When discharged from hospitals, homeless face a bleak dilemma

August 30, 2012 | Samantha Melamed

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FALLOUT SHELTER: Rev. Sam Peake speaks to men at the Sunday Breakfast Rescue Mission, a privately run shelter where some homeless find themselves following discharge from hospitals.

Derrick Brown had plenty to worry about, but on an oppressively hot evening this July, it was his feet — or what was left of them — that concerned him.

A surgeon had cut away the toes of his left foot and the side of his right foot, and both kept getting infected — forcing him back into the hospital five times in six months, he explained from a wheelchair in a noisy, fluorescent-lit hallway in the Sunday Breakfast Rescue Mission. Sleeping on a mattress on the hallway floor of this men's shelter at 13th and Vine streets, where he said the hospital directed him less than a week after his surgery, wasn't helping: It was hard for him to keep his dressings clean, get the rest he needed or follow his discharge instructions. "They told me I had to be in sanitary places," he said. His medical paperwork — along with all his other documents — had been stolen from the shelter's storage area. He wasn't sure how he'd refill his prescriptions.

Source: Philadelphia City Paper, http://www.citypaper.net/news/2012-08-30-sick-and-mired.html

As Brown has learned, being both homeless and sick in Philadelphia is a dangerous, potentially fatal, combination.

That's because hospitals, faced with spiraling costs, often discharge patients like him even if they have no appropriate place to go. City shelters, able to offer only bare-bones health-care services, can't accommodate them. And lack of coordination between hospitals, the city and nonprofit agencies means patients often don't receive recommended follow-up care. The Philadelphia Homeless Death Review for 2009-'10 cited gaps in health care as a contributing factor in outcomes for Philly's homeless, whose average age at death was 53, or 25 years younger than the mean U.S. life expectancy. One major recommendation from the study: The creation of a medical respite program, of the type that's springing up across the country. Such programs offer places for people like Brown to stay while recovering — breaking the cycle of expensive emergency-room visits while giving them a chance to get back on their feet. But creating such a program in Philly is easier said than done.

"There's currently no standard of care when treating patients who are homeless. … Often [they're] simply discharged back to the street," says Dr. Bon Ku, assistant professor of emergency medicine at Thomas Jefferson University. "The real problem lies with patients who are not sick enough to be admitted to the hospital but too sick to recuperate on the streets, because the shelters don't have the ability to treat these patients. They end up in a kind of no-man's zone."

As a result, says Dainette Mintz, director of the city's Office of Supportive Housing, the shelters sometimes clash with hospitals over discharges. "We have people discharged who arrive still hooked up to IVs, and we send those people back to the hospital. We've had all manner of inappropriate admissions: We have some people who are sent to us and they're still catheterized. That's not the norm, but there have been instances of that."

The city shelters can't take anyone who needs an oxygen tank, who is incontinent or who has a contagious disease. They also would not accept someone, like Brown, with open wounds still requiring care. All this puts those in situations like Brown's in a perilous state of limbo.

Brown, for one, owes his life to the American health-care system — but his is also one of its horror stories. He came here from Jamaica 16 years ago, and not long afterward was diagnosed with pemphigus vulgaris, a life-threatening autoimmune disorder that manifested in sores and skin peeling off his mouth, tongue and face. The medication he required wreaked havoc with his pre-existing diabetes and exacerbated his heart problems; he lost circulation to his feet, which grew infected and eventually had to be partially amputated. "My doctor said I wouldn't make it six weeks," he says.

He lived, but his medicine alone cost him $2,300 a month. He sold off everything he owned and drained his bank account to keep up; seven months ago, he became homeless for the first time in his life, staying at the city-run Ridge Center. Brown, 58, wishes he could go home to Jamaica, but he can't. "My dermatologist told me Jamaica don't know about this sickness. If I go down there, I will die."

Source: Philadelphia City Paper, http://www.citypaper.net/news/2012-08-30-sick-and-mired.html

So after Ridge closed this summer, he says, the hospital sent him to the Sunday Breakfast Rescue Mission, where those who can't make it upstairs to the dorms are sometimes allowed to sleep on the hallway floor. (Neither Hahnemann University Hospital nor Penn Health System accommodated City Paper's requests to speak with a discharge planner or explain discharge policies.)

