

LETTER TO THE EDITOR

Housing status as a vital sign: making discharge readiness a clinical competency

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La situation de logement, un signe vital : faire de la préparation à la sortie de l'hôpital une compétence clinique

Dear Editor,

Discharge readiness should be taught as a clinical competency. We propose treating housing status as a “vital sign”: not a physiologic measure, but a prompt to determine whether a treatment plan remains safe and executable after discharge.

During clerkship, we learned to justify why a patient was medically stable for discharge. We were less consistently asked to justify whether the plan could be carried out. Many discharge plans for people experiencing homelessness presuppose the infrastructure of housing: refrigeration for medications, a clean environment for wound care, and a phone for follow-up. Jenkinson et al. describe how people experiencing homelessness are often discharged to shelters or the street, settings that may not support recovery, while most discharge policies and best-practice guidelines are not tailored to patients without a fixed address.¹

Discharge feasibility is therefore a clinical, not merely administrative, concern. In a prospective Toronto cohort of 129 general internal medicine patients experiencing homelessness, 27.1% were readmitted within 90 days.² Active case management was associated with lower odds of readmission (aOR 0.31, 95% CI 0.13-0.76), whereas each additional discharge medication was associated with 12% higher odds (aOR 1.12, 95% CI 1.02-1.23).² These observational findings reinforce the idea that treatment complexity and post-discharge support belong within clinical risk assessment.

A Canadian homeless-health curriculum framework reports that 20% of 116 survey respondents from 11 medical schools said homelessness was not addressed in their training, and 25% said it was minimally taught.³ The framework identifies competencies in communication, advocacy, collaboration, identification of housing instability, and linkage to case management.³

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We propose translating those competencies into one observable bedside practice: every discharge presentation should include a feasibility assessment. Learners should be able to state where the patient will recover; which assumptions the plan makes about storage, supplies, transportation, monitoring, or follow-up; which assumptions are unmet; and how the plan will be adapted. This may require earlier involvement of social work, case management, addiction medicine, pharmacy, or community clinicians; reducing regimen complexity when clinically appropriate; providing necessary supplies; or arranging a warm handoff to an accessible service. The goal is not a longer social history. It is a safer medical plan.

This practice can be embedded without a new course. Case-based learning can require students to identify hidden housing assumptions in discharge plans. On rounds, supervisors can ask, “What would make this plan fail after discharge?” OSCEs and workplace-based assessments can evaluate whether learners identify feasibility barriers, mobilize appropriate supports, and revise the plan accordingly.

Calling housing status a “vital sign” is a teaching prompt, not a biomedical label. It keeps housing from remaining a social-history footnote when it constrains what care is possible. “Medically stable” should not be treated as synonymous with discharge-ready when the plan depends on infrastructure the patient does not have. Medical education should teach learners not only to formulate appropriate treatment, but to test and adapt it for the conditions into which the patient will be discharged.

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Conflict of Interest:

The authors have no competing interests to declare.

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References

1. Jenkinson JIR, Wheeler AJ, Wong C, Pires LM. Hospital discharge planning for people experiencing homelessness leaving acute care: a neglected issue. *Healthc Policy*. 2020;16(1):14-21. <https://doi.org/10.12927/hcpol.2020.26294>
2. Wang A, Pridham KF, Nisenbaum R, et al. Factors associated with readmission among general internal medicine patients experiencing homelessness. *J Gen Intern Med*. 2021;36(7):1944-1950. <https://doi.org/10.1007/s11606-020-06483-w>
3. Hashmi SS, Saad A, Leps C, et al. A student-led curriculum framework for homeless and vulnerably housed populations. *BMC Med Educ*. 2020;20:232. <https://doi.org/10.1186/s12909-020-02143-z>