CLINICAL VIGNETTE

Hospital Care of the Homeless Patient: A Case Report and Discussion

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Introduction

Hospital care of patients experiencing homelessness presents many unique clinical challenges that rarely affect more stably housed patients. Reliable access to regular preventative health care, ability to safely store medications and medical equipment, and safe, clean spaces to rest and recuperate are just a few resources lacking to many homeless patients. Despite some availability of community-based social and healthcare resources for homeless patients, there are multiple barriers facing those experiencing homelessness. It is imperative that hospital healthcare teams be aware of these barriers in their attempts to bridge them. Additionally, the more knowledgeable clinicians are of these matters, the more effectively they can engage with their social work and case management colleagues to provide optimal clinical care.

We present a homeless patient presenting with recurrent leg cellulitis. The discussion includes, engaging with an expert in longitudinal care of undomiciled patients to address some of the highest yield clinical considerations for hospital care providers.

Case Report

A 48-year-old undomiciled male presents with progressive swelling and erythema of bilateral lower legs, more notably on the left. The patient has poorly controlled type 2 diabetes mellitus and chronic venous insufficiency edema with recurrent cellulitis treated with numerous oral antibiotic regimens in the prior two years. On arrival to the emergency room the patient is afebrile and hemodynamically stable. Exam is consistent with cellulitis of the left lower extremity. There is no skin breakdown or ulceration. Laboratory evaluation is notable for leukocytosis. A plain film shows no evidence of osteomyelitis. Intravenous vancomycin is initiated in the emergency room, and the patient is admitted for continued management.

The patient's long-term medical care is somewhat fragmented, which he attributes to difficulty reliably keeping appointments. He has a primary care provider whom he has seen multiple times over the past few years. He is marginally compliant with oral medications for his diabetes, and he notes that his lifestyle makes it very difficult for him to manage his chronic leg swelling. Hemoglobin A1c on admission is 8.6%.

The patient lives on the street near the beach. He has some experience with homeless shelters in the area but has found them to feel less safe and more restrictive than his preferred street location. His medications and belongings are frequently stolen or lost during relocations, contributing to his poor medication compliance. He was previously advised that his diabetes be managed with insulin, but while on insulin, he has lost syringes, needles and the insulin itself. Additionally, he does not have access to appropriate refrigeration for insulin. He is tangentially aware of some outpatient social assistance programs available to him but has not engaged with any substantially.

During the hospitalization the patient is maintained initially on intravenous vancomycin with substantial improvement in his leg erythema within the first 48 hours of hospitalization and his leukocytosis resolved. The patient has ongoing bilateral leg edema, but with consistent elevation, it is less prominent and more manageable. He also tolerates placement of bilateral compression stockings. By hospital day 3 the patient is close to discharge-ready, but given issues with medication compliance and frequent episodes of cellulitis, the hospital team is hesitant to convert to oral medications too early.

The patient is visited by the unit social worker during the hospitalization on several occasions, receiving information about available community resources to assist him with his care upon discharge. He is given information about rehab placement at discharge, but he prefers discharge back to the street. Ultimately after substantial clinical improvement, the patient is converted to oral antibiotics and discharged on hospital day 5. An appointment with his primary care provider is arranged for him upon discharge.

Over the subsequent 12 months, the patient re-presents to the hospital emergency department three additional times with similar complaints and is re-admitted once for intravenous antibiotics.

Discussion

We present a question-and-answer approach to address some of the highest yield clinical considerations for hospital care of homeless patients. Questions have developed by hospitalist, and answered by Medical Director of the Homeless Patient-Aligned Care Team (H-PACT).

Are there any clinical pearls that you, as an outpatient provider to homeless patients, would want inpatient providers to be aware of?

