Thinking Beyond the Emergency Department: Addressing Homelessness in Residency Education

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INTRODUCTION

There is no universal definition of homelessness which can make identification of those suffering from lack of shelter particularly challenging in an emergency department (ED) setting. The term itself is multifaceted and encompasses an ever-changing spectrum of patients who frequently present to EDs to address their health care needs.

The United States (US) Public Health Service Code defines being homeless as being an "individual who lacks housing, including an individual whose primary residence is a supervised public or private facility that provides temporary living accommodations and an individual who is a resident in transitional housing."[1] It further breaks down forms of homelessness as chronic, episodic, transitional, and hidden (Table 1).

The US Department of Housing and Urban Development uses 4 distinct categories to further characterize people experiencing homelessness relative to applying for homeless assistance. They define homelessness as literally homeless, imminent risk of homelessness, homeless under other federal statutes, and fleeing/attempting to flee domestic violence (Table 2).[2] Per their definitions, the Department of Housing and Urban Development estimated that 580,000 people were homeless on any given night in 2020 and approximately 3.5 million Americans experienced an episode of homelessness in a given year.[3]

In this narrative review, we will focus on people experiencing homelessness in relation to the ED. We will describe factors contributing to homelessness, the medical vulnerabilities of people experiencing homelessness, and their barriers to care. We will then discuss how emergency physicians and emergency medicine residencies can provide education on these issues when training residents. We will offer different interventions that can be used at the bedside, hospital, and community levels to improve quality of care for people experiencing homelessness.

FACTORS CONTRIBUTING TO HOMELESSNESS

Educating emergency physicians on the factors contributing to homelessness is integral to understanding the health care barriers of people experiencing homelessness. While not fully inclusive, this section will address some contributors to the lack of adequate shelter.

Adverse Childhood Experiences

Adverse childhood experiences are traumatic events that occur before adulthood (eg, foster care, childhood abuse) and can lead to delinquency, legal troubles, and reduced access to family resources, all of which can increase the risk of homelessness.[4,5] Children who move multiple times are more likely to have a chronic disease diagnosis, poorer physical health, and lack of adequate medical insurance.[6] Although multiple moves could be for a variety of reasons, this social finding may represent a clue to earlier identification of children suffering from unstable housing, which may precede homelessness.

Incarceration

Individuals with a history of incarceration often find it difficult to reestablish themselves in society due to social stigmas, psychosocial trauma, and parole limitations.[5] People who have been incarcerated experience homelessness at a rate 7 times higher than that of the general public, and those incarcerated more than once have homelessness rates 13 times higher.[7] Moreover those with a history of incarceration were still likely to have housing instability 5 years later.[8]

Policy

The convergence of several federal and state-level policy decisions led to a steep rise in homelessness in the 1980s.[9] Wage stagnation, cuts to social welfare programs, economic recessions, and medical bankruptcies have forced many into financial difficulty in the past 50 years. Today, there are inadequate supplies of affordable rental units for extremely

Table 1. Definitions of homelessness per the US Public Health Service Code.[1]

Category Characterizing Homelessness	Definition
Homeless (general)	An individual who lacks housing, including an individual whose primary residence is a supervised public or private facility that provides temporary living accommodations and an individual who is a resident in transitional housing
Chronic homelessness	Being homeless for longer than 1 year, with nearly 15% of individuals remaining homeless for extended periods spanning multiple years
Episodic homelessness	A person who has experienced >3 episodes of homelessness within a given year
Transitional homelessness	Results from major life change or catastrophic events, such as a natural or man-made disaster
Hidden homelessness	Individuals living "doubled up" with family or friends without immediate prospects for permanent housing

low-income families in nearly every state in the United States.[10] Without proper housing, it becomes difficult to overcome barriers to employment (eg, substance use, homelessness-related anxiety), leading to a cycle of homelessness.[11]

Mental Health and Substance Use

Studies suggest that mental illness and cognitive disability are associated with homelessness due to reduced ability to maintain employment and housing,[12,13] higher risk for substance use,[14] more limited social networks,[13,15,16] and limited or absent family support.[12,16] National data shows that approximately one third of people experiencing homelessness have mental health conditions and 50% have co-occurring substance use disorders.[17] The combination of poor social support, lack of access to mental health and addiction services, and continued substance use worsens the cycle of homelessness and places individuals at risk for overdose and prolonged mental illness.[5,18]

