CASE STUDIES JULY 2026

Lessons from the Field: Rural Health Care Service Models and Case Studies

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

INTRODUCTION

In *Key Issues in Rural Health Care and Homelessness*, we examined the ways that homelessness may look different in rural communities than it does in urban areas in the United States. We considered definitions and spectrums of rurality, examined some barriers to health care access in rural areas and resultant poor health outcomes, and touched upon regional differences impacting the homeless population in different rural areas.

FACT SHEET JULY 2026

Key Issues in Rural Health Care and Homelessness

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

INTRODUCTION

Homelessness is sometimes broadly framed as an urban issue facing cities in the United States, but evidence suggests that homelessness rates continue to rise in rural areas of the country, as well as urban ones. The U.S. Department of Housing and Urban Development's (HUD's) 2024 Annual Homeless Assessment to Congress (AHAR) report showed that the homelessness rate increased 18% between 2023 and 2024, to an all-time high of 771,480 homeless people living in sheltered or unsheltered situations — and 126,288 of these people were located in a rural Continuum of Care (CoC). Of these, nearly half of the people in rural CoCs (56,528 people) were unsheltered. This number represents a 12% increase in unsheltered homelessness in rural CoCs, and a 36% increase in unsheltered family homelessness in rural CoCs.

It is also likely that these numbers under-account for the problem of homelessness in rural communities. Because fewer resources, including shelter resources, exist in rural areas, there are likely many homeless people and those facing housing instability who are living too far off the grid to be counted, or who are "hidden" as they stay with family members, couch-surf, live in a car or camper, or otherwise navigate housing precarity. Moreover, social and regional understandings of the nature of homelessness may impede communities from clearly seeing the local landscape of homelessness, and the sprawling geography of rural areas may render it even more invisible.

Despite the prevalence of homelessness in rural areas, many resources for providers of health care for unhoused populations draw from research and service models developed in urban settings. Expanding access to health care to homeless individuals in rural areas requires understanding the specific conditions that give rise to both homelessness and poor health in those areas and utilizing service models and approaches that are responsive to the specific needs and challenges facing rural communities.

This resource will examine some key issues related to rural homelessness, including definitions of rurality, rural barriers to health care access and the health impacts that result from this lack of access, and common landscapes of homelessness in rural areas.

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In this companion piece, we will be taking a closer look at specific care providers and their organizations providing health care services for homeless populations in different parts of the country. Through this lens, we'll be able to examine some of the geographic, socioeconomic, and regionally-specific variances that impact the landscape of homelessness in different areas. For each organization, we'll be considering the service models and approaches being used to meet the unique needs of the local population and summarizing some key lessons for care providers who are seeking to expand health care access and services to homeless individuals in rural areas. These case studies highlight key themes such as the varied faces of homelessness in communities, the importance of recognizing and addressing stigma as foundational to this work, partnerships formation, and the crucial role that non-traditional healthcare settings – such as mobile health, street outreach, and medical respite—play in bridging gaps in care.

These case studies highlight key themes: The varied faces of homelessness in communities, the importance of recognizing and addressing stigma, and the crucial role that non-traditional healthcare settings play in bridging gaps in care.

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PUBLC HEALTH OUTREACH ON THE NAVAJO RESERVATION

with Dr. Elizabeth Stranges and Dr. Elizabeth Glaser (Arizona – 11.5% rural)

Key themes: Faces of homelessness, ancestral lands, outreach and backpack medicine

The Indian Health Service (IHS) is a federal health care system that provides medical care to American Indian and Alaska Native populations. On the Navajo Reservation near the northeast part of Arizona, the IHS operates the Chinle Comprehensive Health Care Facility (CCHCF), a 60-bed hospital which offers primary care, hospital care, obstetric care, and emergency services; medical staff includes Family Physicians, Internists, Pediatricians, General Surgeons, OB/GYNs, Anesthesiologists, and a Psychiatrist. **Dr. Elizabeth Stranges** and **Dr. Elizabeth Glaser** (PhD, MS, ACRN) both previously worked for the IHS in Chinle—Dr. Stranges as a Primary Care Physician and Dr. Glaser as a RN and Sexually Transmitted Infection (STI) Case Lead. (Dr. Stranges is now a Primary Care Physician with Hennepin County Health Care in Minneapolis, Minnesota, and Dr. Glaser is now an Infectious Disease Outreach Nurse with Boston Health Care for the Homeless.)

