CAEP Position Statement - Draft

Improving Emergency Care for Persons Experiencing Homelessness

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EXECUTIVE SUMMARY

See supplementary document.

CAEP POSITION

Homelessness and unstable housing are modifiable risk factors for poor health outcomes and increased emergency department (ED) utilization. Housing is a key determinant of health that is commonly encountered in EDs.

The Canadian Association of Emergency Physicians (CAEP):

1. Recognizes that people experiencing homelessness are at higher risk of acute illness and death

2. Affirms that people experiencing homelessness should receive supportive care and planning in the ED that avoids involuntary discharge into homelessness

3. Encourages ED care providers to
    a. adopt a trauma-informed approach for all care;
    b. recognize when homelessness or unstable housing contributes to the ED visit;
    c. facilitate access to services that address determinants of health and offer referral to social service providers; and
    d. identify substance use disorders, when present, and offer management and harm reduction.

4. Advocates for system-level policy changes toward an end to homelessness.

SUPPORT FOR CANADIAN GUIDELINE

CAEP endorses the Canadian clinical guideline for homeless and vulnerably housed people, which were developed by an expert group consisting of people with lived experience, providers from diverse medical specialities and health professions, and significant representation across the country.(1) The guideline is also supported by the Canadian Medical Association, Canadian Public Health Association, The Canadian Alliance to End Homelessness, and the Canadian Nurses Association, among others.

BACKGROUND

In Canada, approximately 235,000 people experience homelessness annually, and around 35,000 people are homeless on any given night(2) Compared to the general population, people experiencing homelessness have higher rates of cardiovascular disease, traumatic brain injury, cancer, and other

chronic illnesses.(3-5) As a result of poor living conditions, they are at increased risk of exposure to infectious diseases (e.g., tuberculosis, HIV, and hepatitis C) and face barriers in accessing care.(6, 7)

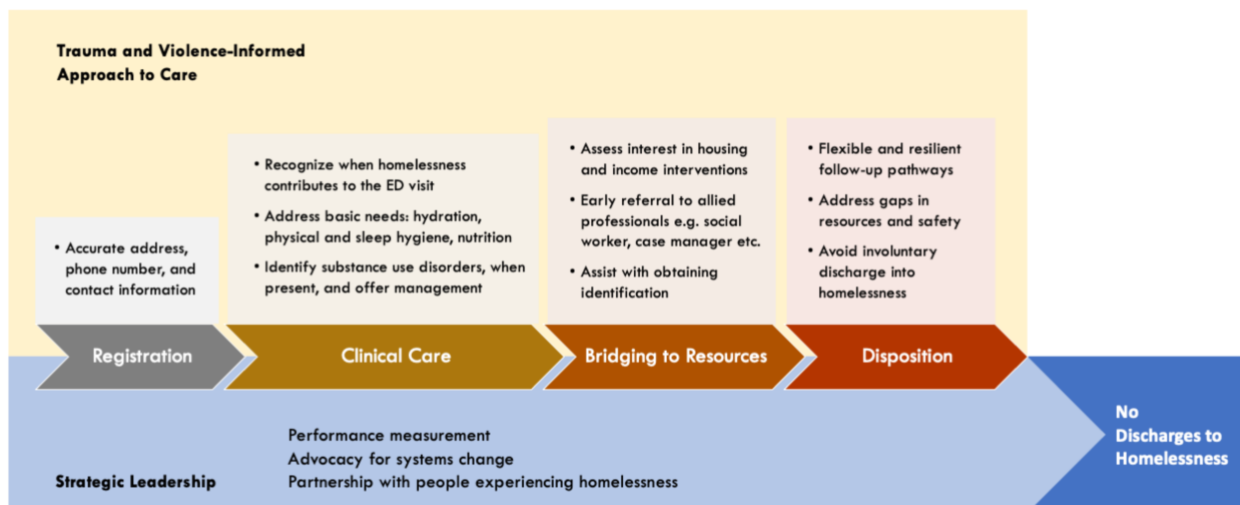
Compared to age-matched controls, those who experience homelessness have significantly higher mortality, with reported rates up to eight times higher for men (8) and 32 times higher for women.(9) ED visits are often related to acute exacerbations of chronic health conditions or medical complications of being homeless.(10) Despite this high risk, homelessness remains an underrecognized determinant of health and disproportionately few resources have been directed towards improving health outcomes for people experiencing homelessness.

As first responders in public health crises and working at a critical intersection of health systems, ED care providers are in a unique position to intervene. People experiencing homelessness present to EDs more than 8 times the rate of matched cohorts (6), and averaging 12 visits per year.(11) However, studies have also found that patients admitted to hospitals experienced at managing homelessness were less likely to be readmitted or return to the ED within 30 days (12) and ED visits declined when people experiencing homelessness were housed.(13, 14) Consequently, ED visits can be an opportunity to support people at high risk for morbidity and mortality within broader efforts to end homelessness.

