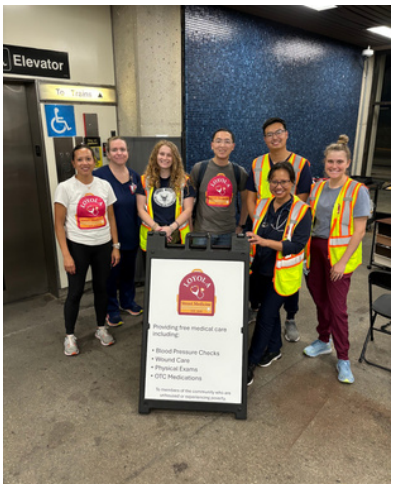
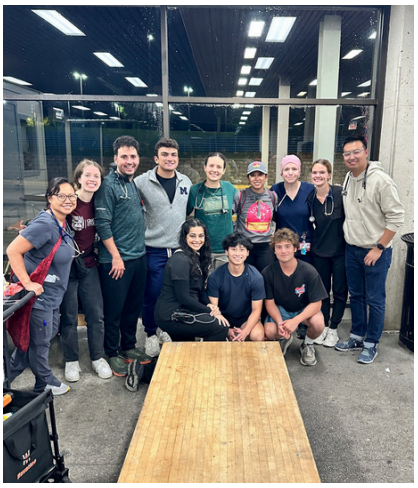
STREET MEDICINE CASES





UNDERSTANDING SAFE DISCHARGE PLANNING, PATIENT AUTONOMY

CASE:

A 56 year old male with a past medical history significant for hypertension, diabetes mellitus, heroin use, and sick sinus syndrome was admitted for evaluation of palpitations. His hospital course was complicated by multiple episodes of symptomatic bradycardia requiring atropine administration, followed by intermittent episodes of tachycardia necessitating rate-controlling medications. Cardiology was consulted and recommended permanent pacemaker placement; however, the patient adamantly declined the procedure and elected to leave the hospital against medical advice.

Several days later, the patient returned to the emergency department following a heroin overdose and was admitted for cardiac monitoring due to persistent bradycardia. During this subsequent hospitalization, additional social history revealed that the patient was experiencing unsheltered homelessness, alternating between sleeping on the streets and with a friend. He reported limited and inconsistent access to food, water, and restroom facilities. Although he had attempted to engage with outreach organizations, including Housing Forward, he described difficulty maintaining contact due to lack of a personal cell phone.

The patient was a frequent user of emergency services, with seven emergency department visits or hospital admissions in the preceding year. He reported having a LINK card but had recently lost disability benefits after missing a required appointment. He endorsed daily heroin and cocaine use but expressed interest in rehabilitation services.

QUESTIONS TO CONSIDER:

1. **What are the ethical and legal considerations for both the ED and hospital when discharging a homeless patient to the streets?**
2. **How might the primary care team taking care of the patient help address some of his social and medical needs?**
3. **How can you effectively assess whether or not a patient is able to refuse care?**
4. **What system-level barriers (e.g., loss of benefits, lack of communication access) contribute to frequent hospital use, and what interventions could improve continuity of care for unsheltered patients?**

STREET MEDICINE CASES

KEY LEARNING POINTS:

- People experiencing homelessness have worse health outcomes than the general population and limited access to primary/preventative healthcare. This leads to high hospital readmission rates. **Effective discharge planning can improve recovery rates and reduce hospital costs.**

- The ethical obligation to provide a reasonably safe discharge option from the inpatient setting is often confounded by the context of homelessness. Living without the security of stable housing is a known determinant of poor health, often complicating the safety of discharge and causing unnecessary readmission.

- **Leaving against medical advice may reflect unmet social needs rather than lack of insight,** highlighting the importance of addressing housing, communication barriers, and basic necessities during inpatient care.

- **Unsheltered homelessness limits access to outpatient services,** particularly when patients lack reliable communication tools such as a cell phone.