Chinle, located an hour and a half drive west of Gallup, New Mexico, is a town of 5,000 people. The catchment area for CCHCF contains about 37,000 people. The Navajo Reservation encompassing Chinle is approximately the size of West Virginia, so the areas served by the clinic are vast. Dr. Stranges worked inside the clinic, and Dr. Glaser was involved in starting a field outreach unit to respond to a syphilis epidemic in the Four Corners region—the area where Utah, Arizona, Colorado, and New Mexico share a border—which was at the time reporting the highest rates of syphilis, including congenital syphilis, in the country.

Homelessness on Native American reservations can be particularly difficult to identify and define. Dr. Stranges cites the statistic that one-third of people on the Navajo Reservation don't have access to running water or electricity, and explains:

> A lot of folks may be living in a shelter but may not have basic services. Maybe they use wood burning stoves for heat and rely on firewood. One older gentleman I knew—and this was not uncommon—lived in a shed and didn't have reliable heat. He just used a lot of blankets. It's very cold there at night, 5 or 10 degrees with very cold wind, sleeping in the shed under blankets. He would not consider himself unhoused. But by urban standards that's probably equivalent.

There are other factors influencing understanding of what homelessness is for a People with such strong ancestral ties to the land. There is a sense of family and community belonging that comes from being on family land, even if basic needs are not being met there, and the history of displacement is woven through the land. Members of Native communities may consider themselves homeless when they are living on the streets in a city, but not when they come home to family land, as there is a sense that a person can't be homeless on ancestral land or family property.

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Kinship structures in local communities impact the sense of responsibility to care for family, but communities may struggle to care for members with mental health and/or substance use challenges. Dr. Glaser notes that the most destructive substance widely used in Chinle is methamphetamines, and that substance use disorder treatment, while available, can be challenging to access for many reasons.

Analysis has found that American Indian and Alaska Native (AIAN) housing conditions are substantially worse than in U.S. households generally, with overcrowding problems, electrical and heating insufficiencies, lack of clean and available water, poor housing conditions, and more.[1] According to one study, "The Navajo Nation faces a multifaceted housing crisis rooted in various challenges. Overcrowding is prevalent, with homes being 6.5 times more crowded than the US average, often accommodating multigenerational families due to community practices and housing shortages. Infrastructure deficits are significant; approximately 32% of homes lack electricity, and many still do not have access to running water."[2] Moreover, most reservations have few, if any, options available in terms of shelters or supportive or transitional housing programs, and the amount and quality of housing available at all generally tends to be limited.

According to Dr. Stranges, one of the most common versions of homelessness she saw around Chinle was people living on home sites (or family land) without access to power or running water. These people might be living in run-down structures with no services, or, as

Dr. Glaser saw, isolation shacks that had been donated to the community during the COVID-19 pandemic. Some folks live with family members, including distant family members, or friends.

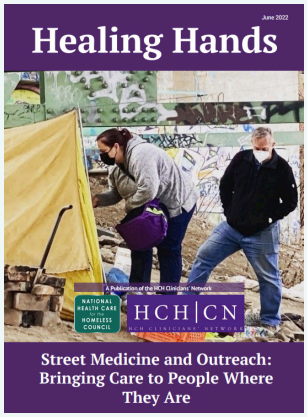
There are also some people living in small groups in town, in tents or dilapidated structures, and some people who would travel off the reservation for seasonal work and live in their cars for weeks or even months at a time while traveling. Another form of seasonal movement that Dr. Glaser saw was people spending the summertime in summer camps in the mountains where the animals grazed, then moving back to family land or town when the colder season arrived—or, in some cases, going to Phoenix or Gallup or another city and living on the streets or in a shelter there.

When asked to identify some of the key challenges that people without stable housing face accessing health care on the Navajo Reservation, Dr. Stranges identifies transportation as one of the major barriers. There is no public transportation available, and people live spread across great distances. She notes that remote areas also pose health risks in and of themselves, and people are more in danger of not being found in a crisis (e.g., a fall or an accident). Dr. Glaser agrees and adds that "rural homelessness involves many of the same challenges as urban homelessness, but magnified."