ED providers are committed to caring for people experiencing homelessness, but may face serious moral distress in feeling unable to identify effective interventions. This strain can lead to inaction and acceptance of the status quo. The intent of this position statement is to provide evidence-informed approaches to improve care for persons experiencing homelessness in EDs across Canada. A range of practices and clinical considerations are advanced to support the application of the Canadian clinical guideline for homeless and vulnerably housed people (**Figure 1**).(1) These practices are pragmatic considerations to promote better care that are adaptable to different contexts and resource levels.

The following sections consider strategies to improve the identification of homelessness, reduce barriers to care, enhance the patient and provider experience, and develop disposition plans that address important needs and resource constraints (**Table 1).** This position statement was developed with the participation of people with lived experience of homelessness; however, no group of authors can represent all important perspectives and local circumstances. Implementation of this position statement should occur in light of evolving knowledge and innovations in care, and in consultation and partnership with affected individuals and communities.

Figure 1 Summary of interventions along the care pathway



IDENTIFYING HOMELESSNESS

a) *Recognize when homelessness or unstable housing contributes to the ED visit and perform targeted screening to inform discharge planning and service delivery.*

EDs are uniquely accessible contact points for the healthcare system. In one Toronto survey, 54% of homeless individuals reported using an ED in the preceding year and EDs were the most commonly reported location to receive care.(15) Identifying homelessness or unstable housing can improve the quality and safety of care and facilitate disposition planning and follow-up.

Homelessness may take varying forms depending on the setting and factors contributing to poverty, such as adequacy of social assistance, intimate partner violence, availability of employment, and access to healthcare for chronic conditions.(16) Instead of focussing on whether a person lacks a structure for habitation ("absolute homelessness"), broader definitions recognize a spectrum of unstable, insecure, and inadequate housing (**Table 2**).(17) While most research on urban populations has focused on people in emergency shelters, people in both urban and rural communities often face "hidden" or relative homelessness, characterized by a lack of affordable housing, unfavourable employment or loss of employment, discrimination and stigma, and a lack of centralized support resources.(18, 19) Where emergency shelters are accessible in rural areas, specialized services (e.g. support for domestic violence) may not be available.

Screening can improve the identification of patients living in unsafe or inadequate housing situations; however, routine screening without a management plan may not be effective. At registration, accurate demographic information can provide indicators of potential homelessness, such as the lack of phone or health insurance numbers or an emergency shelter address as the place of residence. Reviewing the

chart and asking questions such as "Do you have a safe place to go after you leave the ED?" can help to identify homelessness, contribute to disposition planning, and lead to early mobilization of allied health workers.

While not always readily actionable towards care plans, universal screening for social determinants of health in the ED may be useful as part of individual care, as well as for ED-based population-level interventions. Screening for determinants of health such as poverty and cost-related nonadherence to medications have been supported by evidence and should be adapted to the needs and available resources in the local context.(20, 21)

STRATEGIES TO IMPROVE CARE

a) *Use a trauma- and violence-informed approach for all ED care*

Homelessness has numerous severe health and social consequences: surviving despite these disadvantages requires significant resilience to hardships. Many people experiencing homelessness are also suffering from the effects of psychological and/or physical trauma which can profoundly affect their interactions with healthcare providers. Traumatic events may have occurred recently or be related to the ED visit. Taking a trauma- and violence-informed approach to care may have a positive impact on patients' care experience in the ED.(22)

Trauma arises from an event(s) or circumstances that are experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's function and physical, social, emotional, or spiritual well-being.(23) These events can both precipitate loss of housing and occur as a result of being homeless.(24) In addition, the experience of adverse childhood events has been associated with increased morbidity and mortality, as well as increased health care utilization.(25) Traumatic events occur beyond the individual's control, a disempowering experience which ED care providers should avoid replicating during healthcare encounters.(26)

Four principles for implementing trauma- and violence-informed approaches to care can be applied to clinical practices in the ED (27):

1. Understand that trauma and violence affect people's lives and behaviours
2. Create emotionally and physically safe environments
3. Foster opportunities for choice, collaboration and connection
4. Provide a strengths-based and capacity-building approach to support coping and resilience.