The inpatient setting is an invaluable opportunity to engage patients experiencing homelessness. Typically, hospitalized patients are vulnerable and uniquely aware of that vulnerability. Additionally, homelessness is correlated with a higher rate of substance use disorders, and inpatient stays provide a sober environment of care.[1]

This is a time to be honest and communicative, ensuring that the conversation goes both ways, via open-ended questions and a holistic approach. Seeking to understand the patient's perspective and priorities early on during hospitalization will improve trust and rapport, elements that are crucial for members of this marginalized population, ultimately, translating to improved patient health and housing outcomes.

What are the biggest limitations to outpatient care of patients experiencing homelessness? Are there certain medications or situations that should be avoided if possible?

Outpatient care is incredibly challenging. Patients without stable housing often do not have consistent access to a phone, adequate storage, appropriate sleeping environments (sometimes sleeping in their car or in an unhygienic environment), and other limitations. Additionally, their engagement in healthcare is often unreliable, due to multiple competing priorities, including access to food, shelter, transportation and clothing.[2] *Building trust can take multiple visits, which can be difficult to achieve, due to underlying mental health conditions, trauma, and lack of social support.*[3]

Are there high-yield clinical intervention that could reasonably be made during hospitalization to assist in longitudinal care of a homeless patient?

Homeless patients are often in a vulnerable situation, uniquely poised to accept help, listen to medical recommendations, and follow guidance during hospitalization. Understanding that traumatic brain injury and residual trauma are higher in this population, approaching patients with a patient-centered approach is crucial.[4,5] *Additionally, explaining medical recommendations with simple reasoning, instructions, and a feedback loop is important.*

Scheduling appointments prior to discharge improves the likelihood of follow-up, as telephone access is limited for most homeless patients.

Length of stay limitations often limit evaluation of chronic issues. However, when possible, completing labs, imaging, or referrals for chronic issues while awaiting appropriate discharge allows patients to complete evaluation of chronic issues that have gone unevaluated due to missed appointments, failed lab completion, general mistrust of medical recommendations.

When we "consult social work" for "homeless resources", what exactly should we expect? Could we engage with social work any more effectively in these cases?

As the saying goes, 'discharge planning begins on Day One.'

By immediately involving social work, the social worker is able to engage the patient and start: 1. Referrals to available Emergency Shelters or Transitional Housing programs; 2. Applications for appropriate benefits; 3. Coordination with community-based case managers, who may already be providing beneficial wrap-around services.[6] *Effectiveness varies depending on the chronicity of the patient's homelessness and their underlying mental health. Some patients, may start on a path toward permanent housing. Others, may simply be another conversation during a patient's pre-contemplative phase of housing readiness. Early referrals allow social workers to effectively complete referrals, make a few steps pursuing additional benefits, and coordinate with community case managers to optimize post-hospitalization care.*

If a patient engages longitudinally with a care team, what can ultimately be offered to them in terms of healthcare and housing long term?

There are many housing and clinical resources available to homeless patients. There are Permanent Supportive Housing programs, which provide subsidized housing, with ongoing case management to support patient care. Additionally, clinical programs through Los Angeles County Department of Mental Health, local Community programs and Federally Qualified Health Centers can support patients to engage in preventative care, mental health care and even work toward employment, benefits, and other resources. The Los Angeles Homeless Service Authority is the lead authority in organizing housing and services for homeless individuals and families in Los Angeles County. Their webpage is www.lahsa.org. Special populations, including Youth and Veterans have additional resources that can provide additional clinical care, housing and benefits.

Coordinating discharge planning actively with social work colleagues will allow them to pursue these connections, while accounting for the anticipated discharge date.

Conclusion

Homelessness in Los Angeles is a complex and frustrating issue that affects our patients' health, well-being and support structures. Treating patients with housing instability starts with establishing a therapeutic alliance with the patient and early involvement of social work to strategize housing, medical care, social supports and medication/equipment needs.

While housing instability adds a layer of management to the care of a hospitalized patient, the hospital system, County, and community partners have a network of resources that are

available to help patients situate and recover, and hopefully work toward permanent housing over time.

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