Moreover, the process of deinstitutionalization from state psychiatric facilities that was initiated in the 1950s without the augmentation of outpatient and community mental health services forced many people with mental health conditions into a cycle of moving between group homes, their own homes, and the streets.[19]

Structural Racism

Minority groups have made up a disproportionate percentage of the population living at or below the poverty line.[20,21] In 2020, Black Americans, American Indian/Alaska Natives, and Hispanic/LatinX people accounted for 39.4%, 3.3%, and 22.5% of the homeless population, respectively.[3] There are pervasive systemic features that perpetuate this inequality, and the contributions of systemic racism and substantial racial disparities could easily be discussed in an entire review alone.

An example is the segregation of low-income housing by race coupled with the lack of available affordable housing

Table 2. Definitions of homelessness per US Health Resources and Services Administration US Department of Housing and Urban Development.[2]

Category Characterizing Homelessness	Definition	Source
Homeless individual	An individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations and an individual who is a resident in transitional housing	HRSA
Literally homeless	Persons who lack fixed and adequate nighttime residence	HUD
Imminent risk of homelessness	Individuals or families who will imminently lose their primary nighttime residence within 14 days of applying for homeless assistance	HUD
Homeless under other federal statutes	Unaccompanied youth under 25, or families with children who do not qualify as literally homeless but have not had a lease, ownership interest, or occupancy in permanent housing during the 60 days prior to homeless assistance application and can be expected to continue in such status for an extended period	HUD
Fleeing/Attempting to flee domestic violence	Homeless as they attempt to escape domestic violence, have no other residence, and lack resources to obtain permanent housing	HUD

HRSA, US Health Resources and Services Administration; *HUD*, US Department of Housing and Urban Development.

for the number of individuals in need. There are 3 families on a waitlist for a housing voucher for every 1 family with an active voucher.[22] In Chicago, the majority of low-income developments are constructed in high-poverty, majority-Black areas.[23,24] Black family recipients of federal housing subsidies are less likely to result in movement to an area with lower amounts of poverty compared to White families,[25] which could be explained by existing family or community ties, proximity of landlords willing to accept housing vouchers, and short expiration dates on vouchers.[25]

Economic Stability

Food insecurity is associated with postponing medications,[26] and housing instability has been suggested to lead to postponing medical care.[26] People working full-time, minimum-wage jobs may still live at or below the federal poverty line. As recently as 2004, a full-time, minimum-wage worker could make less than the poverty line for a family of 2.[27] One may be more likely to live in temporary housing to secure funds for other needs. The fragile financial juggling required to remain housed may explain how some are forced into a state of homelessness.

Disparities in Access to Education

Being from a lower socioeconomic status is associated with worse academic achievement and is a significant predictor of a child's academic future.[28] In an emergency housing shelter, a lower level of completed education was associated with a longer period since first homeless episode,[29] implying that less schooling predisposes one to chronic homelessness.

HOMELESSNESS AND THE ED

The ED often serves as one of the only points of contact with the health care system for people experiencing homelessness. As discussed, people experiencing homelessness chronically have greater social and medical vulnerabilities. They are predisposed to premature coronary artery disease, hypertension, and dementia.[30] They are also more likely to suffer from chronic injury, infectious diseases (eg, tuberculosis, HIV, hepatitis C), substance use disorder, acute traumatic injury, and mental illness.[31-34] Older homeless individuals are more likely to suffer further from geriatric syndromes, such as visual impairment, frailty, urinary incontinence, and functional impairment.[30,35] As a result, people experiencing homelessness chronically have a mortality rate 3 to 4 times that of the general population.[36]

People experiencing homelessness account for more than 500,000 ED visits annually in the United States and are 3 times more likely to use the ED than nonhomeless people.[37] They are 4 times more likely to have a repeat ED visit within 3 days and twice as likely to have a repeat visit within a week of hospitalization.[37] On average, people experiencing homelessness visit EDs 5 times annually, with nearly $19,000 spent annually per person experiencing homelessness.[38] Ku et al[37] found that increased ambulance utilization and ED use shortly after recent hospital care leads to significant monetary costs and exacerbates overburdened emergency care networks. However, a Canadian study reported increased ED usage despite increases in ambulatory access, suggesting that the reasons are beyond access alone.[39]

