








PERSPECTIVE

COVID-19 and emergency care for adults experiencing homelessness

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Abstract

Homeless individuals face many barriers to accessing healthcare, and EDs are often their primary entry point to the healthcare system. The COVID-19 pandemic has the potential to exacerbate existing social inequities and health disparities, including barriers to accessing social services and healthcare. Addressing the complex social and chronic health issues associated with homelessness can be challenging within the acute care environment. This perspective reflects upon the delivery of emergency healthcare to patients experiencing homelessness, and highlights strategies for optimising health outcomes during and beyond the pandemic.

Key words: *coronavirus, COVID-19, emergency medicine, homelessness, pandemic.*

Background

According to the most recent census data, more than 116 000 people were homeless in Australia on a single night in 2016.¹ Homeless

individuals face numerous barriers to accessing healthcare, and EDs are often the primary entry point to the healthcare system. Although EDs are generally capable of meeting the immediate medical needs of this population, they are not always effective at addressing the complex social and chronic health issues associated with homelessness.

The COVID-19 pandemic, caused by the coronavirus SARS-CoV-2 virus, has the potential to exacerbate existing social inequities and health disparities, including barriers to accessing social services and healthcare. It is imperative that the emergency care community reflects upon the delivery of healthcare to patients experiencing homelessness, with a view to identifying strategies for optimising health outcomes during and beyond the pandemic.

COVID-19 and homelessness

People who are homeless are at disproportionate risk of contracting SARS-CoV-2 and experiencing a more severe disease trajectory. Knowledge of the pathogenesis of

COVID-19 continues to evolve, but available data indicate that males, older adults and people with comorbidities such as hypertension, diabetes, cardiovascular and respiratory disease are at higher risk of critical illness or death from COVID-19. These risk factors are elevated among homeless people, who are predominantly male and suffer a high burden of chronic health conditions (often poorly controlled) at a younger age than the general population, in addition to mental health and substance use problems. The standardised mortality ratio among the homeless population is 2 to 5 times greater than for the general population.²

The majority of people experiencing homelessness in Australia sleep in 'severely' crowded dwellings (44%), supported accommodation (18%), boarding houses (15%) or with other households on a temporary basis (15%).¹ Untenured, congregate living conditions are not conducive to physical distancing, commonly lack amenities necessary to maintain hygiene, and place individuals at greater risk of exposure to infection.³ Moreover, for those who are sleeping rough or staying in congregate shelters, there is little or no opportunity for effective isolation or quarantine measures.

In addition to the risks posed by unstable and unsuitable housing, people who experience homelessness may be unduly affected by lockdown and containment measures, as many support services have been reduced or suspended to comply with government restrictions. For instance, in

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Victoria, drop-in services and day meal programmes have been deemed non-essential services. Although such restrictions have been implemented to reduce community transmission and to prevent outbreaks, contraction of these services may adversely affect the physical and mental health of homeless individuals and hinder community engagement. Closure of community-based services may also lead to increased demands on EDs for health and social care.

Emergency care for homeless people during a pandemic

In order to provide effective care during the COVID-19 pandemic, emergency care providers must be agile in responding to the unique needs of people experiencing homelessness. Clinicians working in urgent and emergency care settings may be the first and only health professionals to have contact with homeless people.⁴ As such, it is essential that ED encounters are used to address the complex healthcare needs of this population and to improve linkages between hospital and community services.

Identification

Homelessness is dynamic and can be challenging to identify. Most existing healthcare systems are poor at identifying homeless patients and underestimate the prevalence of homelessness in the ED.⁵ Under-recognition is exacerbated in emergency settings where homelessness is frequently perceived to be synonymous with 'rough sleeping', despite rough sleepers accounting for only 7% of Australia's homeless population.¹ In the midst of a global pandemic, the urgency to identify people who are homeless is magnified, both because homelessness poses inherent risks that exacerbate potential exposure to infection, but also because there are widespread implications for public health, including community transmission, contact tracing and the provision of isolation and quarantine services. The integration of standardised housing questions into triage screening or routine clinician

history taking may improve the identification of patients experiencing homelessness, as well as those whose housing is at risk.⁶

