

# Caring for patients with lived experience of homelessness

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## Abstract

**Objective** To guide family physicians working in a range of primary care clinical settings on how to provide care and support for patients who are vulnerably housed or experiencing homelessness.

**Sources of information** The approach integrates recommendations from evidence-based clinical guidelines, the views of persons with lived experience of homelessness, the theoretical tenets of the Patient's Medical Home framework, and practical lessons learned from family physicians working in a variety of clinical practice settings.

**Main message** Family physicians can use simple and effective approaches to identify patients who are homeless or vulnerably housed; take initial steps to initiate access to housing, income assistance, case management, and treatment for substance use; and work collaboratively using trauma-informed and anti-oppressive approaches to better assist individuals with health and social needs. Family physicians also have a powerful advocacy voice and can partner with local community organizations and people with lived experience of homelessness to advocate for policy changes to address social inequities.

**Conclusion** Family physicians can directly address the physical health, mental health, and social needs of patients who are homeless or vulnerably housed. Moreover, they can champion outreach and onboarding programs that assist individuals who have experienced homelessness in accessing patient medical homes and can advocate for broader action on the underlying structural causes of homelessness.

People experiencing homelessness or who are vulnerably housed often experience income insecurity, exposure to violence, substance use, and a high incidence of physical and mental health conditions.<sup>1</sup> Paradoxically, they are less likely to have access to a dedicated family physician or Patient's Medical Home.<sup>2</sup>

At least 235 000 Canadians experience homelessness each year, and 35 000 people are homeless on any given night.<sup>3</sup> Furthermore, it is estimated that many more people use "couch surfing" or other approaches to avoid staying in shelters or living on the street—particularly women, youth, elderly persons, or people living in remote and rural areas<sup>4,5</sup>; people in these situations are under-reported by conventional point-in-time homeless counts<sup>6</sup> and often are referred to as *provisionally accommodated* or *hidden homeless* (Box 1).<sup>7-9</sup> According to the 2016 census, approximately 2.3 million Canadians aged 15 years and older (ie, 8% of the population) experienced hidden homelessness in their lifetimes.<sup>10</sup>

Beyond those experiencing homelessness, there is an even larger segment of the population who are vulnerably housed and at risk of homelessness (Box 1).<sup>7-9</sup> Certain population subgroups overrepresented among

## Editor's key points

▶ Family physicians, regardless of their practice setting, can help patients experiencing homelessness by providing comprehensive, patient-centred, trauma-informed care. By supporting patients who have experienced marginalization, in collaboration with local community organizations, family physicians can connect patients with support services for accessing housing, income assistance, case management, and other health-related social interventions.

▶ Management plans should be tailored to each person's unique circumstances, help re-establish stable housing, and redress the circumstances that contributed to the person's homelessness in the first place.

▶ Continuity of care can be facilitated using interprofessional team approaches that ensure patients can reach out more easily to team members for different needs. For instance, family physicians can work with nurses, case managers, patient navigators, housing workers, or specialized teams to help patients stay connected to care and receive ongoing support.

▶ Family physicians can use health advocacy competencies at different levels to support patients who are experiencing homelessness or who are vulnerably housed. They can also partner with patients and community organizations to draw attention to broader structural challenges and propose policy reform at municipal, provincial, and federal levels to address the underlying structural causes of poverty, addiction, and homelessness.

### Box 1. Understanding homelessness and the housing precarity continuum

#### Definition of homelessness

According to the Canadian Observatory on Homelessness, homelessness is “the situation of an individual, family or community without stable, permanent, appropriate housing, or the immediate prospect, means and ability of acquiring it.”<sup>7</sup> There are several types of homelessness that exist along a continuum of housing precarity.

