2024, Volume 56, Issue 2, 142-143, e-ISSN 1938-3800

Family Medicine

LETTER TO THE EDITOR

Being Housed Versus Having a Home: Navigating Health Care for Unsheltered Patients

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HOW TO CITE: Wongpaiboon M, Shelton JL. Being Housed Versus Having a Home: Navigating Health Care for Unsheltered Patients. *Fam Med.* 2024;56(2):142-143. doi: 10.22454/FamMed.2024.333142

PUBLISHED: 1 February 2024

TO THE EDITOR:

The article "Training Students as Navigators for Patients Experiencing Homelessness" is an important contribution toward advancing medical students' perceptions and capability for serving patients experiencing homelessness.[1] The authors designed a curriculum that connected students with residents of a homeless shelter to identify health care access barriers and recognize local resources—core competencies that can train physicians to tailor health care services to this demographic. Of considerable importance is the significant improvement in self-assessments of preparedness, including efficacy, competence, and skills, following completion of this curriculum. Perceptions of an increase in the need for social advocacy and responsibility also were demonstrated. We appreciate the authors' disclosure about these assessments and how they can be subjected to cognitive biases. Although more difficult to measure, considering an objective structured clinical examination that is geared specifically toward the homeless population and implemented throughout medical training may be beneficial.

Homelessness constitutes poorer health outcomes due to the complex psychosocial state that impacts biological outcomes and care management.[2] Complex and advanced medical conditions not only persist in this population but also are often exacerbated by socioeconomic issues.[3] Systems-level barriers such as lack of a primary care physician, health insurance, and access to care, coupled with individual-level barriers such as implicit biases, misconceptions, and distrust between both physicians and homeless patients, provide a unique challenge for the health care system. These barriers highlight the need for specific training programs such as the one previously mentioned.

Medical school curricula surrounding health care of patients of low socioeconomic status is sparse, with formal integrated curricula and exposure to health care of the homeless even more limited.[4] We presume that a comprehensive medical school curriculum that implements both didactic and clinical (ie, during family medicine clerkship) exposure in the interface of shelter-based settings, preceptorships, street medicine, or primary care clinics serving underserved patients can provide an opportunity for students to identify their specific needs early in their medical career while destigmatizing attitudes surrounding this undeserved group. Homeless patient-centered curricula should not be limited to medical schools but extended into postgraduate education for family medicine residents. Incorporation of both longitudinal experiential and knowledge-based approaches during residency can help reinforce the abilities of family medicine physicians as they care for patients experiencing homelessness, addiction, or refugee status.[5] A combination of both required formal-based education and elective student-run programs can be revolutionary for physicians and physicians in training.

In conclusion, the success of the authors' formal student-run patient navigation program can be attributed to the program's core competencies that were catered to the homeless demographic. This success highlights the need for like curricula to be implemented not only during preclerkship and clerkship years but also throughout family medicine residency training. We anticipate that implementation of both program-led and student-run programs at all levels of medical education can foster cultural competency, recognition of patient priorities, and the development of skills in an environment that lacks the infrastructure related to health care in an impoverished community.

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