- **Emergency departments often serve as primary points of care for unhoused individuals**, underscoring opportunities for harm reduction, engagement in addiction treatment, and linkage to community resources.

RESOURCES & ADDITIONAL READING:

- Diaz Vickery, Katherine, MD, et all. Ama J Ethics. How Should Autonomy of Persons Experiencing Homelessness be Balanced with Public Health During a Pandemic?
- Georgina D Campelia, James N Kirkpatrick, Patsie D Treece, Jamie L Shirley, **Denise M Dudzinski**. NIH Pubmed. Discharging to the Streets: When Patients Refuse Medically Safer Options
- **Guidance related to safely discharging and placing people experiencing homelessness into City of Chicago shelters**
- Jesse Jenkinson, Adam Wheeler, Claudia Wong, Louisa Mussells Pires. Hospital Discharge Planning for People Experiencing Homelessness Leaving Acute Care: A Neglected Issue - PMC
- Know the discharge laws in your state! For example: California discharge law: CALIFORNIA'S DISCHARGE PLANNING LAW
- Ward Martha, MD. AMA J Ethics. When and How Should Clinicians View Discharge Planning as Part of a Patient's Care Continuum?

CASE FOLLOW UP:

This patient was hospitalized multiple times over the course of the following 9 months, often leaving against medical advice, but eventually agreed to pacemaker placement. After getting the pacemaker, the patient reported having more energy and not feeling as short of breath. He continued to live on the streets but had regular contact with the Housing Forward outreach worker. He was ultimately able to be placed in an apartment through the Housing is Recovery program.

STREET MEDICINE CASES

RE-ENTRY CONSIDERATIONS / CRIMINALIZATION OF HOMELESSNESS

CASE:

A 32 year old male with a past medical history of asthma was admitted as a Level 2 trauma following a pedestrian–motor vehicle collision at approximately 55 mph. He sustained multiple injuries, including a subdural hematoma, splenic laceration, pulmonary contusions, and multiple ankle and foot fractures requiring surgical intervention. Postoperatively, he developed psychotic symptoms with delusions and hallucinations, prompting psychiatric consultation and initiation of antipsychotic therapy.

As his mental status improved, he disclosed a history of prolonged unsheltered homelessness, sleeping on CTA trains, buses, and park benches. He reported staying near hospitals due to asthma symptoms and concern for extreme weather. He had previously attempted to engage with housing outreach services but lost contact after losing his cell phone, identification, and Social Security card. He reported no income or disability benefits.
Once medically and psychiatrically stabilized, the patient was discharged with housing resources; however, placement prior to discharge was limited by his psychiatric status and lack of available options, and he did not meet criteria for inpatient psychiatric hospitalization.

Approximately one month later, he was readmitted from an outside hospital for a suspected surgical site infection of his foot. He reported that following his prior discharge, he had been incarcerated after an altercation in which a bus driver allegedly closed a bus door on his injured foot; in response, he damaged the bus and was arrested. After his release, he was living unsheltered and had lost access to the housing resources previously provided. He was subsequently found to have a wound infection requiring several weeks of intravenous antibiotics. During this admission, the Street Medicine team collaborated with the Medical Legal Partnership to provide legal advocacy and assist in securing pro bono legal representation. They were also able to call the courthouse to notify them that the patient was currently hospitalized and unable to make his court appearance.

QUESTIONS TO CONSIDER:

- **What medical, psychiatric, and social vulnerabilities are most pronounced during the transition from incarceration back to the community, particularly for individuals experiencing homelessness?**
- **How does recent incarceration complicate continuity of medical care, including access to medications, wound care, and follow-up appointments?**
- **What barriers do recently incarcerated individuals face in accessing housing, identification, and benefits, and how do these barriers contribute to repeat hospitalizations?**
- **How can hospitals and street medicine teams better coordinate with correctional facilities to ensure continuity of care upon release?**
- **What role can Medical Legal Partnerships play in addressing legal barriers—such as pending charges or loss of identification—that directly impact health outcomes?**
- **How can health systems intervene earlier to prevent the cycle of hospitalization, incarceration, and homelessness?**