#### Types of homelessness

Types of homelessness include the following:

- **Unsheltered:** A person who is homeless and living on the streets or in places not intended for human habitation (eg, cars, makeshift shacks)
- **Emergency sheltered:** A person staying in overnight shelters for people who are homeless, shelters for women and children affected by family violence, and emergency shelters for people affected by natural disasters (eg, flooding, forest fires)
- **Provisionally accommodated:** A person who is homeless and without permanent shelter who accesses temporary accommodation, including people who are “hidden homeless” or “couch surfers” staying with friends or family, institutionalized persons who might transition into homelessness after their release in the absence of sufficient discharge planning, recently arrived immigrants and refugees in temporary settlement housing, etc
- **Precariously housed\* and at risk of homelessness:** A person or family whose current housing is in core housing need, which can lead to an imminent risk of homelessness in the event of a crisis or worsening of one or more underlying risk factors (eg, job loss, eviction notice, exacerbation of addiction or mental illness, marital separation, escalating violence)

#### Adequate, suitable, and affordable housing

According to the Canadian Mortgage and Housing Corporation, a person or family’s household is in core housing need if the “housing is unacceptable (does not meet one or more of the adequacy, suitability or affordability standards)” and “acceptable alternative housing in the community would cost 30% or more of its before-tax income.”<sup>8</sup>

- **Adequate housing** does not require major repairs for poor heating, unclean water, defective plumbing or electrical wiring, structural repairs, mold decontamination, etc
- **Suitable housing** has enough bedrooms for the size and composition of the household, according to National Occupancy Standard requirements<sup>9</sup>
- **Affordable housing** costs less than 30% of the total before-tax household income

\*The terms *precariously housed* and *vulnerably housed* are often used interchangeably. While the former is the more accurate term, the latter is preferred in this article to reduce jargon and be more readily understood by a wider readership. However, the term *vulnerable populations* is increasingly replaced by *underserved populations* to highlight the resilience of people with lived experience and the need for structural and societal changes to redress what are primarily structural and societal problems.

those vulnerably housed and experiencing homelessness include refugees and others newly arrived in Canada, people living with disabilities, members of lesbian, gay, bisexual, trans, queer, intersex, asexual, and 2-spirit (LGBTQIA2) communities, people with mental health and substance use problems, and people exiting institutionalized settings such as foster care or the correctional system. Indigenous peoples are particularly overrepresented, as they are affected by colonization, ongoing structural racism, and jurisdictional ambiguity in access to services.<sup>11-13</sup>

Relatively few family physicians work in shelter-based specialty clinics, community-based outreach models, or primary care clinics targeting underserved populations.<sup>14,15</sup> Even fewer “onboarding” models exist to assist people experiencing homelessness to access comprehensive, team-based care in clinics serving the general population.<sup>16</sup> As a result, people who are vulnerably housed or experiencing homelessness overly rely on the “revolving-door medicine” of emergency departments and walk-in clinics, which can lead to even higher rates of morbidity and premature mortality.<sup>17</sup>

Caring for marginalized patients is central to our social accountability mandate as family physicians.<sup>18</sup> Therefore, regardless of practice setting, family physicians in cities, towns, and rural areas across the country will need to become better equipped to provide care for this underserved population.

The aim of this article is to guide family physicians in a variety of practice settings and contexts in caring for patients who are experiencing homelessness or vulnerably housed.

### Case descriptions

**Case 1.** Ms X. is a 60-year-old woman of Scottish-Canadian descent. She is a retired librarian who suffers from chronic low back pain and anxiety. She injured her back in a fall 20 years ago, making it difficult to work a steady job since, leading to years of housing precarity. She moved apartments 10 times in the past 10 years. Living alone in unsafe settings has repeatedly exposed her to violence, which has taken a toll on her mental health. Without a regular family physician, she has had difficulty getting her prescriptions refilled, including for opioids and benzodiazepines. She is tired of going to walk-in clinics and emergency departments where each time she must retell her story.

