms of encampment sweeps, as they allowed street medicine teams to learn about these actions in advance and plan accordingly. This was a controversial relationship that some teams tried to avoid because it could damage the rapport with patients, as the team could be seen as collaborating in and endorsing encampment sweeps. Because of that, some teams avoided any relationship with law enforcement, and those who did have one were very careful not to disclose patient information to the police and to clarify to patients that they were not working with law enforcement. The interactions between street medicine teams and law enforcement and city officials, more generally, went beyond a one-way flow of information about the time and place of encampment sweeps behind closed doors. Street medicine teams also openly advocated for concrete actions to prevent and mitigate the harms of care discontinuity.

Clinical Advocacy

Street clinicians engaged in direct advocacy actions, also referred to as *clinical advocacy* (Brewer and Timmermans Forthcoming), to seek structural solutions to facilitate continuity of care for their patients. Clinical advocacy in the street medicine context was primarily focused on two system-level barriers to continuity of care: encampment moves procedures and direct referrals regulations. Street clinicians directly confronted city officials about how they were carrying out encampment moves and the risks that they posed to their patients' health. Consider the following interaction at an LA County Street Medicine Coordination Workgroup meeting conducted over Zoom in August 2023:

The county's street medicine program manager and street doctor, Cory Vance, expressed his concern about continuity of care after encampment cleanings if street medicine providers are not involved. They need to be able to keep helping patients as they move indoors, he said. "How are they going to continue their care?"

Another street medicine program manager followed up on that comment, saying they needed a seat at the table when decisions about cleanings are being made. Her team wants to help coordinate the operations.

"What are the best practices for cleaning notifications. One week at least?" asked Daniel Kauffman, a health equity consultant working with street medicine teams.

Street doctor Michael Stevenson intervened next, saying it varied by jurisdiction, but that, as a best practice, he and his team believe it should be 30 days' notice.

Kauffman now asked the question directly of the Deputy Mayor of Homelessness and Community Health, who had not yet intervened in the meeting. After introducing herself, the Deputy Mayor said she supported wrap-around services for the city's Inside Safe initiatives. She added that although the city doesn't have a medical team, they coordinate with Dr. Vance and his team at the county.

Kauffman raised one eyebrow and frowned faintly, appearing unconvinced by the Deputy Mayor's response since the person the Deputy Mayor said she coordinated medical care with, Dr Vance, had just said the opposite, that his team would like to be part of encampment cleaning operations. Next, Daniel Kauffman repeated the question. The Deputy Mayor continued to give a vague answer about the city's notice: "Depends on encampment initiative". She added that it was "a work in progress for Inside Safe to

define the amount of time for cleaning notices”. The exchange was getting tense. Daniel Kauffman pushed back and said, “Well, Dr Stevenson said that sometimes it is 7 days; does that sound like what the city does? The Deputy Mayor’s answer was, “It depends”.

Dr Stevenson interjected, trying to relieve the tension: “We haven’t seen anything less than a week since January, Daniel; this is observational data. Politicians want to keep shorter notice periods because if they give longer ones, people will game the system. Street medicine is supposed to be involved in encampment maneuvers pre and post”. The second thing he wants people to keep in mind, especially the Deputy Mayor, to whom he seems to be directing this, is that encampment cleanings need to prioritize the sickest patients. Dr Stevenson pointed out that the sickest people are not necessarily in encampments, but that is what the city is targeting. He asks that the city make its decision to put people in motels based on a triage of mental health, chronic conditions, and substance use.

In this meeting, street medicine providers voiced their concerns directly to a high-up city official about the disruptions to care caused by encampment moves. They demanded to be included in the planning of such actions and to actively participate during and after them. It was particularly noticeable and a clear symptom of the fragmentation of care that the County’s team had not been included in these operations and demanded to be. They also advocated for a longer notice period, so encampment residents and street medicine teams could be better prepared to mitigate the risks posed by encampment cleanings. Dr. Stevenson also raised another concern: encampment resolution programs—that is, encampment cleanings in which people were offered a motel room to move to—were not targeting the sickest unhoused people. Instead, as Dr. Stevenson complained to me numerous times, they followed a location-based logic, which he found profoundly problematic for him and some of his colleagues because it meant motel rooms were distributed based on the complaints of politicians and neighbors rather than on people’s healthcare needs.

Street medicine teams continued to advocate for participation in encampment resolution operations and for the humane treatment of encampment residents, with mixed results. Some

teams were directly invited to participate in encampment resolution operations, while others learned about the operation in their area of work through internal and external professional networks, as explained in the previous section. What they struggled with even more was redesigning encampment resolution operations in the city to be structured around healthcare needs rather than location. However, when street medicine providers managed to participate in these operations, street clinicians did successfully advocate for the sickest among the people in the encampment to get a room and be placed in a motel where the team could reach them. They also gamed the system and let their sick patients know about these operations, encouraging them to move into the encampment or come during the operation so they could be considered for a room.

The frequency and aggressiveness of encampment moves substantially escalated in the summer of 2024 because of the Supreme Court’s ruling in *Johnson v. Grant Pass* and Governor Newsom’s Executive Order N-1-24. These legal and policy developments authorized and even directed cities and state agencies to arrest and ticket people for sleeping outside, despite the lack of safe alternatives. The escalation of encampment sweeps led street medicine providers to work more actively to mitigate their impact on continuity of care and on their patients' health more broadly. For instance, a day after a street medicine round where Dr. Stevenson and I learned about an upcoming sweep at the RV encampment, he told me: “I called my contact at the LA Times to tell him about the RV encampment move, but he said it’s all moved now. (...) People need to know that old school encampment moves are back!” By “old school”, Dr Stevenson—who had been working for 15 years as a street doctor—meant the type of encampment sweeps where unhoused people and their belongings are forcefully removed from public spaces without being offered an adequate alternative place to sleep. Like him, other street clinicians talked to the press

about the escalation of encampment sweeps and their harmful effects on unhoused people's health and wrote op-eds advocating against encampment sweeps and demanding humane treatment for their street patients (Arbelo Cruz et al. 2024; Duvoor 2026).

A second issue related to continuity of care that street medicine teams advocated for was direct referrals. For months, they negotiated with managed care plans (MCPs) behind closed doors and reached agreements to be contracted as PCPs. However, this did not completely resolve the issue of direct referrals, since changes to PCP assignments can take 4-6 weeks to take effect. To avoid delays in care that can be a matter of life or death, street medicine providers led a campaign for legislative change. They co-sponsored a bill (AB 543) that allows street medicine providers to deliver medically necessary services without becoming the patient's PCP or obtaining a PCP's order.

AB 543 is a critical step toward ensuring Medi-Cal truly serves our unhoused neighbors by allowing field medicine providers to deliver medically necessary services directly at the point of care. Under current rules, patients are too often denied diagnostics, referrals, durable medical equipment, and other essential services simply because their licensed field medicine provider is not recognized as their assigned primary care provider. This bill removes that harmful barrier and ensures patients can receive timely, life-saving care without delay. (...) By signing AB 543, you will help save lives, reduce costs, and advance health equity across California. (Letter addressed to Gov. Newsom in support of AB 543, Sept. 2025)

In this letter of support, as well as press declarations and testimonies before the state senate, street medicine providers advocated for unhoused patients to access medically necessary services regardless of their PCP assignment. One of the core arguments against PCP gatekeeping and in favor of direct referrals was that although 70% of unhoused people in California have Medi-Cal, less than 10% of them had seen their PCP. This meant that assigned PCPs were being paid for services they were not providing, that the street clinicians providing care were not reimbursed for those services, and that patients were not receiving the services they needed and

were entitled to. In his testimony before the state senate, José Luis Gonzalez, medical director at the street medicine program, illustrated the case of one of his patients who could not access their primary care provider to say: “The taxpayers are paying for this gentleman to have insurance. He has insurance and he can't access it. Us providing the service, we're not even getting paid for this.” (Offner and Schrank 2025) .

Another argument street medicine advocates raised in favor of direct referrals was that it reduced the state's emergency service costs. Assembly member Mark González, who co-authored the bill, made this point clear in both the fact sheet of the bill and declarations to the press, where he said: “This [bill] is the first line of defense. Street medicine is preventative so that we don't clog up those [emergency] resources.” (Offner and Schrank 2025). The bill, which was also co-authored by street medicine teams, managed care plans, community-based organizations, and federally qualified clinics, received unanimous support throughout the legislature and was signed into law by Governor Newsom in September 2025, facilitating unhoused people’s access to continuity of care.

“THE BEST CARE IS THE CARE YOU ACTUALLY GET”

As this chapter has illustrated, continuity of care was an onerous task in the streets. The coexistence and constant tension between the structural impairments street medicine teams endured and their efforts to navigate them created an environment where continuity of care, though the north star, was hard to achieve. When confronted with the importance of continuity of care for their patients, a common response among street medicine providers was that “the best care is the care you actually get”. This phrase, which became a staple of street medicine teams, reflected a logic of compensation they adopted to lend their work legitimacy, regardless of the level of care they could provide, while operating within a health care system in which continuity

was the gold standard for quality of care. It also kept expectations realistic, helping street medicine teams cope with the frustration of the extra work required to fulfill the professional goal of continuity of care. There were two core aspects to this logic. First, people on the streets tend to be so sick that even a single visit would have a positive impact on the patient. Second, the level of need on the streets was so high that, even when care was interrupted for one patient, street clinicians always had someone else who could benefit from their services.

For instance, when I presented preliminary findings from my research to a room full of street medicine providers, public health scholars, and a managed care plan representative and noted that the team's geographic boundaries could undermine continuity of care, the medical director of one of the street medicine programs became quite defensive. She intervened and said that while teams might have to make decisions against following up with a patient because they were hard to reach, the teams use that time to care for someone as sick or sicker within their area of work. Similarly, other providers in the room emphasized that even a single visit with a patient was better than none, and that it was better to serve a few people in a contained space but provide as much care as possible than to spread themselves thin.

The ethos of "The best care is the care you actually get" contributed to street medicine teams having minimal formal internal (team-based) and external (payer-based) expectations for, and loose oversight of, continuity of care. Some teams defined their scope of work as urgent care, making continuity of care an optional service at the clinicians' discretion. Similarly, teams with a primary-care scope aimed to provide continuity of care but generally avoided formal accountability mechanisms, such as protocols, performance metrics, or visit quotas. Externally, grants from cities and philanthropy rarely required multiple visits or connections to medically necessary services. Moreover, even the most prescriptive contracts that street medicine teams

had, which came from payers within the health care system such as MCPs and hospitals, included flexible requirements regarding continuity of care.

Each patient is the same based on our panel. [Each one] is, you know, two touch points, so I have to prioritize certain appointments with certain patients. I'm like, "Okay, I'm not going to get all four of your appointments done this month. What are the two that you want done this one?" And they're like, "Okay, great, wait till next month". I'm like, "Yeah, that's it. I can't allocate 10 hours to you." And because if I did that for each one of my patients, well, you know. So we essentially are banking on there being some patients that are, like, five-minute patients, and patients that are three hours.

"Hey, how are you? Hey, how are you doing? You're doing well, good. Glad to hear it. Are you feeling well? Like, do you need anything? Nope, okay, see you later", and then you just check that. That was a touch point. And that's what all my coworkers do, too. It's the, like, secret little things that we all talk about. And then there's, like, some patients who need to see the doctor frequently, have a lot of referrals. Calling doctors offices is, specialty referral, is the worst part about my job. Nobody likes it in their personal life. Well, you triple hate it when it's a MediCal office. (Luz, Case manager)

Medi-Cal paid the street medicine organization where Luz worked the same rate for each patient they coordinated care for, regardless of the patient's level of need. Coordinating a patient's care had to occur at least twice a month for payment to be made. This coordination could be as simple as checking in with the patient by phone to ask how they are doing. But it could also be a time-consuming, highly involved process, such as spending three hours trying to send two referrals, then another hour locating the patient and coordinating their transportation, and so on. This broad definition of care coordination and the minimal requirements gave street medicine teams discretion over who among their patients would receive continuity of care. There was certainly an element of need, but that was not the full story. In Luz's team, the longitudinal care patient panel was a combination of patients who were fairly healthy and therefore were "easy touchpoints" and those who were in great need. Other criteria that Luz's team and teams from other street medicine programs used to provide continuity of care were that patients be easy to locate and demonstrate engagement with services.