In the case of Dr. Glaser's outreach work during the syphilis epidemic,[3] she found that the people impacted by the syphilis epidemic were sometimes involved in methamphetamine use and unstably housed. Dr. Glaser noticed that people who received a diagnosis of syphilis while visiting the hospital were often hard to find for follow-up treatment, so she began to ask: If people can't get in to see us, why don't we take care to them? She and her team began traveling to find people with an untreated syphilis diagnosis, sometimes locating them in encampments or with family members. Using an outreach approach, her team was able to achieve treatment rates over 90%. In addition to offering syphilis treatment, the team also sought to relink people back into regular care or let them know of other services offered by the hospital—for example, the bridge clinic providing substance use treatment and groups.

This project also illustrates the importance of integrating systems of peer support into health care initiatives. This communication strategy was key in both community

HEALING HANDS ON STREET MEDICINE AND OUTREACH



The June 2022 issue of Healing Hands (*Street Medicine and Outreach: Bringing Care to People Where They Are*)[4] contains history about the street medicine movement and examples of urban street medicine and outreach programs, plus a rural example in Hawaii.

The term "street medicine" refers to the provision of medical care for homeless individuals while living on the streets, and in some ways reflects the fact that urban agencies tend to have more resources available to allocate to outreach services. But some rural care providers prefer the term "backpack medicine," since outreach also happens in places where there are no streets.

In Kailua-Kona, Hawaii, outreach workers with the West Hawaii Community Health Center (WHCHC) travel across lava fields and through jungles to reach people who are living unsheltered. WHCHC's outreach teams go to great lengths to find people and encampments, often covering up to six miles of shoreline and forested territory per day. They have even partnered with a helicopter company to fly around Kona and spot where the encampments were, creating maps that could be used for outreach.

This publication uses both "street medicine" and "backpack medicine" to indicate that all along the spectrum of rurality, care providers are moving on foot, carrying their medical supplies along with them, to find people in need of care in all sorts of environments, from streets to forests to deserts to mountains.

education and getting access to set up testing sites throughout the community. Dr. Glaser, who has worked in rural health care settings in multiple countries, emphasizes the importance of working with and supporting teams who are embedded in the local community and able to translate back and forth between clinicians who may be "outsiders" and community members.

Now, in Boston, Dr. Glaser is working with people with serious injection-related infections who experience high mortality rates. Her small team works to connect people with care and keep them in treatment. She thinks of outreach work both in terms of providing care to individuals and providing public health support and information to the greater community. "The work I'm doing now in Boston and I did with the Navajo Nation bringing syphilis treatment to people has given me this mantra," she says:

> We need to be flexible. We need to bring the standard of care to non-standard settings. Instead of saying, you have to conform to how we offer care, we have to be flexible. Instead of continuing to blame people when they can't get to a place, we have to bring the standard of care to the setting. We're not talking about doing surgery in a van, but we can do an awful lot with a mobile unit—or even just with a car and a provider.

PUBLIC HEALTH INITIATIVES, DATA COLLECTION, AND COMMUNITY COLLABORATION

with Ashley Jarrett (North Carolina – 33.3% rural)

Key themes: Outbreak mitigation, outreach and backpack medicine, partnership

Ashley Jarrett (DNP, RA, CPH) is the Assistant Health Director at the Burke County Public Health Department in North Carolina. In 2021, Ms. Jarrett was a communicable disease nurse who was tasked with managing COVID-19 outbreaks as well as a Hepatitis A outbreak that was occurring nation- and state-wide with high rates of person-to-person transmission rather than a more typical foodborne outbreak. Historically, Burke County had not had much in the way of homelessness initiatives, but through infectious disease investigation, state and local officials identified three populations that were at higher risk of contracting and spreading Hepatitis A: Men having sex with men, people using intravenous drugs, and homeless individuals.

It was clear to Ms. Jarrett that mitigating this outbreak required collaboration between agencies, but she found that though agencies existed to work with the first two populations, there wasn't a homeless health system in Burke County. Ms. Jarrett began assembling street medicine teams to take Hepatitis A testing and treatment supplies into streets and encampments. She developed collaborations with local law enforcement, soup kitchens, Emergency Medical Services, and public health

Continuum of Medical Outreach

Image from National Healthcare for the Homeless Council. [5]

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officials—and working together this collaboration was able to decrease the community Hepatitis A infection rate from the highest rate in the state to no new infections in just a couple of months.