**Case 2.** Mr P. is a 24-year-old student. After 12 years in a displaced persons camp in Nigeria, he arrived in Canada at the age of 16 as an unaccompanied refugee. After years intermittently spent sleeping on the couch or in the spare room at the homes of friends and family (ie, couch surfing), he began studying at a trade school and co-boarding in a rooming house.

Last week he awoke with plaster and bricks falling onto his bed when the landlord unexpectedly started renovations and threw all his belongings onto the street. He now has a bruised and swollen knee, a noticeable limp, and nowhere to sleep. Before going to a shelter, he asks his family physician for advice.

### Sources of information

The recently published “Clinical guideline for homeless and vulnerably housed people, and people with lived homelessness experience”<sup>19</sup> identifies core evidence-based interventions and approaches all physicians can employ when working with homeless and vulnerably housed individuals. These include facilitating access to housing, income assistance, case management, and substance use programming. This companion article draws upon the broader homelessness literature<sup>20</sup> to contextualize these guideline recommendations and to assist family physicians with practical considerations in their implementation. The scientific evidence synthesized is further complemented by a practical tips section (**Box 2**) that compiles first-hand lessons learned from practitioners working in a variety of primary care settings across Canada (eg, general family medicine clinics, health services targeting low-income and otherwise socially marginalized populations, refugee health clinics, women’s drop-in centres, addiction medicine services, community-based outreach clinics), and a patient perspectives section (**Box 3**) to ensure that the values and preferences of those with lived experience remain at the centre of care. Separate working groups within the guideline development process examined recommendations for women and youth experiencing homelessness.<sup>21,22</sup> A distinct project is also developing Canadian guidelines for Indigenous people experiencing homelessness, although its findings are not yet available and therefore have not been considered in the writing of this article.<sup>23</sup>

### Main message

Regardless of their practice setting, family physicians can identify patients who are vulnerably housed or experiencing homelessness, inquire about their priority health and social needs, and work collaboratively to create a shared management plan.

Given the broad definition of homelessness (**Box 1**),<sup>7-9</sup> many family physicians likely have certain patients in their clinical practices who are vulnerably housed to varying degrees and for a variety of reasons (eg, exposure to violence, poverty).

To begin, it is important to identify which patients are experiencing or at risk of homelessness. To help patients share their stories in their own words, ask about their social context using open-ended questions such as “How is your living situation?” “Do you ever feel unsafe?” or “Do you have trouble making ends meet at the end of the month?”<sup>24</sup> When red flags are raised, active case finding

### Box 2. Practical tips from family physicians working on the front lines of care

The following are first-hand lessons learned from practitioners working in a variety of primary care settings across Canada:

- People who are vulnerably housed or experiencing homelessness are not a homogeneous group. Experiences, expectations, and needs vary among individuals with different life experience, and family physicians should consider and address each individual’s unique context and situation to better tailor their approach
- To help stay in touch with patients experiencing housing instability, regularly update your patient’s contact information in the electronic medical record, including telephone numbers of the patient’s pharmacy, relatives, friends, and contact information of allied health partners such as social workers, case managers, or other relevant contacts. This will help prevent patients from becoming lost to follow-up if their address changes or their telephone gets disconnected
- When last-minute cancellations or “no-shows” occur, it is important to avoid penalizing patients and to be proactive in re-establishing contact. At the next encounter, ask patients about what is going on in their life that might be making it difficult for them to attend appointments and explore ideas to reduce these barriers
- An important complement to social work referrals, when they are unattainable or involve long delays, is making a bridge with even one or two community support resources. For instance, using an updated resource booklet, referral to a drop-in community referral service, calling a 211 hotline to obtain information on community services, and calling a 311 hotline to learn about local municipal government services can all be helpful approaches to connecting patients with local supports specific to their needs
- Do not forget to document patients’ social needs in the medical record, including the management plan for addressing these needs, to enable easier follow-up and ongoing monitoring of progress at future clinical visits

is warranted.<sup>25</sup> A thorough social history can include many topics (eg, immigration status, employment, gender identification, history of substance use).<sup>26</sup> Several clinical practice tools exist to assist in social history-taking, such as the IF-IT-HELPS social history tool.<sup>27,28</sup>

