Toward Thriving

Understanding Health and Homelessness

Findings from the California Statewide Study of People Experiencing Homelessness

Benioff Homelessness and Housing Initiative

UCSF

University of California San Francisco

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Executive Summary

PEOPLE EXPERIENCING HOMELESSNESS IN CALIFORNIA FACE HIGH RATES OF CHRONIC ILLNESS AND DISABILITY, and numerous barriers to care. Nearly half of adults experiencing homelessness rate their health as poor or fair—about four times the rate in the general U.S. population. These health challenges make it harder for people to obtain and retain housing, and homelessness worsens health, trapping people in a vicious cycle. As the homeless population ages, these burdens deepen, with profound implications for individuals, communities, and the systems that serve them. **California's homelessness crisis is a public health crisis**, demanding coordinated responses across housing, healthcare, and social service systems.

Drawing on data from the California Statewide Study of People Experiencing Homelessness (CASPEH), the largest representative study of homelessness in the United States in 30 years, this report presents findings on the physical health of people experiencing homelessness, how they use the healthcare system, and recommendations to address these challenges.

WHO EXPERIENCES HOMELESSNESS AND POOR HEALTH

Individuals with extensive life-course adversity, limited access to healthcare, and prolonged exposure to poverty and discrimination face the highest risk of poor physical health. Many enter homelessness already in poor health; homelessness worsens health outcomes.

- Nearly half (45%) of California adults experiencing homelessness rated their health as poor or fair—four times the rate in the general U.S. population.
- Poor health was common across all age groups, increasing with age: 28% among those 18–24, 40% among those 25–49, 55% among those 50–64, and 46% among those 65 and older reported their health as poor or fair.
- Cisgender women reported poor or fair health more often than cisgender men. Despite being younger on average, Latine adults were as likely as other groups to report poor or fair health.
- People with complex behavioral health needs—regular drug or heavy alcohol use, hallucinations, or recent psychiatric hospitalization—were more likely report poor or fair health (51%) than those without (41%).
- Over three-quarters (78%) of homeless adults spent most nights in unsheltered settings; 57% outdoors and 21% in vehicles. Those living unsheltered reported health outcomes similar to those in shelters, highlighting the significant health challenges people face across settings.

CHRONIC HEALTH CONDITIONS

Chronic and life-limiting illnesses—such as hypertension, diabetes, and heart disease—are widespread among adults experiencing homelessness. Without regular care, these conditions can lead to disability and premature death.

- Sixty percent (60%) of adults experiencing homelessness reported at least one chronic condition; 16% reported two; 12% reported three or more.
- Rates of multiple chronic diseases increased with age. Among adults 50 and older, more than one in six (18%) reported three or more chronic health conditions.
- The most common illnesses were hypertension (30%), chronic lung disease (25%), and heart disease or stroke (15%).

TOBACCO USE

Tobacco use is widespread among adults experiencing homelessness, reflecting both the stresses of homelessness and limited access to cessation support. Smoking contributes substantially to the high burden of chronic disease, respiratory illness, and early mortality in this population.

- Seven in ten (70%) adults experiencing homelessness in California were current smokers—a rate six times higher than in the general U.S. population.
- Just one in ten (10%) were former smokers, reflecting the difficulty of quitting while experiencing homelessness.
- People who were unsheltered were more likely to smoke than those who were sheltered. Among people who were unsheltered, 58% smoked daily and 17% smoked some days; among those who were sheltered, 42% smoked daily and 12% smoked some days.

FUNCTIONAL LIMITATIONS AND DISABILITY

Functional impairments make daily life—and escaping homelessness—far more difficult. These disabilities can both contribute to and be worsened by homelessness, creating a cycle that deepens health challenges and housing instability.

- Over one-third (34%) of adults experiencing homelessness reported difficulty with at least one activity of daily living (ADL), such as bathing, dressing, toileting, transferring, or eating.

- Among adults 50 and older, nearly half (43%) had at least one ADL limitation, and 23% had three or more.
- Mobility limitations were common. Nearly one in four (22%) reported difficulty walking across a room; among adults 50 and older, 32% did.
- Twenty percent used a mobility aid such as a cane, walker, or wheelchair— 32% of adults 50 and older did. Participants frequently reported losing or having these aids damaged during thefts or encampment sweeps.
- Two-thirds (66%) of people with mobility or ADL impairments reported their accessibility needs created a barrier to finding housing.

