The Last Mile:

HIV Street Medicine to Reach the Unsheltered

Tyler B. Evans, MD, MS, MPH, DTM&H, FIDSA

Continuum 2026 • June 22-24, 2026 • Puerto Rico

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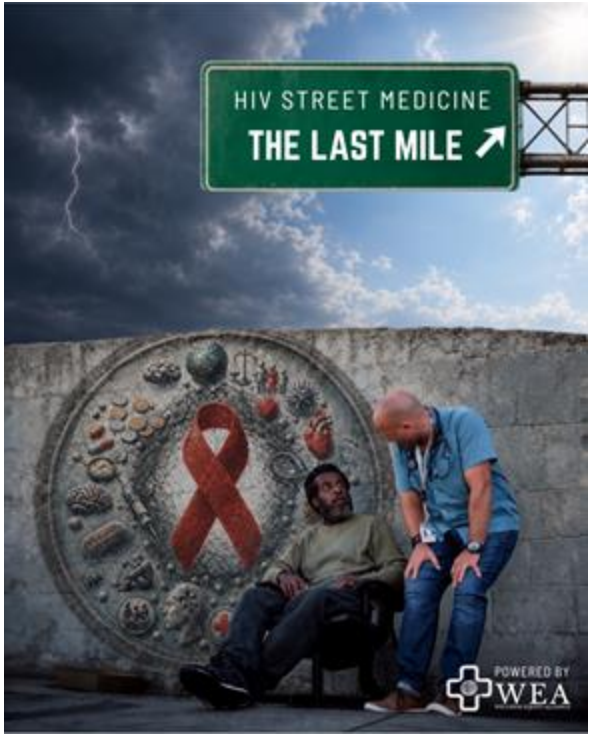


Tyler B. Evans, MD, MS, MPH, DTM&H, FIDSA

Chief Executive & Medical Officer (CEO/CMO) & Founder, Wellness Equity Alliance

Adjunct Associate Professor, USC Keck School of Medicine

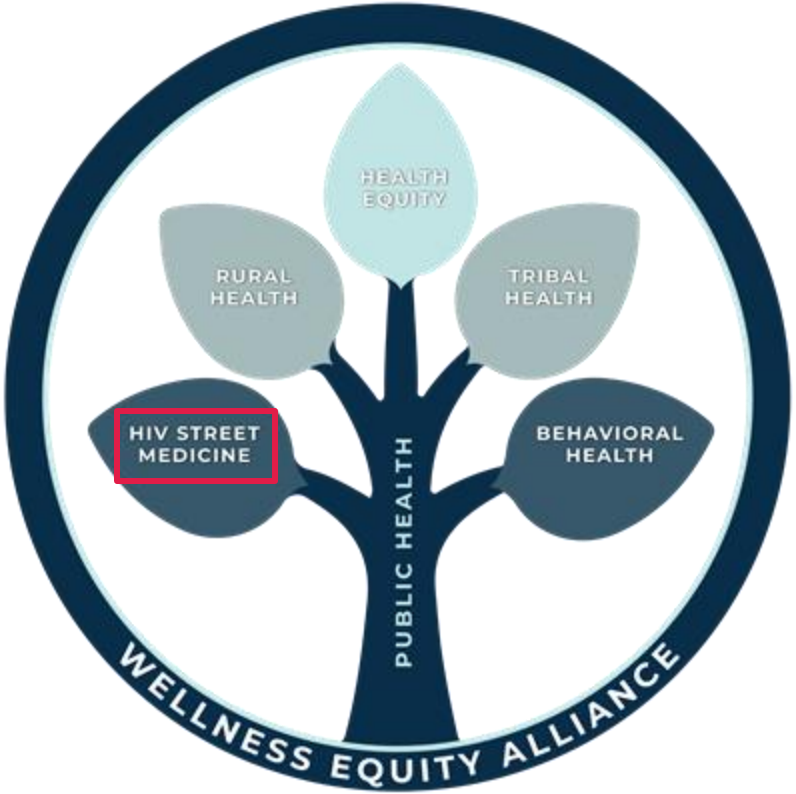
Former: CMO, NYC COVID-19 Response | Curative | Marin County HHS

Author: *Poverty, Pandemics, and Politics*

20+ year career spans 20+ countries, from Ebola in West Africa to COVID-19 in the U.S., always at the intersection of medicine and equity.

"We're living in a world where millions die every year of their impoverishment... and it's absolutely unnecessary."

Who Is WEA?



Meeting People Where They Are

Students and Families

Rural & Indigenous Communities

People Experiencing Homelessness

LGBTQIA+

Migrants and Refugees

Justice-Impacted Individuals

Inside Facilities

On the Streets

In The Community

Street Medicine with WEA

Health Equity in Action

WEA
WELLNESS EQUITY ALLIANCE

A national alliance of population and public health leaders

Serving:

- Los Angeles
- San Diego
- New Mexico
- San Bernardino
- Riverside
- Colorado

Bringing care directly to communities outside traditional healthcare settings

Combining on-the-ground expertise with innovative tech to reduce barriers

The Last Mile Team

WEA
WELLNESS EQUITY ALLIANCE

UNIVERSITY OF MIAMI

Center for Health Care Strategies

Community Health Center, Inc.

Keck Medicine of USC

Healthcare IN ACTION

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HIV Street Medicine: The Last Mile

Meet J

The Face of HIV Street Medicine

Patient Case: Meet J

Clinical Presentation

J is a chronically unsheltered, wheelchair dependent 57 y/o cisgender gay man from Israel presenting to us in a parking lot c/o acute on chronic nonproductive cough and dyspnea.