Family physicians can then work in a trauma-informed and anti-oppressive way to help individuals and families access evidence-based interventions (**Box 4**).<sup>19</sup> Family physicians can also engage in systems-level advocacy to redress underlying structural challenges and power imbalances such as systemic racism, sexism, economic systems that perpetuate income inequality, transphobia, and ableism, and to help prevent discrimination, stigma, and social exclusion, which often underlie homelessness.<sup>29</sup>

### Box 3. Keeping the patient perspective at the heart of care

The following are patient perspectives to ensure that the values and preferences of those with lived experience remain at the centre of care:

- When interacting with people who are vulnerably housed or experiencing homelessness, recognize the possibility that some people might have low levels of health literacy and that not everyone might want to be connected to a primary health care team. Be respectful of people's choices, use plain language, and avoid the power imbalance that comes with jargon
- It takes time to build trust. The first visit is critical, but continuity of care is very helpful where possible, as the next 3 to 4 visits are also important stepping stones in developing relationships of trust with the primary health care team. This process could take even longer, especially for patients with previous negative experiences with the health system. Recognize that telling one's story can be traumatizing for patients reliving these experiences. Being cautious about avoiding emotional triggers and ensuring unobstructed access to the examination room door provides a perception that a quick exit is available if patients become overwhelmed
- When it comes to referral to community resources, be realistic. Avoid overcommitting services and underdelivering to prevent retraumatization. Patients do not expect physicians to be up to date on all local resources but knowing how to reach one or two resource experts in established community organizations who can then connect people to further resources would be helpful. The challenge is that such resources might not exist in all communities, particularly in rural and remote areas
- Peer support workers can serve as important partners within primary health care teams to assist new patients in building trust and can also provide assistance in navigating resources
- Having broader conversations with patients about their housing, employment, legal needs, etc, can enhance the doctor-patient interaction and lead to better health outcomes
- Improving care for people experiencing and at risk of homelessness will likely require the involvement of physician champions and support from leadership to promote these approaches in their clinical teams

While family physicians have different levels of experience in working with individuals experiencing or at risk of homelessness, and different access to resources to support this type of care, all family physicians can nonetheless use the following 4 strategies to improve the quality of care for individuals and families experiencing or at risk of homelessness (**Box 5**).<sup>19,30-32</sup>

**Providing accessible care.** Family physicians can make their clinic environments safe and welcoming, from

### Box 4. New evidence-based recommendations on homelessness

The following are the main interventions recommended by the new evidence-based *CMAJ* guidelines on homelessness<sup>19</sup>:

- Referral to permanent supportive housing (eg, Housing First)
- Assistance in accessing income support (eg, disability benefits, tax credits)
- Referral to community mental health programs (eg, Assertive Community Treatment)
- Access to opioid agonist therapy for patients with opioid use disorder
- System navigation assistance using case management support where possible

having posters in the waiting room celebrating diversity, cultural safety, and access to interpretation services, to office staff and peer support workers communicating compassionately and providing assistance with referrals and navigation.<sup>33</sup> Yet many people in need of care do not even present to the clinic or telephone to book a first appointment. They might not have reliable telephone access, a fixed mailing address, a health insurance card, the ability to take a sick day from work, literacy in Canada's national languages, an understanding of local medical culture, or knowledge of how to navigate the often-fractured health system. Others might have had previous negative encounters with the health system, making them reluctant to return.<sup>34</sup> Targeted community engagement and outreach with the help of local community partners might be required to overcome these initial barriers and assist those in need with access and onboarding to primary care services.<sup>35</sup>

Once patients are being followed regularly in primary care, family physicians can also consider whether patients are financially able to fill their prescriptions or experiencing barriers to attending follow-up appointments, and what additional logistical supports they might need (access to income supports, transportation, child care, etc). Simplified processes for making appointments, including a direct telephone number to speak with a team member, urgent-care hours for which an appointment is not needed, advanced access scheduling with one's own physician, and extended hours for evening and weekend clinics, can assist with access to services. Similarly, waiving accessory fees for "noninsured services" such as filling out forms or for missed appointments can also remove barriers to accessing care.

