# COMMUNITY SERVICES POLICY COMMITTEE
**Friday, March 28, 2025**
**10:00 a.m. - 2:00 p.m.**
**Marriott Burbank Airport Hotel, Academy 2**

## AGENDA

**I. Welcome and Introductions**
*Speakers:* *Chair, James Kyriaco, Council Member, Goleta*
*Vice-Chair, Tamala Takahashi, Vice Mayor, Burbank*

**II. Public Comment**

**III. Presentation: Governor's Homelessness Initiatives** *Informational*
*Speaker:* *Hafsa Kaka, Senior Advisor on Homelessness, Office of Governor Gavin Newsom*

**IV. Presentation: Home Again Los Angeles** *Informational*
*Speaker:* *Albert Hernandez, Chief Executive Officer, Home Again Los Angeles*

**V. Update: City of Napa Senate Budget Sub-Committee Testimony** *Informational*
*Speaker:* *Molly Rattigan, Deputy City Manager, City of Napa*

**VI. Legislative Agenda** *(Attachment A)* *Action*
*Speaker:* *Caroline Grinder, League of California Cities*
**1.** AB 543 (González) Medi-Cal: Street Medicine.

**VII. Legislative and Budget Update** *Informational*
*Speaker:* *Caroline Grinder, League of California Cities*
Cal Cities Community Services Sponsored Bills can be found here.

**VIII. Adjourn**

**REMINDER:** To better understand how cities are responding to homelessness, Cal Cities requests that cities complete this **brief survey**. Please check with your city manager to ensure your city has submitted this survey.

**Next Meeting - Virtually: Friday, June 13, 9:30 a.m. – 12:30 p.m.**

*Brown Act Reminder: The League of California Cities' Board of Directors has a policy of complying with the spirit of open meeting laws. Generally, off-agenda items may be taken up only if:*
*1) Two-thirds of the policy committee members find a need for immediate action exists and the need to take action came to the attention of the policy committee after the agenda was prepared (Note: If fewer than two-thirds of policy committee members are present, taking up an off-agenda item requires a unanimous vote); or*
*2) A majority of the policy committee finds an emergency (for example: work stoppage or disaster) exists.*
*A majority of a city council may not, consistent with the Brown Act, discuss specific substantive issues among themselves at League meetings. Any such discussion is subject to the Brown Act and must occur in a meeting that complies with its requirements.*

**ATTACHMENT A**

# COMMUNITY SERVICES POLICY COMMITTEE
## Legislative Agenda

**Staff:** Caroline Grinder, Legislative Advocate, Community Services
Betsy Montiel, Legislative Affairs and Policy Analyst

### 1. AB 543 (González) Medi-Cal: street medicine.

**Bill Summary:**
This measure would enable street medicine providers to more effectively utilize Medi-Cal to deliver healthcare services to individuals experiencing homelessness.

**Bill Description:**
AB 543 has several key provisions, including:

1) Presumptive Eligibility:
This measure establishes a program of presumptive eligibility for Medi-Cal providers, including street medicine teams, to grant immediate, full-scope Medi-Cal coverage to individuals experiencing homelessness. This presumptive eligibility aims to enable providers to enroll individuals in Medi-Cal immediately, facilitating faster access to on-site medical services.

2) Data Sharing and Coordination:
This measure requires Medi-Cal and the California Statewide Automated Welfare System to establish a homelessness identifier within Medi-Cal and share data on the status of Medi-Cal applicants or beneficiaries experiencing homelessness to enable better tracking for service coordination, and connection to eligible benefits and programs.

3) Medi-Cal Managed Care Plan Requirements:
This measure requires Medi-Cal managed care plans to allow beneficiaries experiencing homelessness to seek covered services directly from any participating Medi-Cal provider, irrespective of network assignments such as primary care providers.

**Background:**
Securing investments to address homelessness and increase affordable housing is one of Cal Cities' top priorities this year. California is home to 187,000 unhoused individuals, accounting for 66% of the nation's unsheltered population. The mortality rate for people experiencing homelessness is ten times higher than that of housed individuals.