The institutional flexibility around continuity of care also gave street providers space to define how much time and resources they allocated to it. In Luz's excerpt, this manifested in her decision to only address a few referrals at a time. She let patients choose which referrals they wanted, but in other cases, street medicine teams exercised greater discretion in determining which referrals to pursue, considering both patients' needs and the time and resources each referral demanded (e.g., a dentist appointment was easier to make than a rheumatologist appointment due to the larger availability of the former).

Ultimately, continuity of care was both valued and selectively enacted. Street medicine teams sought to provide it whenever possible, but they also relied on institutional flexibility to determine who received it, what form it took, and how much time and resources they could devote to it. This discretion was a pragmatic response to the gap between the profession's aspirations and the structural impairment to continuity of care.

CONCLUSION

This chapter has illustrated the structural barriers to providing continuity of health care for unhoused patients and medical providers' responses to these barriers. I argue that the commercial nature of the health care system, the fragmentation of the welfare state, and the criminalization of homelessness shape the extent to which unhoused people access care as they impair the potential of street medicine. Street clinicians' professional agency, as outlined in this chapter, provides a framework for social medicine practice in which social networks, advocacy, and immersion in patients' lived environments are leveraged to resist structural barriers and improve care. I argue that the coexistence of these actions and structural barriers redefines standards of care on the streets, where some care is better than none and continuity of care is an

achievable but heroic outcome, contingent on each team's capacity and willingness to go beyond the conventional limits of their practice.

CHAPTER 3

CRAFTING PATIENT ENGAGEMENT: AUTONOMY, TRUST, AND THE ALLOCATION PARADOX

So there are some folks that, as much as we educate and let them know, like, “hey, it's really concerning. Like, we really want you to be okay, or, next time, I don't want you to be convulsing the whole night.” And sometimes they're more like, “I've been living with it for 15, 20 years; what's the difference now?” (...) Maybe you're [refusing care] so you can feel that self-autonomy, or also, I feel like it involves trust. You have to be able to trust someone to allow them to come into your personal space, even if it's just to hug you; you want to allow someone. You have to give them that trust, even to hug you, or sometimes to have a conversation with you. (Jena, Physician Assistant)

One of the few things people living on the streets have autonomy over is whether they accept medical care. They have little control over where they live, what they eat or wear, but, for the most part, they can certainly decide to let a medical provider take care of their open wound, administer an injection, or conduct a physical exam. In other words, unless they are unconscious or gravely disabled—and sometimes even when they are—unhoused people have the freedom to engage in medical care or not (Barnard 2023; Gong 2024). While some unhoused people enthusiastically accept street medicine services, others, as Jena mentioned at the beginning of the excerpt, often reject them. The unwillingness to engage in medical care might signal that the person does not need it because they receive it elsewhere or that they do not feel sick, but it can also be evidence of quite the opposite. Street medicine providers were aware that the rejection of their services could also indicate greater need; people who refused to engage with them were likely to not have engaged in health care with any provider in a long time despite being at high medical risk due to their experience of homelessness. Patient engagement is also nuanced; patients might accept and even seek some treatments and diagnoses but reject others that are

lifesaving. How do street clinicians engage difficult or disengaged patients, that is, those who reject some or all aspects of medical care, while respecting their autonomy?

When patient autonomy is both a professional value and a right, engaging these difficult-to-reach and potentially higher-risk patients in medical care requires building and sustaining trust. Trust, as Jena shared, facilitates conversations between clinicians and patients, something seemingly simple yet with crucial implications for medical care. Patient-clinician interactions are the foundation of medical diagnoses, treatment, and prognosis (Heritage and Maynard 2006). This chapter examines the strategies street clinician teams use to build and sustain trust with patients and the consequences of these given the high-need, limited-resource context in which they operate. I argue that building and sustaining trust with disengaged patients is a time-consuming, labor-intensive process that contributes to an allocation paradox street clinicians must constantly navigate: the very practices that enable patient engagement also constrain how broadly and intensively they can provide care. I begin the chapter describing how street medicine teams build and sustain trust. Then I explain the three domains of the allocation paradox. Finally, I illustrate the professional repertoires street medicine teams use to navigate this paradox and how they shape the provision of health care.

BUILDING AND SUSTAINING TRUST: STRATEGIES FOR PATIENT ENGAGEMENT

Trust is always critical for patient engagement, but even more so in low-barrier health care models, such as street medicine. Unlike most medical interactions in clinics and hospitals, in street medicine and low-barrier models of care alike, health providers usually seek out patients, not the other way around. Offering unsolicited medical care can certainly provoke distrust among potential patients. A street medicine instructor with more than 20 years of experience as a street

clinician illustrated this point by making an impression of how a street medicine provider might sound to someone they are reaching out to: “Hi, we’re here and want to do all this medical stuff to you that you didn’t ask for. Please give us your bodily fluids.”

This feature of the model can significantly change how patient-clinician interactions unfold. Seeking care usually signals that the person has adopted the sick role; that is, they recognize they may have a health issue and want to address it through expert care from a medical provider (Parsons 1951). Therefore, when a person goes to a medical provider, at least a minimal level of trust in the provider is present. This trust does not mean the patient will follow everything the clinician recommends, but it is the bedrock of clinicians’ legitimacy to conduct diagnoses and provide treatment (Heritage and Maynard 2006). When providers approach patients instead, trust cannot be assumed; it must be built.

In the next two sections, I describe how street medicine providers build and sustain trust to engage difficult patients in medical care. Patient engagement is a time-consuming, labor-intensive, twofold process consisting of a relational dimension, in which patients agree to interact with providers, and a clinical one, in which diagnoses and treatment are discussed and negotiated.

Relational engagement

Street medicine seeks to create safety both physically and emotionally, as if our presence can wrap a bubble around us with a person in that safe space out on the street when we're interacting. (...) So I'm going to be thinking about how my words and actions affect people because I want them to be in their window of tolerance. And the things you can do to enhance a person's feeling of safety, both physically and psychologically and emotionally with you, are going to be the things that you really want to do to build trust, because it's within that window of tolerance that you want your friend out on the street to be when you're interacting with them so they have the ability the brain function to work with you, to solve problems. (Emily, Street Psychiatrist)

Street medicine providers had to perform intense emotional labor (Hochschild 2012) to engage difficult patients. They have to “induce or suppress feeling in order to sustain the outward countenance that produces the proper state of mind in others” (Hochschild 2012, p. 20). This involved instrumentalizing their own emotions (deep acting), those they portrayed as their own (surface acting), and those of their patients. As Emily mentioned, and as I will illustrate later, to build trust, street clinicians must act and present themselves in ways that evoke safety and care in the patient and prevent fear and anger during the encounter. While fear and anger trigger trauma, which usually manifests as people wanting to fight, leave, or freeze—reactions that are likely to prevent a medical interaction from taking place—safety opens the “window of tolerance” that allows people to have a productive interaction (“to work with you, to solve problems”).

Creating a safe space required acting in a caring and compassionate way, including distributing humanitarian goods such as water and food, smiling, and acknowledging pets. It also meant reducing the power differential typical of the patient-doctor interaction by sitting at eye level and avoiding professional staples like white coats and clipboards—some providers even left their scrubs behind and wore casual clothes. To avoid provoking fear and retraumatizing patients, street medicine providers refrained from wearing masks or sunglasses, speaking or walking quickly, and asking patients too many questions that could overwhelm them or make them suspicious. When communicating with potential patients, especially during the initial or relational engagement phase, they fostered trust by listening to their stories, laughing at their jokes, and avoiding overpromising, pathologizing, or imposing social stigma. Although these were trust-building best practices regardless of the patient's level of engagement, they were indispensable when interacting with difficult patients.

“I don’t want your fucking pills. I’ll call the police if you ever come close to me again”, Paul shouted at the two team members who had just approached him. Nurse Gaby, who

had stayed in the van until now, grabbed a juice from the van's cooler and wound care supplies, put a big smile on her face, and stepped out of the van. The outreach workers who referred Paul to the team said he has open wounds, so she is going to give it a try. She said "Hi" in a warm, soft voice, knelt next to Paul, the patient, who was sitting in a camping chair on the sidewalk, and asked how he was doing. He accepted the juice and the wound care supplies as well as a spinach wrap and a coffee that she offered to buy for him. While Nurse Gaby was at the store, the rest of the team asked Paul how he was doing. The patient started talking about a conspiracy theory that included the military and the state. We all listened, nodding sporadically.

Paul was zipping up the coffee Gaby had just brought to him, she, crouching beside him, asked how his wounds were doing. Paul took his shirt off to show her. As he was doing that, Gaby looked at me briefly with a triumphant smile. She looked at the wounds and asked him what medication he was taking. He took everything out of his backpack and showed her all the medical supplies he had. His antibiotics were in a bottle that Gaby could not immediately open, so Paul offered her a stick that he said he used to open it. She kept trying until she gave up and returned the bottle to the patient to open, laughing and recognizing how stubborn she was. The patient laughed with her. At the end, Gaby offered to help him pack his bag again, adding that she loves to organize things but understands that the way she might do it might not make any sense to him. He agreed he wanted to do it himself.

Back in the van, I told Gaby that I noticed she hadn't offered to clean and bandage Paul's wounds. She said she didn't want to push things. She felt like they made progress by being able to see the wounds, and that pushing for more could have damaged the little trust they had built.

Paul's engagement illustrates street medicine providers' efforts to build trust with difficult patients. The smile Nurse Gaby intentionally put on her face, her soft voice, and the food and drinks she shared with the patient were signs of care. Nurse Gaby's initial embodiment and the engagement tools she used were well received by Paul, who had previously refused to engage with the team and now showed his wounds and shared a laugh with them instead. He moved from a state of fight into the window of tolerance, where they could talk.

As part of the trust-building process, Nurse Gaby fostered an informal and warm environment compared to what people usually expect in a medical interaction; she made fun of herself for being unable to open the bottle and shared a little about herself (being stubborn and

loving to organize), to which the patient responded with complicity. Moreover, she made sure to express her respect for the patient's autonomy by not imposing her own way of organizing Paul's bag, while still offering to do so, which continued to show care. Similarly, when she was gone buying the coffee and spinach wrap, the rest of the team kept him engaged by asking how he was and listening without judging what sounded like psychosis.

Street medicine providers also had to assess how far they could go with their trust-building efforts in providing actual medical care by gauging the patient's emotional state. To not overwhelm the patient, Nurse Gaby refrained from offering to clean and bandage Paul's wounds. She considered that they had already asked enough from the patient and that something more involved, like wound or psychiatric care, could set back the progress they had made by making him uncomfortable.

Clinical Engagement

Being able to engage in conversation with the patient did not necessarily translate into clinical treatment, as we saw in Paul's case, but it was a first step. Patient engagement had both relational and clinical dimensions. The relational aspect involved talking and interacting with patients. Clinical engagement, though built on relational engagement, meant taking a step forward in the therapeutic relationship by providing medical care. This involved the patient accepting and following a provider's therapeutic recommendations (e.g., diagnostic tests, behavioral changes, medications, and medical procedures). To engage a patient clinically, street medicine providers had to continue to build and sustain trust, which was mostly done through clinical empathy, a specific type of emotional labor "that allows physicians to incorporate emotional experiences as part of clinical decision-making" (Uderman and Hirshfield 2016, p. 97).

During our ride, Natalia (nurse practitioner) complained that the psychiatrists who sometimes went out with her wanted to either impose medication on people or give up as soon as the patients said no. They “don’t get” how to treat homeless patients. She went on and said it takes time and a different approach than the clinic. It involved starting the therapeutic engagement with basic things (e.g., food, water) and “then the patient might mention they haven’t slept well, and that’s when the provider can say, ‘Do you want something to help you with that?’”

Natalia described one common strategy to incorporate and instrumentalize emotions in the clinical encounter to foster trust and clinical engagement. That was to elicit and closely attend to statements and cues that reflect the patient’s emotional state. Not sleeping well was one of many situations (e.g., getting into a fight with a loved one, feeling physically unwell) that brought up negative feelings in people, such as discomfort, anger, and frustration, that could motivate the patient to change their behavior, including accepting psychiatric medication and going into rehab. Under that premise, street clinicians like Natalia attentively waited for those situations and the feelings around them to come up in conversation. They also brought them up intentionally with general questions (e.g., how are you doing?) or specific questions (e.g., how’s your sleep? how does that make you feel?). These nudging openings created opportunities to introduce or reintroduce clinical work to ultimately address the patient’s negative feelings.