Social History

He endorses methamphetamine use and cigarette smoking. He was **previously incarcerated for 20 years**. He notes he was **kicked out of every shelter and CBO due to violent behavior.** Chronic homelessness has also resulted in the **loss of medications.**

Physical Examination

- Fever (**101.4 F**), **hypoxemia** (SpO2 <88%)
- **Tachycardia** (HR: 110)
- Pulm: **Wheezing** & **RLL rhonchi**

Past Medical History

HIV/AIDS (1992): nadir CD4 <30, prior PCP & cocci

Liver: Decompensated cirrhosis, ascites, hepatic encephalopathy

Substance Use: Methamphetamine & ETOH disorders

Neurological: C-spine injury (C4), wheelchair dependent

Other: COPD, HTN, GERD, Polyneuropathy

Prior Hep A, B, C exposure; SVR; DAA use unclear

Relevant Laboratory Results

CD4: <30 cells/μL **(L) [nadir]**

CD4/CD8 ratio: 0.09 **(L)**

% pos CD4 lymphocytes: 6% (L)

WBC: 2.2 **(L)**

Platelets: 90 **(L)**

Mycoplasma hominis: (+)

Ureaplasma: (+)

RPR: Reactive, 1:2

Hep A Ab: (+) Hep B core Ab: (+)

HCV Ab: Reactive

Patient Case: Meet J

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EMS activated with rapid transport to local med center. J has now:

- Transitioned to LAI; cabotegrovir
- Achieved stable housing via our housing coordination
- Maintained virologic suppression
- And d/c methamphetamine and cigarette use

Meet J

Poll 1: Patient Case & Management

Despite reported adherence to ART, J experienced recurrent interruptions in medication access secondary to housing instability and fragmented healthcare engagement. He presented with profound immunosuppression (CD4 count <30 cells/μL), severe hypoxemia (SpO_2 <88%), and wheelchair dependence. His care was further complicated by exclusion from multiple shelters and CBOs due to violent behavior, as well as repeated episodes of leaving the hospital AMA.

How would you manage this patient?

a) Restart oral ART and schedule routine clinic follow-up only

b) Focus on housing placement before addressing HIV care

c) Refer to the emergency department whenever medications are lost

d) None of the above

Meet J

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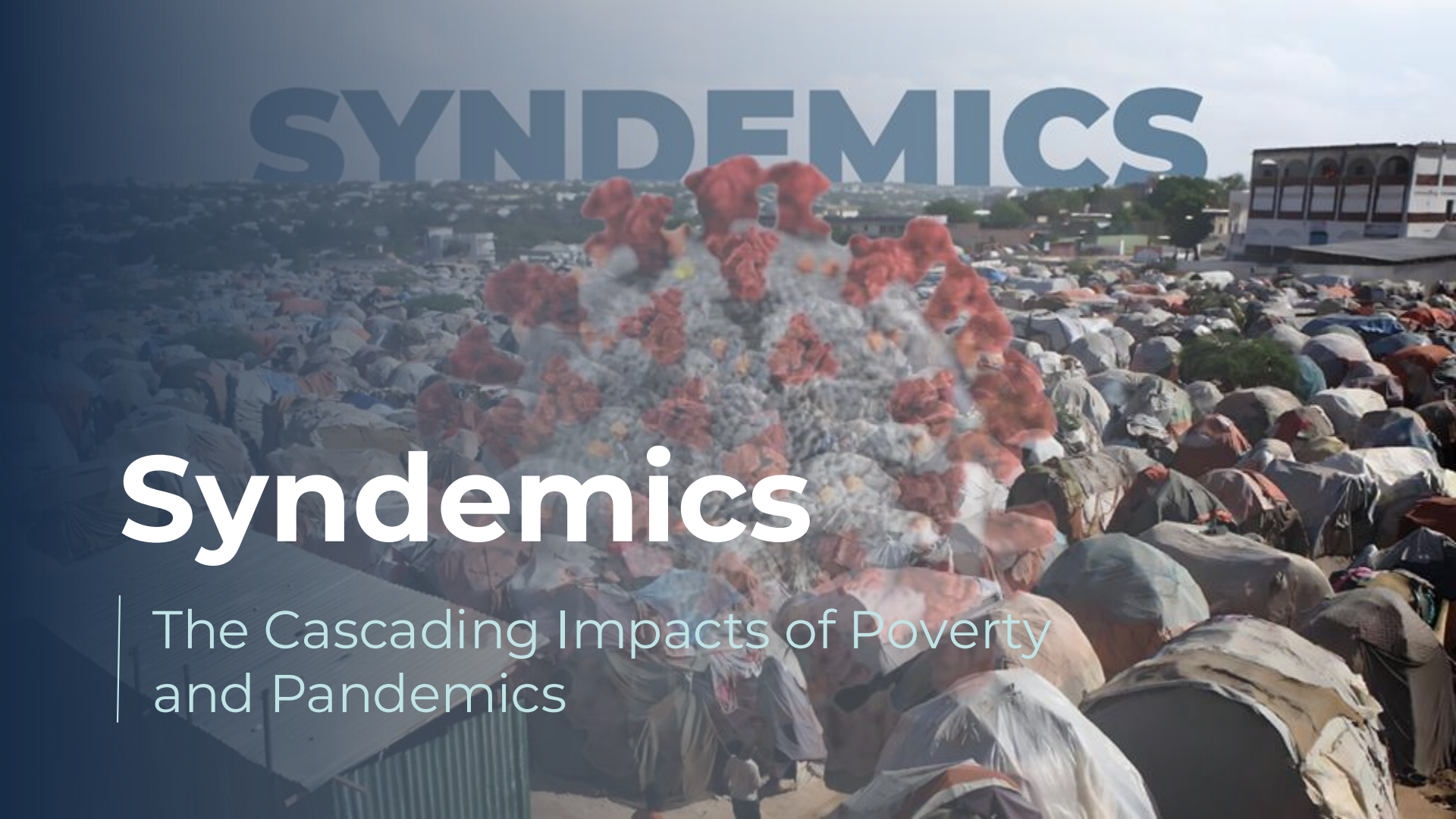
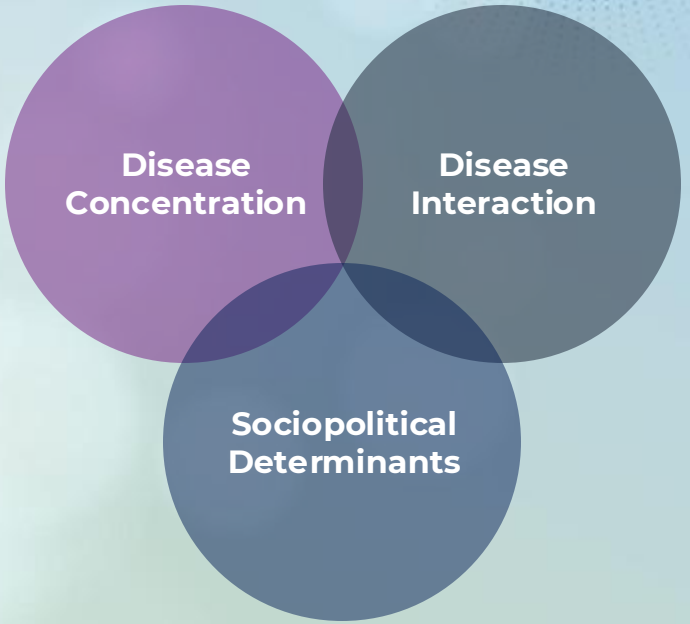


