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Western Journal of Emergency Medicine: Integrating Emergency Care with Population Health

Title

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Permalink

<https://escholarship.org/uc/item/2x38614f>

Journal

Western Journal of Emergency Medicine: Integrating Emergency Care with Population Health, 27(3.1)

ISSN

1936-900X

Authors

Lui, Ryan
Schiedel, Maya
Williams, Janiada
[et al.](#)

Publication Date

2026-06-14

DOI

10.5811/westjem.66260

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for the ED cohort, highlighting the necessity of intervening sooner for patients with a higher risk of comorbidities. The ED cohort being more likely to be Black/Latino is consistent with previous findings and may be related to systemic barriers to medical treatment these groups have historically faced. Systemic barriers to treatment, whether socioeconomic or racial inequity, warrant further research.

24 Is Housing Stability Associated with Telehealth Utilization among Emergency Department Patients?

Ryan Lui, MS, Maya Schiedel, Janiada Williams, Alexa Placencia, Angeles Rodriguez, Chun Nok Lam, PhD, Elizabeth Burner MD, MPH, PHD, Tiffany Abramson, MD, MS

Background: Housing instability is a major social determinant of health and is associated with increased reliance on emergency healthcare. Emergency departments (ED) often serve as an entry point to healthcare for people experiencing homelessness (PEH). Telehealth use has expanded rapidly since the COVID-19 pandemic. The majority of PEH own a mobile phone; many PEH perceive mobile health to be supportive and increase healthcare accessibility. However, telehealth use may be limited by a lack of awareness, inconsistent internet access, and limited access to charging. This study describes the relationship between telehealth utilization and housing stability.

Methods: This is a cross-sectional study conducted during Summer 2024, Spring 2025, and Summer 2025 in an urban safety-net ED. Patients were included if ≥ 18 years old and spoke English or Spanish. They were excluded if altered, critically ill, intoxicated, in law enforcement custody, or on a psychiatric hold. Research associates systematically sampled patients who visited the ED using standardized questions. Telehealth use was defined as accessing healthcare via phone or video call. Housing stability was defined as having a steady place to live (AHC-HRSN). Questions were adapted from a previously tested survey instrument. Chi-square analysis and logistic regression were performed.

Results: Of the 1,164 included patients, 39% used telehealth, 14% reported housing instability, and 89% owned a smartphone. Telehealth utilization was higher in individuals with stable housing (41% v 28%, $p = 0.001$), who own a smartphone (41% v 30%, $p = 0.018$), and with education at the college level or above (47% v 36%, $p = 0.001$). After adjusting for smartphone ownership, health literacy, age, and education, people with stable housing (OR: 1.65, 95% CI 1.13-2.42) and higher education (OR: 1.45, 95% CI 1.09-1.91) had statistically significantly greater odds of telehealth use. Smartphone ownership, age, and health literacy did not have significant associations with telehealth use.

Conclusion: Housing stability and higher education

level are associated with higher rates of telehealth utilization. Innovative and culturally tailored resources may be needed to increase telehealth use for individuals who are affected by social risk factors, specifically housing instability. Limitations include self-reported data from a single site.

25 Patient Outcomes Following Prehospital Naloxone Administration in San Francisco

Jacob Perez, BS, Alyssa Falise, PhD, MSPH, Mireya Arreguin, BS, Amanda M. Sutphin, BSHCA, EMT-P, Michael Mason, MPA, CP-C, Jesus Acosta, CP-C, Joseph Graterol, MD, Rachel Culbreth, PhD, MPH, Kim Aldy, DO, MBA, MS, Sharan Campleman, PhD, MPH, DABT, Jeffrey Brent, MD, PhD, Paul Wax, MD

Background: Naloxone (NLX) is available to laypersons and an effective public health intervention. In 2024, San Francisco, CA recorded 638 opioid-related deaths, showing the opioid crisis and need to expand bystander NLX access. As NLX is often administered before EMS arrival, understanding prehospital use patterns and transport dispositions is critical. This study quantifies the effects of these interventions on the EMS system.

Methods: The Toxicology Investigators Consortium (ToxIC) Real-World Examination of Naloxone for Drug Overdose Reversal (RENDOR) project is an ongoing multisite observational study where EMS providers collect prehospital data on opioid overdose cases, including demographics, scene type, NLX administrator/dose/route, transport disposition, and provision of leave-behind NLX. Patients were grouped by administrator: Pre-EMS only (family/friend/stranger, police (PD), non-transport fire, and community/social services (C/SS) staff), EMS only, and Pre-EMS + EMS. EMS encounters from 6/2024-12/2025 were included.

Results: Among San Francisco cases ($n = 350$), 79.1% ($n = 277$) were male, and the mean age differed by group ($p = 0.010$): EMS-only recipients were older (45.5 y) than pre-EMS-only (40 y) and pre-EMS + EMS (41.7 y). Most overdoses were on streets/sidewalks ($n = 264$, 75.4%), with pre-EMS responders giving NLX 73% ($n = 193$) of these cases. EMS-only responses were more common in private residences ($n = 24$, 54.5%; $p = 0.001$). IN NLX was predominant among pre-EMS responders ($n = 184$, 93.9%) compared to IN + IM/IV/IO ($n = 4$, 2.0%). EMS used IN in 44.2% ($n = 46$), similar to IM/IV/IO use ($n = 38$, 36.5%), and more often than IN + IM/IV/IO ($n = 19$, 18.3%). Among pre-EMS administrators, bystanders accounted for 87.8% ($n = 216$), with smaller contributions from PD ($n = 10$, 4.1%) and C/SS providers ($n = 20$, 8.1%). Most patients were transported ($n = 253$, 72.3%), while 25.1% ($n = 88$) refused/eloped. On-scene deaths were rare ($n = 6$, 1.7%). No significant difference in transport outcomes was not found for patients