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Dennis Culhane's primary areas of research are homelessness, assisted housing policy, and policy analysis research methods. His current work includes studies of the dynamics of homelessness among families and adults, and the impact of homelessness on the utilization of health, education and social services. He is the Director of Research for the U.S. Department of Veterans Affairs's National Center for Homelessness among Veterans. He is also working with several states and cities to develop preventative approaches to homelessness, including "rapid exit" and community-based housing stabilization programs.

Policy Brief: The Aging of the Adult Homeless Population: Implications for Health and Housing Policy[1]
Prepared for: The US Interagency Council on Homelessness
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Problem Statement:

The demographic composition of the single adult homeless population in the US reveals striking evidence of a "cohort effect" – the problem disproportionately impacts persons born between 1954 and 1966 (Culhane, Metraux & Bainbridge, 2010). As shown in Figure 1, this was true in 1990, when this cohort had a mean age of 30, and it was true in 2010, when their mean age was 50. The excess risk for homelessness associated with this cohort is evident in Figure 2, in which the age distribution of the adult homeless is compared to the general population.[2] Based on other research, it is estimated that adults who are chronically homeless have a life expectancy of 62 years (Metraux et al, 2009). Thus, the predominant subpopulation of people who are chronically homeless will pass through their life expectancy in the next fifteen years, most of them dying in the next 10 years, and with one-third of them dying in the next seven years. With increasing age and approaching mortality, rates of morbidity will increase sharply, chronic disease management issues will multiply, and health care costs will grow accordingly. Given that many of these persons will not be able to be managed medically in a homeless setting, hospitalization and nursing home costs could rise substantially.

Opportunities from Evidence-based Interventions:

Permanent supported housing (PSH) is an established evidence-based practice that reduces homelessness and prevents recurrence in most cases over two years (see Campbell Collaborative review, Anttila et al, forthcoming). The intervention has also been found to reduce health care costs through reduced acute care services use, and improved chronic disease management (see Culhane, 2008 for a review). Indeed, cost-offsets equivalent and greater to the costs of PSH programs are estimated to be achievable with the top 20-30% of acute care health service users within the first year of placement (Flaming, Matsunaga & Burns, 2009; Poulin et al., 2010). Even more importantly, significant cost avoidance opportunities are possible among those whose current costs may be low, but which can be expected to rise substantially over the next ten years, if appropriate housing and support options are not provided.

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[1] Data for this brief were made available through a special tabulation request from the US Bureau of the Census; special thanks are owed to David Langdon for facilitating the 2010 special tabulation, and to Annetta Clark Smith for facilitating the 1990 and 2000 special tabulations.
[2] Figures are for adult males only. Data for females are not included because the females are predominantly homeless mothers with children, and would obscure the pattern among single adults. It was not possible with the Census data to separate household types. It is expected that the female adult homeless who are unaccompanied by children have a similar age distribution to that of the men, and are similarly aging, based on data from New York City.

Critical Time Intervention (CTI) is another evidence based practice (for example, see Herman et al., 2009) that may provide a more efficient, but equally effective approach to some of the supportive service needs of persons transitioning from chronic homelessness to housing. The intervention is time-limited and focused on achieving housing stabilization and improved independent living skills within a nine month period. The nature of the intervention may fit well as a reimbursable service by Medicaid under the Home and Community based waiver or as an eligible service under a defined benefit package targeting persons who are chronically homeless. Consideration and guidance should be given these and related opportunities.

Recommendations:

Develop guidance for states as to how the ACA can be used to leverage Medicaid resources on behalf of the housing stabilization and supportive services needs of persons transitioning from homelessness to housing, including CTI.

More housing vouchers are clearly indicated and more funding through the McKinney-Vento Homelessness Assistance Act to enable communities to rehouse people experiencing chronic homelessness.

Expanded SSI outreach and enrollment could lead to improved housing incomes. SSI income and improved supplements to SSI by states could enable many people who are chronically homeless to afford placements in rooming houses and boarding homes. Indeed, given the urgency and magnitude of the need, communities may be encouraged to master lease units and buildings for this purpose, and coordinate services accordingly.

While many communities have created 10-year plans to address homelessness, in light of the new data, communities could be asked to develop specific methods and timelines for achieving these objectives within the next three years, and in accordance with the timeline of ACA implementation in their states.

