'Care In Your Heart': Homeless Health Care Costs Prompt Experiments On The Margins

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BOSTON -- The first time Ron died, he had already been in the emergency room dozens of times.

He was 62 when he suffered that first heart attack in 2010 and momentarily flatlined. It happened again two months later, the result of years of drugs and alcohol abuse that left him homeless, uninsured and forced to rely on the ER for nearly every medical need he had collected during some 30 years of living on the street.

Ron, who agreed to speak with The Huffington Post on the condition that his last name be withheld, is an extreme case. A bipolar alcoholic and crack addict, he is wiry and worn at 64. Extreme or not, cases like Ron's place a significant burden on local health care systems. And for countless men, women and children themselves, homelessness is an insurmountable sentence to a lifetime of poor health and inadequate care -- both of which can feed on one another in an unforgiving cycle.

"Being homeless is not a nice life to be living," Ron says. "I'm constantly fighting with the devil."

Radical poverty puts enormous stress on the U.S. health care system, which often struggles to address poor patients' most basic needs. People who live in what the Centers for Disease Control and Prevention calls "low socioeconomic circumstances" are far more likely to engage in unhealthy behaviors, have limited access to health care, get poorer quality of care and, not least, simply wither and die.

For overworked emergency rooms and underfunded safety-net hospitals, chronic conditions are particularly hard to treat. In many cases, preventative care is all but a fantasy. As a result, low-income Americans are much more prone to preventable hospitalizations, to the tune of $6.7 billion and 1 million hospital visits per year, according to the federal Agency for Healthcare Research and Quality.

Once extreme poverty leads to homelessness, things get even worse. Homeless patients are less likely to seek out or have access to follow-up care or fill critical prescriptions, resulting in numerous return visits for the same problems. Research in the *New England Journal of Medicine* suggests that homeless hospital patients generally stay at least four days longer per visit, which can mean thousands a pop to a safety-net hospital teetering on the edge of bankruptcy.

"It's a horrible mess," says John Lozier, executive director of the National Health Care for the Homeless Council, "and it all becomes more pronounced with the longevity of homelessness."

Though precise data on the U.S. homeless population is fuzzy, the Department of Housing and Urban Development states that of the 636,000 Americans it estimates spent a night homeless last January, roughly 1 in 6 were chronically homeless, beginning another cycle from the street to a shelter, an emergency room or jail.

Within that group, many battle a complex "trimorbidity" of health problems, including substance abuse, mental health issues and chronic conditions like diabetes and heart disease exacerbated by years on the street. According to the not-for-profit housing-placement group Pathways to Housing, chronic homelessness cuts average lifespan by about 25 years.

Policy prescriptions for long-term homelessness have languished for decades. In the past two years, however, a radical pilot program launched by Boston Medical Center has helped top ER users like Ron more proactively, betting their health will improve with a permanent roof over their heads.

In addition to housing, the pilot program -- known as High Utilizers of Emergency Services to Home, or HUES to Home -- seeks to provide the most frequent homeless visitors to Boston Medical, a 508-bed, private, nonprofit safety-net hospital in the city's South End, with intensive case management, helping them get sober or get treatment for mental illness.

"You and I, and most of us who have a place to go to if we're sick, you know, have to deal with the disease," says Andy Ulrich, Boston Medical Center's executive vice chair of emergency medicine. "When you take that same medical condition, or that same psychiatric condition or that same level of substance abuse and you add to it that they're living under a bridge somewhere or they're living in the shelters, it adds to the complexity and difficulty."

Added complexity also means added costs. From October 2009 to June 2010, Medicaid reimbursed Boston Medical for more than $3.6 million in costs, excluding costs from other ERs and respite centers, as well as claims not yet paid. At that rate, a year's care would cost those 35 patients a combined $5.4 million, an average of roughly $155,000 each.

"You're talking about the most addicted, the most mentally affected people," says Boston city councilor Mike Ross who, in 2009, convened a city council meeting championing permanent supportive housing, and who, along with city mayor Thomas M. Menino, supported the HUES to Home program.

"These aren't choirboys," Ross admits. "Some of these people have done bad things."

Two years in, the program is still relatively unproven. Internal data suggests that participants have seen substantial drops in key measures like ER usage and calls to EMS. Yet the actual cost savings of those changes remains undetermined, and participants continue to battle serious, even life-threatening, addiction and other health issues. Meanwhile, more traditional homeless advocates argue that such funding is better spent on more broad-based shelters.

Still, even in these incipient stages, the program's directors and participants say even the smallest signs of success are promising, given the scope of the challenges the chronically homeless face.

"In all of the shelters, in the street life, in the places I've been, there's a lot of people out there that need help, believe me," Ron says. "We really, seriously need some help."

