Serving Unsheltered People with Severe Service Needs

Unsheltered Homelessness and Severe Service Needs

People who are experiencing unsheltered homelessness are a priority for the U.S. Department of Housing and Urban Development (HUD), as evidenced by a Continuum of Care (CoC) Supplemental to Address Unsheltered and Rural Homelessness Special Notice of Funding Opportunities (Special NOFO) issued by the Office of Community Planning and Development in September of 2022. Through this initiative, HUD is promoting coordinated approaches—grounded in Housing First and public health principles—to reduce the prevalence of unsheltered homelessness and improve services, health outcomes, and housing stability among highly vulnerable unsheltered individuals and families. This Special NOFO, designed in collaboration with people with lived experience of homelessness, outlines strategies communities may implement to address the severe service needs of unsheltered people within their homeless response systems and supports serving the needs of people with complex and multiple service needs. It assists CoCs in their efforts to identify and connect people living in unsheltered situations, including encampments, with health and housing resources.

According to Law Insider, a client may have severe service needs when any combination of the following factors apply to them: 1) they require a significant level of support in order to maintain permanent housing because they are facing significant challenges or functional impairments—including any physical, mental, developmental, or behavioral health disabilities regardless of the type of disability[1]; 2) they require high utilization of crisis or emergency services to meet basic needs, including but not limited to emergency rooms, jails, and psychiatric facilities; 3) they currently live in an unsheltered situation or have a history of living in an unsheltered situation; 4) they are experiencing a vulnerability to illness or death; 5) they have a risk of continued or repeated homelessness; and 6) they are experiencing a vulnerability to victimization, including physical assault, trafficking or sex work.

Vulnerability and Acuity

People experiencing unsheltered homelessness frequently have high service needs due to a lack of stable housing, which increases their vulnerability, and the acuity of the complex condition(s) and disease(s) they experience, often due to a lack of culturally appropriate early interventions. Vulnerability and acuity are interrelated, and both must be assessed and addressed in order to effectively serve individuals and families with complex needs. Unsheltered homelessness requires individuals and families to navigate personal, structural, and systemic challenges to access health services that address their **diseases and conditions** for the most positive healthcare outcomes. Additionally, people who are unhoused will often not seek out routine preventative care and screenings until their condition reaches an advanced or acute state. For example, a lack of routine vision or dental screenings can lead to vision loss or acute dental conditions requiring emergency care. The lack of routine cancer screenings may result in delayed diagnosis and treatment, if any, with higher rates of morbidity.

[1] This factor focuses on the level of support needed and is not based on disability type.

Vulnerability refers to the harm a household faces if they continue to be un-housed. While everyone who experiences housing instability has some level of vulnerability, the high-acuity person is the most vulnerable and may require a larger allocation of resources over a longer period of time to remain successfully housed. It is vitally important that appropriate supportive services are in place to ensure the best possible chance of sustained housing success.

Acuity refers to the level of care a person needs. Some of the indicators that can contribute to their level of acuity are illness; physical, mental, and behavioral health (diagnoses, chronicity of illness, severity); and cognitive functioning (memory, reasoning, decision-making, and communication skills). There are strategies for homeless service providers to support the high acuity of people identified as unsheltered homeless.

Fast Facts

Most common **diseases** among people experiencing unsheltered homelessness:

- Cardiovascular disease
- Diabetes mellitus
- Hepatitis
- Communicable diseases (e.g., COVID-19)
- HIV/AIDS
- Influenza
- Substance use disorders
- Tuberculosis

Fast Facts

Most common **conditions** among people experiencing unsheltered homelessness:

- Chronic pain
- Cognitive impairments from traumatic brain injuries
- Disability
- Extreme weather-related injuries
- Mental illness
- Trauma
- Oral and visual health concerns
- Inadequate nutrition
- Reproductive health concerns