STREET MEDICINE CASES

KEY LEARNING POINTS:

- **Re-entry from incarceration is a period of extremely high medical and social vulnerability**, particularly for individuals experiencing homelessness and chronic illness.
- **Interruptions in care during incarceration and upon release often lead to worsening health outcomes**, including untreated infections, medication lapses, and missed follow-up.
- **Lack of stable housing, identification, and income creates significant barriers to recovery**, even when appropriate medical treatment is provided.
- **Medical-Legal Partnerships are essential in addressing upstream legal barriers** that directly affect health, including criminal charges, benefits reinstatement, and housing eligibility.
- **Cross-sector collaboration between hospitals, correctional systems, and community organizations** is critical to improving continuity of care and reducing preventable readmissions.
- **Health care encounters may represent rare opportunities for engagement** for individuals cycling between homelessness and incarceration, underscoring the importance of trauma-informed, patient-centered care.

RESOURCES & ADDITIONAL READING:

- Asiegbu, Grace, and Adriana Martinez-Smiley. "Homecoming." Injustice Watch, 8 Jan. 2024.
- Housing Not Handcuffs
- Loyola Street Medicine Podcast: Criminalization of Homelessness. Spotify Podcast
- Loyola Street Medicine Podcast: Legal Challenges. Spotify Podcast
- Mayer, Christopher, and Jessica Reichert. "The Intersection of Homelessness and the Criminal Justice System." ICJIA.
- National Healthcare for the Homeless Council Clinicians' Network. Healing Hands: Incarceration and Homelessness: Reentry Considerations for Health Care Providers
- Re-Entry Employment Service Program
- Re-entry resources for prisoners and former prisoners | Illinois Legal Aid Online

CASE FOLLOW UP:

The patient was discharged to a subacute rehab facility so he could receive physical therapy services for his injuries as well as nursing care for his IV antibiotics. The facility also assists the patient with his specialist follow ups upon discharge. He was established with our Medical Legal Partnership team to assist with his ongoing legal matters.

STREET MEDICINE CASES

HOMELESSNESS AND FAMILIES

CASE:

A 6 year old male with a history of asthma presented to the emergency department with acute shortness of breath. On arrival, he was tachypneic with a respiratory rate of 56 breaths per minute and an oxygen saturation of 91%. His mother reported that he had run out of his inhalers due to financial constraints.

Further history revealed that the family of five is unhoused. Most recently, they had been living in a shared room with strangers who smoke. Previously, they had been staying with relatives but could no longer do so. The mother has been unable to secure employment, and the father's income is insufficient to support the family. While they are SNAP beneficiaries, they do not receive additional public assistance. The three children were not enrolled in school due to housing instability.

During the patient's hospitalization, the family was able to stay at the Ronald McDonald House. However, they reported that after discharge, they would likely have to sleep in a park. The Street Medicine and Social Work teams collaborated with local outreach organizations to secure temporary housing for the family and assist with enrolling the children in school.

QUESTIONS TO CONSIDER:

- **What are the ethical and legal considerations for caring for pediatric patients with unhoused families?**
- **How does housing instability impact the management and outcomes of pediatric asthma?**
- **What are best practices for discharge planning for children with chronic respiratory conditions who experience housing insecurity?**
- **How does unstable housing contribute to increased exposure to environmental triggers, such as secondhand smoke?**
- **How can multidisciplinary collaboration (e.g., social work, case management, child protection services, community shelters) be optimized to support families presenting to the ED with acute housing loss?**

STREET MEDICINE CASES

KEY LEARNING POINTS:

- **Secondhand smoke** is a well-documented trigger for asthma exacerbations in children. Exposure is often more severe in families experiencing housing instability due to lack of smoke-free environments.
- **Need for Harm Reduction and Advocacy** - Counseling caregivers on reducing smoking exposure is crucial. Engagement with social services (housing assistance, smoke-free shelters) is often necessary.
- **Healthcare System Adaptations** - Flexible care models (school-based clinics, mobile health units) can improve access for homeless children. Multidisciplinary approach including social workers, case managers, and community resources is key.
- **Housing instability is a medical and social emergency for families with infants**, as it directly impacts safety, health, and access to basic needs.

