

Rural Street Medicine



Introduction

Healthcare access in rural settings is often challenging (Javed, 2025), and this is especially true for residents who are unsheltered (NCH, 2020). Bringing street medicine to rural communities can be incredibly impactful for those who are unsheltered and the entire community.

Population and Needs Assessment

- **Setting:** Unsheltered homelessness (defined as living in places not meant for human habitation) in rural areas and small towns can look similar to urban areas such as people sleeping on sidewalks or under highway overpasses, but it can also present as:
 - Tents or encampments in wooded areas, along major rivers or railroad tracks, or close to critical locations such as the only store, social service, or bus station in town
 - Groups of vehicles or trailers that may or may not function
 - Repurposed emergency/disaster shelters such as temporary travel trailers or manufactured housing meant for short-term use
 - Poor quality structures that are often unsafe, abandoned, lacking in basic utilities, and/or overcrowded with many individuals
- **Isolation:** Isolation for people living unsheltered in rural communities is similar to urban areas, but magnified by the geographic remoteness, lack of telecommunications infrastructure, and limited or unavailable public or private transportation options. Additional isolation stems from:
 - Lack of community and mutual support due to geographic remoteness as well as stigma due to reputation ("small-town dynamics"), perception of not being self-made, and social norms against homelessness and substance use (Buck-McFadyen, 2022).
 - Outmigration from urban locations to rural communities resulting in newcomers with fewer community and social service connections (Schiff et al., 2016).
- **Health Needs:** Similar to urban locations, unsheltered people in rural areas have high rates of chronic illnesses including diabetes, heart disease, and pulmonary disease. Other health needs issues may differ:
 - Substance use patterns differ include higher rates of alcohol, smoking, and/or stimulant use.
 - Lack of available services, stress, and stigma against accessing care in rural areas can exacerbate mental health needs (HCH Clinicians' Network, 2001).
 - Increased risk of traumatic injury due to pedestrian/bicycle vs. vehicle accidents due to lack of sidewalks and/or public transportation. Injuries lead to excessive morbidity/mortality and hesitancy to access healthcare services due to fear of being struck again.
 - Increased likelihood of zoonotic diseases or exposures due to proximity to wildlife and livestock. Increased dog ownership increases risk of dog bites and need for related wound care.
- **Lack of Services:** Social services that offer assistance with birth certificates, disability claims, and housing case management may be more limited in rural areas. Some small communities lack local

health care services, forcing people to find care elsewhere which can lead to further fragmentation of care. Equally, if a rural community relies on one healthcare system for all care, stigma from being “flagged” in the system increases the risk of poor care and mistrust between unsheltered individuals and their clinicians.

- **Inaccurate Counts:** Point-in-time or other counts and assessments of unsheltered people are difficult due to the winter timing in January and large/remote areas leading to lack of visibility (NACRHHS, 2014). This in turn can often lead to an undercount and as a result decreased awareness, support, and funding.
- **Poor Housing Access:** Due to limited purpose-built rental housing and lower rates of community development than urban areas, people living unsheltered in rural areas have fewer options for housing.

Tips and Considerations

Engagement

- Standard procedures for safe conduct should also be followed in rural areas.
- Team attire:
 - Footwear suitable for distance and rugged/unpaved surfaces is crucial, as well as insect repellants and treatments for common outdoor bites and stings.
 - Consider bringing a change of clothes and rain covers for backpacks/wagons.
- People living unsheltered in rural areas can be hidden within existing neighborhoods and may not be recognized as unhoused by their neighbors. Consider avoiding very large teams or multiple vehicles, marked vehicles with large banners, or loud/flashy announcements upon arrival.
- Wait for the person to calm or leash their pets on arrival and check with the owner before extending your hand or giving the animal any treats. Consider partnering with vet outreach services to provide vaccination and other services.
- Consider informing the county or town’s community-based organizations at least 1-2 weeks in advance of arrival if planning to organize outreach at a community-based organization. Word of mouth in rural communities is paramount, and small communities may rely on personal recommendations and local networks rooted in deep trust.

Transportation and Equipment

- Transportation
 - Programs will likely need a vehicle as the service area can be expansive. Consider a vehicle with appropriate off-road capability (all-wheel drive or four-wheel drive) in order to navigate unpaved roads, mud, deep snow, and steep inclines. A vehicle will allow the team to bring additional medications, equipment, and supplies to provide more needed services.
 - Team members can use the longer travel time to review charts, chart encounters (such as voice-to-text dictation), discuss more complicated cases (“huddle”), or perform coordination services. Teams can “run the list” at the beginning and debrief on the drive back at the end of services. Staff time should include additional time needed for tasks that cannot be done while traveling.
 - In walkable areas or towns, consider wagons/carts with robust tires.

- There may be a need for hotspots, satellite phone/communications, or alternatives to cell phones and cellular services due to limited coverage. It can be helpful to use paper record keeping in the field and chart in the Electronic Medical Record afterwards.
- Consider having a lightweight camp chair and table for use in the field and portable battery packs so that patients can access information stored in their uncharged phone.

