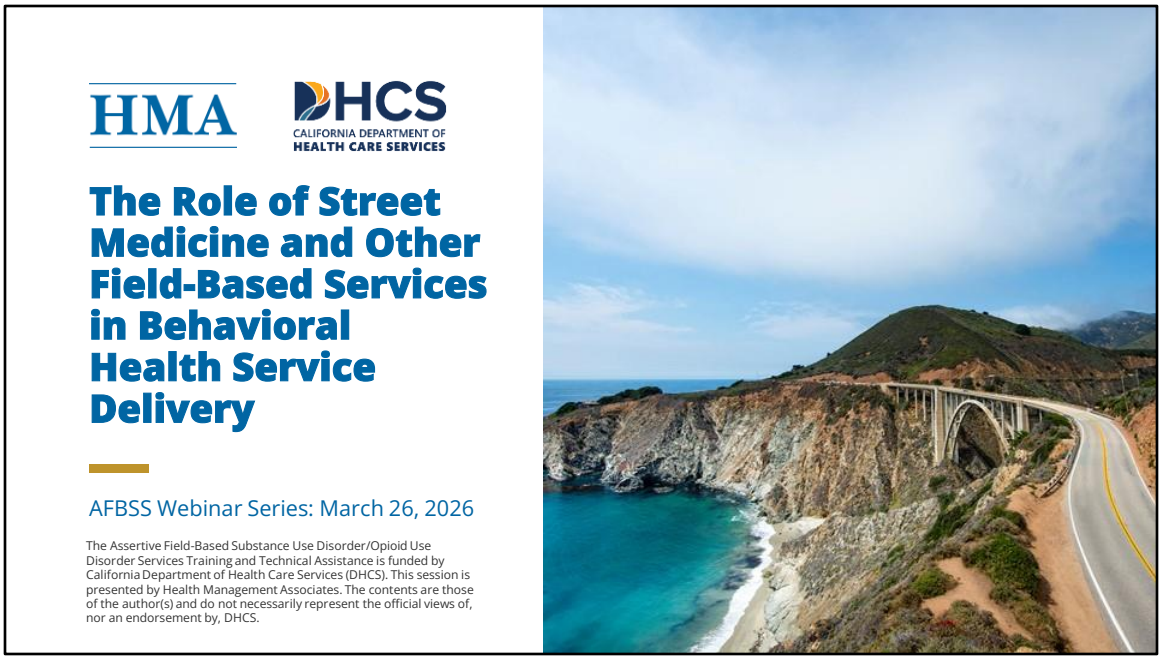

[Slide Image Description: This cover slide introduces the title of this webinar. It contains the logos for Health Management Associates.]

Disclaimer: This session is presented by Health Management Associates. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, California Department of Health Care Services.

Disclosures

Faculty	Nature of Commercial Interest
Brett Feldman, MSPAS, PA-C	Mr. Feldman discloses that he is an employee of USC Street Medicine and Keck School of Medicine of University of Southern California and Vice Chair of the International Street Medicine Institute.
Nai Kasick, MPH	Ms. Kasick discloses that she is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of health care clients.
Jeanene Smith, MD, MPH, CME Reviewer	Dr. Smith discloses that she is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of health care clients.

HMA discloses all relevant financial relationships with companies whose primary business is producing, marketing, selling, re-selling, or distributing health care products used by or on patients.

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[Slide Image Description: This slide shows Continuing Education disclosures.]

- Brett Feldman, MSPAS, PA-C: Mr. Feldman discloses that he is an employee of USC Street Medicine and Keck School of Medicine of University of Southern California.
- Nai Kasick, MPH: Ms. Kasick discloses that she is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of health care clients.
- Jeanene Smith, MD, MPH: Dr. Smith discloses that she is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of health care clients.

Presenters

Brett Feldman, MSPAS, PA-C
Director and Co-Founder
USC Street Medicine
Associate Professor of Family Medicine
Keck School of Medicine of USC

Nai Kasick, MPH
Principal
Health Management Associates
(HMA)

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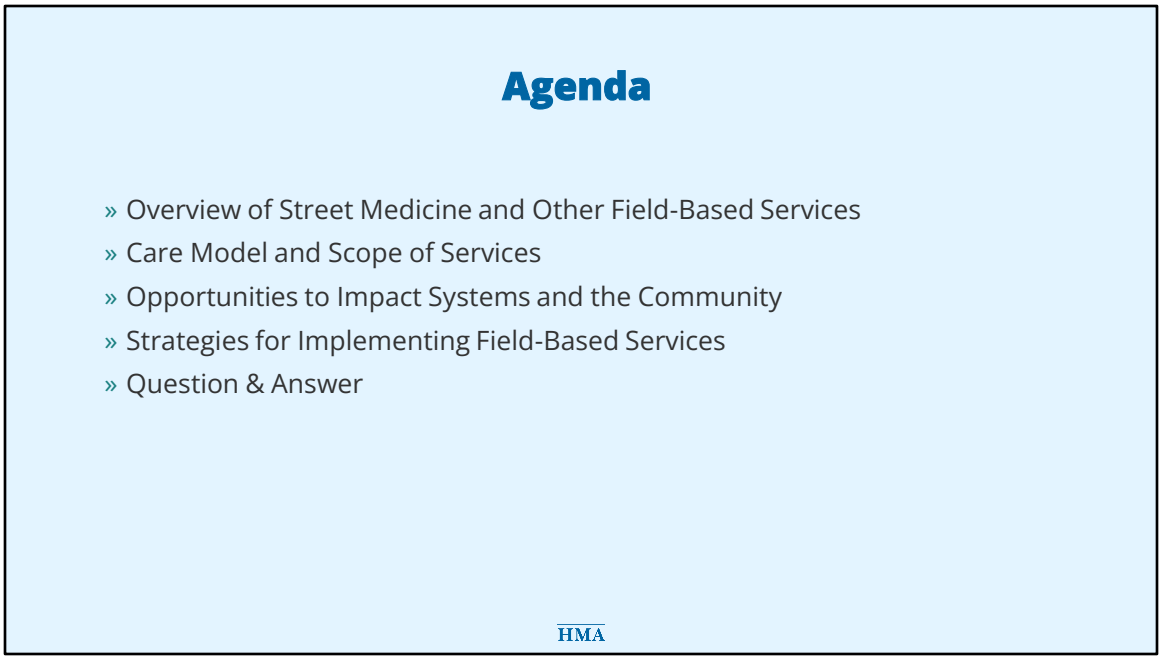
[Slide Image Description: This slide includes images of the presenters of this webinar on a light blue background.]

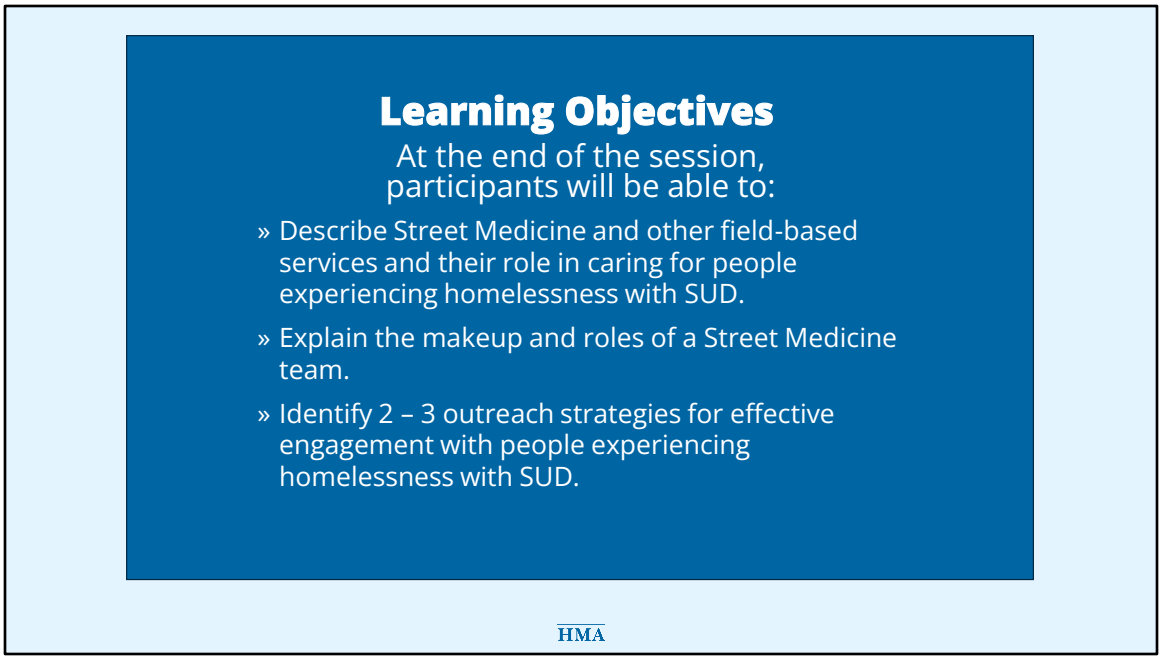
Brett J. Feldman, MSPAS, PA-C, is the Director and co-founder of USC Street Medicine and is an Associate Professor of Family Medicine. Mr. Feldman is the outgoing Vice Chair of the Street Medicine Institute and has practiced street medicine since 2007. In Mr. Feldman's role with USC and the Street Medicine Institute, he participated in the establishment or expansion of over 200 street medicine programs internationally. He has led advocacy efforts to integrate street medicine into mainstream healthcare while keeping its values and philosophy intact.

A mission-driven transformational leader, Nai Kasick advances healthcare equity and access through operational, technological and programmatic improvement strategies. With over a decade of executive experience in program development, community and provider engagement, quality improvement and health equity, Nai leverages her background in health plan operations to foster healthier communities and positively impact lives.



[Slide Image Description: This slide shows the major sections of this webinar on a light blue background.]

Agenda:
- Overview of Street Medicine and Other Field-Based Services
- Care Model and Scope of Services
- Opportunities to Impact Systems and the Community
- Strategies for Implementing Field-Based Services
- Question & Answer



[Slide Image Description: This slide shows the learning objectives for this webinar with a light blue background.]