RESOURCES & ADDITIONAL READING:

- Cutuli JJ, Ahumada SM, Herbers JE, Lafavor TL, Masten AS, Oberg CN. Adversity and children experiencing family homelessness: Implications for health - PMC Epub 2016 Jul 3.
- JPAM Featured Article What Interventions Work Best for Families Who Experience Homelessness? Impact Estimates from the Fam | APPAM
- National Coalition for the Homeless: Families with Children Experiencing Homelessness. Families, Youth & Education - National Coalition for the Homeless
- Schickedanz A, Chung PJ. Addressing Family Homelessness in Pediatrics – Progress and Possibility - PMC. Pediatrics. 2018 Oct.
- Shinn M, Gibbons-Benton J, Brown SR. Poverty, Homelessness, and Family Break-Up - PMC. Child Welfare. 2015.

CASE FOLLOW UP:

STREET MEDICINE CASES

CONSIDERATIONS FOR UNDOCUMENTED PATIENTS

CASE:

A 62 year old male was admitted to the hospital following a pedestrian–motor vehicle collision and was found to have multiple traumatic injuries, including sacral, tibial, and fibular fractures. He underwent surgical repair of his lower extremity fractures.

During admission, it was discovered that the patient was experiencing homelessness and was also undocumented. He had been unhoused for approximately five months after his roommate relocated out of state, leaving him unable to afford rent independently. He had been sleeping on park benches and intermittently relied on a local bar owner for access to water and restroom facilities. The patient reported that he was struck by a vehicle while crossing the street to use the bar's restroom. Although he occasionally stayed with his two brothers, long-term housing with family was not feasible. He had not been previously connected with outreach organizations, likely due to limited awareness of available services and language barriers, as he is Spanish-speaking. He relied on friends and family for meals and limited financial support.

Given the extent of his injuries, the patient required significant physical and occupational therapy to regain mobility and function. He was non–weight bearing on the injured extremity, and his sacral fracture was managed non-operatively, resulting in slow rehabilitation progress due to pain. Discharge planning was complicated by his undocumented and uninsured status, which significantly limited post-acute rehabilitation options. Although he applied for hospital charity financial assistance, coverage for inpatient rehabilitation was not approved.

QUESTIONS TO CONSIDER:

- **How does undocumented status influence access to trauma recovery services, including rehabilitation, durable medical equipment, and follow-up care?**
- **What ethical challenges arise when medically necessary care is unavailable due to immigration or insurance status, and how should clinicians navigate these situations?**
- **How do language barriers compound health disparities for undocumented patients, and what strategies can hospitals implement to improve communication and trust?**
- **What role do community organizations and informal support networks play in supporting the health of undocumented immigrants, and how can health systems partner with them?**
- **How should discharge planning be approached when standard post-acute options are inaccessible, and what alternative models of care might better serve undocumented patients?**
- **What policy or system-level changes could improve health outcomes for undocumented immigrants following serious injury?**

STREET MEDICINE CASES

KEY LEARNING POINTS:

- **Undocumented status significantly limits access to post-acute care**, including inpatient rehabilitation and skilled nursing facilities, even when medical need is clear.
- **Traumatic injury can rapidly precipitate homelessness and medical vulnerability** for undocumented individuals who lack financial, legal, and social safety nets.
- **Language barriers and lack of familiarity with the health system reduce engagement with outreach services**, contributing to delayed care and unmet needs.
- **Reliance on informal community support** (friends, family, local businesses) often substitutes for formal systems of care among undocumented patients.
- **Pain, immobility, and prolonged non–weight-bearing status disproportionately impact unhoused and undocumented patients,** increasing the risk of poor functional outcomes.
- **Hospital charity programs may be insufficient to meet rehabilitation needs**, highlighting structural gaps in care for uninsured and undocumented populations.
- **Inpatient hospitalizations represent critical opportunities** to address language access, connect patients to community resources, and advocate for equitable discharge planning.

