Rhetoric without Resources: Evaluating Health Risk Communication in the Bay Area's Unhoused Community

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ABSTRACT

The Bay Area is home to the third-largest unhoused population in the United States. Recent public health crises, such as infectious disease outbreaks and fentanyl contamination, have stressed the importance of clear and effective public health risk communication in this community. This study evaluates how closely local Bay Area public health communication toolkits follow evidence-based crisis communication practices. The methodology for this study is a systematic qualitative analysis of eight policy documents spanning 2018-2024. Additionally, this qualitative analysis uses a three-stage iterative coding framework that centers on Risk and Crisis Communication Theory, the Health Equity Implementation Framework, and Implementation Science. This framework identifies 80 relevant passages across these toolkits and analyzes them according to descriptive, conceptual, and thematic factors. The findings of this analysis are summarized by a Gap-to-Action ratio of 1.39:1, indicating that aspirational rhetoric outweighs actionable, resourced practice. A comparative analysis between infectious disease toolkits and fentanyl-related toolkits reveals a stark difference in ratios: 0.43:1 and 1.96:1, respectively. The observed contrast suggests that operationally mandated crises receive higher-fidelity communication than stigmatized ones. This study concludes by arguing for a shift towards a resourced communication-centered infrastructure, the core of Bay Area agency operations.

KEYWORDS

Public health communication; Homelessness; Risk communication; Implementation fidelity; Fentanyl; Infectious disease; Bay Area; Qualitative coding; Health equity

INTRODUCTION

The Bay Area is home to the third-largest unhoused population in the United States, with its growth in recent years accounting for more than a quarter of the growth in the total homeless population in the U.S (BACEI, 2019; BACEI, 2021). This striking increase has made the community in the Bay Area especially vulnerable to inequities and crises in public health due to the distinct challenges they face as a population: rapid disease spread, inequitable access, negative past history of care, provider turnover, and other systemic barriers (Thorndike, 2022). In particular, the lack of effective health

communication has substantially risked public health in the unhoused community. For instance, the COVID-19 pandemic, fentanyl crisis, and hepatitis A outbreaks exemplify how ineffective health communication combined with crowded living conditions, limited hygiene, and pre-existing health conditions exacerbate dangers for unhoused individuals (YAAH, 2023). In terms of regional context, while in other parts of the country such as New York, COVID-19 was the leading cause of death, in the San Francisco Bay Area, 82% of deaths were associated with synthetic drug overdoses such as fentanyl (Kurtzman, 2022). This statistic further emphasizes the growing need for effective preventative risk communication across crises. Although this necessity continues to grow, prior research has reliably demonstrated these specific difficulties in communicating with unhoused communities, posing a barrier to impactful and essential health communication (Andrews, 2020; Ward, 2023). A combination of these challenges makes the Bay Area a critical zone of interest in understanding and planning for the communication of public health crises to people living in unhoused communities. This study argues that these public toolkits released by Bay Area agencies rely more heavily on aspirational rhetoric than on resourced, actionable language, demonstrating a critical gap in scientific communication across crises.

This paper contributes to the broader scholarly conversation surrounding health communication policy in three key ways. Firstly, it provides an evaluation of the current climate of health communication in the Bay Area's unhoused communities by applying a multi-step qualitative coding framework to documents spanning from 2018 to 2024. Secondly, it provides a way of quantitatively examining toolkit implementation using a measurable Gap-to-Action ratio, allowing for an evaluation of crisis communication infrastructure. Lastly, by comparing communication surrounding infectious disease outbreaks and fentanyl contamination, it highlights a loss of fidelity in the context of more stigmatized issues. As a whole, the central argument of this study centers on a lack of actionable rhetoric from Bay Area agencies, particularly on more stigmatized issues, and an urge to implement communication-focused infrastructure.