ACCESS TO HEALTHCARE

Most people experiencing homelessness have health insurance, almost all of whom had Medicaid (known as Medi-Cal in California). Despite this, significant barriers prevent them from accessing care.

- Eighty-three percent reported having health insurance, primarily Medi-Cal. Despite this, only half (52%) had a regular place for care other than the emergency department.
- Just 39% had a primary care provider. Those who were sheltered were more likely to report having a primary care provider (53%) than those unsheltered (35%).
- Half (49%) had received care from an outpatient setting (not including the emergency department) in the prior six months.
- Nearly one in four (22%) reported needing healthcare in the prior six months but being unable to obtain it.
- People experiencing homelessness reported multiple barriers to receiving needed healthcare. These included lack of transportation, limited access to phones or internet, difficulty managing appointments, stigma, and fear of losing belongings during absences from encampments.
- Nearly one-quarter (22%) reported being unable to fill needed prescriptions; among people with an ADL limitation, 32% did.

EMERGENCY DEPARTMENT AND INPATIENT CARE

Poor access to primary care and the high burden of illness among people experiencing homelessness led to high use of the emergency department and inpatient hospitalizations.

- Over one-third (37%) of adults experiencing homelessness visited an emergency department (without being admitted) in the prior six months.
- One in five (21%) had been hospitalized for a physical health condition in the prior six months.
- High emergency and inpatient use reflect the high burden of illness and limited access to preventive and outpatient care.
- Some participants were discharged from hospitals to unsheltered settings, endangering recovery. Others accessed recuperative care programs that provided medical stabilization and expedited housing for some.

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Policy Recommendations

Based on the findings from this report, we provide recommendations for the healthcare system (including Medicaid) and the homelessness and housing response system.

People experiencing homelessness face a disproportionate burden of poor health while confronting immense barriers to care. As the homelessness crisis continues, states must build a responsive and integrated healthcare system that meets people where they are. This requires a multi-pronged strategy that ensures stable health coverage, delivers care in non-traditional settings, and adapts the broader health system to meet the unique needs of people experiencing homelessness.

PROACTIVELY ENROLL AND RETAIN PEOPLE IN MEDICAID

Consistent health insurance is the bedrock of access to care. For most people experiencing homelessness, this means Medicaid (known as Medi-Cal in California). We must make it easier to obtain and keep this essential coverage.

- **Expand Enrollment.** Equip healthcare and homeless service providers, including street outreach and shelter staff, with the tools and training to enroll eligible individuals into Medicaid.
- **Ensure Continuous Coverage.** Given new work requirements, healthcare, homelessness response, and social service providers must work together to avoid coverage interruptions.

DELIVER CARE IN NON-TRADITIONAL SETTINGS

Traditional clinic settings can be inaccessible to people experiencing homelessness, whether in unsheltered or sheltered settings. To improve access, policymakers and program leaders must invest in care models that bring services directly to them, build trust, and create a bridge to the broader health system.

Strengthen and Scale Street Medicine

- **Build a Sustainable Financial Foundation.** California's leadership in making street medicine a Medicaid benefit should be replicated and improved upon. States should increase reimbursement rates to reflect the true cost of care, streamline contracting between Medicaid Managed Care Plans (MCP) and street medicine providers, and provide start-up funding and technical assistance to help providers build the capacity for billing. In states like California that already allow Medicaid billing for street medicine, MCPs should employ direct access contracts with street medicine providers. States whose Medicaid programs do not yet allow billing for street medicine should adopt best practices from those that do.
- **Integrate with other benefits and services.** Street medicine is most effective when it serves as a trusted entry point to a broader system of care that addresses a person's full range of health and social needs. Blend street medicine with initiatives like California's Enhanced Care Management program and Community Supports. This creates a seamless system where trusted street medicine teams can connect patients to intensive case management and housing navigation services.
- **Expand Service Scope and Uphold Quality.** Encourage street medicine teams to offer a comprehensive range of services including primary care, urgent care, wound treatment, behavioral health services, and medications for substance use disorders like buprenorphine. Street medicine teams should follow the evidence-based standards of care outlined by the Street Medicine Institute and other experts to ensure that care is delivered in a humane, trauma-informed, and effective manner, building the trust required to engage and heal.

