# Eviction as a Significant Health Event: A Case Study

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## Context

- Older patients can have unique barriers to care including frailty, cognition, digital literacy, limited social support and poverty
- Risk factors for homelessness amongst older adults include: low income, physical and mental health problems including dementia, substance use, gambling problems, relationship breakdown, elder abuse, death of a close relative and unstable housing history (1)
- The number of unhoused older adults is projected to triple over the next decade (2) and seniors are the only demographic to have increased shelter usage over past decade (3)
- Older adults experiencing homelessness are more likely to experience geriatric syndromes and accelerated cognitive impairment, falls, frailty and functional impairment (4)
- Navigating the intersection of emerging frailty, social isolation and structural vulnerability of older adults (particularly during the Covid-19 pandemic) is challenging in primary care; and it is important to consider ways we can optimally support the health and social care of these individuals

## Methods

Qualitative case study

Data sources included:

- Chart review
- Discussion with patient
- Consultation with multidisciplinary care team involved in case (nursing, social work, pharmacy, family medicine)
- Structured literature review

## References

(1) Ploeg, J et. al. A case study of a Canadian intervention programme for elderly people. *Health Soc Care Community* (2008) 16(6), 593–605.

(2) Culhane, D et. al. The emerging crisis of aged elderly. (2019).

(3) Homeless Hub. Who is homeless? (2021).

(4) Brown, R. Geriatric syndromes in older homeless adults. *J Intern Med* (2012) 21, 16-22.

## Discussion

### *What happened?*

- This case outlines the various factors that led to the eviction and subsequent homelessness of a previously stable 65-year-old man
- Older adults experiencing the intersection of medical frailty and structural vulnerability (such as precarious housing and social isolation) are at particular risk of severe adverse outcomes such as homelessness

### *Why did it happen?*

- Lack of patient contact via digital and telephone means resulted in limited capacity for communication and follow-up between the patient and multidisciplinary team
- Covid-19 pandemic restrictions amplified already scarce community resources with limited in-person availability of housing programs, home visits, and resource closures
- Poorly integrated system of healthcare between acute care, specialist care, social services and primary care team resulted in fragmented care goals
- Lack of advanced care directives and social network in place limited ability to enact capacity assessments
- Baseline patient medical and structural vulnerability created risk for housing insecurity

### *What did we learn?*

1. Leverage the multidisciplinary care team
2. Employ non-traditional means of patient contact
3. “No shows” can be a symptom of clinic- and patient-level barriers
4. Integrate written care plans and contingency plans
5. Engage patients in early advanced care planning
6. Value of informational, relational and management continuity (1)
7. Importance of coordination and communication amongst all care team members
8. Identify key risk factors for structural vulnerability and homelessness

## Timeline of Events