3rd Annual
What’s new in homeless health care?
A no-jargon summary of the latest research

May 17, 2018

Travis Baggett
Kate Diaz Vickery
Stefan Kertesz
Disclosures

- Dr. Baggett: UpToDate royalties
- Others: None
See 4 articles about spn-E (HOMELESS) gene function.
See also: spn-E (HOMELESS) spindle E in the Gene database.
homeless in Drosophila melanogaster Drosophila willistoni All 2 Gene records

Search results
Items: 1 to 20 of 10103

1. Differences in Experiences With Care Between Homeless and Nonhomeless Patients in Veterans Affairs Facilities With Tailored and Nontailored Primary Care Teams.
   Jones AL, Hausmann LRM, Kertesz S, Suo Y, Cashy JP, Mor MK, Schaefer JH Jr, Gundlapalli AV, Gordon AJ.
   Med Care. 2018 May 12. doi: 10.1097/MLR.0000000000000926. [Epub ahead of print]
   PMID: 29762272
   Similar articles

2. Missing Millions and Measuring Progress towards the Millennium Development Goals with a focus on Central Asia States.
   Carr-Hill R.
   PMID: 29755862
   Similar articles

3. Employment and Other Income Sources Among Homeless Youth.
   Slesnick N, Zhang L, Yilmazer T
Staying up-to-date on this rapidly growing body of research presents considerable challenges

- Identifying and prioritizing what to read
- Accessing articles themselves
- Making sense of obscure methods

**Objective:** To present a plain-language summary of the latest research on health, health care, and housing for homeless people
Literature search strategy

- All searches were conducted in PubMed only
- Initial literature search (04-10-18)
  - Search terms “Homeless Persons” [MeSH] OR homeless
  - Date limits: 01/01/2017 – 03/31/2018
  - Language: English
- Result: 715 articles
Literature search strategy (cont.)

- Manual review of titles & abstracts to weed out:
  - Articles not primarily concerned with homelessness or homeless people
  - Articles that did not present new data or a new systematic review and synthesis of existing data
  - Articles not focusing on or including North American homeless people
  - Articles highlighted in last year’s review

- Result: **325 articles remained**
2\textsuperscript{nd} manual review of titles & abstracts to categorize these 325 papers into the following domains:

- **Health status**: Articles describing the burden or consequences of physical or mental health conditions among homeless people (N=129)
- **Health care**: Articles describing health care access and utilization, health care organization and delivery, and/or health care interventions for homeless people (N=118)
- **Housing**: Observational or interventional studies examining the impact of housing on the health or well-being of homeless people (N=58)
- **Other**: Articles not fitting into any of the above 3 domains; not considered further (N=20)
Each of us reviewed papers in one domain and identified “top 10” based on rigor, impact, novelty

- **Health status:** Baggett
- **Health care:** Vickery
- **Housing:** Kertesz

All 30 papers are presented in an annotated bibliography available at end of session

- Concise summary of results
- Brief explanation of “why we chose this paper”
- Links to “related papers” for those interested

We will review 15 papers (5 per category) today
Some comments & disclaimers

- 2017 and early 2018 was another prolific year
  - VA and Canada remain dominant in this field of study!

- We tried to be meticulous
  - But we may have missed something!

- If you published a paper on homelessness this year
  - Thank you for your contribution!
  - If we didn’t include it here, don’t assume we didn’t like it!
    (we had to make some difficult choices)

- If you don’t like the methods or results of a particular paper
  - We are (in most cases) merely the messengers!
We want you to participate!

- Phone-based, anonymous audience response system

- To join:
  - Text travisbaggett to 22333 if you have a good cell signal, or
  - Go to PollEv.com/travisbaggett if you’re on Wifi (network: Hyatt Meeting Space; password: HCH-2018)

- Live-tweeting is encouraged!
  - @TPBaggett, @KateDiazVickery, @StefanKertesz
  - Be sure to tag with #HCH2018
Health Status

Travis P. Baggett, MD, MPH
Assistant Professor, HMS / MGH
Director of Research, BHCHP
All of the following are true of older homeless adults, except:

- Joint pain, fatigue, and back pain are the most common physical symptoms
- Over half report psychological symptoms within the past 6 months
- Loneliness and regret are uncommon
- Half have 2 or more chronic health conditions
Physical, Psychological, Social, and Existential Symptoms in Older Homeless-Experienced Adults: An Observational Study of the Hope Home Cohort

Patanwala M, Tieu L, Ponath C, Guzman D, Ritchie CS, Kushel M

Methods
What did they do?

