

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 11
(I-21)

Introduced by: Alexandria Wellman, MD, MS

Subject: Improvement of Care and Resource Allocation for Homeless Persons in the Global Pandemic

Referred to: Reference Committee

1 Whereas, The COVID-19 pandemic has shown the ability to shelter in place as a social
2 determinant of health¹, and the reduction of homelessness should be a major focus of public
3 health efforts within the United States²; and
4

5 Whereas, The high prevalence of chronic health conditions such as cardiac disease, pulmonary
6 disease, liver disease, smoking, and accelerated aging in the homeless population increase
7 their risk for poor disease outcomes for SARS-CoV2^{2,3}; and
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9 Whereas, Homeless shelters and encampments are particularly susceptible to large outbreaks
10 of SARS-CoV2², and the crowding in informal settlements make self-quarantine nearly
11 impossible leading to increased likelihood of rapid infection spread⁴; and
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13 Whereas, Interventions that are designed to house, space, and treat homeless persons to allow
14 for adequate ability for persons to socially distance and quarantine are first steps to begin
15 addressing this issue³; and
16

17 Whereas, Implementing housing-first interventions for homeless persons improves their quality
18 of life while also reducing ineffective public service spending⁵; and
19

20 Whereas, Healthcare spending has been found to be up to 3.3 times higher for homeless
21 persons than the national average of Medicaid spending per enrollee⁶, and homelessness is
22 linked to greater usage of acute hospital services⁵; and
23

24 Whereas, Involvement in drugs and untreated mental illness, compounded with other negative
25 life events, are social determinants that often lead to homelessness⁵; and
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27 Whereas, Current American Medical Association (AMA) policy has not made any measurable
28 changes within this public health crisis by virtue of being too broad, therefore necessary and
29 changes must be added to make specific, measurable, and worthwhile changes to advocate for
30 the health of individuals experiencing homelessness in the United States; therefore be it
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32 RESOLVED, That our AMA advocate that law enforcement receive specific training to
33 understand the needs and vulnerabilities for the homeless and unhoused population in order to
34 become compassionate outreach personnel while they engage with their communities during
35 their duty hours; and be it further
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37 RESOLVED, That our AMA advocate for mobile homeless outreach teams consisting of
38 psychiatrists, social workers, and law enforcement specially trained in homeless outreach to

1 connect homeless persons with and bring them to the location for appropriate housing and
2 medical resources for their individual needs; and be it further
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4 RESOLVED, That our AMA advocate for the creation of government-funded assisted living
5 communities with high quality inpatient and outpatient psychiatric services for those psychiatric
6 disorders; and be it further
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8 RESOLVED, That our AMA advocate for the creation of government-funded assisted living
9 communities with high quality inpatient and outpatient addiction medicine services; and be it
10 further
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12 RESOLVED, That our AMA advocate for housing-first initiatives for homeless and housing-
13 insecure individuals; and be it further
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15 RESOLVED, That this resolution be immediately forwarded to our AMA House of Delegates at
16 the November 2021 Special Meeting.

Fiscal Note:

References:

1. Coughlin CG, Sandel M, Stewart AM. Homelessness, Children, and COVID-19: A Looming Crisis. *Pediatrics*. 2020;146(2):e20201408. doi:10.1542/peds.2020-1408
2. Baggett TP, Racine MW, Lewis E, De Las Nueces D, O'Connell JJ, Bock B, Gaeta JM. Addressing COVID-19 Among People Experiencing Homelessness: Description, Adaptation, and Early Findings of a Multiagency Response in Boston. *Public Health Rep*. 2020 Jul/Aug;135(4):435-441. doi: 10.1177/0033354920936227. Epub 2020 Jun 9. PMID: 32516035; PMCID: PMC7383767.
3. Perri M, Dosani N, Hwang SW. COVID-19 and people experiencing homelessness: challenges and mitigation strategies. *CMAJ*. 2020;192(26):E716-E719. doi:10.1503/cmaj.200834
4. Corburn J, Vlahov D, Mberu B, Riley L, Caiaffa WT, Rashid SF, Ko A, Patel S, Jukur S, Martínez-Herrera E, Jayasinghe S, Agarwal S, Nguendo-Yongsi B, Weru J, Ouma S, Edmundo K, Oni T, Ayad H. Slum Health: Arresting COVID-19 and Improving Well-Being in Urban Informal Settlements. *J Urban Health*. 2020 Jun;97(3):348-357. doi: 10.1007/s11524-020-00438-6. Erratum in: *J Urban Health*. 2021 Apr;98(2):309-310. PMID: 32333243; PMCID: PMC7182092.
5. Stafford A, Wood L. Tackling Health Disparities for People Who Are Homeless? Start with Social Determinants. *Int J Environ Res Public Health*. 2017 Dec 8;14(12):1535. doi: 10.3390/ijerph14121535. PMID: 29292758; PMCID: PMC5750953.
6. Koh KA, Racine M, Gaeta JM, Goldie J, Martin DP, Bock B, Takach M, O'Connell JJ, Song Z. Health Care Spending And Use Among People Experiencing Unstable Housing In The Era Of Accountable Care Organizations. *Health Aff (Millwood)*. 2020 Feb;39(2):214-223. doi: 10.1377/hlthaff.2019.00687. PMID: 32011951; PMCID: PMC7384249.

