Episode: *Ethics Talk: How Do Street Clinicians Use EHRs?*

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[mellow theme music]

[00:00:03] TIM HOFF: Welcome to *Ethics Talk*, the *American Medical Association Journal of Ethics* podcast on ethics in health and health care. I'm your host, Tim Hoff. The information in a patient's electronic health record is important. It directs clinical encounters by centralizing clinicians' communications, actions, orders, and observations, particularly changes in a patient's condition. EHRs can be subpoenaed by a court and used to review and assess organizational compliance with federal and state regulations, and they're also key sources of health information for researchers and help streamline billing and payment structures in the health sector. EHRs can also be used to forge virtual networks among brick-and-mortar health care settings. In short, EHRs are sites of consolidated health data that has value to many stakeholders, and that deserves our attention and scrutiny.

But where and how are health records maintained for patients who are seen by clinicians in non-traditional health service delivery settings, such as the streets of a city? Clinicians who practice street medicine provide health services to unhoused people wherever they are, and they need an infrastructure for documenting and coordinating those services for each patient that they see. EHR use by organizations that support street health is more common now than ever, but the lack of standardization and slow implementation poses unique practical and ethical questions about how to maintain continuity of services for some of the most vulnerable, marginalized, and clinically complex patients in the US health care system.

Today on the podcast, we'll talk about how EHR use in street health continues to evolve. Joining us to do that is Brett Feldman, a physician assistant who directs and co-founded the University of Southern California Street Medicine program. Brett is also the vice chair of the International Street Medicine Institute. Brett, thank you so much for being here.

BRETT FELDMAN: Thank you for having me. [music fades]

[00:02:05] HOFF: Street health care has evolved, and evolved rapidly at that, alongside large and similarly rapid changes in EHR development and implementation. So let's start there. How has the use of EHRs in street medicine contexts actually worked in practice?

FELDMAN: The advent of EHRs has really revolutionized how street medicine can be practiced, because when I started in 2007, most people did not have a EHR, or at least

it wasn't, or at least didn't have the ability to take it out on the street. So most of us had paper charting, which meant that if we had 1,000 patients, all the paper charts were back at the office. And then we would go to the streets, under the bridges, in the woods, in the riverbeds, wherever people were, with just a backpack and some supplies. Which meant that for the most part, we had to actually memorize the patient charts and really know the patients well by memory. And we would take some notes in the field and then come back and then actually write the note when we got back to the office.

[00:03:10] HOFF: Mm-hmm. Presumably some of the reason that you didn't bring EHRs out to the street was in part technological. I mean, handheld device technology just wasn't where it is now 20 years ago. But is there also a legal element to that where you simply aren't allowed to have patient records outside of hospital grounds or something like that?

FELDMAN: Yeah, that's a great question. I mean, primarily it was a technology issue, where there was laptops, but we couldn't hotspot at the time. There was like a Wi-Fi router hotspot, which was an external device that you had to bring with you. And it took a really long time to set up in the field to the end that it just wasn't practical to bring out. There are some laws around transporting patient charts, and we did have a HIPAA-protected box that we could bring with us on wheels. So if we were doing a shelter-based clinic or setting up in a soup kitchen, we would bring that box. But to go out onto the street, or sometimes we'd hike a mile or more into the woods, and it just wasn't practical to bring to those street medicine locations.

[00:04:26] HOFF: Hmm. Wow, yeah. It sounds like it'd be cumbersome to lug around that HIPAA-compliant box. But I imagine that having to simply remember patient details also brought its own issues. And in fact, obviously, as you know, EHR integration has changed how clinicians interact with patients in clinical encounters, in that documentation happens in real time at the site of care. So now that we have the technological means to have that EHR onsite, how has this played out in street health care?