- HOPE HOME is a longitudinal cohort study of older (≥50 years) homeless adults in Oakland, CA
  - Principal investigator: Margot Kushel
- Assessed multiple types of symptoms in 283 HOPE HOME participants 18 months after enrollment
  - Median age 59 yrs, 76% male, 82% Black
- Symptom domains included:
  - Physical: symptom burden questionnaire
  - Psychological: depression, PTSD, anxiety, other symptoms
  - Social: Loneliness scale
  - Existential: Regret
Results

What did they find?

- Participants endorsed a median of 6 physical sx
  - Joint pain, fatigue, back pain, and trouble sleeping were most common
  - 34% had moderate-high physical sx burden
- Psychological symptoms were also highly prevalent
  - 47% moderate-severe depression, 36% anxiety, 21% PTSD, 58% any psychological sx
- Social and existential concerns were notable
  - 27% had high levels of regret about past life experiences
  - 40% endorsed loneliness, which was strongly associated with high physical symptoms
Implications
Why is this important?

- Reinforces the high burden of physical and psychological health problems among older homeless adults
- Draws attention to other symptom domains (e.g. loneliness) that might be easy to overlook
  - More common than in general population
  - Associated with worse health outcomes

Former surgeon general sounds the alarm on the loneliness epidemic
During an outbreak of Shigella infections in Portland, Oregon:

Few homeless people were affected

Cases occurred more frequently during summer months

Rainfall was associated with more cases among both homeless and non-homeless people

Rainfall was associated with more cases among homeless people only
Heavy precipitation as a risk factor for shigellosis among homeless persons during an outbreak – Oregon, 2015-2016

Hines JZ, Jagger MA, Jeanne TL, West N, Winquist A, Robinson BF, Leman RF, Hedberg K

Methods
What did they do?

- Analyzed data on 105 cases of *Shigella sonnei* infection during an outbreak among Oregon residents between July 2015 and June 2016
  - Median age 42 years, 75% male
  - 96% in Portland metropolitan area
Methods
What did they do?

- Assessed for homelessness in the week preceding symptom onset
  - To account for lag time between exposure and illness
- Examined the association between precipitation and *Shigella* cases
  - Broken down by whether or not cases experienced homelessness the week before their illness
Results
What did they find?

- 43% of *Shigella* cases experienced homelessness in the week before illness onset
- 84% of *Shigella* cases among homeless people occurred during Oregon’s rainy season (Nov-Mar)
  - Whereas 62% of cases among housed people occurred during the rainy season
- In statistical models that controlled for multiple factors
  - Increasing rainfall was associated with increased *Shigella* infections in homeless people
  - But not among housed people
Implications
Why is this important?

- Uses classic epidemiologic investigation methods to illustrate how environmental conditions can adversely impact the health of homeless people.

- Potential mechanisms by which weather might enhance the spread of enteric infections among homeless people:
  - Increasing crowding in shelters and encampments
  - Exacerbating poor sanitation and hygiene
  - Contaminating untreated water sources

- Could inform efforts by homeless service agencies to help mitigate these risks during foul weather.
Compared to women in the US general population, the prevalence of alcohol use disorder among homeless women is about:

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Prevalence and predictors of substance use disorders among homeless women seeking primary care: An 11 site survey

Upshur CC, Jenkins D, Weinreb L, Gelberg L, Orvek EA

Methods
What did they do?

- Assessed the prevalence of substance use disorders in a random sample of 780 female patients at 11 HCH programs in 9 states
  - Sites: Atlanta, Cleveland, Houston, LA, Manchester, NYC, Omaha, Phoenix, Hyannis, Springfield (MA), Martinez (CA)
  - Members of Practice-Based Research Network (PBRN)
  - Mean age 44 years, 42% Black
- Participants completed self-administered surveys that asked about alcohol and drug use
- Parallel review of randomly sampled clinic charts assessed for documented substance use disorders
  - This was a separate sample from the surveys
Results
What did they find?

