Homelessness is a national problem that is worsening. Some challenges the homeless face—lack of shelter, food, health care, support, and opportunities—are well known. Cancer, an unrecognized problem among the homeless, is a leading cause of their deaths.

AT A GLANCE

- Homelessness is a complex situation resulting from internal and structural factors.
- Homelessness makes cancer even more challenging because of lack of resources, a peaceful environment, and family and friends.
- Increasing awareness of homelessness, knowing about healthcare resources, counseling on smoking cessation, and advocating for better cancer care are some ways oncology nurses can make a difference to people who are homeless.

KEYWORDS
homelessness; access to health care; smoking cessation; palliative care

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Homeless With Cancer

An unrecognized problem in the United States

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On a single night in January 2017, the U.S. Department of Housing and Urban Development ([HUD], 2017) conducted a point-in-time (PIT) survey, counting more than half a million people as homeless in the United States; this was the first increase in seven years. This is equivalent to 17 in every 10,000 people being homeless (HUD, 2017). HUD's report to Congress included the fact that about two-thirds of homeless people live in sheltered environments, like emergency shelters, transitional housing programs, and safe havens (see Table 1). In addition, one-third of the homeless population's nighttime stays were at a public or private location that is not a usual sleeping accommodation (e.g., sidewalks, parks, vehicles, tents). The PIT survey showed the greatest changes in the year to be a decrease of 5% in homeless families and an increase of 12% in individuals with chronic patterns of homelessness (those homeless for more than a year) (see Table 2). For the first time, the PIT survey provided baseline data of 40,799 homeless youths in the United States (HUD, 2017). The PIT survey did not report on those who were ill or had cancer.

The basis for homelessness can be a synergistic relationship between individual factors (e.g., poverty, early childhood adverse experiences, mental health and substance misuse problems, personal history of violence, association with the criminal justice system) and structural factors (e.g., absence of low-cost housing, jobs, and income support) (Fazel, Geddes, & Kushel, 2014). For homeless individuals aged 12–25 years, their individual factors are different and include family conflict, victimization, nonheterosexual identity, and child welfare system experience (Fazel et al., 2014).

Within the healthcare system, domestic violence, social disconnection, poverty, psychological trauma, and unemployment experienced by people who are homeless may not be recognized as their social determinants of health (Stafford & Wood, 2017). These social determinants interplay with health to lead to frequent emergency department visits and hospitalizations of those who are homeless (Stafford & Wood, 2017).

Compounded by Cancer

Cancer is a leading cause of death among homeless people, second only to drug overdose (Baggett, Hwang, et al., 2013). More than one-third of these cancer deaths were caused by cancers of the trachea, bronchus, and lung, with mortality rates two to three times higher than those in the general population (Baggett, Hwang, et al., 2013).

Although information on homelessness and cancer is limited, research on the veteran population provides some foundation for data. Hwa, Dua, Wren, and Visser (2015) found that, of 90 veterans with hepatocellular cancer, 30% were homeless and 21% lived with a family member, with a friend, or in a trailer; the others were able to rent (26%) or own (23%) a home, with 15% receiving housing

assistance. Hepatocellular cancer was the second most commonly occurring cancer in Baggett, Hwang, et al.'s (2013) research.

Historic documents have noted that adequate housing affects health outcomes. In general, the mortality rate is three times higher for homeless veterans than for those who live in a home (Gabrielian, Yuan, Andersen, Rubenstein, & Gelberg, 2014).

Options for Health Care

Many people who are homeless are uninsured, and they, as well as healthcare providers, may think they have no options for health care. Although they may be eligible for Medicaid, the application process may be too challenging because they may not have the necessary documentation and an address. Other options for coverage include the National Health Care for the Homeless Council (NHCHC), safety net hospitals, and medical respite facilities.

Since 1986, homeless people have been receiving health care through NHCHC. NHCHC has more than 200 health clinics nationally, with one in every state and in Washington, DC, and in Puerto Rico; these offer primary care and supportive services (NHCHC, 2018b).

Safety net hospitals, both public and private, throughout the United States receive federal funding to provide open-door health care. The Institute of Medicine ([IOM], 2000) provided the following definition of safety net providers:

> These providers have two distinguishing characteristics: (1) either by legal mandate or explicitly adopted mission they maintain an 'open door,' offering access to services for patients regardless of their ability to pay; and (2) a substantial share of their patient mix is uninsured, Medicaid, and other vulnerable patients. (pp. 3–4)

The IOM's (2000) review concluded that safety net providers are needed until there is universal health coverage or a different paradigm to provide health care for vulnerable populations in the United States.