Even when patients had accepted the therapeutic intervention from street clinicians, such engagement was not static and fluctuated frequently. The following excerpt is from an interaction between physician assistant Finn and patient Bella. Finn and Bella have had a patient-clinician relationship for several months, which started when she was still living outside. During that time, I saw Bella’s relational engagement being closely cultivated with Finn’s signs of care and emotional proximity, such as sharing pictures of his baby with Bella and helping her move her tent and belongings to avoid getting a ticket from a police officer. Bella’s clinical engagement, however, was more volatile.

Bella looked very sad. She sat on the old carpet right next to the heater in the motel room she recently moved into. She seemed cold and skinny. The team told me she was having a rough time. She cries almost as soon as Finn says “hi” to her with a warm smile. Finn crosses the room to sit next to her.

Finn: Seems like you might have been struggling more since you moved in?

Bella: Yeah

Finn: Is it because of all this [moving inside] shit?

Bella: Yes

Finn: You need to take those pills every day (HIV antiretroviral). Taking them for a few days at least is still a win. Don’t beat yourself up if you miss a pill. Some treatment is better than no treatment. Take it as much as you can so we can put your white cells up. It’s for 3 months.

Bella: I’m gonna fuck it up anyway. That’s why I don’t want to [take the oral antiretrovirals] anywhere. I’m ready, but I’m not ready.

Finn: Life is just life, it’s fucking complicated. You have been outside a lot. You have been outside for so long. Most people get fucked for that. That’s heavy.

Bella: This is too much for me.

Finn shared that he took crystal when he was 16 and gave it to his 12-year-old brother and added, “I still think I fucked him up, that I fucked up. That’s me judging myself in way that I shouldn’t. I didn’t have a mom. I didn’t have a dad, I was trying to do my best with what I had. I know you have been in a bad situation for a long time. It’s not you; it’s all that fucked up shit”.

Bella: I want it, I’m ready for the shot (HIV antiretroviral long-acting injectable).

Finn: Call me anytime. I don’t care, I’ll shut up and listen. Stay here, stay here. We can help you better here, I promise.

Finn and Bella’s interaction illustrates common strategies among street medicine providers to clinically engage patients. Bella was struggling with two medical-related decisions that her clinician Finn strongly recommended, and she had initially agreed to: taking oral HIV antiretrovirals and staying in the motel room. To keep her clinically engaged, which, in this case, meant staying indoors and taking the oral medication for three months, Finn first employed the strategies of eliciting feelings (“*Seems like you might have been struggling more since you*

moved in?) and demonstrations of care (e.g., approaching her to the other side of the room) that I have previously discussed. In addition to these strategies, the interaction shows the use of affirmations and the adaptation of care strategies of clinical engagement. Finn addressed Bella's feelings of fear with affirmations that validated what Bella was experiencing ("*You have been outside for so long. Most people get fucked for that*") while also gently counteracting the fear Bella had of "fucking it up". He did that by placing the causes of her previous hardship outside of her ("*it's not you, it's all this fucked up shit*"). He used his own experience with meth to illustrate that "bad situations" make people make bad decisions and then judge themselves for them. Sharing a personal experience like that served not only as an example but also as a way to keep cultivating the emotional proximity between them².

As much as the emotional work of eliciting and affirming patients' feelings was a common strategy for clinical engagement in street medicine, so was adjusting therapeutic interventions to the patient's emotional state. Finn did this with the antiretrovirals when he said, "taking it a few days is still a win" or "some treatment is better than no treatment," even though the ideal dose was to take the pills every day. Following the same "some treatment is better than no treatment" philosophy, street clinicians allowed behaviors that other clinicians would typically try to change before treating a patient (e.g., opioid use) in order to clinically engage patients. This helped patients not feel judged and reduced individual-level barriers to treatment.

Finally, the way the interaction between Bella and Finn ended illustrates the complexity of clinical engagement was as an emotionally intense and time-consuming process. Part of

² Although Finn often shared aspects of his personal life as part of his patient engagement practices, that was not usual or expected of street medicine providers. However, when providers did so, it was not seen as unprofessional as it would be in the more traditional patient-clinician interaction. Moreover, even if providers did not use their own experiences to shift the emotional state of their patients, they did frequently bring up other patients' experiences.

achieving clinical engagement was protecting the relational engagement that underpinned it. Because of that, street clinicians had to avoid confrontation with their patients, which led to strategies that street medicine educators called “rolling with resistance” and “shifting focus”. When Bella showed that she had not changed her mind (“*I want it, I’m ready for the shot*”), Finn stopped insisting and accepted the resistance (i.e., “rolled” with it). While sometimes this meant ending the conversation with gestures of care and emotional proximity (e.g., Finn telling Bella to call him anytime and that he would listen to her), other times it meant shifting the conversation from the contentious topic to one on which the patient and the provider were more aligned. The goal was to end the interaction on a good note that preserved their relationship.

THE ALLOCATION PARADOX

The labor-intensive nature of patient engagement, combined with limited resources and high levels of need, produced an allocation paradox: the very practices that enabled providers to engage patients who were otherwise difficult to reach also constrained how broadly and intensively they could provide care. This paradox emerged in three domains. First, providers had to consider how to allocate scarce time and emotional labor across patients and forms of care. Second, within individual patient relationships, they had to balance preserving trust with pursuing urgent medical intervention. Finally, street clinicians had to balance making care accessible in the streets with preparing patients to transition to less accommodating but clinically more comprehensive models of care.

Engagement vs Reach

Street clinicians were constantly confronted with the decision of whether to invest substantial time and resources in engaging difficult patients or to provide care to a larger number of people who were open to care and therefore did not require as much engagement from the

provider. Although street clinicians were prepared to engage “difficult” patients—those who required intensive trust-building efforts—in practice, many people were open to their services. The latter were “engaged” patients, people whose baseline trust level saved street providers considerable time and effort compared to treating difficult, disengaged patients. Prioritizing engaged patients could free up time to see more patients, helping address the high need for medical services across the city.

I don't wanna say wasting our time, but like, in a way, wasting pulling us to go, you know, meet with a person every day, and we roll in and try to work with them, and they are refusing help like we can't be every day called out to visit with someone who is not cooperating, not consenting to the services, like that's a drain on us. We're only a handful of people, and there's a lot of people in LA who need help, so that's another dynamic of the whole situation, where we need to respect ourselves here, respect our limited resources, respect ourselves as professionals that we are not being chronically called out to deal with people who are not cooperating. (Max, Case Manager)

In this excerpt, Max, a case manager on a street medicine team, expressed his frustration with spending time and resources trying to engage unhoused people who were unreceptive to services from the outset, describing these efforts as both wasteful and draining. He justified these feelings by pointing to the immense unmet need across the city, while also reflecting on the respect owed to service providers and their time. Although the latter sentiment was more specific to Max, the broader tension between investing substantial time and energy to engage a single difficult-to-reach patient and using those same resources to care for multiple others emerged repeatedly throughout my fieldwork and interviews with street medicine providers. In the same amount of time—and with considerably less emotional labor—clinicians could often reach several patients who were already receptive to care.

At the same time, because engaged patients were usually more willing to accept referrals, treatment, and other services, providers could accomplish substantially more clinically than with

disengaged patients. Doing more clinical work, rather than spending time on rapport-building and emotional labor, gave providers a stronger sense that they were performing the core work of medical practice. It also had financial implications: seeing more patients and providing more billable clinical services contributed to the financial sustainability of programs, making intensive engagement with fewer patients more difficult to justify from an organizational standpoint. Finally, greater clinical activity made the impact of their work more visible, as successful treatment and improved health outcomes provided evidence of street medicine's clinical value and helped establish its legitimacy as a meaningful healthcare model.

This dilemma was particularly difficult because street medicine teams believed that disengagement did not necessarily indicate a lack of medical need. While some unhoused people avoided street medicine because they did not perceive themselves as needing it, either because they felt healthy or had established care elsewhere, many others were reluctant to receive medical care in general, possibly indicating they had gone without medical attention for extended periods and were therefore likely to have greater unmet health needs than patients already engaged in care. As a result, street medicine providers worried that moving on too quickly could mean abandoning those who needed them most, whereas investing heavily in one reluctant patient inevitably reduced the number of people they could reach.

Trust vs Clinical Urgency

A common scene in street medicine was when clinicians identified a medical issue that required attention, but the patient refused treatment as recommended. In these situations, providers faced a difficult decision: allocate time and effort to build trust and convince the patient to get treatment, or protect their time, resources, and rapport with the patient while risking clinical complications. In other words, they had to balance two professional goals that

had become conflicting: advancing the patient's health and respecting the patient's autonomy. This dilemma arose in different stages of the patient-clinician relationship. It surfaced when providers first met the patient and felt they did not have enough time to build the rapport that could help persuade the patient. Introducing the idea of treatment at such an early stage of the therapeutic relationship could close the door to any future interactions. It also occurred when rapport was already established, and providers wanted to preserve it, but the clinical cost of doing so could be too high, as in Anna's case next.

He has really bad diabetes that he is always refusing [care for]. I saw him one time, and he was very sick. His vitals were not good, and I was like, "You need to go to the hospital." This was right before, like, a week before he got admitted, and he was refusing, and I signed him out against medical advice. And, you know, I talked to his psychiatrist, I talked to the director of our FSP team, and we all were just like, I don't know, like, is this a psychiatric hold? Because he technically has very severe depression, you know, and he understood that this could lead to his death, but he doesn't really care. Like, he's not afraid of death. He says he doesn't care if he dies. And so we're kind of like, well, you know, he's pretty, you know, he's linear. His thoughts are clear; he understands that this is serious, and I don't know if this is a psychiatric hold because it's kind of a very big gray area. Like, do we respect this person's wishes for self-determination to be like, look, we're not going to force you, but we also want to make sure that we're not missing, you know, like that we should have put him on a hold? It was not clear-cut, and we ultimately decided that he was not foldable. And then, eventually, he fainted, and paramedics came and took him. But it was a big discussion between all of us because we didn't, it's just so much that goes into that, you know, it could fracture the rapport. (Ana, Physician Assistant)

Here, Anna described a situation in which she faced the challenge of addressing a clinical emergency while risking the rapport she had carefully crafted with her patient. The patient required hospitalization for severe complications of diabetes but refused to go. Because the situation was potentially life-threatening, Anna first had to determine whether the patient's refusal reflected an autonomous decision or one impaired by an acute mental health illness. This was a recurring grey area in street medicine practice. Deciding whether to place a patient on an

involuntary psychiatric hold was difficult not only because the threshold for grave disability was often ambiguous, but also because, as Anna reflected, doing so—even when legally justified—could fracture the therapeutic relationship. Providers knew that when patients returned from the standard 72-hour hold, they could be grateful for the intervention, or they might feel betrayed and refuse to engage with the provider again. If putting people on a psychiatric hold was far from solving the issue, a clear-cut ruling out grave disability did not make things easier. With no mental illness or substance use impairing the patient’s decision, street clinicians had to deliberate how much they should try to save a patient who had autonomously decided they do not care about dying.

Sometimes patients accepted some treatment rather than none. Although this eased the tension, it did not resolve the trust vs. clinical urgency dilemma. Consider the following scenario: a provider worried that prescribing antibiotics in the field, rather than insisting the patient go to the emergency department, would enable the patient to keep refusing what she considered the most clinically appropriate course of treatment (hospitalization). Yet withholding the antibiotics could allow the patient’s condition to deteriorate and risk fracturing the rapport needed to eventually persuade him to seek emergency care. Whether patients refused all or some treatment, street clinicians faced competing professional obligations: on the one hand, providers felt responsible for preventing death and improving their patients' health; on the other, they recognized that prioritizing patient engagement by respecting their decision-making was essential to maintaining or initiating a therapeutic relationship through which patients might eventually accept the recommended care—or, at the very least, continue receiving treatment for other, less contested health needs.

Accessibility Vs Integration

A third manifestation of the allocation paradox concerned the downstream consequences of making care on the streets highly accessible. The time and emotional attentiveness that facilitated engagement could also create expectations on patients that conventional healthcare settings (e.g., hospitals, clinics) could not meet, complicating their transition to other, usually more comprehensive, sources of care. At the same time, accommodating patients' behaviors to preserve access on the streets could reinforce what were considered deviant behaviors in conventional healthcare settings, further complicating the patient's integration.