CASE FOLLOW UP:

Given limited discharge placement options, the patient was initially discharged to a local medical respite facility. However, medical respite programs require patients to be independent with activities of daily living, and due to his non–weight-bearing status, he required a higher level of support than the respite setting could provide. He was readmitted to the hospital later that same day. He remained hospitalized for several additional days for pain management and additional physical therapy. Due to his undocumented status and ineligibility for medical respite or inpatient rehabilitation, he was ultimately discharged back to the streets after he regained more strength and mobility. Prior to discharge, the street medicine team provided education on available community resources and supplied information on shelters, food access, and the Street Medicine CTA Clinic.

RESOURCES & ADDITIONAL READING:

- Aborode, Abdullahi T.a,b; Lawal, Lukmanc,d; Agwuna, Favour O.e; Adewunmi, Rhoda O.f; Ubechu, Samuel C.g; Badri, Rawah,i. Health disparities among illegal immigrants and homeless people in the USA: a struggle within. International Journal of Surgery: Global Health, November 2023.
- Kaur H, Saad A, Magwood O, Alkhateeb Q, Mathew C, Khalaf G, Pottie K. Understanding the health and housing experiences of refugees and other migrant populations experiencing homelessness or vulnerable housing: a systematic review using GRADE-CERQual - PMC. CMAJ Open. 2021.
- Martinez O, Wu E, Sandfort T, Dodge B, Carballo-Dieguez A, Pinto R, Rhodes SD, Moya E, Chavez-Baray S. Evaluating the Impact of Immigration Policies on Health Status Among Undocumented Immigrants: A Systematic Review - PMC. J Immigr Minor Health. 2015 Jun.
- Tanya Broder, Ben D'Avanzo, Sarah Krieger, and Matthew Lopas. National Immigration Law Center: Overview of Immigrant Eligibility for Federal Programs - NILC

STREET MEDICINE CASES

PREGNANT / WOMEN'S HEALTH

CASE:

A 32 year old pregnant woman at 14 weeks' gestation with a medical history significant for type 1 diabetes, end-stage renal disease status post renal transplant, gastroparesis, and hypertension presented to the emergency department with intractable vomiting. Her persistent emesis had prevented adherence to multiple medications, including her post-transplant immunosuppressive regimen. She reported recurrent nausea and vomiting throughout her pregnancy, which had resulted in job loss due to repeated absences.

The patient and her boyfriend had been living in her late aunt's home; however, after losing her job, she was unable to keep up with household expenses. Several utilities had already been shut off, and she had received a foreclosure notice requiring them to vacate the home by the end of the month. Her boyfriend's income was insufficient to cover housing costs, and although she had attempted to engage with community outreach programs, she was ineligible for assistance because she had not yet formally lost her housing. She received SNAP benefits but was not enrolled in social security or disability programs.

Her complex medical conditions required close follow-up with multiple specialties, but she reported difficulty affording her medications and lacked reliable transportation to appointments. These challenges, combined with worsening gastrointestinal symptoms and imminent housing loss, posed significant risks to both her health and the well-being of her developing fetus.