At the end of the session, participants will be able to:

- Describe Street Medicine and other field-based services and their role in caring for people experiencing homelessness with SUD.
- Explain the makeup and roles of a Street Medicine team.
- Identify 2 – 3 outreach strategies for effective engagement with people experiencing homelessness with SUD.

[Slide Image Description: This is a section divider slide to indicate a major section of this webinar.]

This first section provides an overview of street medicine and other field-based services.

Assertive Field-Based Medication Assisted Treatment (MAT) Access Requirements

» Counties must ensure rapid access to all Food and drug (FDA)-approved Medication Assisted Treatment (MAT) through each of three core strategies:

- Data-informed, targeted outreach
- Mobile field-based programs
- Open-access clinics

SOURCE(S): California Department of Health Care Services (DHCS), 2026.

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[Slide Image Description: This slide shows information on assertive field-based medication assisted treatment access requirements, with an image of the California state capitol building.]

Before jumping into field-based medicine, let's take a moment to review the AFBSS requirements. Counties are expected to strengthen or establish efforts in three key areas:

- Data informed, targeted outreach
- Mobile field-based programs
- Open-access clinics

Together, these create multiple entry points into care.

SOURCE(S): California Department of Health Care Services (DHCS), 2026.

Assertive Field-Based MAT Access Requirements (Continued)

Prioritize	Prioritize high-risk populations (e.g., overdose survivors, individuals experiencing homelessness, justice-involved individuals).
Use	Use coordinated referral pathways with Emergency Medical Services (EMS), Emergency Departments (ED), and public health for rapid post-overdose follow-up.
Locate	Locate services in high-need settings (EDs, encampments, housing sites, syringe programs, jails).
Build on	Build on existing programs or develop integrated models that combine outreach, mobile care, and low-barrier clinics.
Ensure	Ensure confidentiality compliance.
Be	Phased implementation allowed: July 1, 2026 – July 1, 2029; approach must be outlined in county Integrated Plans.

SOURCE(S): DHCS, 2026.

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[Slide Image Description: This slide shows information on assertive field-based medication assisted treatment access requirements, with a colorful chart highlighting details.]

- The intent is to proactively engage individuals who may not seek treatment on their own, especially those at highest risk, including people who have experienced overdoses, are unhoused, or are involved in the justice system.
- A strong emphasis is placed on using data to guide outreach and partnering with EMS, emergency departments, and public health to quickly connect individuals to services following an overdose event.
- Programs should be located where need is greatest—such as emergency departments, encampments, supportive housing sites, syringe service programs, and jails—to reduce barriers and meet people where they are.
- Counties can build on existing infrastructure, partner with current providers, or create integrated models that combine outreach, mobile care, and low-barrier clinic access.
- All activities must continue to follow established confidentiality protections.
- Recognizing that counties are at different stages of readiness, DHCS is allowing a phased implementation period from July 2026 through July 2029. Each county will need to outline its strategy for meeting these requirements in its Integrated Plan.

SOURCE(S): DHCS, 2026.

Case Example: Meet David

- David suffered from schizophrenia.
- Trust built over treating his scabies, beginning mental health (MH) treatment, then referring to County Department of Mental Health (DMH) resulting in improved treatment and housing.

Disclaimer: This is a hypothetical case example. Any resemblance to an actual person is purely coincidental, including race, nationality, and gender.

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[Slide Image Description: This slide shows a case example of David, with an image of trees in front of a building.]

Meet David, the case example.

- David suffered from schizophrenia.
- Trust was built with David over treating his scabies, beginning mental health (MH) treatment, then referring to county resulting in improved treatment and housing.

Disclaimer: This is a hypothetical case example. Any resemblance to an actual person is purely coincidental, including race, nationality, and gender.

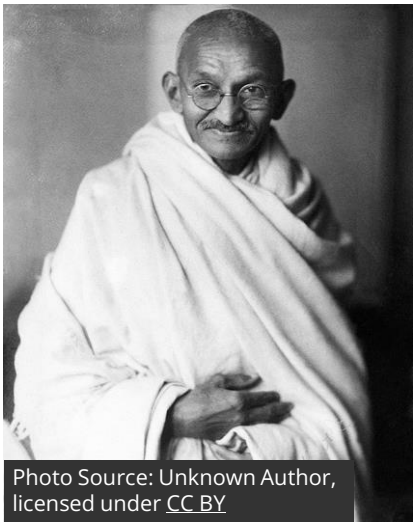

Photo Source: Unknown Author, licensed under CC BY

Gandhi Provides a Compass

"When in doubt, call to mind the face of the poorest or weakest person you have ever seen. Ask yourself if that policy will be of any use to them."

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[Slide Image Description: This slide shows a quote from Ghandi, with an image of him.]

Ghandi provides a compass. Consider this quote:
"When in doubt, call to mind the face of the poorest or weakest person you have ever seen. Ask yourself if that policy will be of any use to them."

The idea that the purpose is to find the last person, the one least likely to be able to access care but needs it the most.

An International Model

SOURCE(S): Street Medicine Institute, n.d.

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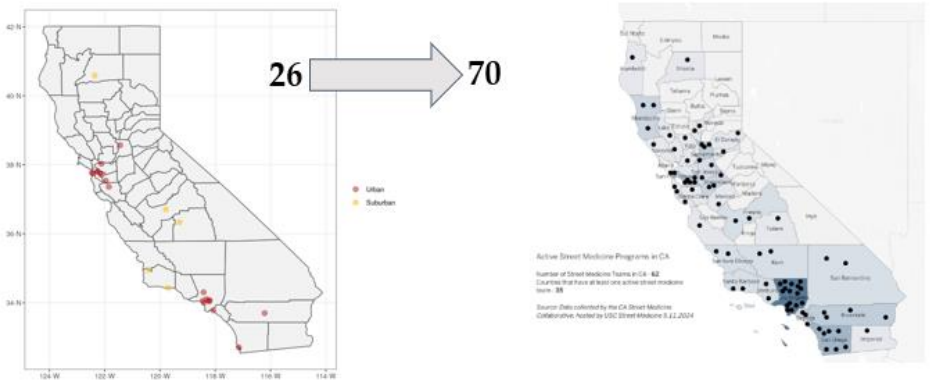
[Slide Image Description: This slide shows a map of Street Medicine programs worldwide.]

The approach of street medicine is a global movement; we aren't alone.

SOURCE(S): Street Medicine Institute, n.d.

Growth of Street Medicine from 2023 to Now



SOURCE(S): USC Street Medicine, n.d.

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[Slide Image Description: This slide shows a map of Street Medicine programs in California, with an arrow from 26 to 70 programs.]

With support from DHCS, this has grown. Previously concentrated in large metro areas, now spread to 35 counties. These teams represent potential partners for county behavioral health.

SOURCE(S): USC Street Medicine, n.d.

California Street Medicine Collaborative

SOURCE(S): USC Street Medicine, 2026.

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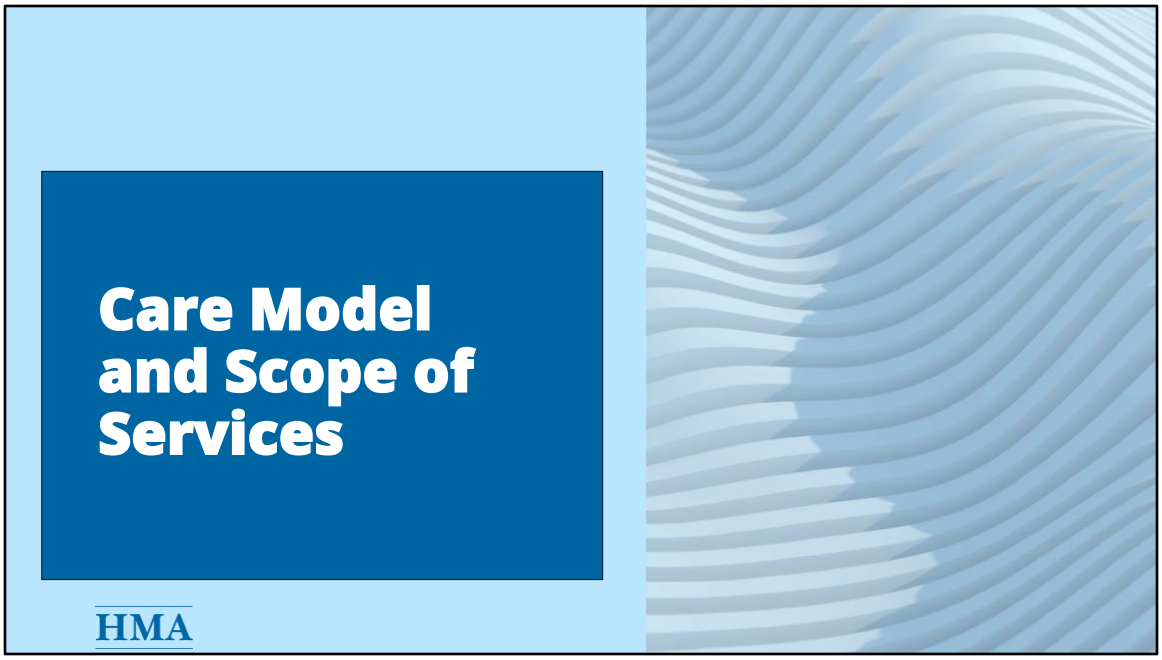
[Slide Image Description: This slide shows a logo from the California Street Medicine Collaborative, with images from street medicine efforts.]

The community is welcome to join with the California Street Medicine Collaborative. It's made up of 300+ organizations coming together for a community of practice, sharing best practices, education and discussion of policy implementation.

SOURCE(S): USC Street Medicine, 2026.



[Slide Image Description: This is a section divider slide to indicate a major section of this webinar.]

This second section reviews the care model and scope of services for street medicine and other field-based services.

Defining Street Medicine: Global Definition

» Street Medicine includes health and social services developed specifically to address the unique needs and circumstances of the **unsheltered homeless delivered directly to them in their own environment**.

SOURCE(S): Street Medicine Institute, n.d.

