

The chiropractor's role in addressing social determinants of health: a case report of a U.S. Veteran with acute housing instability

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Objective: Housing is a well-established social determinant of health (SDOH) where housing instability can negatively affect physical health and access to health care. We present a case where housing instability was reported while under chiropractic management of neck pain and headaches.

Clinical features: A 54-year-old male under care at a Veterans Affairs chiropractic clinic for mechanical neck pain and cervicogenic headaches, presented at follow-up visit four with new-onset nausea, change in headache, and recent residential furnace failure.

Rôle du chiropraticien dans la prise en compte des déterminants sociaux de la santé: rapport de cas concernant un vétéran américain en situation d'instabilité résidentielle aiguë

Objectif: Le logement constitue un déterminant social de la santé (DSS) bien établi, et l'instabilité résidentielle peut nuire à la santé physique et à l'accès aux soins de santé. Nous présentons un cas dans lequel une situation d'instabilité résidentielle a été signalée pendant la prise en charge chiropratique de douleurs cervicales et de céphalées.

Caractéristiques cliniques: Un homme de 54 ans suivi dans une clinique chiropratique du département des Anciens Combattants pour des douleurs cervicales mécaniques et des céphalées cervicogènes a signalé, lors de sa quatrième visite de suivi, l'apparition récente de nausées, une modification de ses céphalées et une panne récente du système de chauffage de son logement.

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Conflicts of Interest:

The authors received indirect support from their institutions in the form of computers, workspace, and time to prepare the article. The authors have no disclaimers, competing interests, or sources of support or funding to report in the preparation of this manuscript. The views expressed in this article are those of the authors and do not reflect the official policy or position of the United States Department of Veterans Affairs or the United States Government. There are no conflicts of interest to disclose.

The involved patient provided signed consent for case publication. The Butler VA Health Care System Privacy Officer approved this submission.

Intervention and outcome: Care coordination was initiated by the chiropractor with the social work team due to concerns of housing instability. Following furnace repairs and return to stable housing, the veteran reported significant symptom improvement and was lost to follow up.

Summary: We demonstrate real-world recognition of an SDOH impacting a presenting complaint to a chiropractic clinic. Timely action was taken by the chiropractor to coordinate appropriate care to address acute housing instability.

(JCCA. 2026;70(2):228-235)

KEY WORDS: case report, chiropractic, housing instability, social determinant of health, biopsychosocial

Intervention et résultat: En raison des préoccupations liées à l'instabilité résidentielle, le chiropraticien a entrepris une coordination des soins avec l'équipe de travail social. Après la réparation du système de chauffage et le rétablissement de conditions de logement stables, le vétérinaire a signalé une amélioration considérable de ses symptômes, puis a été perdu de vue.

Résumé: Ce cas illustre le repérage, en contexte réel, d'un déterminant social de la santé ayant une incidence sur le motif de consultation dans une clinique chiropratique. Le chiropraticien est intervenu rapidement pour coordonner les soins nécessaires afin de remédier à la situation d'instabilité résidentielle aiguë.

(JACC. 2026;70(2):228-235)

MOTS CLÉS: rapport de cas, chiropratique, instabilité résidentielle, déterminant social de la santé, biopsychosocial

Introduction

A foundational framework for healthcare delivery is the biopsychosocial (BPS) model of care.¹ The broader *social* constructs weave within and alongside the *bio-* and *psycho-*components of the BPS model and are referred to as social determinants of health (SDOH).² The World Health Organization defines SDOH as non-medical factors that affect a person's health outcomes such as where a person is born, and where a person grows, works, lives, worships, and ages which are influenced by broader systems such as social structures, policy, or governmental systems.³ Healthy People 2030 categorizes SDOH by domain: economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context (Table 1).^{3,4}

Spine pain is a major societal concern in the United States, annually costing hundreds of billions of dollars in medical care, lost productivity, and lost wages.^{5,6} There is a broad range of care options for those suffering from spine pain with an emphasis in recent years on non-pharmacological care including complementary and integrative health options.⁷ This is evident particularly with the Veterans Health Administration (VA), the largest inte-

Table 1.
Social determinants of health (SDOH) subdomains according to Healthy People 2030.⁴

