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CONCEPT

Exploring the complexity of homelessness in emergency medicine: Dissecting myths, evidence, and solutions

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Abstract

Background: Emergency departments serve as critical-access points for people experiencing homelessness (PEH). These patients face significant health disparities and are subject to stigmatization and misconceptions, often contributing to suboptimal care and moral distress among providers. Structural competency, a framework that addresses the social, political, and economic determinants of health, is crucial in rethinking the care of PEH in emergency medicine (EM).

Methods: This paper is based on the proceedings of the SAEM24 didactic session, which utilized a structural competency framework to address common misconceptions about unhoused patients. The session was developed through comprehensive literature reviews conducted by a multidisciplinary team and focused on integrating structural competency into EM practice.

Results: To confront the bias and stigma surrounding PEH, the didactic session provided evidence throughout four key areas: the diversity and changing demographics of homelessness, understanding the structural and infrastructural drivers of homelessness, identifying the impact of homelessness on health and health care access, and implementing practical interventions aimed at improving health outcomes for unhoused individuals. These areas are critical in educating EM providers on the complexities of caring for unhoused patients and the systemic issues that exacerbate their health crises.

Conclusions: Addressing homelessness within EM through a structural competency framework is imperative for researching and delivering effective health care. Continuous education and policy advocacy are vital to confront the underlying structural determinants of health and enhance emergency care for unhoused populations.

KEYWORDS
health services, homelessness, housing insecurity, social emergency medicine, unhoused

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INTRODUCTION

Since 2017, there has been an increase of 6% in the overall rate of homelessness in the United States, an estimated 653,104 persons on a single night. Within this population, rates of unsheltered homelessness are trending upward (up to 40%) and counts of chronically homeless individuals in 2022 reached record highs, 15.6% of patients experiencing homelessness (PEH).[1] As the safety net of the health care system, the emergency department (ED) cares for many PEH. Unhoused patients have higher rates of substance use disorder and mental illness and higher morbidity from treatable diseases than housed patients, resulting in more frequent ED visits. While there is not a consistent definition of "frequent use" within the literature, the study by Moore and Rosenheck[2] examined a 90-day period and found PEH to use the ED more than the general public, with 50% reporting at least one ED visit and 12% reporting three or more. This population also experiences a considerable amount of stigma and bias, which contribute to health disparities and increased mortality.[3] The following article describes the proceedings from an SAEM24 didactic presented in May 2024, which used an evidence-based, structural competency framework to address the most common biases and misconceptions among PEH; introduce the concept of structural violence and the infrastructural policies underlying homelessness; contextualize the burden of disease and healthcare use patterns among this population; and explore what might be done to address the issues, both at a systems level and at an individual level[4] (see Table 1 for supplemental definitions and examples of commonly used terminology throughout this article).

Emergency medicine (EM) providers can have a major impact on the lives and health outcomes of PEH. Our interactions with this population present pivotal opportunities for assessment, intervention, and linkage to care.[10,11] They also are determining moments in a patient's perception of the health care system. The challenge of meeting these patients' complex needs can contribute to moral distress when physicians are unable to provide care that aligns with their ethical values.[12]

Our didactic was designed for an inclusive audience: attending physicians, researchers, residents, advance practice providers, and students. The goal of the didactic was to provide a comprehensive and evidence-based understanding of the multifaceted challenges faced by unhoused patients in the United States and to empower participants to make a positive impact on the lives and health outcomes of individuals experiencing homelessness.

The session opened with describing the changing demographic landscape of homelessness in the United States. We then explored chronic disease prevalences among unhoused patients alongside the health implications of homelessness itself. We characterized patterns of acute care utilization, hospitalization, associated costs, and mortality rates. We addressed the evidence for interventions, such as housing-first models, encampment and street outreach, peer navigation, medical–legal partnerships (MLPs), and research methods that can be implemented to improve health outcomes for this population. Our didactic session provided an evidence-based overview of homelessness within the realm of EM. Participants gained knowledge and practical insights and left with a heightened ability to contribute to more compassionate, equitable, and effective health care for individuals experiencing homelessness.