The integration of these approaches into ED care (28) and nursing education (29) have been identified as key actions and reflect a paradigm shift from "What is wrong with you?" to "What happened to you?". This approach is consistent with training milestones such as "ME 2.4 Development and implement management plans that consider all the patient's health problems, their social context, and their

expressed wishes in collaboration with the interprofessional team."(30) Many provinces have developed learning modules and/or resource guides to facilitate provider education in this area.(31)

Taking a trauma- and violence-informed approach creates a safer environment for both providers and patients and can result in greater empathy and understanding. Evidence suggests that ED provider attitudes towards people experiencing homeless become more negative over time.(32, 33) Moreover, care providers also experience trauma in their own lives, and this can occur in the workplace. This vicarious trauma may be accompanied by compassion fatigue.(28) Recognizing when behavioural responses are associated with experiences of trauma can facilitate de-escalation, improve the quality and safety of care in the ED, and reduce the risk of re-traumatization.

b) Adapt care strategies in response to different experiences of homelessness and individual needs

Just as arrhythmia management is tailored to patient presentation and risk factors, different care strategies may be needed for different precipitants and experiences of homelessness (**Table 1**). For example, patients faced with eviction may benefit from income support to prevent homelessness, people experiencing homelessness with children may qualify for rapid access to housing for families, and people with functional disabilities may require assisted living arrangements or accessible shelter facilities. Spaces with necessary accommodations for disabilities are more limited in availability and should be considered in discharge planning. The considerations included below illustrate differences within the population, but are not exhaustive.

Recent studies have shown that urban Indigenous peoples are eight times more likely to experience homelessness than non-Indigenous populations.(34) Effects of intergenerational trauma, colonialism, and structural racism contribute to states of homelessness and comorbid conditions which may precipitate ED visits. Practices for advancing good relations when working with Indigenous people experiencing homelessness include trauma-informed and culturally appropriate care, such as the four protocols described by Thistle and Smylie: "situating one's self", "visiting", "hospitality", and "treat people as you would treat your own relative".(35, 36)

LGBTQ2S youth are overrepresented in the homeless population, comprising up to 40% of homeless youths.(37) Shelter may be difficult to obtain as many leave home due to family rejection and emergency shelters are often segregated by birth sex, where people exposed to trans- or homophobia frequently face threats and violence. People identifying as LGBTQ2S may have access to programs or shelters that protect them from discrimination.

Women are systematically undercounted in homelessness statistics and many services for people experiencing homelessness are not designed for their needs.(38) Compared to men, women are more likely to experience poverty, be the sole parent in a family experiencing homelessness (39), be survivors of sexual assault or trafficking, and remain in unstable or unsafe living situations as their source of housing.(38) These experiences of being sheltered in insecure, inadequate, or at-risk housing are termed

"hidden" or "relative" and less well studied than absolute homelessness (**Table 1**). Overall, the use of emergency shelters by women and children and families is increasing, with families staying unhoused up to three times longer than other groups.(40)

Other situations of hidden homelessness include people living in overcrowded conditions, without adequate heating, or "couch surfing". During the COVID-19 pandemic, individuals in relative homelessness face significant barriers to following public health guidelines, such as physically distancing, isolation and quarantine.(41) In addition, newcomer populations in temporary or transitional housing, including migrants and refugees, may experience difficulties navigating support systems due to financial, language, and other barriers.(42)

Respectful inquiry and a trauma-informed approach can help to avoid cognitive biases and stereotypes that lead to medical errors or systematically under-identify homelessness.(43) Furthermore, broader definitions of homelessness may be recognized by patients, providers, and health or social assistance programs. Familiarity with local resources or early referral to providers familiar with these resources can help to optimize care.

c) Manage complications of substance use and facilitate appropriate follow-up.

People experiencing homelessness who use substances may benefit from pharmacologic and non-pharmacologic interventions. Substance use can prolong homelessness when shelters, long-term care facilities, home care services or housing programs have restrictive policies prohibiting drug or alcohol use, or possession of harm reduction supplies. Appropriate management of withdrawal and pain can mitigate premature discharges.(44) The benefits and effectiveness of substance use disorder management in the ED have been described in detail elsewhere.(45) For example, patients with an opioid use disorder can be offered a naloxone kit, opioid agonist therapy, information about supervised consumption services, and counselling on safer consumption practices. Patients with alcohol use disorders can be prescribed medications for withdrawal management and craving reduction, or referred to managed alcohol programs.(46, 47) Follow-up may be facilitated through primary care providers, community health centres, addiction medicine clinics, and/or residential withdrawal management services.

d) Offer services that identify and address gaps in basic needs

Patients experiencing homelessness may lack resources for basic needs, such as clean water, nutritious food, facilities for personal hygiene, and uninterrupted sleep. In the ED, acute illness may be masked by efforts to address malnutrition, dehydration, sleep deprivation, and poor hygiene, which themselves contribute to the higher morbidity and mortality of homelessness.(43) Attending to these basic physical needs, such as offering food and access to facilities to shower, can allow a patient to engage with other forms of healthcare investigations and interventions.(26)