Syndemics

The Cascading Impacts of Poverty and Pandemics

What Are Syndemics?

- **A synergistic epidemic of more than one epidemic colliding and causing an amplified outcome.**
- **They are driven by disparities that are largely socially-determined, and should include the following criteria:**
  - Two or more epidemics must co-occur within certain contexts (disease concentration)
  - They must interact in meaningful ways, often through biological processes but potentially through social or psychological processes (disease interaction)
  - They must share one or more upstream factors driving their co-occurrence and interaction, which may include dynamics that are structural, social, cultural, ecological and economic in nature. (sociopolitical determinants)



CREDIT: SINGER

Disease Concentration Among People Experiencing Homelessness

HIV++

HIV: 3-5x prevalence vs. general pop. [1]

TB Incidence: 34-452x higher, depending on the setting [2]

HCV Prevalence: 4%–36.2% [2]

STIs

Composite prevalence: 7.3% to 39.9% [3]

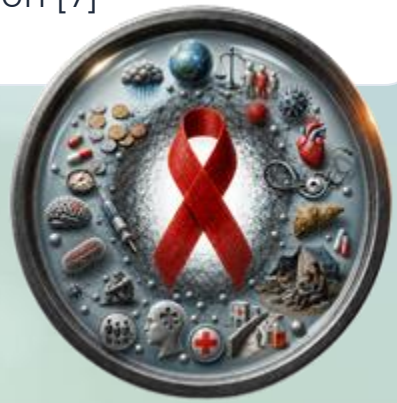
Chlamydia/gonorrhea: Peaking at 7.8%–13.2% in younger populations [4]

Mental Health & SUD

SUD: 30%–50% of PEH (4-5x housed) [5]

Serious Mental Illness: 25%–32% prevalence [6]

Co-occurring psychiatric illness and SUD are common [7]



"Diseases don't just coexist – they compound through inequity."

HIV and Homelessness

The Bigger Picture

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HIV Street Medicine: The Last Mile

THE SCALE

30–50%

of people living with HIV will experience homelessness.

HIV prevalence in urban homeless is 10–20% vs. 0.4% nationally.

HOW WE GOT HERE

1980s–90s: Epidemic collided with deinstitutionalization & War on Drugs.

2000s–Pres: Housing became the strongest predictor of mortality.

Today: Mutually reinforcing epidemics of HIV & homelessness.

THE POLICY CASE

HOPWA (1990)

The only federal housing program dedicated to PLWH — proved housing is health infrastructure.

EHE INITIATIVE (2019)

Goal of 90% reduction in new HIV infections by 2030 is unreachable without a paradigm shift

STREET MEDICINE

Yields **55% viral suppression** within 6 months — meeting patients where they are.

Addressing homelessness is a public health intervention — and the missing last mile of the HIV response.

The Suppression Gap

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Housing instability is the primary barrier to viral suppression — and to ending the epidemic.

Unhoused

32%

achieve viral suppression

Treatment failure • Drug resistance
Higher viral loads • Higher transmission

VS

Stably Housed

75%

achieve viral suppression

Consistent ART • Viral suppression
Undetectable = Untransmittable (U=U)

Same drugs. Same science. Different address. This is a delivery failure — not a treatment failure.


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Science
When Policies Clash with the Data

The Attack on Science

The Rise

The growing global assault on scientific institutions, expertise, and evidence-based research directly threatens public health by undermining vaccination efforts, weakening pandemic preparedness, and emboldening policies that prioritize ideology over data-driven solutions that save lives.