Central to our approach is the concept of structural competency, a framework that calls for medical professionals to recognize and respond to health as a product of larger social, economic, and political structures.[5] This requires a shift from focusing solely on individual behaviors and toward an understanding of how socioeconomic structures shape health outcomes. By integrating structural competency into EM, we aim to enhance practitioners' ability to see and address the broader forces that contribute to homelessness and disparate health outcomes.

TABLE 1 Key concepts and definitions.

Term	Definition	Example
Structural competency	A framework that helps health professionals understand how social, political, and economic structures impact health and illness[5]	An emerging approach to medical education that aims to address health-related social justice issues
Structural factors	Interactions with the criminal justice system and consequences[6–8]	Limitation of employment and housing due to criminal record
Infrastructural factors	Policy-created inequities and systemic inequality rooted in capitalism and structural racism[6–8]	Lack of affordable housing, discriminatory housing policies, criminalization of homelessness
Housing insecurity	Living with insecure housing and persistent threat of homelessness[9]	Housing cost burden (spending more than 30% of your income on housing); residential instability; living at risk of eviction and other forced displacement; living with others to share housing costs; living in overcrowded settings or in substandard, poor-quality housing; and living in neighborhoods that are unsafe and lack access to transportation, jobs, quality schools, and other critical amenities
Unhoused	Living without fixed, regular, and adequate nighttime residence[9]	Living in homeless shelters, hotels, or other temporary housing
Unsheltered	Those staying in places not intended for habitation[9]	Living in cars, staying in parks, living on sidewalks, living on bridges, and living in abandoned buildings

METHODS

The methodology for developing the didactic and this article involved a comprehensive literature review conducted by a group of experts specializing in care for unhoused patients. The presenting group was strategically formed through the Social Emergency Medicine and Public Health Interest Group, which sponsored the didactic. Each author independently conducted a comprehensive literature review focused on one of the foundational pillars described in detail below. The findings from these literature reviews were then collaboratively discussed and integrated into the didactic presentations, ensuring a well-rounded and evidence-based approach to each topic discussed. The presenting panel was composed of the authors of this article, whose backgrounds span the academic spectrum from research, policy, education, operations, and clinical experience: Dr. Cailin Ryus, MD, MPH, is the leader of the Yale ED Homelessness Task Force; Dr. Kian Preston-Suni, MD, MPH, is the leader of the ED-based housing screening program throughout the Los Angeles VA hospitals; Dr. Hannah Janeway, MD, MS, is the leader of the Enhanced Care Management program for UCLA's Homeless Healthcare Collaborative; Dr. Christine Shaw, MD, is completing her fellowship in social EM and global health and is co-medical director of the UAB Street Medicine clinic. Our collective expertise informed the unique analytical perspectives and educational recommendations presented herein.

Common biases were identified through group consensus, based on the clinical and teaching experience, and through the literature review of the panel. Common biases concerning homeless patients in EM include the misconception of overutilization, where homeless patients are stereotypically viewed as frequenting EDs for nonurgent reasons.[13,14] Visibility bias also contributes, whereby the noticeable presence of homeless individuals in emergency settings reinforces stereotypes of high health care usage, yet many have substantial, unmet medical needs that go unrecognized due to the stigma surrounding mental health and homelessness.[15,16] Another bias, implicit bias on the part of providers, is the attribution of homelessness to poor personal choices, overshadowing structural issues like housing and employment instability.[13] This stigma can affect the credibility of homeless patients, impacting the care they receive and their engagement with health care services.[17]

The conceptual framework of the didactic was built around five foundational pillars designed to address key areas of bias concerning unhoused patient populations.[5,13,14] These pillars draw upon the principles of structural competency to ensure that participants are equipped with the knowledge and skills to address the structural factors affecting this vulnerable population[5]:

1. *Recognize the diversity within homelessness*: Participants will gain an appreciation for the changing demographics within the population of people experiencing homelessness (PEH) in the United States. This pillar aligns with structural competency's goal of recognizing the structures that shape clinical interactions by emphasizing the importance of understanding how broader social, economic, and political forces contribute to the health disparities observed among different subpopulations of unhoused individuals.
2. *Appreciate the origins of the homelessness crisis*: Participants gained an understanding of the systemic and policy drivers of homelessness and the perpetuating role of structural and infrastructural violence. Structural competency requires that clinicians develop an "extraclinical language" of structure, which enables them to articulate how policies such as housing regulations, incarceration, and employment laws contribute to the vulnerabilities faced by unhoused individuals.[5] This pillar guided participants in analyzing the historical and contemporary policies that have led to the current homelessness crisis, encouraging them to consider these influences when developing care plans, interventions, and research programs.
3. *Identifying the impact of homelessness on health and health care access*: This pillar focused on understanding how structural barriers specific to homelessness directly influence health outcomes and access to medical care. It underscored the need for health care to adapt to the complexities faced by unhoused individuals, who may experience disrupted care, exacerbated chronic conditions, and heightened exposure to environmental risks. By integrating principles of structural competency, the session highlighted the importance of creating health care services that are not only accessible but also responsive to the living conditions and systemic disenfranchisement experienced by homeless populations.
4. *Challenge biases and misconceptions*: Through thoughtful reflection and evidence-based insights, this session fosters critical examination of common biases and misconceptions that often surround PEH. In line with the structural competency framework, this pillar encourages participants to move beyond simplistic cultural explanations for patient behavior and instead frame patient interactions in terms of broader structural constraints, such as limited access to health care, housing, or employment.
5. *Implement practical interventions*: We showcased interventions and practice recommendations that can be applied in a wide range of practice settings from community to large academic medical centers. This pillar reflects the structural competency component of observing and imagining structural interventions by offering practical strategies that participants can implement in their daily practice to address structural inequalities. These might include interventions such as community-engaged research (CER) methodologies or partnerships with housing, legal, and social service organizations.

Each pillar was designed to equip EM physicians and researchers with the knowledge and tools necessary to improve care and outcomes for unhoused individuals. By integrating structural competency into this framework, we aim to ensure that participants are not only aware of the immediate clinical needs of this population but also of the broader structural factors that perpetuate homelessness and poor health outcomes. The following sections of the article will delve into each pillar in detail, discussing their implications for research, practice, and policy in EM.

DISCUSSION OF DIDACTIC PILLARS

Recognize the diversity within homelessness

Housing insecurity includes homelessness; housing cost burden (spending more than 30% of your income on housing); residential instability; living at risk of eviction and other forced displacement; living with family or friends to share housing costs (doubling-up); living in overcrowded settings or in substandard, poor-quality housing; and living in neighborhoods that are unsafe and lack access to transportation, jobs, quality schools, and other critical amenities. Homelessness is often defined as a lack of fixed, regular, and adequate night-time residence and unsheltered homelessness refers to staying in places not intended for habitation, such as cars, parks, sidewalks, bridges, and abandoned buildings.[9]

Homelessness is more common than perceived.[18] While often difficult to measure, it is estimated that one in 20, or 4%–5% of the U.S. population, will experience homelessness at least once in their life, for at least 1-month duration. As of 2023 over 600,000 people are homeless, which is a 12% increase from 2022, and an aging population as well, with over 39,000 over the age of 64.[1] Overall, there is a significant racial discrepancy within PEH, as described by homelessness rates per 10,000 people which indicates disproportionally Native Hawaiians (121.2 per 10,000) and Black Americans (48.2 per 10,000) are overrepresented compared to their white counterparts (11.6 per 10,000).[1,9] Rephrased, the Black community, which comprises approximately 12% of the U.S. population, represents 39% of the sheltered homeless population.[9] There is also a male predominance of PEH, and 30%–40% live unsheltered.[1] Of those living unsheltered, people from minoritized racial, ethnic, and sexual and gender identities and people who have been previously incarcerated are disproportionally represented.[1] This is most experienced by the LGBTQI+ community, where 78% of homeless persons who are gender questioning live unsheltered, and 56% of transgendered homeless live unsheltered.[1]

