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EDITORIAL

Health Policy

Invited Editorial: Dedicated homeless clinics and emergency department utilization: a new horizon?

In this issue, an article by Wang et al,[1] "Dedicated Homeless Clinics Reduce Inappropriate Emergency Department Utilization," describes the impact of a "bricks and mortar" dedicated homeless clinic compared to a regular hospital clinic on reducing inappropriate emergency department (ED) utilization by persons experiencing homelessness. This single-center study of over 5000 subjects over a 12-month period in Fort Worth, Texas, suggests that the dedicated homeless clinic reduced ED use by persons experiencing homelessness. This article adds to the literature on the integration of acute episodic care provided in the ED to the continuum of care necessary to optimize the health and wellbeing of persons experiencing homelessness.

It is estimated that there are over 550,000 persons experiencing homelessness in the United States.[2] EDs are the safety net for this vulnerable population of persons who are 3–4 times more likely to use the ED compared to the general population.[3,4] There are many barriers to accessing care for persons experiencing homelessness, including transportation, insurance coverage, lack of access to primary care, and challenges in adhering to medication or other prescribed treatment plans.[5,6] The high rate of ED use by persons experiencing homelessness is multi-factorial; however, alcohol- and drug-related disorders and psychiatric conditions are associated with both ED visits and increasing rates of and longer hospitalizations in this population.[7]

The results presented by Wang et al[1] can help to inform policies that meet the unique and complex health care needs of the population of persons experiencing homelessness, particularly in the setting of acute, unscheduled care. Further study is necessary to determine whether the "bricks and mortar" availability of a dedicated space or the focus on specific services were associated with the reduction in ED use reported in the paper. In addition to the dedicated primary care physicians and street outreach teams described by Wang et al,[1] stigma prevention and the availability of specialty care that meets the needs of this population could maximize the value of a dedicated homeless clinic located near a homeless shelter. These services should include mental health and substance abuse resources (including access to psychiatrics and psychologists), as well as robust care management services imbedded into the dedicated homeless clinic. The availability of evidenced-based care for substance and alcohol use disorders is critical to reducing morbidity and mortality in persons experiencing homelessness[8] and in itself might result in decreased ED use. Social services that are aimed at addressing and improving the causative social determinants of health that exacerbate the health risks and poor health outcomes associated with housing insecurity and homelessness must be an integral part of comprehensive care for persons experiencing homelessness.

Recent work has suggested that homelessness is under recognized among persons presenting to the ED.[9,10] The ED can provide acute, episodic care but is only one component of meeting the needs of persons experiencing homelessness. ED screening for homelessness and housing insecurity might help to identify individuals who might benefit from the ongoing care available at a dedicated homeless clinic as described by Wang et al.[1] Screening could be integrated into regular ED care and should not negatively impact patient care or create additional administrative burdens on an already strained emergency care system.

Coordination of care following discharge from the ED is a challenge, and a lack of this coordination likely contributes to repeat ED visits for acute exacerbations of chronic health conditions by persons experiencing homelessness. Ensuring this continuum to provide continuity of care is particularly challenging.[11] In California, SB 1152, signed into law and effective January 1, 2019, attempts to ensure a safe, coordinated discharge from the ED for persons experiencing homelessness. Unfortunately, this legislation presents significant practical challenges and negative unintended consequences to ED workflow and patient care.[12–14] A dedicated homeless clinic might be the ideal venue for seamless, post-ED follow-up and ongoing care after the ED encounter.

There are important limitations to consider in the application of the work presented by Wang et al.[1] The provision of comprehensive services in a dedicated homeless clinic is more realistic in more densely populated settings where larger numbers of persons experiencing homelessness are concentrated, limiting the effectiveness of this model for persons facing homelessness and housing insecurity in more rural settings. Additionally, the success of a dedicated homeless clinic is dependent on partnerships, collaboration, and multidisciplinary services and resources that are not available in many communities whether rural, urban, or suburban. Finally, coordination of care requiring the sharing of clinical information, usually via an

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integrated electronic health record. The sharing of this information can be a practical and logistical barrier.

A dedicated homeless clinic located near a homeless shelter offers a promising and innovative alternative to ED use for selected conditions. It should be aimed at comprehensive, whole-person care including housing security and should be implemented in coordination with other local health care resources and services, including local public health agencies, EDs, hospitals, and social service resources. Establishing this continuum of care in a cooperative way will maximize the "synergistic effects" of multiple interventions to ensure the health and wellbeing of individuals experiencing homelessness and housing insecurity.

CONFLICTS OF INTEREST

The author declares no conflicts of interest.

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