MISINFORMATION | POLITICAL POLARIZATION | ERODING PUBLIC TRUST

The Impact

- Disempowered agencies
- Polarized health messaging
- Regional public health fiefdoms
- Global impact

Political Disinformation

Politicization of public health leads to systemic failure.

"When science is politicized, systems collapse and inequity widens."

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Systems

"Broken systems create broken outcomes."

Rudolph Virchow, 1848

The Four Types of Systems

Hospital Networks

Community Health

Public Health

Population Health

A Primer in Health Systems

- Healthcare ≠ Health
- The Systems in Place Are Not Communicating

The Systems

Poll 2: Patient Case & Management

J was discharged from incarceration with ART and was eligible for multiple social services. Yet he experienced recurrent treatment interruptions and progressive clinical decline.

What is the most appropriate intervention?

a) Re-refer J to the social services programs he was previously eligible for and ensure he has a follow-up appointment at the HIV clinic

b) Contact his parole officer to help coordinate care compliance and medication adherence

c) Deploy a street medicine team to meet J where he is, delivering ART, wound care, and wraparound services without preconditions

d) Admit him to a skilled nursing facility for medication management and stabilization

The Systems

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The Streets
Revolution in Street Medicine

Philosophy of Street Medicine

Meeting Patients where They Are

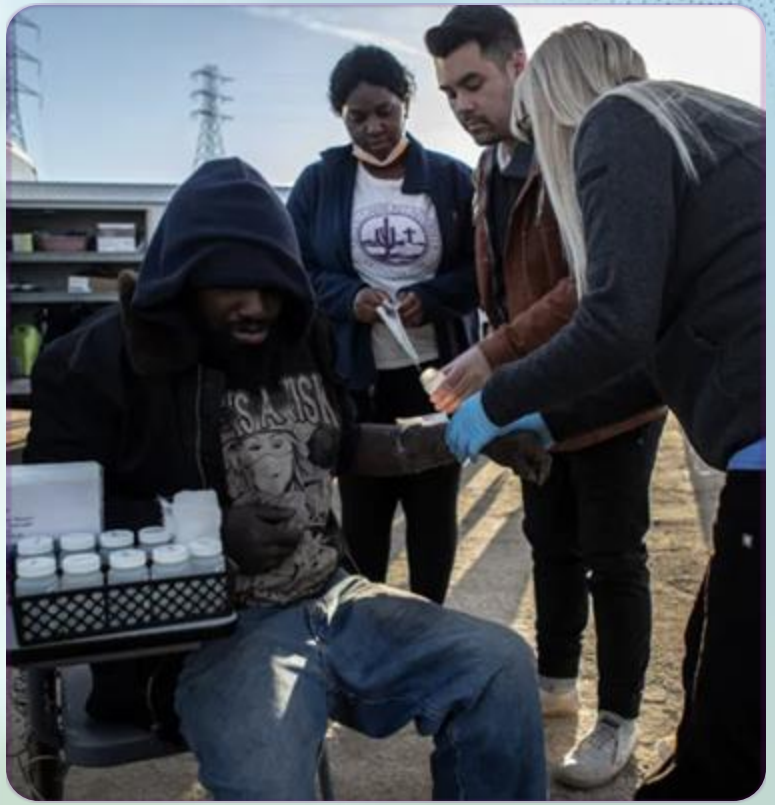
Street medicine brings care directly to individuals — **accepting patients entirely as they are, where they are.**

Radical Trust Over Institutional Authority

Prioritizes the **therapeutic relationship** above all else; for those failed by institutions, **trust is the treatment.**

Addressing Root Causes

Practitioners become **advocates for structural change** — recognizing that a prescription alone cannot fix what policy and society have broken.



History of Street Medicine

The Pioneering Era

Dr. Jim Withers pioneered Street Medicine in the early 1990s in Pittsburgh, Pennsylvania, specifically for the homeless population.