QUESTIONS TO CONSIDER:

- **In what ways do housing instability and utility shutoffs heighten medical risk for pregnant patients with high-acuity conditions, and how should these social factors be incorporated into risk assessment and disposition planning?**
- **How might early identification of social needs—using tools such as social risk screening or collaboration with community health workers—alter the clinical course for patients facing imminent homelessness?**
- **What unique challenges do pregnant patients face when they are at risk of losing stable housing, and how should these factors influence clinical decision-making and disposition planning in the emergency department?**
- **In what ways can housing instability exacerbate barriers to prenatal care, medication adherence, and specialty follow-up for medically complex pregnant patients?**
- **How can healthcare systems proactively identify pregnant patients who are precariously housed—before they become literally homeless—and connect them with early interventions or support services?**
- **What are the ethical considerations in caring for pregnant patients whose social circumstances (e.g., utility shutoffs, transportation barriers, food insecurity) pose direct risks to fetal well-being?**

STREET MEDICINE CASES

KEY LEARNING POINTS:

- **Medication nonadherence in high-risk pregnancy may be driven by social circumstances rather than patient behavior,** including inability to tolerate oral intake, lack of financial resources, and barriers to accessing medications. This is particularly consequential in transplant recipients who rely on strict adherence to immunosuppressive therapy.

- **Impending homelessness is itself a medical emergency for pregnant patients,** as utility shutoffs, food insecurity, and unstable living environments can directly harm maternal health and threaten fetal development.

- **Patients who are "precariously housed" often fall into a gap where they are not eligible for homelessness-targeted services,** despite facing imminent eviction or foreclosure. This structural barrier delays intervention until patients reach crisis levels.

- **Social determinants of health—housing, transportation, financial instability—can have equal or greater impact on pregnancy outcomes than medical factors,** highlighting the need for routine, early social risk screening in emergency and prenatal settings.

RESOURCES & ADDITIONAL READING:

- Committee Opinion No. 576: Health Care for Homeless Women | ACOG Obstetrics & Gynecology 122(4):p 936-940, October 2013.
- Lewis JH, Andersen RM, Gelberg L. Health Care for Homeless Women: Unmet Needs and Barriers to Care - PMC. J Gen Intern Med. 2003 Nov.
- Loyola Street Medicine Podcast: Maternal and Reproductive Health. Spotify Podcast
- Loyola Street Medicine Podcast: Maternal Health and Pregnancy Complications. Spotify Podcast
- Marea CX; Arno CA; McShane KS; Lozano A; Vanderpuije M; Robinson KN; Grace KT; Jeffers N; "Navigating Homelessness Assistance While Pregnant: A Rapid Qualitative Research-to-Policy Collaboration in Washington, DC | Health Equity." Health Equity, U.S. National Library of Medicine.
- National Healthcare for the Homeless Council Resources: Women - National Health Care for the Homeless Council
- Sarah's Circle - Ending Homelessness for Women. Sarah's Circle
- St Martin, Brad S, et al. "Homelessness in Pregnancy: Perinatal Outcomes." Journal of Perinatology : Official Journal of the California Perinatal Association, U.S. National Library of Medicine, Dec. 2021.

CASE FOLLOW UP:

STREET MEDICINE CASES

UNDERSTANDING MEDICAL RESPITE

CASE:

A 59 year old woman with a history of hypertension and asthma presented to four different emergency departments over the course of one week with severe lower abdominal pain radiating to her back. During the fourth visit, she additionally reported three months of abnormal uterine bleeding. A CT scan obtained in the emergency department demonstrated a complex adnexal mass, and follow-up transvaginal ultrasound confirmed a lesion with solid and cystic components concerning for malignancy. Gynecologic Oncology consultation and comprehensive diagnostic workup ultimately established a diagnosis of stage IV cervical cancer.

Further history revealed significant social instability. The patient had been living intermittently in a homeless shelter and in her car after losing her job several years earlier. Although she had recently secured a new job offer, she was unable to begin work because of progressive fatigue and pain. Screening with the HOUSEDBEDS tool identified high acute-care utilization, including more than ten ED visits in the preceding six months, as well as difficulty attending outpatient appointments. She was receiving SNAP benefits but had not yet accessed social security or disability benefits for which she likely qualified.