**Providing patient-centred comprehensive care.** Trauma-informed and anti-oppressive care helps create safe spaces for disclosure and relationships of trust within the physician-patient encounter, which is an essential starting point.<sup>30,36</sup> Violence is a frequent cause of homelessness (eg, for women and youth fleeing toxic family relationships, refugees fleeing political violence, specific groups such as Indigenous peoples, the Black



### Box 5. Strategies to improve care for individuals and families experiencing or at risk of homelessness

#### Providing accessible care

- Signal a welcoming environment (eg, posters welcoming people of diverse backgrounds)
- Be aware of barriers to accessing care (eg, opening hours, transportation, child care)
- Use engagement and outreach to make contact (eg, partner with community groups)
- Create culturally safe spaces (eg, finding a cultural broker from the local community)
- Simplify processes for making appointments and talking to the care team (eg, direct telephone line)
- Waive accessory fees (for copying medical records, completing forms, missed visits, etc)

#### Providing patient-centred, comprehensive care

- Practise trauma-informed and anti-oppressive care to build a relationship of trust<sup>30</sup>
- Establish the patient's agenda at the outset using open-ended questions
- When red flags are raised (eg, violence, poverty, social exclusion), engage in active case finding using a thorough social history (eg, housing, employment, income, social supports)
- Be sensitive to emotional triggers and use verbal de-escalation techniques if needed (eg, respect personal space, be nonconfrontational, use active listening, offer choices)<sup>31</sup>
- Co-create a management plan offering evidence-based options (**Box 4**)<sup>19</sup> and referral to local community support resources tailored to the causes of homelessness

#### Providing continuity of care

- Maintain an ongoing connection to care (via navigators, outreach workers, etc)
- Update contact details in the electronic medical record to facilitate follow-up
- Use automated health provider reminder and recall systems to flag inactivity in the file
- Introduce advanced access models (eg, same-day access to primary care services)
- Ensure scheduling that permits flexibility (eg, urgent care, extended clinic hours)
- Engage the support of volunteers (eg, peer support workers, Health Leads<sup>32</sup>)

#### Providing socially accountable care

- Assist patients in accessing treatment and care (eg, referrals, tests, medications)
- Work with health institutions, health system managers, community partners, and people with lived experience to close system gaps and provide greater options for care
- Advocate for structural changes to prevent homelessness and housing precarity
- Partner with local community groups and existing coalitions working in this area
- Catalyze local constituencies and support their collective voice in being heard
- Encourage changes to social norms through education, research, and awareness raising

community, other racialized groups, the LGBTQIA2 community, or people with disabilities experiencing structural racism, stigma, and discrimination).<sup>37-39</sup> Patients might be reluctant to disclose sensitive information to family physicians for many reasons (eg, lack of opportunity, shame, stigma, fear of deportation, fear that children will be taken by youth protection, fear of reprisal and worsening violence by the abuser).<sup>40,41</sup> Chronic exposure to toxic stress including adverse childhood experiences and other experiences of trauma can lead to maladaptive coping strategies such as turning to substance use or high-risk sexual behaviour.<sup>42</sup> Family physicians can normalize patient experiences by reassuring them that this is a common response to difficult life circumstances, and help them to regain a sense of safety and control, recognizing and building on patient strengths.<sup>43</sup>