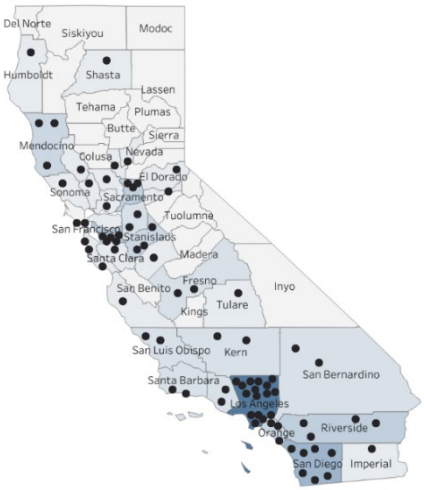
Data suggests that while over 70% of this population is enrolled in Medi-Cal, only 8% have seen a primary care provider, compared to 82% of the general population. Street

medicine seeks to address these challenges by delivering healthcare and social services directly to people experiencing unsheltered homelessness in their living environments, such as under bridges, along riverbanks, and in encampments.

Street medicine teams provide full-scope primary care, including diagnostics, medications, wound care, psychiatry, mental health and substance use treatment, and care coordination. In fact, over 70% of street medicine programs provide full-scope primary care, behavioral healthcare, and treatment for substance use disorders and over 80% dispense medication. Additionally, street medicine teams assist individuals in securing housing and other essential services to exit homelessness.

In recent years, the state and federal government have prioritized street medicine. This includes initiatives such as California Advancing and Innovating Medi-Cal (CalAIM). CalAIM is a multi-year program that aims to provide more integrated, person-centered care. These efforts aim to integrate physical health, behavioral health, and social services to support individuals experiencing homelessness, those with chronic medical conditions, and people involved in the justice system. CalAIM initiatives will span a multi-year period, with the first reforms implemented in January 2022 and additional reforms phased in through 2027. Street medicine directly aligns with CalAIM's primary goal to identify and manage comprehensive needs through whole-person care approaches and social drivers of health.

Additionally, the Department of Health Care Services (DHCS) issued an All Plan Letter in 2022 and 2024 to Medi-Cal managed care health plans on the opportunities to use street medicine to address the health needs of Medi-Cal members experiencing unsheltered homelessness. Previously, street medicine programs had to cobble together funding to cover their costs. This change allowed street medicine programs to get reimbursed for important functions like care coordination and to cover the cost of important nonclinical members of street medicine care teams, like community health workers, neither of which have historically been billable services.




These efforts have facilitated reimbursement for street medicine and contributed to the field's rapid growth, with programs expanding from just six in 2018 to over 66 in 2025 across 35 counties.

According to the sponsors of AB 543, street medicine significantly increases access to care, reduces hospital admission and hospital stays, improves chronic disease management, and even enhances opportunities for housing placements. However, current Medi-Cal policies limit data tracking and exchange of information while also imposing constraints due to Medi-Cal delegation. These barriers prevent street medicine teams from delivering timely care, even when directly in front of patients needing critical care.

AB 543 seeks to address these gaps by ensuring that people experiencing homelessness can access Medi-Cal-covered services without unnecessary delays or administrative

barriers. The bill streamlines care delivery by establishing presumptive eligibility, expanding access to street medicine services, and introducing a homelessness identifier code within Medi-Cal systems. The goals outlined in this measure would improve health outcomes, reduce preventable deaths, lower avoidable hospital costs, and enhance coordination between health and social service systems.

**Existing Cal Cities Policy:**

Housing for Homeless

Homelessness is a statewide problem that disproportionately impacts specific communities. The state should make funding and other resources, including enriched services, and outreach and case managers, available to help assure that local governments have the capacity to address the needs of the homeless in their communities, including resources for regional collaborations.

