

Challenges Faced by the Homeless Population in New York City: An Analysis of HealthCare Delivery and Utilization of Care

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ABSTRACT

Homelessness is a significant public health challenge in major US cities and has been identified as a social determinant of health. Homelessness and chronic diseases have a bi-directional relationship; consequently, chronic diseases, mental health disorders, and inadequate access/utilization of health care services disproportionately affect the homeless population.

This article reviews the peculiarities of the homeless individuals in New York City (NYC), which has the highest homeless population across the US. An appraisal of some of the available programs for the homeless population in NYC was conducted and challenges faced in initiating/implementing programs to assist the homeless population were identified. We also identified a sub-population to be prioritized in public efforts, with the potential for a higher return on public health funds invested.

INTRODUCTION

Homelessness, defined as a lack of permanent housing, leads to instability and uncertainty in night time residence.¹ Broadly speaking, two categories of homeless individuals exist – sheltered homeless or unsheltered homeless.¹ Sheltered homeless individuals include those who live in public temporary housing assistance units (government-run shelters), families and individuals in transitional shelters, inadequately-housed individuals, and families that “double up” or have no other option but to “squat” with other family members or friends.¹ Unsheltered homeless individuals usually take shelter in open public spaces like parks, buildings under construction, and other places on the street.² In 2016, 549,928 people were homeless in the US on a single night, with 68% living in emergency shelters, transitional housing programs, or safe havens; 32% were in unsheltered locations. A total of 355,212 of those who were homeless were single adults and 194,716 were part of families.³

The causes of homelessness include job loss/unemployment, economic hardship, emotional and mental disorders, substance use disorders, and fleeing from physical and emotional abuse. Others causes include natural disasters like hurricanes, gentrification, and changes in neighborhood layout.⁴ Disproportionate increases in rent and income/pay rise are also a factor, as rent has increased by 18% in NYC from 2005 to 2015, while wages rose by only

5%.⁵ This disparity rent has led to eviction of tenants. Changes in policies, such as reduced public subsidized housing, appear to be the most significant factor.⁴

The homeless population was at a record highest during the tenure of NYC's immediate past mayor, Michael Bloomberg, due to a failure of policies for homeless individuals.^{4,6} He provided tax incentives for real estate firms to stimulate building more housing.⁷ However, the new buildings were not designated as affordable housing and therefore worsened inadequate housing as taxpayer's money was used to incentivize the building of luxury housing. These luxury condos could only be afforded by households that made annual income of more than \$100,000.⁴ Another failed policy was the discontinuation of prioritizing homeless individuals and families for federal housing programs like public housing and Section 8 rental vouchers.^{4,6}

The homeless population faces relevant socioeconomic issues, such as family separation, domestic violence, criminalization, difficulty with gaining employment, substance abuse issues, and sexual and physical assault.¹ These issues further perpetuate their homelessness and share a bi-directional etiology with their situation.⁸ These socioeconomic problems are also associated with many health issues, the most challenging of which is inadequate or lack of access and utilization of health care services.¹ Therefore, homelessness has been identified as a concrete social determinant of health.⁹ Relevant subpopulations among the homeless include veterans, youths, elderly, families with children, lesbians gay bisexual transgendered individuals, those with drug abuse problems, and those with mental disorders.¹

In this article, we highlight some of the most pragmatic programs for the homeless population in NYC and their public health impact. We also provide suggestions to various stakeholders on how to improve challenges faced by homeless individuals.

NEW YORK STATE STATISTICS ON THE HOMELESS POPULATION AND THOSE UNSTABLY HOUSED

New York State (NYS) is one of the five states that accounts for nearly half of the nation's total homeless population.³ Homelessness nationwide decreased by 11% between 2007 and 2015; however, it increased in 18 states, of which NYS recorded the highest increase of 41% (62,601 to 88,250 people) during this time period.¹⁰ Between 2014 and 2015, NYS's homeless population increased by 7,660, the largest recorded increase in any one-year period, accounting for almost 33% of NYS's total homeless population growth in the eight-year period between 2007 and 2015.¹⁰ In fact, 98% of the total NYS homeless population is in NYC.