Economic Stability
Employment
Food Insecurity
Housing Instability
Poverty
Education Access and Quality
Early Childhood Development and Education
Enrollment in Higher Education
High School Graduation
Language and Literacy
Health Care Access and Quality
Access to Health Services
Access to Primary Care
Health Literacy
Neighborhood and Built Environment
Access to Foods That Support Healthy Dietary Patterns
Crime and Violence
Environmental Conditions
Quality of Housing
Social and Community Context
Civic Participation
Discrimination
Incarceration
Social Cohesion

grated healthcare system in the United States, taking a leading role in delivering complementary and integrative health services as part of the care package.⁸ Integrated healthcare delivery is an asset in the holistic evaluation and management of patients. In this setting, clinicians may recognize negatively impacting SDOH and coordinate with the appropriate resources that extend beyond the patient's presenting primary complaint. Regarding spine pain, patients often experience coexisting burdens within SDOH domains that complicate spinal pain recovery including housing instability, mental health comorbidities, illiteracy, and job loss as barriers to routine healthcare.⁹⁻¹¹

The chiropractic profession is an integral part of the array of care pathways offered for spine pain.^{8,12} As licensed independent clinicians, chiropractors evaluate, diagnose, manage, and coordinate care specific to a patient's condition, most often neuromusculoskeletal complaints.¹³ Beyond the chief complaint, chiropractors consider past medical history, treatments, co-morbid conditions, and patient preferences among other aspects of the intake. Chiropractors have the resources to evaluate and act on identifying key SDOH contributing to patient presentation irrelevant of practice setting.^{14,15}

Numerous examples of chiropractors' consideration of SDOH in the clinical environment are described in the literature such as tobacco cessation¹⁶, substance use¹⁷, self-directed violence¹⁸, and intimate partner violence¹⁹. Some suggest a demonstrable lack of attention to the *psycho-* and *social-* constructs of the BPS model in chiropractic practice while others indicate more broad fragmentation and limited implementation of the BPS model of health care.^{2,20,21} Further, there is an evident knowledge gap and limited curriculum integration of SDOH in doctor of chiropractic programs, creating a potential barrier to identifying and addressing social needs in clinical settings.^{22,23}

Chiropractors working in integrated care settings, such as VA, may have the opportunity to optimize and model best practice considerations to identify and triage care for social needs (e.g., SDOH). At VA, chiropractors are positioned with resource accessibility to streamline referrals and co-manage for the benefit of the patient which includes a shared electronic health record, interdisciplinary co-localization, patient aligned care teams, pre-defined response teams for medical, behavioral, and social emergencies, and housing and substance use support teams.

Chiropractors' modeling of real-world identification and subsequent appropriate action for concerns of a SDOH impacting a patient is lacking in the literature.

Thus, we present a clinical case where a chiropractor triaged and activated social work services related to an acute, housing instability circumstance for a veteran seeking care for a neuromusculoskeletal complaint. The patient provided consent for the publication of this case report.

Case report

Patient information

A 54-year-old male Army veteran was referred to the Butler VA Health Care System chiropractic clinic with a chief complaint of mechanical neck pain and associated headaches to consider acupuncture as an adjunct to rehabilitative exercises. Neck disability index (NDI) at the initial visit scored 10 out of 50 (20%), with a score of 5/5 on question 5, which is specific for headache. The Pain Intensity, Enjoyment of Life, General Activity (PEG-3) scored a composite of 10 and an average of 3 out of 10.

His medical history was remarkable for chronic migraines, hyperlipidemia, and insomnia. His psychiatric history included generalized anxiety disorder, depression, post-traumatic stress disorder, and a remote history of suicidal ideation. For social history, he denied use of tobacco or recreational drugs and had been sober from alcohol for 24 years. He was an automotive salesman at a car dealership, and he lived in an apartment with his teenage daughter.

He had experienced stable, near-daily intermittent left-sided neck pain with radiating pain to the left side of his head for the past five years. His cervical spine pain was localized to the left suboccipital region, and the pain radiated in a "question mark" pattern over his left ear ending at the temporal region of his head. He denied radiating pain or paresthesia to either left or right upper extremity or face.

Prior to the evaluation in the chiropractic clinic, he had attended two sessions with the VA physical therapy clinic for the same concern of neck pain and headaches. He was responsive to repeated end range loading strategies and continued performing cervical retractions several times per day for home exercise, which improved his suboccipital and temporal pain frequency from 4-5 times to 2-3

times per week. Otherwise, he had no prior history of conservative, interventional, or surgical procedures for this presenting concern.