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) recognizes the need for an effective, evidence-based national plan to eradicate homelessness;
- (5) encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons;

(6) 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;

(7) 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;

(8) 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;

(9) (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

(10) 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. [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]

The Mentally Ill Homeless 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. [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]

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. [Res. 116, A-12; Reaffirmation A-15]

Multiple-Drug Resistant Tuberculosis - A Multifaceted Problem H-440.938

- (1) Testing for tuberculous infection should be performed routinely on all HIV-infected patients, according to current recommendations from the U.S. Public Health Service.
- (2) Testing for HIV infection should be routinely performed on all persons with active tuberculosis.
- (3) Reporting of HIV infection and tuberculosis should be linked to enhance appropriate medical management and epidemiologic surveillance.

- (4) Aggressive contact tracing should be pursued for cases of active tuberculosis, especially if HIV-infected contacts or multiple-drug resistant tuberculosis strains have been involved.
- (5) HIV-infected health care workers and their physicians must be aware of the high risk of clinical TB for persons whose immune systems are compromised, due to HIV or other causes. They should be carefully apprised of their risk, and the risks and benefits of their caring for persons with active TB or suspected TB should be carefully considered.
- (6) HIV-infected and other immunocompromised patients should be sufficiently separated from tuberculosis patients and the air they breathe so that transmission of infection is unlikely.
- (7) All health care workers should have a tuberculin skin test upon employment, with the frequency of retesting determined by the prevalence of the disease in the community. Individuals with a positive skin test should be evaluated and managed according to current public health service recommendations.
- (8) Health care facilities that treat patients with tuberculosis should rigorously adhere to published public health service guidelines for preventing the nosocomial transmission of tuberculosis.
- (9) Adequate and safe facilities must be available for the care of patients with tuberculosis; in some areas this may necessitate the establishment of sanitariums or other regional centers of excellence in tuberculosis treatment.
- (10) Clinical tuberculosis laboratories should develop the capability of reliably performing or having reliably performed for them rapid identification and drug susceptibility tests for tuberculosis.
- (11) Routinely, drug susceptibility tests should be performed on isolates from patients with active tuberculosis as soon as possible.
- (12) A program of directly observed therapy for tuberculosis should be implemented when patient compliance is a problem.
- (13) The AMA should enlist the aid of the Pharmaceutical Research and Manufacturers of America (PhRMA) in encouraging manufacturers to develop new drugs and vaccines for tuberculosis.
- (14) The federal government should increase funding significantly for tuberculosis control and research to curtail the further spread of tuberculosis and encourage development of new and effective diagnostics, drug therapies, and vaccines.
- (15) The special attention of physicians, public health authorities, and funding sources should be directed toward high risk and high incidence populations such as the homeless, immigrants, minorities, health care workers in high risk environments, prisoners, children, adolescents, and pregnant women.
- (16) The AMA will develop educational materials for physicians that will include but not be limited to the subtleties of testing for TB in HIV-infected individuals; potential risk to HIV-infected individuals exposed to infectious diseases, including TB; and other issues identified in this report.
- (17) The AMA encourages physicians to remain informed about advances in the treatment of tuberculosis, including the availability of combination forms of drugs, that may reduce the emergence of drug-resistant strains. [BOT Rep. OO, A-92; Sub. Res. 505, I-94; Reaffirmed and Modified: CSA Rep. 6, A-04; Reaffirmed: CSAPH Rep. 1, A-14]