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Authors

Doran, Kelly M
Raven, Maria C

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Authors: Kelly M. Doran¹, MD, MHS; Maria C. Raven², MD, MPH, MSc

1) Kelly M. Doran, Ronald O. Perelman Department of Emergency Medicine and
Department of Population Health, NYU School of Medicine, New York, New York.

kelly.doran@nyumc.org. [Corresponding Author]

2) Maria C. Raven, Department of Emergency Medicine, University of California San
Francisco, San Francisco, California. maria.raven@ucsf.edu.

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In many emergency departments (EDs) around the country, providers care for patients experiencing homelessness on every single shift. Despite its proven impact on health, housing status is not a routine part of the history taken by most emergency providers, and in many cases providers are unaware that they are caring for someone who has no stable home. Patients experiencing homelessness have unique needs spanning acute and chronic illness, injury, behavioral health diagnoses, and material deprivation. Yet, with few exceptions, we receive no formal training on caring for this vulnerable population, there are no consensus guidelines on treating ED patients experiencing homelessness, and—until now—there had been no published review of the literature on homelessness and emergency medicine. The review by Salhi, et al. in this month's *AEM* is, therefore, an especially important contribution.

It is notable that Salhi, et al. found only 28 studies focused on homelessness and emergency medicine given it is one of the most common and vexing problems our specialty faces. Several studies examined health services use, finding that people experiencing homelessness have above average rates of ED use and are disproportionately represented among frequent users. Even in studies using NHAMCS—which, as noted by Salhi, et al., significantly underestimates homelessness due to measurement limitations—people who are homeless accounted for around 0.5% of ED visits nationally; studies in individual EDs using more robust measurement found much higher rates. Most studies have been in urban areas, but one recent study found that even at a suburban ED 9.1% of patients were homeless or at-risk for homelessness.¹ Salhi, et al. also highlighted that—despite caring for them commonly—emergency physicians report uncertainty and frustration in knowing how to best serve patients experiencing homelessness.

Where do we go from here? Salhi et al. provide several recommendations for research, education, and practice; we expand upon their recommendations and discuss the relevant national context. We agree that research must be conducted in diverse sites and

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examine multiple subgroups of people experiencing homelessness. Research must go beyond documenting rates of homelessness in the ED. We must instead identify the gaps in services we provide and research the most effective ways to provide care for and intervene with people experiencing homelessness in an ED setting. This will necessitate longitudinal and intervention studies, and cross-disciplinary collaboration.

We agree with Salhi et al. that formal education on homelessness must be included in residency curricula. Curricular interventions should be evidence-based, integrated as a core part of training, and monitored for their effects on knowledge, attitudes, and feelings of burnout. We also agree with Salhi et al. about the need for evidence-based practice guidelines, both for our traditional “medical” practice and also for how to best address patients’ social determinants of health (SDH) such as homelessness. As a basic starting point, providers should undress and examine every patient. Contrary to the common stereotype, most patients experiencing homelessness do not use the ED “just for a place to sleep” or “for a sandwich” (although human kindness would dictate that we do address such survival needs when feasible). National studies have found that people experiencing homelessness have similar triage acuities to other patients², and a wide body of research has shown that they are sicker than average in general.

Progress requires knowing who in our EDs is experiencing homelessness. We recommend that standard questions about housing status be integrated into every history, as a stable living environment is as crucial to health as are other co-morbid conditions. Questions like this can feel intrusive, but are essential. A simple question we use is “where are you staying these days?” with options given such as “a friend’s house, a shelter, outside, in your own apartment” if needed. In our experience, this phrasing is acceptable and non-stigmatizing, especially if asked routinely. It is easy to identify as homeless the frequent ED user who lives on the streets and has a cart full of bags. But there are segments of the

homeless population who are undoubtedly under-identified in the ED, including women, children, the elderly, and those who are only transiently homeless. And, those who are marginally housed or in danger of eviction must also be identified when receiving ED care, as these circumstances can also impact treatment and follow-up plans.

Where homelessness is prevalent, EDs might consider more formalized universal screening. No question(s) to screen for housing instability or homelessness have yet been adequately validated for ED use, but there are examples from other settings. The Veterans Health Affairs clinic system has a mandatory, 2-item screener used nationwide.³ Others also exist.⁴ Some forward-thinking health systems have developed EHR-based tools to document SDH such as homelessness. Absent this more advanced technology, every ED in the U.S. can easily use the existing ICD-10 codes for homelessness (Z59.0) and inadequate housing (Z59.1).

Adding another screening question to ED triage, or asking busy providers to add to their histories, poses challenges. But it is important: homelessness is common in the ED and is a key predictor of poor health outcomes and early mortality. Indeed, chronic homelessness is one of the most deadly conditions we see in the ED. Despite its importance, we are sometimes asked, “Why should we ask about housing status if we can’t *do anything* about it?” There is plenty we can “do” with this knowledge, short of the often unrealistic goal of providing immediate housing. Delivering appropriate, quality medical care requires knowing about our patients’ living situations, as this directly affects their ability to take medications, follow discharge instructions, and more. Knowledge of patients’ housing status is necessary to make sound clinical decisions about diagnosis, treatment, disposition, and follow-up plans. Routine documentation of patients’ housing status will also improve research capability; prior research has been limited by lack of housing status data in health administrative records and reliable data are needed to affect policy changes.

