WellSky

White paper

The emerging crisis of aged homelessness

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About the author

Dennis Culhane is the Dana and Andrew Stone Professor of Social Policy at the School of Social Policy and Practice at the University of Pennsylvania. He also directs the Actionable Intelligence for Social Policy (AISP) initiative, a MacArthur-funded project to promote the development of integrated database systems by state and local governments for policy analysis and systems reform. Dr. Culhane's work has resulted in federal legislation requiring all cities and states to develop administrative data systems for tracking homelessness services in order to receive HUD funding.

The number of seniors experiencing homelessness is growing rapidly and will continue to increase sharply for the next decade. Left unaddressed, this trend will place heavy burdens on the healthcare system, nursing homes, and public services.

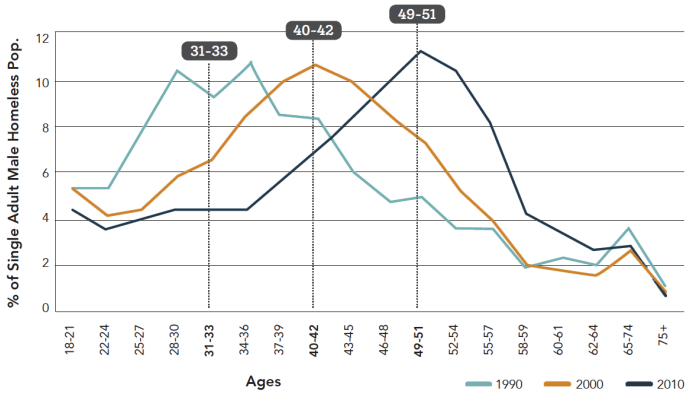
It is critical for government and community leaders to consider approaches to proactively reduce these costs. One solution is a set of housing models that include basic healthcare and assistive services. This approach could potentially reduce hospital and nursing home costs.

This paper summarizes the findings of the study *The Emerging Crisis of Aged Homelessness.* It offers background on the problem and reviews the implications for the various stakeholders who would be need to get involved in a policy to address the problem. This information was also presented in a WellSky webinar.

Senior homelessness: A birth cohort phenomenon

Demographer Richard Easterlin hypothesizes that individuals born after the peak of the baby boom (1955 -1965) are more likely to be economically disadvantaged due to an excess supply of workers at the time of their labor market entry. The graph below shows this generational wave experiencing homelessness.

Age distribution of adult male shelter users in the United States

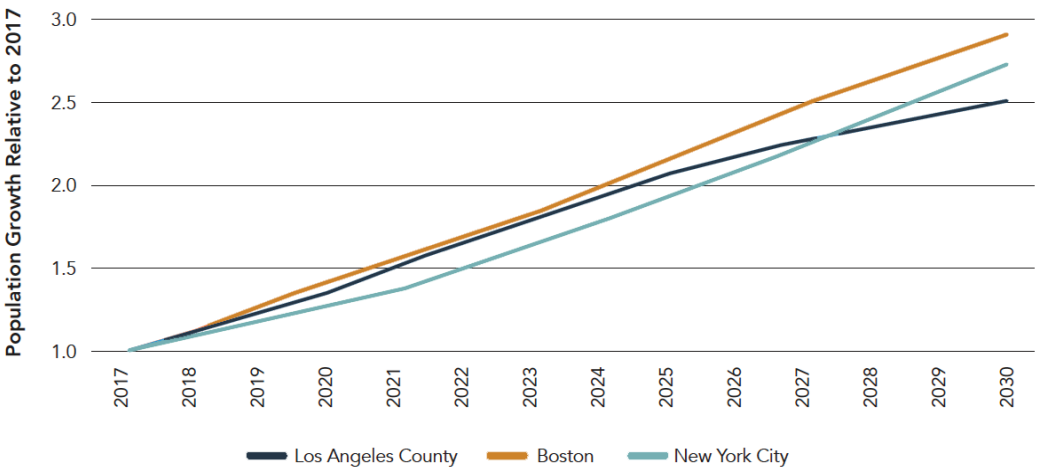


Source: Culhane et al. (2013)/ U.S. Census Bureau Decennial Census Special Tabulation

In 1990, the average age for male shelter users in the United States was 30. In 2000 it was 40. And in 2010 the average age was 50. When the 2020 census is published, we'll see that the average age of this group is 60. Due to this trend, projections based on data for Los Angeles, New York, and Boston indicate the elderly homeless population will triple between 2017 and 2030.