Equity Considerations and Barriers

People with high service needs are often members of stigmatized groups in society. Stigma and discrimination impact the health and healthcare needs of vulnerable populations. Social stigma can be identified as the negative perceptions, attitudes, and characteristics a society places on individuals and group members. Social stigma feeds the prejudices and discrimination people with high acuity service needs can encounter based on those needs and the intersectionality of group identities inclusive of being identified as experiencing homelessness. Another consideration is the disparity in access to, and quality of, health care individuals can experience due to long-standing structural and systemic oppressive practices and behaviors that support negative outcomes for the stigmatized in society. Meeting the service needs of individuals and families when race, ethnicity, sexual orientation, gender identity, language, family, undocumented status, and other identifying factors serve as barriers requires homeless service providers and physical, behavioral, and mental health practitioners to identify ways to bridge the gap between people with high acuity and those who can support them in obtaining and providing the services they need. The Primer on Serving People with High-Acuity Needs provided insight for responding to peoples' high-acuity needs during the pandemic and can be a guide to address common diseases and conditions.

A growing number of people experiencing homelessness are older than 50 years old. Many are representative of the role neurodegenerative disease has in increasing the number of seniors counted among the homeless. Neurological disorders related to aging are generally diagnosed as dementia and Alzheimer's disease, but other neurological disorders affecting those experiencing homelessness can also include the diagnosis of traumatic brain injury, migraines, and epilepsy. Much attention has been given to individuals identified as homeless living with mental illness or mental disorders, and poor mental health is consistently listed as a primary cause of homelessness. Health issues connected to the nervous system or neurological degenerative factors have received less attention, and in many cases have been incorporated into and overshadowed by mental health and behavioral health remedies and practices. People living with neurological disorders must navigate a homeless provider response system that historically has not understood their specific needs and more often than not has provided inadequate assistance, particularly for those living in unsupportive environments such as in encampments, on the streets, and in other unsheltered spaces.

People experiencing unsheltered homelessness are susceptible to the same illnesses, diseases, and conditions as people who are sheltered or housed. Homeless provider systems should understand how to address the impacts that severe service needs have on the ability of people to access and retain housing. This includes developing essential partnerships with healthcare providers; addressing the health effects of homelessness, as well as the social, structural, and systemic considerations; and eliminating racial and ethnic inequities existing across healthcare systems to ensure more positive outcomes.

Service Strategies, Promising Practices, and Community Examples

The HUD Office of Policy Development and Research report Implementing Approaches to Address Unsheltered Homelessness highlights how economic status; physical, behavioral, and mental health conditions; and social and emotional outcomes contribute to homelessness. These negative aspects manifest in different ways for people who are experiencing sheltered or unsheltered homelessness. Evidence indicates that individuals who are experiencing unsheltered homelessness are more vulnerable than people in shelters and deal with higher rates of issues related to physical and mental health and substance abuse. Addressing unsheltered homelessness requires innovative approaches in the delivery and implementation of different ways to meet the severe service needs of individuals and families who are unsheltered. People experiencing unsheltered homelessness generally do not seek or receive preventive health care or regular treatment for severe health conditions. The following are strategies and community examples that can support coordination and cooperation between public

health officials, homeless provider service systems, and other community partners.

Mobile Health Care

People who are experiencing homelessness, especially those who are unsheltered, face many obstacles to accessing health care. It can be difficult to get to a clinic or hospital and to keep track of appointments and medications while living unhoused. Leaving personal possessions and pets behind may inhibit people from leaving their sleeping places due to fears of theft or law enforcement raid activities. People experiencing unsheltered homelessness need alternative medical options, namely street medicine and outreach that bring care to where they are. All of these challenges are further complicated by the complex and severe health and behavioral health conditions that may be experienced by people identified as unsheltered homeless.

Community health centers, especially those funded through the Health Resources and Service Administration's Health Care for the Homeless program, have long been at the forefront of providing medical services to adults and children experiencing homelessness. Mobile units offer necessary health services to individuals with high acuity needs by providing an alternative healthcare option to some of the most vulnerable community members and building community partnerships to provide health services. According to the National Health Care for the Homeless Council (NHCHC) Fact Sheet Delivering Health Care to People Experiencing Homelessness, meeting health care needs requires strong partnerships and community resources that allow entry into spaces where people experiencing unsheltered homelessness can be engaged to build rapport and where providers can maintain continuity of services.