Early activation of allied health workers can facilitate access to safe places to sleep when this basic need cannot be addressed in the ED. In cases when the safety of discharge is in doubt, for example if emergency shelter beds are not available during winter, alternative disposition plans must be made to avoid placing the patient at high risk of harm. In addition to securing shelter, many EDs collect and offer weather-appropriate clothing to patients as part of discharge planning.

e) Inclusion of patients and lived experience experts to improve care

People with lived and living experience of homelessness may be able to anticipate needs and possess valuable and specialized expertise in health and social system navigation. In this capacity, "peer support workers" or "health navigators" have been hired in ED programs to advocate for patient care needs, provide supportive care, and complement the role of EM providers and social workers.

The involvement of peers in a trauma-informed approach may promote positive interactions in the ED, for example by reducing alienation and stigma, to address the lack of trust towards healthcare institutions based on past negative experiences.(22, 48, 49) Furthermore, peers can provide insights to inform care pathway design and ED quality improvement. Evidence from a trial of compassionate care providers in the ED demonstrated reduced visits (50), with enhanced trust and satisfaction proposed as potential explanations. Newer studies into the effect of lived experience peer workers are ongoing. As potentially important contributors to patient care quality and satisfaction, peer workers or navigators should be appropriately compensated for their time and expertise.

f) In the context of higher risks for medical illness, review management plans when patients are alert and clinically stable.

ED visits are often precipitated by acute illness or exacerbations of chronic conditions that also cause altered cognition, including mental illnesses, seizures, substance use disorders, traumatic brain injuries, and infections.(51) The patient's condition during initial assessment may not be conducive to effective communication.(43) Hand-overs and shift changes also increase the risk of quality and safety issues.

As with other ED patients, if a person experiencing homelessness was not initially alert and clinically stable, the disposition should be reconsidered prior to discharge from the ED. To improve safety, given the high health and social burdens of homelessness, management plans that address their specific needs, in their specific context should be confirmed when patients are able to participate. An example of disposition considerations that can be adapted for training or practice standardization is shown in Box 1.

BRIDGING PATIENTS TO RESOURCES

a) *Assess interest in housing and/or income interventions and offer resources when appropriate.*

The higher frequency of ED visits by individuals experiencing homelessness may signal high unmet needs or access barriers to outpatient care.(6, 15) Provision of housing has been linked to improved outcomes across numerous social and medical indicators. A Canadian survey found that residential stability was associated with a lower odds of having unmet healthcare needs and ED utilization.(13) Similarly, a randomized controlled trial showed that an intensive housing case management program reduced hospitalizations, hospital days, and ED visits when compared to usual care.(52) In another study, 24% of respondents stated that if they were provided with food, shelter, and safety they would not have presented to an ED.(53)

Combined with lengths-of-stay which are often longer than ambulatory care consults and the concentration of resources in hospitals, ED visits present opportunities to link patients with housing and/or income resources. Experienced allied health professionals can greatly improve the quality of bridging to supports. Referral to social workers, case managers, housing coordinators, or centralized service coordination programs (such as nationwide 211 services) can reduce ED workload and improve systems navigation.(54) Specialized services may be available based on gender, sexual orientation, age, Indigenous heritage, ethnicity, or trauma history due to the important influence of these factors on homelessness and marginalization. Although this is not possible in all regions served by EDs, the process for housing case management should be initiated whenever possible. When patients have been lost to follow-up with their existing case management, for example, due to lack of access to a telephone, ED visits provide opportunities for re-engagement.(52) A recent literature review provides other examples of ED initiated programs.(55)

As with all patients, people experiencing homelessness have different needs and preferences, which may be related to factors that are not readily apparent to care providers, including experiences of violence, trauma or theft, a sense of community among peers, avoidance of stigmatization, desire to remain with partners or family, and prior negative experiences with institutional settings. For example, some individuals may prefer to be unsheltered ('sleeping rough') or in a tent encampment to reduce exposure to theft, violence, or infections. Assessing a patient's goals and including them in management plans is an important step toward building trust, fostering person-centred care within a trauma-informed approach, and enhancing the effectiveness of interventions.

b) *Ensure that people without identification are able to access ongoing care*

Not having a safe and reliable place to store belongings leads to a heightened risk of theft, loss, or damage of personal identification, including health cards, SIN cards, and birth certificates. ED services must be provided regardless of insurance status, however follow-up care and access to health resources, such as vaccines and prescription medicines, may be impeded by a lack of documentation.(56, 57)

Identification is also necessary to find employment or access essential services, including government programs, housing and income supports.(58)

Government service providers, community agencies, health authorities, and hospital-based programs can assist with applications for document replacement. Facilitating this process reduces barriers and gaps in future care for the patient and inefficiencies for colleagues and other healthcare providers. For example, "ID clinics" are associated with many community health centres in Ontario and Alberta Health Services has provided the "AHS ID program" since 2014.(59)

For prescription medications, especially controlled substances, pharmacies consistently used by an individual may have a record of their identity details. Consider contacting the pharmacy to discuss alternative identification such as a fax or letter containing the patient description to facilitate medication dispensing.