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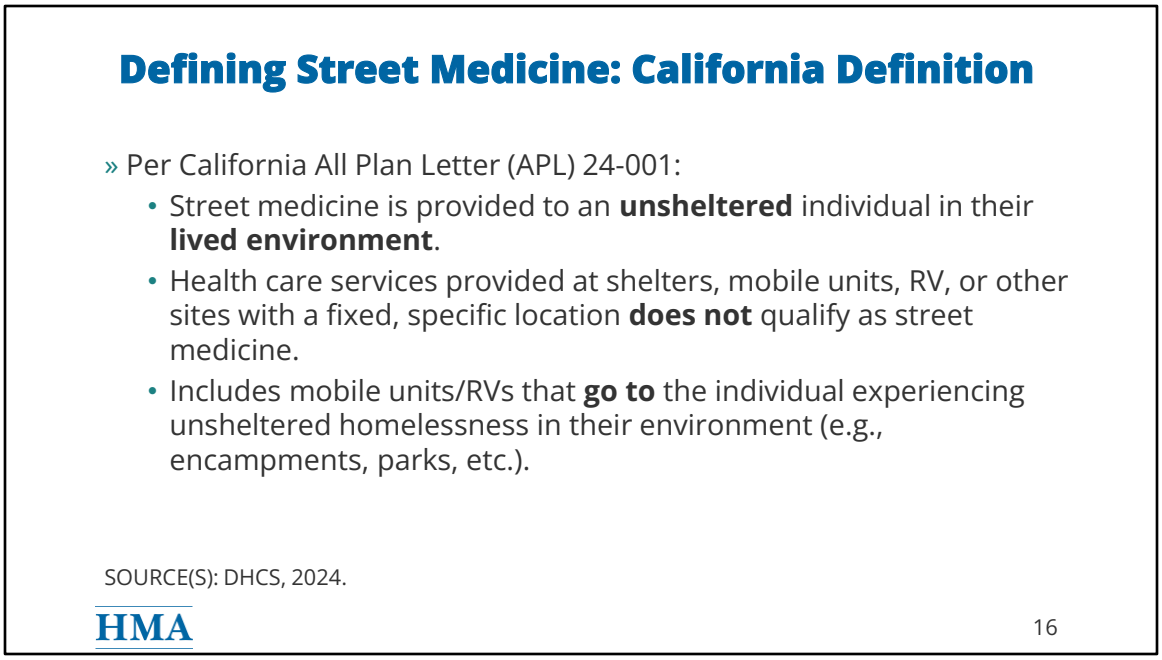
[Slide Image Description: This slide defines street medicine, with the logo from the Street Medicine Institute.]

Global definition: Street Medicine includes health and social services developed specifically to address the unique needs and circumstances of the unsheltered homeless delivered directly to them in their own environment.

SOURCE(S): Street Medicine Institute, n.d.



[Slide Image Description: This slide defines street medicine.]

California All Plan Letter (APL) 24-001 provides guidance to Medi-Cal managed care plans (MCPs) on opportunities to utilize street medicine providers to address clinical and non-clinical needs of their Medi-Cal Members experiencing unsheltered homelessness.

APL 24-001 defines street medicine as the following:

- Street medicine is provided to an unsheltered individual in their lived environment.
- Health care services provided at shelters, mobile units, RV, or other sites with a fixed, specific location does not qualify as street medicine.
- Includes mobile units/RVs that go to the individual experiencing unsheltered homelessness in their environment (e.g., encampments, parks, etc.).

SOURCE(S): DHCS, 2024.

Federal Recognition for Street Medicine

» The U.S. Centers for Medicare & Medicaid Services (CMS) reimburses for street medicine through point-of-service (POS) code 27 (Outreach Site/Street) effective October 1, 2023.

27	Outreach Site/ Street	A non-permanent **location on the street or found environment,** no described by any other POS code, where health professionals provide preventive, screening, diagnostic, and/or treatment **services to unsheltered individuals.** (Effective October 1, 2023)

SOURCE(S): Centers for Medicare & Medicaid Services (CMS), 2024.

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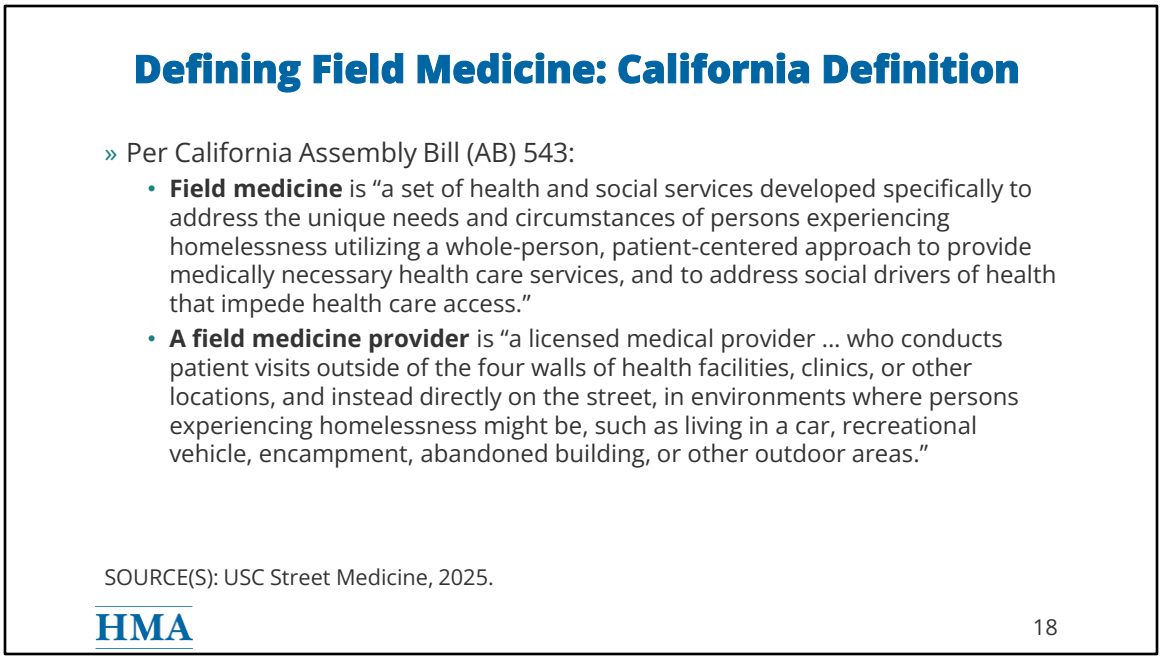
[Slide Image Description: This slide defines federal recognition for street medicine, with a screenshot from the U.S. Centers for Medicare & Medicaid Services code 27.]

Street medicine is recognized federally and also reimbursed by the U.S. Centers for Medicare & Medicaid Services (CMS) through place of service (POS) code 27 (Outreach Site/Street) effective October 1, 2023. This is a non-permanent location on the street or found environment, not described by any other POS code, where health professionals provide preventive, screening, diagnostic, and/or treatment services to unsheltered homeless individuals.

SOURCE(S): Centers for Medicare & Medicaid Services (CMS), 2024.



[Slide Image Description: This slide defines field medicine.]

California Assembly Bill (AB) 543 defines field medicine as the following:

- Field medicine is "a set of health and social services developed specifically to address the unique needs and circumstances of persons experiencing homelessness utilizing a whole-person, patient-centered approach to provide medically necessary health care services, and to address social drivers of health that impede health care access."
- A field medicine provider is "a licensed medical provider … who conducts patient visits outside of the four walls of health facilities, clinics, or other locations, and instead directly on the street, in environments where persons experiencing homelessness might be, such as living in a car, recreational vehicle, encampment, abandoned building, or other outdoor areas."

SOURCE(S): USC Street Medicine, 2025.

Street Medicine as Part of the Continuum

Continuum of Medical Outreach

SOURCE(S): National Health Care for the Homeless Council, 2022.

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[Slide Image Description: This slide defines street medicine as part of the continuum, with a screenshot of the Continuum of Medical Outreach from the National Health Care for the Homeless Council.]

All part of same continuum—no right or wrong, all are needed.

SOURCE(S): National Health Care for the Homeless Council, 2022.

Going to the People RADICALLY

SOURCE(S): California Health and Human Services Agency, 2023.

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[Slide Image Description: This slide shows a map of Los Angeles, with icons.]

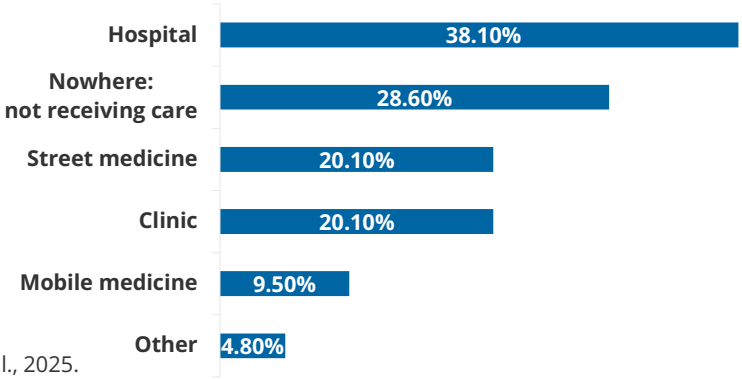
Why it's important to still separate street medicine—demonstrates proximity.

SOURCE(S): California Health and Human Services Agency, 2023.

MacArthur Park, Los Angeles

22 brick and mortar clinics in 3 blocks

Where do you currently get healthcare? (N=63)



SOURCE(S): Feldman, C. T., et al., 2025.

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[Slide Image Description: This slide shows MacArthur Park, Los Angeles, with a table of where folks currently get healthcare.]