'I'M SICK OF GOING DOWN'

One of the program's first 11 patients to be housed, Ron says his problems began early, though he offers varying accounts of just how early. He first says he began taking harder drugs when he was 13, then later says he was 6. Before that, he says his parents gave him his first alcoholic drink at age 4.

Ron is more consistent on the question of what he has taken: a lot. Alcohol and crack cocaine were long his drugs of choice, but he has also dabbled in heroin and says he has chugged motor oil, even hand sanitizer, to get high.

Equally challenging for Ron: his history of mental illness. He says he first received a diagnosis of bipolar disorder when he was 18, and has treated it with medication off and on since the late 1980s. He tears up when he talks about how difficult that has been, saying he has a devil inside of him that he just can't beat.

"I'm tired of going down, if you know what I mean. I'm sick of going down. Every time I pick up a drink normally within the first three or four days, I'm okay," Ron says one brisk March day, seated on two bare, cornflower-blue mattresses piled on the floor of his studio apartment. "After that, once I pick up the drink, I'm gone, forget it. I don't eat. I don't do nothing right."

When he is on the street, Ron says, he hangs out with the wrong people and can be an angry, abusive drunk.

He is trying to do better. A student of metaphysics, he has a copy of Robert Wolke's "What Einstein Didn't Know" along with the Alcoholics Anonymous Big Book on his bureau, among a mess of loose, wrinkled papers and plastic bags. Though he doesn't call himself smart, "I try and advance my knowledge as much as possible," he says, "because I don't want to be considered a fool."

He's no stranger to gainful employment, either. Before becoming homeless, Ron spent 16 years cleaning parks and streets in Boston's Public Works department and driving a cab at night. A few years ago, he took some community college courses, though he did not receive a degree.

But time and again, addiction, mental illness and Ron’s own bad choices have dashed his plans and left him homeless. At times he has stayed in the woods, an elevator shaft or, more

commonly, one of Boston's shelters. Years ago, substance abuse cost him housing assistance from the Boston Housing Authority and a local nonprofit.

His new apartment, where he has lived for three months, provided by HUES to Home, is sparsely furnished but meets his needs. Near a messy glass table sits a small TV, and past the bureau, in a corner near the bathroom, a wide, blue recliner has been piled with clothes.

The mess hints at Ron's ongoing struggle. In February, he was admitted to the hospital four times in several days. "Ron was in crisis," his case manager, Ezequiel Lopes, says. He recovered from that bender, and received care for a hurt leg in a 'temporary respite' care center run by the nonprofit Boston Health Care for the Homeless Program.

A place to call home hasn't solved all of Ron's problems. His home holds reminders of his failures: A cardboard box near his front door, under a handwritten sign that reads, "Love has the capacity to change any situation," holds an empty bottle of Listerine, which he drank during his most recent setback.

But Ron says he's been clean for up to three years at a clip, and he sees housing as key. "If I stay out there in the damn street, I'm going to screw up sooner or later," he says. "I can only stay out there for so long -- after a while, I just say 'To hell with everything, I don't care.' You've got to have some care in your heart."

'**HOUSING FIRST**'

While HUES to Home is a new program, its core ideas have been gaining sway for the past three decades in U.S. homelessness policy circles.

Once a fringe notion, the 'housing-first' or 'low-threshold' housing model is built around providing the chronically homeless a permanent home as a starting point for patient treatment, support and addiction services. Brief relapses do not cost patients their homes.

"We know that provision of housing for people is one of the major things that we can do to help address behavioral health problems and to reduce these somatic health issues," says Paolo del Vecchio, acting director of the Center for Mental Health Services with the Substance Abuse and Mental Health Services Administration.

"I say over and over again, this is not the easiest way, this is the hardest way," says Joe Finn, president and executive director of the Massachusetts Housing and Shelter Alliance. "But it's also the most effective way."

Finn helped launch Boston's first major housing-first initiative, Home & Healthy For Good, which has helped house 555 chronically homeless Bostonians since its inception in 2006. According to internal surveys that asked participants to rank factors like how pleased they are with their lives on a scale from "very dissatisfied" to "very satisfied," respondents' overall life

satisfaction has increased by nearly 35 percent, while health satisfaction has increased by 22 percent.

Del Vecchio warns, however, that housing-first is not the best model in all cases. Many people benefit, he says, from more traditional transitional group settings designed to get them sober or clean before moving forward.

"There are different models and approaches, not just housing-first," Del Vecchio says. "The recognition now is that we need to have approaches that can be individualized and states need to use a variety of models."

As housing-first has gained support, the custodians of more traditional models have often been the loudest voices of opposition. One of their primary complaints: It tends to provide disproportionate support to the chronically homeless, a minority of the homeless population, instead of using that money to fund broader aid programs. "It's the notion that you're prioritizing one sub-population over another," says Neil Donovan, executive director of the National Coalition for the Homeless.