Appreciate the origins of the homelessness crisis

Homelessness is driven by a complex interplay of individual, structural, and infrastructural factors. While individual-level risk factors like poverty, substance abuse, unstable family life including early childhood adverse experiences, and personal violence such as intimate partner violence are significant, they often are overemphasized and overshadow the deeper structural and infrastructural causes that create and perpetuate housing insecurity.[9] Structural causes are those such as association with the criminal justice system, wherein having a criminal record limits employment and housing opportunities due to bias. Financial burdens from medical bills and aggressive debt collection also contribute. Infrastructural issues, including a lack of affordable housing, discriminatory housing policies, and systemic inequality rooted in capitalism and structural racism, further shape the landscape of homelessness.[6–8] Capitalism perpetuates wealth inequality by exploiting and marginalizing specific populations, thereby maintaining a cycle of homelessness. Displacing individuals from their land has been a fundamental tenant of American history. This is evident in historical practices like redlining and restrictive covenants that have systematically excluded people of color from homeownership, disproportionately affecting Black individuals who are five times more likely to experience homelessness.[7] Moreover, responses to homelessness often fail to address these systemic disparities because they have not been designed to identify or respond to racial disparities.[8] For example, many homeless outreach teams include police action, and 43% include encampment removal without actual relocation plans for assistance.[19] Seventy-eight percent of mayors say that the police have at least some influence over their homelessness policies and the homeless response system, which triages, supports, and rehouses PEH.[19,20] These practices highlight the need for EM providers to develop structural competency, recognizing and addressing the broader contexts and systemic inequities that underpin the homelessness crisis, to effectively advocate for and implement trauma-informed and equitable interventions.[10]

Identifying the impact of homelessness on health and health care access

Living without regular housing has a significant impact on one's health.[21] Without shelter one may lack safety, hygiene, and food security. This insecurity extends to one's belongings, including medications, such that PEH also may lack adequate storage of medications. This phenomenon is described as "competing priorities for those unmet human needs," which includes the struggle to accommodate basic human needs (food, water, security, shelter, personal space for hygiene practices), health care needs (affordability, access, transportation, ability to comply), lack of resources to accessing care (lack of paperwork/ID, literacy rates, transportation, insurance status), and social needs/social isolation (support systems, assistance programs, laundry).[22] As a result, PEH experience higher rates of many chronic and uncommon diseases and higher mortality from these diseases and often experience these diseases and their complications at an earlier age leading to subsequent premature death.[23] Unhoused people experience higher rates of all medical conditions, including conditions classified as "uncommon" in the United States such as TB, HIV, and HCV. Furthermore, PEH are more likely to experience physical and sexual assault, meaning higher rates of traumatic injuries. Violence is uniquely both a risk factor for becoming homeless and a consequence of living unhoused, with nearly 50% reporting having experiences physical or sexual assault within the past year.[2,24] As a result of this violence, PEH understandably have much higher rates of PTSD and other anxiety-related illnesses.[22]

Challenge biases and misconceptions

The average ED lacks adequate methods of screening for and identifying homelessness and housing insecurity, which leads to poor

quality data regarding housing status among ED patient populations.[25–27] Many of the studies that report increased ED utilization among PEH are based on samples drawn from ED patient populations, which can create a skewed perception of the frequency of use due to right censoring.[28] In contrast, community-based samples of PEH demonstrate that only half of individuals had used the ED in the past year, and only a small minority (8%–12%) of PEH report using the ED more than three times in a year.[2,29,30] Similarly, national studies of PEH indicate that only 23%–32% of PEH visit the ED, and only 1.55% had visited more than five times.[1,31] The perception within health care of PEH being overusers of the system is a misrepresentation of the entire population, due to this sampling bias.[32] This is, by definition, a Berkson's bias: a type of selection bias that occurs in case–control studies where the cases and controls are selected from a hospital population, which is not representative of the general population.[33] This is demonstrated in the study by Kushel et al.[29] study indicating that 50% of ED visits by unhoused patients come from only 5% of users (1540 visits by just 199 persons).