RESEARCH QUESTION

With an emphasis on recent Bay Area public health crises including infectious disease outbreaks and drug contamination emergencies (e.g., fentanyl), to what degree have local agencies succeeded at communicating preventative health risk measures to unhoused communities across crises, and how well do currently used practices align with evidence-based communication strategies shown to improve trust and efficacy?

LITERATURE REVIEW

The vast majority of existing literature surrounding public health communication in unhoused communities highlights key aspects of effective risk communication for people experiencing homelessness (PEH). Throughout the literature, there is a repeated emphasis on trust in

communication channels. Effective practices often include measures that involve interpersonal interactions rather than succinct alerts. For example, face-to-face communication is consistently preferred for the clarity and personalization it offers, allowing PEH to build trust with known channels (Allen, 2022). In interviews and ethnographic studies, participants repeatedly mention wanting to interact in person. As one participant explained: "I needed to be looked at, I needed for you to see what I'm talking about. I don't need to tell you over [a] telephone… I know that you can't see pain, but you can see the pain in my face" (Zahir, 2023).

In addition to the medium of contact, effective communication also relies heavily on the format of the content. In a qualitative study done in New York, a PEH participant expressed that the most helpful information was simple, actionable, and resource-oriented. Specifically, they described instances when agencies communicated the delivery of sanitary supplies and made them aware of common symptoms and bad practices (Allen, 2022). These ideas are repeatedly underscored by other studies in the field that find effective health communication requires simple and digestible messaging, tailored for unhoused populations through trusted channels (Allen, 2022).

This emphasis on proper messaging is present across crises. A study examines how the differences in fentanyl risk messaging efficacy vary with age, as care providers have a more difficult time communicating risks to youth experiencing homelessness (YEH) (Gunn, 2020). In terms of regional context, a 2023 UCSF report on Bay Area YEH during the COVID-19 pandemic noted that inconsistent access to a mobile device and housing instability hindered access and prevented participants from following public health recommendations.

Specifically with regard to inconsistent access to cell phones, although phone ownership is common, it is difficult for unhoused communities to gain consistent access to service and Wi-Fi (Allen, 2022; YAAH, 2023). This specifically presents one of the many structural barriers to effective scientific communication. Moreover, many of the YEH who were interviewed held distrust of vaccines and lacked knowledge on self-protection, demonstrating the failures in currently used communication channels (YAAH, 2023).

Other studies in the literature examine how there is a need for patient-centered approaches in reproductive health communication for unhoused women, and how social media can both disseminate information and perpetuate stigma during outbreaks like hepatitis A (Wingow, 2023; Oren, 2020). Despite these insights in the extensive field of research, a comprehensive analysis assessing how local Bay Area agencies communicate across a variety of public health emergencies is limited. There is an ever-growing need for a detailed examination of current efforts in preventative risk communication by organizations, through the lens of messaging formats, content, and channels, all within the unique context of the Bay Area's diverse unhoused communities.

METHOD AND THEORY

This study employs several research methods to comprehensively examine public health communication in the Bay Area. My research strategy for this study involves a side-by-side analysis of academic literature and Bay Area policy. More specifically, these include a systematic qualitative coding analysis and a cross-policy literature comparison. Both of these pieces of the methodology play an essential role to this examination: the framework for the coding analysis integrates scholarly literature published on effective communication and the cross-literature analysis provides space for further research and discourse within the subject.

This study specifically focuses on infectious disease and fentanyl outbreaks which comprise a significant portion of deaths in the Bay Area's unhoused communities (Kurtzman, 2022). Using qualitative analysis, this study examines and interprets public-facing language to assess implementation quality and relate policy language to program efficacy. This study was not centered on a solely quantitative approach, as the unique difficulties of data collection in unhoused populations make it a significantly more challenging framework in this field of research. Regarding the collection of primary sources for the policy and literature analysis, this study examines existing risk communication plans, including policy briefings and toolkits for community organizations in the Bay Area. These community organizations were collected in order to span across jurisdictions in the Bay Area, so that the results of this analysis are not simply localized, but rather, convey a broader message. Examples of these include the San Francisco DPH and Alameda County PHD. The focus primarily lies on documents from these organizations relating to infectious disease outbreaks and fentanyl contamination. Additionally, material from homeless care providers in the Bay Area have been incorporated into the literature analysis to provide perspectives from both the institution as well as the individual.