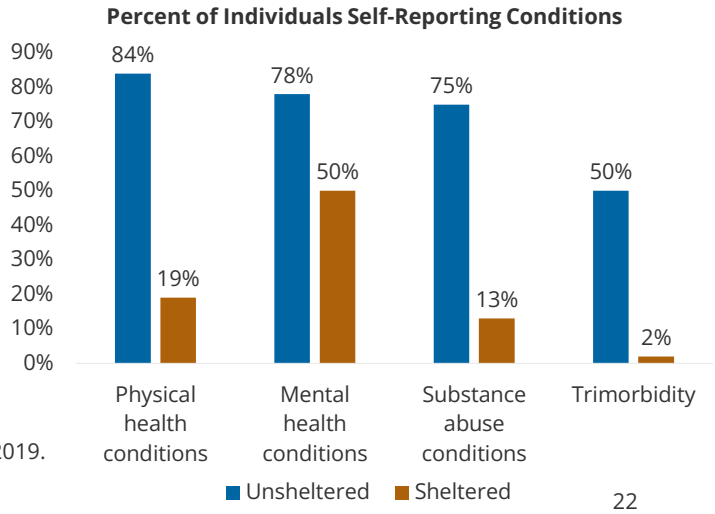
Not just proximity; there are other reasons why people can't go to clinics.

There are 22 clinics in 3 blocks of the park, and clinics and street medicine are used the most, but there is not an equitable distribution of resources. Unfortunately, hospitals and no care are still most common.

SOURCE(S): Feldman, C. T., et al., 2025.

Physical Health, Mental Health, Substance Abuse, and Trimorbidity by Shelter Status

» Regardless of access, many need care. 50% of individuals self-reporting conditions in shelters have Trimorbidity (physical health, mental health, and substance use conditions).



SOURCE(S): Rountree, J., et al., 2019.

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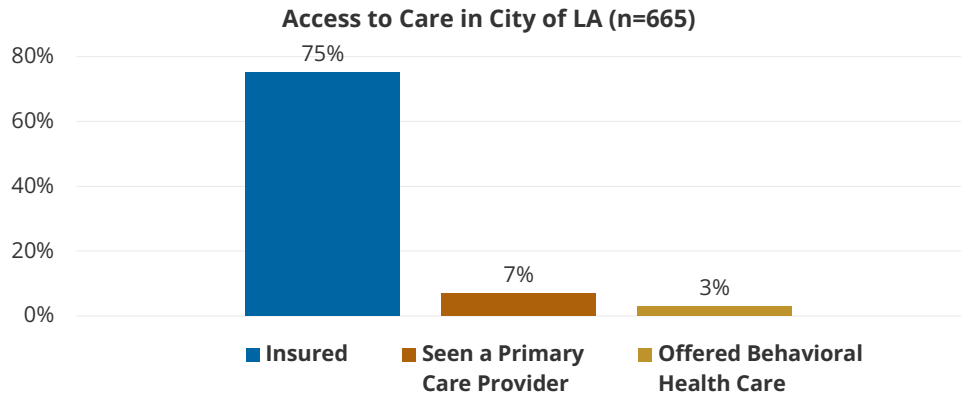
[Slide Image Description: This slide shows trimorbidity by shelter status, with a graph showing physical health conditions, mental health conditions, substance abuse conditions, and trimorbidity among unsheltered and sheltered populations.]

Regardless of access, many need care. 50% of individuals self-reporting conditions in shelters have Trimorbidity (physical health, mental health, and substance use conditions).

SOURCE(S): Rountree, J., et al., 2019.

Objective Reality of the Street: Illusion of Access



SOURCE(S): Kogan, A. C., et al., 2025.

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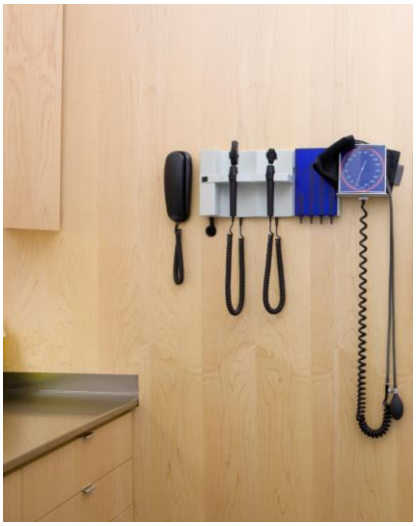
[Slide Image Description: This slide shows a graph of access to care in the city of Los Angeles, with 75% insured, 7% have seen a primary care provider (PCP), and 3% are offered behavioral health care.]

Even though 75% are insured, few have access.

SOURCE(S): Kogan, A. C., et al., 2025.



Discrimination in the Healthcare Setting

- **Distrust of physicians** and/or feel unwelcome in a healthcare setting.
  - Treated poorly or **discriminated against** in the past.
- "**Significant disparities** in in-hospital care and mortality between homeless and non-homeless adults with cardiovascular conditions."

SOURCE(S): Wen, C. K., et al., 2007; Martins D. C., 2008; Wadhera, R. K., et al. 2020.

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[Slide Image Description: This slide defines discrimination in the healthcare setting, with an image of a clinic.]

When individuals are accessing care, many face discrimination in healthcare settings. This is another reason individuals may not want to receive care. Individuals may have been treated poorly or discriminated against in the past. For example, there are "significant disparities in in-hospital care and mortality between homeless and non-homeless adults with cardiovascular conditions."

SOURCES: Wen, C. K., et al., 2007; Martins D. C., 2008; Wadhera, R. K., et al. 2020.


Photo Source: USC Street Medicine

Make-up of a Team

- Prescriber (Psychiatrist/Physician, Physician's Assistant, Nurse Practitioner)
- Nurse
- Peer Support Specialists (Community Health Workers)
- Substance Use Disorder (SUD) Counselor
- Employment Specialist
- Additional recommended team members:
  - Associate or Licensed Clinical Social Workers (ACSW/LCSW)
  - Occupational therapists (OT)
  - Enhanced Care Management (ECM)
  - Housing Navigation

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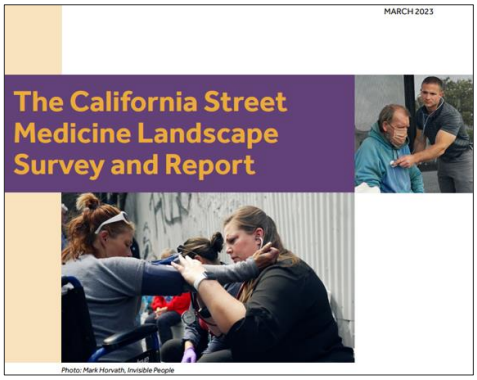
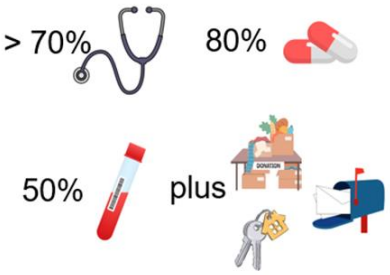
[Slide Image Description: This slide shows information on the makeup of a street medicine team, with an image of a team in the field helping an individual in a wheelchair.]

Make-up of a team:

- Prescriber (Psychiatrist/Physician, Physician's Assistant, Nurse Practitioner)
- Nurse
- Peer Support Specialists (Community Health Workers)
- Substance Use Disorder (SUD) Counselor
- Employment Specialist
- Additional recommended team members:
  - Associate or Licensed Clinical Social Workers (ACSW/LCSW)
  - Occupational therapists (OT)
  - Enhanced Care Management (ECM)
  - Housing Navigation

Scope of Practice





SOURCE(S): Feldman, B. J., et al., 2023

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[Slide Image Description: This slide describes scope of practice, with an image of the California Street Medicine Landscape Survey and Report and various icons.]

Our response is to bring full scope of practice to them. Over 70% provide full scope primary care + psych care, 80% dispense meds, 50% do phlebotomy and much more.

SOURCE(S): Feldman, B. J., et al., 2023

Street Psychiatry and Psychiatry for the Non-Psychiatrist


Photo Source: USC Street Medicine


Photo Source: USC Street Medicine

SOURCE(S): Street Medicine Institute, n.d.

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[Slide Image Description: This slide shares images of state street medicine providers known for psychiatry.]

Since the landscape study, there has been growth in behavioral health on the street. Previously, there were only five full time employees of street psychiatry in the state. Also, there are more primary care providers practicing at the top of their scope for psychiatry. Photos are of state street medicine providers known for psychiatry.

SOURCE(S): Street Medicine Institute, n.d.

Treatment for Substance Use Disorders

Photo Source: LAist

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[Slide Image Description: This slide shares an image of a state street medicine providers.]

Also, there has been big growth with SUD treatment. Providers in photos are double boarded in addiction medicine and pioneering direct to inject treatment in the street.

[Slide Image Description: This is a section divider slide to indicate a major section of this webinar.]

This third section reviews opportunities to impact systems and the community.

Determine Scope of Service

- Engage → Refer → Treat
- Transitional Behavioral Health Care
- Full-Scope Behavioral Health Care
- Focus on transitions between healthcare continuum and housing continuum

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[Slide Image Description: This slide describes the scope of service, with an image of providers holding the hand of a patient.]

Each provider must decide for themselves what scope they will bring to the field. Full scope is best.

- Engage → Refer → Treat
- Transitional Behavioral Health Care
- Full-Scope Behavioral Health Care
- Focus on transitions between healthcare continuum and housing continuum

Determine Coverage

Geographic Coverage

- Area divided into regions

Population Coverage

- Number or percent of people seen in the area

Which do we find more useful?

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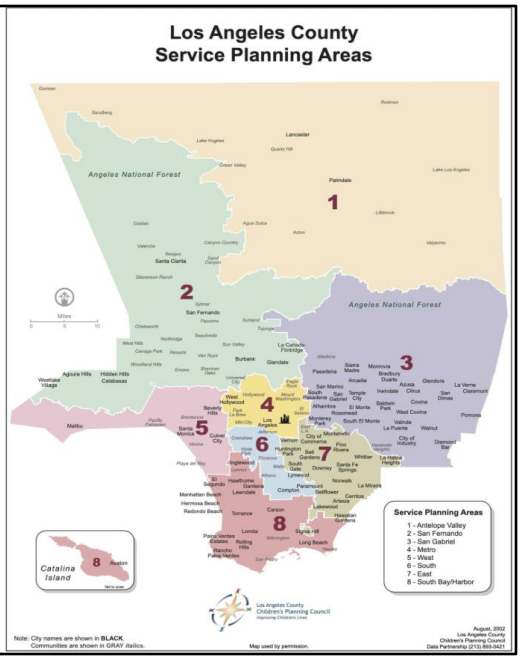
[Slide Image Description: This slide determines coverage, with an image of a map with tacks.]