For pertinent findings from the review of systems, he reported chronic, stable migraines that were separate and distinct from his five-year history of neck and head pain. He experienced migraines once per month, with associated blurry vision, “dots” in his visual field, and photophobia. Migraines were well-managed with daily propranolol for prophylaxis and zolmitriptan as an abortive therapy. At the initial chiropractic clinic visit, his last migraine had occurred approximately three weeks prior.

Physical exam

Heel, toe, and tandem walks were performed without difficulty and Romberg was unremarkable. Neurological exam was largely unremarkable with cranial nerves within normal limits, and upper extremity strength, deep tendon reflexes, and sensation were intact throughout C5-T1 dermatomes bilaterally. There was no evidence of dysmetria, tremor, or pronator drift. As this was a regional complaint, no lower extremity examination was performed.

Observed active cervical range of motion was full and unrestricted, with perceived tightness at end range in all planes of motion. Shoulder depression was provocative for concordant neck and head pain with right lateral flexion while all other cervical orthopedic loading maneuvers were unremarkable for symptomatic provocation. End range loading procedures, slouch-over-correct, and seated cervical retraction decreased neck pain.

Palpatory findings

Palpation found the left suboccipitals were tender and provocative for concordant neck and head pain, and the left splenius capitis and left levator scapulae were hypertonic. Segmental dysfunction was identified at left C0-C1, C1-C2, and C2-C3 with concordant pain provocation on segmental joint loading assessment.

Imaging

Plain films of the cervical spine on file from three years prior demonstrated multilevel degenerative changes and neural foraminal narrowing of the lower cervical spine. A prior brain magnetic resonance imaging study demonstrated a few isolated subcortical white matter foci of T2/

FLAIR hyperintensity which correlated with sequelae of migraine headache.

Clinical impression of primary complaint

The working diagnosis was mechanical neck and associated cervicogenic headache due to cervical derangement and secondary myofascial involvement. A trial course of acupuncture was recommended for a series of six visits at a frequency of one time per week to supplement his cervical retraction end range loading home exercise program provided by his VA physical therapist.

Acute housing instability

At his fourth visit to the chiropractic clinic for acupuncture, he reported new-onset nausea over the prior few days. In this same time period, his cervicogenic headache pattern progressed from intermittent to constant, and cervical retraction end range loading was no longer an effective self-management strategy for neck pain and headache. During the day, his headache severity improved while at work only to increase in severity upon returning home to his apartment. He denied new onset diplopia, dysarthria, dysphagia, nausea, loss of consciousness, weakness, or vomiting.

He disclosed that the heat in his apartment building had not worked for several days, and outdoor minimum nighttime temperatures ranged from 23-37 degrees Fahrenheit in the prior four nights.²⁵ His landlord was aware of the furnace failure, and on inspection of the building, heating ventilation and air conditioning (HVAC) systems were all shut off. The patient understood this meant there was a risk of carbon monoxide in the apartment. He and his 16-year-old daughter stayed at his residence the night prior to this scheduled chiropractic clinic visit and used extra layers of blankets for warmth. His daughter had also complained of daily headaches since the time the heat had stopped working.

Due to a concern for housing instability (Table 2) at the visit, the chiropractor immediately contacted the patient's primary care social worker to discuss care coordination options. The chiropractor then contacted the medical center's Health Care for Homeless Vets (HCHV) team coordinator.²⁶ A same-day visit was arranged with the on-site U.S. Department of Housing and Urban Development-Veteran Affairs Supportive Housing (HUD-VASH) team social worker who met the patient after he completed his

Table 2.
Housing instability definitions according to Watson and Carter.²⁶

Term	Definition
Housing insecurity	A significant lapse for a given household of one or more elements of secure housing
Secure housing	Stable occupancy of a decent, safe, and affordable housing unit
Affordable	Shelter costs are manageable over the long term without severely burdening or compromising other consumption that normally is essential for health and well-being
Stable Occupancy	Household does not face substantial risk of involuntary displacement for economic or non-economic reasons
Decent and Safe	The housing unit has physical attributes* that satisfy functional needs for well-being related to health, security, and support for activities of daily living.

*Attributes include appropriate facilities for excluding: external threats, providing climate control, storing and preparing food, maintaining physical and mental hygiene, and developing human potential.

appointment at the chiropractic clinic. It was determined that the patient did meet criteria of acute housing instability, and he was provided with county resources. The chiropractor coordinated care and communicated with the patient's primary care team, HCHV team coordinator, and HUD-VASH team through available telecommunication modalities, allowing for regular updates and closing the loop on next steps for his case management.