- In comparison to women in US general population:
  - Prevalence of alcohol use disorder (17.3%) was 4 times higher
  - Prevalence of drug use disorder (24.1%) was 12 times higher

- Depression and sex work were both associated with a greater likelihood of alcohol / drug use disorder

- Prevalences of charted alcohol and drug use disorders were about half of those found by survey
Implications
Why is this important?

- Update on the high burden of substance use disorders among homeless women
  - Underscores need for addiction treatment services
- Lower prevalence of charted substance use disorders could suggest under-diagnosis in HCH clinical settings
  - Although other explanations are possible
- Illustrates the value of the HCH PBRN
  - Feasibility of conducting a multisite study in HCH settings
Among street-involved people who use drugs:

Most have a single drug of choice and rarely use anything else

Benzodiazepine misuse is uncommon

Psychotropic meds are often used to augment highs or ease withdrawal symptoms

Most psychotropic meds are acquired without a prescription
“I love having benzos after my coke shot”: The use of psychotropic medication among cocaine users in downtown Montreal

Motta-Ochoa R, Bertrand K, Arruda N, Jutras-Aswad D, Roy É

Methods
What did they do?

- Collected 500 hours of ethnographic (intensive observational) data on 50 street-involved people who use cocaine in downtown Montreal, Canada
  - Two-thirds male, predominantly white and French-speaking
- In-depth interviews with 25 of the participants
- Major goal was to understand how and why participants co-use psychotropic medications with other drugs
Results
What did they find?

- Most used other illicit drugs besides cocaine
  - Two-thirds injected heroin

- Almost all used some type of psychotropic medication regularly
  - Two-thirds used benzodiazepines (esp. clonazepam, branded as Rivotril in Canada, or “rivos” on the street)
  - Over half used quetiapine (Seroquel)
  - One-third used antidepressants
  - Over three-quarters obtained these medications through prescriptions
Results
What did they find?

- Psychotropic meds served several functions:
  1) “Downers” from a cocaine high
     - benzodiazepines, quetiapine, trazodone, pregabalin
  2) Enhancers of opioids or cocaine
     - benzodiazepines, clonidine, methylphenidate
  3) Reducers of opioid withdrawal
     - benzodiazepines
  4) An alternative “high” by themselves
     - benzodiazepines (“rivotrips”)
  5) Treatment for mental or physical problems
     - benzodiazepines, quetiapine, antidepressants
Implications
Why is this important?

- Sheds light on the phenomenon of psychotropic medication misuse within the complex milieu of polysubstance use
  - Especially important in the context of the opioid epidemic and the spread of fentanyl, where co-use of certain meds may enhance lethality

- Reinforces the need for careful risk assessment before prescribing certain medications (e.g. benzodiazepines, quetiapine) in clinical practice
  - While underscoring the legitimate unmet need for psychiatric treatment among many of these individuals
Among low-income families with young children:

- Unstable housing is bad for the child but not for the parent

- Homelessness is associated with poor health, but housing instability is not

- Being behind on rent is stressful for the parent but has no bearing on child health

- Moving 2 or more times in the past year is associated with worse health in the caregiver and child
Unstable Housing and Caregiver and Child Health in Renter Families


Pediatrics 2018;141(2). pii: e20172199.
Methods
What did they do?

- Surveyed 22,324 publicly insured or uninsured families from renter households with children ≤48 mos old in 5 urban health centers across the US
  - 93% of caregiver respondents were biological mothers
  - Caregiver mean age 27 yrs, 53% Black
- Assessed 3 types of housing problems:
  - Behind on rent in the past year
  - Multiple (≥2) moves in the past year
  - Currently or formerly homeless
- Examined associations with measures of child and caregiver health and other measures of hardship
Results
What did they find?

- Housing problems were common
  - 27% had been behind on rent
  - 8% had moved 2 or more times in the past year
  - 12% were currently or previously homeless
  - 34% had experienced any of these
Results

What did they find?

- In comparison to families in stable housing, each of these housing situations was associated with:
  - Worse child health outcomes
  - Worse caregiver health
  - Higher odds of caregiver depression
  - Higher burden of other material hardships (e.g. food insecurity)

- Magnitude of risk was fairly similar across the 3 types of housing problems
  - E.g. Behind on rent, multiple moves, and homelessness were each associated with about 2-fold higher odds of fair/poor caregiver health
Implications
Why is this important?