Next, determine coverage.

- Geographic Coverage
    - Area divided into regions
- Population Coverage
    - Consider thinking beyond the geographic area, and look at the number or percent of people seen in the area
- Which do we find more useful?

Geographic Coverage in Los Angeles County Service Planning Areas (SPAs)



SOURCE(S): Mental Health America of Los Angeles, 2021.

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[Slide Image Description: This slide shows a map of Los Angeles County Service Planning Areas.]

As we discuss program coverage, this slide represents Los Angeles County Service Planning Areas (SPAs) to illustrate why geographic density of programs does not equal adequate population coverage and why field-based services remain necessary even in resource-rich regions.

Los Angeles County is divided into eight Service Planning Areas (SPAs) used for behavioral health and service planning. Data presented show that every SPA has at least five street medicine programs, with one SPA hosting as many as 19 programs. At face value, this suggests dense service availability across the county.

SOURCE(S): Mental Health America of Los Angeles, 2021.

Geographic Coverage in Los Angeles County SPAs (Continued)

SPA	1	2	3	4	5	6	7	8
Number of Programs	5	5	5	19	5	9	6	10
2024 PIT	5,538	6,997	3,630	12,185	4,143	8,682	4,342	3,992

Service Planning Area (SPA)
The Point-in-Time (PIT) count of the homeless is conducted annually by the Los Angeles Homeless Services Authority (LAHSA)

SOURCE(S): Street Medicine Institute, n.d.; Los Angeles Homeless Services Authority, n.d.

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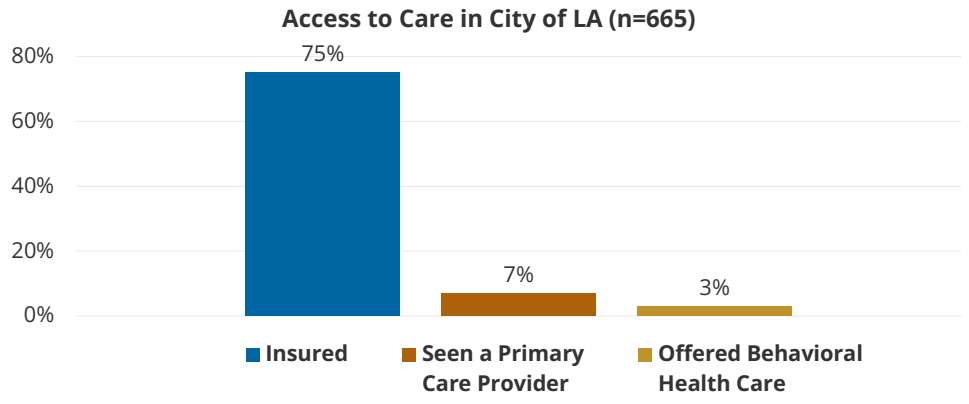
[Slide Image Description: This slide has a chart of geographic coverage in Los Angeles County.]

By geographic coverage, Los Angeles looks crowded. Every Service Planning Area (SPA) has at least 5 street medicine providers, with 1 having 19. Seems like there is duplication of services but there isn't.

SOURCE(S): Street Medicine Institute, n.d.; Los Angeles Homeless Services Authority, n.d.

Objective Reality of the Street: Illusion of Access?



SOURCE(S): Kogan, A. C., et al., 2025.

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[Slide Image Description: This slide shows a graph of access to care in the city of Los Angeles, with 75% insured, 7% have seen a primary care provider (PCP), and 3% are offered behavioral health care.]

By population coverage, likely need much more.

SOURCE(S): Kogan, A. C., et al., 2025.

LA County Population Coverage from System Perspective

- Panel size: 350 patients per provider fulltime equivalent (FTE)
- Annualized PIT Count 2023: 121,858
- Total Needed: 348
- "Field Medicine" FTE: 33
- Current Engagement: 9.4% of the population

SOURCE(S): L.A. Care Health Plan, n.d.; Feldman, B. J., et al., 2023.

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[Slide Image Description: This slide describes the LA County Population Coverage from a system perspective, with an image of a provider treating a patient.]

Consider using the following formula to calculate what your county may need:

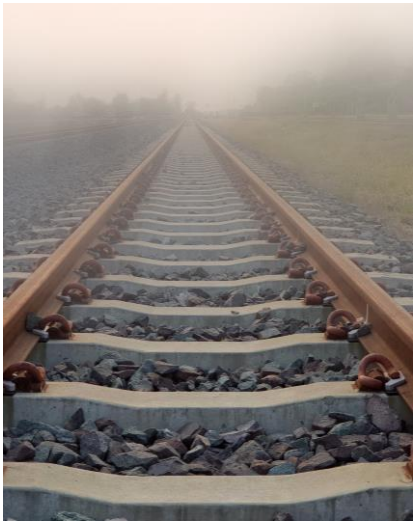
- Panel size: 350 patients per provider FTE
- Annualized PIT Count 2023: 121,858
- Total Needed: 348
- "Field Medicine" FTE: 33
    - Source L.A. Care/ HealthNet
- Current Engagement: 9.4% of the population

SOURCE(S): L.A. Care Health Plan, n.d.; Feldman, B. J., et al., 2023.

Strategies to Extend Reach

» Find "lifeguards“
- Physical assets (shelters, food banks, parks, riverbanks, transit)
- Social supports (faith-based organizations, Community Supports providers)
- Services gaps (where needs exist but services are limited or absent)

» Relationships and pathways (street outreach providers, encampments, mobile clinic providers, food/meal providers)



HMA

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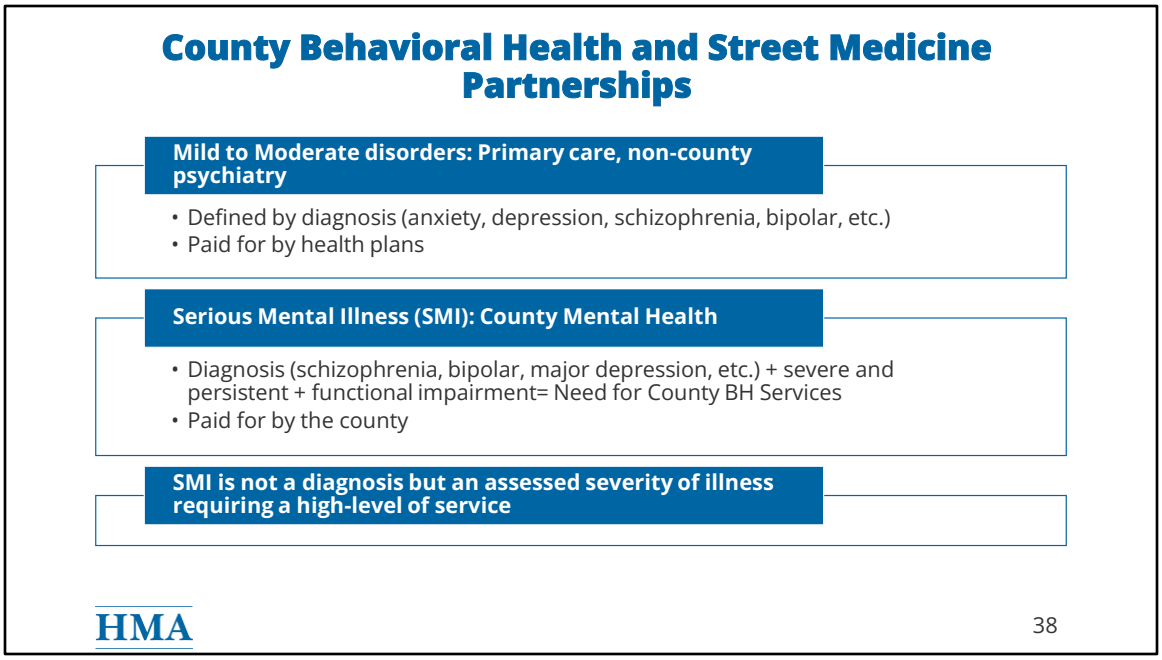
[Slide Image Description: This slide describes strategies to extend reach, with an image of a railroad track.]

Given many counties may not have enough coverage, community relationships are important.

- Find "lifeguards"
  - Physical assets (shelters, food banks, parks, riverbanks, transit)
  - Social supports (faith-based organizations, Community Supports providers)
  - Services gaps (where needs exist but services are limited or absent)
- Relationships and pathways (street outreach providers, encampments, mobile clinic providers, food/meal providers)

[Slide Image Description: This is a section divider slide to indicate a major section of this webinar.]

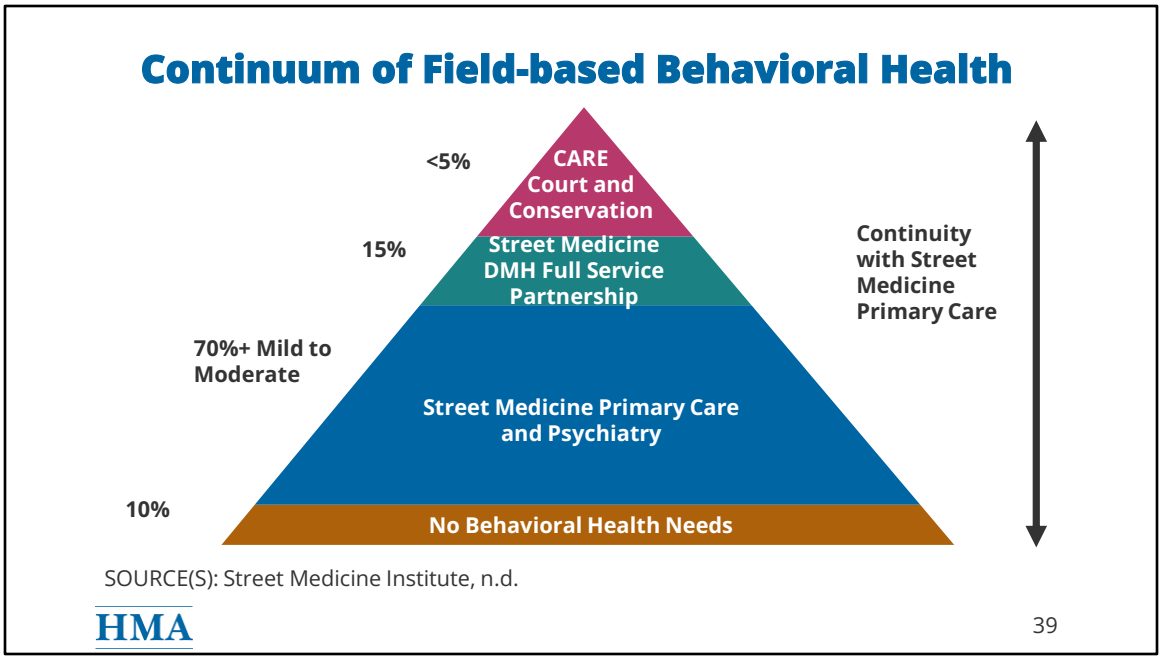
This fourth section provides strategies for implementing field-based services.