"Getting people together and going to encampments and having services accepted by people who live there made me wonder why we didn't do this for everything," says Ms. Jarrett:

> Why did it take an outbreak for us to do this? I began digging into the system, wondering who do people usually go to? Our FQHC was the most common place for accessing care—but what type of care and how often were people coming in? They identified big gaps in time between service, and a lot of people going to the emergency department first. I learned more about the local landscape and decided if I can vaccinate in encampments, I can bring primary care to encampments. So we built a volunteer street medicine program to test such a program in Burke County.

In this case, the public health initiative served as a doorway into discovering a homeless population who were going unserved—and from there, Ms. Jarrett began to think about what other needs the population might have. She learned that there were some encampments located near towns, but that these were often being broken up in sweeps. Other people were camping, sleeping in a car, couch-surfing, or staying in abandoned buildings on the outskirts of town. There were also people camping far into the woods, up the mountain.

This street medicine program represented a departure from typical public health department activities, which are usually more focused on gathering data and disseminating public health information, not on program administration; "not many homeless health initiatives at all, let alone street medicine programs, are run through a health department," says Ms. Jarrett. In this example, because of Burke County Public Health Department expertise and connections to local academic partners, they were able to develop an evidence-based pilot program that also collected data and contributed to the understanding of best practices.

Working with the UNC Gillings School of Global Public Health as an academic partner, Ms. Jarrett and her department were able to develop the backpack medicine project then pass the program to an organization that was better equipped to administer it, serving as technical assistants and sharing best practices and lessons learned. The university team also helped conduct focus groups to incubate a project based off local community need—a women's health bus for homeless women.

Their experiences emphasize the importance of collecting data on an ongoing basis and making sure that pilot programs are continuously responsive to evolving community needs. Through methodologies like focus groups, timebound pilots that include data collection, and technical assistance groups, projects can both serve immediate community needs and build a knowledge base for others to learn from.

For Ms. Jarrett, the connection between public health and outreach programs is intuitive: "You need to know where people are in order to mitigate a communicative disease outbreak," she explains. But this is not to say it is always easy; these projects have also faced resistance that has caused her to think about tiers of readiness in the community. She thinks of public health as community health, and as a trust-building exercise: "You have to go at the pace of the community," she says. "Resources are not always immediately forthcoming, but resources follow changing minds and changing systems."

She emphasizes the importance of thinking closely about community relationships in project development, and being careful about wording and language in order to effectively navigate local contexts. "I apply the principles of patient-centered care when I'm working with community stakeholders, too, where patients drive their own journey" she explains:

> This is true of the whole community. You have to understand the community, individual stakeholders, their backgrounds, their ties, the language they use. If they don't believe homeless individuals should have health care, then you have to start there. You have to let people guide their own way toward understanding that people need health and that housing matters…

The health department's street medicine and outreach programs have important lessons for other projects, and also hold echoes of the past. "In these communities," Ms. Jarrett says, "we used to have community doctors, who knew everyone and their families and where they lived, and who understood local problems. They made house calls and essentially were local leaders. We had community doctors who lived for the community. Street medicine is an opportunity for that to happen again." Though backpack medicine is in many ways designed as a bridge-building that helps people re-engage with the larger health care system, it also presents opportunities to re-imagine the personal nature of health care. "The mobile bus will always be useful for rural areas," says Ms. Jarrett, "and our ultimate goal is combining mobile medicine with backpack medicine."

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These communities used to have community doctors ... who understood local problems. They made house calls and essentially were local leaders. Street medicine is an opportunity for that to happen again.

Photo courtesy of Dr. Christine Teague

BLENDING MOBILE CARE AND BACKPACK MEDICINE IN THE MOUNTAINS

with Dr. Christine Teague (West Virginia – 55.2% rural)

Key themes: Mobile health, outbreak mitigation, stigma, peer specialists

Combining mobile care units with backpack medicine for maximum reach in far-flung rural areas is exactly what Vandalia Community Connect is doing in West Virginia. Dr. Christine Teague (PharmD, MPH, AAHIVP) is a clinical pharmacist and the Program Director of Vandalia Community Connect, which is part of the Vandalia Health System that includes the four hospitals and outpatient clinics of Charleston Area Medical Center. The main urban center in the area is Charleston, Kanawha County, with a population of about 50,000 residents, and the surrounding area is highly rural.