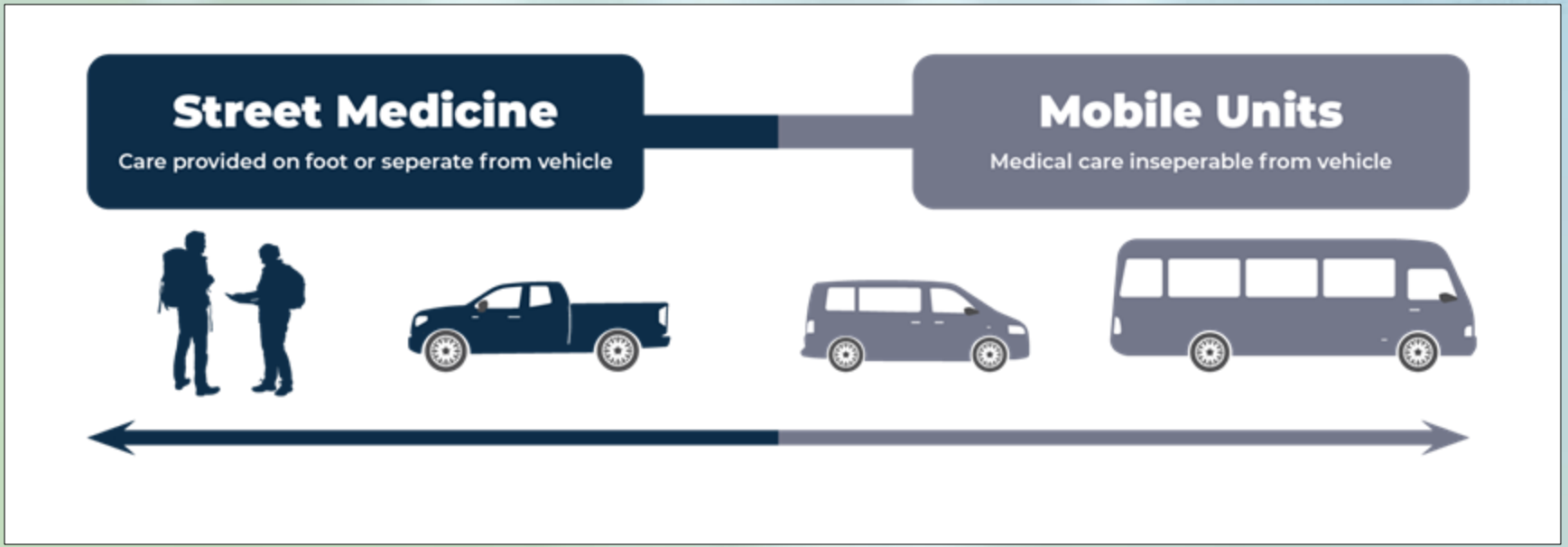
A Global Evolution

What started as a local initiative in the U.S. has now evolved into a significant global movement.

Core Philosophy

The concept emphasizes delivering healthcare directly to those living on the streets, meeting them where they are.

Continuum of Medical Outreach



The WEA Way: Public Health Perspective

Effective street medicine models should integrate multiple relevant specialties to meet patients where they're at.

Public Health Systems

Focuses on Protecting and Improving Health of people and their communities.

Many public health systems in the US are not connected to direct clinical services.

Street Medicine

Allows Public Health and clinical services to intersect and address top priorities:

- Communicable disease and control prevention
- Behavioral health prevention and treatment

Clinical Services
(Community Health)

Due to disconnections, both clinical services and public health systems are prone to emergency management.

Street Medicine extends public health mission into the streets, directly reaching the unhoused or street involved populations who are often disconnected from traditional healthcare systems.

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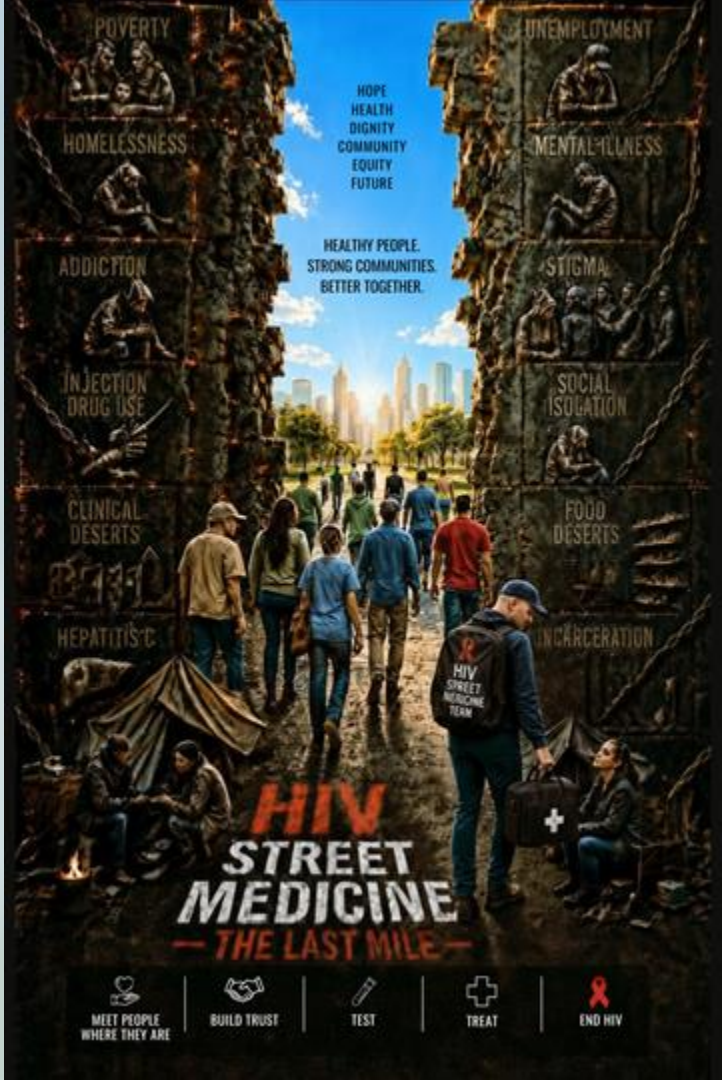
HIV Street Medicine

The Last Mile



Why HIV Street Medicine Matters?

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HIV Street Medicine: The Last Mile

Prevention

Homelessness Barrier
Severely limits access to primary care, disrupting the path from exposure to PrEP and treatment.

The Care Continuum

Prevention → Testing → Treatment → Prescription → Suppression

Street medicine removes barriers at every stage.