Scope of Services

- Consider expanding mobile capability including phlebotomy and point-of-care testing to allow faster diagnosis and initiation of treatment.
- Incorporate education, harm reduction, and peer navigation into any care especially relating to substance use and/or isolated areas. This includes guidance and supplies on self-care and peer-care such as first aid and wound care.
- Provide street mental health services as a core component of street medicine care.
- Consider preventative services including vaccinations and screening tests.
- Consider dispensing meds onsite instead of prescribing and use injectable medications when available/appropriate. Programs can have patient prescriptions mailed to them then deliver it when outreach occurs.
- Subspecialty care can be a significant barrier whether due to overbooked specialists in the area or none at all. Investigate the possibility of telemedicine services or arranging transportation with peer support when appointments are made.
- Due to the travel time, conventional quality measures on volume or patients per hour are poor measurements of effectiveness or efficiency. Advise the host institution and/or stakeholders that rural street medicine care cannot use the same benchmark as clinics. Consider alternative quality measures such as increased access to services and the provision of comprehensive multimodal care during the visit to maximize impact for the same travel time.

Collaboration

- The street medicine team has an outsized opportunity to affect social determinants for their patients, given that services may be inaccessible otherwise in rural areas. Programs should consider offering additional services or collaborate with others for food/nutrition, sanitation, health insurance or housing applications, legal needs or disability benefits, healthcare system navigation, harm reduction services, and/or transportation (Roncarati et al., 2025).
- Rural communities in the United States tend to be more politically conservative, and available services may more often have a religious affiliation. While this may make collaboration complex, the limited number of people/organizations also present an opportunity. Familiarity and shared values can foster communication, and this in turn can lead to respect and enhanced teamworking amongst community partners. The impact may be felt more directly by stakeholders including health/legal systems, and they may therefore be more willing to offer support and resources.
- People may be additionally vulnerable to environmental risks and natural disasters due to the rural isolation and lack of access to urgent/emergent care or emergency shelters. Programs should coordinate with others to help people prepare beforehand and recover afterwards.
- Consider relationship building with natural area maintenance crews and wildlife/habitat workers.

- Advocate with other community agencies and stakeholders on the needs of those who are unsheltered and preventing others from becoming unsheltered (NAEH, 2010).

Narratives and Experiences

From Morgan Buda, MD, East Tennessee State University in Tennessee:

Our Street Medicine programs in Johnson City, Kingsport, and Bristol, TN, three small cities embedded between the Blue Ridge Mountains and the Great Appalachian Valley, may be in their infancies but already show innovation and resilience - just like our patients and communities. Family Medicine was awarded a \$2.4 million Health Resources and Services Administration training grant to fully fund the programs. We are inspired by our Appalachian culture that emphasizes resourcefulness, mutual aid, and solidarity. In our short time as a program, I repeatedly hear profound realizations during our outreach from the team, whether from resident physicians, pharmacy technicians, case managers, or social workers, and it's some form of "This is what I signed up to do in my career". What is that of which they speak? I suspect it's connecting with our patients, our community, and discovering deeper purpose in work. The fragmentation of health care and social services available to patients experiencing homelessness remains ever present, even oppressive, but the street medicine model takes healthcare workers away from our computers, clicks, checkboxes and brings us directly to marginalized and vulnerable people.

At first, our new team walked through downtown and wooded encampments asking if we could talk with folks, who were initially (and reasonably) hesitant and untrusting. We kept showing up, and slowly but surely we were given the opportunity to listen. Case in point, word of mouth in our communities recently saw us hiking to an unknown encampment to a patient asking for "that street team" to come meet her and treat her worsening lower extremity cellulitis. These days, we're still listening and learning, and we're increasingly able to address patient's needs and help them navigate support networks because of their developing trust in us.

From Tim Nolan, NP, High Country Community Health in North Carolina:

Our program started initially as a collaboration with a local mobile harm reduction agency. By initially meeting the unhoused community by providing them with clean injection supplies, a deep trust within this marginalized network was established. It rapidly became apparent that other services were both necessary and wanted, including treatment of hepatitis C infection, low barrier MAT care, and significant behavioral health care including prescription management and trauma-informed therapy. All of this was implemented without the individual needing to come to a clinic appointment, as this would only present another barrier in our rural community. All of these services continue, along with wound care and varying levels of both primary and urgent care, in the setting of unhoused and underhoused individuals living in rural North Carolina. And all of it is still initiated within the provision of harm reduction services.

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SMI Resources

These resources cover care in both rural and small town settings.

[Street Side Podcast](#) Episodes

- Innovation in Allentown with Seth Campbell, PA (March 7th, 2026)
- HOPE Services Hawai'i - finding 'āina through street medicine (August 3rd, 2025)

[Street Medicine ECHO](#) Webinars

- Meet the TABLE: Integrating People Experiencing Homelessness into Programs and the Broader Community (April 2026)
- Running a Rural Street Medicine Program (October 2025)
- Trauma-informed Care (December 2023)

References/Additional Reading

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