

# “House Calls Without Walls”: A Survey of Current Street Medicine Programs

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## Introduction

People experiencing homelessness (PEH) in the United States represent a uniquely vulnerable healthcare population, facing numerous health disparities stemming from adverse social determinants of health, systemic inequities, and limited access to healthcare<sup>1</sup>. In 2024, nearly 800,000 people experienced homelessness on a single night in the U.S.; the highest ever recorded. The affordable housing crisis, rising inflation, systemic racism, public health crises are all suspected causes<sup>2</sup>.

Compared to those with stable housing, PEH are at significantly greater risk for both communicable and noncommunicable diseases such as infectious diseases, chronic illnesses, mental health disorders<sup>1</sup>. Due to insufficient resources and social factors, there is a growing contingent of unsheltered PEH, who are at even higher risk for health complications while also being even less likely to utilize healthcare services compared to sheltered PEH<sup>3</sup>.

Indiana University School of Medicine has been laying the groundwork for a street medicine (SM) program since 2022 with a focus on building trust and relationships with local community organizations.

Homelessness is rising in Indianapolis and across the nation<sup>4</sup>. With massive effects on State of Indiana budget cuts in 2025 to safety net hospitals and expected major cuts in Medicaid and other programs for Hoosiers<sup>5</sup>, establishing a SM program will help us fill in necessary gaps in community care. In order to advance program development, our team interviewed and surveyed existing SM programs to gain insight into SM program operations and promising practices. The following are summaries of responses across the most critical components of developing a SM program.