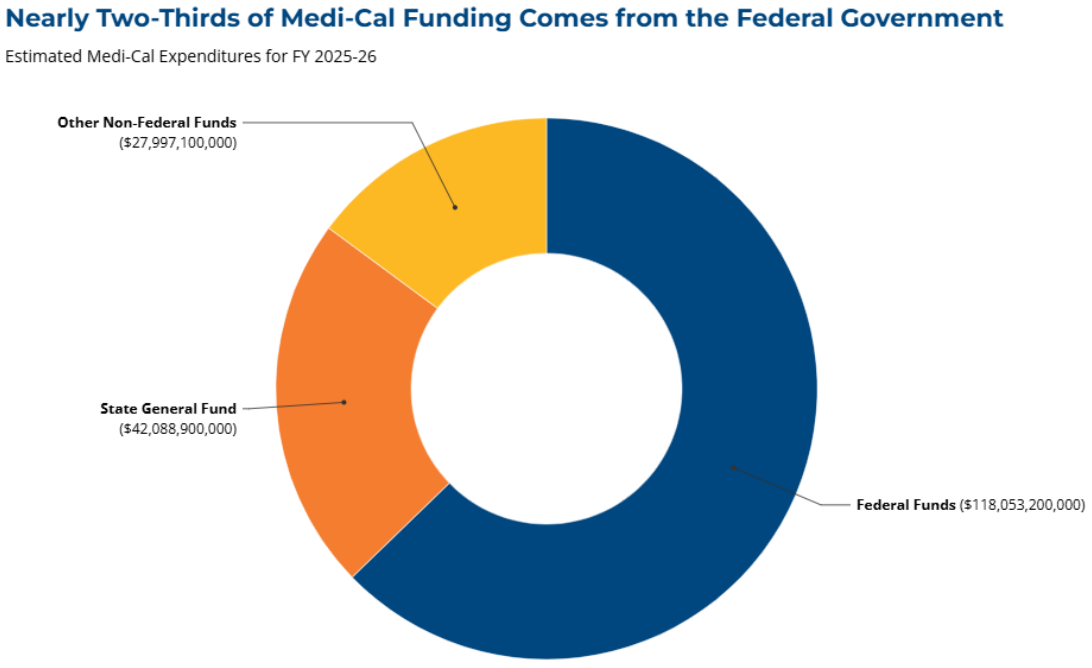
Behavioral Health

Cal Cities supports additional funding and resources to expand access to behavioral health services, including efforts to assist California's homeless population, especially those individuals experiencing mental health and substance use disorders. This includes, but is not limited to, supporting counties in expanding community based care settings to provide for prevention, intervention, treatment, infrastructure, and recovery systems.

Substance Use

Cal Cities supports additional funding and resources to address the substance use crisis through appropriate prevention and intervention efforts, educational awareness campaigns, and increased access to life-saving overdose treatment aids such as naloxone.

**Fiscal Impact:**



Medi-Cal is primarily funded by the federal and state government. The federal government contributes a share of the costs through the Federal Medical Assistance Percentage (FMAP) formula. In California, nearly two-thirds of Medi-Cal funding comes from the federal government. Medi-Cal covers one in three Californians.

Members of Congress have floated cuts to Medicaid to offset tax cuts. Federal cuts to Medicaid could lead to a significant budget shortfall in California, forcing the state to make difficult choices such as reducing Medi-Cal benefits, limiting provider payments, or restricting eligibility. If federal funding losses were to approach or exceed $10 billion per year, California could not replace federal funds with existing state resources alone.

In the absence of federal funding cuts, AB 543 strengthens CalAIM alignment, potentially making it easier for cities to leverage state resources instead of using general fund dollars for homeless health outreach. The author's office argues that AB 543 simply opens a new pathway for unhoused individuals to access care through an existing reimbursable service – street medicine.

**Staff Comments:**
AB 543 aligns with Cal Cities' existing policy that supports expanded access to behavioral health services for California's homeless population. However, Cal Cities has not previously engaged in Medi-Cal or street medicine issues. Committee members are encouraged to consider how this proposal relates to cities and the impacts of expanded access to street medicine in communities.

**Support:**
California Street Medicine Collaborative (Co-Sponsor)
University of Southern California (Co-Sponsor)
California State Association of Psychiatrists
National Alliance to End Homelessness (NAEH)
Street Medicine Institute (SMI)
CommuniCare+OLE
Elica Health Centers
Homeless Outreach Program Integrated Care System (HOPICS)
Capital Compassion

**Opposition:**
No registered opposition at this time.

**Staff Recommendation:**
Staff recommends the committee discuss AB 543 and make a position recommendation to the Cal Cities Board of Directors.