Following the review of the case and discussion of available resources with HUD-VASH, the patient elected to remain at the apartment with his daughter without functioning HVAC. The treating chiropractor and social work team concurred the possibility of carbon monoxide exposure, and the patient elected to open a window for ventilation as a precautionary measure rather than seek temporary housing elsewhere. He expressed appreciation for the rapid response by the care team and was pleased with the community resources presented to him by the HUD-VASH team social worker.

At the patient's fifth planned visit the following week, he shared that the climate control had been restored to his apartment building, and HVAC repairs were underway. The complaint of daily headaches at the prior visit had resolved. His response to care at visit five was positive for symptom reduction, with numeric pain rating of 1 out of 10, and stating, "My neck is ten times better. It's looser and not as tight." Coincidentally, in the same time frame, he had a routine interval follow-up visit with neurology regarding his chronic migraines who modified his medi-

cations, with an increased propranolol dosage and rotated to a disintegrating zolmitriptan with prochlorperazine and naproxen.

Unfortunately, the patient was lost to follow-up after the fifth visit at the chiropractic clinic and did not return for additional care. As the trial of care was intended for six visits, outcome assessment measures were not collected for pre-post evaluation due to the loss to follow-up.

Discussion

We present a case of an Army veteran with an acute housing instability circumstance during the course of a care plan for mechanical neck pain and associated cervicogenic headache at a VA chiropractic clinic. The loss of heat during cold winter months in the patient's apartment, leading to a rapid deterioration in his housing status and acute change in his headache presentation was confounded by suspicion, though not confirmed, of acute carbon monoxide exposure due to faulty HVAC. This case models a real-world example of identification and triage based on changes in SDOH at a follow-up visit to the chiropractic clinic. While his rapid symptomatic progression and resolution cannot be directly attributed to treatment in the chiropractic clinic, the veteran's acute housing instability warranted care coordination with the VA Medical Center's social work services and highlights the importance of understanding how SDOH such as environmental exposure and housing status may result in changes in neuromusculoskeletal concerns and, more im-

portantly, the nuances of care available within integrated care systems.

SDOH accounts for 30-80% of health outcomes, highlighting the importance of their prudent consideration during all patient encounters.^{3,27,28} Housing instability is just one example of an SDOH that afflicted over 35,000 veterans and over 650,000 Americans total in 2023, according to the Annual Homelessness Assessment Report.²⁹ It is associated with increased risk of acute and chronic medical conditions, increased pain severity and functional limitations, and reduced accessibility and impairs continuity of care.^{11,30,31} Housing instability and insecurity may present in a variety of forms including affordability, stable occupancy, or decent and safe housing. (Table 2).^{12,13,32} In our case, the specific concern for housing instability is deviation from decent and safe housing due to inadequate climate control and carbon monoxide exposure.

Particular to lumbar spine pain and SDOH's impact on care delivery, social isolation increases the likelihood of imaging, specialty care, and physical therapy visits; housing instability increases the likelihood of emergency department visits, hospitalizations, and imaging; food insecurity increases the likelihood of emergency department visits, hospitalizations and specialty visits; and financial strain increases the likelihood of physical therapy visits while it reduces the likelihood of emergency department visits and hospitalization.³³ In our case, outpatient chiropractic services had the opportunity to engage the patient immediately on identification and seek out the appropriate resources.

Chiropractors can play a key role in the evaluation, management, and care coordination for SDOH as they relate to care, especially considering the increased rates of chiropractic services in integrated healthcare settings and underserved communities.^{12,13,32,34} Although there appears to be no widely accepted and standardized screening process for housing instability, such as the number or depth of questions, as well as at what phase of care these screenings occur³⁵, screening questions may still open routes to additional care coordination should they be needed. In the VA, as an example, any clinician may utilize screening tools such as the Homelessness Screening Clinical Reminder to identify at-risk veterans.³⁶ This tool and associated referral pathways to social work or other housing services are programmed into the electronic health record system. For the majority of chiropractors in private prac-

tice or those outside of unique integrated settings, unified and coordinated systems may not be available within the electronic health record, making identification and appropriate referrals more nuanced to the local region, county, or province. Chiropractors can strive to overcome these barriers by understanding housing instability risk within their patient population and familiarizing themselves with services offered internal to their healthcare organization and local support services including state or province and county programs.