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Though knowledge of patients' housing status is critical to providing good, routine emergency care, we also believe that emergency medicine could—and should—be playing a larger role in helping to end homelessness. Because the ED is uniquely accessible for individuals experiencing homelessness, we have unique opportunities to assist as part of larger efforts to end it. Ideally, efforts would be aligned with national best practices (described in the U.S. Interagency Council on Homelessness' *Opening Doors*), as well as with local priorities. Both of us have been involved in such efforts leveraging the unique role of the ED and working in collaboration with community and governmental organizations to “move upstream” and chip away at the underlying problem of homelessness faced by our patients by connecting them with supportive housing, developing a medical respite program, or working to prevent homelessness.^{5,6} Emergency providers can be some of the most effective advocates for stable housing as a necessary component of good health. A new Social Emergency Medicine section of the American College of Emergency Physicians was formed this year and may facilitate advocacy efforts.

The notion of housing as health care—and the health care system playing a role in housing and homelessness—has gained traction over the past several years. Now even mainstream organizations have bought into the idea. For example, in 2017 the American Hospital Association put out a report *Housing and the Role of Hospitals*, and the Epic CEO said they must “knock the [hospital] walls down” to consider SDH.⁷ Health care payment models are beginning to follow suit. For example, Massachusetts Medicaid now includes two SDH factors in its risk adjustment models, one of which is unstable housing.⁸ Medicare is also considering ways to account for social risk factors in its payment and incentive models.⁹ And the Centers for Medicare & Medicaid Services is embarking on a nationwide trial of Accountable Health Communities, which aim to reduce costs by screening for and addressing beneficiaries' SDH. ED visits are often framed narrowly by policy makers and others as

health care encounters that should be avoided. Instead of accepting this view of our practice, we must position ourselves as the critical providers that we are when it comes to SDH like homelessness. Emergency medicine has a strong voice in the health care system that policy makers will listen to, but we must speak up.

Homelessness is a crisis reflected within our EDs nationwide. The solution to homelessness is not rocket science, but while our nation continues to work towards policies that will provide more affordable and permanent housing for those in need, we in emergency medicine must act. The ideas underlying the broad role of our specialty in addressing homelessness are at least as old as Rudolf Virchow, who is reported to have written in 1848, “The physicians are the natural attorneys of the poor, and social problems fall to a large extent within their jurisdiction.”¹⁰ Like it or not, the social problem of homelessness has fallen squarely at our doorstep. Responding in the right way has the potential to enhance the value proposition of emergency medicine while also helping to alleviate the human crisis of homelessness.

References

1. Feldman BJ, Calogero CG, Elsayed KS, et al. Prevalence of homelessness in the emergency department Setting. *West J Emerg Med* 2017;18:366-72.
2. Ku BS, Scott KC, Kertesz SG, Pitts SR. Factors associated with use of urban emergency departments by the U.S. homeless population. *Public Health Rep* 2010;125:398-405.

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3. Montgomery AE, Fargo JD, Byrne TH, Kane VR, Culhane DP. Universal screening for homelessness and risk for homelessness in the Veterans Health Administration. *Am J Public Health* 2013;103 Suppl 2:S210-1.
 4. Billioux A, Verlander K, Anthony S, Alley D. *Standardized screening for health-related social needs in clinical settings: the accountable health communities screening tool*. Discussion Paper, National Academy of Medicine, Washington, DC. 2017.
 5. Raven MC, Doran KM, Kostrowski S, Gillespie CC, Elbel BD. An intervention to improve care and reduce costs for high-risk patients with frequent hospital admissions: a pilot study. *BMC Health Serv Res* 2011;11:270.
 6. Doran KM, Greysen SR, Cunningham A, Tynan-McKiernan K, Lucas GI, Rosenthal MS. Improving post-hospital care for people who are homeless: Community-based participatory research to community-based action. *Healthcare (Amsterdam, Netherlands)* 2015;3:238-44.
 7. Monegain B. Epic CEO Judy Faulkner is standing behind switch from EHRs to 'CHRs'. *Healthcare IT News*. 2017 Oct 6.
 8. Ash AS, Mick EO, Ellis RP, Kiefe CI, Allison JJ, Clark MA. Social determinants of health in managed care payment formulas. *JAMA Internal Medicine* 2017;177:1424-30.
 9. National Academies of Sciences, Engineering, and Medicine. *Accounting for social risk factors in Medicare payment*. 2017. Washington, DC: The National Academies Press. doi: 10.17226/23635.
 10. Virchow R. Introductory article, 'The Aims of the Journal "Medical Reform"', in the first edition of *Die medizinische Reform* (10 Jul 1848). Various translations from the original German exist. Available at: https://todayinsci.com/V/Virchow_Rudolf/VirchowRudolf-Quotations.htm.