The common misconception that people experiencing homelessness mainly use the ED for shelter, food, and safety can lead to premature dismissal when, in fact, ED use among people experiencing homelessness is most often attributable to higher-acuity illness and medical needs.[30] A survey of 191 people experiencing homelessness in an urban ED found that only 29% of patients reported food, shelter, or safety concerns as their primary reason for their visit and this did not account for whether there was an additional medical component.[40]

Perhaps the greatest operational hurdle for emergency care of people experiencing homelessness is at discharge. Comprehensive planning is often required to ensure a safe shelter in addition to access to follow-up care and medications.

EMERGENCY DEPARTMENT INTERVENTIONS FOR PEOPLE EXPERIENCING HOMELESSNESS

We have identified 5 major areas for action that EDs can take to facilitate better care for people experiencing homelessness (Table 3).

Education

In light of these data, emergency medicine residency programs should incorporate training regarding specific health care needs of people experiencing homelessness to better prepare residents to care for this patient population. People experiencing homelessness are likely to be seen by a physician in training in the ED,[37] but most residents resort to pattern recognition, observation of others, and trial-and-error methods to learn how to care for people experiencing homelessness.[41,42] However, people experiencing homelessness are medically complex, and their needs often require physicians to revise their care plans accordingly. Salhi et al[43] described caring for the homeless as defying "traditional conceptions of health and health care delivery in [emergency medicine]…thereby challenging [emergency physicians] to engage with social determinants of health."

Table 3. Examples of emergency department-based interventions.

Category	Examples
Education	Learn about ongoing and changing dynamics of the housing system and intersections with health care.
Screening	Ask about a patient's housing status as part of a social history.
Resource Provision	Be familiar with available resources within the ED as well as community resources for shelter, warming centers, detoxification/addiction treatment, and meal resources.
Data Collection	Document appropriate ICD codes relating to a patient's housing status.
Community Outreach	Volunteer, fundraise, advocate, lead community workshops.

ICD, International Classification of Diseases.

Emergency medicine residents ill-equipped to address the social needs of people experiencing homelessness are more likely to feel frustrated or burned out.[42] ED staff may also begin to feel resigned about people experiencing homelessness with complex social needs and may be less likely to connect them with social resources due to perceived lack of ability to make an impact.[44]

Education should include an assessment of implicit bias toward people experiencing homelessness and efforts to overcome this. People experiencing homelessness often feel prejudged as "drug seeking" and feel that they receive worse care for chronic pain, addiction, and mental health disorders.[45] In simulation cases, medical students were less likely to reassess pain control in people experiencing homelessness than in identical patients of a higher socioeconomic status.[46] Terms in the literature such as "frequent flyer" and "super-utilizers" carry connotations that can remove humanity from people experiencing homelessness and affect their clinical care. Addressing unconscious bias requires awareness of its existence and deliberate integration of educational interventions to reduce the effects of unconscious bias.[47]

A dedicated curriculum composed of didactics and community exposures has been shown to evolve residents' attitudes toward caring for people experiencing homelessness.[48] Training should ideally make residents comfortable with asking about housing status, leading to improved identification of people experiencing homelessness, though additional research on the best method of education is needed. Residents who shadow a social worker in the ED increase their knowledge of the scope of a social worker and when to offer appropriate services.[49] Fostering relationships with local community organizations may allow residents to make connections and increase exposure to obstacles people experiencing homelessness may face.[50] To this end, some programs have integrated visits to local institutions addressing poverty into their orientation.[51]

The goal of dedicated education should be to equip residents with guidelines and standards of care for people experiencing homelessness to ensure that there is consistency in care. Prepared with these tools, residents can effectively use social services and community-based programs to assist people experiencing homelessness.

Screening

A pragmatic step in providing high-quality care for people experiencing homelessness is implementing universal social determinants of health screening. Asking all ED patients about housing status will broaden our identification of people experiencing homelessness, particularly the "hidden homeless."

Various screening tools have been developed and validated (Table 4). A simple 2-question screening tool (Figure) can be implemented in triage to identify individuals who require additional screening for interventions, with high sensitivity and specificity for

Table 4. Screening tools for patients experiencing homelessness.