Limitations

The limitations of this study are consistent with case reports as it describes one example of acute housing instability for one patient in one chiropractic clinic. This example cannot be generalized to all cases of acute housing instability. This case does not highlight the complexities and challenges of chronic housing instability or homelessness, nor does it address the nuances of identifying and coordinating care when in private practice. The treating chiropractor sought HUD-VASH referral to address acute housing instability and did not pursue additional diagnostic lab work to confirm carbon monoxide poisoning thus the diagnosis is empirical and related to patient reporting and changes to his housing situation only.

Summary

We describe an Army veteran who attended care at a VA chiropractic clinic for neck pain and cervicogenic headache who underwent acute housing status change. By nature of the integrated setting, a chiropractor identified concerns for housing and could seek to address this SDOH through care coordination. This case exemplifies the benefits of an integrated health care delivery for care coordination and the opportunity to consider housing as an SDOH in the delivery of a patient's care who had a primary neuromusculoskeletal complaint at a chiropractor's office.

References

1. Nicholas MK. The biopsychosocial model of pain 40 years on: time for a reappraisal? *Pain*. 2022;163(S1):S3.
2. Kapos FP, Craig KD, Anderson SR, et al. Social Determinants and Consequences of Pain: Toward Multilevel, Intersectional, and Life Course Perspectives. *J Pain*. 2024;25(10):104608.

3. Social determinants of health. Accessed April 22, 2024. <https://www.who.int/health-topics/social-determinants-of-health>
4. Social Determinants of Health – Healthy People 2030 [odphp.health.gov](https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health). Accessed May 4, 2025. <https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health>
5. Dieleman JL, Cao J, Chapin A, et al. US Health Care Spending by Payer and Health Condition, 1996-2016. *JAMA*. 2020;323(9):863-884.
6. Gaskin DJ, Richard P. The Economic Costs of Pain in the United States. In: *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research*. National Academies Press (US); 2011. Accessed February 19, 2025. <https://www.ncbi.nlm.nih.gov/books/NBK92521/>
7. Qaseem A, McLean RM, O’Gurek D, et al. Nonpharmacologic and Pharmacologic Management of Acute Pain From Non–Low Back, Musculoskeletal Injuries in Adults: A Clinical Guideline From the American College of Physicians and American Academy of Family Physicians. *Ann Intern Med*. 2020;173(9):739-748.
8. Taylor SL, Hoggatt KJ, Kligler B. Complementary and Integrated Health Approaches: What Do Veterans Use and Want. *J Gen Intern Med*. 2019;34(7):1192-1199.
9. Edward J, Carreon LY, Williams MV, Glassman S, Li J. The importance and impact of patients’ health literacy on low back pain management: a systematic review of literature. *Spine J*. 2018;18(2):370-376.
10. Yang H, Haldeman S. Chronic Spinal Pain and Financial Worries in the US Adult Population. *Spine*. 2020;45(8):528.
11. Tsai J, Szymkowiak D, Kertesz SG. Top 10 presenting diagnoses of homeless veterans seeking care at emergency departments. *Am J Emerg Med*. 2021;45:17-22.
12. Halloran SM, Coleman BC, Kawecki T, Long CR, Goertz C, Lisi AJ. Characteristics and practice patterns of US Veterans Health Administration doctors of chiropractic: A cross-sectional survey. *J Manipulative Physiol Ther*. 2021;44(7):535-545.
13. Himelfarb I, Johnson CD, Green BN, Bond GD, Shotts BL, Ouzts Jr. NE. Practice Analysis of Chiropractic 2025. Accessed June 5, 2025. <https://www.nbce.org/practice-analysis-of-chiropractic-2025-2/>
14. Karran EL, Fryer CE, Middleton JW, Moseley GL. Exploring the Social Determinants of Health Outcomes for Adults with Low Back Pain or Spinal Cord Injury and Persistent Pain: A Mixed Methods Study. *J Pain*. 2022;23(9):1461-1479.
15. Karran EL, Grant AR, Moseley GL. Low back pain and the social determinants of health: a systematic review and narrative synthesis. *Pain*. 2020;161(11):2476.
16. Buettner-Schmidt K, Maack B, Larson M, Orr M, Miller DR, Mills K. Systems change to improve tobacco use identification and referral in the chiropractic setting: a pilot study. *Chiropr Man Ther*. 2018;26:45.
17. Gliedt JA, Reynolds M, Moonaz S, Long CR, Russell R, Schneider MJ. Identifying and addressing patient substance use: a survey of chiropractic clinicians. *Chiropr Man Ther*. 2023;31:18.
18. Daniels CJ, Anderson DR, Cupler ZA. Coordination of Care Between Chiropractic and Behavioral Health Practitioners Within the US Department of Veterans Affairs Health Care System: A Report of 3 Patients With Pain and Mental Health Symptoms. *J Chiropr Med*. 2022;21(1):1-8.
19. Shearer HM, Bhandari M. Ontario Chiropractors’ Knowledge, Attitudes, and Beliefs About Intimate Partner Violence Among Their Patients: A Cross-Sectional Survey. *J Manipulative Physiol Ther*. 2008;31(6):424-433.
20. Gliedt JA, Schneider MJ, Evans MW, King J, Eubanks JE. The biopsychosocial model and chiropractic: a commentary with recommendations for the chiropractic profession. *Chiropr Man Ther*. 2017;25:16.
21. Cormack B, Stilwell P, Coninx S, Gibson J. The biopsychosocial model is lost in translation: from misrepresentation to an enactive modernization. *Physiother Theory Pract*. 2023;39(11):2273-2288.
22. Gliedt JA, Battaglia PJ, Holmes BD. The prevalence of psychosocial related terminology in chiropractic program courses, chiropractic accreditation standards, and chiropractic examining board testing content in the United States. *Chiropr Man Ther*. 2020;28:43.
23. Khan JA, Battaglia PJ, Gliedt JA. A narrative review of social determinants of health education in health professional programs and potential pathways for integration into Doctor of Chiropractic programs. *J Can Chiropr Assoc*. 2023;67(1):19-37.
24. Butler, PA Weather History | Weather Underground. Accessed February 23, 2024. <https://www.wunderground.com/history/weekly/us/pa/butler/KBTP/date/2023-10-29>
25. Health Care for Homeless Veterans. VA.gov | Veterans Affairs. Accessed February 23, 2024. <https://www.va.gov/homeless/hchv.asp>
26. Watson N, Carter G. Toward Implementation of a National Housing Insecurity Research Module. *Citiescape J Policy Dev Res - Hous Tenure Financ Secur*. 2020;22(1):227-248.
27. Magnan S. Social Determinants of Health 101 for Health Care: Five Plus Five - NAM. October 9, 2017. Accessed May 4, 2025. <https://nam.edu/perspectives/social-determinants-of-health-101-for-health-care-five-plus-five/>
28. Hood CM, Gennuso KP, Swain GR, Catlin BB. County Health Rankings: Relationships Between Determinant Factors and Health Outcomes. *Am J Prev Med*. 2016;50(2):129-135.