DEVELOPING RESILIENT DISPOSITION PLANS

a) *Develop follow-up plans in collaboration with patients, ensuring that plans reflect their lived reality*

People experiencing homelessness were 2-4 times more likely than the general population to have a repeat ED visit within 7 days in U.S. urban settings (60) and are more likely to be readmitted, or lost to follow-up after discharge.(61) Traditional discharge pathways may not be suitable for patients experiencing homelessness and should be adapted to reflect the realities of their circumstances. For example, many clinics require patients to have a phone to schedule appointments, yet mobile phones are expensive, frequently stolen, and difficult to maintain in functioning condition without a permanent home. Inflexibly scheduled appointments may be a barrier to patients experiencing social instability or who do not have a timekeeping device. Moreover, some clinics may be inaccessible by public transport. Problems can be mitigated by discussing the suitability of follow-up options with the patient and noting potential barriers and contingencies in the referral letter.

Outpatient follow-up pathways can be designed to improve access and reduce unplanned missed appointments. For example, some addiction medicine clinics do not require scheduled appointments or referral letters and have been effective in providing ongoing management.(47) Other strategies include agreements to assess patients without appointment on the next clinic day, providing the patient (or primary care provider, or with permission, friend, case worker etc.) with the clinic phone number, and having consult services assess patients in the ED prior to discharge. Given the reliance on telecommunication as a prerequisite for access to healthcare, some EDs have piloted programs to redistribute mobile phones with prepaid SIM cards to people experiencing homelessness.(62)

To aid planning, consider developing a discharge checklist for patients leaving the ED, including elements that review the clinical condition, discharge environment, follow-up, and need for additional support (Box 1). The patient's social context may include factors that are unfamiliar to even providers experienced with addressing homelessness, hence planning should aim to explore and resolve relevant patient concerns. A systematic approach may also identify patients who are not suitable for discharge so that alternative options can be activated early.

b) Address complex health needs and capacity to effectively manage illness in the community.

People experiencing homelessness may require coordinated management of severe or multiple comorbidities and social needs to stabilize their health, including mental illness and/or substance use disorders. Social workers, community resource navigators, the 211 service, community health centres, or the primary care providers may be able to connect the patient with multi-disciplinary support services, such as "intensive case management", "assertive community treatment", "critical time intervention", comprehensive primary care, or population-specific programs.(1) These programs may have different names depending on the setting. Some patients may already be enrolled and communicating with the program team can facilitate a "warm hand-over" to rapid follow-up from care providers familiar with the individual's needs.

People experiencing homelessness may also have greater difficulty managing or recovering from illness as outpatients than individuals with adequate housing. Structural factors include lack of access to a safe, clean, and private space to recover, lack of daytime shelter (many emergency shelters only allow access overnight), lack of reliable access to water and nourishment, lack of access to facilities for personal hygiene (sinks, toilets, showers), difficulty obtaining prescription medications and devices, storing medications securely, and self-administering medications on a regular schedule.(12) Awareness of resources available within the local shelter system may improve disposition planning and avoid return visits to the ED. Some shelters offer on-site primary care or are accessible to home care and virtual care services. If appropriate, send a summary of the ED visit to shelter-based clinics with patient consent.

When safe and effective management of illness in an outpatient setting is not possible, inpatient admission should be considered in discussion with the patient. When available, discharge to a medical respite facility can also be considered. Medical respite care has been associated with decreased readmission rates to hospital and may decrease ED use.(43)

c) Consider the risk of community transmission for patients with suspected or confirmed infections

Infectious disease outbreaks have been frequent in the emergency shelter system, including Group A *streptococcus* (63), tuberculosis (64), and influenza. Consider sanitation requirements for the expected illness course such as reliable access to a private washroom for gastroenteritis or regular bathing for

wound care. Similarly, people experiencing "hidden" or relative homelessness may live in overcrowded or inadequate conditions where infection control is not possible.