The development of my qualitative coding framework was guided by scholarly theories in critical public health communication. The specific theories I employed in this study are Risk and Crisis Communication Theory, Health Equity Implementation Framework, and Implementation Science. As a whole, these theories emphasize methods that improve trust between members of the community and outreach workers while recognizing the structural barriers that marginalized groups face. Risk and Crisis Communication Theory, outlined in Reynolds et al., emphasizes the need for clarity and transparency in order to build trust in times of crisis. The Health Equity Implementation Framework adds on the necessity of culturally-informed communication that is tailored to the needs of a diverse community (Woodward, 2019). Lastly, the broader field of Implementation Science provides the foundation for studying how interventions are delivered and sustained in communities. As a whole, these theories highlight gaps in service plans whether that is through unfunded mandates, performative language, or the lack of a medium to effectively communicate (Reynolds, 2005; Woodward, 2019; Bauer, 2015). Together, these theories lay the foundation for a careful assessment of current practices and by using these

principles, I created a system of evaluating local Bay Area health agencies and their communication efforts during public health emergencies.

From this data collection, this study examines a curation of 8 public health documents (see Figure 1) that I deemed representative of Bay Area policy in relation to public health communication in unhoused communities. These documents span a period from 2018–2024, across 2 jurisdictions, and inform communities on both policy and operational methods. These eight documents were selected according to three criteria: (1) the document had to be publicly available and issued by a public health group or federal/state body operating in the Bay Area; (2) a substantive portion of the document had to address either infectious disease outbreaks or fentanyl/overdose prevention in unhoused settings; and (3) the document needed to fall in the 2018-2024 time frame so that the study could reflect post-COVID communication priorities. Excluded documents only briefly mentioned unhoused communities or were strictly clinical without a communicational aspect. By including two national-level toolkits, I hoped to allow for benchmarks for high-fidelity implementation that could serve as a contrast to lower-fidelity local practices.

FIGURE 1: Document Curation

Category	Document Title	Source / Issuer
Drug Contamination	*Fentanyl Opioid Prescriptions 2023*	Alameda County
Drug Contamination	*Overdose Prevention Policy 2022 Update*	San Francisco Department of Public Health (SFDPH)
Drug Contamination	*SFDPH Overdose Plan 2024*	SFDPH
Drug Contamination	*Alameda County Communications Strategy (2018)*	EveryOne Home RFP
Infectious Disease	*Communicable Diseases Infection Control Practices 2023*	Alameda County
Infectious Disease	*Alameda County Emergency Shelter Standards 2023*	Alameda County
Infectious Disease	*Infectious Disease Toolkit for Continuums of Care (CoCs)*	HUD Exchange (National)
General Toolkit	*LEAB Toolkit April 2024*	Federal/State Agency (General)

The data collection largely consisted of analyzing these toolkits for text segments that referenced public health communication in unhoused communities on the surface level. Once the excerpts were collected, they were put through a three-stage iterative coding process: descriptive-level coding, conceptual-level coding, and a thematic synthesis. My descriptive-level coding assigned codes to the excerpts, describing what facet of health communication the excerpt had covered.

For the conceptual-level coding, I examined the larger ideas that each description fell under, pointing to whether the code was a gap in policy or a success. Lastly, my analysis combined the descriptive and conceptual codes with a thematic analysis that synthesized the two. This process of weighing codes pointing at gaps within implementation against those demonstrating good practices allows for an evaluation of current policy according to evidence-based principles. To increase the reliability of my results, I refined

my coding definitions iteratively as I read through the toolkits, redeveloping codes until they were accurate. Additionally, I tested each code against multiple passages so that they were consistent across the study. Lastly, in order to avoid confirmation bias, I deliberately searched for excerpts that contradicted my preliminary hypothesis of there being prevalent inadequacies.