**Committee Recommendation:**

**Board Action:**


# AB 543 - STREET MEDICINE

## Fact Sheet

### Bill Summary

AB 543 establishes presumptive eligibility for people experiencing homelessness to receive full Medi-Cal coverage, allowing Medi-Cal providers, including street medicine teams, to establish eligibility on the spot and provide immediate care.

AB 543 prohibits Medi-Cal managed care plans (MCPs) and their delegates from denying care based solely on network assignment.

AB 543 requires Medi-Cal and the state's welfare system to share data on homelessness status by introducing a homeless identifier code, enabling better tracking, service coordination, and connection to eligible benefits and programs.

### Existing Law

Establishes the Medi-Cal program, administered by the DHCS, under which low-income individuals are eligible for medical coverage. (WIC §14000)

Provides presumptive eligibility for targeted population, including pregnant persons, children, and patients at qualified hospitals. (WIC §14011)

### Background

California is home to 66% of the country's unsheltered population, and 28% of the nation's total homeless population. Over 187,000 people live on the streets in the state, facing severe health challenges and a mortality rate ten times higher than the general population, largely due to barriers in accessing care.

Although over 70% of this population is enrolled in Medi-Cal, only 8% have access to a primary care provider. Due to capitated payment models, MCPs and primary care providers (PCPs) continue to receive reimbursement from DHCS, with a federal match, even while failing to provide care to the remaining 92% of enrollees. This lack of access prevents exits from homelessness, leads to premature deaths, and results in unnecessary suffering.

Street medicine addresses these challenges by delivering healthcare and social services directly to people experiencing unsheltered homelessness in their living environments, such as under bridges, along riverbanks, and in encampments. Street medicine teams provide full-scope primary care, including diagnostics, medications, wound care, psychiatry, mental health and substance use treatment, and care coordination. Additionally, they assist individuals in securing housing and other essential services to exit homelessness.

In recent years, state and federal entities have prioritized street medicine. This includes initiatives such as CalAIM, DHCS's All Medi-Cal Managed Care Plans Letter (APL 24-001), and the Center for Medicare and Medicaid Services' development of the Place of Service Code 27 for street medicine. These efforts have facilitated reimbursement for street medicine and contributed to the rapid growth of the field, with programs expanding from just six in 2018 to over 66 by 2025.

The California Street Medicine Collaborative, which convenes 175 member organizations from 35 counties, includes medical providers, health plans, community-based organizations, and other stakeholders. This collaborative works to scale the street medicine model, advance best practices, and address policy challenges. Alongside DHCS, these organizations have been working diligently to improve care for unsheltered individuals in California. Their efforts aim to increase system visibility through a homeless identifier, enroll eligible individuals in Medi-Cal more efficiently, and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streamline care by reducing bureaucratic barriers within Medi-Cal that hinder service delivery in street-based environments.

**Need for AB 543**

Evidence-based models like street medicine are recognized as best practices in homeless healthcare. They significantly increase access to care, reduce hospital admission and hospital stays, improve chronic disease management, and even enhance housing placements. However, current Medi-Cal policies limit data tracking and exchange while also imposing constraints due to Medi-Cal delegation. These barriers prevent street medicine teams from delivering timely care, even when directly in front of patients.

AB 543 addresses these gaps by ensuring that people experiencing homelessness can access Medi-Cal-covered services without unnecessary delays or administrative barriers. By establishing presumptive eligibility, expanding access to street medicine services, and introducing a homelessness identifier code within Medi-Cal systems, the bill streamlines care delivery. This approach improves health outcomes, reduces preventable deaths, lowers avoidable hospital costs, and enhances coordination between health and social service systems. It ensures that Medi-Cal members can access the benefits to which they are entitled, regardless of their housing status.

