Housing-First in Greater Cincinnati

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Overview of SDH (Housing) and Community Impact

The social determinant of health that is being addressed is Housing. The housing-health connection has long been recognized, dating as far back as Victorian England, where the severity of cholera and other communicable diseases were postulated to poor housing conditions and improvement of such saw drastic drops in infection and mortality. A 2011 study by WHO quantified the number of deaths per 100,000 attributed to various housing factors such as low indoor temperatures, environmental tobacco smoke, house mold, traffic noise exposure, and lack of home safety features. Housing difficulties contribute to the development of chronic diseases as well as the efficacy of managing chronic diseases. Lack of housing/unstable housing situations negatively impact physical and social health, leading to diseases. Prioritizing basic needs leads to reduced visits to doctor (Emergency Room visits) and increased medication adherence.

Cincinnati Policy (Emergency Medicine and the Housing-First Population)

Emergency Medical Treatment and Labor Act (EMTALA)

Rational for Policy Modification

The findings of the interviews suggest that individuals experiencing homelessness and substance abuse have more negative experiences related to the Emergency Department than to providers in primary care or specialty fields. This indicates that to improve healthcare experiences in populations such as these, the healthcare system should closely examine Emergency Departments and their policies.

Bursch et al. found in a survey of 258 ED patients, the five variables rated most impactful on patients' overall ED experiences were: wait time before being seen; perceived level of care by nurses; perceived staff organization; 4-perceived level of care by physicians; and 5-informationprovided to them about their care (Bursch). This correlates with our interview results, as the residents often cited not feeling well cared for as the primary reason for discontent with ED visits.

Proposed Advocacy Strategy

Our findings: Through interviews with a population of people with a history of housing instability, substance use disorder, and various psychiatric disorders, we found many common threads in their experiences with healthcare. They perceived many barriers to

receiving care, both intrinsic – from their personal biases – and extrinsic – from systematic issues. Many of the residents described feeling stigmatized by their medical, psychiatric, and living conditions, so they delayed their care until it became emergent. They reported the most negative experiences in the Emergency Department, and conversely, they reported the most positive experiences from primary care and specialty providers. Many of these issues, when discussed further, rooted from the patient's desires for the provider to listen, show respect, and give them time.

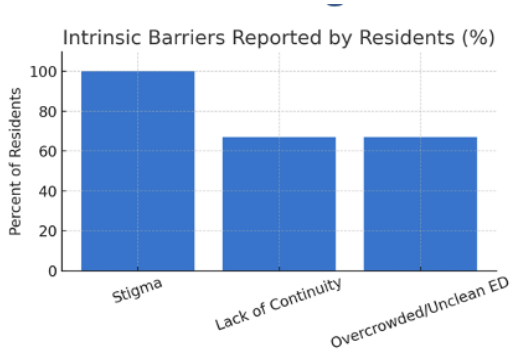

Figure 1: Intrinsic Barriers Reported by Residents

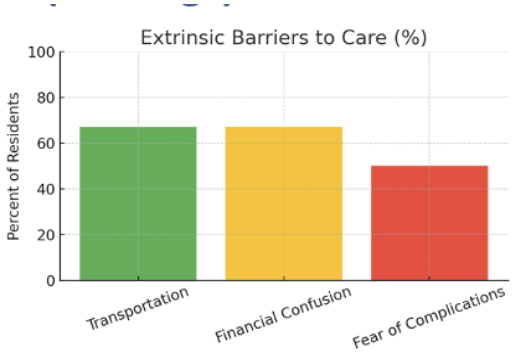

Figure 2: Extrinsic Barriers to Care

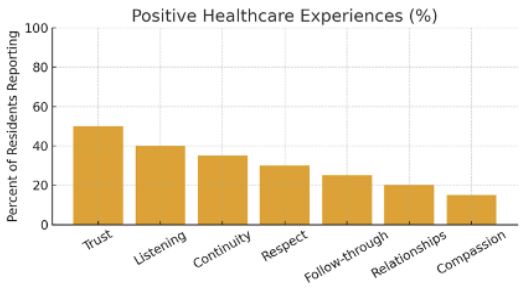

Figure 3: Positive Healthcare Experiences

Figure 4: Advocacy Strategy Focus Areas

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