This trend is not unique to New York, Los Angeles, or Boston. States like Arizona, Florida, Michigan, Texas, Oregon, and North Carolina are all seeing the same trends in the adult homeless population.

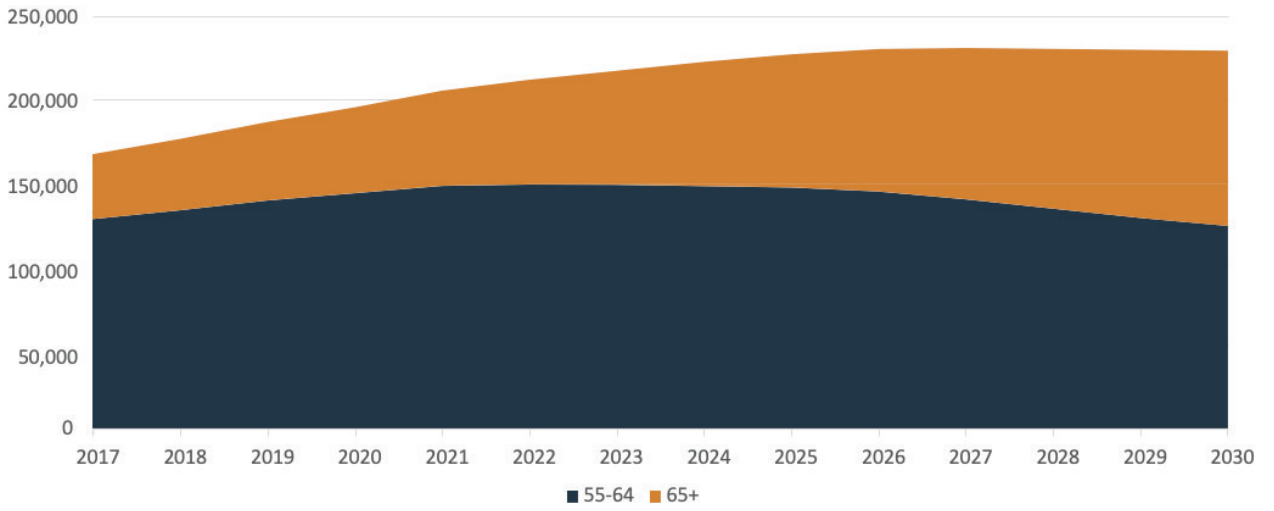
Forecasted relative change in the 65 and older homeless population compared to 2017



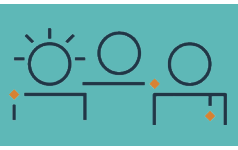
Source: Culhane et al. (2013)/ U.S. Census Bureau Decennial Census Special Tabulation

Older people experiencing homelessness are also aging at a rate about 15 years ahead of their chronological age, and this group will face many of the health issues associated with old age in the next 10 years.

National projections of older homeless adults: 2017-2030



Estimates are that the number of homeless people over the age of 55 will grow to about 225,000 people by 2030, from a baseline of around 160,000 in 2017. And as the share grows of those over 65, this group will get significantly more frail over time.

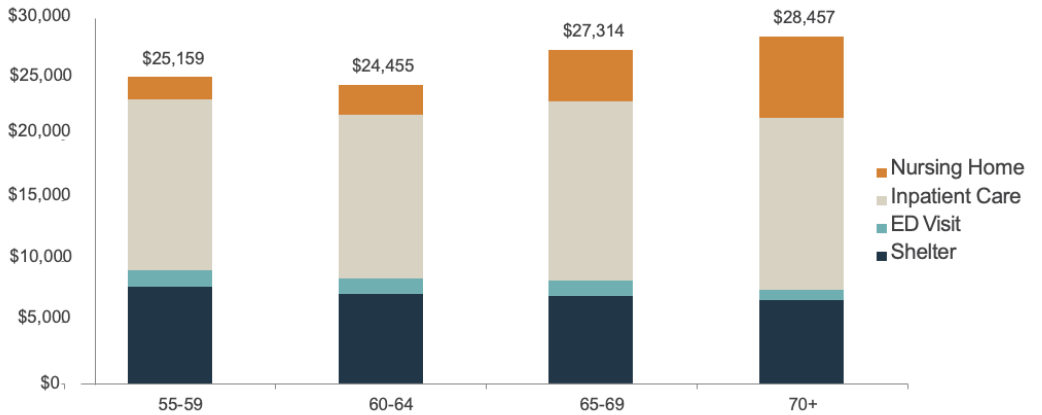


The elderly homeless population in many cities will **triple between 2017 and 2030.**

Costs will rise as this cohort ages

Researchers looked at the health care utilization patterns of this elderly homeless population compared to the general population of people the same age. Data from 2014 to 2018 was compiled from records in California, New York, and Massachusetts. Not surprisingly, the elderly experiencing homelessness are significant users of healthcare, nursing homes, and shelters. Data from New York City suggest the average senior over the age of 70 experiencing homelessness costs the community nearly $30,000 per year.