Enhance Health Services in Shelters and Interim Housing Sites

Integrate Healthcare into Shelter Settings. Shelters can be critical hubs for health. In addition to inviting street medicine providers and mobile health clinics to shelters, shelters should expand on-site clinics and embed staff from Federally Qualified Health Centers (FQHCs) to provide triage, crisis support, and a direct link to primary and specialty care. Leverage telehealth to expand access to both primary and specialty services, allowing providers to deliver timely care when in-person visits are not possible. Follow best practices outlined by the National Health Care for the Homeless Council, which emphasize on-site staffing, integrated care models, and telehealth to extend specialty services.

CREATE A RESPONSIVE AND INTEGRATED HEALTH SYSTEM

Beyond outreach, the entire healthcare system must adapt to better serve homeless Californians, from clinics and hospitals to pharmacies and health plans.

Adapt Clinic-Based Care to Reduce Barriers

Adopt Proven Models. Clinics serving large numbers of homeless patients should adopt best practices, such as the U.S. Department of Veterans Affairs Homeless Patient Aligned Care Teams (H-PACT) model. This high touch, integrated model includes open-access scheduling, multidisciplinary care teams, and co-located wraparound services.

Integrate Physical and Behavioral Health. Given the high rates of behavioral health conditions, clinics must embed robust mental health and substance use treatment. Conversely, behavioral health providers should co-locate with physical health services.

REIMAGINE ACUTE CARE AND HOSPITAL TRANSITIONS

Enhance Emergency Department (ED) Connections. For EDs that serve a high number of homeless patients, embed case managers to connect individuals with housing and social support. EDs should also offer preventive services like vaccinations, HIV and hepatitis C testing and treatment pathways, and brief smoking cessation services.

Support and Scale Medical Respite. Medical respite programs, also known as recuperative care, often serve as the missing link between hospital discharge and stable recovery — providing access to temporary housing and medical care when people are too sick or frail to heal on the street or in shelters. Through California's Medicaid 1115 waiver Community Supports, Medicaid can be used to pay for some recuperative care costs; several states have adopted similar options. Expanding access to medical respite can prevent hospital discharges to unsheltered settings and promote stable recovery.

Expand Alternatives to the ED. Invest in and expand alternative destinations like sobering centers. These programs provide safe and appropriate care for people who are intoxicated, connect people to services, and prevent unsafe discharges back to the street. Under California's CalAIM Community Support benefit, sobering centers can contract with Medicaid Managed Care programs for reimbursement. Other states can learn from California's model to develop sustainable funding for sobering centers.

Ensure Access to Medications and Essential Supports

Remove Barriers to Prescription Medications. Ensure patients are discharged from emergency departments and hospitals with critical medications. Street medicine teams should be supported by pharmacists who can help navigate formulary restrictions (rules that limit which drugs are covered or require prior authorization), and clinic staff should confirm a prescription is covered and available before sending a patient to a pharmacy.

Provide Essential Supports. Medicaid Managed Care Plans should ensure access to non-emergency medical transportation. Health plans and health systems should leverage Community Supports and Community Benefits to provide services like basic cell phones, so that individuals can schedule appointments, engage in telehealth, and stay connected with their care teams.

Promote Health and Wellness Through Targeted Interventions

Support Smoking Cessation. Given the high rates of tobacco use, shelters and outreach teams should be trained and equipped to offer evidence-based smoking cessation support, including counseling and nicotine replacement therapy. This improves individual health and reduces secondhand smoke exposure in congregate settings. To reduce second-hand smoke exposure, shelters should be smoke-free. To decrease barriers to shelters for people who smoke, shelters should make smoking areas accessible but provide low-barrier smoking cessation counseling.

Strengthen Access and Care Quality Through Culturally Responsive Care

Because people from racially marginalized groups are overrepresented among those experiencing homelessness, have higher rates of poor health, and face unique barriers to care, health systems must be intentionally designed to deliver care that is culturally and linguistically responsive and that builds trust across communities.

Expand Culturally and Linguistically Responsive Services. Expand access to bilingual clinicians, interpreters, and care coordinators. Fund community health worker programs to deliver outreach, health education, and preventive care in trusted community settings.