**Support**

California Street Medicine Collaborative (Co-Sponsor)
University of Southern California (Co-Sponsor)
California State Association of Psychiatrists (CSAP)


**For More Information:** Brad Fingard, Legislative Director | Brad.Fingard@asm.ca.gov | (916) 319 2054


# AB 543 (Mark Gonzalez)
# *Medi-Cal: Street Medicine*
# Frequently Asked Questions (FAQ)

## 1. What is in AB 543?

AB 543 introduces three critical reforms aimed at removing barriers to Medi-Cal access for individuals experiencing homelessness:

- Ensures unhoused Medi-Cal members have access to Medically Necessary Services (MNS) by prohibiting denials based solely on Medi-Cal Managed Care Network Assignment, regardless of delegation (PCP/IPA).
    - **Issue this addresses:** Medi-Cal contracted street medicine providers are unable to order medically necessary services (MNS) that would typically need prior authorization – such as Durable Medical Equipment (DME) like wound care supplies or wheelchairs, diagnostic studies like X-rays, or a referral to specialty care – because they are not the patient's assigned PCP or within the IPA, even though the patient themselves is a member. This results in increased morbidity, mortality, and suffering for patients.

- Allows Presumptive Eligibility (PE) for people experiencing homelessness. PE provides immediate Medi-Cal coverage, bypassing the usual 4-6 weeks delay in approval. Currently, this is given to children, people who are pregnant, and hospitals. AB 543 permits any Medi-Cal contracted provider treating an unhoused person to assist them in obtaining coverage.
    - **Issue this addresses:** Individuals experiencing homelessness encounter delays in accessing critical health care due to a lack of Medi-Cal coverage, despite being eligible. When they enroll in Medi-Cal, the process takes weeks. This often results in delayed care and worsened health outcomes.

- Creates a homeless indicator and data exchange process to improve coordination and access to already existing benefits.
    - **Issue this addresses:** Existing administrative systems for accessing benefits for low-income persons (e.g., Medi-Cal, CalSAWS, CalAIM programs) lack a definitive identifier for individuals experiencing homelessness, making it difficult to determine eligibility, track benefits received, or ensure access to future programs for which they would benefit. This leaves government systems, health plans, and health care providers to develop their own proprietary methods of identification which are incomplete, untethered to the system, and vary widely in quality.

## 2. Why is AB 543 needed?

California has the largest population of unsheltered individuals in the country, with over 187,000 people experiencing homelessness. Currently, Medi-Cal's network-based system results in delays and service denials for people experiencing homelessness. Although a vast majority of people who are unsheltered are enrolled in Medi-Cal and have an assigned primary care provider (PCP), very few can access their PCP. AB 543 establishes three critical reforms that improve access to full Medi-Cal coverage for people experiencing homelessness, allowing Medi-Cal providers, including street medicine teams, to establish eligibility on the spot and provide immediate, life-saving care.

## 3. Are unhoused patients really being denied medically necessary services (MNS) based solely on their Medi-Cal Managed Care Network Assignment?

Yes. After enrollment in Medi-Cal, members are assigned to a Managed Care Plan (MCP), then the MCP assigns them to a PCP, sometimes through an Independent Practice Association (IPA). The MCP, IPA, and PCP receive a per-member-per-month payment regardless of whether the patient is seen—and in many cases, they are not. The problem is that the assigned PCP acts as gatekeepers to many MNS, including:

- **Diagnostic tests** (e.g., X-rays, Ultrasounds, CT scans)
- **Specialist referrals** (e.g., Cardiology, Neurology, Oncology)
- **Durable Medical Equipment** (e.g., wheelchairs, oxygen tanks, wound care supplies)

Despite providing care on the street, and permitted by state professional licensure, street medicine providers can't order these basic but lifesaving services because they aren't the patient's assigned PCP, even in instances where the street medicine provider is contracted with the patient's MCP. AB 543 allows street medicine providers to order MNS within the patient's network and IPA, even if they are not the assigned PCP.

## 4. What are some real-life examples of patients being denied medically necessary services?

Here is one street medicine provider's firsthand experience attempting to access MNS for their Medi-Cal Managed Care patients on March 10, 2025:

> **Patient 1:** An electrician with severe sciatica living in a doorway needed an X-ray to begin treatment and return to work. His street medicine provider has spent eight weeks attempting to coordinate an appointment with his assigned PCP to place an X-ray order the provider is licensed to order directly. He remains in chronic pain and unable to work.
>
> **Patient 2:** A married patient who cares for her sick husband, both living in a tent, suffers with epilepsy. The street medicine provider is unable to order the needed EEG and neurology referral because street medicine isn't the assigned PCP, although licensed to order those tests. There is not established relationship with the assigned PCP, resulting in denial by the PCP to order on behalf of street medicine.
>
> **Patient 3:** A 72-year-old man, formerly a Long Beach State football player and now living under the freeway, has a history of two strokes and presented with an irregular heartbeat—highly suggestive of atrial fibrillation, placing him at significant risk for another stroke. Street Medicine is unable to order an EKG, an echocardiogram, or a cardiology referral because they aren't the PCP, although licensed to do so. Instead, they had to arrange and pay for a rideshare to his assigned PCP, whom he had never seen, delaying potentially life-saving treatment. The street medicine provider has a contract with their Managed Care Plan and will get reimbursed for the visit, but the patient is still unable to access care.

**Patient 4:** A young woman with dreams of becoming a nurse developed a seizure disorder after being hit by a car five years ago. Thanks to anti-seizure medications prescribed by street medicine, she had been seizure-free for three months while waiting for her PCP to order an EEG and neurology referral—both of which street medicine is legally permitted to order. Two weeks ago, her medications were stolen, but her insurance refused to refill them, citing it was "too early to refill." Last week, she suffered another seizure and was taken to the hospital, only to be discharged with instructions to follow up with her PCP—whom she has been unable to see despite three months of trying. Meanwhile, street medicine remains unable to order the EEG and neurology referral she needs to manage her condition. The PCP is held to quality metrics for post-hospital follow-up, which was met by the street medicine team's visit, but the patient still lacks access to diagnostic testing.

**Patient 5:** "Papa," named for the care he provides to others in his encampment, has been diagnosed with Hepatitis C. Five years ago a mass was discovered on his liver, raising concerns about cancer. To begin Hepatitis C treatment and determine whether the mass is cancerous, he needs a CT scan—yet street medicine was unable to order it because they aren't the PCP. The patient declines to go to his PCP because he's afraid to leave his belongings which will be stolen, resulting in an impossible decision between health and immediate survival.

## 5. How does AB 543 fix the issue of patients being denied medically necessary services?

AB 543 addresses this by allowing street medicine providers – who are contracted with a Medi-Cal Managed Care Plan – to order medically necessary services within the patient's assigned Medi-Cal and IPA network, thus bypassing the PCP, to ensure timely and life-saving care.

## 6. How do people who are unhoused get their Medi-Cal Managed Care Network Assignment?

When someone is enrolled in Medi-Cal, their enrollment package is sent to them by mail, providing them an opportunity to select a PCP. If they do not select a PCP, a PCP is automatically assigned to them based on **proximity to their home residence**. However, people experiencing homelessness often do not have a stable mailing address and thus never receive this information. Therefore, it's rare for them to have chosen their PCP or to know who they are.

## 7. Why don't people experiencing homelessness just see the PCP assigned to them through their Medi-Cal Managed Care Network?

The vast majority of experiencing homelessness never see the primary care provider (PCP) assigned to them through Medi-Cal Managed Care because they don't know who their assigned PCP is and have no practical way to access them. Some reasons include:

- **No access to a phone** – Many individuals cannot call to schedule appointments, navigate automated phone systems, or receive follow-up instructions.
- **Inability to leave encampments** – Fear of theft of belongings, losing their only shelter due to sweeps, or being forced to abandon pets prevents many people from leaving their location for extended periods.
- **Severe illness or mobility challenges** – Many individuals are too sick, injured, or physically disabled to make it to their assigned provider.
- **Transportation challenges** – Without reliable transit options, reaching a clinic across town is often impossible.

- **Strict clinic hours** – Many PCP offices operate on schedules that do not align with the unpredictable realities of homelessness, where securing food, shelter, and safety often take priority.

As a result, while over 70% of people experiencing homelessness are enrolled in Medi-Cal, less than 10% have seen a primary care provider.[1][2] Instead, they rely on emergency rooms or street medicine teams. Yet, street medicine providers are unable to order basic medical services because of network restrictions. AB 543 is designed to eliminate these barriers.