Vandalia Community Connect is the primary health care provider for adults with HIV/AIDS in the community. The program has expanded and now provides services related to Hepatitis C, STI treatment and prevention, urgent care on streets, addiction medicine, wound care, with federal grant funding for people living with HIV; and state/local grants and in-kind hospital support for individuals without HIV. Before 2018, most of their work was done in the clinic setting with people who were mostly housed. "But then the opioid epidemic hit West Virginia hard," says Dr. Teague, "and our numbers flip-flopped. We went from 80% sexual transmission of HIV to 80% of transmission being associated with injected drugs."

"It is impossible to understand homelessness in this region without understanding the substance use disorder epidemic, which began with opioids," says Dr. Teague. There are strong associations between the substance use disorder epidemic and

homelessness, particularly in communities strongly impacted by substance use disorder. Not only can the use of opioids and methamphetamine be a driver of homelessness, particularly amongst people without strong support systems, but homeless individuals are more likely to experience death from overdose than low-income housed individuals.[6]

Two years into the Kanawha County HIV outbreak, Dr. Teague's team was able to secure funding to develop a mobile unit:

> We began by going to a few areas with the highest concentration of the HIV outbreak and have now expanded to other areas of community need. We have bus service in the city of Charleston but not outside the city. If you're even 10 minutes away there is no transportation. If you don't have a car, you don't have any access to care. Many people don't have internet or phones. So we are taking the bus out to those areas. It is a clinic on wheels with a full team and full scope of services. Half of our patients are currently served by the unit, with the rest now coming to the clinic.

The mobile unit is first focused on people who are living unsheltered, many of whom have substance use disorders or co-occurring mental health issues. There are some small groups of people clustered around the towns, which generally have some services available for them, but the landscape changes rapidly just a few miles outside of town. There, people are more likely to be living alone in tents or in abandoned buildings—"many of which the local city and/or county leadership is often trying to raze," adds Dr. Teague.

To increase the reach of the mobile unit, backpack medicine is also utilized. Dr. Teague explains: "We park in a location then the team is mobilized with backpacks of meds and supplies to go to the riverbank or tent city or wherever people are."

Photos courtesy of Dr. Christine Teague

Combining mobile units with backpack medicine has enabled the team to reach people who would be unreachable through other methods: "75% of people on the mobile unit have undetectable viral loads," says Dr. Teague. "The number of new infections went down to 10 last year, from 46 in 2021. That's an 80% reduction, and we are really attributing that to decreasing community viral load."

Photo courtesy of Dr. Christine Teague

Because of the success of the mobile units combined with backpack medicine, the program has since expanded beyond HIV/AIDS care and into the realm of primary care. "We want to do more primary care for people outside of Charleston," says Dr. Teague, "because we know there is little service of any kind in those areas. For many people the main source of service is a dollar store or gas station… We know we can help prevent continued re-admission to the emergency department because we offer a variety of services. We're here for the community."

One of the important lessons of this case study is a lesson about understanding and combating stigma. In this case, there are multiple intersecting stigmas—around HIV/AIDS, around drug use, and around homelessness—that arise on multiple levels. Within unhoused communities themselves, there may be stigma about HIV/AIDS; within larger communities, there may be stigma about homelessness; among health care workers, many of whom also have distressing personal experiences related to the opioid epidemic, there may be stigma about people who use drugs. People are complex, and so these stigmas can sometimes intersect and emerge in surprising ways. Care providers need to be clear-eyed about the existence of these stigmas in order to effectively educate different communities and combat preconceptions. "How you present yourself and what you're offering should be tailored to the population," says Dr. Teague. She credits the Addiction Care Department's peer recovery specialists as key contributors to the project of dismantling stigma. Peer recovery specialists can put a human face to addiction recovery, and can provide bridge-building education to patients and care providers alike.