In determining a management plan, offering choice empowers patients and reduces power hierarchies and feelings of helplessness.<sup>44</sup> Evidence-based recommendations for improving health and social outcomes among patients who are vulnerably housed or experiencing homelessness are listed in **Box 4** and described in more detail in the newly published "Clinical guideline for homeless and vulnerably housed people, and people with lived homelessness experience."<sup>19</sup> There are clinical practice tools that family physicians can also use to assist patients in accessing community support resources, such as the CLEAR tool kit,<sup>45</sup> which is available in more than a dozen languages, or the Poverty clinical tool,<sup>46</sup> which has been adapted to each province, among other resources.<sup>47</sup> Exploring Your Life Intentions is a further example of a clinical practice tool that patients can complete before a clinic visit or in the waiting room to clarify their immediate health needs and overall life goals, enhance motivation to address these issues, and assist in tracking progress at follow-up appointments.<sup>48</sup>

People living on the street and using shelters might have different health and social needs compared with people experiencing hidden homelessness, and specific clinical guidance exists to improve care for people experiencing unsheltered or emergency sheltered homelessness.<sup>49</sup> Similarly, people living in inner-city settings might have different needs and access to resources compared with those living in rural and remote contexts.<sup>50</sup> People who are refugees or newcomers to Canada might also have different needs compared with Indigenous peoples or members of the LGBTQIA2 community, and in some cases a person's narrative will intersect across different forms of marginalization and social exclusion.<sup>51</sup>

The wider evidence base on homelessness provides guidance on additional interventions that can complement those in **Box 4** to better adapt care to specific population groups.<sup>19</sup> For example, youth experiencing homelessness might benefit from family therapy to repair unsupportive dynamics, brief motivational interviewing to reduce reliance on maladaptive coping behaviour,

and mindfulness training to better manage stressful situations.<sup>21</sup> For women with children experiencing homelessness, priority access to permanent housing subsidies can reduce child separations and foster care placements, allowing women to maintain the integrity of their family unit.<sup>22</sup> As well, Housing First programs for families, critical-time interventions during times of crisis, and therapeutic communities are associated with lower levels of psychological distress, increased self-esteem, and improved quality of life for women and their families.<sup>22</sup>

It is therefore important to tailor management plans to each person's unique circumstances, help re-establish stable housing, and redress the reasons for becoming homeless in the first place. According to family physicians working in neighbourhoods with among the lowest incomes in the United Kingdom, "consultations are more likely to be successful if carried out in a systematic way, establishing the patient's agenda at the outset, picking up clues ('psycho-social red flags') and ending with clear agreement as to what has been decided."<sup>52</sup>

**Providing continuity of care.** Continuity of care can be facilitated using interprofessional team approaches that ensure patients can reach out more easily to team members for different needs. For instance, family physicians can work with team nurses, case managers, patient navigators, housing workers, or specialized teams (eg, community outreach teams, crisis intervention teams) to help patients stay connected to care and receive ongoing support.

Whether working in a solo practice or a larger team-based practice, peer support workers or even volunteer patient navigators (eg, the US-based Health Leads student navigators<sup>32</sup>) can help foster patient trust, provide orientation during initial onboarding to the family medicine practice, and ensure ongoing health and social service navigation.<sup>53</sup>

Automated health provider reminder and recall systems can help trigger family physicians to reconnect with marginalized and underserved patients who might have been lost to follow-up if there has been no contact for several months.<sup>54</sup> These systems are particularly effective when the patient has previously assisted in completing the contact information section of the electronic medical record to include a variety of contact options (eg, telephone numbers of family members, a case worker, their usual pharmacy).