FELDMAN: So, right now, I mean, obviously, since 2007, street medicine has just expanded tremendously. I mean, just in California, I started the program at USC in 2018. We were the second program in Los Angeles and the sixth in the state. Now there's at least 70 in the state that we know of. And we're really at this unique time where we're taking what was once a radical fringe movement and incorporating it into mainstream health care while trying to ask the right questions, which is not, how do we bend and mold street medicine, which we know works, to fit mainstream health care, which hasn't worked for this population? But rather, how do we bend and mold mainstream health care to fit what we know works in street medicine? And part of that relates to how we're documenting in the patient medical record using the EHR. So, for the most part, we still don't bring, or we still don't document in the field. Obviously, hotspotting is much easier than it was when I started.

I'll usually bring my laptop into the field, and I only take it out if I'm showing the patient maybe some lab results or going over a diagnostic image that we show to them,

because that's a very trauma-informed way of providing services, and I don't want to lose that. But I don't document like I would in an office in real time with the patient. Over the years, I've learned to remember a lot in the field. It's partially because of how we started. But most people will take notes and then go back and put it into the EHR. And then now, of course, in the recent years, we can get the EHR on our phones, so we don't even have to bring out a laptop and hotspot. We can open up the record on my phone and get instant access to medications as if I was in the clinic.

The other really important technological advance is the health information exchanges. So, our patients usually will go to whatever hospital is closest to them or in front of them, which might change, or whatever hospital EMS takes them to. And now with the information exchanges, we can see each other's notes in real time, which is extremely helpful. Because before, we were only relying on essentially their memory, which can be hard, especially over the years with multiple and very complex medical issues.

[00:07:30] HOFF: Sure. Yeah, it sounds like things are moving quickly on the technological front. And in our conversation leading up to this podcast, you mentioned that the increased integration of AI tools into street medicine is happening more rapidly. Can you talk a bit about that?

FELDMAN: Yeah. AI is just starting to be kind of imagined how to use it in the street medicine setting. And some of the early ideas is, for example, we have a hospital-based consult service where we know people experiencing homelessness have higher rates of hospitalization, much longer length of stays, and then much higher hospital readmission rates. And so, when somebody has been identified as experiencing unsheltered homelessness, we'll go into the hospital, see them in the hospital, and then follow them out onto the street. And one of the primary challenges in that is correct patient screening, on just identifying who's experiencing homelessness. And then especially in our county hospital where at any given time there's over 100 people admitted experiencing homelessness, and we don't have the capacity to see everybody. So how do we decide out of those 100 which 20 we might follow at a time? And so, the idea is using AI to one, much better identify people experiencing homelessness, because the screening tools vary widely in effectiveness. And then helping us decide which of those 100 patients are most in need of this limited resource. So, it's nothing that I think has been implemented, at least to my knowledge yet, but lots of people are thinking about it.

[00:09:23] HOFF: Yeah, yeah. Those seem like two important problems to solve if you want to get care to the people who need it, but I think it highlights another potential difficulty for street medicine. Which is that unhoused patients who are also undocumented—or I guess even those who aren't undocumented but might be suspected of being undocumented because of their apparent race—might hesitate or refuse to identify themselves in health records for fear of being targeted by immigration enforcement. And I can imagine this issue will only get worse in the coming months until we publish this particular episode, especially in LA where you are. So which best practices have you developed to gain patients' trust, perhaps especially patients who are even more distrustful of health professionals and digital health surveillance than others?

FELDMAN: Oh, yes. This is definitely a very clear and present issue with the people that we're serving. And the most important thing that I've found in building trust is to be trustworthy. And so, if it is true that health information can be used to identify people who might be undocumented and used as an enforcement, then our medical records are no longer trustworthy from their perspective, and we will lose trust. And rightfully so, if that's how they'll be used. Typically—and this has been used by a few programs—the idea of surveillance is not always a bad thing for the people that we're serving under the right ethical circumstances where patients have given consent to use these trackers. They've been shown to be effective in certain unique circumstances.