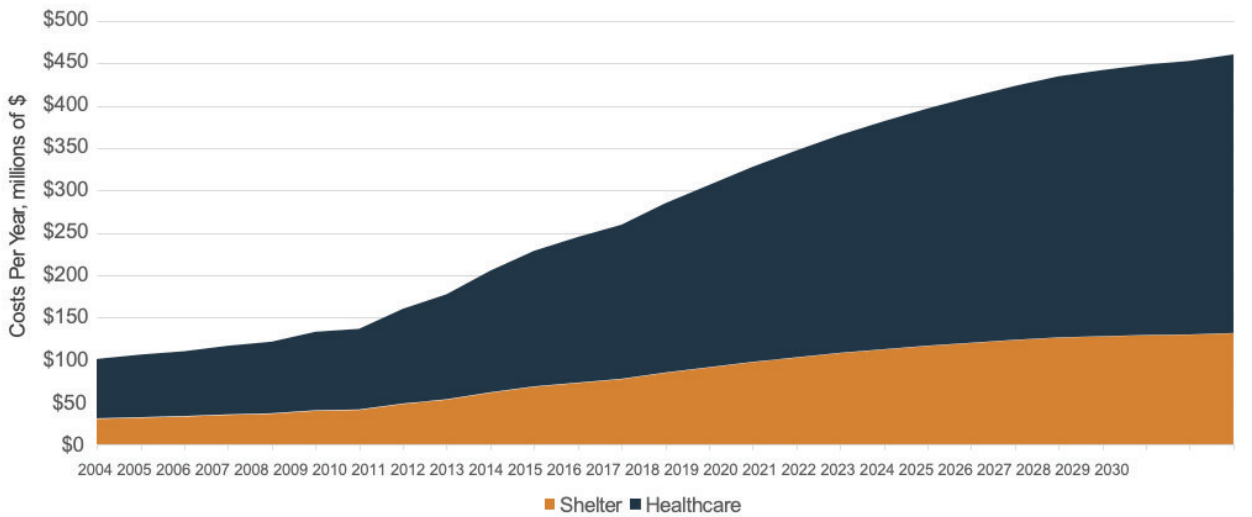
Average annual per person costs by age: New York City



Source: Culhane et al. (2013)/ U.S. Census Bureau Decennial Census Special Tabulation

As this group ages, the projected impact of these healthcare costs by 2030 grows even more concerning. In New York City alone, costs will grow from roughly $250 million to more than $450 million annually if left unaddressed.

Projecting Total Costs through 2030: New York City



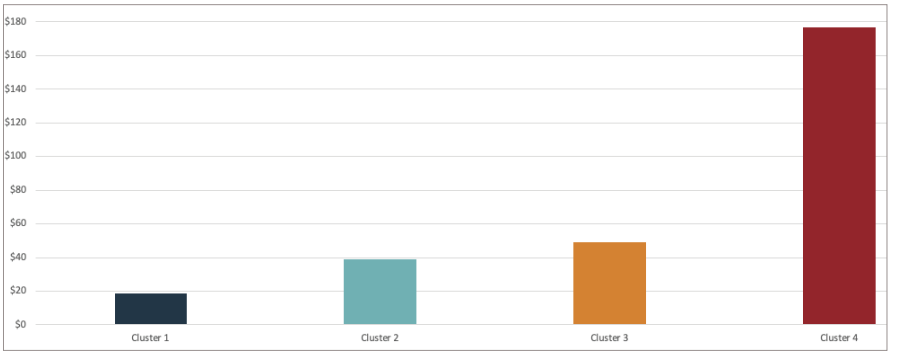
Source: Culhane et al. (2013)/ U.S. Census Bureau Decennial Census Special Tabulation

The researchers concluded that a housing strategy for the elderly would need to have appropriate sets of support services for various segments of this homeless population. Analysis of the senior homeless population and how they access housing and healthcare services yielded four clusters:

- The largest cluster of people (85% of this population) experienced moderate use of shelter and healthcare.
- The second cluster (11%) had a high degree of shelter use and moderate medical need.
- The third cluster (1.5%) had very high shelter and moderate medical needs.
- The fourth cluster (2.5%) had very high healthcare costs but low shelter use.