Diversify and Train the Healthcare Workforce. Recruit and retain healthcare workers who reflect the communities most affected by homelessness and health inequities. Ensure that all healthcare and behavioral health providers—including those in street medicine and shelter-based settings—receive ongoing training in cultural humility, trauma-informed care, and structural competency to strengthen trust and improve quality of care.

Ensure Access Regardless of Immigration Status. Work to ensure that all people—regardless of immigration or documentation status—can access health services.

ENHANCE ACCESSIBILITY AND HEALTH CONNECTIONS IN SHELTERS AND OUTREACH

For many, the first point of contact with the response system is an outreach worker or an emergency shelter. These critical entry points must be equipped to serve an aging population with high rates of mobility and functional limitations.

Ensure Physical Accessibility and Safety. Shelters must be equipped to welcome and support individuals with disabilities. This includes providing wheelchair-accessible facilities, beds, and bathrooms to ensure safety, preserve dignity, and prevent further injury.

Empower Staff as Healthcare Connectors. Homeless outreach and shelter staff are trusted messengers. They should be trained and resourced to help clients enroll in Medicaid, understand their benefits, and connect with local healthcare providers.

Deliver Supportive Services in Shelters and Encampments. Extend Medicaid Home and Community-Based Services (HCBS)—such as personal care assistance—to unsheltered and shelter settings, enabling people to manage daily activities and maintain independence.

Recognize Technology as a Lifeline. Access to a charged cell phone and the internet is a healthcare necessity. Shelters and drop-in centers should provide reliable charging stations, internet connectivity and support, so clients can schedule appointments, participate in telehealth visits, and communicate with their care teams.

To better serve an aging population as well as people with increasingly complex physical health conditions and disabilities, our homelessness response system must evolve beyond providing basic shelter and orient itself toward meeting the needs of individuals with significant health challenges. This requires intentionally integrating healthcare principles, accessibility standards, and supportive services into every aspect of the system, from street outreach to permanent housing.

CREATE ACCESSIBLE AND SUPPORTIVE HOUSING FOR THE LONG TERM

The ultimate goal is to help people move into stable housing that can support their long-term health and well-being. This means expanding the availability of housing that is not only affordable but also physically accessible and linked to the services people need to thrive.

- **Increase the Supply of Accessible Housing.** Policymakers must use every avenue to increase the supply of deeply affordable housing. To meet the needs of an aging population, there is a need for accessible units.

- **Integrate Proven Models of In-Home Support into Permanent Supportive Housing (PSH).** Permanent supportive housing programs should expand their ability to house people with significant functional limitations, scaling promising models like CAPABLE, which helps residents adapt their homes and routines to remain independent. Medi-Cal should provide coverage for these types of services in PSH settings to support residents' health and prevent unnecessary and costly moves to institutional care like nursing homes.

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Introduction

People experiencing homelessness face threats to their health and safety.

Homelessness and health are interconnected: health issues can decrease people's ability to afford housing and increase their risk of homelessness, and homelessness has numerous direct and homelessness negatively impacts health.