## 8. Why can't street medicine provider just become the PCP?

They can and they do, when patients request it. However, this process takes 4-6 weeks, delaying critical services the patient is entitled to. Additionally, patients relocate, or are relocated, frequently. Even if their PCP does street medicine, there's a need for flexibility to allow for immediate access when patients move and are seen by another street medicine team.

## 9. Does AB 543 increase Medi-Cal costs for California?

AB 543 is not an expansion of Medi-Cal and doesn't add any additional covered services. It also does not seek to expand funding for street medicine. The bill's purpose is to decrease barriers to care and time to receiving care. AB 543 prohibits the denial of referrals based on network assignment by allowing members to access Medically Necessary Services (MNS) through street medicine providers regardless of their PCP assignment, within the patient's MCP network. This enables street medicine providers to refer within the patient's network and IPA, even if the provider themselves is not the PCP or contracted with that network. DHCS has already paid networks made up of managed care plans who have already paid IPAs and PCPs to provide care for these patients. This simply opens a new pathway to accessing care for the unhoused through an already reimbursable service – street medicine. Additionally, this increases efficiency and access to care, avoiding more costly care in the future.

## 10. How does Bill AB 543 benefit stakeholders beyond street medicine?

- **Allows non-hospital providers, including FQHCs,** to provide immediate care through PE, eliminating delays from Medi-Cal determinations and improving quality metrics by allowing whoever is seeing the patient to help provide critical quality care while also contributing to quality metrics, not just the PCP.
- Closes critical care gaps **post-hospital discharge** by allowing street medicine teams to implement care plans immediately. Street medicine has shown to increase post-hospital follow up 3-fold compared to brick-and-mortar care.[3]
- **Reduces costly ER visits and hospitalizations** by ensuring timely, coordinated care for individuals experiencing homelessness.
- Enhances state accountability by tracking Medi-Cal access and **improving resource deployment**.
- Strengthens street medicine's role in crisis response and housing services by removing PCP assignment barriers, **enabling street medicine to more effectively respond to referrals they receive from local government, first responders, and community partners**.

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[1]Gelberg L, Gallagher TC, Andersen RM, Koegel P. Competing priorities as a barrier to medical care among homeless adults in Los Angeles. *Am J Public Health*. 1997; 87:217-220.

[2] Feldman CT, Feldman BJ, Chowdhury T, McConnaughy M, Phan C, Yoon E, Coulourides Kogan A. Unmet health needs for people experiencing unsheltered homelessness in MacArthur Park. January 2025. DOI:10.170605/OSF.IO/6HPYK

[3] Feldman BJ, Kim JS, Mosqueda L, Vongsachang H, Banerjee J, Coffey CE Jr, Spellberg B, Hochman M, Robinson J. From the hospital to the streets: Bringing care to the unsheltered homeless in Los Angeles. Healthc (Amst). 2021 Sep;9(3):100557. doi: 10.1016/j.hjdsi.2021.100557. Epub 2021 May 27. PMID: 34052622.

## 11. What can I do to support AB 543?

a) **Sign the Joint Letter of Support**: Sign our joint letter of support, alongside organizations and associations from across the state. **By March 25,** send your organization name, logo, and signatory to Kaitlin Schwan, Director of the California Street Medicine Collaborative, at kaitlin.schwan@med.usc.edu.

b) **Submit a Letter of Support Through the California Legislature Position Letter Portal**: To officially register your support, submit your letter through the Position Letter Portal. You can access the portal here: Position Letter Portal. Be sure to include your organization's logo, signatories, why you support the bill, and (if appropriate) include a patient story.

c) **Reach Out to Your Local California State Assemblymember, State Senator, & County Supervisor:** Contact your local Assemblymember, State Senator, and County Supervisor to explain why AB 543 is important and encourage them to support the bill. Share how the bill will positively impact your community and the people you serve, and ask them to publicly support it.

d) **Invite Legislators and Stakeholders on Street Rounds**: Invite legislators and other relevant stakeholders to join street rounds to witness firsthand the challenges faced by the individuals you serve.

## More questions?

Please send any questions, comments, or requests to meet to:

- Kaitlin Schwan, Director of the California Street Medicine Collaborative, at kaitlin.schwan@med.usc.edu
- Brett Feldman, Director of USC Street Medicine, Brett.Feldman@med.usc.edu