The keys to building these relationships are open communication, listening to partners and the community, practicing cultural humility, assessing the community, and under-promising and over-delivering. Building partnerships to operate a mobile unit involves:

- Demonstrating investment in the community.
- Learning what types of services are needed and where.
- Identifying gaps in care that you will not be able to provide.
- Strategizing solutions for addressing concerns.
- Laying out the roles and responsibilities of each organization.
- Assessing for cultural appropriateness.

Telehealth

Telehealth has the potential to bring medical care much closer to individuals who are unable to access facility-based care. The COVID-19 pandemic prompted many healthcare providers to expand this capacity, and others have implemented mobile solutions. One example is the Center for Care Innovations' telehealth project funded by Kaiser Permanente. The project consists of individuals known as health tech navigators who provide virtual health care to unhoused individuals in Los Angeles County. During the COVID-19 pandemic, telehealth was offered as an option for housed individuals and families as one way to receive health services while decreasing in-person contact and potential exposure to the virus. The stigma and challenges associated with homelessness support the fears, distrust, and invisibility felt by many and demonstrate the importance of structural considerations such as transportation to much-needed health care and therapy services. Another factor for consideration in accessing health care is affordability. The Northeast Valley Health Corporation (NEVHC)_advocates promoting health care for all. NEVHC operates 14 health centers in the San Fernando and Santa Clarita Valleys, providing equitable access to behavioral health and support services by linking low-income and patients experiencing sheltered and unsheltered homelessness to

online therapy.

Medical Respite Care and Hospice

When people experiencing unsheltered homelessness become sick enough to need hospitalization, they spend more time there than people who are housed. This is overwhelmingly due to discharge decisions that are impacted by the lack of stable, safe, and clean spaces or housing to maintain follow-up care. According to the National Institute for Medical Respite Care (NIMRC), the frequent use of emergency rooms for primary health care services and hospital stays for people experiencing homelessness leads to higher rates of having severe multiple health challenges, making health care more complex and expensive. This revolving door from hospital to homelessness and back again is marked by continually declining health and eventually, early death.

Medical respite offers a safe place to recuperate as well as acute and post-acute care for those who do not have a home to return to when discharged from a hospital. These programs offer care and support services, laundry facilities, showers, and other comforts. They provide follow-up treatment, including wound care, medication assistance, transportation, care coordination, and much more. Many medical respite care (MRC) facilities connect with the local CoC and coordinated entry, helping people move on to permanent housing and preventing a return to homelessness. Though designed to be short-term, the time people can stay is flexible, ranging from days to months. As discussed in the *Journal of Health Care for the Poor and Underserved*, medical respite for people experiencing homelessness comes with multiple financial considerations that can also serve as a barrier to people having access to the healthcare services they need.

According to the NIMRC's article on the state of MRC, there are 133 medical respite programs in 38 states and territories. They can be located through the Medical Respite Program Directory. Each is unique. With as few as three and as many as 210 beds, the median capacity is 17 beds. Sponsors include nonprofit agencies, federally qualified health centers, hospitals, local governments, and others. Most have multiple funding sources, including grants, contracts, and other revenue streams including Medicaid reimbursement. Medical respite programs face the challenge of covering funding gaps, leading to a wide variation in scale and services. Medicaid reimbursements are not enough to cover the operating expenses for medical respite programs. Transportation, room and board, housing navigation, employment assistance, and many other costs are not Medicaid-reimbursable.

While MRC programs run by federally qualified health centers can access payments for comprehensive patient care, they are left to find the funding needed for room and board. On the other hand, shelters that run MRC programs may receive funding for room and board but may not be able to access reimbursement for medical care. Other models, including those run by not-for-profit agencies, may be balancing volunteer labor, donations, grants, and other short-term strategies that do not easily lead to sustainability. Fortunately, there are several creative strategies to fund MRCs in place throughout the country.