- Draws attention to the serious health implications of homelessness and housing instability for both caregivers and children
  - Health risks associated with behind on rent and multiple moves were similar to those for homelessness
- Minimal overlap among the 3 adverse housing conditions
  - Suggests that not assessing each dimension of housing insecurity may miss a number of people living in hardship who may be at risk for poor health outcomes
Health Care / Interventions

Kate Diaz Vickery, MD, MSc
Assistant Professor, University of Minnesota
The V.A. has developed patient-centered medical homes tailored to the needs of Veterans experiencing homelessness. Such models have been shown:

- To reduce ED visits
- To increase ED visits
- To reduce ED visits and increase primary care use
Patient-aligned Care Team Engagement to Connect Veterans Experiencing Homelessness With Appropriate Health Care

Gundlapalli AV, Redd A, Bolton D, Vanneman ME, Carter M, Johnson E, Samore MH, Fargo JD, O'Toole TP

*Med Care.* 2017 Sep;55 Suppl 9 Suppl 2:S104-S110.
Methods: What did they do?

• Used V.A. medical and insurance records to assess whether enrollment in the Homeless Patient Aligned Care Team (H-PACT) resulted in different health care use.

• Compared ED, primary care, mental health, and other visits; also examined “avoidable” ED use among:
  i. Intervention = Recipients of H-PACT
  ii. Unenrolled = Veterans not enrolled at sites with H-PACT
  iii. Usual care = Veterans at sites without H-PACT and not in PACT

• Specific examination of ED high utilizers (with 2+ visits over 6 months)
Results: What did they find?

- H-PACT enrollees more likely than comparators to be:
  - Older age, white males
  - Unmarried
  - More chronic diseases

- H-PACT compared to usual care and non-enrolled showed:
  - **Less ED use** among H-PACT over 18 mo. especially among highest ED-users with stable use of primary care and other services
  - Increase in proportion of emergent (non-avoidable) ED visits

- Decreased ED use among non-enrolled: Spillover effect?
Implications: Why is this important?

- The U.S. Veterans Health Administration is conducting substantial, comprehensive, well-funded efforts to end homelessness

- Tailored clinical care delivery structures have widespread implications for non-Veteran health care delivery
  - Need to look at literature and talk to experts to identify which parts of these programs seem most important and how they are delivered

- See also:
Compared to those with stable housing, people with unstable housing have a chance for diabetes-related emergency department and hospital use that is:

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Unstable Housing and Diabetes-Related Emergency Department Visits and Hospitalization: A Nationally Representative Study of Safety-Net Clinic Patients

Berkowitz SA, Kalkhoran S, Edwards ST, Essien UR, Baggett TP.

Methods: What did they do?

- Cross sectional analysis of self-reported data from nationally representative survey of community health center patients with diabetes (Health Center Patient Survey)
- Identified those with **unstable housing** (not homelessness):
  - Lack of money for rent/mortgage
  - Moving 2+ times in 1 year
  - Doubled up (Staying somewhere without paying rent)
- Measured association with diabetes-related emergency department or hospital visit
Results: What did they find?

- 1,087 adults with diabetes (I or II) who were not homeless, representing 3,277,165 U.S. adults
- 36% reported unstable housing and 13.7% reported a diabetes-related ED visit or hospital stay
- Those with unstable housing had over five times the chance to have a diabetes-related emergency department or hospital visit
  - After adjusting for age, sex, clinic type, rural residence, race/ethnicity, language, nativity, insurance, education, income, mental illness, drug use, alcohol use, and insulin use
- Of those with unstable housing, only 0.9% reported getting help with housing
Implications: Why is this important?

• Unstable housing is very common! Likely contributes to excess costs for diabetes-related, and other, avoidable acute health care use

• <1% of people with unstable housing get support from their health center

• Much work needs to be done to improve linkage of clinics seeing unstably housed people and housing support programs!
  • Also see Erin Johnson and team’s study “No Wrong Door” in *Psychological Services* about how engagement in clinical care might provide an opportunity to support transition into stable housing
True or false: Homeless women Veterans are less likely to have long-acting reversible contraception than their military service record-matched, housed peers.
Long-acting Reversible Contraception Among Homeless Women Veterans With Chronic Health Conditions: A Retrospective Cohort Study

Gawron LM, Redd A, Suo Y, Pettey W, Turok DK, Gundlapalli AV

Med Care 2017 Sep;55 Suppl 9 Suppl 2:S111-S120.
Methods: What did they do?

