

The JAMA Forum

Improving Health Care for Homeless People

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Addressing the medical issues of homeless people is the health equity challenge of our time. The most recent US Department of Housing and Urban Development (HUD) [report on homelessness](#), published in 2015, estimated that about 564 000 homeless people in the United States live in shelters and on the streets. This figure, based on a point-in-time snapshot on a single night each January, may well be an underestimate, given varying definitions of homelessness, peripatetic populations, and the lack of robust surveillance systems.

Despite official figures documented in the HUD report noting an overall recent population decline of about 11% from 2007 to 2015, numbers of homeless individuals have increased in cities with rising housing costs, such as New York and Los Angeles. Some estimate [as many as 2.3 million](#) to 3.5 million individuals experience homelessness each year; [persons of color](#) are disproportionately affected, with one-third unsheltered.

This vulnerable population comprises a human kaleidoscope of people [often excluded from mainstream society](#): run-aways, LGBT (lesbian, gay, bisexual, and transgender) youth, those targeted by domestic violence, struggling veterans, displaced factory workers, migrant laborers, refugees, illiterate individuals, fragile elderly persons, and those discharged from mental hospitals or overcrowded prisons. For many, the daily struggle for food, shelter, clothing, and safety relegates health to a distant priority which, in turn, exacerbates disease, complicates treatment, and drives excess mortality. [One recent analysis](#) shows death rates for homeless youth are more than 10 times greater than for the general population.

Health disparities are heightened by a complex burden of simultaneous medical, mental health, and substance use problems. A [recent study](#) attributes 52% of homeless deaths in Boston to tobacco, alcohol, or other drugs. Chronic conditions such as cancer and heart disease, fueled



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by tobacco use in approximately three-quarters of the population, [represent major causes of death](#). Infections, injuries, and other acute conditions fester, and communicable diseases such as tuberculosis, AIDS, and viral hepatitis readily spread. [Violence complicates all aspects of life](#) in crowded shelters.

Tackling all these special needs requires not only better ways to care for individuals but also broad policies to address homelessness itself.

Patient-Centered Care With Service Integration

"Patient-centered care" holds special salience for people who often feel marginalized and detached from the health system. More than 250 [health care for the homeless \(HCH\) projects](#), funded by the Health Resources and Services Administration as federally qualified health centers, now feature multidisciplinary teams of clinicians that use an array of dedicated care strategies.

For example, in 1986, the Boston Health Care for the Homeless Program (BHCHP) was [the first HCH project to send physicians and nurses directly to the streets](#), not only through an overnight van bringing food, clothing, and blankets to those in need but also by daytime walk

rounds throughout the inner city. In this way, a consistent, nonjudgmental clinician presence can engender the trust and engagement critical for continuous primary care. Multidisciplinary teams can also co-locate medical, mental health, and addictions services, coordinate vertical integration of components within the health care system (such as the clinic, health center, emergency department, and hospital), and facilitate horizontal integration with other key sectors, including the criminal justice system, after-jail services, social services, and housing.

Continuity of care also requires innovation in the face of ongoing national changes in health care trends. For example, as the locus of health care has steadily shifted over several decades from inpatient settings to outpatient and home-based ones, medical respite services can provide valuable support in the form of preoperative and postoperative care after surgical procedures, as well as palliative and end-of-life care. Although not yet recognized by the Centers for Medicare & Medicaid Services (CMS), [nearly 80 respite programs](#), led since 1985 by BHCHP and Christ House (now associated with Unity Health Care) in Washington, DC, function throughout the country.

Housing Interventions and Housing First

A decade ago, strategies for housing usually involved a treatment-first, continuum-of-care approach, in which clients were required to progress through milestones (such as sobriety, psychiatric treatment, and independent living skills) before being offered a home. Current federal efforts now favor “low-threshold supportive housing.” This is particularly true of [Housing First](#), which offers timely access to a home without such requirements, thereby providing clients opportunities to link quickly with caregivers who can help address mental and physical health needs.

[Some studies](#), primarily using preintervention and postintervention designs, associate Housing First with less alcohol use as well as fewer hospitalizations and emergency department services. The few randomized trials that have so far investigated Housing First and other supportive housing programs, including [a recent major trial](#) in 5 Canadian cities, suggest that Housing First improves time in housing (at 2 years of follow-up), but with the exception of AIDS, [may not improve health-related quality of life](#). Additional research is critically needed to clarify precise effects and to document longer-term outcomes.

Although HUD budgets for low-income housing remain considerably lower than in the 1970s, dedicated efforts by Salt Lake City, Minneapolis, and other

cities [have substantially improved housing](#) for selected segments of the homeless population. Specific programs [targeting homeless veterans](#) have [contributed to a national decline](#) in this subpopulation, by about a quarter between 2009 and 2015.

Insurance and Health Care Financing

Medicaid expansion in 32 states as part of the Affordable Care Act now provides new insurance options for people experiencing homelessness, especially previously ineligible single adults. In expansion states, [health coverage rates for patients in HCH projects](#) increased from 45% in 2012 to 67% in 2014 vs 26% to 30% in nonexpansion states during the same period. Through various waiver and plan options, states can request that the CMS approve [Medicaid plans that cover housing costs](#), as long as the plans are cost-saving or cost-neutral.

The US Interagency Council on Homelessness coordinates national efforts with 19 federal agencies, state and local governments, and service providers. Other leading groups to address homelessness and its associated health challenges include the National Alliance to End Homelessness, the National Coalition for the Homeless, the National Health Care for the Homeless Council, the Corporation for Supportive Housing, and the Mayors Challenge to End Veterans Homelessness.

Despite some progress over the last several decades, the obstacles remain monumental. Accelerating efforts to reduce health disparities will require even greater societal commitment to improve health for this most vulnerable population. ■

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