[00:11:19] So, for example, there are a few street medicine organizations that if they meet a patient in the hospital, for example, what makes it easier to meet somebody in the hospital is that they've just had this very recent beautiful medical workup. What makes it hard is that you don't know where they live, and you have to find them somewhere on the streets of your city. In contrast, if you meet them on the street, you maybe know nothing about them medically, but you at least know where they live. And so, some organizations have offered voluntarily for the patients to hold a tracker so they can find them on the street. Another use is the syphilis rates are fairly high in Los Angeles, and we need to find them three weeks in a row in order to give them their penicillin injection or their Bicillin injection. And they want to be found, for the most part. They don't want syphilis. They want us to find them and give them their injection. And so, for that limited time, they might agree to a tracker. This isn't something that we've tried, but I know other organizations have tried it and have done it successfully, again, when the patients have consented to that happening.

[00:12:34] HOFF: You've mentioned a few times about providing care for unhoused people, both on the street and in clinical spaces. So how does the street medicine team, I guess—I don't know how it breaks out administratively—but how does the people who work in street medicine work with other clinicians in the hospital setting when patients are identified as being unhoused? Or if somebody who normally receives care out on the street comes into the hospital, how does that coordination of care work?

FELDMAN: Yeah, that's exactly how we've set it up, as an in-house specialty. So, if a patient has been identified as experiencing homelessness by any one of those methods, mostly through a screening, then they can consult us, just like they consult any specialty service like cardiology or nephrology. We come into the hospital with three goals. The first goal is to help the inpatient team understand what their version of homelessness looks like and how that impacts their hospital stay. So, for example, believe it or not, our number one cause of diagnosis is congestive heart failure. Or our number one cause of admission is congestive heart failure. So if we talk to them and we learn that they have poor access to food, poor access to water, they walk around all day in the heat of Los Angeles wearing multiple layers of clothing, not because they have psychosis, but because they have no dresser to store the clothes, then their requirements for Lasix is going to be different on the street than in the hospital in a controlled setting, and we would give that recommendation.

The second is to help avoid a discharge to the street. For example, our number three reason for admission is injuries. So, for example, if somebody is hit by a car, they have a broken leg, and they walk them in the halls of the hospital with a walker 50 feet, cleared for home with home PT, but we learn that they live in a riverbed. And in order to get food, which is one of their activities of daily living, they have to climb out of the river bed, hop a fence, and walk a half a mile just to get food, then they actually can't perform their ADLs and need a respite stay or recuperative care stay for short-term rehab. And then the third is if they do hit the street, we follow them up as their primary care providers.

[00:15:05] HOFF: Hmm. As street medicine is increasingly, let's say, legitimized, are there more types of clinicians going out onto the street? You mentioned earlier that an unhoused patient might be discharged with an order for home health physical therapy. Are there PTs, for example, who go out, or is the on-the-street portion of street medicine still a pretty limited roster of clinicians?

FELDMAN: It's pretty rare. I don't, I'm not going to say it never happens. I know a number of occupational therapists that do street medicine. We have a psychiatrist and an HIV specialist, and occasionally you'll have some other specialists that might rotate through teams. But typically, the makeup of a team would be somebody who can prescribe, so either a doctor, PA, or nurse practitioner. Because if you don't have somebody who can prescribe, you're still relying on a brick-and-mortar clinic to do most of the care. And then the other person that's really core to the team is a community health worker. Some people might call them peer support or patient navigators, but the idea is that there's somebody with lived experience who acts as your street guide. And then after that, there's many nurses, social workers, case managers, lots of other people that come out onto the street.

[00:16:26] HOFF: Let's wrap up by talking about one of the important uses of EHR, which is, at least from an organizational perspective, tracking and aggregating patients' health outcomes. Have EHRs helped solidify some organizations' support of street health programs as they see these patient health outcomes getting better over time?