"It has become accepted wisdom that housing-first works and that it saves money," says Patrick Markee, a senior policy analyst for the coalition. "But the tendency to say 'This is the stuff that works' can de-emphasize the need for emergency shelter. At this time of economic crisis, when you've had many more people becoming homeless and turning to the shelter system in crisis, it's important to maintain that vital safety net and not divert essential resources."

While they serve far fewer people, the model's proponents say housing-first programs are a more efficient use of funds. According to Pathways to Housing, a New York City-based program that has placed more than 2,000 people in homes since 1992, each program user costs the city $57 per night, versus $73 per night to keep someone in a shelter, $164 per night for jail and $519 for a night in the ER.

Pathways boasts retention rates somewhere between 85 and 90 percent, relying on funding that comes from government and other grants, Medicaid, private contributions and client rent payments. In 2011, the program's operating revenues totalled more than $23 million, with more than $1 million provided by clients.

Academic studies have also supported the cost-efficiency arguments of housing-first advocates. A 2009 paper published in the *Journal of the American Medical Association* reported that total costs for 95 chronically homeless patients with severe alcohol problems fell by more than $4 million following one year of permanent housing assistance in Seattle.

"Reductions in health care and criminal justice system use and costs and alcohol consumption support expansion and replication of this low-threshold approach," the paper's authors wrote.

MISSING PIECES

Still, the relative value of housing-first initiatives can be somewhat difficult to measure, because most emergency rooms, for example, do not collect detailed information on the lives of their patients, chronically homeless or otherwise.

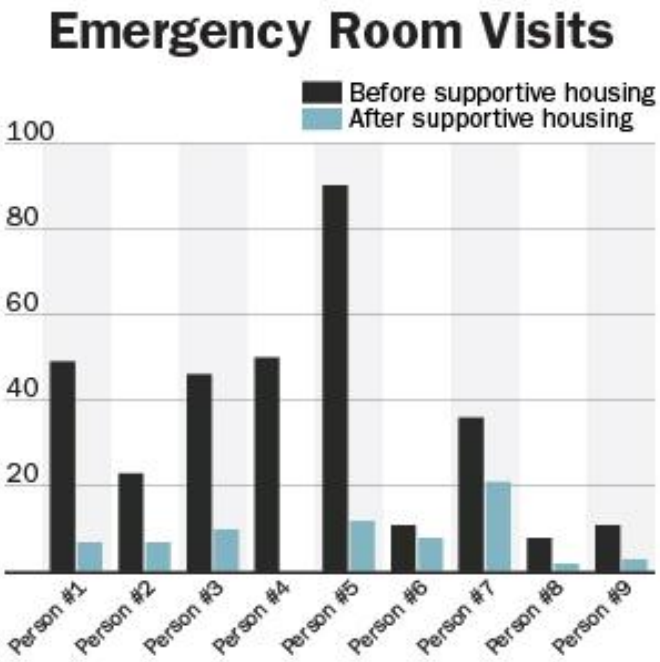
"Hospitals, in general, don't often think of it as their role to reach out beyond their walls and really try to affect the patients," says Jessie Gaeta, director of the Boston Health Care for the Homeless Program and a faculty member at the nearby Boston University Medical Center. "In the institution of medicine in general, there can be this emphasis on the biological rather than the social determinants of health."

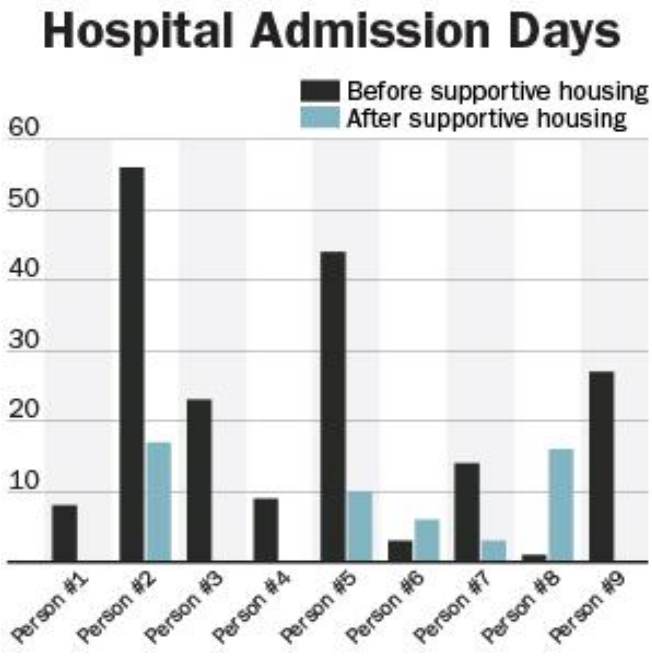
Boston Medical has been one of the first to change that. Before joining forces on HUES to Home, the hospital identified patients for the program by tracking its most frequent ER visitors -- those regularly making several appearances in a single week, often drunk or high.