Figure 1- Distribution, by Age, of Male Shelter Users in the US, 1990, 2000 and 2010 (US Census)

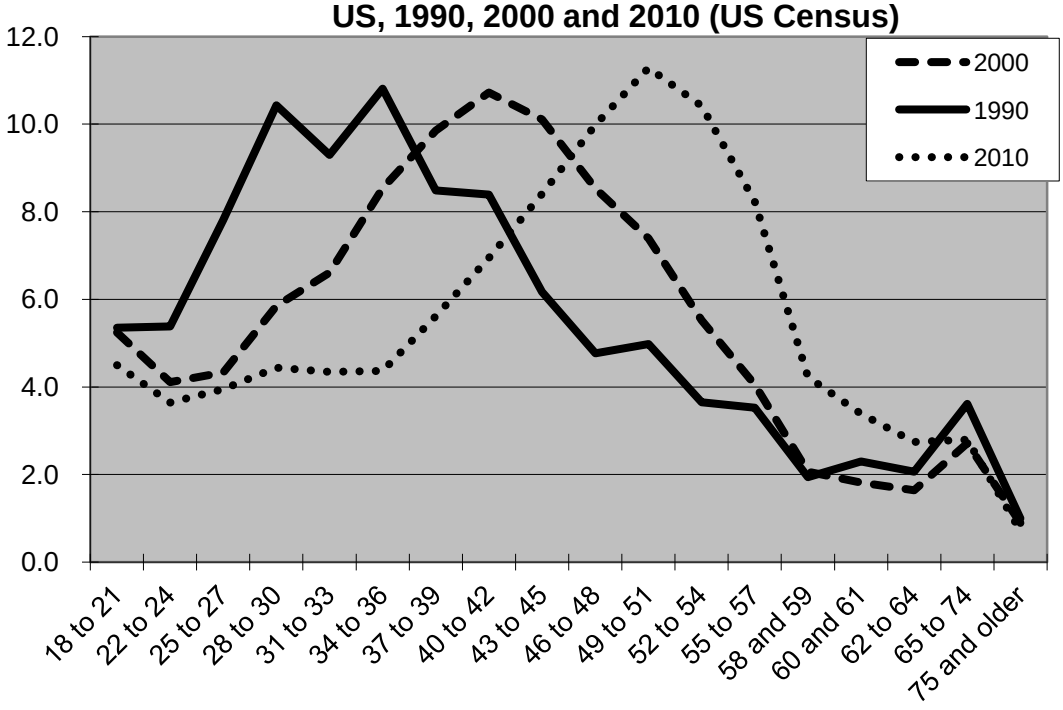
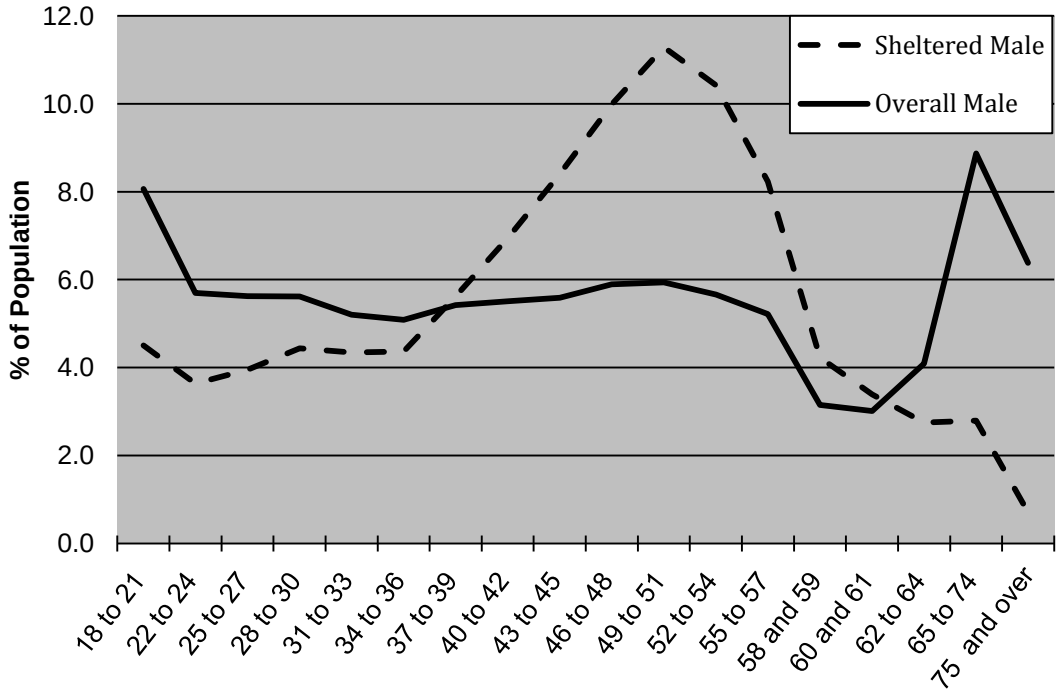


Figure 2-Age Distribution for Males in 2010 -Overall and Sheltered Populations (US Census)



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