And, she says, taking the time to build trust and personal relationships goes a long way toward breaking down prejudices:

> Start by going places in person, even before the unit goes, dressed in jeans, scrubs, sweatshirts, hats. Try not to look intimidating. Start meeting people and asking what they need help with; start building those relationships. What people tell you they need is what drives what you're going to do for them. It takes time. It takes years to establish rapport and trust with people. You have to show up every time—if you say you're going, you're expected to be there. If you don't show up, they may not come back

THE IMPORTANCE OF LOCAL PARTNERSHIPS, RELATIONSHIPS, AND LIVED EXPERIENCE IN RURAL COUNTIES

with Katelyn McGuire and Macrea Love
(Tennessee – 34.7% rural)

Key themes: Faces of homelessness, lived expertise, partnership

Katelyn McGuire is the Executive Director and **Macrea Love** is the Director of Outreach for the Tennessee Valley Coalition for the Homeless (TVCH). TVCH serves 12 counties surrounding Knox County in east Tennessee. A few of these counties have some suburban areas (such as Sevierville, Pigeon Forge, Gatlinburg, Maryville, and Oak Ridge), but the rest of the area is very rural, with some small towns and wide expanses of rural space, including mountains and wooded areas.

A key component of TVCH's programming is street outreach in all 12 counties, covering as much of the area as possible (although some parts of the mountains are inaccessible). The outreach team goes into the woods to look for encampments, share resources and goods, and refer people to local partners—including medical care providers. They also help individuals work toward their goals whether it be housing, employment, obtaining documentation, and so on.

Many of the people who are reached via outreach activities are living in the woods and mountains in tents and old structures. Encampments in supported communities illustrate the sometimes-blurry boundary between rural poverty, housing insecurity, and homelessness. As an example, Mr. Love mentions that his team recently connected with a campground with people living in 30 old RVs by a lake, none of which have running water or electricity. "Here we have to tread lightly," he explains, "because we don't want to offend anyone who doesn't think of themselves as homeless, and some of these folks don't think of themselves as homeless. They have a home!" In spaces like these, traditional definitions of homelessness don't quite capture the rural reality.

Local partnerships are key to TVCH's operations. In some counties, partners provide hot meals at outreach events; in others, partners offer mental health care, substance use disorder treatment, and medical services. The street outreach services vary from community to community depending on these local partnerships. Because there is a general lack of resources for organizations working in these communities, Ms. McGuire emphasizes the importance of understanding local funding landscape

Photos courtesy of Katelyn McGuire and Macrea Love

and cooperation rather than competition between local partners. Rather than re-inventing the wheel in a battle for scarce resources, it is better to partner with organizations that are already offering services in a given area. "We try not to duplicate services," says Ms. McGuire. "We sit down at tables and talk about where we fit into a community."

Part of cultivating these community partnerships is speaking about homelessness in a way that raises community awareness and fights stigma. All of the care providers interviewed for this issue reported a recent uptick in stigma and criminalization of homelessness in the small towns and rural areas where they work. Rural areas tend to be close-knit and insular, and may have "if we build it, they will come" concerns about introducing local homeless services, leading to community resistance to offering services. In today's landscape, says Ms. McGuire, "we need to be doing advocacy and education at the local, state, and federal levels—and we need to understand the importance of local relationships and conversations in fighting stigmas about homelessness."

Mr. Macrea adds:

> I often remind my team that relationships are key in this work. With rural homelessness, there's not a lot of money, not a lot of resources, not a lot of people doing the work in general. So building relationships with members of the community and people you serve is just as important as any dollar you get donated to you. These relationships will govern how wisely your money is spent and where it can best be put to use. We could get a million dollars tomorrow and it would be misused if we didn't have partners and relationships to steer us in the right direction.

"Sometimes people hear about homelessness and think they are not impacted", says Ms. McGuire, "but you can also phrase it like 'what happens when this funding decreases and those social services go away' and relate it back to them or their family member or the services that they would expect to seek if they fall on hard times." Ms. McGuire also thinks of these conversations as homelessness-prevention work, noting that it costs a lot less to help a person avoid eviction than it does to get someone re-housed after they have been evicted—and part of encouraging people to access help proactively lies in de-stigmatizing the need for help in the first place.