FELDMAN: Yeah, I think this is still very much an evolution, and there's two main uses for it. On one side is the clinical quality piece of it. Because street medicine is still fairly new, and we were essentially invisible to the system until October of 2023, when the new Place Of Service Code was released by CMS, which made it that you could accurately track visits that happened on the street. And if you could track those, then you could measure quality on the street. And even though we've been doing this—street medicine's been around for over 30 years—and now we can provide the same care on the street that you'd expect in a brick-and-mortar clinic, not everybody believes that. And so, now we can actually pull quality data from the street, and one, see how it compares to other places. But mostly the right answer, the right question to ask is, for people experiencing unsheltered homelessness, how does street medicine compare to other settings like a brick-and-mortar clinic? So there's a quality aspect of it. And then the second aspect relates to equitable reimbursement. Where right now, street medicine, for the most part, except for in California, is reimbursed at the same rates as

a brick-and-mortar clinic, but for many reasons should be reimbursed higher, which is probably outside of the scope of this conversation. But a lot of that data could be pulled from the EMR in order to calculate a rate.

[00:18:32] HOFF: I want to go back briefly. You said the right question would be that for people experiencing unsheltered homelessness, how does street medicine care compare to care in brick-and-mortar clinics? Is there an answer to that question yet, or is that still something that the evolution of the EHR is helping to illuminate?

FELDMAN: Oh, yes. So, I guess if there was a right question, the wrong question to ask in terms of quality metrics would be—because I've done this before—would be, what's the hypertension control of patients seen by street medicine compared to the hypertension control of patients seen in the clinic? And that would not be the same patient population because.... And so, the right answer is for this, or the right question is for the same patient population. For people experiencing unsheltered homelessness, how does the street compare to the clinic? But up until now, that question has really been extremely system-centric, where you only know where.we're just relying on people who have come into the clinic and not the more larger general denominator of people on the street. And so, we don't actually have accurate baseline data for people experiencing unsheltered homelessness.

[00:20:01] HOFF: And finally, I wanted to ask you to expand on, you said that there's data within the EHR that might justify a higher rate of reimbursement for street medicine. Can you talk about that briefly to wrap us up here?

FELDMAN: Oh, yeah. [laughs] So, why street medicine should justify a higher rate is, well, for one, there's one of the measures they use to calculate a rate is a relative risk ratio, which measures morbidity and mortality, a 1 being of average risk. And so, on a population level for a typical clinic, you would have—in a shared risk model, which is what we have—you would have some people that are less than 1, some people greater than 1, and it all evens out to about 1. Just experiencing homelessness, not even unsheltered homelessness, just homelessness has a relative risk ratio of almost 6. So it's six times higher than the general population. And if you— And so, that's the highest relative risk ratio of any comorbidity. Number two and number three are mental health and substance use disorders, whose relative risk ratios are about 3. So one, that tells you how risky homelessness is, but also, that our patients mostly have relative risk ratios much higher than 6. So they're much sicker, much more complex.

Second, the payments, the per member per month payments, that most clinics get presuppose that about a third of patients will never come. And that's typically thought to be okay because others will come more than that, and it all evens out. In street medicine, because it's an assertive model, we don't have that third that never come. A hundred percent are engaged, and 100 percent have that higher relative risk ratio.

And then there's other things around the makeup of the team. So for example, typically a provider has to bill high enough to support the other non-billable members of their team. In street medicine the volume is much lower. Some things are inherent in street

medicine, like for example, it's always going to take longer to go out searching for your patients than for them to come to you. [theme music returns] So you have lower volumes and a higher number of non-billable providers like the community health workers that are required for the team. So they have, so providers have to support the rest of their team on lower volumes.

[00:22:45] HOFF: Brett, thank you so much for your time on the podcast today. I appreciate you sharing your expertise with us.

FELDMAN: Thank you very much for having me.

HOFF: That's all for this episode of *Ethics Talk*. Thanks to Brett Feldman for joining us. Music was by the Blue Dot Sessions. To read the full November 2025 issue on *Electronic Health Record Evolution* for free, visit our site, journalofethics.org. Find us on Bluesky @amajournalofethics for all of our latest news and updates. And we'll be back next month with an episode on Aging. Talk to you then.