Medical respite is different than respite programs that provide care for an ill person while daily caregivers have a break; medical respite provides shelter for homeless people who are too sick to be living on the street or in a shelter, but are not ill enough for hospitalization. These acute and after-acute housing care programs reduce hospitalization, length of stay, and readmissions, but there is insufficient evidence regarding emergency department use (Doran, Ragins, Gross, & Zerger, 2013). NHCHC (2016) wrote the first standards for medical respite programs in October 2016 to provide a framework to facilitate safety, effectiveness, development, and growth.

TABLE 1.
HOMELESS PEOPLE BY HOUSEHOLD TYPE AND SHELTERED STATUS IN 2017

VARIABLE	%
Sheltered	65
Individuals	35
People in families	30
Unsheltered	35
Individuals	32
People in families	3

Note. Based on information from Abt Associates for the U.S. Department of Housing and Urban Development, 2017.

Palliative Care

When oncology nurses think of palliative care, the concept of people with cancer living their lives comfortably in their homes, surrounded by loving support from their family, friends, and healthcare team, may emerge. Unfortunately, people who are homeless do not have this experience (Biedrzycki, 2017).

Homelessness, Smoking, and Cancer

The high prevalence of smoking and the frequently occurring cancers of the trachea, bronchus, and lung among homeless people provide the rationale for smoking cessation. It is estimated that 73% of homeless adults smoke cigarettes (Baggett, Hwang, et al., 2013). Through a national survey study conducted among 2,678 people using U.S. federally funded clinics, Baggett, Lebrun-Harris, and Rigotti (2013) discovered that a history of homelessness is independently associated with cigarette smoking, but homeless smokers' desire to quit does not differ from that of other smokers.

Efforts to reduce smoking cessation are hampered by the inability to reach and keep people who are homeless in a smoking cessation program. Through a secondary analysis of data from a randomized, controlled study of 430 people who were homeless and smokers, Ojo-Fati et al. (2016) discovered that those who were depressed were less motivated to quit smoking and adhered less to nicotine replacement therapy. Ojo-Fati et al. (2016) suggested that depression and

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TABLE 2.
CHANGES IN HOMELESSNESS FROM 2016–2017

DEMOGRAPHIC	2017 PIT SURVEY ESTIMATE	CHANGE FROM 2016 (%)
All people	553,742	+ 1
Individuals	369,081	+ 4
Families with children	184,661	– 5
Individuals with chronic patterns of homelessness	86,962	+ 12
Unaccompanied homeless youth	40,799	–
Veterans	40,056	+ 2

PIT—point-in-time
Note. Based on information from Abt Associates for the U.S. Department of Housing and Urban Development, 2017.

motivation to quit should be addressed in smoking cessation programs using nicotine replacement therapy.

The Cochrane Library's review of nursing interventions for smoking cessation determined that there is moderate-quality evidence that nurses' advice and support are effective in smoking cessation (Rice, Health, Livingstone-Banks, & Hartmann-Boyce, 2017). There is no evidence to support that oncology nurses' advisement that smoking will improve health to people who are homeless would be less effective than it is to people with homes. The elimination of smoking in shelters may lead to decreased smoking and possibly smoking cessation, as well as reduce the risks from secondhand smoke.

Education and Advocacy

The first step to action is increasing awareness of the factors associated with homelessness and available services for homeless people with cancer. When oncology nurses understand more about the plight of people who are homeless with cancer, advocacy for better oncology care for the homeless will be the next natural step.

Oncology nurses can get involved with World Homeless Day (www.worldhomelessday.org) or the Homeless Person's Memorial Day (www.nationalhomeless.org/about-us/projects/memorial-day).

The National Health Care for the Homeless Clinicians' Network (www.nhchc.org/clinicians) produces a publication, *Healing Hands*; each issue focuses on a different topic within the categories of advocacy, medical treatment, peer support, palliative care, and special populations. Oncology nurses may choose to join through a complimentary membership for clinicians that can lead to further involvement (NHCHC, 2018a).

Within the clinical setting, oncology nurses can learn more about what plans are in place for care of people who are homeless with cancer. Investigating what is available within the clinical setting and the community will guide the advocacy mission.

Conclusion

Cancer is a leading cause of death among people who are homeless. Although homeless people have a higher rate of cigarette smoking and, therefore, an increased risk of smoking-related cancers, research indicates that they have the same desire to quit as the general population. Nurses' advice and support for smoking cessation have proven to be effective in the general population and, therefore, should also be beneficial for people who are homeless or have a history of homelessness, because they are part of the general population who desire to quit.

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