Ms. McGuire also emphasizes the importance of learning from people with lived experience in order to craft supportive offerings that are both effective and supporting:

> I experienced homelessness as an adolescent. I was a first-generation college student. They told us to go home for the break and I realized I had no home. In that moment I realized "I am homeless." For the past few years I'd been experiencing it. I had residence housing and had stayed with friends and had connections, and I had even lived in my car. But sometimes people don't identify as [homeless] ...so they don't make the connection that they can utilize the resources. I was never even educated that resources like that existed. I didn't know there was anything for homelessness or prevention or folks that could help with rent and food. It wasn't until my sophomore year in college that I found out about campus resources for first-generation students, free tutoring, etc.
>
> It's important to learn from people with lived experience not just because we've lived it and we know the trauma and the feelings of not having access to resources—but also because it gives that hope of "and look what I've become!" I'm the executive director of a regional nonprofit and I hold a bachelor's and masters' degree, but I was homeless, living in my car, and precariously housed for 3 years of my life. People need to see that just because people are experiencing homelessness doesn't mean that they are never going to be someone who makes a difference in society. And that difference can look so many different ways.

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MEDICAL RESPITE PROGRAMS AND CARE GAPS IN RURAL SETTINGS

with Brandon Cook and Britt La Shier (South Carolina – 31.8% rural; Maine – 61.5% rural)

Key themes: Medical respite, partnership

Brandon Cook (MBA-HA) is the Senior Medical Respite Manager at the National Health Care for the Homeless Council. He previously worked with the Medical Respite Program at New Horizon Family Health Services in Greenville, South Carolina: "My own professional experience with medical respite in South Carolina was in Greenville, the most populous county in the state which has a densely populated city center where majority of homeless services are housed." (The 10 medical respite beds in this program are the only 10 medical respite beds in the whole state of South Carolina, at present.) Outside of Greenville, the landscape becomes rural rapidly, so the health center and hospital systems, including the medical respite program, are relied upon by both the urban area and surrounding rural counties.

Mr. Cook's current work with NHCHC involves "supporting communities as they develop and expand medical respite programs. At last check, there were 237 medical respite programs across 45 states and territories in the USA. Some states have a lot more programs than others (e.g., California), and funding, state-level support, and Medicaid expansion are key factors that support the development of medical respite programs." In this work, Mr. Cook notes that state-level support is a critical piece of the development of medical respite programs. In Illinois, for instance, he's been working with a state project for 3 years: "They started with 4 medical respite programs and through the state capacity building initiative, they've gone from 4 to, at last check, 12 to 15 programs. Previously those 4 programs were all located in Chicagoland, and now it's more widespread, including in more rural areas in the southern part of the state."

Medical respite programs are less common in rural areas than in urban, which means there is limited information available about the role and potential impacts of medical respite programs in rural areas.[7] But in thinking of common challenges

with rural healthcare generally—access, hospital closures, transportation, long distances between healthcare facilities—medical respite programs are well suited to fill access and service linkage gaps. The medical respite model brings together medical and clinical expertise with social service expertise to provide holistic care. In rural settings, where people may not be able to access these different care components individually, medical respite offers an alternative approach and solution. Mr. Cook emphasizes that medical respite is a key intervention for reducing stresses on emergency departments and hospitals with limited resources, while improving patient outcomes, noting:

> Medical respite is an important intervention in terms of disrupting the cycle of homelessness. It's about giving vulnerable people leaving the hospital a safe place to recover from their condition but also to have the opportunity to work on those health related needs social needs from a holistic kind of perspective. Fundamentally, the big challenge is, what resources are available and how can we leverage them? Especially for newer programs, key partnerships and relationships may be brand new. They haven't gotten to know each other over years and done other ventures together, so building those relationships can often be somewhat challenging. It's about identifying the right champions of some of those other resources (specifically with hospitals—but also other resources that folks may need to leverage for clients in medical respite). That's the big challenge. When programs can come up with solutions for how to leverage sparse resources, then they'll see those programs be of benefit to people in the community.