1: CODING ON THE DESCRIPTIVE LEVEL

In the first step of the coding process, I identified the descriptive content of the excerpts. Of the text segments I compiled, most excerpts fell into the following categories: communication channels, communication content, target populations, crisis type, and resource allocations. Every relevant sentence was tagged with one or more of these descriptors to create a comprehensive catalogue of codes (see Figure 2).

FIGURE 2: Descriptive Codes

Descriptive Code	Definition
Communication Channels (COMM-CHANNEL)	Medium used for communication
Communication Content (COMM-CONTENT)	Specific Message or information conveyed
Target Population (TARGET-POP)	Specific audience segment within unhoused community
Crisis Type (CRISIS-TYPE)	Specific public health emergency
Resource Allocation (RESOURCE-ALLOC)	Examples of funding, staffing, or material resources tied to communication effort

2: CODING ON THE CONCEPTUAL LEVEL

In the second stage, I analyzed each descriptive passage within the context of their larger excerpt and examined whether they met the requirements of effective risk communication. My evaluation standards for these excerpts originated from the existing theories in public health I used to develop my framework as well as research surrounding evidence-based communication practices. From the two, I was able to identify conceptual codes for the key gaps in practices mentioned while also documenting instances of practical action and effective communication: implementation fidelity, practical action, practice gaps, specificity gaps, resource gaps, and performative language (see Figure 3). This conceptual layer is essential because it marks a transition from what was communicated to how well it adhered to the theoretical and practical principles of effective public health communication.

FIGURE 3: Conceptual Codes

Conceptual Code	Definition
PRACTICAL-ACTION	Effective and actionable communication steps
IMPLEMENTATION-FIDELITY	Resourced and measurable actions (specific teams, metrics)
PRACTICE-GAP	Deviation from evidence-based principles (i.e.personalization, trust, actionability)
SPECIFICITY-GAP	Failure to tailor to unique needs of target population or crisis
RESOURCE-GAP	Absence or inadequacy of resources to execute plan
PERFORMATIVE-LANG	Was the language designed for the public rather than practical action

Additionally, in order to quantify my results and easily determine the efficacy of different toolkits, I took the ratio of deficits and gaps to good, actionable practices. Specifically, it compares the deficit codes (FIDELITY-GAP, SPECIFICITY-GAP, RESOURCE-GAP, PERFORMATIVE-LANG) to action codes (PRACTICAL-ACTION, IMPLEMENTATION-FIDELITY). A ratio above 1 indicates a larger proportion of rhetoric over implementation. Using this metric allows for additional analysis across crisis types (fentanyl vs. infectious disease).

3: THEMATIC SYNTHESIS

In the third step of my qualitative coding process, I organized my conceptual codes into broader themes that were emphasized in the theories of crisis communication I employed. The first of these themes was the gap between knowledge and action. In the context of crisis communication, it speaks on the idea that agencies possess knowledge of best practices, yet often lack the resources to put them into practice. This idea was repeatedly mentioned in implementation science literature where it describes a present "gap between what is known and what is implemented" (Bauer et al., 2015). Secondly, the conceptual codes speak to a deprioritization of communication where it is treated as an optional or unfunded suggestion rather than a necessary intervention. This idea exists throughout literature on Crisis and Risk Communication theory where communication is treated as core to public health interventions and agencies that neglect communication readiness is heavily critiqued (Reynolds et al., 2005). The third theme I identified in the conceptual codes is a lack of tailored communication. This theme essentially addresses the reliance on one-size-fits-all templates across various crises and within diverse communities. Within Crisis and Risk Communication literature, it is stressed that messaging must be audience-specific and adapted to community needs (Reynolds et al., 2005). The last theme I identified relates to the maintenance of trust in unhoused communities. This theme

stems from the performative language conceptual code and draws on ideas surrounding transparency in communication described in Reynolds and Seeger's risk communication framework. More specifically, they emphasize that communication loses credibility when agencies rely on bureaucratic phrasing instead of offering specific, actionable guidance (Reynolds et al., 2005).