I have patients that are remarkably stable, and I am having a hard time getting them to stop calling me, because I will set them up with a clinic and they'll say, "they can't see me fast enough. They can't see me enough". And now I'm in a position where I'm like, I have to, like, I'm talking to my medical director about strategizing this. I have to give you a hard deadline and say I can't follow you after this date because I've already let you go to like, three different clinics, and you will not find somebody that will give you the amount of attention and the degree of service that we're offering our patients, which is a challenge from my perspective, as patients are moving forward. I'm trying to see, how do we strategize, like graduating patients from the program when we're giving them this level of service, and then they expect it moving forward, but they don't get it anywhere else. (...) As it gets to a point, [they] are more stable, I cannot provide [them] the same degree of attention that I did previously, and I know that's [on us] and being patient with yourself as a provider too, recognizing that we've now taught [them] to expect that [they] deserve this level of services. But now we have to enforce boundaries too. (Finn, Physician Assistant)

Providers like Finn worried that the relational nature of street medicine could itself become a barrier to patients' integration into clinic or hospital-based care. This integration was needed mostly in two opposing scenarios: when the patient was clinically stable and ready for a clinical home (so limited street medicine resources could focus on higher-need patients), or when they needed medical services not available on the streets. As Finn explained, the same attentiveness and emotional investment that made street medicine successful at engaging patients

also created expectations that conventional health-care settings were rarely able to meet. As a result, some providers worried that patients would become reluctant to transition. In this way, clinicians faced an enduring tension between maximizing present accessibility and promoting patients' long-term integration into more comprehensive and clinically appropriate care.

Integration also meant that patients would likely receive care in a less flexible environment than the one fostered by street medicine providers. The low-barrier approach of street medicine sometimes involved enabling behaviors that compromised their access to other forms of care. Ongoing substance use, profanity, and other deviant conduct that were tolerated during street encounters were sanctioned in conventional clinical settings. One street medicine team affiliated with a clinic, for instance, repeatedly encountered and cared for patients banned from the clinic for behaviors providers had tolerated on the streets. Although this complicated patients' access to clinic-based care, clinicians also recognized that imposing the same limits in street encounters might have left patients with no care at all.

FACING THE PARADOX

Low-barrier, emotionally intensive care was essential for engaging patients both relationally and clinically, but it was not a panacea. In the context of resource scarcity and high need, pursuing patient engagement created an allocation paradox. Teams did not approach the different manifestations of this paradox uniformly; instead, street clinicians developed professional repertoires to navigate it based on the patient's circumstances, their judgment and values, and the team's organizational capacity and scope of practice.

One way in which teams managed the allocation paradox was by concentrating their work in encampments and shelters rather than among isolated individuals. By focusing their efforts on geographically clustered patients, clinicians spent less time traveling between

encounters and more time providing care and cultivating relationships. This organizational arrangement enabled teams to reach more people without substantially reducing the time devoted to engagement with each patient, but made access to street medicine more challenging for unhoused people who lived by themselves or were not visibly homeless. Focusing on shelters also created a new moral conflict for some providers who felt they were retreating from the street and therefore from the most vulnerable patients.

The amount of time and energy street providers put into engaging a patient was also closely related to how the patient became visible to them and their perception of the patient. For example, street clinicians allocated more effort to establishing an initial relationship (what I have called the relational engagement) with people who appeared to be high-need during outreach or had been referred by an existing patient or a partner organization than with those who were not.

The outreach workers were taking Dr. Stevenson to the next patient at the encampment when he said he should actually go see the lady in the pink sweater, whom she pointed at as she started walking towards her. Her name is Debra and she's sitting on the sidewalk with her legs straight and her torso upright. She has a blank stare. Dr Stevenson made sure to be in front of her as he approached. He's kind on his knees so his face is at the same height as hers. They talk, and she's not super responsive but she answers some questions. He's asked her how she ended up homeless. She says multiple times that her bike was recently stolen. It was blue, and someone took it while she was napping; she said she was too tired to lock it up. Dr Stevenson is persuading her to go to a shelter. He asked her if she would be interested in doing that. He then tells me she was a little bit hesitant. While they're having this conversation, he's asking one of the case managers from SJC to get her on the list of the shelter nearby. She's on it. He describes what he's doing to Debra, hoping she gets more interested in it. But her affect is flat. He asks Debra if he can take his blood pressure and other vitals. She says she has an eye doctor, that he's very handsome, and that he's going to be jealous if she lets Dr Stevenson take her as a patient. It's hard to tell if she's being totally serious. She's not like a hard no on being medically assessed. He invites her to come with him to the van. To do that, she needs to stand up. She's clearly struggling, so he offers to help her. He is doing that with one arm, and then one of the case managers comes to help with the other. When she finally stands up, they realize she was sitting on her urine. That seems to alarm Dr Stevenson, who starts asking the case manager to get clothes for Debra. He also brings

up the idea of a motel room for her. Instead of walking to the van for the assessment, Dr Stevenson decides to drive the van to Debra to make things easier.

Here we see Dr Stevenson engaging a patient from scratch, and all the time and effort that implied. Dr Stevenson approached and invested in engaging Debra because he could sense something was particularly wrong with her. He could not tell what was wrong immediately, but her flat affect, blank stare, and posture signaled a high need. A similar slow approach was deployed when patients were referred by another patient or a partnering organization, as we saw in the vignette between Nurse Gaby and Paul at the beginning of the chapter.

When referrals and clear medical need were not present, street medicine clinicians rarely initiated patient engagement from scratch. Instead, they frequently invoked the outreach principle of "meeting halfway", although it was more like "meet me one-third of the way" because, while they did not expect unhoused individuals to be totally open to the team's services, they generally looked for some indication of willingness to engage before committing scarce clinical resources. During outreach visits to encampments, clinicians would introduce themselves and offer medical services, usually by walking through the encampment and stating their name, organization, and services until someone showed interest. If individuals declined or did not respond—signals interpreted as a lack of readiness to engage—they typically continued to the next tent or person. Providers saw that engagement as a sign of medical need, but they were aware that many people fell through the cracks as a result of this approach (e.g., those people who were not visibly sick or connected to partner organizations). In fact, in my interviews with unhoused people who were not street medicine patients, they mentioned not engaging with the team because they did not think they needed medical care, but also because they did not know those services were open to them, were unsure if they would have to pay, and distrusted medical providers.

Street clinicians had different professional repertoires when confronted with medically urgent situations in which patients refused the proposed course of action, particularly when the patient's level of grave disability status was ambiguous or discounted. One of those was a persuasive approach that sought to convince patients by reframing the purpose of a medication or intervention and emphasizing the potential consequences of declining treatment. Alongside this was an autonomy-centered approach that limited the clinician's role to explaining the risks and respecting the patient's decision, without further attempts to influence it.

Dr. Williams saw the Abilify on the table and asked Theo, "How about those meds? Have you gone through them?" Theo said he has read the instructions, and he fits a lot of the criteria to have bad outcomes, and added that he is never taking anything that can cause an overdose. He's also worried about having a bad reaction. Dr Williams gently said that's why they do an evaluation after the first month of treatment. Theo is still unconvinced and said that he didn't think that what he had would be cured with that psych medication (he says his condition is autism and chemical sensitivity). Dr Williams' response was, "This type of medication (Abilify) helps people get organized so they can do [better]. I'm not trying to push this on you, but just to finish a thought. We think this could help you; we don't have any other agenda,". Theo resists saying that he is part of the population that doesn't do well with medications. Dr. Williams gave him a smile, nodded, and said: "Then, the goal of the week is to take a shower and get some clothes?" Theo nodded.

In this interaction, we can see Dr. Williams using a persuasive approach to address Theo's refusal to take the antipsychotic medication, which he considered the best course of action. He not only stated that he had no other agenda but also gave a loose explanation of what the medication was for, seeking to persuade Theo to take it. A common rationale among providers who leaned on the persuasive approach was that medicine had to be assertive and goal-oriented. This meant guiding patients toward what they considered healthier choices by offering them the most appropriate care but leaving the decision to them. Although this approach was extremely rewarding when it worked, when it did not, providers felt defeated and deliberated

over whether to let go and keep persuading little by little in each interaction, or reconsider grave disability with a flexible lens and opt for a more directive approach.

Theo was referred by the street medicine team to the county's Homeless Outreach Mobile Engagement (HOME) team a few weeks after the interaction described in the fieldnotes excerpt above, which took place in a motel room that the street medicine team paid for Theo to stay in for two weeks. The HOME team was involved after Theo went back to the streets following the end of the motel funds the team had for him and his refusal to go to a shelter—he had told me before he had been raped twice in a shelter and would never want to put himself in that situation again. The team decided to call the HOME team—one of their recurrent collaborators—arguing that Theo had schizophrenia and could not take care of his medically necessary care (his blood pressure was dangerously high) because of it (a criterion of grave disability), which they saw as the last resort to get him indoors, given the larger resources the HOME team had, including their ability to do psychiatric holds. Not long after the referral, one of Theo's street doctors showed me a picture of Theo at the residential facility he had moved to, smiling next to his case manager from the HOME team, with his long beard and hair shaved, and the charcoal that had covered his skin and clothes all washed out.

Although Theo stayed inside and it became impossible to know if his rapport with the team had been affected by their referral to the HOME team and the following psychiatric hold he went through, this was a risk that some street providers were comfortable taking. I observed them rebuilding that rapport with patients when they returned to the community, with varying degrees of success. This persuasive approach and its ramifications coexisted with an autonomy-centered approach to treatment refusal.

I asked Kailey if she ever needs to get a bit authoritative with patients who do not follow her medical advice. She said no, authoritative never because it's always the patient's

decision. What she does make sure to say is, “If you don’t do this, you might die.” She told me about a patient she had who had high blood pressure for a few days, and she was afraid he could have a heart attack. She explained to him that he might die, but he didn’t want to go to the hospital; he would rather die on the streets, and that’s what happened. “Do I wish it didn’t happen? Of course, but it was his decision”, Kailey said.

Just like Theo, the patient Kailey was referring to had high blood pressure and refused to follow the provider’s advice. Unlike Theo, however, Kailey’s approach to his patient’s risk of a heart attack and refusal to get treatment was substantially different than Dr Williams’s approach. She opted to share the information about the risks of his decisions and then refrained from trying to convince him. This is not to say that these approaches determine who lives and who dies (although that is what happened in these particular cases), but to illustrate how they differ and the rationales behind them. Keiley represented a type of street medicine approach common among what Dr Stevenson liked to call “purist” street medicine providers. This group usually rationalized their minimal persuasion as part of respecting the patient’s autonomy, their right to self-determination, which for many providers was kind of sacred, as they thought of that as the only thing patients had left given the state of complete dispossession they lived in. Providers considered their role in the patient’s journey to restore their dignity by respecting their wishes, even if it meant witnessing a preventable death. Overall, it meant the “radical acceptance” that not everyone had to have a severe mental illness or substance use to not care about dying. This course of action was not easy. Although the provider spent less energy persuading the patient, they had to deal with the grief of potentially losing a patient and being unable to fulfill their professional goals of healing and preventing death.

Finally, to help patients transition into less flexible and personalized models of care without substantially altering how they provided care on the streets, providers drew on the resources and institutional connections available to their programs. Programs with greater

resources could sometimes assign caseworkers or other staff to accompany patients to appointments, helping them navigate less flexible healthcare settings and supporting continuity across settings. Providers also sought to make these settings more accommodating by communicating with clinicians and staff in advance and encouraging them to be more receptive to their patients' needs and circumstances. However, providers often reserved these limited resources for patients perceived as more deserving, either because they had greater needs or a closer relationship with the team. When such support was unavailable, providers had different repertoires. They could coach and educate patients about how to navigate conventional clinical settings while continuing to accommodate their behavior on the streets, or introduce firmer boundaries in street encounters to encourage patients to adapt to the behavioral expectations they would face in those settings, even when doing so risked alienating the patient.

CONCLUSION

Engaging patients who refuse or resist medical care while respecting their autonomy over health care decisions is one of street medicine's central goals, as these patients often have some of the greatest unmet healthcare needs. Yet patient engagement is a time-consuming, labor-intensive process centered on building and sustaining trust. Providers must manage their own emotions in relation to patients' emotional states, which they must closely attend to, creating a safe space where patients feel able to open up and become receptive to clinical recommendations. They must also adapt treatment decisions to patients' preferences and circumstances, even if it is not the best course of action. In a context of limited resources and high need, the substantial time and effort required to engage patients therefore produced an allocation paradox that providers navigated by making difficult decisions about whose needs to

prioritize and accepting that some undesirable outcomes could not be avoided—including losing patients altogether or losing the trust that made ongoing care possible.