Key Statistical Comparisons

Metric	General Population	People Experiencing Homelessness
HIV Prevalence	~0.4% (US)	**3–10%+** (varies by city/study)
New Infection Risk	Baseline	**2–10x higher**
PrEP Uptake	~30% of eligible	**<10% of eligible**
HIV Testing Rates	Moderate	Lower, more inconsistent
Viral Suppression	~65–70%**	**~30–50%**
Linkage to Care	Higher	Significantly lower

ELSEVIER

JOURNAL OF ADOLESCENT HEALTH

www.jahonline.org

Original article

Knowledge and Attitudes About Pre-Exposure Prophylaxis Among Young Adults Experiencing Homelessness in Seven U.S. Cities

Diane Santa Maria, DrPH.[a,*], Charlene A. Flash, M.D., M.P.H.[b], Sarah Narendorf, Ph.D[c], Anamika Barman-Adhikari, Ph.D.[d], Robin Petering, Ph.D.[e], Hsun-Ta Hsu, Ph.D.[f], Jama Shelton, Ph.D.[g], Kimberly Bender, Ph.D.[d], and Kristin Ferguson, Ph.D.[h]

[a] *Department of Nursing Systems, Cizik School of Nursing, The University of Texas Health Science Center at Houston, Houston, Texas*
[b] *Department of Medicine, Division of Infectious Disease, Baylor College of Medicine and Legacy Community Health, Houston, Texas*
[c] *Graduate College of Social Work, University of Houston, Houston, Texas*
[d] *Graduate School of Social Work, University of Denver, Denver, Colorado*
[e] *Suzanne Dworak-Peck School of Social Work, University of Southern California, Los Angeles, California*
[f] *School of Social Work, University of Missouri, Columbia, Missouri*
[g] *Silberman School of Social Work, at Hunter College, New York, New York*
[h] *School of Social Work, Arizona State University, Phoenix, Arizona*

Santa Maria, et al. (2018)

A B S T R A C T

Purpose: Evidence suggests that young adults experiencing homelessness (YEH) are at elevated risk of HIV compared to housed youth. Given the limited research on pre-exposure prophylaxis (PrEP) awareness among YEH, this study examined their PrEP knowledge and attitudes.

Methods: Data from a cross-sectional survey among YEH (ages 18–26) (n = 1,427) in seven U.S. cities were used to assess their knowledge and attitudes regarding PrEP to inform HIV prevention efforts.

Results: Participants were primarily male youth of color. The mean age was 20.9 years. While 66% felt at risk for HIV, only 14% strongly agreed that they try to protect themselves from getting infected with HIV. Most (84%) were eligible for PrEP based on risk, yet only 29% had knowledge of PrEP. Despite this, 59% reported they were likely/extremely likely to take PrEP. Access to free PrEP (55%), HIV testing (72%), healthcare (68%), and one-on-one (62%), and text messaging support (57%) were rated as very/extremely important for PrEP uptake and adherence.

Conclusions: The results of this study suggest missed opportunities to prevent new HIV infections among YEH. Efforts to increase PrEP uptake among this population should consider provider- and system-level interventions to increase PrEP awareness, decrease PrEP-associated healthcare costs, improve access to PrEP providers, and provide in-person and text messaging support.

IMPLICATIONS AND CONTRIBUTION

Despite evidence that YEH are more likely to get HIV than their housed peers, PrEP awareness is low. However, once informed, the participants in this study showed interest in PrEP and endorsed several factors that can support PrEP uptake and adherence.

Santa Maria, et al. (2018)

Why HIV Street Medicine Matters?

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HIV Street Medicine: The Last Mile

From Testing to Treatment

The Care Continuum

Prevention → Testing → Treatment → Prescription → Suppression

Street medicine removes barriers at every stage.

Homelessness Barrier
Severely limits access to primary care, disrupting the path from exposure to PrEP and treatment.

HIV positive → ✕ **Testing** → **Treatment** → **Suppression**

Homelessness
(= Failure in accessing Primary Care)

Why HIV Street Medicine Works

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HIV Street Medicine: The Last Mile

Street Medicine delivers care where people live, while building the trust and relationships that traditional systems never could.

Meets patients in their environment

Removing logistical barriers that keep the unsheltered from ever walking through a clinic door.

Prioritizes trust and continuity

Same faces, same team, until the relationship earns the treatment. Consistency is the core of healing.

Treats the whole person

Medical care, behavioral health, and social needs addressed together, breaking down traditional silos.

Why HIV Street Medicine Works

#CONTINUUM2026
HIV Street Medicine: The Last Mile

Reduction to the Bottom Line

$2.50 Saved

For every $1 invested in supportive housing and street-level care*

40% Reduction

In ER utilization among chronically homeless individuals**

Street medicine programs have been shown to **significantly reduce** costly **emergency department visits and hospitalizations.**

These initiatives translate into **millions of dollars in savings** annually for **hospitals and healthcare systems** that would otherwise absorb the cost of uncompensated emergency care.

* Lynch KA, Harris T, Jain SH, Hochman M. The case for mobile "street medicine" for patients experiencing homelessness. *J Gen Intern Med.* 2022;37(15)
** Gillespie, S., Hanson, D., Oneto, A. D., et al. (2021). Costs and offsets of providing supportive housing to break the homelessness-jail cycle: Findings from the Denver Supportive Housing Social Impact Bond Initiative. Urban Institute.

How HIV Street Medicine Works

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HIV Street Medicine: The Last Mile

Rethinking the Operational Model for Effective Care

Patient-Centered Care Plan

Integrated Support Team

Coordinating RNs, Mental Health specialists, and Social Workers into a cohesive plan that prioritizes personal goals and crisis management.