[Slide Image Description: This slide describes partnerships with colorful boxes.]

For implementation, first, what is the county BH role.

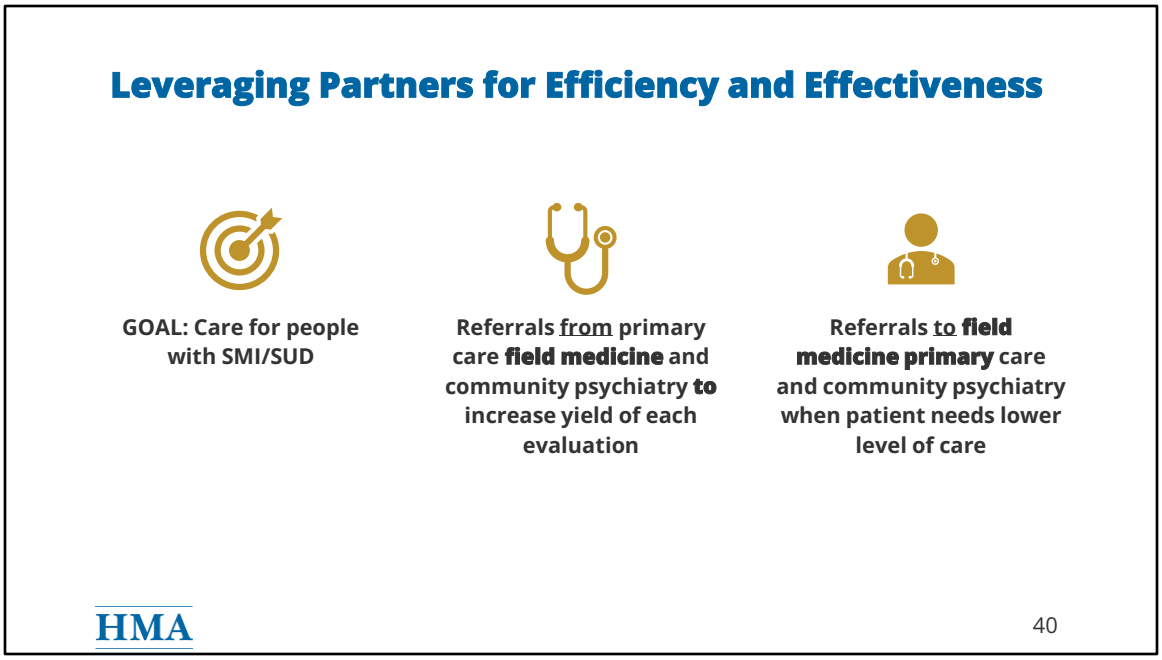
- Mild to Moderate disorders: Primary care, non-county psychiatry
    - Defined by diagnosis (anxiety, depression, schizophrenia, bipolar, etc.)
    - Paid for by health plans
- Serious Mental Illness (SMI): County Mental Health
    - Diagnosis (schizophrenia, bipolar, major depression, etc.) + severe and persistent + functional impairment
    - Paid for by the county
- SMI is not a diagnosis but a severity requiring high-level of service.



[Slide Image Description: This slide shows a graphic of the continuum of field-based behavioral health.]

Field-based Full-Service Partnership (FSP) is the 15% that is currently missing. This will fill the gap. The majority of people experiencing homelessness can be cared for with primary care and community psychiatry. The top two are county behavioral health. This is also a counter narrative to the current story that the majority have SMI and need conservatorship.

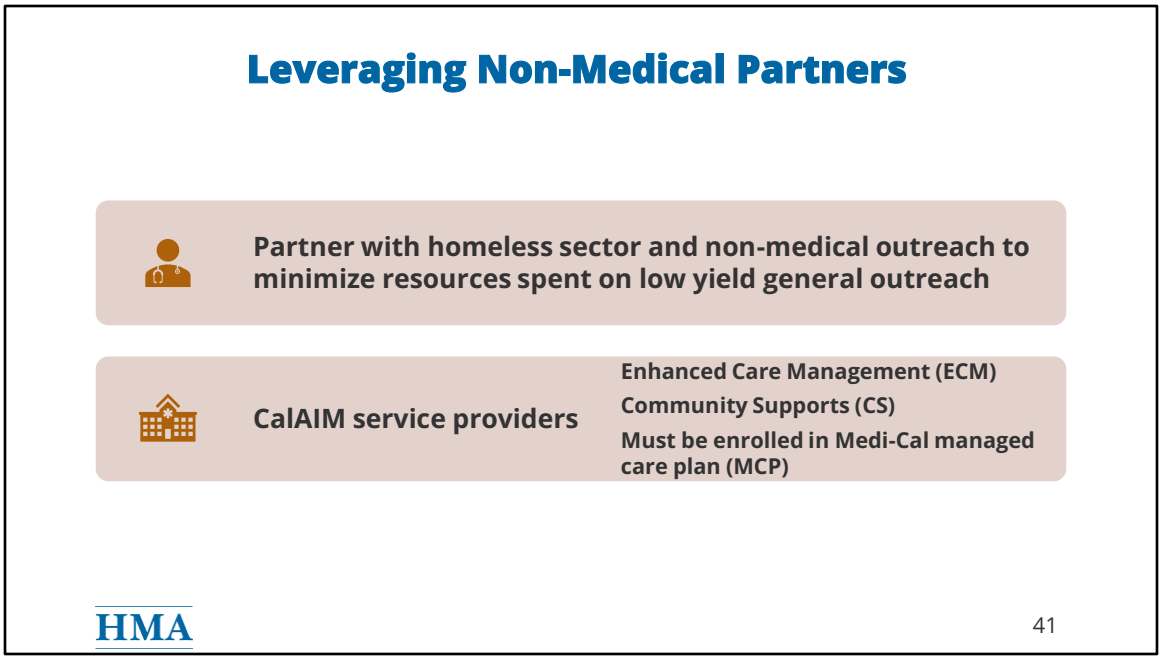
SOURCE(S): Street Medicine Institute, n.d.



[Slide Image Description: This slide describes leveraging partners, with icons of a bullseye, stethoscope, and provider.]

Tips for increasing reach with limited resources using primary care street medicine, if available:

- GOAL: Care for people with SMI/ SUD
    - Maximize time spent caring for enrolled patients
- Referrals from primary care and community psychiatry field medicine to increase yield of each evaluation
- Referrals to primary care and community psychiatry field when patient needs lower level of care

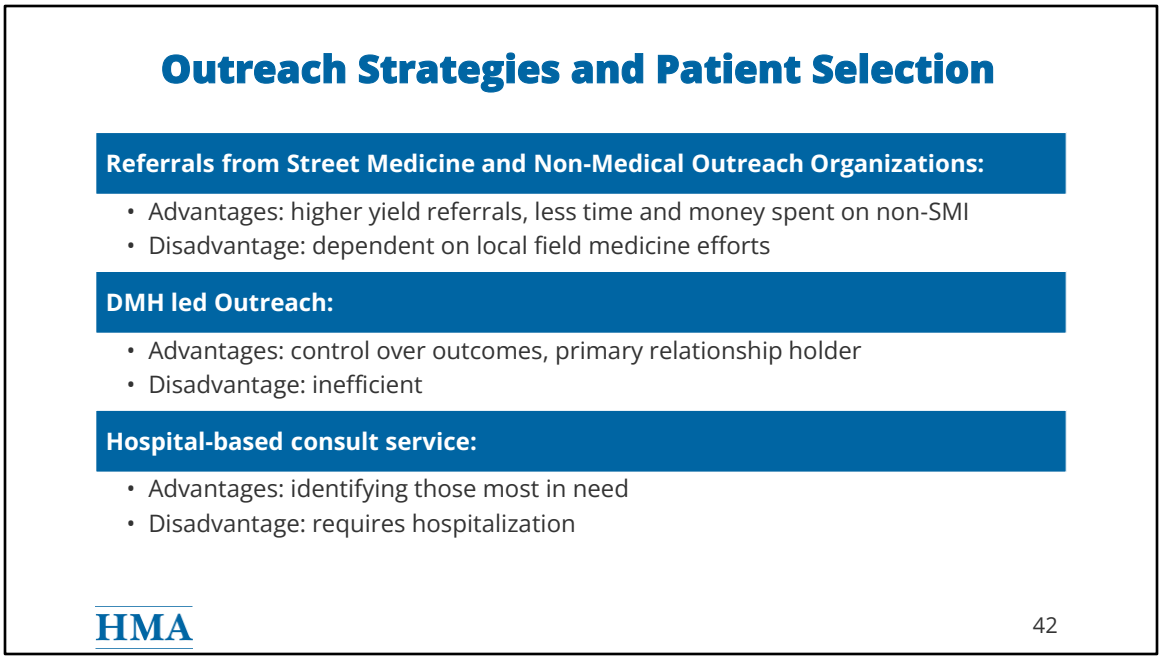


[Slide Image Description: This slide describes leveraging non-medical partners, with icons of a provider and hospital.]

Other partnerships are important too.