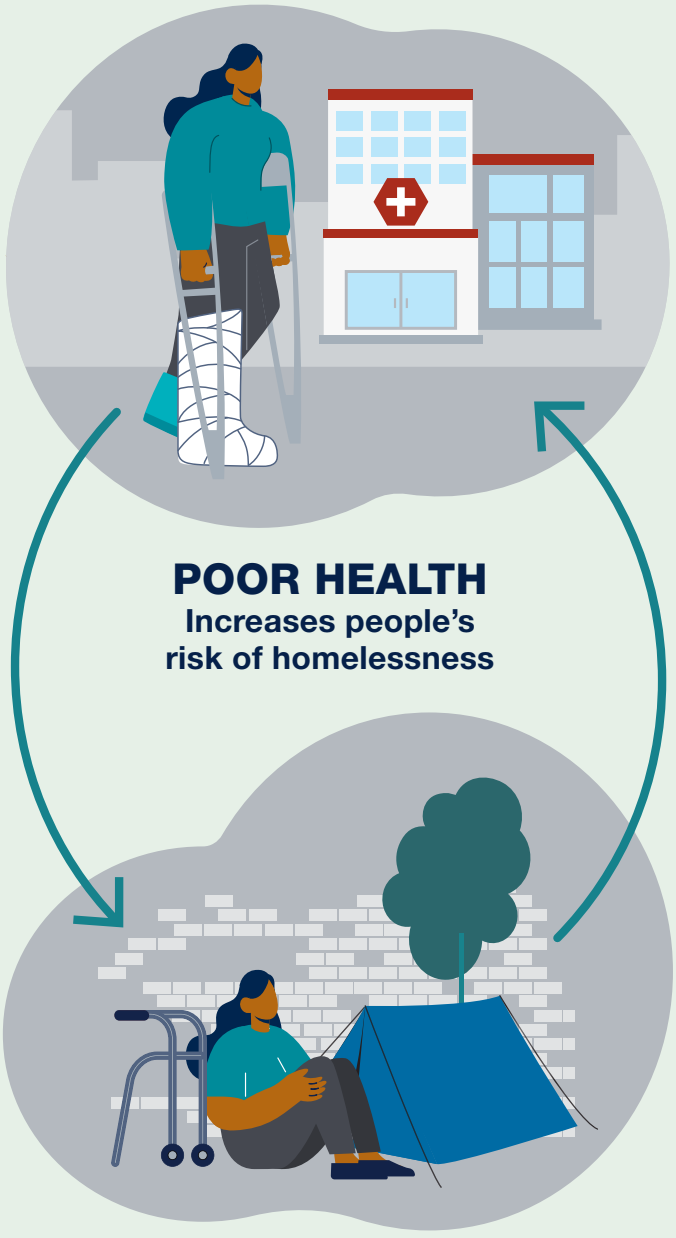
The main driver of homelessness in any community is the lack of housing that people with the lowest incomes can afford. However, individual vulnerabilities can increase a person's risk of becoming homeless by interfering with their ability to compete for housing in an expensive market.

People with extremely low incomes —those earning less than 30% of the Area Median Income (AMI)—are at the highest risk of homelessness. They are more likely to be in poor health than those with higher incomes due to factors like chronic stress, exposure to racism, unsafe working conditions, and a lack of access to healthy food, exercise, a healthy environment, and healthcare. Illness—whether acute or chronic—can interfere with a person's ability to work or lead to unexpected medical expenses, increasing an individual's risk of homelessness. Mental health and substance use disorders, and prior trauma can increase one's risk of homelessness and lead to physical health problems. The interconnectedness of health and homelessness is especially true for older adults who enter homelessness more often due to health crises and are more profoundly impacted by the effects of homelessness on their health.

Homelessness negatively impacts health, directly and indirectly. The environmental conditions of homelessness—including exposure to the elements and violence, inability to store medications, lack of hygiene facilities and healthy food, disrupted sleep, and stress all take a toll on health. People experiencing homelessness struggle to get appropriate and timely medical care; without transportation, a way to receive messages, and access to the internet, they struggle to schedule and attend appointments. With enormous competing demands on their time as they struggle for shelter and food, healthcare often takes a backseat to more urgent needs.

Thus, people in poor health have an increased risk of homelessness and homelessness worsens health, creating a vicious cycle. Combined with significant barriers to healthcare, it is unsurprising that people experiencing homelessness are in poor health and rely on acute care settings such as emergency departments and hospitals for treatment. The aging of the homeless population has worsened these issues.

Drawing on data from the California Statewide Study of People Experiencing Homelessness (CASPEH), the largest representative study of homelessness in the United States in 30 years, this report presents findings on the physical health of people experiencing homelessness, how they use the healthcare system, and recommendations to address these challenges.



California's homelessness crisis is a public health crisis, demanding coordinated responses across housing, healthcare, and social service systems.

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STUDY OVERVIEW

The California Statewide Study of People Experiencing Homelessness (CASPEH) is the largest representative study of homelessness in the United States since the mid-1990s. Researchers at the University of California, San Francisco Benioff Homelessness and Housing Initiative (UCSF BHHI) recruited a representative sample of adults experiencing homelessness; all respondents (3,200) completed an administered questionnaire. A subset participated in in-depth interviews. UCSF BHHI has released a series of reports, including a comprehensive report; focused reports on intimate partner violence, racial equity (with separate analyses of Black people and Latine people experiencing homelessness), older adults, and behavioral health. BHHI released several shorter topic briefs, including one on pregnancy and unsheltered homelessness. This report looks at the intersection of health and homelessness.

WHO EXPERIENCES ADULT HOMELESSNESS?