In more than 60 other cities around the country, medical respite would have been an option for Brown. In Philly, though, the one serious attempt to initiate such a program fizzled out five years ago. Back then, the city had tentatively agreed to set aside six shelter beds for respite, Mintz says; it was just waiting for an area hospital to obtain funding for the health-care component. That funding never materialized. And since then, things have gotten worse. "The situation has changed since 2007, and we now probably no longer have the luxury of taking six beds offline to make available," Mintz says.

About half of the nation's medical-respite programs are funded by hospitals, according to Sabrina Edgington, program and policy specialist at the National Health Care for the Homeless Council, an advocacy organization. There's good reason for hospitals and insurers to step up. Studies of Boston and Chicago respite programs found a 50 percent reduction in emergency-room utilization among those with access to respite services.

That equals vast savings, says Jefferson's Ku, who is studying the costs associated with homeless patients who are frequent visitors to emergency departments. "In one calendar year, our top user accrued almost half a million dollars in hospital charges," he says. Yet hospitals continue to skimp on dedicating resources to the issue. "There's this vicious cycle of these patients coming to the emergency department to get care, the care is episodic, they get discharged to the street and they end up back in the emergency department. … That's not adequate to bring them back to health."

That's not to say the situation is hopeless. One bright spot is the newly renovated Mary Howard Health Center, run by the Public Health Management Corporation (PHMC). The center, which started in a church basement and expanded to 10 sparklingly clean exam rooms last year, is dedicated to serving the homeless and, hopefully, diverting them from the emergency department. The nurse-run practice offers everything from primary care to nutrition and diabetes education to mental-health counseling and referrals. The center also does shelter outreach and is launching an initiative to connect with hospitals and make follow-up appointments before homeless patients are discharged, increasing the likelihood of continued care.

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MEDICAL ADVANCES: The Mary Howard Health Center is working to break the cycle of emergency-room visits for homeless patients.

"This works really well if we know who the patients are and they're in the system," says Dorothea McGlaughlin, a clinician at the health center. "It's the patients that end up in the hospital that don't have any connection with us that end up being lost."

Patient-privacy laws may create challenges to sharing information, but that type of cooperation needs to become more common, says Ku. "Government agencies, hospitals and nonprofits treat the same populations, but they often don't speak to each other. So the homeless patient gets cycled through" the various agencies, without getting the assistance that's required.

That's what happened to Barry Norman, 58, who has been in the hospital six times this year — each after getting dizzy and collapsing. The last time, he fell down the steps at an El station and spent three days in the hospital; he tore a ligament and his legs were swollen and bruised for days. The recovering addict and cancer survivor says he's never received follow-up care or a diagnosis for his "episodes," though he now intends to do so. "When the incidents happen, as soon as I feel better I don't follow up," he admits. "This time I am."

A handful of options that could help connect homeless patients to follow-up care, housing and short-term respite are in the works. For one, PHMC is currently investigating possibilities for a medical respite program, says Sandy Orlin, PHMC clinical director of health care for the homeless. She says they were motivated by the Death Review results. "It's always impossible to say whether a death can be avoided," she says, but "everyone on the review committee agreed on

the need [for a respite-type program].” Meanwhile, Ku is working with the social-service nonprofit Depaul USA to develop what he hopes, pending funding, will be long-term housing for 30 homeless people with complex medical problems.

At Penn Medicine, Dr. Shreya Kangovi is trying a different tactic with the Patient Centered Transition Project, which uses community health workers to help patients, while they’re still in the hospital and afterward, to navigate social-service systems and apply for subsidized housing. “We need to treat these housing issues like we’re treating a health problem,” Kangovi says. “Social issues are a huge threat to people’s health.” But Kangovi’s program, too, is in a pilot phase only.

As for Brown, he’s now staying at a friend’s house and, with more time to rest and less stress, starting to recover. The doctors still fear they’ll have to amputate his right foot, but he’s newly optimistic.

“I know I’m going to walk,” he says. “I’m not listening to no doctor, Just give me my medication and leave the walking to me.”

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