Lozier says lobbying hospitals to track such information is a major focus for his organization, but it has been slow going. "They're slammed, for starters," he says, "and their data systems aren't necessarily set up to handle it."

Health care providers are also not typically trained to deal sensitively with a homeless patient's non-medical background, Lozier notes. "Asking 'Are you homeless?' is a tricky question," he says. "There's all kinds of stigma and definitional issues involved."

The 'before' and 'after' data from the first round of HUES participants may strike hospitals as compelling enough to start training in greater earnest. Most spent fewer days in the hospital and an overwhelming majority made fewer emergency medical calls. After receiving housing, one patient who had visited the emergency room 50 times the year before didn't see the inside of an ER a single time in 10 months.





Researchers have yet to translate these results to concrete dollar figures, but Ross says he expects millions in savings every year, particularly as other area hospitals get involved.

"The concern can be, 'Where does this end? If we do this for 35 people, do we have to do it for 3,500 people?' At some point, we can make that determination," Ross says. "What I'm suggesting is that we find the top 50 or so people every year and give them the help they need. Instead of spending $4 million, we spend $1 million on housing and a social worker."

Progress is slow. Despite the tentative success of the HUES pilot, heartwarming stories of chronically homeless patients are still rare in the ER.

"A very difficult part of working with this population is the repeated -- I don't want to say failures -- but the repeated events that you feel like you're not accomplishing anything and you're right back where you started," says Ulrich, Boston Medical's emergency medicine executive vice chair. "As an ER physician, that's a very, very frustrating part of the job."

AN UPHILL BATTLE

HUES to Home recently hired two new case managers for its 20-odd patients it hopes to start housing soon, but before that Lopes was the sole case manager for the first 11. Seated in a spartan conference room on the second floor of the Woods Mullen Shelter across the street from Boston Medical, Lopes and several members of the Boston Public Health Commission discuss the program's first round of successes and failures, which often overlap.

The city's busiest shelter, Woods Mullen also sits adjacent to the temporary respite care house. Communication among those sites, as well as the police and emergency medical responders, has proven essential to keeping tabs on patients, Lopes and the others say. Though the leaders of the various agencies say their model could be replicated elsewhere, that level of collaboration, with so many moving parts, is a high bar to clear.

And HUES doesn't always clear it. One patient suffering from alcohol and drug abuse was housed in a single-room occupancy apartment for nine months and saw his ER visits drop dramatically -- from 90 to 12. "He did very well," Lopes says, "and then he went into this depression and started drinking."

"At one point, he was really drinking, and drinking too much, and I'm not sure exactly what happened," Lopes says. "I went over there two days in a row and knocked on the door, and he didn't answer. And then the house manager found him dead."

While they don't pretend these are victories, some administrators say they take comfort in knowing such patients didn't have to live out their last days on the street.

"Well, you know, he died in his home," says Beth Grand L'Heureux, a director of the commission's homeless-service bureau. "In his last nine months, he had a quality of life that was different."

Of course, cost savings aside, it can be challenging to measure success, with Ron or others.

Another member of the first HUES patient group, Paul, 46, is trying to find a way. The native Bostonian worked with Lopes to find housing that he thought would be a good fit, settling on a room in a three-bedroom apartment he shares with a local woman and her 13-year-old granddaughter.

A longtime alcoholic, Paul suffers from neuropathy, severe nerve damage exacerbated by his habits. A former carpenter who built houses, he has lost all feeling in one of his hands. "Most of it's because of drinking," he says.

He may not have gotten sober, but he has tenancy. He is not exactly healthy -- he was back in temporary respite care, wheelchair-bound, for several weeks in late March -- but at least he is not on the street where once he was so drunk, and it was so cold, that the tip of a finger fell off his right hand without him noticing.

The program leaders say that having made contact with him and cemented his trust, they can help Paul get more appropriate services and coordinate with one another to prevent tragedy if he starts to slip, a possibility he confronts daily.

"The drinking is the hardest. I can stop, it's a matter of staying stopped," Paul says. "It's a thing I've had all my life. I'm always going to have it."

Ron knows his struggles will likely continue. "It's not easy. Like I said, I got this alcohol, drug situation. I'm bipolar. I always wondered, 'What the hell is wrong with me?'" he says. "I can't understand it. It's crazy."

But, he is quick to add, he is glad to have a home. "Living on the street is not a beautiful life," he says, "in no kind of way, shape or form."