CONCLUSIONS

This dissertation sought to answer the following research question: *How do street medicine teams address the health needs of a patient population facing acute and intertwined social and medical risks while respecting their autonomy and working within and alongside organizations and a regulatory system that both constrain and facilitate their provision of care?* Street medicine teams contributed to the well-being of unhoused patients by assessing their biomedical and social needs, stabilizing urgent physical and psychiatric issues, and treating or managing chronic and infectious diseases directly where their patients live. They also advanced their patients' health by facilitating relocation into housing and healthcare facilities and helping them navigate the healthcare system with a compassionate approach.

To provide this care long-term and comprehensively, they implemented strategies that reduce the impact of encampment sweeps, insurance enrollment and prescription rules, and fragmented care. *Streetwise doctoring*, a top-down strategy to adapt clinical work, in coordination with patients and their support system, to the cultural, social, and material reality of homelessness; *network mobilization*, a lateral strategy to overcome barriers to continuity of care in coordination with other service providers; and *clinical advocacy*, a bottom-up strategy in which they appeal to authorities for structural change.

Street medicine teams also circumvented individual barriers to care. Caring for patients who refuse treatment while maintaining their autonomy required street medicine teams to engage in a time-consuming, labor-intensive process centered on building and sustaining trust. Providers managed their own emotions in relation to patients' emotional states, which they had to attend to closely, creating a safe space where patients felt able to open up and become receptive to clinical

recommendations. They took on non-clinical tasks and adapted treatment decisions to patients' preferences and circumstances, even when it was not the best course of action.

Contributing to the well-being of unhoused patients in the ways I have described comes with some important costs. Street medicine teams' limited resources and institutional power, along with the material constraints of operating from a van or backpack, mean they must engage in organizational partnerships and collaborations that expand their reach and impact but also frame and restrict who they see. To secure funding streams and continuity of care for their patients, they worked alongside and within organizations that make unhoused people inserted in particular geographic locations and institutional processes, not necessarily the sickest, more visible. These institutions can also use street medicine to justify punitive actions by local governments, early hospital discharge, and denying access to patients who are deemed too sick or not the right type of sick for certain transitional housing options.

Finally, the intense emotional, logistical, and non-clinical work that street medicine clinicians and their teams endure to engage difficult patients creates an allocation paradox: the very practices that enable patient engagement also constrain how broadly and intensively they can provide care. Navigating such a paradox requires making decisions about who is more or less deserving of clinicians' time, contributes to burnout, and can lead clinicians to favor working in clustered locations where they can conserve time.

In short, street medicine advances the health of unhoused people. However, much of this impact depends on the extraordinary efforts of street medicine teams rather than on structural changes that address the root causes of illness among unhoused people. In this sense, street medicine offers an important case of how professionals can resist institutional and structural constraints, achieve meaningful outcomes, and demonstrate that different ways of organizing and

delivering care are possible. At the same time, it reveals the persistence of the structural conditions—criminalization, the lack of affordable housing, and the commercial nature of health care—that continue to shape unhoused people’s health.

Contributions to the Sociology of Poverty

These findings make several contributions. For the sociology of poverty, street medicine reveals a care-oriented, treatment-intensive model of homelessness governance that is expanding across the country. Medicine has long been central to the regulation of homelessness, but street medicine departs from the more common punitive and coercive uses of medicine (e.g., Gowan 2010; Herring 2019; Mathieu 1987) while also extending beyond efforts to keep people alive through emergency care or harm-reduction initiatives (DiMario 2023; Seim 2021). The rise of street medicine does not mean those punitive and palliative strategies of homelessness governance have vanished; rather, it offers an alternative.

By assessing patients’ urgent, primary, psychiatric, and substance use needs and addressing some of them in situ, street medicine teams improve their patients’ health in ways that otherwise would not be addressed or would be handled by overcrowded emergency services. These actions also make people more houseable: crafting houseable clients is a multilayered, dynamic process in which clinicians not only sign disability forms (Gong 2024; Osborne 2018) or provide pseudo-therapeutic interventions focused on self-reflection and blame (Lyon Callo 2000; Gowan 2010), but also actively make people fit for housing opportunities through medical evaluations and biomedical treatment.

Street clinicians’ medical interventions also help reduce public disruptions caused by or attributed to patients, offering a care-oriented, treatment-based alternative to policing (Herring 2019; Stuart 2014). Their referrals help relocate patients to healthcare facilities where they can

receive ongoing treatment and, in some cases, move in. Their interactions with unhoused individuals also differ from the coercive disciplining or the tolerant containment described in earlier homelessness governance literature (Gowan 2010; Lyon Callo 2000; Stuart 2014; Gong 2019). Through compassionate disciplining, they encourage unhoused individuals to use healthcare and welfare services more effectively by explaining how these services work and why appropriate usage can help them reach their goals.

Beyond its empirical contribution—showing how street medicine introduces new strategies for regulating homelessness—this study intervenes in theories of poverty governance by highlighting professional authority as a factor shaping how the poor are governed. Existing scholarship distinguishes frontline workers primarily by their location within the “left” and “right” hands of the state, emphasizing whether their work is oriented toward care or punishment (Wacquant 2009). Beyond this distinction, however, frontline workers are often treated as a relatively undifferentiated group whose practices are shaped by organizational mandates, including financial and legal imperatives (Lara-Millán 2021; Wacquant 2009), and by their relationships with other frontline workers and the people they serve (Lipsky 1980; Seim 2020). This approach obscures how differences in workers’ professional authority may produce substantively different forms of governance.

Street clinicians, like other frontline workers, operate within policies and organizational mandates and are influenced by their interactions with colleagues and the people they serve. Yet the content and consequences of these relationships differ because street clinicians possess a distinctive form of professional authority. Unlike occupations, professions exercise jurisdiction over a recognized domain of work, operate under professional mandates, and receive state protections and oversight (Abbott 1988; Freidson 1970). They also possess specialized expertise

that can not only sustain life but alter behavior and improve patients' health and quality of life. These capacities confer both cultural authority—the legitimacy to define what constitutes a problem—and social authority—the ability to direct the actions of patients and other workers (Starr 1982). I therefore argue that theories of poverty governance should attend to the professional authority of frontline workers rather than treating them as largely equivalent actors differentiated primarily by their location within the state's "left" or "right" hand. Professional authority should also be understood as a spectrum: occupations within the same domain of poverty governance (e.g., medicine, carceral-legal system) can possess substantially different degrees of jurisdiction, expertise, legitimacy, and authority, with consequences for how they govern the people they serve.

Contributions to the Sociology of Medicine

For medical sociology, street medicine providers offer a case of what I call *engaged clinicians*: advanced health care providers who leverage both their professional discretion and their relationships with other service providers and patients to circumvent administrative and financial barriers to care and mitigate the structural conditions that undermine their patients' health. Other scholars have documented how clinicians in hospital and clinic settings confront third-party profit maximization and their patients' financial constraints to care through clinical advocacy and informal resource brokerage (Brewer and Timmermans Forthcoming; Raudenbush 2020). Clinical advocacy encompasses four strategies through which physicians seek to unlock medical resources within hospitals: appealing to decision makers, altering medical records, manipulating hospital stays, and changing treatment plans (Brewer and Timmermans Forthcoming). Similarly, Raudenbush (2020) describes providers in low-income clinics as

“informal resource brokers” who leveraged professional connections with colleagues, offered to pay for services, and encouraged patients to share prescriptions to circumvent financial obstacles.

The concept of ENGAGED CLINICIANS builds on these forms of clinical advocacy and informal resource brokerage while extending them beyond conventional health care settings and to patients experiencing extreme poverty. In street medicine, this agency takes additional forms, including collective efforts to modify insurance policies, adapting treatment to the cultural and material conditions of extreme poverty, and mitigating direct structural harms such as policing and the lack of housing. Despite their positive impact, the strategies employed by engaged clinicians carry important costs: they divert clinicians’ limited time and expertise from patients who need their clinical care, contribute to provider burnout, and force decisions about whom to assist based on subjective judgments of deservingness. Yet these strategies represent an adaptive response from medical providers working at the intersection of a biomedically focused, financially driven health care system and a patient population whose health needs are both resource-intensive and structurally reproduced.

Ultimately, the concept of engaged clinicians intervenes in long-standing debates in medical sociology about clinicians’ role in advancing patient health. While system-level explanations situate clinicians within countervailing forces that, through financial logics, shape the allocation of clinical attention and constrain what care they can provide to their patients (Light 2010), other scholarship examines how providers can hinder patients’ health within medical interactions by making diagnostic and treatment decisions based on patients’ socioeconomic status, gender, race, migration status, cultural capital, and perceived social worth (Shim 2010; Timmermans 1998; Lara-Millán 2014; Welch et al. 2012). The concept of engaged clinicians shows that clinicians’ ability to provide medically necessary care is shaped not only by

these countervailing powers and dynamics within clinical interactions, but also by the intra- and interprofessional networks they mobilize. I argue that these networks become particularly consequential as clinicians increasingly work across criminal-legal and welfare fields and as the health care workforce diversifies to include a wider range of allied professions and professional roles (Seim and DiMario 2023; Lara-Millán 2021). These networks constitute a form of social capital that enables clinicians to extend professional authority across the institutional fields that also shape patients' health. This is especially important for the poor, whose health depends not only on access to medical care but also on their encounters with policing and the criminal-legal system and their access to social services and the welfare system. Understanding how clinicians advance the health of marginalized patients therefore requires attention to the networks they mobilize across these fields, alongside the organizational and interactional forces that shape medical practice.

Contributions to Health Disparities Scholarship

For scholarship on health inequalities, my findings show how health inequalities among unhoused people can persist even when progressive, social-medicine-oriented programs such as street medicine expand access to care. First, this study extends the growing literature on the health consequences of the criminalization of homelessness (e.g., Chien et al. 2026; Goldshear et al. 2023; Herring 2019). I extend this literature by showing that policing and encampment sweeps not only interrupt care provided on the streets (Chang et al. 2022), but also disrupt access to specialty care and other health-related services that street medicine facilitates, such as placement in interim housing. Efforts to prevent and mitigate the harms of criminalization also place an additional burden on street medicine teams, adding to their stress and potentially leading

to burnout. Moreover, policing can also undermine patients' trust in street medicine teams if they believe the teams are associated with such actions.

Second, access to street medicine itself is uneven; not everyone who is unhoused has the same opportunities to become a street patient. People living in large encampments, residing in parts of the city with greater financial, symbolic, or political value, or maintaining connections to social service agencies linked to street medicine teams are more visible to street medicine teams. By contrast, people who live alone or in less visible locations, lack connections to social service organizations, are undocumented, or refrain from hospital-based care may be less likely to encounter street medicine providers despite substantial medical needs. More broadly, positioning within and between institutions—including health care, social services, housing, and immigration systems—shapes who becomes visible to street medicine and therefore who has opportunities to access it. With these findings, I demonstrate that, beyond the intersections of gender, race, and ethnicity creating differences in access to health care among people experiencing poverty, variations in access among this group are also produced by their position within medical, welfare, and punitive organizations: those constituted as organizational problems become more apparent to healthcare providers than those that are not.

Third, analyzing the work of street medicine teams revealed shortcomings in the interim housing system that contribute to the reproduction of health inequalities among unhoused people. Unhoused people can face a double bind in which they are too sick to qualify for certain transitional housing opportunities but not sick enough to remain in the hospital, leaving them without an institutional setting equipped to meet their health needs. Although street clinicians sometimes adjust patients' diagnoses or treatments to help them access one institution or the

other, people without access to street medicine can fall through the cracks, left without a place to go despite their health needs and potentially becoming sicker as a result.

Health inequalities are also reproduced when we consider how difficult it can be to build trust and establish medical engagement among many unhoused people, especially those who are likely to need care the most. Engaging in this time-consuming but critical work with limited resources and high levels of need creates an allocation paradox: time spent engaging people who are less willing or able to accept care could instead be used to care for people who are more willing to accept it. Crafting engagement can also complicate transitions to more comprehensive, long-term, traditional care settings, while the time required for engagement can affect providers' ability to address urgent medical needs. Navigating these competing demands requires providers to make decisions that can sometimes come at the expense of some patients, such as visiting encampments to reach multiple patients at once and investing in health care transitions for patients they deem deserving.

Contributions to the Field of Street Medicine & Future Research

To the field of street medicine, this study adds empirical evidence of how the benefits currently attributed to street medicine are produced (e.g., Carter et al. 2019; Perna et al. 2024; Withers 2011). More specifically, it describes how street medicine teams build trust, improving access to care for people who might otherwise receive no health care. It also shows how street medicine can facilitate people's transition indoors, reduce the suffering of those who remain outside, and alleviate pressure on emergency services. Street medicine advocates can use these findings to support claims about the value and impact of their work.