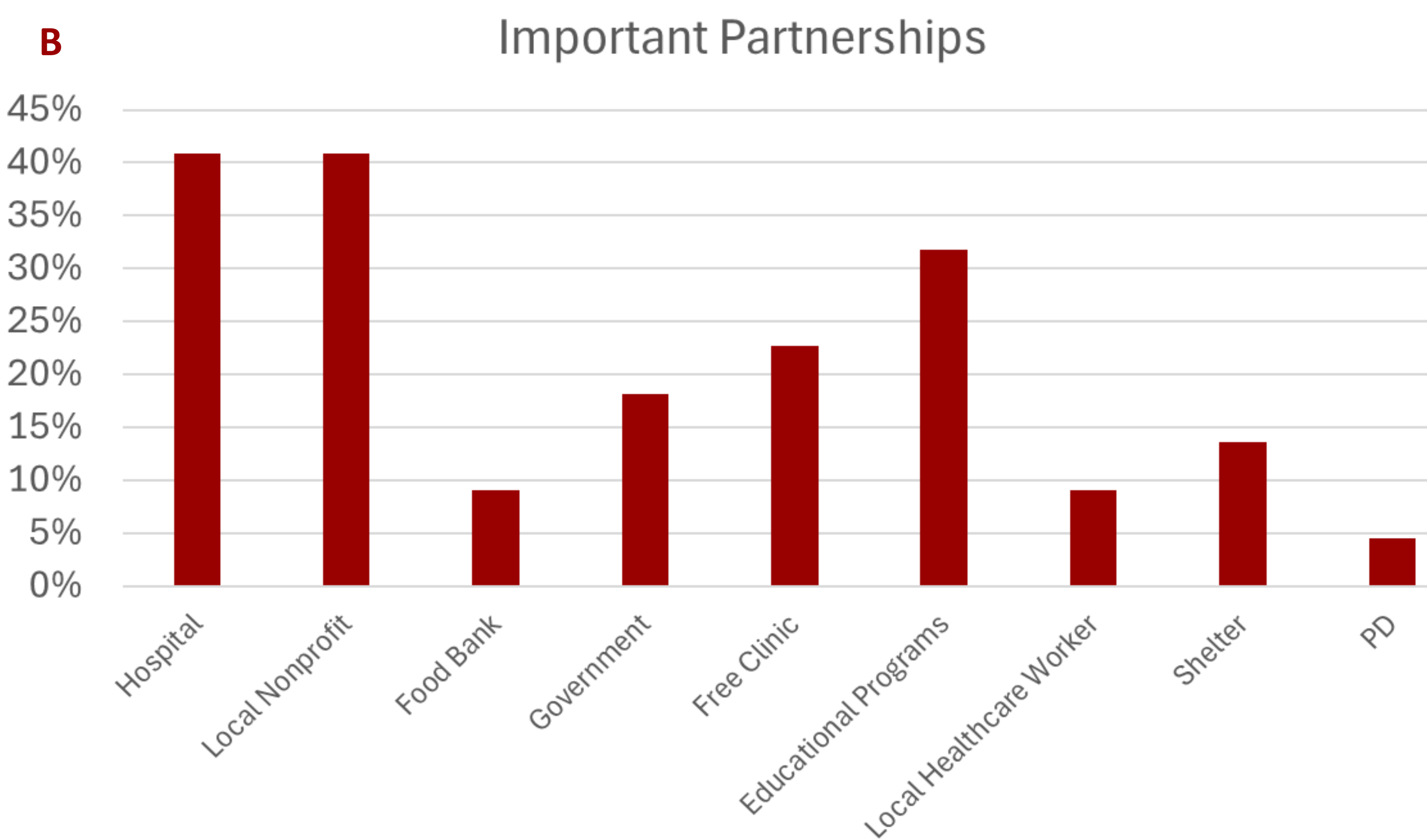
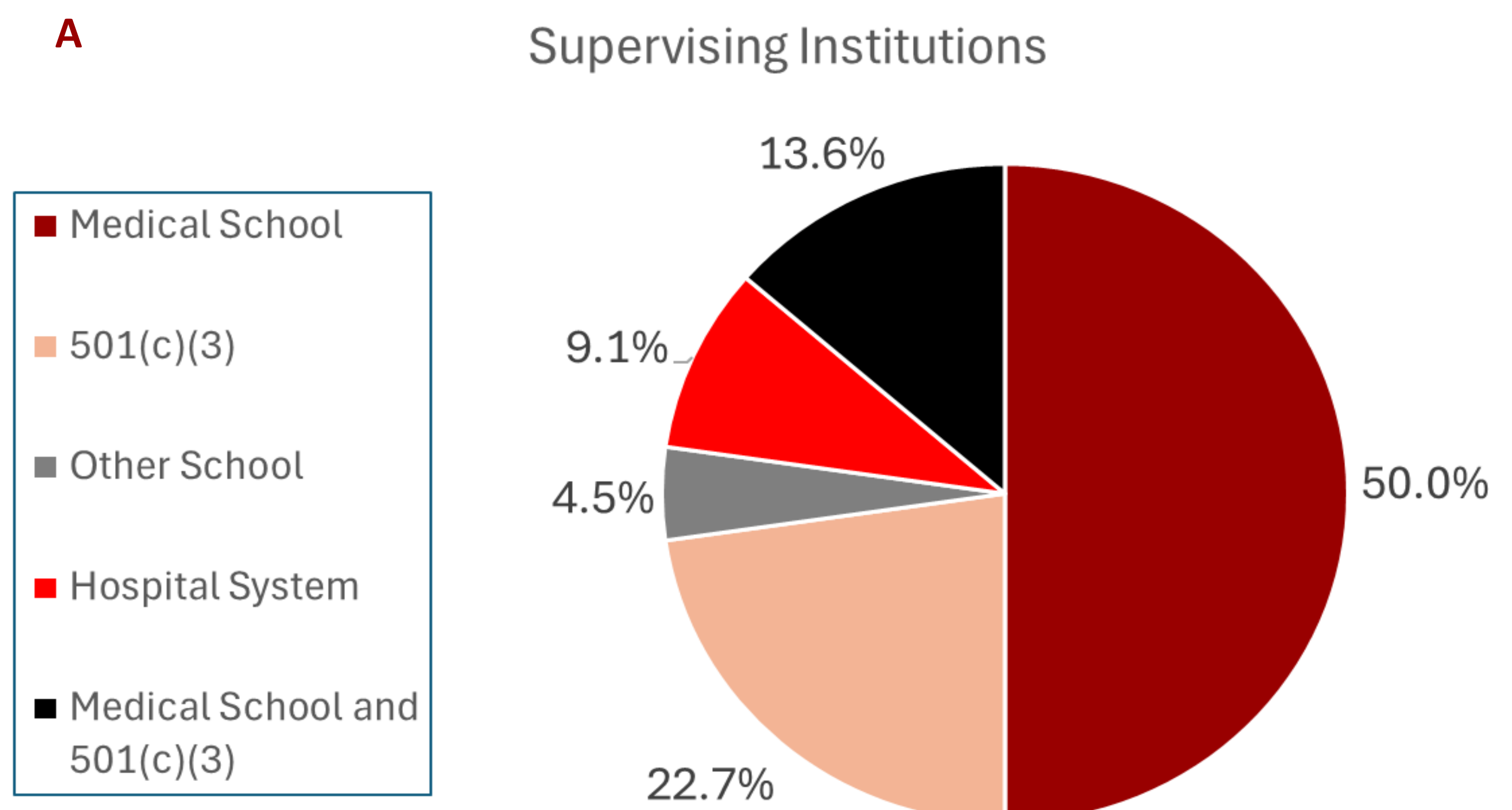
## Methods

