

**Written Remarks  
To the  
Joint Committee on Homelessness**

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Good afternoon. My name is Dr. Margot Kushel and I am Associate Professor of Medicine at the University of California, San Francisco. I am a practicing general internist at San Francisco General Hospital, the public hospital of San Francisco City and County and am a health services researcher with substantial experience researching homelessness and health.

I come before you today to address the interrelationship between homelessness and health and to address some potential solutions.

### **Homelessness and health**

Homelessness and health are intertwined. Poor health, both physical and mental, contributes to homelessness. Being homeless can lead to poor health. It will be difficult to address homelessness without addressing the health care issues that contribute to it; it certainly is difficult to address the health of homeless people without addressing their homelessness. While the relationship between poor health and homelessness are most extreme in the setting of chronic homelessness, it is clear that health is affected by even short spells of homelessness. However, because people with chronic homelessness experience the worst health care outcomes and present the biggest challenges to the health care system, I will focus my remarks today on the interplay between health and chronic homelessness.

#### *Chronic Homelessness*

Between 10 percent and 20 percent of adults who experience an episode of homelessness will go on to experience chronic homelessness, which is typically defined as being homeless for one year or more. Homeless people have higher rates of mental health problems than non-homeless people. This problem is exaggerated in those with chronic homelessness. Almost two-thirds of all homeless people have had a mental health problem in their lifetime; the rate is higher for those who are chronically homeless. The issue of causality is complicated. It is clear that those who have a severe psychiatric illness, as evidenced, for example, by a psychiatric hospitalization, are at increased risk of becoming homeless in following years. However, there is also substantial evidence to suggest that homelessness itself worsens mental illness, whether because of the stresses of the environment or the difficulties that homeless people have in accessing treatment.

Homeless people have higher rates of substance abuse disorders than the general or poverty populations. National studies have found that two-thirds of homeless people had a lifetime history of having a problem with

alcohol; one-third had a current problem. Almost two-thirds had a drug problem at some point in their lifetime; a quarter had current drug problems. In studies in San Francisco, we have found that approximately half of the homeless adults had a substance abuse or alcohol abuse problem in the past year; 85% had a substance abuse problem in their lifetime.

Homeless people have higher rates of chronic health problems than the general or poverty populations. This takes the form of higher rates of illnesses such as high blood pressure, heart disease, diabetes, lung disease like asthma and chronic bronchitis and HIV disease. This is reflected in the fact that one-third of homeless people note that their health is fair or poor in comparison with about 10% of the overall population who report that they have fair or poor health.

### **Emerging Trends**

There are two phenomena in California with regards to homelessness and health that are worth noting. The first is that the homeless population is aging. The second is that there are increasing numbers of homeless people who use methamphetamines. Now, approximately 1/3 of homeless people are aged 50 and older. Since the early 1990s, the average age of the homeless population has risen approximately eight months each calendar year. This has two implications: first, it suggests that either the population may be static. Secondly, there has been an increase in the chronic disease burden. On one hand, if the population is relatively static, we may have an opportunity to make a major impact by intervening and housing people now. On the other hand, if we don't intervene, the problems I have spoken of above will only get worse as the population ages.

Another change is that, in cities in California that have been studied, methamphetamine use among homeless people tripled between 1996 and 2003. This may suggest that we are on the cusp of a new group of people at high risk for becoming homeless. Because the methamphetamine epidemic has been seen in rural areas as well as urban areas, this suggests that there may be an increase in homelessness caused by methamphetamine use, in regions of the state that do not have the capacity for serving homeless people.

### **Health Care and Homelessness**

Homeless people have high rates of medical uninsurance. The low rates of public insurance among homeless people is a result both of the way disabling diagnoses are defined and of the difficulty of completing arduous paperwork required to qualify. Many chronically homeless people do not qualify for disability (which would then qualify them for MediCal) because their diagnoses do not fit easily within the framework of qualifying mental health or medical diagnoses. In addition, many people who would qualify do not have benefits because the process of applying is daunting.

Despite their many health problems, homeless people have poor access to and low use of ambulatory medical care. With many health problems and poor access to health care, homeless people wind up relying on episodic care delivered in Emergency Departments and inpatient settings.