Consider the following for leveraging non-medical partners:

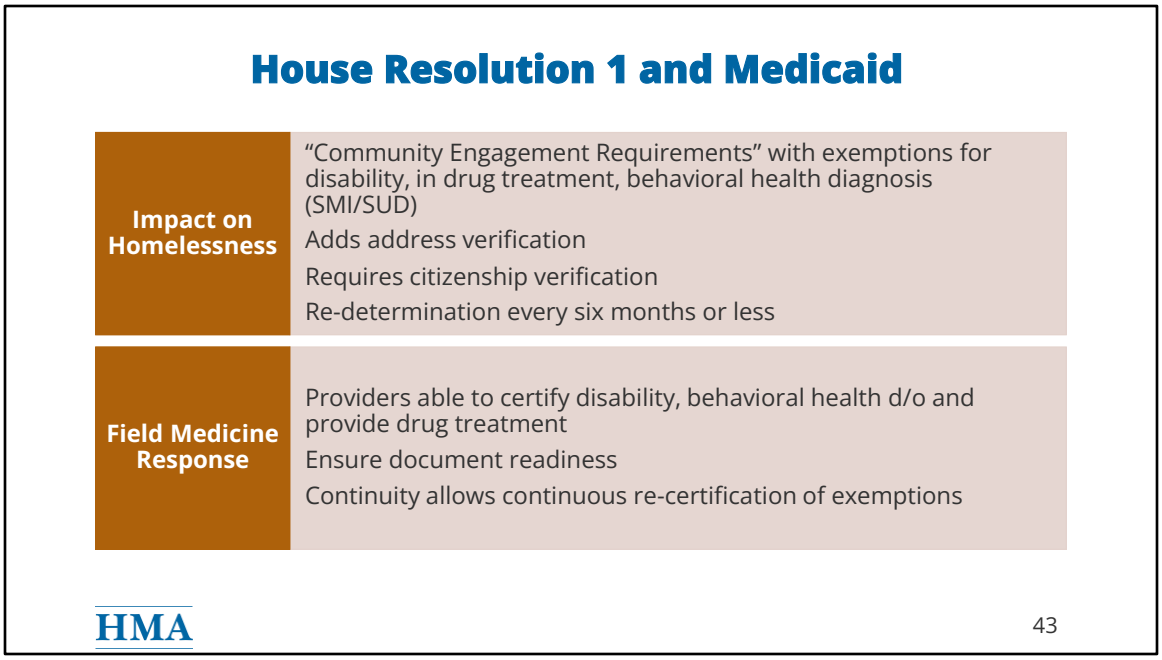
- Partner with homeless sector and non-medical outreach to minimize resources spent on low yield general outreach
- CalAIM service partners
    - Enhanced Care Management (ECM)
    - Community Supports (CS)
    - Must be enrolled in Medi-Cal managed care plan (MCP)



[Slide Image Description: This slide describes outreach strategies with colorful boxes.]

Outreach Strategies and Patient Selection:

- Referrals from Street Medicine and Non-Medical Outreach Orgs:
  - Advantages: higher yield referrals, less time and money spent on non-SMI
  - Disadvantage: dependent on local field medicine efforts
- DMH led Outreach
  - Advantages: control over outcomes, primary relationship holder
  - Disadvantage: inefficient
- Hospital-based consult service
  - Advantages: identifying those most in need
  - Disadvantage: requires hospitalization



[Slide Image Description: This slide describes House Resolution 1 with colorful boxes.]

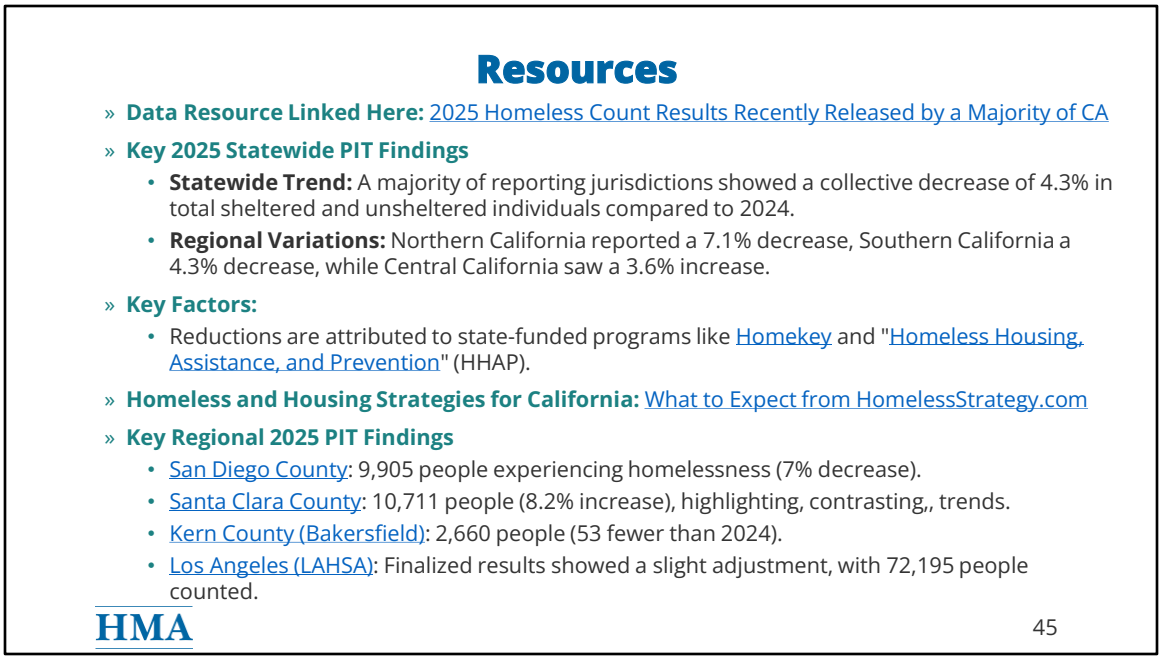
House Resolution (HR) 1 will result in a huge decrease in coverage, but street medicine and county BH can help with exemptions. If not, cost will fall to counties.

Impact on Homelessness:
- "Community Engagement Requirements" with exemptions for disability, in drug treatment, behavioral health diagnosis (SMI/SUD)
- Adds address verification
- Requires citizenship verification
- Re-determination every six months or less

Field Medicine Response
- Providers able to certify disability, behavioral health diagnosis (SMI/SUD) and provide drug treatment
- Ensure document readiness
- Continuity allows continuous re-certification of exemptions

[Slide Image Description: This slide shows the AFBSS email address.]

We are here to support you and provide you with those opportunities to connect and hear about implementing AFBSS. Our email address is **info@afbsstraining.org**.

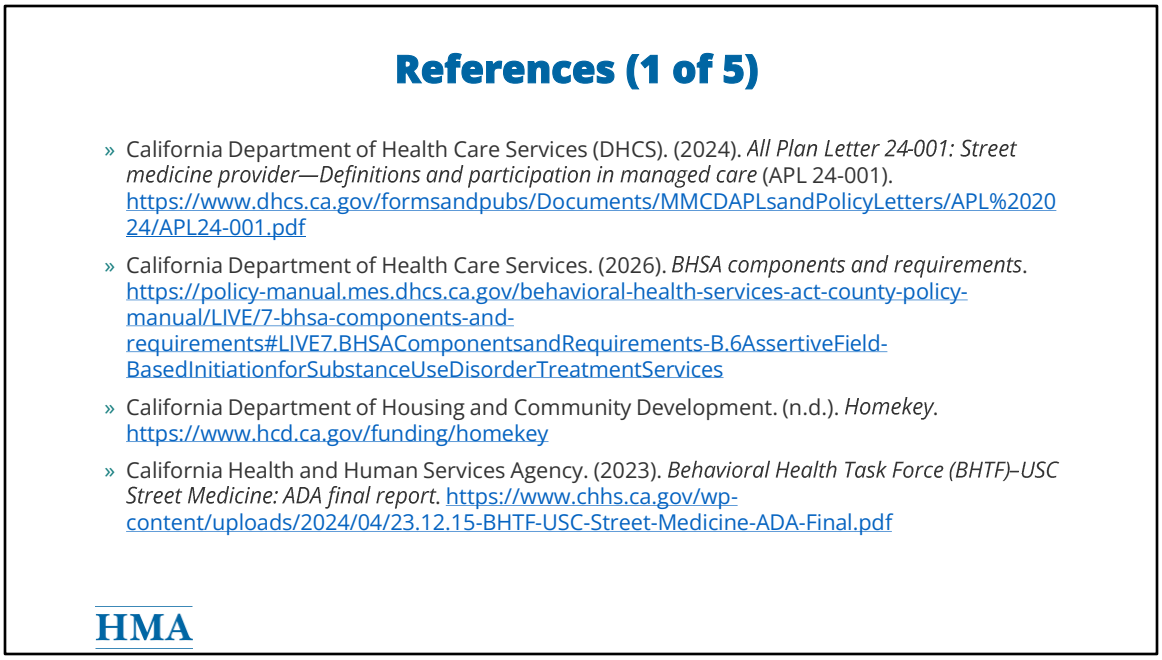


[Slide Image Description: This slide lists webinar resources.]

Resources:

- Data Resource Linked Here: 2025 Homeless Count Results Recently Released by a Majority of CA
- Key 2025 Statewide PIT Findings
  - Statewide Trend: A majority of reporting jurisdictions showed a collective decrease of 4.3% in total sheltered and unsheltered individuals compared to 2024.
  - Regional Variations: Northern California reported a 7.1% decrease, Southern California a 4.3% decrease, while Central California saw a 3.6% increase.
- Key Factors:
  - Reductions are attributed to state-funded programs like Homekey and "Homeless Housing, Assistance, and Prevention" (HHAP).
- Homeless and Housing Strategies for California: What to Expect from HomelessStrategy.com
- Key Regional 2025 PIT Findings

- San Diego County: 9,905 people experiencing homelessness (7% decrease).
- Santa Clara County: 10,711 people (8.2% increase), highlighting, contrasting,, trends.
- Kern County (Bakersfield): 2,660 people (53 fewer than 2024).
- Los Angeles (LAHSA): Finalized results showed a slight adjustment, with 72,195 people counted.