WORKED CODING EXAMPLE

To better understand the iterative coding process a passage undergoes, we can look at the following excerpt from the Alameda County Infection Control 2023: "Staff should educate residents about MRSA." In the initial stage (descriptive coding), this passage was tagged with COMM-CONTENT and TARGET-POP codes to describe the content conveyed and the target population it is directed to. Subsequently, the excerpt is compared to principles of Risk and Crisis Communication Theory, among other leading theories in the field, giving it a conceptual code. This excerpt does not describe a specific delivery channel, measurable target, or staff role. Therefore, it is coded as a FIDELITY-GAP because it falls short of resourced, measurable practices. Lastly, in the thematic stage, these codes are mapped on two different themes: the Knowledge-Action Gap and the Generic vs. Tailored Response theme, which will be explained in more detail later in the study. This example illustrates how the excerpt systematically transitions from the surface-level descriptive coding stage to a more thematic analysis of the overall toolkit.

RESEARCH RESULTS AND DISCUSSION

Establishing this coding framework enables both qualitative and quantitative analyses of these toolkits. This section presents the results of these analyses and discusses the possible reasons for the observed outcome. The discussion is divided into three parts: an overview of the coding distribution and the Gap-to-Action ratio for the full dataset; an in-depth examination of the themes derived from the conceptual codes; and, lastly, a comparative analysis of public health messaging on infectious diseases and fentanyl contamination.

1. OVERVIEW OF DATASET

In the coding analysis, I identified 80 passages across the eight documents I compiled. Of these 80, there were 62 from the Bay Area region and 18 from the national toolkits. The iterative coding process I used allows for a thorough examination of these excerpts. The exact code distributions are shown in Figure 4 below. The ratio of Gaps to Actions for these documents was 53:38 or 1.39:1. Although this ratio demonstrates some level of success, it still suggests that within public health toolkits in the Bay Area, aspirational language outweighs actionable planning. Without taking into account the limitations of the research, it further implies that there are present gaps in communication with unhoused communities.

FIGURE 4: Code Distribution

Code Type	Total Passages (n = 80)	Percentage
PRACTICAL-ACTION	31	38.8%
IMPLEMENTATION-FIDELITY	7	8.8%
FIDELITY-GAP	18	22.5%
SPECIFICITY-GAP	17	21.3%
RESOURCE-GAP	9	11.3%
PERFORMATIVE-LANG	9	11.3%

Note. The counts and percentages in the table below represent the frequency of each conceptual code across the 80 coded passages. Several of these conceptual codes relate directly to gaps within the toolkits: FIDELITY-GAP, SPECIFICITY-GAP, RESOURCE-GAP, PERFORMATIVE-LANG. These codes represent 66.4% of all codes (53/80), while action-oriented codes (PRACTICAL-ACTION and IMPLEMENTATION-FIDELITY) account for 47.6% (38/80).

Prior to examining the gap codes, it is important to first review successes in the toolkits and instances where effective local practices are communicated. These are primarily observed in the PRACTICAL-ACTION code (31 passages and 38.8% of all codes). For example, the Alameda County Communicable Diseases 2023 document explicitly highlights social determinants of health and links housing provision to infection prevention. This acknowledgment aligns with practices supported by the Health Equity Implementation Framework and represents an effective communication practice in the toolkits. Additionally, the SFDPH Overdose Plan 2024 contains targeted overdose response education toward higher-risk populations and communities, tailoring its efforts in accordance with the community at large. These practices highlight that local agencies are not necessarily failing to support populations, but rather the gaps demonstrate that the building blocks of a high-fidelity system exist within the toolkits and simply require the proper prioritization, resourcing, and infrastructure.

