

Module 8. Homelessness

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Objectives

1. Understand the connection between homelessness and poor health outcomes.
2. Understand the benefits of harm reduction and “housing first” in this patient population.
3. Understand the heterogeneity of the homeless population and the importance of the social history.
4. Enable providers to connect homeless patients to services that will address common social barriers to care.

Case:

A 60-year-old male with a history of diabetes and hypertension presenting to the emergency department for a lower leg wound with a new surrounding area of redness. Symptoms started 3 days ago when he scraped his leg against a piece of metal. There is no purulent drainage. He denies other medical problems. The patient drinks 1-2 beers per day and denies drug and tobacco use. Vital signs are within normal limits and the patient is in no apparent distress. On exam, he has a 4cm superficial laceration to his left leg with 6cm area of surrounding cellulitis. You prescribe him Bactrim and Keflex and discharge him home with wound care instructions. The patient returns 3 days later with worsening symptoms: the cellulitis has now spread to his thigh. He did not take the antibiotics. He is febrile and tachycardic and you admit him for IV antibiotics. During your encounter, you demand to know why he didn’t take both antibiotics, frustrated that the patient did not follow your care plan. The pharmacy wanted a co-pay to fill the antibiotic prescription and he did not have the cash. The patient explains that he became homeless after losing his job, also is unable to afford his regular medications, and was denied a bed at a shelter secondary to drinking two 40oz beers per day. He has no way to care for his wound on the streets. You realize that you never asked him if he was homeless because he did not appear to match your image of homelessness and was not intoxicated at the time of encounter. You review the record and note that he has been to the ED at least 2 times a month in the last year for various issues stemming from his difficulty managing his chronic medical problems. You decide to bring this to the attention of the admitting team and they consult social work during his hospital stay.

You later follow up on his hospital course a few days later at which time you note that the social work note mentions that he has been placed in a “Housing for Health” program given his poorly controlled chronic conditions and high emergency department/hospitalization use. Over the next year, he has only 2 ED visits.

Discussion Questions

1. What factors contributed to the patient returning to the emergency department with worsening cellulitis?
2. How does lack of housing affect the patient's health?
3. What can be done to help this patient?
4. What is a "Housing for Health" program?

Teaching Points

1. Homeless individuals represent a heterogeneous group of individuals, many of whom can go unrecognized in the emergency department unless directly engaged in a conversation about housing. Homelessness, too, can represent varying states from living on the streets to couch surfing. Thus, critical social needs may go unaddressed during visits with homeless individuals.
2. Homeless individuals often use the emergency department as their primary source of care and the Emergency Department effectively becomes their only connection to the healthcare system.
3. The emergency department can serve as a community triage and coordinating entity for homeless individuals. Consider asking all ED patients if they have any trouble getting their prescriptions. The ability to obtain the medication prescribed is part of safe discharge and a key aspect of systems-based practice. Screening for homelessness in the ED can be quick and efficient; ask patients if they have stable housing or are concerned that they will not have stable housing in the next few months.
4. Connecting patients with housing has been shown to reduce overall ED visits and health spending. A harm reduction approach (housing without stipulations) can decrease healthcare utilization and improve outcomes in patients with mental illness and substance abuse problems.

Practical Questions:

1. What services are available to homeless patients in the emergency department?
2. What are immediate and long-term options for housing in your community?
3. It is 3am and you are discharging a homeless individual from the ED with a prescription for new medications. What do you need to do to assure maximal adherence with the treatment plan and safety for the individual?

Recommended Screening Question(s):

1. What is your housing situation today?
 - I have housing.
 - I have a place to live today, but I am worried about losing it in the future.
 - I do not have a steady place to live. (I am temporarily staying with others, in a hotel, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
 - Decline to answer

Paired Reading:

Raven MC, Tieu L, Lee CT, Ponath C, Guzman D, Kushel M. Emergency Department Use in a Cohort of Older Homeless Adults: Results From the HOPE HOME Study. Acad Emerg Med 2017;24:63-74.

Discussion Points from the Reading:

1. The median age of a homeless person in the U.S. is now greater than 50 years old. Older homeless have less problems with substance abuse and more issues with chronic medical needs.

2. Over half of the participants in the study rated their health as fair or poor and the majority had at least one chronic illness.
3. Historically homelessness has been defined in research as dichotomous. We recognize now that there are varying levels of homelessness and housing instability. Classifying individuals as homeless at a single point in time may be too simplistic. "Exposure to homelessness" over time may be a better concept to use to assess influence on health outcomes.

Additional Readings:

1. Fitzpatrick-Lewis D, Ganann R, Krishnaratne S, Ciliska D, Kouyoumdjian F, Hwang SW. Effectiveness of interventions to improve the health and housing status of homeless people: a rapid systematic review. *BMC Public Health* 2011;11:638.
2. Basu A, Kee R, Buchanan D, Sadowski LS. Comparative cost analysis of housing and case management program for chronically ill homeless adults compared to usual care. *Health Serv Res* 2012;47:523-43.
3. Morris DM. The Role of the Emergency Department in the Care of Homeless and Disadvantaged Populations. *Emerg Med Clin N Am* 24 (2006) 839-848. Available at: http://sbdww.org/wpcontent/uploads/2011/04/role_of_ed_in_treating_homeless_pt_emerg_med_clin_na_2006.pdf
4. Evicted: Poverty and Profit in the American City by Matthew Desmond