The emergence of SARS-CoV-2 has underlined the critical importance of improved infection prevention and control measures in emergency shelters, as people with a history of homelessness are more likely to contract, be admitted to hospitals and the ICU, and to die of COVID-19.(65) Patients with symptoms consistent with COVID-19 or other infectious respiratory illness should only be discharged to facilities where they are able to isolate according to public health recommendations.(66) Ultimately patients who do not have adequate housing to support their care needs and prevent illness transmission may require admission to hospital, transitional housing, or local alternatives including hotel rooms.

d) Consider dispensing medications to facilitate ongoing management

Patients lacking identification, adequate income, or a fixed address face difficulties filling their prescriptions. In order to address these barriers, some EDs have agreements with pharmacies to reduce dispensing fees or create alternative pathways for identification (for example, a faxed form with a patient's name and identifying physical characteristics). If a patient already receives medications that are dispensed daily (for example, methadone) consider offering to prescribe any new medications as daily dispense to reduce the risk of loss or theft. Many patients experiencing homelessness are eligible for prescription medicine insurance and may benefit from assistance to apply or activate their benefits.

When alternatives are not available, providers can consider dispensing medications directly from the ED (compassionate supply), in accordance with local policies and procedures, to improve adherence and reduce financial burden. Previous research suggests moderate rates of non-adherence for prescriptions from the ED (67), but dispensing medications directly has been shown to reduce repeat visits and save costs overall.(68, 69) This may require advance planning with ED leadership, including nurse managers and pharmacists, to ensure that medications are available when needed, or coverage for the cost of medications if an ED source is not available. Common medications include analgesics, antiemetics, antibiotics, and medications to manage substance use disorders (naloxone, buprenorphine, gabapentin, naltrexone etc.). During the COVID-19 pandemic, some health authorities have expanded insurance coverage for emergency prescriptions and some hospital pharmacies increased their capacity to fill outpatient prescriptions.

e) Avoid discharging patients to homelessness

Being homeless can be life-threatening. Avoid discharging patients into homelessness when access to transitional or permanent housing is available and the patient is interested in these resources.(55) Involuntary discharge of patients without a safe plan for shelter poses immediate health risks. Developing partnerships with local shelters for intake directly from the ED or shelters that can accommodate patients' care needs with medication storage or wound care can help facilitate this

transition. Similar to disposition planning for any other patient, if no formal or informal shelter suitable for a patient's needs is available, the hospital may have to be the shelter of last resort until alternate arrangements can be made.

IMPROVING EVIDENCE AND MEASURING PROGRESS

a) *Accurate documentation of homelessness in demographic information and as a diagnosis when homelessness contributes to the reason(s) for the ED visit*

Accurate registration of demographic information facilitates identification of homelessness and enhances the availability of data for quality improvement and research. Lack of data and problems with data validity reduce recognition of the extent of homelessness and its relative priority in research, policy, and clinical practice. Moreover, linkage of data can help to overcome difficulties in characterizing homeless populations in Canada in terms of demographics, geographic distribution, and health system utilization.(70) "Hidden" and relative homelessness are often not reflected in official statistics and may require targeted screening to identify.(38)

At registration, addresses listed on patient charts may need updating or flagged as emergency shelters. Homelessness can also be documented in the diagnosis field of ED charts and on death certificates when it is relevant to the patient's condition. "Homelessness" and "inadequate housing" are official diagnoses coded as Z59.0 and Z59.1, respectively, in the International Classification of Diseases 10th edition Canadian modification (ICD-10-CA), a standard system used Canada-wide.(71)

If data on social determinants of health are collected, systematically associating the social history with patient records can be valuable for future visits, follow-up appointments, or longitudinal management by other providers. Social data also provides an evidence base to build pathways for additional care, such as dispensing medications or income support as part of the patient's care plan.(72)

b) Identify gaps in ED knowledge about homelessness to target further progress

Recent reviews of the literature and ongoing work by experts have identified gaps in knowledge and training for the management of patients experiencing homelessness.(73) Important questions that remain include the following list and would benefit from further examination in collaboration with people with lived experience of homelessness.

- How should the management of homelessness be integrated into EM training?
- How is screening for homelessness best achieved?
- What housing interventions can be effectively initiated in EDs?
- What should be the role of peer workers?

- What are effective relationships between EDs, public health and housing agencies?
- How can an 'asset-based approach' be applied to practice and research?