NYC is composed of five boroughs – the Bronx, Queens, Brooklyn, Manhattan, and Staten Island. Here, NYC refers to the municipal area including the five boroughs, with a population of 8.538 million distributed over a land area of just 302.64 square miles (783.8 km²), making it the most populous and densely populated major city in the US.¹¹ It has the highest population of homeless individuals (75,323 people) followed only by Los Angeles.^{3,10} Most of these individuals are sheltered because there is a legal mandate that the city council provide safe temporary housing for all eligible homeless citizens.¹² In the NYC 2016 fiscal year, 63,085 individuals (152 fewer people compared to 2015) were part of a homeless family with children, with 26,925 adults (2% increase from 2015) and 36,160 children under the age of 18 (1% decrease from 2015).

Further research into the socioeconomic status of NYC's homeless population revealed alarming data. More than a quarter of families in shelters (28%) include at least one employed adult, and 16% of single adults in homeless shelter are employed; in fact, most

have multiple jobs.¹³ Unexpectedly, up to 79% of heads of families living at homeless shelters had recent work histories, and up to 50% are educated up to a tertiary level of education, qualifying them for employment.¹³ From 2010-2013, the number of working homeless in NYC increased by 57%.¹⁴

HEALTH CHALLENGES FACED BY THE HOMELESS POPULATION

Homelessness and health have a unique, bi-directional cause-and-effect relationship.¹⁵ While some health problems precede and contribute to homelessness, some are consequences of being homeless, as homelessness complicates the treatment of many illnesses and some diseases and treatments may cut across all patterns of interactions.

When controlling for gender, comorbidity, age, and shelter status, homeless individuals have a 1.5 to 11.5 fold greater risk of dying compared to the general population.¹⁶ The mortality rate among adults who used the family shelter service was 1.5 times higher than the general population.¹⁷ The leading causes of death among the homeless share some similarities with the leading causes of death among the general population of NYC, such as heart disease, which is the leading cause of death in both populations.¹⁷ Heart disease accounts for 20% of deaths in homeless individuals, followed by drug overdose (17%), accidents not related to drugs or intoxication (13%), and alcohol abuse (6%); suicide/self-harm, assault, and malignant neoplasm each accounted for 4% of deaths.

Homeless individuals have a longer hospital stay (35%) at acute care facilities compared to those in the general population, which results in significant increases in cost per admission.^{18,19} Mental health illness, substance abuse, and alcohol abuse account for 69% of hospitalizations among the homeless compared with 10% of those in the general population.¹⁷ In addition, up to one-third of chronic homeless individuals have some form of mental illness.²⁰ Infectious and communicable diseases are also prevalent in homeless adults, and HIV/AIDS diagnosis rates are more than twice the rate of the general population; in addition, the tuberculosis rate is three times higher than the general population.¹⁷ Homeless individuals suffer from lack of access and utilization of healthcare services, especially primary care services, which presents a major social determinant.²¹ The homeless population in NYC, like other parts of the country, have many other health issues which no epidemiological data exists to substantiate; these issues include hypothermia from cold exposure and malnutrition.²¹

COMMUNITY ASSESMENT AND APPRAISAL OF AVAILABLE PROGRAMS FOR THE HOMELESS

NYC has a high potential to tackle homelessness, as it has been leading the effort to tackle the plight of the homeless population compared to other cities in the country.²² The most significant factor in its positive force for change is the strong political will to overcome the problem. Due to the 1981 Callahan vs. Carey consent decree, NYC is bound by law to provide shelter for homeless individuals.¹² A political party formed solely for the purpose of bringing down the cost of house rent, "Rent is too damn high party," was founded by Jimmy Mcmillan.²³ However, NYC also receives a continuously high immigrant population, as it is one of the best states for new immigrants due to its ethnic diversity.²⁴ This results in an increase in population beyond projection, which further worsens the problem of affordable housing.