• Retrospective cohort study of administrative data about women Veterans from 2002-2015
• Compared ever-homeless to housed women with similar military service records
• Compared:
  • Socio-demographic factors
  • Health conditions
  • Long-acting reversible contraception use
Results: What did they find?

- 41,747 ever-homeless women Veterans and 46,391 housed comparators; subgroup of younger women in recent military operations

- Ever-homeless women were more likely to have:
  - No marital history
  - Black, non-Hispanic race/ethnicity
  - Experienced military sexual trauma
  - More chronic conditions, especially mental health and substance use disorders

- Ever-homeless women used more long-acting reversible contraception
  - 9.3% ever-homeless vs. 5.4% in housed overall
  - Among younger vets: 14.1% ever-homeless vs. 8.2% housed
Implications: Why is this important?

• Highlight unique challenges of homeless women, Veterans
• Demonstrate the feasibility and acceptability of long-acting reversible contraception among young, homeless women
• Illustrate possibility for improved access and coverage of contraception within non-Veteran homeless care sites
True or false: A single, evidence-based, optimal strategy for tuberculosis screening and treatment in homeless populations exists independent of setting or context.
Comparing different technologies for active TB case-finding among the homeless: a transmission-dynamic modelling study

Mugwagwa T, Stagg HR, Abubakar I, White PJ

Methods: What did they do?

• Advanced mathematical modeling (transmission-dynamic) of the effectiveness of different approaches to tuberculosis screening:
  1. Chest x-ray
  2. Sputum sampling (GeneXpert; takes 90 min. to process)
  3. Chest x-ray → if positive, sputum sample for GeneXpert
     With and without enhanced case management
• Model included variation on: size of homeless population; TB prevalence, resistance; patient willingness for screen/wait, & more
• Outcomes: health (quality adjusted life years), TB burden, cost
Method can examine tradeoffs of rapid testing (CXR) vs patient wait (GX)

Overall recommendations:
• Active case finding is efficient when TB prevalence exceeds 78/100,000
• Enhanced case management increases treatment completion but can be resource intensive
• Choice of screen and follow-up plan is setting-specific
Implications: Why is this important?

• Tuberculosis outbreaks among people who are homeless are common, costly, and present substantial public health risks.

• Mathematical modeling can account for complex combinations of factors that influence outcomes at the population level.

• Such approaches may allow for improved service delivery and rapid resolution and/or prevention of future TB outbreaks.
True or false: Supported work programs for people who are homeless with mental illness have been evaluated and show little evidence of this population's ability to gain competitive employment.
A Randomised Controlled Trial of Evidence Based Supported Employment for People Who have Recently been Homeless and have a Mental Illness

Poremski D, Rabouin D, Latimer E

Canadian randomized control trial of Individual Placement and Support, structured supported employment model for people with mental illness

Embedded within At Home study of Housing First for adults with mental illness and homelessness in Montreal

Randomized people to Individual Placement and Support and controls to standard support within treatment as usual (case management, housing, insurance)

Primary outcome: Competitive employment, Secondary outcome: Satisfaction with services
Results: What did they find?

• 45 people in Individualized Placement and Support and 45 to usual care
  • 1 lost to f/u in each group; 3 died in usual care group
• Overall, 15/44 intervention participants got a competitive job (34%) and 9/41 in control group (22%) – not significantly different
• Adjusting for other known factors related to employment, intervention participants has a 2.4 x better chance of getting competitive employment
• Those receiving job support were more satisfied with services
Implications: Why is this important?