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Britt La Shier, the Street Outreach Liaison with the City of Biddeford, Maine, can vouch for the impacts of medical respite programs. She previously worked in the social services department of Maine's only medical respite program, which opened in Portland in 2022. In Portland, there were 300 people or more staying outside on any given night, and all the shelters were at maximum capacity. Based on her experiences with medical respite in Portland, Ms. La Shier sees medical respite as a way of filling gaps in rural health care services. But sending rural patients to urban medical respite programs can present challenges; when patients from rural areas found their way into the medical respite program in Portland then were discharged back to small towns or rural areas, follow-up became extremely difficult.

Biddeford, where Ms. La Shier currently works, has a population of 22,000 people and is surrounded by rural areas. She was invited to apply for "what was initially a police liaison position—traditionally occupied by someone who operated

out of the Biddeford Police Department, had an office there, and did ride-alongs with police to respond to substance use and mental health needs." Upon taking the job, though, Ms. La Shier requested to re-create the role into Street Outreach Liaison, a non-police-affiliated role, working independently with folks outside and in shelters.

"Before COVID", she says, "there were maybe one to five people living outside in this town. In 2025, there were about 80 people living outside. It was a huge influx that the city had never seen before and did not know how to tackle. Working in Portland, I had seen the repercussions of being reactive instead of proactive and watching numbers increase after COVID." Most of the unhoused people in and around Biddeford are living in tents—in small groups and one larger encampment that nears 50 people in the summertime. The town has one cold-weather shelter that was a day fund until it received emergency funds a few years ago and developed 50 overnight beds for the wintertime.

Because Biddeford does not have a department of social services, Ms. La Shier functions as a team of one, operating off word-of-mouth referrals that come from cultivating trust:

> I don't have an office; my office is outside, my car, coffee shops, the local shelter, the library. It's a team of just me, although I did have a university student intern this semester. I do street outreach and provide harm reduction supplies, I set up PCP appointments and often transport people to Portland for medical, dental, and counseling needs. I do our coordinated entry system with folks, which involves assessment, getting them into the HCIS system, trying to obtain vouchers. I do probation work with people, helping them navigate the system, setting up appointments, and attending probation appointments with officers.

Ms. La Shier is also working on setting up a street medicine program, with nurses from Portland who are volunteering to provide wound care and other medical care onsite. Ms. La Shier also has a goal to use her contacts in Portland to set up a "sister" medical respite program in Biddeford. Having a medical respite system in Biddeford would enable people to receive care post-hospitalization and more seamlessly be folded back into the health care system. "Even a handful of medical respite beds would be monumental," she says.

But of course, there are the challenges associated with creating this sort of partnership in a less-resourced area. "Helping the community become more proactive," she says, "takes a lot of communication and a lot of time. It requires patience and perseverance." She sees opportunities to engage community leaders as allies in promoting more education about homelessness throughout the community: "It starts at the top." she says.

Helping the community become more proactive takes a lot of communication and a lot of time. "It requires patience and perseverance," La Shier says.

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

ABOUT NHCHC

The National Health Care for the Homeless Council is the premier national organization working at the nexus of homelessness and health care. Grounded in human rights and social justice, the NHCHC mission is to build an equitable, high-quality health care system through training, research, and advocacy in the movement to end homelessness. Visit nhchc.org to learn more.

CONCLUSIONS

Ms. LaShier, like other care providers interviewed for this publication, has worked in both urban and rural areas and sometimes misses the larger network of resources and care providers that work together in a city. "The more people around a participant, the better," she says. "In Portland, medical providers, street outreach folks, case managers, housing specialists, and peer recovery coaches all worked together… In Biddeford, though, I have felt isolated. There are only a few people working at the shelter, and one outreach worker who works throughout the whole county." Ms. La Shier is conscious about maintaining her contacts in Portland—both for purposes of maximizing client care, and to maintain her sense of her own place in the community of care providers.

As Ms. McGuire explained from East Tennessee, an integral part of working in rural settings is getting creative and resourceful about partnerships. The collaborations may not come as easily or naturally as in cities, and funding landscapes may be sparse, and barriers to health care access are all around. But there are also hidden opportunities in rural areas to leverage relationships and develop unexpected partnerships. Across the country, care providers are building mobile programs and strapping on backpacks and taking health care into forests and across rivers. And as they "bring the standard of care to non-standard settings," as Dr. Glaser put it, they are also creating networks, building community, and developing models of care that can respond to the unique needs of rural communities.

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