AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 117
(A-23)

Introduced by: Texas

Subject: Payment for Physicians Who Practice Street Medicine

Referred to: Reference Committee A

Whereas, A person experiencing homelessness is defined as someone who lacks a fixed, regular, and adequate nighttime residence; and

Whereas, The U.S. Department of Housing and Urban Development estimated that in 2022, nearly 600,000 Americans experienced homelessness, which is likely severely underreported; and

Whereas, Cities across the country report rising rates of evictions; and

Whereas, Street medicine's approach is to engage people experiencing homelessness exactly where they are by providing medical care to unsheltered populations experiencing homelessness in locations like encampments, parks, and under bridges versus mobile or stationary clinics focused on this population; and

Whereas, Homelessness reduces one's life expectancy by more years than do any of the major contributors to death in the U.S. (e.g., heart disease, smoking, diabetes, breast cancer), with people experiencing homelessness living 17.5 years less than the general population; and

Whereas, Many physical and mental health disparities exist between people experiencing homelessness and the general population as seen in, but not limited to, the prevalence of diabetes (18% vs. 9%), hypertension (50% vs. 29%), heart attack (35% vs. 17%), HIV (20% vs. 1%), substance use disorders (58% vs. 16%), depression (49% vs. 8%), and dual diagnosis of a mental health condition and a substance use disorder (30% to 70% vs. 2.5%); and

Whereas, People experiencing homelessness are five times more likely to be admitted as inpatients and have an average length of stay in the emergency department that is 2.32 times that of the general population due to untreated conditions escalating into life-threatening emergencies; and

Whereas, In terms of hospital admissions, it costs $2,559 more to treat patients experiencing homelessness than the general population, even after adjusting for age, gender, and hospital resource use; and

Whereas, Street medicine has been shown to decrease hospital admissions, hospital length of stay, and emergency department visits, and saved one health system $3.7 million in emergency department visits; and

Whereas, People experiencing homelessness are 11 times more likely to face incarceration, and formerly incarcerated individuals are approximately 10 times more likely to become homeless compared with the general population, thus perpetuating a "revolving prison door"; and

Whereas, The government spends an average of $35,578 per year for every person who must endure chronic homelessness toward publicly funded crisis services, including jails, hospitalizations, and emergency departments; and

Whereas, More than 95% of prisoners eventually return to the general population, along with their health conditions, and 80% are without health insurance upon reentry into the community; and

Whereas, Street medicine offers the opportunity to help former inmates who return to society to access continuous health care treatment for their mental and physical health conditions and find stable housing; and

Whereas, Grant-funded street medicine programs continue to expand across the country, including the nation's first emergency medicine street medicine fellowship in Fort Worth, Texas; and

Whereas, Even though the majority of street medicine programs are nonprofit programs, there are publicly funded pilot programs and resident-run clinics that demonstrate the efficacy of a standardized payment system; and

Whereas, In December 2022, California Medicaid published guidance for Medicaid managed care plans to follow regarding the use of street medicine to address the health needs of Medi-Cal members experiencing unsheltered homelessness; and

Whereas, Several American Medical Association policies (H-160.903, H-160.978, 11.1.4, and H-345.975) advocate for increasing access to care for underserved populations and eradicating homelessness but do not contain specific verbiage on compensation for physicians who practice street medicine; and

Whereas, There is no explicit AMA policy in support of Medicare and Medicaid payment for physicians who practice street medicine, and thus street medicine is an innovative program for the AMA to support to address a large problem for a long-term basis; therefore be it

RESOLVED, That our American Medical Association support the development of street medicine programs to increase access to care for populations experiencing homelessness and reduce long-term costs (New HOD Policy); and be it further

RESOLVED, That our AMA support the implementation of Medicare and Medicaid payment for street medicine initiatives by advocating for necessary legislative and/or regulatory changes, including submission of a recommendation to the Centers for Medicaid & Medicaid Services asking that it establish a new place-of-service code to support street medicine practices for people eligible for Medicare and/or Medicaid, with "street medicine" defined, in keeping with the Street Medicine Institute, as "the provision of health care directly to people where they are living and sleeping on the streets." (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 5/24/23