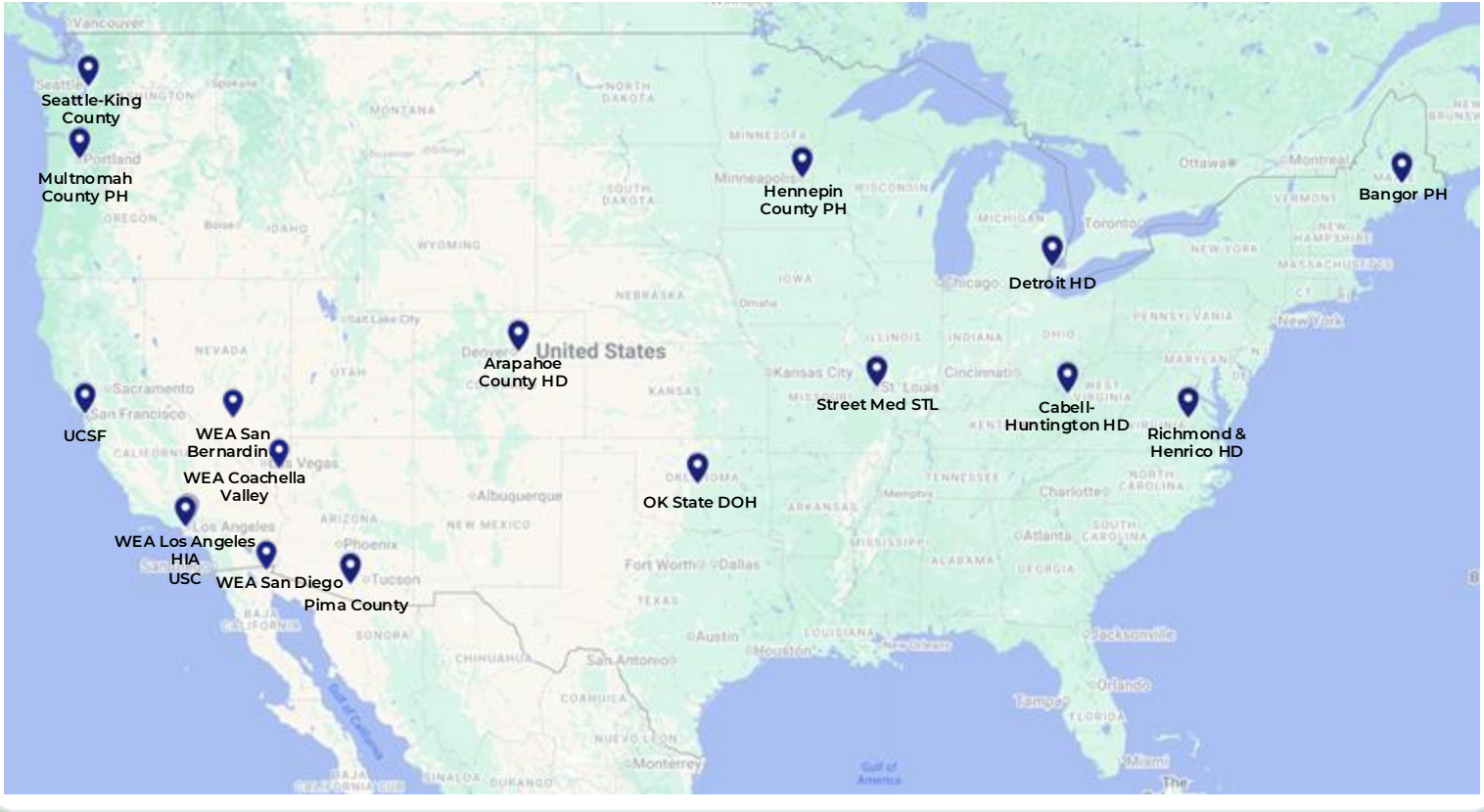
Street Medicine Team Composition:

0.25 FTE Chief Medical Officer
0.20 FTE Chief Nursing Officer
0.25 FTE Program Manager
1.00 FTE RN Care Manager / NP / PA
2.00 FTE CHWs / Navigators
0.01 FTE Consulting Psychiatrist

Equitable HIV Prevention and Treatment Delivered Directly to Patients

Where?

Boots on the Ground



The Future...

HIV street medicine is the solution to ending the HIV epidemic in the U.S.

Epidemics do not exist in **silos** - we must frame all efforts from a **syndemic** standpoint.

We need to invest in **integrated systems** that connect public health, healthcare, and population health.

Leverage **data on social drivers** to determine where to invest protection efforts.

Double down on the most vulnerable and historically marginalized.

We must engage in Humanitarian Entrepreneurship with multi-sectoral responses to scale innovative solutions.

The End is in Sight

HIV Street Medicine | The Last Mile

01

Access over Science

Ending the HIV epidemic is no longer a question of science but of **access**.

02

National Pathway

HIV Street medicine provides a **powerful pathway** to bring equitable care directly to those who need it most.

03

The Opportunity

Focused policy action between cities, counties, states and providers allows the U.S. to move closer to **EHE**.

Ending the HIV Epidemic

Integrated Clinical Service Delivery Models Work: Testing + Treatment + Behavioral Health + Primary Care

Closing the Last Mile

Why It Matters Now

We are closer to ending the HIV epidemic than at any point in history.

The science works. The tools exist.

We just need to close the last mile.

