

Shay Martinez, MD (Adapted from Audrey Young,MD)
Original Date/Last reviewed February 2010

Care of the Indigent Patient

Learning Objectives

- Define what homelessness is
 - Recognize some of the challenges facing homeless individuals, and the subsequent challenges in caring for them
 - Improve ability to safely transition this population to the outpatient setting
-

Case

You are called by the ED to admit a 37 yo woman with pneumonia. On social history you learn that she is currently “staying with a friend” but is not sure how long she will be able to stay there. She responds well to IV antibiotics overnight and is ready for discharge the following day.

Background

- *Homelessness* is defined as lack of a fixed, regular, and adequate night-time residence. Homeless individuals may live on the streets, in shelters, in vehicles, or abandoned buildings. Importantly, the federally-accepted definition of “homeless” does not take into account those individuals and families who are *marginally housed*, meaning “couch surfers” staying intermittently with friends or family, those living in single room occupancy hotels, or who are incarcerated.
- Poverty is the number one cause of homelessness in the United States
- Studies have shown that homeless patients have an average hospital stay that is 30-40% longer than other patients, even after adjusting for rates of mental illness, substance abuse, and other demographics. (NEJM)
- Homeless women are at >3 times the risk of sexual assault than even women living in marginal housing such as shelters or low-rent motels.
- Homeless individuals suffer from 6-9 concurrent medical problems. The national average age of death for a homeless individual is 50 years. This is the average age of death for a typical American living in 1900.

Hospital care on initial presentation

Take a good history. In addition to the standard clinical history questions, be sure to ask the patient where s/he is living, sources of food, and any support systems (friends or family). Obtain any history of mental illness, use of alcohol or illicit drugs, exposure to violence or abuse, and history of incarceration. Also, determine the patient’s level of literacy, as many homeless adults are functionally illiterate and may have difficulty understanding written instructions. All of these factors will be important when determining the appropriate treatment plan for these patients, ones that are realistic for their individual circumstances.

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. These include schizophrenia and dementia; substance abuse; lice; scabies; STIs, tuberculosis and HIV; dental disease; diseases of exposure such as sunburn, frostbite, dehydration, ulcers, hypothermia; asthma; trauma; and immersion (trench) foot. Although not many homeless deaths are directly attributed to exposure-related causes such as these, the risk of death from other causes can be increased up to eightfold in people who have suffered from these conditions in the past.

Also common in this vulnerable population is history of abuse, and both mental and physical trauma resulting from this.

Hospital care during hospitalization:

Work with the patient to prioritize post-discharge goals. Recognize that homeless individuals may be focused on a different tier in the hierarchy of needs- placing higher priority on fulfilling basic needs such as food, water, income and shelter over medical care. This may greatly impact their ability to follow through with a prescribed treatment plan. Social Work may be able to assist with addressing some of these concerns.

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: While it is not possible to provide long term housing immediately on discharge, medical respite is a good alternative for those patients requiring prolonged protection from the elements. Social work should be involved to assist with more long term assistance

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.

Follow up: If possible, be sure to get a good contact number or mailing address so that patients can receive any test results or appointments that may result after discharge. Effort should be made to make follow up appointments with PCPs and subspecialists prior to discharge so that patients can have these appointment slips in hand when leaving the hospital. Remember to check whether patients' literacy status. The patient's PCP should be informed of their stay, any medication changes and follow up needed. If patients do not have PCPs they should have an appointment made at a community clinic close to where they spend the majority of their time. Case managers should be informed of these appointments to help ensure patients

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.

Test Your Knowledge... Back to our case

1. Name 3 things you need to consider when planning a safe discharge for this patient.
2. Where will you send her on discharge?

References:

1. <http://www.kingcounty.gov/healthServices/health/personal/HCHN/about.aspx>
2. <http://www.cehkc.org/scope/cost.aspx>
3. Health Care for the Homeless Clinician's Network
4. www.HUD.gov
5. National Alliance to End Homelessness. 2007. Fact Checker: Chronic Homelessness. www.endhomelessness.org
6. Committee to end homelessness in king county. <http://www.cehkc.org/hikc-scope.shtml>
7. US Department of Labor website: <http://www.dol.gov/esa/minwage/america.htm>
8. Burt, M. R. 1999. *Homelessness: programs and the people they serve: findings of the National Survey of Homeless Assistance Providers and Clients: summary*. Washington, D.C.: The Council: U.S. Dept. of Housing and Urban Development
9. Burt, Martha, Laudan Y. Aron, and Edgar Lee, with Jesse Valente. 2001. *Helping America's Homeless: Emergency Shelter or Affordable Housing?* Washington, D.C.: Urban Institute Press.
10. <http://www.homelessinfo.org/onc.html>
11. <http://www.metrokc.gov/health/hchn/2006-annual-report-homeless-deaths.pdf>
12. <http://www.metrokc.gov/health/news/04121301.htm>
13. <http://www.rwjf.org/files/newsroom/cshLewinPdf.pdf>
14. Levy BD, O'Connell JJ. Health care for homeless persons. *New England Journal of Medicine* 2004; 350: 2329-2332