2. THEMATIC CODING

Theme 1: The Knowledge–Action Gap

Of the 80 passages, there were eighteen displaying gaps in fidelity in comparison to seven showing implementation fidelity. In conjunction with the literature, this contrast reveals an awareness of best practices but inconsistencies in implementing them. For example, the Alameda County Infection Control 2023 instructs staff to "educate residents about MRSA," yet omits delivery mechanisms, responsible personnel, or evaluation loops. In

contrast, the national HUD Infectious Disease Toolkit outlines a structured Incident Command System with a Vulnerable Populations Action Team (VPAT), demonstrating a high-fidelity, resourced model with accountability pathways. This contrast highlights the first theme, the Knowledge–Action Gap: knowledge exists but is not always put into action. The national templates contain explicit staffing models and communication metrics, while local plans lack logistic detailing.

Theme 2: Deprioritization of Communication

With regards to the second theme, there were nine passages with resource deficit codes and nine with performative language codes. This distribution speaks to the idea that public health communication for the unhoused is relegated in Bay Area policy. The Alameda County Communications Strategy states "an amount not to exceed $50,000 is available" to create a countywide homeless communication system. The listed budget falls short in creating an effective communication initiative, spanning multiple cities, demonstrating the deprioritization of communication. However, one document hinted at structural insight: Alameda County Communicable Diseases 2023 linked housing provision directly to infection prevention, implicitly recognizing social determinants. Integrative thinking such as this parallels the principles of implementation fidelity, but within the context of these documents, it remains isolated rather than systemic.

Theme 3: Generic vs. Tailored Response

For the third theme, there were seventeen passages that demonstrated gaps in specificity, highlighting a pattern of one-size-fits-all communication templates. These codes speak to a lack of tailored communication for unhoused communities. The majority of excerpts involved examples of agencies conflating different PEH subgroups under a single label. With this type of rhetoric, specificity is lost in crisis response, resulting in inadequate care. Moreover, when digital channels are prioritized over interpersonal outreach, messaging is even further compromised. At the same time, however, there were instances where the fentanyl-use toolkits emphasized care for those at a higher risk of fentanyl overdose: "Scale up public overdose response education… in settings with people at highest risk of overdose" (SFDPH, 2024). This emphasis shows the presence of tailored communication, but it is still overshadowed by template-based frameworks in the compiled toolkits.

Theme 4: The Breakdown of Trust

Within the literature, trust emerged as a key determinant of communication success. Nine performative language and eighteen fidelity gap codes pertained specifically to this greater theme of community trust in organizations. While several toolkits highlighted making informational content accessible, there was little to no emphasis on outreach efforts or interpersonal exchange (SFDPH, 2022). Local plans often favored more passive forms of informing over relational communication. Moreover, the

bureaucratic phrasing of the documents focused more on compliance instead of engagement. This gap brings with it the risks of reinforcing distrust among PEH. On the other hand, national documents underscored the need for two-way communication loops. The HUD Infectious Disease toolkits emphasized that outreach staff consistently communicate with PEH and report conditions to public health authorities who, in turn, adjust guidance: "Weekly cross-agency debriefs to review outreach metrics and adapt messaging." This recursive model creates space to build trust through responsiveness and functionality.

3. COMPARATIVE ANALYSIS: FENTANYL VS. INFECTIOUS DISEASE COMMUNICATION

FIGURE 5: Separate Crisis Distributions

Document Group	Gap/Performative Codes	Action/Fidelity Codes	Gap : Action
Fentanyl/Opioid (58 passages)	47	24	**1.96 : 1**
Infectious Disease (22 passages)	6	14	**0.43 : 1**

Note. The Gap-to-Action ratios depicted in the table below are the key form of quantitative analysis in this study. The ratio represents the composition of a toolkit's practices with a ratio greater than 1 describing a toolkit with a majority of aspiration and rhetorical language. A ratio less than 1 indicates the opposite: an action-dominant sample.