Research can influence health care, resource allocation, and health policy. It can also perpetuate stereotypes and inequities; thus it is important that researchers are cognizant of this power. Research that focuses solely on ED utilization may inadvertently reinforce the stereotype of unhoused patients as "frequent flyers."[28,32] These studies such as those by Raven[15] and Kanzaria et al.[32] discuss the risks of emphasizing ED utilization alone, which may overlook the broader, complex health and social needs of unhoused patients and reinforce stigmatizing narratives. Again, as demonstrated in the study by Kushel et al.[29] described before. High ED use signifies substantial medical and social needs which challenge providers and researchers to identify and address these complex needs. Alternative outcome measures such as consistent prescription utilization, housing stability, disease-specific outcomes, and patient-centered outcomes (i.e., decrease in the mortality rate) can provide a more comprehensive understanding of the impact of housing on health and health care utilization.[15,17,28]

Furthermore, the bias that unhoused patients visit the ED for nonmedical, nonurgent complaints should be challenged. The intersection of housing and healthcare is a complex and multifaceted issue, particularly for PEH, a population with high medical and social needs.[21,31,32,34] In the context of higher rates chronic illnesses, increased risks of violent injury, traumatic injury from motor vehicles, burns from campfires, hypo- and hyperthermia from elemental exposures, decreased access to routine care, and difficulty obtaining and storing medications, the ED is often a necessary touchpoint for PEH.[35,36]

The subsequent impact of the higher morbidity within this population results in a higher likelihood of admission and longer hospital stays that housed patients.[37] PEH have an average of 2.32-days-longer hospital stay and $1000 higher costs per discharge compared to housed patients,[37] yet despite an increased likelihood of admission and longer hospital stays, unhoused patients are 5.5× more likely to sign out against medical advice.[38] The most common reasons for hospitalization among those who self-discharged were severe medical conditions including sepsis, myocardial infarction, and respiratory failure.[38] Severe health conditions must compete in patients' hierarchy of needs against compelling reasons with profound consequences for the patient, such as fear of losing encampment, belongings, shelter bed due to curfews, marginal employment, or pets and companions.

Implement practical interventions

Numerous strategies have been explored to address the complex needs of the unhoused patient population. The following interventions were explored during our didactic to discuss benefits, challenges, and evidence.[39–45] It is the hope that these interventions may propose physicians with skills to act in alignment of their professional values to improve the welfare of this population and thus hope to improve burnout and moral injury.[12]

Housing first is an approach to addressing homelessness that prioritizes providing housing without preconditions such as sobriety, employment, or participation in treatment programs. This includes immediate access to housing and providing additional support services like social workers, mental health, and substance use program referrals. However, research on supportive housing's effect on health care outcomes, including ED visits, has shown varying results. Evidence from an RCT in Chicago showed that permanent supportive housing interventions may decrease ED use among homeless patients by as much as 24%.[39] A recent RCT from Denver showed that permanent supportive housing decreased ED visits while increasing outpatient psychiatric visits.[40] A study in Los Angeles indicated that rapid rehousing had no effect on ED use or any other public health metrics in the study.[41]

Medical respite programs are short-term residential care for homeless individuals who are too ill or frail to recover from an illness or injury on the streets or in a traditional shelter but are not sick enough to remain in a hospital. It provides a safe environment for recuperation with access to medical care and support services.[21,42,43] While the goal is to assist the patient with permanent housing, often these programs are short-term and underfunded to fully achieve this goal.