Before we delve into health status, it is helpful to understand **who** experiences adult homelessness. For more information, see Toward a New Understanding.

Homeless adults in our study ranged in age from 18 to 89, with a median age of 47.[1] Forty-four percent of all homeless adults were aged 50 and over. In keeping with other studies of homelessness, over two-thirds (69%) identified as cisgender men, 30% as cisgender women, and 1% as trans or non-binary or other gendered. Due to differences in risk factors due to racism and exclusion, Black and Indigenous Californians are overrepresented within the homeless population. In our study, 27% identified as white, 26% as Black, 26% as Latino/a, 15% as multiracial, 3% as Native American, 2% as Asian/Pacific Islander, and 1% as other.

The median length of time homeless during this episode was 22 months. Because the environment of homelessness can be related to health, we asked participants where they spent the most nights in the prior six months. Over three-quarters (78%) had spent the majority of their time in unsheltered settings (21% living in a vehicle and 57% living outdoors, or in a place not meant for human habitation). Only 22% spent most of their nights sheltered.

Health Status

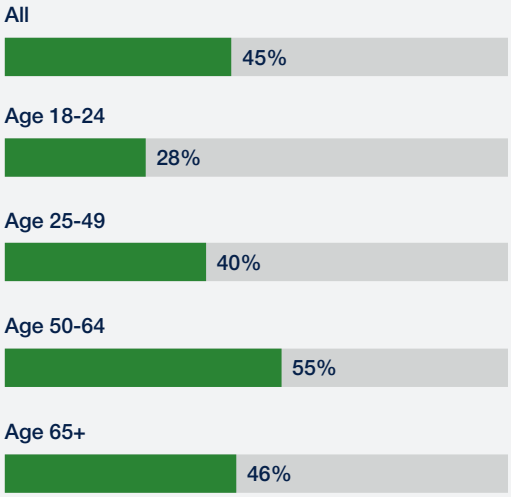
Homeless Californians reported extremely poor health, emphasizing the urgency of ending homelessness.

By every measure, homeless Californians were in extremely poor health, emphasizing the urgency of ending homelessness. When we asked people who entered homelessness from housing what led to their becoming homeless, 9% noted that they lost housing due to health conditions. Some people reported that their health problem led to their losing their job; others reported that health crises that led to long hospital stays caused them to miss paying rent. As one participant said: "Well, I lost my job. Got sick and lost my job. Lived with my sister. I wasn't making any money. She's like, 'You gotta go', so, you know, 'like give me a week and like where am I gonna go? No money'. So I winded up on the street."

One of the most impactful indicators of a person's health is their self-report of their health as "poor, fair, good, very good, or excellent." Self-reported health is powerful because it reflects an overall measure of well-being, including physical and mental health, and one's ability to function. People who report their health as poor or fair are at higher risk of death. We found that a large proportion of those experiencing homelessness reported poor or fair health, demonstrating this vicious cycle. Nearly half (45%) of homeless Californians reported their health as poor or fair—about four times the rate in the general U.S. population (11.2%) and nearly double the rate among those living below the Federal Poverty Level (24.6%).[2]

As is true for all, as participants aged, they were more likely to report their health as poor or fair—but in every age category, homeless adults were significantly more likely to do so than the general population. Among homeless adults, over a quarter (28%) of those 18-24 reported their health as poor or fair (compared to 6.5% in the general population), as did 40% of those 25-49, 55% of those 50-64, and 46% of those 65 and over.

FIGURE 1 Self-Reported Fair or Poor Health Status by Age



"I've been feeling anxiety lately, because of my condition, you know, my breathing and stuff, my heart condition is at 20 percent. It doesn't matter what I do. It is what it is. And I've gotten diagnosed from the specialist and the doctors, and I'm a candidate for a pacemaker, so, I mean, sometimes I get bummed out and stressed out and anxiety kicks in. Sometimes I can sleep and sometimes I can't. Lately I haven't been able to."

Cisgender women—at every age—were more likely to report their health as poor or fair than cisgender men. Despite being younger than other groups, Latine adults were as likely to report that their health was poor or fair as members of other racial and ethnic groups.

In a prior report, we found that nearly half (48%) of homeless adults had one of four conditions—heavy alcohol use, regular drug use, hallucinations, or a recent psychiatric hospitalization, signaling complex behavioral needs. Those with complex health needs were more likely to report their health as poor or fair (51%) compared to those without (41%).