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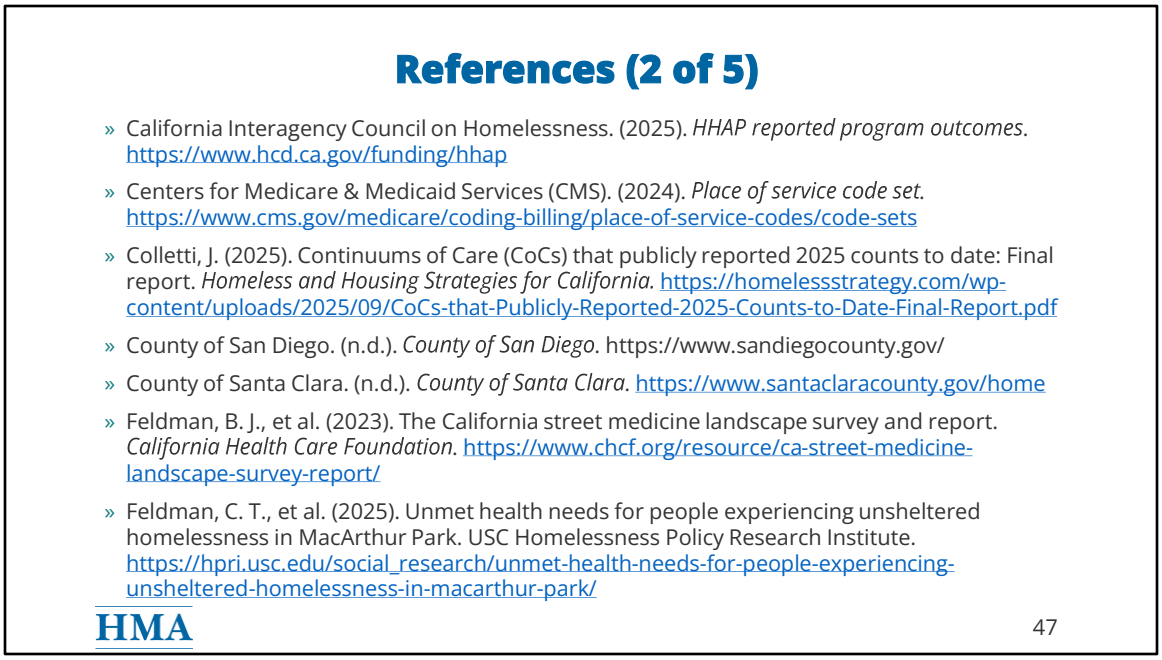

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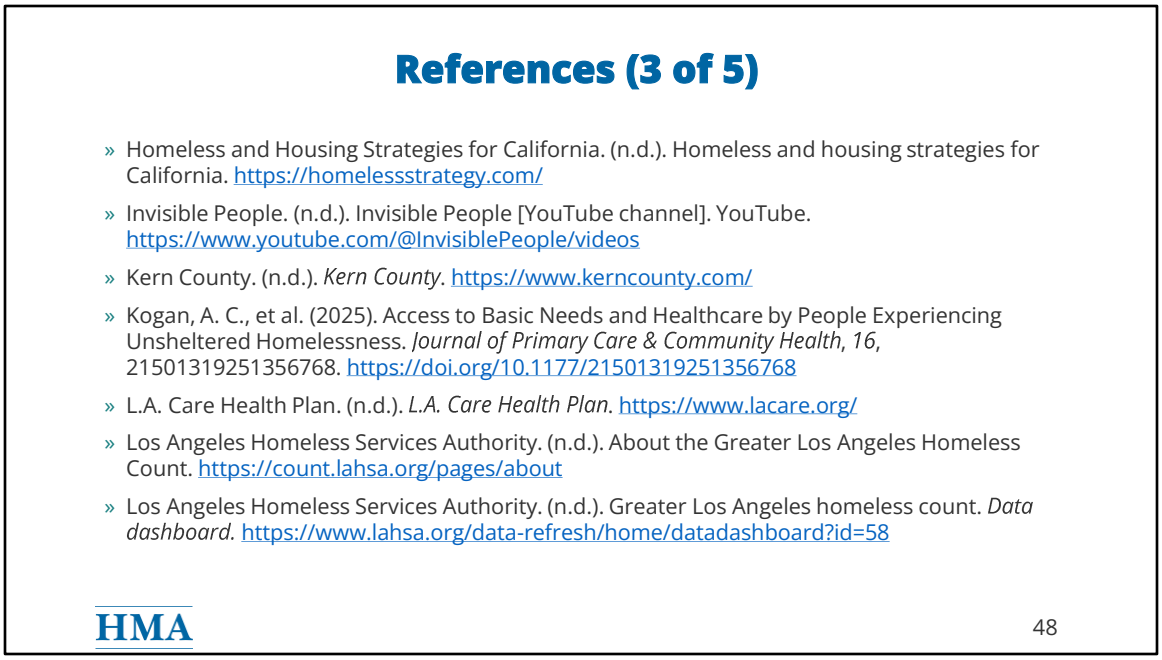

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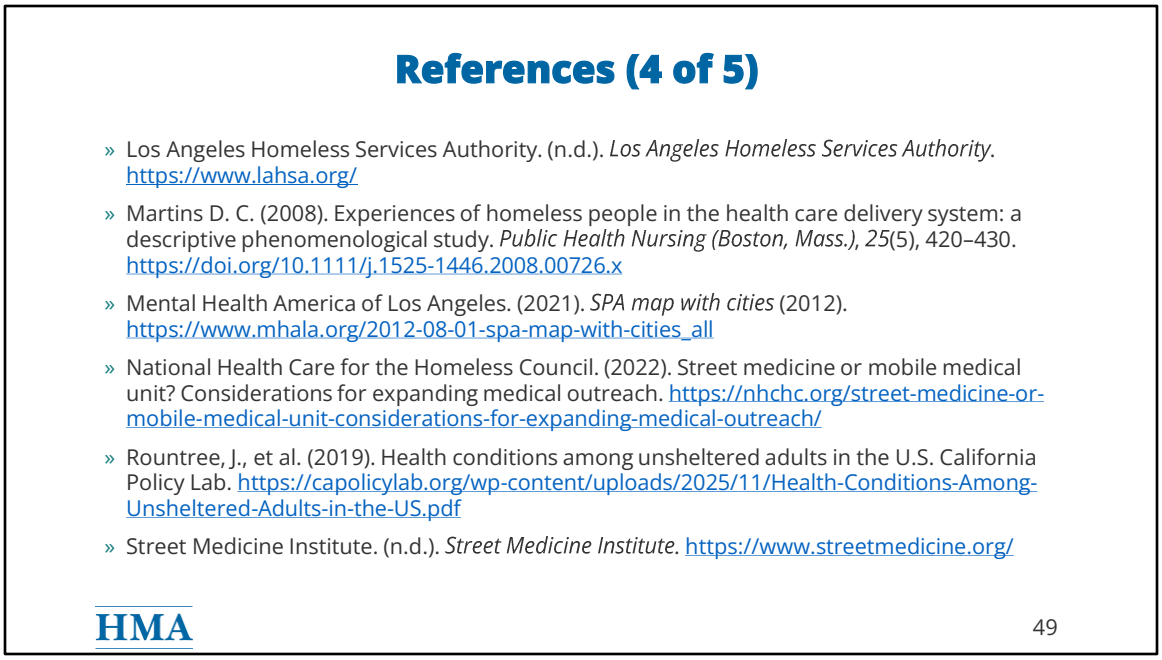

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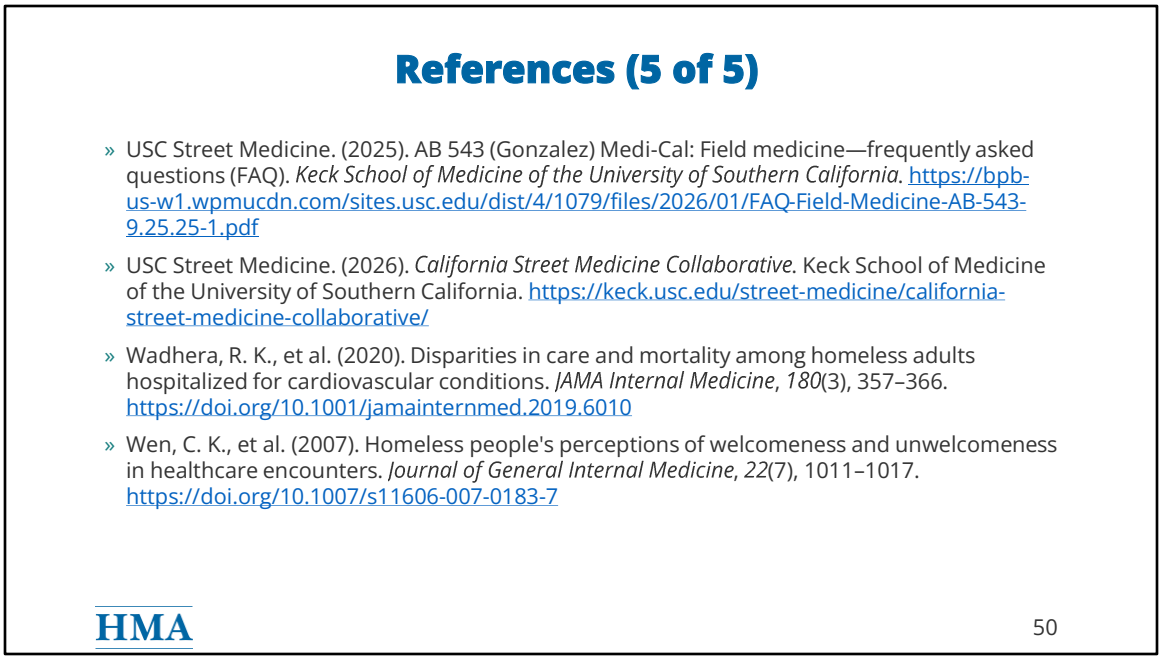

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