These findings can also help make the case for higher reimbursement rates, a current priority among street medicine advocates (Hart 2023b). Although much of street medicine's

value proposition rests on its cost-efficiency, this study also shows the limitations of operating under financial constraints. Engaging patients in care and treating seriously ill patients require substantial time and resources. Limited funding places additional strain on providers, potentially affecting their well-being and the quality of care they provide. Moreover, low reimbursement rates increase street medicine programs' dependence on external funding, potentially requiring them to distribute their services according to organizational logics that do not always coincide with clinical ones.

This study also provides evidence of the risks of co-optation associated with the expansion and institutionalization of street medicine. It can help street medicine programs and advocates anticipate and develop strategies to counterbalance the use of their services to justify policing, promote a housing-readiness regime in place of Housing First, or facilitate early discharge and, in some cases, discourage hospital admission.

Future research should compare how street medicine operates across contrasting sociopolitical contexts. My research was conducted in urban California, a state characterized by comparatively less aggressive anti-homelessness policies and more comprehensive Medicaid services and eligibility criteria. Examining how street medicine teams operate—and what they are able to provide to patients, as well as the compromises they must make—in states with more restrictive Medicaid policies or more aggressive criminalization practices could broaden our understanding of street medicine as a field and contribute to sociological research on how structural conditions, policies, and politics shape everyday practice and poverty governance.

This research is particularly urgent as federal policy changes take effect. The full implementation of H.R. 1 in January 2027 is expected to substantially alter Medicaid eligibility criteria, potentially leaving thousands of unhoused people without coverage. At the same time,

changes to federal housing policy may increase housing insecurity and homelessness, while the health care services that remain available to unhoused people—and in some cases receive increased funding—are increasingly concentrated in substance use and mental health services. Given street medicine's vast international presence, comparisons across nation-states could also contribute to the sociology of poverty and medical sociology as well as to global health research.

Another area for future research concerns street medicine's growing role in medical education. Examining how participation in street medicine shapes medical students' and physicians' understandings of the structural causes of illness, as well as their perceptions of medicine's role in addressing or accounting for these conditions, could illuminate how ideas about structural determinants become incorporated into clinical practice. Finally, my dissertation briefly described immigration status as an important dimension of access to street medicine. Future research should explore this relationship in greater depth, particularly given the intensification of immigration enforcement and the retrenchment of benefits for undocumented immigrants, including in states such as California. Research should also examine more closely how race, gender, sexuality, and ethnicity shape people's access to street medicine and their interactions and relationships with clinicians.

REFERENCES

- Abbott, Andrew. 1988. *The System of Professions: An Essay on the Division of Expert Labor*. Chicago: University of Chicago Press.
- Adams, Jennifer, Robert Rosenheck, Lauren Gee, Catherine L. Seibyl, and Margot Kushel. 2007. "Hospitalized Younger: A Comparison of a National Sample of Homeless and Housed Inpatient Veterans." *Journal of Health Care for the Poor and Underserved* 18(1):173–84. doi:10.1353/HPU.2007.0000.
- Alsan, Marcella, and David M. Cutler. 2025. "Prescription for Division: Healing the Growing Gap in Physician Trust." *JAMA Health Forum* 6(12):e256765–e256765. doi:10.1001/JAMAHEALTHFORUM.2025.6765.
- Andreassen, Hege K., and Marianne Trondsen. 2010. "The Empowered Patient and the Sociologist." *Social Theory and Health* 8(3):280–87. doi:10.1057/STH.2010.9/METRICS.
- Arbelo Cruz, Fabiola, Annie Harper, Billy Bromage, and Lori Wallace. 2024. "Medical Providers and Researchers Call to End CT Homeless Encampment Displacements." <https://www.courant.com/2024/11/14/opinion-medical-providers-and-researchers-call-to-end-ct-homeless-encampment-displacements/>.
- Baggett, Travis P., Daniel E. Singer, Sowmya R. Rao, James J. O'Connell, Monica Bharel, and Nancy A. Rigotti. 2011. "Food Insufficiency and Health Services Utilization in a National Sample of Homeless Adults." *Journal of General Internal Medicine* 26(6):627. doi:10.1007/S11606-011-1638-4.
- Barnard, Alex V. 2023. *Conservatorship: Inside California's System of Coercion and Care for Mental Illness*. Columbia University Press.
- Beagan, Brenda L. 2003. "Teaching Social and Cultural Awareness to Medical Students: 'It's All Very Nice to Talk about It in Theory, but Ultimately It Makes No Difference.'" *Academic Medicine : Journal of the Association of American Medical Colleges* 78(6):605–14. doi:10.1097/00001888-200306000-00011.
- Beckett, Katherine, and Steve Herbert. 2009. "Banished: The New Social Control in Urban America." *Banished: The New Social Control In Urban America* 1–216. doi:10.1093/ACPROF:OSO/9780195395174.001.0001.
- Beijer, Ulla, Achim Wolf, and Seena Fazel. 2012. "Prevalence of Tuberculosis, Hepatitis C Virus, and HIV in Homeless People: A Systematic Review and Meta-Analysis." *The Lancet. Infectious Diseases* 12(11):859–70. doi:10.1016/S1473-3099(12)70177-9.
- Betancourt, Joseph R. 2006. "Cultural Competence and Medical Education: Many Names, Many Perspectives, One Goal." *Academic Medicine : Journal of the Association of American Medical Colleges* 81(6):499–501. doi:10.1097/01.ACM.0000225211.77088.CB.
- Bourgois, Philippe, and Jeff Schonberg. 2009. *Righteous Dopefiend*. University of California Press.

- Brewer, A., and S. Timmermans. Forthcoming. "Clinical Advocacy: How Physicians Fight Back against Bureaucratic and Financial Pressures." *Journal of Health and Social Behavior*.
- Brown, Rebecca T., Jennifer L. Evans, Karen Valle, David Guzman, Yea Hung Chen, and Margot B. Kushel. 2022. "Factors Associated with Mortality among Homeless Older Adults in California: The HOPE HOME Study." *JAMA Internal Medicine* 182(10):1052–60. doi:10.1001/JAMAINTERNMED.2022.3697.
- Brown, Rebecca T., Kaveh Hemati, Elise D. Riley, Christopher T. Lee, Claudia Ponath, Lina Tieu, David Guzman, and Margot B. Kushel. 2017. "Geriatric Conditions in a Population-Based Sample of Older Homeless Adults." *The Gerontologist* 57(4):757. doi:10.1093/GERONT/GNW011.
- Brown, Rebecca T., Dan K. Kiely, Monica Bharel, Laura J. Grande, and Susan L. Mitchell. 2013. "Use of Acute Care Services among Older Homeless Adults." *JAMA Internal Medicine* 173(19):1831. doi:10.1001/JAMAINTERNMED.2013.6627.
- Budnyk, Mary Beth. 2023. "Lancaster Street Medicine Team Meets Patients Where They Are." <https://www.pennmedicine.org/news/lancaster-street-medicine-program-meets-patients-where-they-are>.
- Carter, Jamie, Barry Zevin, and Paula J. Lum. 2019. "Low Barrier Buprenorphine Treatment for Persons Experiencing Homelessness and Injecting Heroin in San Francisco." *Addiction Science & Clinical Practice* 14(1):20. doi:10.1186/S13722-019-0149-1.
- Caton, Carol L. M., Nabila El-Bassel, Andrew Gelman, Susan Barrow, Daniel Herman, Eustace Hsu, Ana Z. Tochtermann, Karen Johnson, and Alan Felix. 2013. "Rates and Correlates of HIV and STI Infection among Homeless Women." *AIDS and Behavior* 17(3):856–64. doi:10.1007/S10461-012-0198-X.
- Chang, Jamie Suki, Philip Boo Riley, Robert J. Aguirre, Katherine Lin, Marius Corwin, Nicole Nelson, and Madison Rodriguez. 2022. "Harms of Encampment Abatements on the Health of Unhoused People." *SSM - Qualitative Research in Health* 2:100064. doi:10.1016/J.SSMQR.2022.100064.
- Charles, Cathy, Amiram Gafni, and Tim Whelan. 1999. "Decision-Making in the Physician–Patient Encounter: Revisiting the Shared Treatment Decision-Making Model." *Social Science & Medicine* 49(5):651–61. doi:10.1016/S0277-9536(99)00145-8.
- Chien, Jessie, Benjamin F. Henwood, and Randall Kuhn. 2026. "Criminalizing Homelessness: Longitudinal Associations of Police Encounters and Homeless Sweeps with Psychosocial Health among the Unhoused Community in Los Angeles." *Social Science & Medicine* (1982) 393. doi:10.1016/J.SOCSCIMED.2026.119033.
- Chilman, Natasha, Peter Schofield, Dionne Laporte, Amy Ronaldson, and Jayati Das-Munshi. 2025. "The Prevalence of Multimorbidity with Mental and Physical Health for People Who Experience Homelessness: A Systematic Review." *European Journal of Public Health* 35(6):1170–77. doi:10.1093/EURPUB/CKAF144.
- Chisolm, Deena J., Daniel L. Brook, Mary S. Applegate, and Kelly J. Kelleher. 2019. "Social Determinants of Health Priorities of State Medicaid Programs." *BMC Health Services Research* 19(1):167–. doi:10.1186/S12913-019-3977-5/TABLES/4.

- City of Los Angeles. n.d. “Inside Safe .” Retrieved March 31, 2026.
<https://mayor.lacity.gov/InsideSafe>.
- Clarke, Adele E., Janet K. Shim, Laura Mamo, Jennifer Ruth Fosket, and Jennifer R. Fishman. 2003. “Biomedicalization: Technoscientific Transformations of Health, Illness, and U.S. Biomedicine.” *American Sociological Review* 68(2):161–94.
doi:10.1177/000312240306800201.
- LA County Homeless Services & Housing. n.d. “Pathway Home in Santa Monica .” Retrieved March 31, 2026. <https://homeless.lacounty.gov/news/santa-monica/>.
- Culver City. 2024. “Healthcare in Action Begins Services in Culver City.”
<https://www.culvercity.gov/News/Healthcare-in-Action-Begins-Services-in-Culver-City>.
- DiMario, Anthony. 2022. “To Punish, Parent, or Palliate: Governing Urban Poverty through Institutional Failure.” *American Sociological Review* 87(5):860–88.
doi:10.1177/00031224221116145/ASSET/IMAGES/LARGE/10.1177_00031224221116145-FIG1.JPEG.
- Duvoor, Aashika. 2026. “Encampment Sweeps Disrupt Care for Sacramento Street Medicine Patients.” <https://davisvanguard.org/2026/04/unhoused-community-sacramento-care/>.
- Enich, Michael, Emmy Tiderington, and Andrea Ure. 2023. “Street Medicine: A Scoping Review of Program Elements.” *International Journal on Homelessness* 2022(1):1–49.
doi:10.5206/IJOH.2022.2.15134.
- Epstein, Steven, and Stefan Timmermans. 2021. “From Medicine to Health: The Proliferation and Diversification of Cultural Authority.” *Journal of Health and Social Behavior* 62(3):240–54. doi:10.1177/00221465211010468.
- Fazel, Seena, John R. Geddes, and Margot Kushel. 2014. “The Health of Homeless People in High-Income Countries: Descriptive Epidemiology, Health Consequences, and Clinical and Policy Recommendations.” *Lancet (London, England)* 384(9953):1529.
doi:10.1016/S0140-6736(14)61132-6.
- Fazel, Seena, Vivek Khosla, Helen Doll, and John Geddes. 2008. “The Prevalence of Mental Disorders among the Homeless in Western Countries: Systematic Review and Meta-Regression Analysis.” *PLOS Medicine* 5(12):e225.
doi:10.1371/JOURNAL.PMED.0050225.
- Feldman, Brett J. 2024. “Solidarity with, or Retreat from, the Street: A Look Forward at Street Medicine in California.”
- Feldman, Brett J., Corinne T. Feldman, Alexis Coulourides Kogan, Sonali Saluja, Michael Cousineau, Alissa Maier, Bernice Sun, Kylie Sloan, Kimberly Yang-Tzu Su, David Panush, Seth Campbell, and Joel Hunt. 2023. *The California Street Medicine Landscape Survey and Report*. <https://www.chcf.org/resource/ca-street-medicine-landscape-survey-report/>.
- Feldman, Brett J., Jeniffer S. Kim, Laura Mosqueda, Hurnan Vongsachang, Josh Banerjee, Charles E. Coffey, Brad Spellberg, Michael Hochman, and Jehni Robinson. 2021. “From