29. The 2023 Annual Homelessness Assessment Report (AHAR to Congress) Part 1: Point-In-Time Estimates of Homelessness, December 2023.
30. Davies A, Wood LJ. Homeless health care: meeting the challenges of providing primary care. *Medical Journal of Australia*. September 3, 2018. Accessed February 19, 2025. <https://onlinelibrary.wiley.com/doi/full/10.5694/mja17.01264>
31. Anastas TM, Stewart JC, Rand KL, Hirsh AT. Pain in People Experiencing Homelessness: A Scoping Review. *Ann Behav Med Publ Soc Behav Med*. 2023;57(4):288-300.
32. Albertson A, Kells H, Sawyer C, Maiers M. Chiropractic Services and Employment Characteristics within U.S. Federally Qualified Health Centers: Cross-Sectional Survey. *J Integr Complement Med*. 2025;31(3):301-307.
33. Pak SS, Jiang Y, Lituiev DS, De Marchis EH, Peterson TA. Evaluating associations between social risks and health care utilization in patients with chronic low back pain. *Pain Rep*. 2024;9(6):e1191.
34. Malika N, Herman PM, Whitley M, et al. Qualitative Assessment CIH Institutions' Engagement With Underserved Communities to Enhance Healthcare Access and Utilization. *Glob Adv Integr Med Health*. 2024;13:27536130241244759.
35. Asthana S, Gago L, Garcia J, et al. Housing Instability Screening and Referral Programs: A Scoping Review. *Jt Comm J Qual Patient Saf*. 2025;51(1):1-10.
36. Byrne T, Fargo JD, Montgomery AE, Roberts CB, Culhane DP, Kane V. Screening for Homelessness in the Veterans Health Administration: Monitoring Housing Stability through Repeat Screening. *Public Health Rep*. 2015;130(6):684-692.