Losses to follow-up can occur when patients find the administrative requirements of arranging future clinic appointments to be burdensome (eg, complicated automated answering machines to navigate before reaching the correct person, waiting on hold or leaving messages, appointments rescheduled without adequate notice). Therefore, a direct telephone line to speak with a team member, advanced access models for same-day appointments, and scheduling that permits urgent-care visits with extended hours on evenings and weekends

might also be helpful in ensuring continuity of care, which is critical, as complex situations require ongoing support and rarely have quick-fix solutions.<sup>55</sup>

**Providing socially accountable care.** Family physicians can use health advocacy competencies at different levels to support patients who are experiencing homelessness or vulnerably housed. This can range from helping patients access specialty care and local support services, to rectifying gaps in the health and social services currently available.<sup>56</sup> Family physicians can also partner with patients and community organizations to draw attention to broader structural challenges and propose policy reform at municipal, provincial, and federal levels to address the underlying structural causes of poverty, addiction, and homelessness. For instance, this might include promoting wealth redistribution (eg, progressive taxation,<sup>57</sup> basic income<sup>58</sup>), strengthening social safety nets (eg, social assistance, disability benefits<sup>59</sup>), and preventing discrimination and exposure to violence.<sup>60</sup>

Evidence indicates that greater investment in social safety nets is positively associated with improved population health outcomes.<sup>61</sup> However, family physicians might be unsure how to support advocacy on larger social issues.<sup>62</sup> As a starting point, identifying local community partners who are already engaged in advocacy work, and joining community-led initiatives and existing advocacy networks and coalitions can strengthen partnerships and allow family physicians to be important allies. In this way, family physicians can help catalyze and support local constituencies to speak and be heard (ie, "nothing about us without us").<sup>63</sup> Family physicians can also advocate through education and research to inform mindsets and social norms within the health system and in society.

## Case resolutions


**Case 1.** Ms X.'s stress reduced considerably since she co-developed a treatment plan for her chronic pain with her primary care team. She was unable to access affordable psychological support for her past trauma; however, after a wait time of 10 months, she received publicly funded cognitive-behavioural therapy to reduce her anxiety and physiotherapy to help manage her pain. She also completed a community-based self-defence class to rebuild her sense of safety and confidence. Ongoing connection with her primary care team during the wait time helped her feel supported. Her family physician referred her to a local community organization that helped her apply for disability benefits and identify high-quality, low-cost housing. She now has enough monthly income to afford a small apartment that is clean and feels safe.

**Case 2.** Without an interdisciplinary primary care team at her service, the physician called 211 to identify

local resources available for Mr P. A student association helped him find temporary accommodation, and the student wellness office at his school also got involved. Within a few months, he was living in a shared student apartment, found a part-time job to supplement his student bursaries, and returned to school part-time. With the help of a legal aid clinic, Mr P. eventually received compensation for having been wrongfully evicted by his landlord.

## Conclusion

Family physicians, regardless of their practice setting, can help patients experiencing homelessness by providing comprehensive, patient-centred, trauma-informed care. By supporting patients who have experienced marginalization, in collaboration with local community organizations, family physicians can connect patients with support services for accessing housing, income assistance, case management, and other health-related social interventions. Moreover, there is recent evidence of greater provider satisfaction when social needs of patients are identified and addressed.<sup>64</sup>

Not all primary health care settings have adequately resourced teams with the supports needed to manage complex health and social needs. Where such resources are lacking, family physicians can nonetheless play a critical role in advocating for the implementation of the Patient's Medical Home model and for making evidence-based interventions more widely accessible, such as permanent supportive housing (eg, Housing First), which improves outcomes for people experiencing homelessness. Family physicians can also serve as catalysts for structural changes, such as reducing poverty, violence, and social exclusion, to prevent housing precarity in the first place. By demonstrating leadership at multiple levels, family physicians can succeed in better supporting patients in their community who are vulnerably housed or experiencing homelessness. 

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### Contributors

**Drs Andermann, Bloch, Kendall, Goel, Salvalaggio, Brcic, Ponka, and Pottie** and **Ms Twan** were involved in the conception of the article, defining the broad content areas, and making substantive edits. **Dr Andermann** drafted the article and made successive revisions. **Ms Twan** and **Dr Salvalaggio** conducted an in-depth analysis of an earlier draft to ensure relevance and coherence from the patient perspective. All authors reviewed and approved the final version.

### Competing interests

None declared

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