Study Tool	Number of Questions	Time to Administer	Validated in ED Population	Diagnostic Accuracy
Montgomery et al[52]	2*	1 minute	No	Sensitivity: 83% Specificity: 86%
Doran et al[63]	2	1 minute	Yes	—
Fryling et al[64]	30	10 minutes (estimate)	Yes	—

*There are 39 additional questions if performing risk assessment during Stage II.

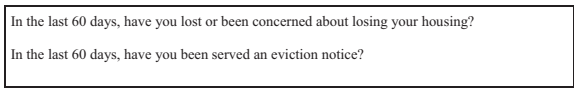

Figure. Example of screening tool. Adapted from Montgomery et al 2014.[52]

people experiencing homelessness.[52] One study of 1,929 ED patients who were not currently homeless found that 5% entered a shelter within 1 year of an ED visit.[53] A universal, well-integrated screening method has shown that newly homeless people frequently seek out health care in the time leading up to becoming homeless.[54]

We strongly recommend that providers also inquire about housing status as part of routine medical history taking. Failure to identify homelessness in the ED can result in missed opportunities for interventions.

Offering Resources

Unfortunately, people experiencing homelessness are often discharged without adequate support and follow-up.[44] Consequently, a frequent factor contributing to return ED visits in people experiencing homelessness is insufficient accounting for their social needs. Aside from screening, there should be processes in place to provide and deliver resources to people experiencing homelessness.

One approach is to improve access to insurance coverage and ambulatory care. A multicenter trial of uninsured children presenting to the ED demonstrated that simply handing out blank insurance applications nearly quadrupled the odds of successful enrollment.[55] Social workers may be able to link people experiencing homelessness with primary care clinics that have experience working with this higher-need population.[56] However, having medical insurance coverage and a primary care provider assignment is not enough to decrease ED utilization.[57]

Social workers familiar with available resources (eg, nearby shelters, warming centers, detox centers, meal resources) can intervene to address unmet social needs. Recognizing there may not be funding for continuous support staffing, it is important for emergency physicians to be aware of the resources specific to their community. Fortunately, data have suggested that most people experiencing homelessness present during daytime or early evening hours, which is when social workers are more commonly available.[58]

Better Identification and Data Collection

Reliable data are necessary to develop strategies for intervention and resource allocation. Including diagnoses like "homelessness," "inadequate housing," and "problem related to housing and economic circumstances, unspecified" (International Classification of Diseases codes Z59.0, Z59.1, and Z59.9, respectively) can help track the local incidence of people experiencing homelessness. Another approach is to create tools within the electronic medical record like the HarborBot, which uses chatbot software to assess for social needs among ED patients.[59] Physicians can advocate for more integrated electronic medical records among nearby hospitals to gain insight into the entire clinical picture of a person experiencing homelessness and promote better follow-up and use of community resources.[60]

Community Outreach

The most tangible ways to improve health for people experiencing homelessness are frequently outside the physical ED. Street medicine programs can bring health care to "meet patients where they are," such as by performing wound checks, distributing vaccines, and providing a link to medication-assisted therapy for opioid use disorder. Establishing and strengthening partnerships with community organizations may be more effective than starting new programs. Some hospitals have set up long-term housing with success.[61] Others have medical respite housing for patients not sick enough to warrant hospitalization but who need safe housing for short-term medical care while also seeking out longer-term housing options.[62]

CONCLUSION AND FUTURE DIRECTIONS

There are a number of topics in social emergency medicine that should be included in resident education. However, the sheer volume of people experiencing homelessness who seek care in the ED makes this an important topic to address. Understanding that the state of homelessness is perpetuated by specific social and political issues (eg, mental health and addiction disorders, exposure to violence, incarceration, a paucity of affordable housing) provides context for the barriers people experiencing homelessness face in accessing high-quality care. Emergency physicians equipped with this knowledge can address disease processes and social barriers of people experiencing homelessness. The ability to develop these skills requires formal teaching, exposure, and longitudinal training. We propose a multimodal approach that includes universal and targeted screening for homelessness, collaborating with social workers in order to provide resources, improving data collection on people experiencing homelessness, and coordinating direct community outreach. Emergency medicine residents and providers

must be intentional in addressing this patient population to address bias and best care for this vulnerable population.

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