DISCHARGE TO HOMELESSNESS IS PREVENTABLE

Homelessness is an unacceptable condition for health and human dignity, especially in a nation as wealthy as Canada. Although the effects of homelessness are seen routinely and acutely in EDs and meaningful steps can be taken to mitigate its harms, strong and generalizable interventions to end homelessness from the ED are few and far between. Ideally, EDs should not be addressing social issues, but we are responding to the existing failures of policy while aiming to prevent needless suffering in the future. In addition to high quality ED care in safe spaces, upstream systemic approaches are necessary to prevent crises of homelessness from becoming emergencies.

a) *Advocating and partnering for change*

Providing care at the individual level is an important step but not a permanent solution. In order to sustainably prevent discharges to homelessness, ED providers can leverage their professional skills and insights to advocate for stable housing for all people in Canada.(74, 75)

Partnerships with community providers of income and housing resources or healthcare to homeless populations can avoid unnecessary ED visits and ensure that ED resources are directed towards the needs of the populations they serve. Rapidly accessible and appropriate community resources would facilitate this goal by allowing "warm hand-overs" to service providers. Advocating for these resources may involve engagement with local, regional and national governments and organizations to lend the support of ED care providers where our support would advance efforts to resolve homelessness.

b) *Prevention of homelessness*

Across Canada, nearly 1 in 8 households live with unsuitable, inadequate or unaffordable housing.((76) According to financial security data, nearly half of renter households have less than one month of savings.(77) Homelessness is a symptom of extreme poverty and not a choice that people make freely. Rather, homelessness results from factors including marginalization, precarious employment, government income assistance below the cost of living, and lack of social infrastructure, such as affordable child care, prescription drug insurance, and housing.(78) For example, people living with mental illness are often excluded from society when barriers to employment contribute to poverty. Poverty further limits participation in society, maintenance of relationships, time and money to seek primary healthcare, and ability to pay for prescription medications.

One evidence-based approach to address the network of factors contributing to homelessness is called "Housing First". In this strategy, permanent shelter is provided along with support services to enable the transition to stable long-term housing. Housing First interventions have been effective at alleviating chronic homelessness (79), are less expensive than emergency shelters and hospital admission (80), and help to restore the individual control and agency necessary for well-being.(81) Connecting people experiencing homelessness with secure and adequate housing, supported by well-aligned social policies, could dramatically improve their outcomes. In Finland, this approach resulted in a 39% reduction in homelessness between 2010 and 2018.(82) Comprehensive resources for policies and interventions to support an end to homelessness have also been developed for Canada (http://cnh3.ca/resources/).

ED care is often directed at problems created by failures of prevention, gaps in policy, and inter-generational inequities of health and well-being. CAEP recognizes opportunities for action outside of the ED's control and advocates for system-level change to facilitate the aim of preventing and ending homelessness.

SUMMARY

As evidence-based clinicians, CAEP supports the improved identification and management of homelessness in EDs in order to improve the health of people at high risk for morbidity and mortality. ED care providers are experts in problem-solving, stabilization, and teamwork no matter the complexity or time of day. We bear witness to the suffering that results from gaps in healthcare, social supports, and policy that perpetuate and aggravate homelessness. As influential members of society, ED care providers are privileged with the trust of the general public and can enact change in partnership with marginalized patients.

Housing is necessary for health. By addressing a key social determinant, ED care providers have an opportunity to improve patient safety, enhance quality of care for all patients, and address a crisis condition that often triggers ED visits. Collectively, we should strive to never discharge a patient from the ED into homelessness. While we work towards this goal, we can intervene to provide high-quality patient-centred acute illness management, facilitate emergency relief support, and contribute to strategies to prevent and end homelessness.

Table 1 Selected ED interventions. A complete summary and examples can be found at [CAEP link]

Situation	Context	Interventions and Examples
All ED care	Promote safer environment for patients and providers	Trauma-informed approach e.g. avoid rigid enforcement of rules that are not immediately needed for safety, allow flexibility in management plans to establish trust, attend to basic needs. More examples: Alberta Health Services module (34)
All ED care	Homelessness is associated with severe deprivation	Attend to basic needs: address dehydration, malnutrition, sleep deprivation, personal hygiene, e.g. offer food, access to shower facilities, appropriate clothing
All ED care	Homelessness is underrecognized	Identify homelessness through accurate registration of demographic, screening when appropriate ("Do you have a safe place to go?"), and as the diagnosis when contributory.
Person identifies as experiencing homelessness	ED visit may be signal of high unmet needs	Assess interest in housing and income interventions. Early involvement of allied health professionals and community resources when appropriate.
Person identifies as Indigenous	May experience effects of racism and intergenerational trauma	Culturally-appropriate care to advance good relations e.g. applying protocols for clinical care: "situating one's self", "visiting", "hospitality", and "treat people as you would treat your own relative"(35), implementing TRC recommendations for health care (36), San'yas training program: sanyas.ca
Person identifies as a woman	More likely to experience poverty, sole parenthood, sexual abuse or trafficking	Consider screening for gender-based abuse and violence Consider resources available for women and families
Person who uses drugs / substance use disorder	Risk of complications from substance use. May have barriers to housing.	Management of substance use, withdrawal and untreated pain, e.g. offer naloxone (45), information on supervised consumption, anti-craving medications, etc.
Individual or family at high risk of homelessness	e.g. "couch surfing", recent eviction notice, sudden loss of income, etc.	Early referral to social worker, case manager, housing coordinator, or community agency. Application for income supports, rent bank funds, access to housing for families, etc.
Disposition planning	Effective planning can improve quality of care and reduce length of stay and return visits	As needed, facilitate access to identity documents, alternate pathways and back-up plans for follow-up, medications, and resources to manage illness in the community, e.g. dispense supply of medications, program to supply reused mobile phones (83), referral to respite care, etc.
ED policies and	Promote trust and positive	Involve people with lived experience of homelessness to