RELEVANT AMA POLICY

Eradicating Homelessness H-160.903
Our AMA:
(1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services;
(2) recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless;
(3) recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis;
(4) supports the use of physician-led, team-based street medicine programs, which travel to individuals who are unhoused or unsheltered and provide healthcare and social services, as well as funds, including Medicaid and other public insurance reimbursement, for their maintenance;
(5) recognizes the need for an effective, evidence-based national plan to eradicate homelessness;
(6) encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons;
(7) will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of homeless patients and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians' role therein, in addressing these needs;
(8) encourages the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital;
(9) encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients;
(10) (a) supports laws protecting the civil and human rights of individuals experiencing homelessness, and (b) opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available; and
(11) recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods;
(12) (a) supports training to understand the needs of housing insecure individuals for those who encounter this vulnerable population through their professional duties; (b) supports the establishment of multidisciplinary mobile homeless outreach teams trained in issues specific to housing insecure individuals; and (c) will make available existing educational resources from federal agencies and other stakeholders related to the needs of housing-insecure individuals.
(13) encourages medical schools to implement physician-led, team-based Street Medicine programs with student involvement.
Citation: Res. 401, A-15; Appended: Res. 416, A-18; Modified: BOT Rep. 11, A-18; Appended: BOT Rep. 16, A-19; Appended: BOT Rep. 28, A-19; Appended: Res. 414, A-22; Appended: Res. 931, I-22;

Housing Insecure Individuals with Mental Illness H-160.978
(1) The AMA believes that public policy initiatives directed to the homeless, including the homeless mentally ill population, should include the following components: (a) access to care (e.g., integrated, comprehensive services that permit flexible, individualized treatment; more humane commitment laws that ensure active inpatient treatment; and revisions in government funding laws to ensure eligibility for homeless persons); (b) clinical concerns (e.g., promoting diagnostic and treatment programs that address common health problems of the homeless population and promoting care that is sensitive to the overriding needs of this population for food, clothing, and residential facilities); (c) program development (e.g., advocating emergency shelters for the homeless; supporting a full range of supervised residential placements; developing specific programs for multiproblem patients, women, children, and adolescents; supporting the development of a clearinghouse; and promoting coalition development); (d) educational needs; (e) housing needs; and (f) research needs. (2) The AMA encourages medical schools and residency training programs to develop model curricula and to incorporate in teaching programs content on health problems of the homeless population, including experiential community-based learning

experiences. (3) The AMA urges specialty societies to design interdisciplinary continuing medical education training programs that include the special treatment needs of the homeless population. Citation: BOT Rep. LL, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmed: CMS Rep. 01, A-16; Reaffirmed: BOT Rep. 16, A-19; Reaffirmed: Res. 414, A-22;

11.1.4 Financial Barriers to Health Care Access
Health care is a fundamental human good because it affects our opportunity to pursue life goals, reduces our pain and suffering, helps prevent premature loss of life, and provides information needed to plan for our lives. As professionals, physicians individually and collectively have an ethical responsibility to ensure that all persons have access to needed care regardless of their economic means.
In view of this obligation,
(a) Individual physicians should:
(i) take steps to promote access to care for individual patients, such as providing pro bono care in their office or through freestanding facilities or government programs that provide health care for the poor, or, when permissible, waiving insurance copayments in individual cases of hardship. Physicians in the poorest communities should be able to turn for assistance to colleagues in more prosperous communities.
(ii) help patients obtain needed care through public or charitable programs when patients cannot do so themselves.
(b) Physicians, individually and collectively through their professional organizations and institutions, should participate in the political process as advocates for patients (or support those who do) so as to diminish financial obstacles to access health care.
(c) The medical profession must work to ensure that societal decisions about the distribution of health resources safeguard the interests of all patients and promote access to health services.
(d) All stakeholders in health care, including physicians, health facilities, health insurers, professional medical societies, and public policymakers must work together to ensure sufficient access to appropriate health care for all people.

Maintaining Mental Health Services by States H-345.975
Our AMA:
1. supports maintaining essential mental health services at the state level, to include maintaining state inpatient and outpatient mental hospitals, community mental health centers, addiction treatment centers, and other state-supported psychiatric services;
2. supports state responsibility to develop programs that rapidly identify and refer individuals with significant mental illness for treatment, to avoid repeated psychiatric hospitalizations and repeated interactions with the law, primarily as a result of untreated mental conditions;
3. supports increased funding for state Mobile Crisis Teams to locate and treat homeless individuals with mental illness;
4. supports enforcement of the Mental Health Parity Act at the federal and state level; and
5. will take these resolves into consideration when developing policy on essential benefit services.
Citation: Res. 116, A-12; Reaffirmation A-15; Reaffirmed: Res. 414, A-22;