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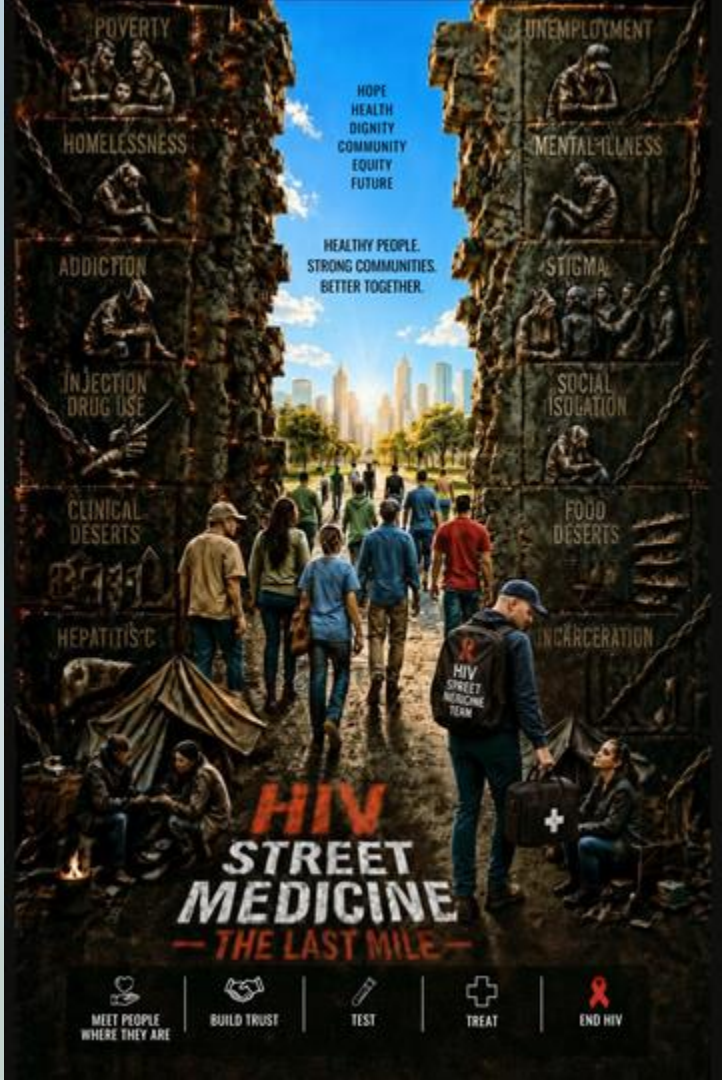
HIV Street Medicine

The Last Mile



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HIV Street Medicine: The Last Mile

Thank You

Visit the WEA Team at Booth 10

Tyler Evans, MD, MS, MPH, DTM&H, FIDSA

Co-Founder, CEO | Wellness Equity Alliance

tyler@wellnessequityalliance.com

WEA
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I am the Proof

Khafre Kjuichagulia Abif, MLS

Continuum 2026 • June 22-24, 2026 • Puerto Rico

Featured Presenter

#CONTINUUM2026
HIV Street Medicine: The Last Mile

Khafre Kjuichagulia Abif, MLS

Founder & Executive Director
Cycle for Freedom, Inc.

Advocacy & Experience

Person Living with HIV • Bisexual • Community Health Advocate

- Program Director, THRIVE SS; Community Organizer, Southern AIDS Coalition
- MLS, Library Science, University of Pittsburgh • BA, Africana Studies
- Federal advocate on HIV and bisexual health equity
- Honored by POZ 100 and PLUS Magazine's 75 Most Amazing HIV+ People

"From the streets to undetectable: a life at the intersection of lived experience and public health practice"

The Past

My life on the street.
My diagnosis.

The Past

Life on the Street

"Unhoused does not mean unseen.
It means the system looked away first."

Being unhoused is not a moral failure — it is the end result of systems that were never designed to catch everyone. I lived it. I know what it feels like to be invisible, to be a number, to be handed a pamphlet instead of care.

The Past

A Diagnosis with Reality

What Care Looked Like

A pamphlet & hotline number.

Referrals impossible without phone, address, or transport.

Inflexible clinic hours.

Housing status seen before the person.

A Reality Check

Sex is a reality for the unhoused.

Testing without treatment was the norm.

Hiding a diagnosis was about **survival**, not shame.

What Was Missing

Proactive outreach.

Trust, continuity, and familiar faces.

Stability-independent care.

Unified understanding of homelessness and HIV.

Comorbidities

HIV is one thread in a complex syndemic.

Poor Oral Health

Podiatry Needs

These symptoms don't just co-exist; they exacerbate each other.

The Present

What street medicine actually looks like from the receiving end.

The Present

HIV In Remission

U=U

Undetectable = Untransmittable

I am in remission.
This is what the science made possible.
This is what street medicine made accessible.

Remission is not just a clinical outcome.
It is the restoration of a life.

I can now stand in front of a room like this one and say: I was that patient. I was the last mile. And I made it, because someone came to where I was.

The Present

What's Working

TRUST

They showed up consistently. Same faces. No judgment about where I was or what I'd done.

TREATMENT

ART on the street. Not a voucher for somewhere else — actual medication, actual monitoring, in my world. Scheduling to keep me on track and in remission.

HUMANITY

When public opinion no longer outweighed humanity. They asked about my life, not just my viral load.

"They came to me. They didn't wait for me to get it together enough to come to them."

The Future

What I'm asking of you.

The Future

People Like You

What it takes:

Passionate people
To complete this last mile together.

A willingness to commit
Resources & manpower to ending the epidemic.

The Future

What You Can Do

payments

Fund it.

Street medicine programs are chronically under-resourced. The evidence is there. The ROI is there. What's missing is the political and financial will. Prioritize it.

record_voice_over

Change the language.

Stop saying "hard to reach." We are not hard to reach. We are easy to ignore. The patient who is homeless is not non-compliant, the system is non-compliant with their life.

volunteer_activism

Build trust first.

Every model that works — every single one — starts with trust, not treatment. Go where people are. Show up consistently. Earn the relationship before you prescribe anything.

"I was the last mile. Make sure the next person doesn't have to wait as long as I did."

"Unhoused does not equal unworthy. Every person living outside tonight is someone's last mile."

— Khafre Kujichagulia Abif, MLS

Thank You

Khafre K. Abif, MLS

Founder/Executive Director Cycle for Freedom, Inc

khafrekujichaguliaabif@gmail.com