- Current policy focus on employment in U.S.
- First trial of Individual placement and support in homeless
- Trial demonstrates impact of well-designed supported employment programs to help individuals overcome barriers of mental illness and homelessness.
- Likely efficacious when embedded within intensive case management, Housing First, and universal insurance coverage
Housing
Stefan G. Kertesz, MD, MSc
Professor, UAB / Birmingham VA
What is Housing First

1. Rapid access to permanent housing in the community.
2. Supportive services to help maintain and promote recovery
3. No preconditions for treatment or sobriety (other than being a responsible tenant)
4. Prioritization of most vulnerable for housing

HUD and VA both have prioritized this approach
Effects of comorbid substance use disorders on outcomes in a Housing First intervention for homeless people with mental illness

Urbanoski K. et al
Addiction 2017;113:137-145
Housing First for people with active addictions gets mixed reactions. What's your view?

- Housing First works for people with addictions
- Housing First works worse for people with addictions compared to other problems
- Housing First works with alcoholics but not drug users
- All of the above
Substance Use Disorders and Housing?

- Housing First: absence of sobriety/treatment prerequisites to enter permanent housing
  - Supportive services should be prominent
- Usually studies find that Housing First programs can accommodate people with addiction
- Usually case managers describe challenging experiences that don’t sound like the studies
- What does a big trial show?
A large Canadian trial

- Randomization of persons in 5 cities
  - Homeless or precariously housed + mental d/o
- Housing First vs “Treatment as Usual” (n=2154)
- Classified as substance use disorder based on a short screener (GAIN SS)
- Assessed housing stability, community functioning, mental health symptoms, general quality of life

“you kept using alcohol or other drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people?” - (2-3 months ago)
Housing First better than Treatment as Usual for housing, better for community functioning

Regardless of trial arm, people with SUD did worse than people without SUD on CF & Housing
Conclusions

- Housing First “works” compared to usual care

- Advocates for Housing First and your slightly cynical housing officer are both correct
  - I caution that the severity of drug use disorder is not analyzed here, and there’s no focused analysis of heavy drug use vs alcohol, etc

- The tendency in this Canadian trial was improvement across the board, even outside of Housing First
Health in the Tenderloin: A resident-guided study of substance use, treatment and housing

Jamie Suki Chan
Social Science & Medicine 2017
176:166-174
What experiences might be most typical for women in supportive housing in "rough" parts of town?

Seeing people who once abused them

Feeling stuck, like they can’t leave

Finding a sense of support from the neighborhood

Being subject to law enforcement and surveillance
Place, space and environment

- Risk environments are physical built spaces that contain social, economic and policy components
- Tenderloin of SF in 1917 - > Immigrants, addiction, homeless, supportive housing, minorities, high-tech gentrification
- Goal: learn from 20 women in supportive housing
- 20 “docent” interviews: interview, walk/photograph, wind-down
Findings

1: Central drug marketplace
   - the **marketplace** for dealing drugs
   - The dealers/gangs/guns transfer in, concentrating all risk around the residents

2: Tethered to the Tenderloin
   - Localized rental vouchers & drug access “tether”
   - Trauma in the buildings and outside leaves many stuck in their rooms all day
Findings

3: Policing/Surveillance/Being Watched

– Being frisked, arrested, charged is common
– Ubiquitous cameras & shared laundry, bathroom
– Surveillance by Tenant Services – dignity loss

4: “Tenderloin is my home”

– Sense of belonging
– Of having people watch out for your
– Sharing experience with others who have suffered

58% referred to funds
Lessons

- We tend to think about substance use as
  - Moral, Criminal or Medical

- By default we transfer our problems to restricted environments (these are upstream decisions that create the spaces that involve stressors, barriers, stigmas and health risks)

- Our policy response likely must take account of the spaces we create, including the problems we transfer
Supportive housing for chronically homeless individuals: challenges and opportunities for providers in Chicago, USA

Quinn K et al.
Health & Social Care in the Community
2018;26:e31-38
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<td>A big rise in service support for people entering housing</td>
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A policy experience

- 554k homeless (2017 PIT), Chronic: 87k
  - Down from 120k (2007), but up since 2016
- Policy push (HUD, VA, others)
  - Prioritize housing + coordinated entry
- Aim to qualitatively examine supportive housing providers experiences and challenges
- 65 interviews (32 admin, 33 direct service providers) (2014)
Highlights

- HUD priority on chronically homeless effective and challenging
  - “I think the number one thing they need ... is ... not just the housing but the services .., if they don’t want it ... they are not going to do well”
  - Acknowledgment that it’s voluntary