- the Hospital to the Streets: Bringing Care to the Unsheltered Homeless in Los Angeles.” *Healthcare* 9(3):100557. doi:10.1016/J.HJDSI.2021.100557.
- Fox, Nick, and Katie Ward. 2006. “Health Identities: From Expert Patient to Resisting Consumer.” *Health (London)* 10(4):461–79. doi:10.1177/1363459306067314.
- Fox, Renee. 1957. “Training for Uncertainty.” in *The student physician*, edited by R. K. Merton, G. Reader, and P. L. Kendall. Harvard University Press.
- Frankeberger, Jessica, Kelly Gagnon, Jim Withers, and Mary Hawk. 2023. “Harm Reduction Principles in a Street Medicine Program: A Qualitative Study.” *Culture, Medicine and Psychiatry* 47(4):1005–21. doi:10.1007/S11013-022-09807-Z/TABLES/1.
- Freidson, Eliot. 1970. *Profession of Medicine: A Study of the Sociology of Applied Knowledge*. The University of Chicago Press.
- Gelberg, Lillian, Teresa C. Gallagher, Ronald M. Andersen, and Paul Koegel. 2011. “Competing Priorities as a Barrier to Medical Care among Homeless Adults in Los Angeles.” <https://doi.org/10.2105/AJPH.87.2.217> 87(2):217–20. doi:10.2105/AJPH.87.2.217.
- Gibson, Kristina E. 2011. *Street Kids: Homeless Youth, Outreach, and Policing New York’s Streets*. New York University Press.
- Goldshear, Jesse L., N. Kitonga, N. Angelo, A. Cowan, B. F. Henwood, and R. N. Bluthenthal. 2023. “‘Notice of Major Cleaning’: A Qualitative Study of the Negative Impact of Encampment Sweeps on the Ontological Security of Unhoused People Who Use Drugs.” *Social Science & Medicine* 339:116408. doi:10.1016/J.SOCSCIMED.2023.116408.
- Gong, Neil. 2019. “Between Tolerant Containment and Concerted Constraint: Managing Madness for the City and the Privileged Family.” *American Sociological Review* 84(4):664–89. doi:10.1177/0003122419859533.
- Gong, Neil. 2024. *Sons, Daughters, and Sidewalk Psychotics: Mental Illness and Homelessness in Los Angeles*. The University of Chicago.
- Gowan, Teresa. 2002. “The Nexus: Homelessness and Incarceration in Two American Cities.” *Ethnography* 3(4):500–534. doi:10.1177/1466138102003004007.
- Gowan, Teresa. 2010. *Hobos, Hustlers, and Backsliders: Homeless in San Francisco*. University of Minnesota Press.
- Halpern, J. 2001. *From Detached Concern to Empathy: Humanizing Medical Practice*. Oxford University Press.
- Han, Beth, and Barbara L. Wells. 2003. “Inappropriate Emergency Department Visits and Use of the Health Care for the Homeless Program Services by Homeless Adults in the Northeastern United States.” *Journal of Public Health Management and Practice : JPHMP* 9(6):530–37. doi:10.1097/00124784-200311000-00014.
- Hansen, Helena, Philippe Bourgois, and Ernest Drucker. 2014. “Pathologizing Poverty: New Forms of Diagnosis, Disability, and Structural Stigma under Welfare Reform.” *Social Science & Medicine* 103:83. doi:10.1016/J.SOCSCIMED.2013.06.033.

- Hanssmann, Christoph, Janet K. Shim, Irene H. Yen, Mark D. Fleming, Meredith Van Natta, Ariana Thompson-Lastad, Maryani Palupy Rasidjan, and Nancy J. Burke. 2022. “‘Housing Is Health Care’: Treating Homelessness in Safety-Net Hospitals.” *Medical Anthropology Quarterly* 36(1):44–63. doi:10.1111/MAQ.12665.
- Hart, Angela. 2023a. “Health Care ‘Game-Changer’? Feds Boost Care for Homeless Americans.” *KFF Health News*, October 19.
- Hart, Angela. 2023b. “Street Medicine Practitioners Are Getting Paid. Now They Want Higher Rates.” <https://kffhealthnews.org/news/health-202-street-medicine-practitioners-want-higher-rates/>.
- Heritage, John, and Douglas W. Maynard. 2006. “Problems and Prospects in the Study of Physician-Patient Interaction: 30 Years of Research.” *Annual Review of Sociology* 32(Volume 32, 2006):351–74. doi:10.1146/ANNUREV.SOC.32.082905.093959/CITE/REFWORKS.
- Herring, Chris. 2019. “Complaint-Oriented Policing: Regulating Homelessness in Public Space.” *American Sociological Review* 84(5):769–800. doi:10.1177/0003122419872671/ASSET/IMAGES/LARGE/10.1177_0003122419872671-FIG6.JPEG.
- Herring, Chris. 2021. “Complaint-Oriented ‘Services’: Shelters as Tools for Criminalizing Homelessness.” *The ANNALS of the American Academy of Political and Social Science* 693(1):264–83. doi:10.1177/0002716221996703.
- Hochschild, Arlie Russell. 2012. *The Managed Heart: Commercialization of Human Feeling*. University of California Press.
- Hopper, Kim, John Jost, Terri Hay, Susan Welber, and Gary Haugland. 2006. “Homelessness, Severe Mental Illness, and the Institutional Circuit.” *Psychiatric Services (Washington, D.C.)* 48(5):659–65. doi:10.1176/PS.48.5.659.
- Human Rights Watch. 2024. “You Have to Move!” *The Cruel and Ineffective Criminalization of Unhoused People in Los Angeles*.
- Hwang, Stephen W., Catharine Chambers, Shirley Chiu, Marko Katic, Alex Kiss, Donald A. Redelmeier, and Wendy Levinson. 2013. “A Comprehensive Assessment of Health Care Utilization among Homeless Adults under a System of Universal Health Insurance.” *American Journal of Public Health* 103 Suppl 2(Suppl 2). doi:10.2105/AJPH.2013.301369.
- Institute of Medicine. 2001. *Crossing the Quality Chasm: A New Health System for the 21st Century*. National Academies Press.
- James, Mathew, Marc Greenhill, and Dan Sullivan. 2023. “Introduction of a Homeless Health Outreach Team in Northern New South Wales: Is Acute Service Usage Reduced?” *Australasian Psychiatry* 31(4):441–44. doi:10.1177/10398562231164869.
- Kaufman, Rebekah A., Mahwish Mallick, Jarvis Thanex Louis, Mollie Williams, and Nancy Oriol. 2024. “The Role of Street Medicine and Mobile Clinics for Persons Experiencing

- Homelessness: A Scoping Review.” *International Journal of Environmental Research and Public Health* 2024, Vol. 21, Page 760 21(6):760. doi:10.3390/IJERPH21060760.
- Knight, Kelly Ray. 2015. *Addicted.Pregnant.Poor*. Duke University Press.
- Kuhn, Randall, Jessica Richards, Sarah Roth, Escholarship Org, and Kimberly Clair. 2020. *Homelessness and Public Health in Los Angeles*.
<https://escholarship.org/uc/item/2gn3x56s>.
- Kushel, Margot B., Jennifer L. Evans, Sharon Perry, Marjorie J. Robertson, and Andrew R. Moss. 2003. “No Door to Lock: Victimization among Homeless and Marginally Housed Persons.” *Archives of Internal Medicine* 163(20):2492–99.
doi:10.1001/ARCHINTE.163.20.2492.
- Kushel, Margot B., Sharon Perry, David Bangsberg, Richard Clark, and Andrew R. Moss. 2002. “Emergency Department Use among the Homeless and Marginally Housed: Results from a Community-Based Study.” *American Journal of Public Health* 92(5):778.
doi:10.2105/AJPH.92.5.778.
- Kushel, Margot B., Eric Vittinghoff, and Jennifer S. Haas. 2001. “Factors Associated with the Health Care Utilization of Homeless Persons.” *JAMA* 285(2):200–206.
doi:10.1001/JAMA.285.2.200.
- Kushel, Margot, and Tiana Moore. 2023. *Toward a New Understanding. The California Statewide Study of People Experiencing Homelessness*.
- Kushner, Jonah, and K. John McConnell. 2019. “Addressing Social Determinants of Health through Medicaid: Lessons from Oregon.” *Journal of Health Politics, Policy and Law* 44(6):919–35. doi:10.1215/03616878-7785823.
- L.A. Care. 2023. “L.A. Care Invests More than \$4 Million in a Street Medicine Initiative.”
<https://www.lacare.org/news/news-releases/la-care-invests-more-4-million-in-street-medicine-initiative>.
- Lara-Millán, Armando. 2014. “Public Emergency Room Overcrowding in the Era of Mass Imprisonment.” *American Sociological Review* 79(5):866–87.
doi:10.1177/0003122414549552.
- Lara-Millán, Armando. 2021. *Redistributing the Poor: Jails, Hospitals, and the Crisis of Law and Fiscal Austerity*. Oxford University Press.
- Lebrun-Harris, Lydie A., Travis P. Baggett, Darlene M. Jenkins, Alek Sripipatana, Ravi Sharma, A. Seiji Hayashi, Charles A. Daly, and Quyen Ngo-Metzger. 2013. “Health Status and Health Care Experiences among Homeless Patients in Federally Supported Health Centers: Findings from the 2009 Patient Survey.” *Health Services Research* 48(3):992.
doi:10.1111/1475-6773.12009.
- Light, Donald W. 2010. “Health Care Professions, Markets, and Countervailing Powers .” Pp. 270–89 in *Handbook of medical sociology*, edited by C. E. Bird, P. Conrad, A. M. Fremont, and S. Timmermans. Vanderbilt University Press.
- Light, Donald, and Sol Levine. 1988. “The Changing Character of the Medical Profession: A Theoretical Overview.” *The Milbank Quarterly* 2(66):10–32. doi:10.2307/3349912.

- Link, B. G., and J. Phelan. 1995. "Social Conditions as Fundamental Causes of Disease." *Journal of Health and Social Behavior* 80–94. doi:10.2307/2626958.
- Lipsky, Michael. 1980. *Street-Level Bureaucracy: Dilemmas of the Individual in Public Services*. Russell Sage Foundation.
- López, Andrea M. 2020. "Necropolitics in the 'Compassionate' City: Care/Brutality in San Francisco." *Medical Anthropology* 39(8):751–64. doi:10.1080/01459740.2020.1753046.
- Los Angeles County Chief Executive Office. 2019. *Homeless Initiative Strategy E6: Countywide Outreach System Implementation Evaluation*. <https://homeless.lacounty.gov/wp-content/uploads/2020/02/rda.outreach011020.pdf>.
- Lynch, Kimberly A., Taylor Harris, Sachin H. Jain, and Michael Hochman. 2022. "The Case for Mobile 'Street Medicine' for Patients Experiencing Homelessness." *Journal of General Internal Medicine* 37(15):3999. doi:10.1007/S11606-022-07689-W.
- Lyon-Callo, Vincent. 2000. "Medicalizing Homelessness: The Production of Self-Blame and Self-Governing within Homeless Shelters." *Medical Anthropology Quarterly* 14(3):328–45. doi:10.1525/MAQ.2000.14.3.328.
- Mackelprang, Jessica L., Janessa M. Graves, and Frederick P. Rivara. 2014. "Homeless in America: Injuries Treated in US Emergency Departments, 2007-2011." *International Journal of Injury Control and Safety Promotion* 21(3):289. doi:10.1080/17457300.2013.825631.
- Marmot, Michael. 2005. "Social Determinants of Health Inequalities." *The Lancet* 365:1100–1104.
- Marmot, Michael, Sharon Friel, Ruth Bell, Tanja AJ Houweling, and Sebastian Taylor. 2008. "Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health." *The Lancet* 372(9650):1661–69. doi:10.1016/S0140-6736(08)61690-6.
- Mathieu, Arline. 1993. "The Medicalization of Homelessness and the Theater of Repression." *Medical Anthropology Quarterly* 7(2):170–84.
- Mead, Nicola, and Peter Bower. 2000. "Patient-Centredness: A Conceptual Framework and Review of the Empirical Literature." *Social Science & Medicine* 51(7):1087–1110. doi:10.1016/S0277-9536(00)00098-8.
- Mechanic, D. 1991. "Sources of Countervailing Power in Medicine." *Journal of Health Politics, Policy and Law* 16(3):485–98. doi:10.1215/03616878-16-3-485.
- Medellin, Teresa, Leticia R. Moczygemba, and Whitney Thurman. 2024. "A Qualitative Study to Describe the Nature and Scope of Street Medicine Programs in the United States." *International Journal of Environmental Research and Public Health* 2024, Vol. 21, Page 1623 21(12):1623. doi:10.3390/IJERPH21121623.
- Metzl, Jonathan M., and Helena Hansen. 2014. "Structural Competency: Theorizing a New Medical Engagement with Stigma and Inequality." *Social Science & Medicine* (1982) 103:126. doi:10.1016/J.SOCSCIMED.2013.06.032.

