EDITORIAL

Treating homelessness as an emergency: learning from the COVID-19 response

Sahil Gupta[1] · Edward Xie[2] · Kathryn Dong[3]

Introduction

Frequent presentations to emergency departments (ED) are both related to and a consequence of homelessness. One study found that 77% of patients experiencing homelessness had visited an ED, with a rate that was 8.5 times higher than the general population [1]. Infections, physical and/or psychological trauma, environmental injuries, substance use, and mental health conditions are the symptoms of chronic insecurity, deprivation, and poverty.

While emergency physicians are experts at treating patients who have been assaulted or found hypothermic in a snowbank, we work in a system that permits these very same patients to be discharged back to homelessness. The research by Formosa and colleagues provides a much-needed systematic review of ED-initiated interventions to improve housing, health status, or access to care for people experiencing homelessness [2].

In the context of COVID-19 mitigation efforts, and for perhaps the first time on such a large scale, homelessness was treated as a life-threatening emergency. When people experiencing homelessness had symptoms attributable to COVID-19 or were unable to self-isolate, temporary housing services became available to meet their immediate need for physical distancing, personal security, rest, and nutrition.

Homelessness costs Canadian society upwards of $7 billion annually in healthcare, social services, and institutional housing costs alone; these do not reflect the lost potential of enabling people to fully participate in society [3]. In EDs,

the price of maintaining the status quo includes recurrent and potentially avoidable visits and challenging disposition plans. Innovative models of care that effectively address social inequities provide opportunities for emergency physicians to address the root causes of ED visits and make a lasting difference in a patient's overall health.

Learning from the COVID-19 response

From the start of the pandemic, it was clear that existing congregate settings such as emergency shelters would not be able to provide adequate space for physical distancing. Across the country, community organizations, community members, health agencies, and all levels of government demonstrated that they were capable of working together and rapidly mobilizing resources. For example, hotels and motels were repurposed in Toronto and Halifax. Drop-in physically distanced shelter spaces were expanded in Edmonton and Montréal. While good first steps for public health, temporary shelters don't provide a reprieve from the everyday displacement people face or the psychological safety of having a closed-door room. Emergency or transitional housing must be a bridge to permanent housing.

The COVID-19 response has shown that an ambitious but necessary goal is attainable for EDs: never discharging people into homelessness. While longer-term solutions, such as new supportive housing units, are beginning to emerge, we must sustain the momentum developed during the pandemic. ED physicians are important partners in identifying unmet needs, initiating services, and advocating for lasting change.

What can we achieve as ED clinicians?

Understanding a patient's social circumstances is critical to successful discharge planning. Knowing where your patient sleeps at night, whether they can fill their ED prescription,

✉ Sahil Gupta
  sahil.gupta2@unityhealth.to

1 Department of Emergency Medicine, St. Michael's Hospital, 30 Bond Street, Toronto, ON M5B 1X1, Canada

2 Division of Emergency Medicine, University Health Network, Toronto, Canada

3 Department of Emergency Medicine, University of Alberta, Edmonton, Canada

and whether they have the health care coverage or ID required for follow up appointments, are all just as important as reviewing past health history and current medications. Taking and documenting a targeted social health history is critical for care planning.

It is also important for emergency clinicians to understand the landscape of local community resources and a patient's housing status beyond "no fixed address". While we work as a team with allied health professionals, clinician awareness can also improve care. For example, shelters vary in their capacity to provide safe storage for medications, have variable access to nursing care, and may have mobility requirements (e.g. accessible by stairs only).

As outlined in the review by Formosa and colleagues, direct referral to Housing First and case management programs from the ED is preferred and these were effective in connecting patients to housing [2]. Where these services do not yet exist, developing partnerships with community and government agencies to explore options may be beneficial.

A major barrier to health system response is not being able to measure the problem. As Formosa and colleagues point out, homelessness was "not included as a key demographic variable in many ED studies [2]." Homelessness, along with other key determinants of health such as prescription drug coverage, personal identification, and income security, are not routinely tracked. Building data tools into electronic health records can integrate this valuable history into population datasets to facilitate more responsive health system planning. Tracking data on social determinants of health can also provide a virtual hand-over to other health professionals who may see the patient in the future. Emergency clinicians can assist by advocating for means to more easily capture and track social determinants into ED assessments.

Reframing the discussion

The elephant in the room remains the lack of investment in long-term solutions. The comorbidities of this chronic problem include large deficits in affordable housing, gaps in health and social services that allow people to fall through the cracks, stigma, and discrimination, and policies that do not prioritize the prevention of homelessness. Had we managed COVID-19 in the same manner, we would never have flattened the curve.

Some may argue that these upstream issues are beyond the control of emergency clinicians. Yet, our emergency medicine community is uniquely attuned to the social needs of our patients and has a strong track record of advocacy in access to care. For instance, emergency physicians have been powerful advocates for more community long term care spaces to address ED and acute care overcrowding [4].

Not being able to directly address housing instability in the ED contributes to a cycle of unmet expectations, burnout in emergency care providers, and ongoing marginalization and hopelessness for our patients. This is one of the best examples in medicine of an opportunity to decrease costs, improve health outcomes for our patients, and prevent provider burnout by addressing social determinants such as housing [5]. The COVID-19 response has shown us that discharge to safe and adequate housing is within reach and definitely healthier than the status quo.

References

1. Hwang SW, Chambers C, Chiu S, Katic M, Kiss A, Redelmeier DA, Levinson W. A comprehensive assessment of health care utilization among homeless adults under a system of universal health insurance. Am J Public Health. 2013;103(Suppl2):S294–301. https://doi.org/10.2105/AJPH.2013.301369 (**Cited 2020 Aug 27**).
2. Formosa EA, Kishimoto V, Orchanian-Cheff A, Hayman K. Emergency department interventions for homelessness: a systematic review. CJEM. 2020. https://doi.org/10.1007/s43678-020-00008-4.
3. Gaetz S, Dej E, Richter T, Redman M. The state of homelessness in Canada 2016. Toronto, ON: Canadian Observatory on Homelessness Press; 2016. Available from: https://homelesshub.ca/sites/default/files/SOHC16_final_20Oct2016.pdf (Cited 2020 Aug 27)
4. Affleck A, Parks P, Drummond A, Rowe BH, Ovens HJ. Emergency department overcrowding and access block. CJEM. 2013;15(6):359–84. https://doi.org/10.1017/S1481803500002451 (**Cited 2020 Aug 26**).
5. Hsieh D. Achieving the quadruple aim: treating patients as people by screening for and addressing the social determinants of health. Ann Emerg Med. 2019;74:S19–24. https://doi.org/10.1016/j.annemergmed.2019.08.436 (**Cited 2020 Aug 29**).