Loyola Street Medicine, in collaboration with hospital social work, arranged for placement in a local medical respite facility to allow the patient to safely initiate cancer treatment, which was expected to include chemotherapy, radiation therapy, and possible surgical intervention. Medical respite provides short-term residential care for individuals experiencing homelessness who are recovering from an illness, injury, or procedure but do not require inpatient hospitalization. These programs offer 24-hour shelter, coordination of medical appointments, medication support, and access to onsite nursing or clinical oversight depending on the facility's resources.

QUESTIONS TO CONSIDER:

- **What opportunities exist in the emergency department to identify patients at risk for high acute-care utilization and missed outpatient follow-up, and how can tools like HOUSEDBEDS be integrated into routine practice?**
- **In what ways can medical respite care improve outcomes for patients with complex medical needs, such as advanced cancer, who do not require hospitalization but cannot safely recover while experiencing homelessness?**
- **What outcome measures should be used to evaluate the effectiveness of medical respite programs—both clinically and socially—in improving patient health, reducing healthcare utilization, and facilitating long-term housing stability?**

In addition to meeting immediate medical needs, medical respite programs address the broader social determinants that contribute to poor health outcomes. Case managers and social workers assist patients with obtaining insurance coverage, disability benefits, and medication assistance; re-establishing primary and specialty care; and securing stable long-term housing. Evidence has shown that medical respite care reduces future emergency department utilization, lowers hospital readmission rates, and improves treatment adherence among people experiencing homelessness. For this patient, respite placement provided the stability necessary to begin cancer therapy, engage consistently with outpatient oncology, and initiate applications for permanent housing and financial support.

STREET MEDICINE CASES

KEY LEARNING POINTS:

- **Delayed cancer diagnosis is often exacerbated by unstable housing,** limited access to routine care, and reliance on emergency departments for episodic treatment rather than preventive or longitudinal services.
- **High emergency department utilization can be an early signal of unmet social needs,** such as homelessness, transportation barriers, or inability to attend outpatient follow-up. Screening tools like HOUSEDBEDS can help clinicians identify these patterns in real time.
- **Medical respite care plays a critical role in bridging the gap between inpatient hospitalization and homelessness,** offering a safe environment where patients can complete chemotherapy, radiation therapy, or surgical recovery when they do not meet admission criteria but cannot manage treatment on the streets.
- **Interdisciplinary coordination—including oncology, social work, case management, and street medicine teams—is essential** to addressing both medical and social needs, improving continuity of care, and reducing reliance on emergency departments.

RESOURCES & ADDITIONAL READING:

- Alliance for Health Equity. Medical Respite Network Guide — The Alliance for Health Equity
- Housing Action Illinois. Expanding Medical Respite Care for People Experiencing Homelessness
- Housing Forward. Housing as Health: How Sojourner House is Paving the Way for Medical Respite Care
- Levi, Ryan, and Dan Gorenstein. "Medical Respite Offers Refuge for Homeless People Recovering from Illness." NPR, 30 May 2022.
- Loyola Street Medicine Podcast: Respite Care. Spotify Podcast
- National Institute for Medical Respite Care. Medical Respite Literature Review: An Update on the Evidence for Medical Respite Care

CASE FOLLOW UP:

As her cancer treatment was initiated, the patient transitioned to a local medical respite facility, allowing her to receive treatment in a safe environment close to her primary hospital. She remained in medical respite for several months while awaiting approval for government assistance, including Social Security and disability benefits. With the support of social workers and case managers at the respite facility, her financial stability improved, enabling her to secure her own apartment with ongoing access to necessary resources and support services.

STREET MEDICINE CASES

SUBSTANCE USE AND HOMELESSNESS

CASE:

A 42 year old male with a past medical history significant for alcohol use disorder, cirrhosis, and a gunshot wound to the right lower extremity requiring surgical repair in 2024 presented to the emergency department with right leg pain and swelling. He was found to be septic secondary to right lower extremity cellulitis and was admitted to the orthopedic surgery service for concern for a possible hardware-associated infection and consideration of hardware removal.