Peer navigation is a hospital-based program in which someone with shared lived experience can help the patient address barriers to access and helps navigate the appropriate channels. These peers are primarily nonclinical and focus on emotional and social support. These programs are shown to improve care connections.[44] However, standardization and training of peers can vary, potentially affecting the consistency of findings. This is an encouraging option; however, more research is still needed.[45]

MLPs integrate legal services into health care settings to address and prevent health-harming legal needs of patients. They involve collaboration between health care providers and legal professionals to improve patient health and well-being by addressing social determinants of health. Programs such as this are a more holistic approach that focuses on issues like housing, benefits, immigration, and family

law that impact health.[43] MLPs require sustained funding and close collaboration between legal and medical professionals, which can be challenging to maintain.

Street medicine and mobile clinics provide medical care directly to unsheltered homeless individuals in the places where they live, such as streets, parks, and underpasses. These services aim to overcome barriers to health care by bringing medical providers to the patients, ensuring they receive necessary care. Health care professionals who go out on foot to provide care and build trust with homeless individuals thereby provide more comprehensive care including primary care, preventive services, wound care, mental health services, and referrals to specialized care.[43,46] Multiple studies have demonstrated the effectiveness of these programs, such that they improve the health of the participants, in addition to deferring ED visits, therefore making it a cost-effective way to provide preventative medicine to PEH.[46,47]

CER is a collaborative approach to research that actively involves community members, local organizations, and researchers in the research process. It aims to address community-identified needs and priorities, leveraging the strengths and knowledge of all partners to improve health and well-being outcomes.[48] CER seeks to leverage the lived experiences and insights of people with lived expertise in homelessness to inform health initiatives and interventions.[49] By engaging directly with those affected, this method fosters strong, respectful, and trusting relationships that not only enhance the relevance and applicability of the research but also challenge and dismantle the biases and misconceptions commonly associated with homelessness.[50] This methodological approach promotes equity and empowers unhoused individuals to participate actively in creating solutions that address their specific health challenges, thereby fostering a sense of agency and community ownership over health outcomes.

There are still insufficient data to definitively characterize the impact of these interventions on health among unhoused patients. Studies focused on health care utilization and cost outcomes for PEH may observe increased use as people living in more stable environments are able to access care. The outcome of health and survival rather than use and spending should be the priority.

LIMITATIONS

Our methodology, which primarily relied on literature reviews and expert panels, was comprehensive yet subject to the inherent limitations of available published research. These sources can carry biases that may influence the scope and interpretation of findings. The retrospective design of our review also constrained our capacity to fully capture the rapidly evolving dynamics of homelessness and its implications within emergency health care. As a review designed to fit a 50-min didactic at SAEM24, there is a limitation to both the scope and the depth of information that can be covered on this topic and thus is only a brief review. Furthermore, our intended data collection during the SAEM24 didactic sessions, aimed at assessing baseline knowledge and attitudes, could not be completed due to technological failures. This limitation restricted our ability to engage with the audience in real time and gather valuable feedback, potentially affecting the depth of our analysis and the robustness of our conclusions.

CONCLUSIONS

In addressing the multifaceted challenges of homelessness within emergency medicine, this article not only underscores the necessity of integrating structural competency into our educational and clinical practices but also highlights practical interventions that can significantly enhance outcomes for unhoused individuals. By fostering a deeper understanding of the social, economic, and policy-driven determinants of health, EM providers are better equipped to implement effective and compassionate care strategies. The didactic sessions detailed herein have provided a blueprint for transforming emergency medical care for unhoused patients from reactive to proactive, emphasizing an approach that extends beyond immediate medical needs to consider long-term health and social stability. Continued advocacy, education, and research in this area are needed to refine and expand our understanding and appreciation of structural determinants of health, ensuring that the care provided in emergency settings is both equitable and effective in addressing the broader context of each patient's life circumstances.

AUTHOR CONTRIBUTIONS

All authors contributed to the conceptualization and design of this didactic. All authors contributed to the drafting and revision of the manuscript. All authors are responsible for the content of and have approved the manuscript as submitted.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

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