People experiencing unsheltered homelessness have high mortality rates. Death is a common possibility whether due to lack of housing or shelter, violence, or as the result of severe medical conditions they may not have accessed health care for or a terminal diagnosis indicating the need for hospice and palliative care programs. Consideration must be given to providing care that allows sheltered and unsheltered homeless individuals to die with dignity. Hospice, the most known end-of-life care, is generally offered as in-home care, largely funded by Medicare and Medicaid. However, people experiencing homelessness encounter multiple barriers to hospice care, including a lack of insurance to pay for it, a lack of a fixed residence where care can be provided, and a lack of a primary caregiver to oversee hospice care. A physician must certify that the patient has a terminal illness that further treatment will not improve, with a prognosis of six months or less should the illness run its usual course. This can be difficult for a doctor to determine and for a patient to accept. Those who want to take advantage of Medicare- or Medicaid-funded hospice services must agree to forgo any curative treatment.

Peer Support

Often, the best outreach to people experiencing unsheltered homelessness with severe service needs is through peer support. People can develop serious medical, behavioral, and mental health conditions before, during, or after the experience of homelessness. Having peer advocates who have the lived experience of homelessness and the expertise to navigate homeless provider systems is an asset as people are connected to needed services and transition out of homelessness. Working in partnership with case managers, peer advocates help individuals with severe service needs obtain housing and connect with recovery support and other needed health care services. Skid Row Housing Trust in Los Angeles provides the aforementioned assistance for new residents during the critical first 90 days of transitioning from homelessness to housing. The individuals they serve have experienced unsheltered homelessness, chronic health conditions, substance use disorders, or mental illness.

Complex Care Shelters

Healthcare systems have a role in reducing healthcare costs and improving healthcare outcomes for society's most vulnerable. People experiencing homelessness who are medically vulnerable can be served through one community solution model known as Complex Care Centers. One such program exists in Anchorage, Alaska, where service providers working with veterans determined that they had to reimagine their homeless shelter system. According to the HUD Annual Homeless Assessment Report Part 1 between 2020 and 2021, the number of veterans experiencing sheltered homelessness decreased by 10 percent. This report has determined that veterans experiencing sheltered homelessness accounted for 11 out of every 10,000 veterans in the country. We know that many veterans are among the unsheltered homeless and can have high acuity needs. Complex care shelters can help meet their needs.

Assertive Community Treatment

Many people experiencing unsheltered and sheltered homelessness live with serious mental illness and substance use disorder. Some individuals may have co-occurring needs involving both, and some live with an intellectual disability or a traumatic brain injury. The Substance Abuse and Mental Health Services Administration (SAMHSA) has developed the Assertive Community Treatment Evidence-Based Practices toolkit, which service providers can utilize to support better health outcomes. The toolkit is an evidence-based model that utilizes a multi-disciplinary team to provide intensive services to persons who live with serious mental illness. Critical Time Intervention is another evidence-based practice that strengthens the service network for people with severe service needs. Each of these resources bridges the gap between housing case management and connecting with community support as needed.

Resources

Continuum of Care Supplemental to Address Unsheltered and Rural Homelessness

NHCHC: Diseases and Conditions

Strategies to Support High Acuity Populations

Addressing Stigma is Not Enough

Primer on Serving People with High-Acuity Needs

Neurodegenerative Disease and the Experience of Homelessness

Racial and Ethnic Inequities in Mortality During Hospitalization for Traumatic Brain Injury: A Call to Action

Implementing Approaches to Address Unsheltered Homelessness

Street Medicine and Outreach: Bringing Care to People Where They Are

Delivering Mobile Health Care to People Experiencing Homelessness

Bringing the Clinic to the Patient: Health Tech Navigators Link Unhoused Patients With Online Therapists in LA County

NEVHC Advocacy Network

National Institute for Medical Respite Care: Creating Places to Heal

The State of Medical Respite Care

Medical Respite Program Directory

Adapting Your Practice: Recommendations for End-of-Life Care for People Experiencing Homelessness

HCH Clinicians Can Help Homeless People Die with Dignity

Peer Support

Peer Advocates Transition Residents from Homelessness

Skid Row Housing Trust

In Anchorage, a Complex Care Shelter Supports Medically Vulnerable People Experiencing Homelessness

HUD Annual Homeless Assessment Report Part 1

SAMHA's Assertive Community Treatment Evidence-Based Practices toolkit

Critical Time Intervention