

CASE: 40 year old homeless woman is admitted with a mild case of pneumonia; the emergency physician tells you that she probably doesn't need to be admitted, except that she's homeless. She receives standard antibiotics and is ready for discharge the following day. Where will you discharge her to? Which medical conditions is she at high risk for while living on the streets? What other considerations are there at the time of discharge?

Care of Homeless Patients in the Hospital

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Background

- Homelessness is defined as a lack of fixed, regular, and adequate housing. Homeless patients are hospitalized 30-40% longer than patients with adequate housing. *Homeless* individuals have an unstable or unreliable living situation which may include missions, shelters, single room occupancy facilities, abandoned buildings or vehicles, or the streets; homeless individuals may also stay with a series of family members or friends. *Marginally housed* individuals may live in facilities such as low-cost hotels.
- Homeless women are at 3.4 times the risk of sexual assault than even women living in marginal housing such as shelters or low-rent motels.
- Homeless adults suffer from 8 to 9 concurrent illnesses.
- Average life span of a homeless person is 45 years.

Hospital care on initial presentation

- **Take a good history.** Ask the patient where s/he is staying; elicit history of substance abuse, mental illness, sexual and assault history, and legal or prison history. Information key to medication decisions includes the patient's access to regular meals and hydration. Ask about exposures to tuberculosis, lice or scabies, and Sexually Transmitted Diseases (STDs). Also, determine the patient's comfort level with reading, as many homeless adults are functionally illiterate and may have difficulty understanding written instructions.
- **Assess the patient's trust** in the health care system. Inquire about a primary care doctor; recognize that many homeless patients have been ostracized by mainstream systems and individuals.
- **Assess for common illnesses in homeless patients**, which include schizophrenia and dementia; substance abuse; lice; scabies; STDs, tuberculosis and HIV; dental disease; diseases of exposure such as sunburn, frostbite, dehydration, ulcers, hypothermia; asthma; trauma; and trench foot.

Hospital care during hospitalization: Work with the patient to prioritize post-discharge goals. Recognize that on the streets, obtaining food and shelter may be higher priority than medical care.

Hospital care at discharge: Homeless patients are at high risk of relapsed or recurrent disease. Addressing issues specific to homelessness at the time of discharge may help the patient transition back to street life.

- **Housing:** Consider whether medical respite is an option; re-admission is lower with discharge to respite. For women, the risk of assault is much lower even if marginal housing such as a shelter bed can be reserved. If there is a risk of violence, create a safety plan with the patient and ask social work to provide resource information.
- **Medications:** Attempt to simplify the regimen as much as possible and to match medications to a patient's living conditions. Consider whether refrigeration is needed for medications, such as insulin, whether side effects such as diarrhea or frequent urination may make it difficult or impossible to comply, and whether medications must be taken at a set time or with food. Set follow-up appointments if blood monitoring is required, and provide adequate supply until the appointment time. Remember to check whether patients' literacy status.

- Conditions that perpetuate homelessness: In drug and alcohol abuse, ask whether the patient has considered quitting, and offer supportive resources to help with abstinence. In mental illness, determine whether the patient has his or her regular medications, contact the case manager, and help the patient to determine follow up for mental health issues.
- Contact after discharge: Sometimes, test results return after discharge and therapy change is indicated. Often, patients have e-mail, voice mail, or other ways to receive messages should issues arise after discharge or may be located at a shelter. Attempt to determine where they are living, i.e. bridge at 6th & Seneca to contact the patient.
- Communication with a primary physician: It is crucial to pass on information about medication changes, important test results, results that need follow-up. If the patient has no PMD, where can s/he establish care?

References.

Buchanan D, Doblin B, Sai T, et al. The effects of respite care for homeless patients: a cohort study. AJ Publishing House 2006 July; 96(7): 1278-81.

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