pathways	interactions, reduce stigma (22, 48, 49)	provide insights, inform design, and establish community relationships. Appropriately compensate participation.
Advocacy to end homelessness	Upstream action is needed to prevent housing emergencies	Advocate and partner with individuals and communities for structural change by leveraging ED care provider professional skills, relationships, and resources.

Table 2 Definitions of homelessness and housing exclusion adapted from the Indigenous Definition of Homelessness in Canada and the Canadian Observatory on Homelessness.(84, 85)

Terms	Definition	Examples and descriptions
Homelessness	Lacking stable, permanent, appropriate housing, or the immediate prospect, means and ability of acquiring it.	
Indigenous definition of homelessness	First Nations, Métis and Inuit individuals, families or communities experiencing homelessness as described through a composite lens of Indigenous worldviews.	Includes isolation from Indigenous peoples' relationships to land, water, place, family, kin, each other, animals, cultures, languages and identities.
Unsheltered, Absolute homelessness	Lack of housing and residing in places not intended for human habitation	Living on public sidewalks or parks ("street homelessness"), in tents, vehicles, or unsafe vacant buildings
Emergency sheltered	Residing in temporary, institutional shelters	Emergency overnight shelters, shelters for people impacted by family violence
Provisionally accommodated	Living in temporary housing without a prospect of permanence, including interim housing and "hidden homelessness".	Residing in prisons, group homes, or other institutions without housing upon leaving; recently arrived immigrants and refugees without means to obtain permanent housing
Hidden homelessness	Living temporarily with others without means to obtain permanent housing	"couch surfing", living with an abusive partner; living in hostels, motels, and rooming houses
Transitional housing, Interim housing	Systems-supported bridge housing between living unsheltered and permanent housing, usually offering time-limited housing security	Housing program offering more privacy, employment pathways, and case management; housing for individuals or families impacted by violence offering trauma-recovery support
At-risk of homelessness, Relative homelessness	Living in housing intended for permanent habitation with economic or housing precarity, or conditions that do not meet health and safety standards	Overcrowding, inadequate heating, sudden unemployment, households facing eviction, violent or abusive situation, institutional care that is unsuitable

Box 1. Discharge Considerations Example:

1. Clinical reassessment
    - ❑ Is the patient awake and alert?
    - ❑ Has the patient been reassessed by a physician prior to the decision to discharge?
2. Discharge environment and transportation
    - ❑ Where will the patient be going from the ED?
    - ❑ Are there any safety concerns at the discharge destination?
    - ❑ Will the patient have adequate functional supports for their expected level of care?
    - ❑ How will the patient get to their discharge destination?
3. Discharge prescriptions
    - ❑ Does the patient understand what has been prescribed and how it should be taken?
    - ❑ Does the patient have coverage for the prescriptions? If not, consider pharmacy consultation or provision of a compassionate supply of medications from the ED.
    - ❑ Would it be beneficial to fax prescriptions directly to the patient's pharmacy?
    - ❑ Should the patient be taking any non-prescription medications () and do they have access to these? If not, consider compassionate supply from the ED. Some common non-prescription medications, such as acetaminophen, may also be covered by government plans.
4. Follow-up plan
    - ❑ Does the patient understand all referrals that have been made and how appointments will be arranged? Alternative contact options may be required, e.g. via case worker.
    - ❑ If the patient will need to be contacted for an appointment, do they have access to a reliable phone number at which they can be reached?
5. Community health and social supports
    - ❑ Have you or the patient identified any other issues that can be addressed from the ED or with appropriate referrals? Consider social work or peer navigator consultation, identification (ID) service for lost or stolen health cards, addiction/mental health supports, referral to housing supports, etc.)
6. Patient concerns
    - ❑ Have all relevant patient concerns been identified and addressed to promote a safe discharge?

If all issues have been addressed, proceed with discharge of the patient from the ED. If any significant outstanding concerns persist, reconsider appropriateness of this patient for discharge.(86)

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