During hospitalization, it was discovered that the patient was experiencing housing insecurity. He had previously lived in stable housing with his long-term partner and their four children while working in the restaurant industry in Chicago. In April 2024, he was robbed at gunpoint on a CTA train and sustained two gunshot wounds to his right leg. He reported a prolonged hospitalization and rehabilitation course lasting nearly one year. Upon returning home, he stated that his partner asked him to leave due to his inability to return to work following his injury.

Since that time, the patient has been unhoused, sleeping on the streets, in police stations, on CTA trains, and at a funeral home. He reported being unable to replace his identification and Social Security card following the robbery, which limited his ability to access food pantries and outreach services. His only source of income was panhandling. Further history revealed daily alcohol use, consuming approximately one liter of vodka per day to manage chronic pain. Chart review demonstrated multiple emergency department visits for alcohol withdrawal and a prior admission for encephalopathy, suspected to be secondary to alcoholic cirrhosis. He had previously participated in substance use treatment but started using again shortly after discharge from treatment. He had been housed at a local medical respite program although he was discharged from the program for continued alcohol use. He expressed interest in re-engaging in substance use rehabilitation.

QUESTIONS TO CONSIDER:

- **How can traumatic injury and prolonged hospitalization precipitate housing loss, and what opportunities exist to intervene earlier to prevent homelessness after injury?**
- **What are the challenges of managing chronic pain in patients with alcohol use disorder and unstable housing, and how can care teams balance pain control with harm reduction?**
- **How do lack of identification and documentation impede access to basic resources, and what role can hospitals play in assisting patients with document replacement?**
- **What are the limitations of traditional substance use treatment and medical respite programs for patients with ongoing alcohol use, and how might more flexible, harm-reduction–based models improve engagement?**
- **How should multidisciplinary teams (orthopedics, medicine, addiction services, social work, street medicine) coordinate care for medically complex unhoused patients with active substance use?**
- **What system-level changes could reduce recurrent hospitalizations among unhoused patients with alcohol-related liver disease and trauma-related disability?**

STREET MEDICINE CASES

KEY LEARNING POINTS:

- **Traumatic injury can serve as a tipping point into homelessness,** particularly when it results in loss of employment and prolonged recovery.
- **Chronic pain is a major driver of substance use,** underscoring the need for integrated pain management and addiction care.
- **Lack of identification and benefits creates significant barriers** to accessing food, shelter, and health services, perpetuating cycles of instability.
- **Rigid abstinence-based housing and respite models may exclude patients with ongoing substance use,** limiting options for recovery-oriented care.
- **Hospitalizations represent critical opportunities to address social determinants of health,** including housing instability, substance use, and legal or administrative barriers.
- **Patient interest in re-engaging in treatment should be met with low-barrier, harm reduction oriented approaches** to improve engagement and outcomes.

RESOURCES & ADDITIONAL READING:

- Center for Substance Abuse Treatment | SAMHSA
- Gomez R, Thompson SJ, Barczyk AN. Factors associated with substance use among homeless young adults - PMC. 2010.
- Miler JA, Carver H, Masterton W, Parkes T, Maden M, Jones L, Sumnall H. What treatment and services are effective for people who are homeless and use drugs? A systematic 'review of reviews' - PMC. PLoS One. 2021 Jul 14.
- Mosel, Stacy. "Substance Abuse and Homelessness: Statistics and Rehab Treatment." American Addiction Centers, 1 Apr. 2025.
- Prescott, Sahvanah. "How Stable Housing Supports Recovery from Substance Use Disorders." Opioid Principles, 5 June 2024.
- Resources - City of Chicago :: Substance Use Disorder

CASE FOLLOW UP:

The patient initially expressed interest in discharge to an alternative medical respite facility; however, the location was too far from his family, and he was concerned about transportation access. He ultimately elected to discharge to a friend's home and was provided with winter clothing, CTA passes, and store gift cards. Housing resources in Chicago, substance use rehabilitation options, and services available through the Loyola Street Medicine CTA clinic were discussed prior to discharge.