We contacted street medicine programs across the country to participate in an online survey and/or a semi-structured virtual interview with standardized questions divided by topics of interest identified as critical to starting a street med program.

- Programs were contacted based on size, affiliation, and age
- Interviews were conducted by two team members, with one recording responses and the other asking questions
- Responses were gathered and separated by section to be analyzed by three independent reviewers.
- 23 total programs participated in interviews, or surveys, or both.

## Program setup and structure

Summary of the surveyed programs' institutional structures (A) and local support (B)



## Operational Logistics

- Outreach team sizes range from 3 to 8 people at a time with providers represented across programs: Physicians, PT, OT, pharmacists, nurses, dentists, optometrists, veterinarians, social workers, APPs, and learners.
- Services include basic meds, harm reduction supplies, wound care, food/water, vaccines, STI testing, with hygiene and sexual health supplies.
- Records are kept by most using various EMRs such as Athena, Practice Fusion, Tebra, eClinicalWorks. Some use spreadsheets or physical notes.
- Many programs had specific safety plans involving buddy systems, codewords if danger is felt, uniforms (scrubs) and nametags.
- Many programs said that safety had never been a problem.

## Continuity of Care

- Considered one of the most important yet most challenging aspect of SM
- Many programs address this with consistency across clinic sites, encampment visits, and familiar volunteers
- Some programs focus on referral to free clinics or FQHCs, often providing transportation – although no-shows are still high
- Some do not provide prescription medications due to lack of follow up.
- There is a lot of mistrust between PEH and healthcare workers; SM programs say effort must be focused on building that trust through their volunteers

## Sustainability

- More than 50% of programs stated longitudinal involvement and transitions of responsibility as important. These were managed largely by long-term commitment, intentional documentation of processes, and overlap of responsibility surrounding leader transitions
- Frequent concern was ensuring financial viability and steady funding
- Some programs stated that they focused on preventing burnout by intentional debriefing and wellness exercises for volunteers and staff

## Legal

- Legal and malpractice concerns were one of the most cited challenges in program establishment and development
- Programs solve this in a variety of ways including coverage under a medical school, hospital system, or the physician preceptors' existing coverage.
- State-based volunteer immunity laws also provide extra protection
- Not all programs cover student volunteers for malpractice, so students help with nonmedical needs such as general outreach and harm reduction
- Overall concern for litigation is very low with programs having never heard of a malpractice suit regarding street medicine.

## Discussion

Our findings have some common characteristics with a similar study<sup>6</sup> that interviewed 13 SM program – that essentially there is high variance across program models due to the focus on meeting specific local needs but similar organizational needs and challenges across programs. This study is still undergoing extensive analysis, but we will note that SM programs may be an optimal way for medical schools to improve learners' education and cultural knowledge of working with PEH patients while also meeting a key community need and generate public goodwill as the public health landscape shifts into unknown, but foreboding, territory.

## References

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