- Frustration with cuts in HUD funding for services
  - Caseloads of 1:40 or 1:60
  - HHS & others not seen as stepping up
Highlights

- Coordinated entry referral
  - Vulnerability ratings on a single list
  - Pushes the top person to the next agency
  - Not always a good match

- Permanency of PSH
  - Lack of new money + stability of residents
  - Inability to house new chronically homeless
  - Permanency can feel like a barrier to ending homelessness
Thoughts

- Actual challenges and contradictions of Housing
  First in US context
- Powerful effects from HUD policy
- Missing
  - Service support $$
  - Remedies for the forces that produce homelessness and make leaving the subsidized unit impossible
For newly homeless families what is the biggest barrier to getting housing assistance?

- Sobriety requirements
- Work requirements
- Lack of available units to use
- Not wanting to leave male family members behind

When poll is active, respond at PollEv.com/travisbaggett

Text TRAVISBAGGETT to 22333 once to join.
Background

This is analysis from a 2010-11 randomized trial for 2282 families in shelters. Randomly referred:
- Transitional Housing (project based or scattered)
- Short-term rental subsidies (6-8 months)
- Long-term rental subsidies (e.g. “Section 8”)

Investigators screened & referred using the criteria that the available programs said they use

The question: do these families get **accepted** and do they actually **use** the service (voucher, etc)

*Long-term rental subsidies received by ¼ of very low income renters*
Dropoff

For transitional housing
- 71% passed initial study screening
- 33% actually moved in
- Common reasons not to be offered a placed were unit sizes (27%), minimum income (21%)
- Wanting to be near family, jobs or schools

For short-term subsidies
- 91% seemed eligible but just 51% used and moved in
Mismatch, mismatch

- **Availability**: One half of families lost access to at least one intervention due to availability.

- **Acceptability**: But <3/5 of families took up short-term or transitional housing they were offered.

- **Requirements to split the family a problem**.

- **Housing choice vouchers, few in number, were highly taken up**.

- **The system currently does not accommodate the families it is designed to serve**.
Impact of a New York City supportive housing program on Medicaid expenditure patterns among people with serious mental illness and chronic homelessness

Lim S et al.

BMC Health Serv Res 2018 Jan 10;18(1)
Which subgroup of patients is most likely to show a Medicaid cost savings if supportive housing is provided? People who are...

- Extremely costly before housing
- In the 2nd most costly group before housing
- Have no Medicaid coverage at all before housing
- People in the middle of the pack, costwise
Cost Savings for Medicaid?

This team devised natural groups of Medicaid expenditures based on 2-year cost-patterns among people who qualified as eligible for NYC supportive housing.

They then compared the cost patterns for those who were placed and those who were not placed in supportive housing.

Tried to sort out if the savings were more prominent in groups with more or less cost.
# Costs by Group (rounded)

<table>
<thead>
<tr>
<th>Group</th>
<th>Costs in 2 yrs prior to baseline (SD)</th>
<th>Savings after placement?</th>
<th>How big</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very low coverage</td>
<td>6500 (19000)</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Low User</td>
<td>25,000 (40,000)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Middle User</td>
<td>20,000 (19,700)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emerging User</td>
<td>32,000 (33,000)</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Second-highest user</td>
<td>57,000 (34,000)</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>High user</td>
<td>149,000 (98,000)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Overall</strong></td>
<td></td>
<td>Yes</td>
<td>-$9500</td>
</tr>
</tbody>
</table>

Savings reflect comparison of placed and not-placed in propensity score adjusted models adjusting for baseline characteristics.
Findings

- Savings found in those with very low coverage by Medicaid initially, and in “emerging users” and in “second-highest use” pattern
- Mostly driven by reduced psychiatric hospitalization, + more managed care enrollment
- Seems like the highest cost folks were just too sick to provide savings on average
Thoughts

- We often say that health care savings can be obtained by housing.
- We often assume that the most costly users will be the ones to provide the savings.
- This hints that maybe it’s the second-most costly users and the very sick people who are not yet Medicaid-covered (but will be and will become costly if we have no plan).
Thank you!

Questions?

tbaggett@mgh.harvard.edu
katherine.vickery@hcmed.org
skertesz@uabmc.edu