Letters to the Editor

Importance of Simplifying Medication Regimens for Patients Experiencing Homelessness

To the Editor: I read the article by Dr. Lanham and colleagues with interest.[1] I commend the authors for their cogent overview of medical care for people experiencing homelessness, which represents a growing crisis within the United States health care system.

I would like to underscore the importance of the authors' specific considerations for simplifying medication regimens in this population whenever possible. My colleagues and I conducted a qualitative study of individuals with heart failure experiencing homelessness in one U.S. city, examining participants' interactions with the health care system.[2] Heart failure is a common condition involving intensive self-management behaviors, especially adherence to medications. New evidence-based treatments for heart failure continue to emerge, and the medication regimens have become increasingly complex.[3] Complex regimens are a known barrier to medication adherence in patients with heart failure.[4]

For participants in our study, homelessness engendered a pervasive sense of instability and a lack of routine. Routine plays a central role in the successful self-management of many chronic conditions such as heart failure.[5] Individuals in our sample expressed difficulty establishing a routine involving heart failure medications. One participant said, "It's hard to take the medication when you're out there… I take 12 different types of medications…the only ones I would take is the torsemide and spironolactone so I can get [fluid] off of me."

This presents an opportunity for primary care clinicians and specialists caring for individuals with heart failure who are homeless. Simplifying medication regimens is associated with improved medication adherence in heart failure.[6] Such an approach, when applied to patients with heart failure who are experiencing homelessness, may reduce the burden on this vulnerable population.

As a cardiologist in a safety-net clinic treating patients experiencing homelessness, I try to incorporate these considerations into my clinical practice. I often preferentially prescribe once-daily metoprolol succinate instead of twice-daily carvedilol (Coreg). Also, I instruct patients to take loop diuretics only when they have reliable access to restrooms.

These are small interventions and do little to address the structural foundations of the housing crisis in the United States, but they are important in the day-to-day care of patients who find themselves marginalized and stigmatized by broader society.

Editor's Note: This letter was sent to the authors of "Care of People Experiencing Homelessness," who declined to reply.

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This series is coordinated by Kenny Lin, MD, MPH, deputy editor.

Corrections

Incorrect symbol. In the article "Alcohol Withdrawal Syndrome: Outpatient Management" (September 2021, p. 253), Table 4 incorrectly used the > symbol instead of the ≥ symbol in the next-to-last row (p. 259). It should have read, "Severe and complicated withdrawal symptoms (CIWA-Ar ≥ 19)." The online version of this article has been corrected.

Vaccination recommendation. In the Practice Guideline "ACIP Approves 2023 Child/Adolescent and Adult Immunization Schedules" (March 2023, p. 319), the recommended schedule for pneumococcal vaccination for adults younger than 65 years was not clearly stated. The first sentence of the second paragraph in the Pneumococcal Vaccination section (p. 321) should have read, "For adults younger than 65 years with certain risk factors (Table 2[2]), either PCV15 and then PPSV23 after eight weeks, or a single PCV20 are recommended." The online version of this Practice Guideline has been corrected.

Incorrect recommendation. In the article "Tuberculosis: Common Questions and Answers" (September 2022, p. 308), the recommended cutoff age for interferon-gamma release assay (IGRA) testing was listed incorrectly. In the first paragraph of the "What Are the Advantages and Disadvantages of TST vs. IGRA?" section, the second-to-last sentence (p. 309) should have read, "Disadvantages of IGRA testing include cost, and it is not recommended for use in children younger than two years." An additional reference has been added to the online version of this article for this sentence and for a footnote in Table 2: Nolt D, Starke JR. Tuberculosis infection in children and adolescents: testing and treatment. *Pediatrics.* 2021;148(6):e2021054663. In Table 2 (p. 310), one of the cons listed for QuantiFERON-TB Gold+ should have read, "Not recommended for children younger than two years*" with the following accompanying footnote: "Guidelines from the Centers for Disease Control and Prevention and the American Thoracic Society state five years and older, but the American Academy of Pediatrics guidelines state two years and older.[32]" The online version of the article has been corrected. ■

TABLE 2

Comparison of Tuberculosis Tests

Test characteristic	Tuberculin skin test	QuantiFERON-TB Gold+	T-SPOT.TB
Format	Purified protein derivative injected intradermally; patient must return in 48 to 72 hours for results	Enzyme-linked immunosorbent assay using whole blood; processed within 16 hours	Enzyme-linked immunosorbent spot test using peripheral blood mononuclear cells; processed in eight to 24 hours (up to 32 hours if T-Cell Xtend is used)
Measurement	Size of skin induration	Interferon-gamma level	Interferon-gamma level
Sensitivity (%)	68.9	94.1	95.6
Specificity (%)	59	97.3	97.1
Positive likelihood ratio	1.68	34.85	32.97
Negative likelihood ratio	0.595	0.029	0.030
Results affected by BCG vaccination?	Yes	No	No
Pros	Lower cost	High specificity Objective results	High specificity Objective results Only reacts to *Mycobacterium tuberculosis*, not other mycobacterial strains
Cons	Requires at least two separate visits Affected by BCG vaccination status False-negative risk if recent live vaccination Subjective results Misreading of skin test results	Cost Availability Not recommended for children younger than two years*	Cost Availability Potential for improper handling and processing Not approved for children younger than two years* Different reactivity criteria in the United States, Canada, Europe

BCG = bacillus Calmette-Guérin.

*—Guidelines from the Centers for Disease Control and Prevention and the American Thoracic Society state five years and older, but the American Academy of Pediatrics guidelines state two years and older.[32]

Information from references 12, 13, and 32.