We know that homeless people tend to use high cost episodic services at high rates. Rates of Emergency Department use, for example are 3-4 times what would be expected. Homeless people have high rates of hospitalization: approximately 20-25% of homeless people report a hospitalization for a physical health, non-pregnancy related hospitalization each year. At San Francisco General Hospital, for example, between a quarter

and a third of all inpatients are homeless. This is despite the fact that homeless patients account for less than one-tenth of the patients cared for by the system of clinics that routinely admit to SFGH. While it is possible that SFGH has a particularly high rate, homeless people being cared for in hospitals is not an isolated problem of either public hospitals or urban areas.

There are several reasons for the high rate of hospitalization among homeless people. Homeless people have high rates of underlying health conditions for which they have difficulty accessing health care; they are exposed to dangerous conditions that leave them vulnerable to injuries and infections. And, finally, health care providers change their decision-making around whether or not to hospitalize and when to discharge patients for patients who are homeless. Many health care providers will lower their admission threshold, meaning that they will decide to bring someone into the hospital with a less severe health problem if they are homeless. Likewise, health care providers will keep a homeless person in the hospital longer than a housed person, because they recognize that they are sending him or her out to an unstable environment. A well done study published in the *New England Journal of Medicine* found that, for the same diagnoses, homeless people spent 33% longer in the hospital as housed poor people.

Despite the fact that homeless people are hospitalized more readily and kept in longer than they would be if they were housed, they are still often too ill to be on the streets or in the shelter system. We are hospitalizing people who don't need hospitalization and keeping them in the hospital long after they need to be—this is expensive, potentially dangerous and does not do anything to help the homeless patients leave homelessness. We are also, in many ways, discharging them too soon: no one should be expected to sleep on a cold street and walk 10 blocks to stand in line for a meal when they are just recovering from a serious illness. This is clearly dangerous. The truth is there is a mismatch between the needs of homeless patients and the systems set up to care for them.

#### *Alternative sites of care*

We need to focus efforts on improving options for the care of homeless patients so that we are neither discharging people from emergency departments and hospitals into unsafe situations nor unnecessarily hospitalizing people or prolonging hospital stays. Instead, we must recognize that hospitalization may represent a crisis period during which at-risk people may plunge into homelessness and, for those who are homeless, be a sign that their tenuous condition is worsening. We need to consider ways to intervene in times of acute illnesses so that we can decrease unnecessary hospitalization, improve healthcare outcomes and intervene to prevent chronic homelessness.

One potential option is respite facilities. Respite facilities are temporary housing with some basic nursing and medical services that serve as a safe place to recuperate for people who are too ill to be on the street but too healthy to be in the hospital. They often have social work services designed to help clients improve housing options. Respite facilities can accept patients post-hospitalization, from Emergency Departments or from homeless service providers.

Studies have shown that respite care can safely reduce hospitalization at costs far lower than hospital care. A barrier to creating and maintaining respite facilities is the lack of designated funding for them. Because they are not hospitals, skilled nursing facilities nor health clinics, there is no clear reimbursement strategy to fund them, even though they may achieve improved outcomes at lower costs than hospitalization or skilled nursing care.

We need to explore options to fund respite through MediCal, knowing that costs of the program may well be offset by decreases in costs of hospitalization and skilled nursing facilities.

## **Frequent Utilizers**

While approximately 40% of homeless people have an Emergency Department visit annually (compared with about 11% in the general population), it is a small group of the homeless who account for the majority of the use. Among homeless people in San Francisco, 8% of the homeless population accounted for over 50% of the Emergency Department use by homeless people. Frequent Utilizers are more likely to be chronically homeless and more likely to have multiple problems such as severe mental illness, complex medical illness and substance abuse disorders. Frequent users tend to be high users of all systems: ambulance, emergency departments, inpatient hospitalizations as well as outpatient medical use, although they do not have coordinated care.

Because there is a small group driving a lot of the use of expensive services, successful efforts to decrease acute care use could potentially focus on a small group of people. Some cities and counties have successfully developed interventions to address frequent utilization.