The cost to shelter and care for each of these populations varies widely. The average cost per year for a person in cluster 1 is roughly $18,500 a year. Clusters two and three totaled $38,000 and almost $50,000 respectively, and the annual cost for a person in cluster four was $175,000.

Healthcare and shelter costs per cluster



Source: Culhane et al. (2013)/ U.S. Census Bureau Decennial Census Special Tabulation

Segmenting solutions based on acuity

For cluster one, the largest group, the researchers applied a framework called progressive engagement. Previous research has found that most adult homelessness is temporary, and about one third to one half of people who experience sheltered homelessness will exit within 30 days with little or no assistance. This "self-resolving" group makes up about a third of cluster 1. Other interventions provided for the remaining two-thirds of cluster one would grow progressively and include:

- **Rapid rehousing** — for those needing relocation grants and case management services, and time limited rental assistance as necessary (22% of cluster 1)
- **Rental subsidies** — with relocation and case management services for those who need ongoing, modest rental assistance, or for shared living arrangements with family, friends, partners, etc. (22% of cluster 1)
- **Rental vouchers** — like those available through HUD's Section 202 program, in addition to light case management, for those expected to be living alone (22% of cluster 1)

It costs a community **$175,000 per year to shelter and care** for the most vulnerable segment of the senior homeless population — those with high healthcare costs.

The researchers concluded that clusters 2, 3, and 4 will likely need permanent supportive housing (PSH), because of high shelter or healthcare use. All three of these groups will also likely need enhanced case management and home care services to allow aging in place. The three percent of adults with the highest health care use in cluster 4 will also require palliative and nursing home transition services.

The researchers considered whether an investment in housing and healthcare services would reduce excess costs associated with homelessness. To estimate this decrease, data from 15 studies of permanent supportive housing were gathered to estimate the expected service cost reductions associated with housing placement. Two scenarios were generated:

- **A more conservative projection** in which findings from all prior studies — including those identifying no change in health care costs in certain cost categories — were considered equally.
- **A less conservative projection** that included only findings of significant cost reductions in calculating anticipated average cost offsets. This latter scenario represents cost reductions that might be expected should the implementation of the housing interventions have an effect more in line with what studies identifying relatively larger impacts have found.

Calculating cost reductions under this proposal

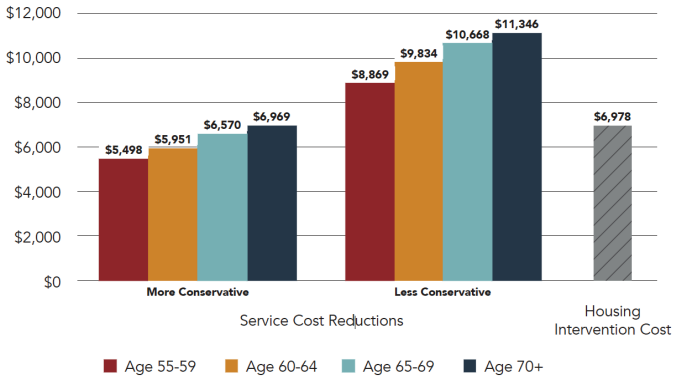
The research team applied these projections to senior homelessness data in LA County, New York City and Boston. The results:

Cost offset scenarios

Cost category	Scenario 1 (more conservative)	Scenario 2 (less conservative)
Inpatient medical	-18%	-33%
Emergency department	-6%	-45%
Outpatient medical	-6%	-45%
Outpatient behavioral health	-48%	-29%
Inpatient behavioral health	-35%	-56%
Nursing home	-42%	-90%

These estimated reductions are averages based on moving people from homelessness to housing. However, the results vary for different age groups.