Provision of acute care

Homeless persons have high rates of ED utilisation and repeat visits.⁷ However, most EDs follow traditional disease models of care and struggle to address the complex social needs of homeless people, alongside tending to their healthcare needs. Despite unresolved needs, people experiencing homelessness often discharge against medical advice or are routinely discharged into unstable housing situations or to the street. Medical step-down facilities under hospital governance (e.g. The Cottage St Vincent's Hospital Melbourne) have been shown to be successful and efficient models to provide healthcare and support, but these are not widely available. There is an urgent need for widespread adoption of innovative and integrated models of ED care, stronger hospital-to-community partnerships and greater collaboration with existing services. For example, the introduction of dedicated homelessness teams and primary care in-reach services into the EDs in Western Australia has proven successful in reducing ED presentations and admissions, decreasing the frequency of discharge against medical advice and producing significant cost savings.⁸ Much of the success of this programme is attributed to the bridging and integration of community services into the acute care setting.

Disposition

Despite ample evidence that 'housing is healthcare', many hospital discharge guidelines fail to acknowledge the implications of housing on health and to consider individual housing needs.⁹ Patient disposition into crowded dwellings or to the street may be especially deleterious during the COVID-19 pandemic and blatantly violate physical distancing restrictions. Indeed, an outbreak of COVID-19 among the homeless

population would be challenging to contain, given the inherent difficulties of contact tracing, isolating and quarantining a transient population. In an effort to avoid this scenario, the Victorian Government has established emergency response homeless hotels for rough sleepers, an Integrated Intake Assessment and Triage Service and COVID-19 Isolation and Recovery Facilities (CIRF) in metropolitan Melbourne. CIRF provide basic healthcare and supported accommodation for people experiencing homelessness who require isolation or quarantine, including patients who are discharged from hospital awaiting test results.¹⁰ Of note, there are no CIRF in regional Victoria and existing CIRF are limited in their capacity to manage behavioural problems and concurrent medical or substance-use conditions that require hospital services.¹⁰ In these instances, EDs may be required to admit patients for ongoing care or at least until SARS-CoV-2 test results are returned, the feasibility of which will vary across services.

Follow up

In order to limit transmission of SARS-CoV-2, maintain public health and better serve and care for people experiencing homelessness, emergency healthcare settings must institute effective systems to identify people who are homeless or at risk of homelessness. Knowledge of housing status is imperative to the provision of adequate treatment and referrals, disposition and ongoing care of homeless individuals.⁶ Furthermore, it provides the base to improve research capability on health and health service utilisation among homeless people, to measure progress, to build evidence, to affect policy change and to provide high-quality services. This is even more important during the era of COVID-19. As communities struggle through this period of economic turmoil and rising unemployment, the number of individuals at risk for homelessness will increase. The absence of point-of-care testing and the associated delays with obtaining swab results

means follow up is frequently conducted via telecommunications. This is problematic and further highlights the importance of CIRF for people experiencing homelessness, as these individuals may be transient, unable to engage with contact tracers, or may not have resources necessary to access telehealth.

Long term

Consistent with the concept of social determinants of health, adequate housing significantly contributes to better health, offering both direct and indirect benefits.³ For these reasons, permanent housing solutions are required, as temporary measures will not eliminate the ongoing risk of COVID-19, nor address the complex health needs within this population. Recent research has demonstrated an association between social deprivation, housing insecurity and COVID-19 infection.¹¹ In order to address the social inequities and the health of people experiencing homelessness, prioritisation and investments in long-term social housing solutions are indicated. COVID-19 may act as the impetus EDs need to advocate for revamped models of care and systemic improvements (including housing) to optimise long-term health outcomes for people experiencing homelessness.

Conclusion

To address the needs of the homeless population during the COVID-19 pandemic, hospitals must consider a range of innovative strategies. These include standardised housing questions, update of discharge guidelines, dedicated homelessness teams and primary in-reach services. EDs are the critical interface between

community- and hospital-based care and are well placed to drive these reforms.

There is a unique opportunity to leverage COVID-19 response efforts to mobilise sustained improvements in health and social care for people experiencing homelessness. In addition to immediate public health benefits, targeted initiatives and multi-sector collaborations have the potential to have a positive, long-term impact on marginalised populations. Addressing the needs of patients experiencing homelessness may be challenging but forms a central component of the social contract between EDs and the communities they serve.

Competing interests

BM, GMOR and GP are section editors for *Emergency Medicine Australasia*.

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