### *Case Management*

The successful interventions involved creating a system of intensive case management focused around frequent utilizers. Case managers play an important role in care coordination and advocacy. The successful interventions generally involved assigning a well trained case manager to work with a relatively small number of frequent utilizers (15-20). The case managers played a critical role in assisting with care coordination, assisting their clients with accessing health care, mental health treatment and substance abuse treatment, and in applying for benefits and identifying housing. Case managers become an integral part of the health care team, working with health care providers to help address the issues facing the clients.

Early results from case management programs for high utilizers show promising outcomes of reducing unnecessary acute care use, assisting with coordinating care, and accessing appropriate services, benefits and housing. While these programs appear to represent a cost-effective strategy, identifying on-going funding remains a challenge. While Targeted Case Management (TCM) programs can pay for some case management services, TCM is not being used systematically. This is in part because there lack clear and consistent policies to encourage the use of existing funding for case management services. Some policies, such as those that require Federally Qualified Health Centers to only be able to bill for Licensed Clinical Social Workers, may actively discourage the use of effective case management services. There is a need for a coherent strategy to encourage the use of case management in vulnerable, high using populations. This may require changes in the MediCal program to incorporate innovations that would allow these types of programs.

## **Supportive Housing**

### *Supportive Housing*

While I have tried to address several strategies for caring for the health needs of homeless people, clearly the most effective strategy would be to eliminate homelessness. For the chronically homeless facing numerous disabilities and barriers to housing, the answer to homelessness is more complicated than merely providing

housing. Supportive housing represents an important potential solution to the problem of chronic homelessness. Supportive housing is defined as subsidized housing with closely link supportive services for people who are chronically homeless or those at high risk of becoming chronically homeless. There is ample evidence that supportive housing is an effective way to keep chronically homeless people successfully housed. By recognizing the complexity of the problems faced by people who are chronically homeless and providing supportive services geared towards those problems (medical, psychiatric, substance abuse) supportive housing allows chronically homeless people to successfully remain housed and to do so with autonomy and dignity, as well as to stay out of emergency departments and hospitals.

There is emerging data that supportive housing might lead to improved health outcomes. There is also, importantly, evidence that the costs of supportive housing may be partially offset by cost savings from expensive health care services. In a large study in NYC that examined supportive housing for those with chronically persistent mental illness, almost the entire annual costs of supportive housing was offset by reductions in the cost of services used in other systems; about 75% of those savings were in the healthcare system. There is growing evidence coming from the field of HIV/AIDS that when housed, formerly homeless people have significant improvements in their health status and decreases in high risk behaviors that placed others at risk for HIV. These early results are compelling and suggest that supportive housing may well lead to reductions in disease specific indicators of health, which could in turn lead to improved health outcomes and decreased use of costly health care services.

The studies of supportive housing that have shown it to be successful have pointed out some common elements. Supportive housing that follows the principles of “low demand” is most effective. This means that successful supportive housing does not require potential clients to be clean and sober prior to entering supportive housing. Once housed, formerly homeless people with substance abuse problems can begin to receive services for their substance abuse disorders and have a better chance of reducing their substance use than they would while homeless.

In order for supportive housing to be brought to scale to reach all those that need it, there will need to be funding streams identified that will allow for it to be sustainable. These funding streams will need to recognize that the problems that create chronic homelessness don't necessarily fall into one category of illness: medical illness, mental health, substance abuse. Restrictions on current funding streams wind up excluding large groups of people who may fall between the cracks. While the state has made great strides pulling together housing and supportive services for people eligible to receive services under Mental Health Services Act, there are many others with serious health problems who don't meet MHSA criteria. Many of those most in need are those with severe medical illness, often complicated by mental health problems and substance abuse problems that don't rise to the level of meeting MHSA criteria. The model which has served so well for those who meet criteria for MHSA funds should be replicated for other groups who suffer from different vulnerabilities.

## **Recommendations**

To adequately address homelessness, we must address the health care issues that complicate homelessness. To start addressing these issues, the California State Government should:

- Explore ways to fund respite care under MediCal. This may require changes in current MediCal requirements.
- Develop clear and coherent strategies that would facilitate the use of MediCal for effective case management services. This may require changes in MediCal policies to allow for effective programs to be funded.
- Explore ways to model successful MHSA-funded supportive housing initiatives for high risk populations who do not qualify under MHSA, particularly those with severe chronic medical illness complicated by mental health and substance abuse problems.