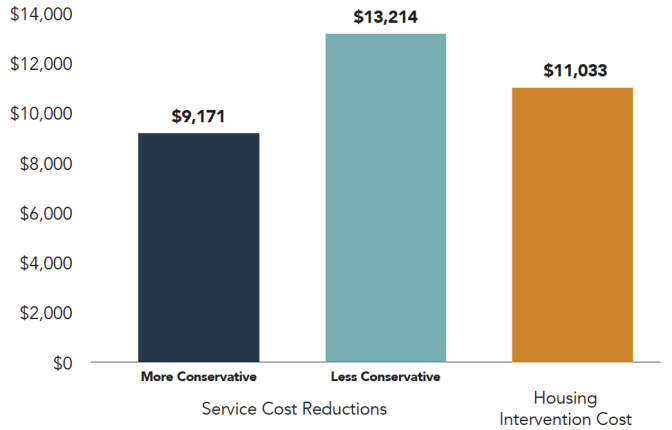
Range of cost reductions across age groups: LA County, average per person, per year



Source: Culhane et al. (2013)/ U.S. Census Bureau Decennial Census Special Tabulation

As people progress to higher age categories, society faces higher costs, so applying these cost reduction strategies generates more savings for this older cohort. More conservative estimates suggest roughly $7,000 in savings per year for an adult in the oldest group. Applying the proposed services to data from New York City produced a similar result:

Cost reduction possibilities — Per person per year New York City



Source: Culhane et al. (2013)/ U.S. Census Bureau Decennial Census Special Tabulation

The third column indicates the estimated cost of services. This suggests a breakeven point at the average of the more conservative and less conservative scenarios. Put differently, a community would spend just as much if it ignores the problem as if it strategically shelters and cares for homeless seniors.

The question posed at the outset of the study was: *could we fund housing solutions for elderly homelessness from the service cost reductions?* The simple answer is yes, it appears that's possible.

What are the next steps?

This is not a simple problem that can be solved with a single program. The solution involves multiple entities paying for healthcare, housing, and shelter. There will have to be a lot of deliberation among key stakeholders including:

- U.S. Dept. of Housing & Urban Development (HUD)
- U.S. Veterans Administration (VA)
- U.S. Dept. of Health & Human Services (HHS)
- Centers for Medicare and Medicaid Services (CMS)
- State units on aging (SUAs) and area agencies on aging (AAAs)
- State Medicaid operating agencies
- Medicaid Managed Care Organizations (MCOs)
- Hospitals & nursing homes
- Homelessness continuums of care (CoCs)
- Housing authorities

The biggest policy consideration is how to fund this housing investment and then recoup the savings. Federal, state, and local leaders can advance dialogue and action among relevant stakeholders by considering these questions:

- **What is the role of federal agencies, such as HUD, VA, HHS?** How can they best support expanded access to permanent supportive housing?
- **How can private Medicaid MCOs shift some of their resources to housing solutions?** These entities stand to gain the most from a plan that reduces institutional care. What regulatory and other barriers can be eliminated, and what incentives can be provided to help MCOs take the lead?
- **What can hospitals do?** Health systems are on the front lines meeting the health needs of people who are aging and homeless. They face enormous costs associated with ER visits and longer-than-necessary hospital stays and would benefit from the offsets described in this paper. Could they participate in bearing some of the costs of housing and healthcare?
- **How can state Medicaid agencies plan and fund housing solutions?** Keeping seniors out of long term care can save these agencies millions, and they may be able to effectively enlist MCO and hospital engagement.
- **What is the role of local governments?** This includes agencies responsible for shelter and homeless services, recruitment, and deployment of housing solutions. Can local homeless programs contribute to housing intervention costs through the substitution of shelter funding for housing assistance?

Conclusion:
Let's not wait for a grand plan

We don't have to wait to get started. Forward thinking organizations can start targeting seniors experiencing homelessness today — particularly those showing up in emergency rooms and shelters. They can expand resources for rapid rehousing, case management, and various housing programs. Many people experiencing homelessness will be discharged from hospitals into expensive nursing homes because they are not well enough to return to the streets. Unfortunately, these nursing home stays often only function as a temporary form of rehabilitation, until the senior can be returned to a shelter.

We know that providing long-term services and supports today will help prevent higher costs in the future. A logical starting point is to expand services for people over 65, where we already have resources, programs, and staffing in place. The next step could be to expand those services. Greater availability of meal supports, home care, and rent subsidies would allow many seniors at risk of homelessness to remain in their homes.

There will soon be twice as many homeless seniors between the ages of 60 to 65 as the 65+ cohort – and there will be three times as many who are 55 to 60. Building capacity now for the 65-and-over group will start to create capacity for the larger populations coming right behind them.