There are many governmental and non-governmental programs for homeless individuals in NYC. A detailed analysis of all of these programs is beyond the scope of this article. Therefore, we have outlined those we deem as the most pragmatic.

Assistance Programs

These programs help single adults and families move out of shelters to public housing; these include housing placement programs, Special Exit and Prevention Supplement, and Home Tenant-Based Rental Assistance. Mayor de Blasio recently reversed a Section 8 policy that denied homeless families priority access to public housing. Between 2006 to 2016, Bloomberg's former policy that denied families priority access reduced the overall federal housing placements for homeless families each year to an all-time low.⁶ The period was considered to be the "lost decade," as 31,935 fewer federal housing placements were made during those nine years.⁶ In 2015, more than 2,700 single adults and families moved out of shelters to public housing.

Homelessness Prevention

The de Blasio administration has invested \$100 million in legal services for low income-tenants in 2017 through a policy called the City Family Eviction Prevention Supplement. This was a proactive step to decrease evictions through increased funding for legal services for low-income tenants. Approximately 40,000 people were able to stay in their homes and, as a result, eviction is no longer the leading cause of homelessness among families.⁶

The Health Care for the Homeless Projects

The Health Care for the Homeless Projects, jointly funded by the Robert Wood Johnson Foundation, the Pew Memorial Trust, and a grant from the Health Resource and Services Administration (HRSA), is the single most effective network of healthcare services developed for homeless individuals across the nation.^{8,25} The Health Care for the Homeless NYC chapter provides supportive and integrated services to people independently of their ability to pay. Services provided include primary care medical services, screening, mental health services, psychotherapy, case management, social assistance, pediatric care, and podiatry.²⁶ There are up to 28 Health Care for the Homeless centers in NYC, and these include Harlem United, Montefiore Center, and William F. Ryan Center.²⁷

New York City Health and Hospital Corporation (NYC H+H)

This public benefit corporation is the largest municipal health organization in the country. Its mission is to provide comprehensive health care to all, regardless of their ability to pay, in an atmosphere of dignity and respect. NYC H+H provides the highest proportion of care to uninsured patients in NYC than any other healthcare provider.²⁸ With a safety net burden of \$698 million in uncompensated care annually, NYC H+H serves as a constant source of health care services to homeless individuals in NYC.²⁸

NYC Supportive Housing for High Risk Unstably Housed Medicaid Recipients

This program provides affordable housing paired with supportive services, such as on-site case management and referrals to community-based services. These services have potential to improve health, reduce hospital use, and decrease health care costs in the long term, especially when frequent users of health services are targeted.⁹

PRIORITIZATION OF PUBLIC HEALTH EFFORTS AND SUGGESTED APPROACHES FOR STAKEHOLDERS

Concrete evidence indicates that coordinated treatment programs for homeless individuals result in better health outcomes and access to health care, especially for those with mental illness and substance abuse issues.²⁹ Coordinated programs that combine intensive case management with supportive housing/rental assistance have shown to be most beneficial.³⁰⁻³⁵ Such programs increase utilization of ambulatory health care and follow-up services and reduce acute care and hospitalization among those with mental illness.^{36,37} They also tackle multiple factors that affect health outcomes and healthcare utilization.^{29,38,39}

The availability of safe and stable housing is a social determinant of health and endeavors to tackle the pervasive issue of homelessness seem to lie mostly on the social support provided by the government.⁴⁰ However, we believe that multiple stakeholders, including non-profits and community organizations, health care organizations, and individual health care providers, also have a significant role to play.

State and city government

Our prioritization effort and identification of a sub-population was based on the Hanlon approach, which seeks to prioritize issues based on the size of the issue, seriousness of the issue, and the effectiveness of potential interventions.⁴¹ Interventions to prevent homelessness in families with children and parents ranked highest in priority among other sub-populations. As part of the Hanlon approach, these issues were tested using the PEARL analysis, which involves consideration of propriety of issue, economic consequences, acceptability, resources, and legality.⁴¹ Based on this analysis, we propose that NYS government grants priority to families with children and parents that work in all housing programs presently available while also creating programs that target this group. Prioritizing this subpopulation may help ensure that such families are stably housed while also preventing the devastating effect of homelessness on children.⁴² With little assistance, we believe this sub-population has potential to remain sheltered and will yield the highest outcome for public health funds invested.