- Mishler, Elliot G. 1981. "Viewpoint: Critical Perspectives on the Biomedical Model." Pp. 1–23 in *Social contexts of health, illness, and patient care*, edited by E.G. Mishler, L. R. Amarasingham, S. T. Hauser, S. D. Osherson, N. E. Waxler, and R. Liem. Cambridge University Press.
- Napoles, Tessa M. 2024. "Rationing Housing: How Technologies, Providers, and Definitions of Homelessness Sort and Stratify by Health." University of California, San Francisco.
- Narayan, Aditya, Nirav Shah, and Michael Hochman. 2024. "Beyond Brick and Mortar: The Rise of Street Medicine." *Journal of General Internal Medicine* 39(14):2853–55. doi:10.1007/S11606-024-08880-X/METRICS.
- Nilsson, Sandra F., Thomas M. Laursen, Annette Erlangsen, Keith Hawton, Merete Nordentoft, and Seena Fazel. 2025. "Homelessness, Psychiatric Disorders, and Risks of Suicide and Self-Harm: A Population-Based Cohort Study." *The Lancet Public Health* 10(7):e559–67. doi:10.1016/S2468-2667(25)00100-8.
- NYC Health + Hospitals. 2025. "NYC Health + Hospitals Street Health Outreach + Wellness Program Enhances Point-of-Care Medical Services." <https://www.nychealthandhospitals.org/pressrelease/nyc-health-hospitals-street-health-outreach-wellness-program-enhances-point-of-care-medical-services/>.
- Offner, Aiko, and Aaron Schrank. 2025. "To Help More Unhoused Patients, LA Street Medics Push to Change State Law." <https://laist.com/news/health/street-medicine-homeless-california-law-medicaid>.
- Olsen, Lauren D. 2021. "'We'd Rather Be Relevant than Theoretically Accurate': The Translation and Commodification of Social Scientific Knowledge for Clinical Practice." *Social Problems* 68(3):761–77. doi:10.1093/SOCPRO/SPAA012.
- Osborne, Melissa. 2018. "Who Gets 'Housing First'? Determining Eligibility in an Era of Housing First Homelessness." *Journal of Contemporary Ethnography* 48(3):402–28. doi:10.1177/0891241617753289.
- Ousager, Jakob, and Helle Johannessen. 2010. "Humanities in Undergraduate Medical Education: A Literature Review." *Academic Medicine : Journal of the Association of American Medical Colleges* 85(6):988–98. doi:10.1097/ACM.0B013E3181DD226B.
- Paradis-Gagné, Etienne, Marie Claude Jacques, Pierre Pariseau-Legault, Houssein Eddine Ben Ahmed, and Ioana Ruxandra Stroe. 2023. "The Perspectives of Homeless People Using the Services of a Mobile Health Clinic in Relation to Their Health Needs: A Qualitative Study on Community-Based Outreach Nursing." *Journal of Research in Nursing* 28(2):154. doi:10.1177/17449871231159595.
- Parsons, Talcott. 1951. *The Social System*. The Free Press.
- Perna, Linda K., Camille Patterson, Amy A. Chairez, Jenny Lewis, Jacqueline Jordan, Hajah Komara, and Harper Harris. 2024. "Healthcare Outcomes for Unsheltered Persons Experiencing Homelessness Using a Street Medicine Model of Care: A Pilot Program Evaluation." *Cogent Social Sciences* 10(1):2328895. doi:10.1080/23311886.2024.2328895;JOURNAL:JOURNAL:OASS20;WGROU:STRING:PUBLICATION.

- Pescosolido, Bernice A., Steven A. Tuch, and Jack K. Martin. 2001. "The Profession of Medicine and the Public: Examining Americans' Changing Confidence in Physician Authority from the Beginning of the 'health Care Crisis' to the Era of Health Care Reform." *Journal of Health and Social Behavior* 42(1):1–16. doi:10.2307/3090224.
- Quadagno, Jill. 2004. "Physician Sovereignty and the Purchasers' Revolt." *Journal of Health Politics, Policy and Law* 29(4–5):815–34. doi:10.1215/03616878-29-4-5-815.
- Raudenbush, Danielle T. 2020. *Health Care off the Books Poverty, Illness, and Strategies for Survival in Urban America*. University of California Press.
- Reynolds, Kristin. 2025. "Cedars-Sinai, Healthcare in Action Care for the Unhoused." <https://www.cedars-sinai.org/newsroom/partnering-for-better-health-on-la-streets/>.
- Richards, Jessica, and Randall Kuhn. 2022. "Unsheltered Homelessness and Health: A Literature Review." *AJPM Focus* 2(1):100043. doi:10.1016/J.FOCUS.2022.100043.
- Romaszko, Jerzy, Iwona Cymes, Ewa Dragańska, Robert Kuchta, and Katarzyna Glińska-Lewczuk. 2017. "Mortality among the Homeless: Causes and Meteorological Relationships." *PLOS ONE* 12(12):e0189938. doi:10.1371/JOURNAL.PONE.0189938.
- Rose, Nikolas. 2001. "The Politics of Life Itself." *Theory, Culture, & Society* 18(6):1–30. doi:10.1177/02632760122052020.
- Roy, Ananya, Ashley Bennett, Jennifer Blake, Jonny Coleman, Hannah Cornfield, Harrell La Donna, Terrie Klein, Samuel Lutzker, Hilary Malson, Jessica Mendez, Carla Orendorff, Gustavo Oztzy, Annie Powers, Chloe Rosenstock, Rayne Larbode Ruiz, William Sens, and Pamela Stephens. 2022. *(Dis)Placement: The Fight for Housing and Community After Echo Park Lake*. <https://escholarship.org/uc/item/70r0p7q4>.
- Roy, Ananya, and Carla Orendorff. 2026. "Encampment Geographies: Refuge, Return, and Refusal." *Environment and Planning D: Society and Space*. doi:10.1177/02637758261442317;WGROU:STRING:PUBLICATION.
- Sabbatini, Amber K., Karen E. Joynt-Maddox, Josh Liao, Anirban Basu, Canada Parrish, William Kreuter, and Brad Wright. 2022. "Accounting for the Growth of Observation Stays in the Assessment of Medicare's Hospital Readmissions Reduction Program." *JAMA Network Open* 5(11):e2242587. doi:10.1001/JAMANETWORKOPEN.2022.42587.
- Salit, Sharon A., Evelyn M. Kuhn, Arthur J. Hartz, Jade M. Vu, and Andrew L. Mosso. 1998. "Hospitalization Costs Associated with Homelessness in New York City." *The New England Journal of Medicine* 338(24):1734–40. doi:10.1056/NEJM199806113382406.
- Schwan, Kaitlin, Kyle Patton, Catherine Weaver, Brian Zunner-Keating, Brett Feldman, Matthew Beare, Corinne T. Feldman, and Katherine Pocock. 2025. *Mitigating the Health Impacts of Encampment Sweeps in California: A Practice Guide for Street Medicine*.
- Seim, Josh. 2020. *Bandage, Sort, and Hustle: Ambulance Crews on the Front Lines of Urban Suffering*. University of California Press.
- Seim, Josh, and Anthony DiMario. 2023. "City of Gauze: Medicine and the Governance of Urban Poverty." *Social Problems*. doi:10.1093/SOCPRO/SPAD041.

- Shim, Janet K. 2010. "Cultural Health Capital: A Theoretical Approach to Understanding Health Care Interactions and the Dynamics of Unequal Treatment." *Journal of Health and Social Behavior* 51(1):1–15. doi:10.1177/0022146509361185.
- Smith, Allen C., and Sherryl Kleinman. 1989. "Managing Emotions in Medical School: Students' Contacts with the Living and the Dead." *Social Psychology Quarterly* 52(1):56. doi:10.2307/2786904.
- Soss, Joe, Richard C. Fording, and Sanford. Schram. 2011. *Disciplining the Poor: Neoliberal Paternalism and the Persistent Power of Race*. University of Chicago Press.
- Sprake, E. F., J. M. Russell, and M. E. Barker. 2014. "Food Choice and Nutrient Intake amongst Homeless People." *Journal of Human Nutrition and Dietetics* 27(3):242–50. doi:10.1111/JHN.12130.
- Stafford, Amanda, and Lisa Wood. 2017. "Tackling Health Disparities for People Who Are Homeless? Start with Social Determinants." *International Journal of Environmental Research and Public Health* 14(12). doi:10.3390/IJERPH14121535.
- Starr, Paul. 1982. *The Social Transformation of American*. Vol. 55. Basic Books.
- Stefanowicz, Michael, Brett Feldman, and Jehni Robinson. 2021. "House Calls without Walls: Street Medicine Delivers Primary Care to Unsheltered Persons Experiencing Homelessness." *The Annals of Family Medicine* 19(1):84–84. doi:10.1370/AFM.2639.
- Stivers, Tanya. 2007. *Prescribing under Pressure: Parent-Physician Conversations and Antibiotics*. Oxford University Press.
- Strange, Cecily, Colleen Fisher, Wendy Chan She Ping-Delfos, Diane Arnold-Reed, and Tom Brett. 2018. "A General Practice Street Health Service: Patient and Allied Service Provider Perspectives." *Australian Journal of General Practice* 47(1–2):44–48. doi:10.31128/AFP-05-17-4201.
- Stuart, Forrest. 2016. *Down, out, and under Arrest: Policing and Everyday Life in Skid Row*. The University of Chicago Press.
- Sufrin, Carolyn. 2017. *Jailcare: Finding the Safety Net for Women behind Bars*. University of California Press.
- Tavory, Iddo, and Stefan Timmermans. 2014. *Abductive Analysis: Theorizing Qualitative Research*. The University of Chicago Press.
- Timmermans, Stefan. 2020. "The Engaged Patient: The Relevance of Patient–Physician Communication for Twenty-First-Century Health." *Journal of Health and Social Behavior* 61(3):259–73. doi:10.1177/0022146520943514.
- Timmermans, Stefan, and Hyeyoung Oh. 2010. "The Continued Social Transformation of the Medical Profession." *Journal of Health and Social Behavior* 51(1_suppl):S94–106. doi:10.1177/0022146510383500.
- Noah, Trevor (Host). 2023. "Mayor Karen Bass Predicts Los Angeles' Future." *What Now?*
- Underman, Kelly, and Laura E. Hirshfield. 2016. "Detached Concern?: Emotional Socialization in Twenty-First Century Medical Education." *Social Science and Medicine* 160:94–101.

- Vinson, Alexandra H., and Kelly Underman. 2020. "Clinical Empathy as Emotional Labor in Medical Work." *Social Science & Medicine* 251:112904. doi:10.1016/J.SOCSCIMED.2020.112904.
- Vohra, Neha, Vibhu Paudyal, and Malcolm J. Price. 2022. "Homelessness and the Use of Emergency Department as a Source of Healthcare: A Systematic Review." *International Journal of Emergency Medicine* 15(1):32. doi:10.1186/S12245-022-00435-3.
- Wacquant, Loïc. 2009. *Punishing the Poor: The Neoliberal Government of Social Insecurity*. Duke University Press.
- Weaver, Lesley Jo, Claire W. Herbert, Dylan J. Podrabsky, and Mackenzie L. Ní Flainn. 2025. "Co-Opting the 'Public' in Public Health: Homelessness and the Specious Logic of Discretionary Displacement in a Mid-Sized US City." *Critical Public Health* 35(1):2455492. doi:10.1080/09581596.2025.2455492;WGROU:STRING:PUBLICATION.
- White, Brandi M., and Susan D. Newman. 2015. "Access to Primary Care Services among the Homeless: A Synthesis of the Literature Using the Equity of Access to Medical Care Framework." *Journal of Primary Care & Community Health* 6(2):77–87. doi:10.1177/2150131914556122.
- Withers, Jim. 2011. "Street Medicine: An Example of Reality-Based Health Care." *Journal of Health Care for the Poor and Underserved* 22(1):1–4. doi:10.1353/HPU.2011.0025.