When examining the two crises separately, I identified a stark contrast in their Gap to Action ratios (see Figure 5). In the case of infectious disease toolkits, the ratio is 0.43:1, indicating an extremely technical set of toolkits with 6 excerpts relating to gaps and 14 relating to actionable, effective measures. In the case of fentanyl toolkits, however, this ratio was 1.96:1 with nearly twice as many gaps as actions. This higher proportion of logistical gaps in fentanyl
risk-communication suggests a lower emphasis on implementation fidelity and rhetoric that falls short of being actionable.

Additionally, this notable difference creates space for discourse surrounding the cause. When considering the nature of the two crises, there is an inherent distinction. While infectious disease communication is driven by operational necessity, fentanyl communication is heavily stigmatized in unhoused populations, causing essential communication to suffer. In the case of disease crises, shelter-based outbreaks require immediate coordination and agency action in order to effectively minimize casualties. More specifically, these toolkits contain a higher number of implementation fidelity excerpts and clearer examples of two-way channels with more consistent mentions of outreach and public health reporting systems.

For drug safety communication, however, the rhetoric tends to be dominated by aspirational language, with there being a dependence on generic channels such as social media for communication efforts (SFDPH, 2024). This pattern suggests that when public health communication is mandated by an operational need, fidelity tends to improve. In situations where there is existing stigmatization, such as for drug use, the rhetoric lacks actionable practices and remains aspirational.

LIMITATIONS AND CONCLUSIONS

The primary sources of limitation for this study stem from the scope and data source. In most academic literature regarding unhoused populations, there are significant barriers to compiling data that are not as prevalent in other fields. Examples of these include difficulties with coordinating follow-ups, highly transient living situations, disorganized medical documentation, and others. With these difficulties, research surrounding the effects of policy on unhoused populations tends to face severe limitations. In response to this, I centered my project around an evaluation and analysis using research-based principles that have applications across public health. While this allowed me to yield substantive results from my research, my qualitative coding process does not take into account measurable outcomes or impact on the target population. My findings simply reflect the gaps and overlap between evidence-based principles and currently implemented toolkits. Additionally, as my evaluation focuses on the public-facing language and intent of toolkits, it holds an assumption that these documents capture the extent of communication practices within these evaluated communities. These limitations give rise to several possible counter arguments. As multiple codes relate to specific gaps in rhetoric, if these gaps are filled through internal organizational work, it would mean that my coding framework omits positive agency practices: trends of high-fidelity communication being implemented within agencies rather than externally. Instead of my coding process evaluating communication practices with the unhoused, it would rather be evaluating communication with the public.

Additionally, another key counterargument to my research could be inadequacies existing upstream from public health agencies rather than within them. Namely, this could be because of structural under-resourcing and a lack of mandated guidelines on the federal level. Further research should seek to incorporate direct feedback from care providers working within unhoused communities to validate the observed gaps and assess the efficacy of communication strategies in practice.

In conclusion, my research demonstrates a moderate gap between aspirational rhetoric and actionable implementation in the Bay Area's public health toolkits. The gap ratio of 1.39:1 highlights this idea, indicating that the documents contain more instances of gaps than actions in their rhetoric. In my analysis of the nature of these gaps, I referenced existing theories on public health to synthesize my codes into larger themes. These themes specifically relate to deficits in community trust, organizational

implementation, tailored care, and resource allocation. This comparative analysis further highlighted a distinction across crises: infectious disease toolkits include rhetoric that is significantly more actionable than those for fentanyl communication. These results suggest a divide between crises driven by operational necessity and those characterized by stigma: a divide that could be addressed with greater emphasis on community outreach and trust-based interventions. To effectively address public health crises in unhoused communities, local agencies must integrate evidence-based communication principles into funded, high-fidelity implementation plans and treat communication as core, resourced infrastructure.

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