Healthcare organizations

There are many challenges within healthcare administration to homeless individuals from a healthcare organization perspective. Homeless individuals are managed mostly in the emergency room of different hospitals yearly, which creates challenges with continuity of care, inadequate medication reconciliation, and fragmented care.^{8,15}

It is therefore important that healthcare organizations in NYC collaborate to improve healthcare delivery to the homeless. A registration system should be developed for homeless individuals and should be linked to electronic medical records. This database can then be shared across participating hospitals and information about homeless individuals can be shared between them to optimize their care whenever they present to any one of the emergency departments of hospitals within NYC.

Individual healthcare providers

Individual healthcare providers face challenges when providing care to homeless individuals. There is always a multiplicity of need, as most homeless individuals have multiple comorbidities like substance use disorders, mental illnesses, and social issues.⁸ It is very challenging to tackle multiple issues in patients who have a high risk of noncompliance. In addition, many homeless individuals distrust the system, authorities, and healthcare sectors due to previous repeated failures of the social service system, discrimination,

criminalization, or have paranoia from mental illness. These reasons often result in rejection of treatment.

Despite these identified challenges, health care providers can optimize interactions with homeless patients to ensure favorable outcomes. Providers must look beyond evidence-based medicine when taking care of these individuals, as there is limited research that supports clinical programs for this population. All interactions should also be based on the patient's reality. For example, it is recommended that a diabetic with glycosylated hemoglobin (A1c) of more than 9% be placed on dual agents (including insulin injection) to control blood glucose.⁴³ However, homeless diabetics with moderate-to-severely elevated A1c requiring insulin will likely not achieve optimal control due to an inability to store refrigerated insulin preparations. In such a circumstance, the provider should consider other alternatives.¹⁵

Non-profit and community organizations

Many non-profit endeavors are geared toward homeless-unsheltered individuals with substance use issues, and they often provide basic physiological needs like food and clothing. Considering the peculiar nature of homeless individuals in NYC, many are educated and some work. More community programs should therefore be geared toward social services that assist in job placements. In addition, there is the need for proliferation of non-profit/community interventions geared toward homeless families with children and parents that work.

CONCLUSION

Homelessness and its associated public health problems have a multifactorial etiology that require collaboration across various stakeholders; it is a chronic problem that requires a long-term solution, which is dependent on the level of social support provided by the government.⁸ High spending on social determinants of health such as housing will lead to less healthcare spending in the long term.⁹ Our present healthcare expenditure proves that point, as the US has the highest healthcare spending among all industrialized/developed nations.⁴⁴ Our spending on healthcare per gross domestic product (GDP) is more than the combined spending per GDP of all other developed nations. However, our public health outcomes are poor, as the US ranks 25th in spending on social services.⁴⁴

NYC has the highest potential to tackle the problem of homelessness, as there is strong political will and high social awareness of the problem. We propose that public health services prioritize homeless families with children and parents that work. This group represents "low hanging" fruit among a sub-population with the highest potential for better outcomes with low assistance.

All stakeholders that try to improve the plight of the homeless face inherent challenges. From a policy standpoint, it is very challenging to develop policies because it is very difficult to study this subpopulation. Healthcare organizations and providers are faced with a multiplicity of needs and most overcome rejection of help and assistance due to mistrust of the system.^{15,45}

Programs that combine intensive case management with housing assistance are the most promising. Investments in such programs like the NYC Supporting Housing program can reduce downstream spending on healthcare costs incurred by homeless individuals from overutilization of emergency health services.⁹ In addition, using housing subsidies to

prevent homelessness saves taxpayers the exorbitant cost of shelters (\$44,000 per year for families and \$34,500 for single adults).⁴⁶ Although it seems as though this problem is solely an issue for the government to handle, various stakeholders have a role to play, including the health care organizations, non-profit/community organizations, and individual healthcare providers.

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