Those spending the majority of time living in shelters reported poor or fair health at about the same rate as those living in unsheltered settings. While adults with health problems may receive priority access to shelters, those with chronic conditions face additional barriers to remaining in shelters. As we outlined in prior reports many people experiencing homelessness want shelter but are unable to obtain it. Some avoid shelters because they judge the risks of shelter as greater than the risks of being unsheltered. These threats include violence, the risk of respiratory illnesses (such as COVID), and poor indoor air quality.

As one participant shared: "I was really sensitive to [smoke]...they didn't really adhere to their own rules about smoking, and... people smoked inside the building and all that."

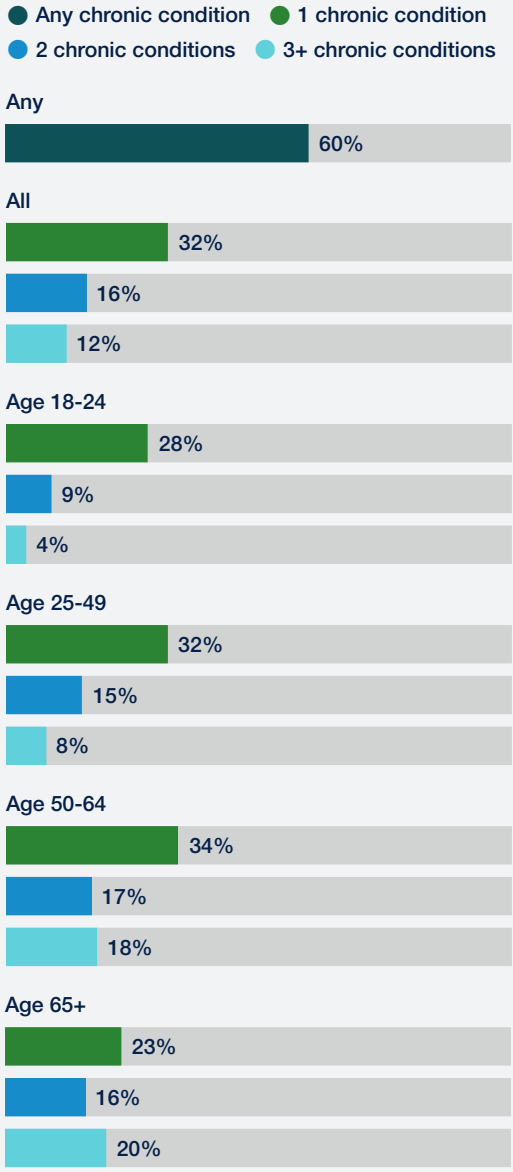
However, unsheltered settings pose numerous threats to health. Some, like exposure to violence and the elements, are well recognized. With extreme temperatures and wildfires increasing due to climate change, these risks have increased. For example, one participant recounted how extreme heat led her to become so sick that she required hospitalization.

"It's 102 out. It's hot. They showed it on a commercial for, 'Don't leave your dogs in the car.' ...that kind of heat is dehydrating you and making you sick on top of being sick already. That's a hazard... when you have to be in a shut-up car ... I ended up with pneumonia ... It turned to poison in my lungs, and then the poison went into my blood... I went septic, and I was like six hours away from dying. An ambulance took me to the hospital because... I couldn't do anything. I couldn't even walk."

CHRONIC HEALTH CONDITIONS

Chronic health conditions—health conditions that are not curable but require ongoing management—present a particular challenge for people experiencing homelessness. Without proper management, these conditions lead to a shortened life span, increased disability, and suffering. Managing these conditions requires regular visits to healthcare providers, adjusting diet and sleep, and taking medications.

FIGURE 2 Self-Reported Chronic Health Conditions by Age



Because a diagnosis requires that one has met with a healthcare provider, many people who have these conditions do not know they have them. We asked all participants about whether they had ever received a diagnosis of one of several chronic conditions, knowing that these estimates understate the true toll of these conditions among people experiencing homelessness.

Overall, 60% reported at least one chronic health condition (32% of homeless adults reported one chronic illness, 16% reported two, and 12% reported having three or more). The likelihood of having multiple chronic conditions went up with age.

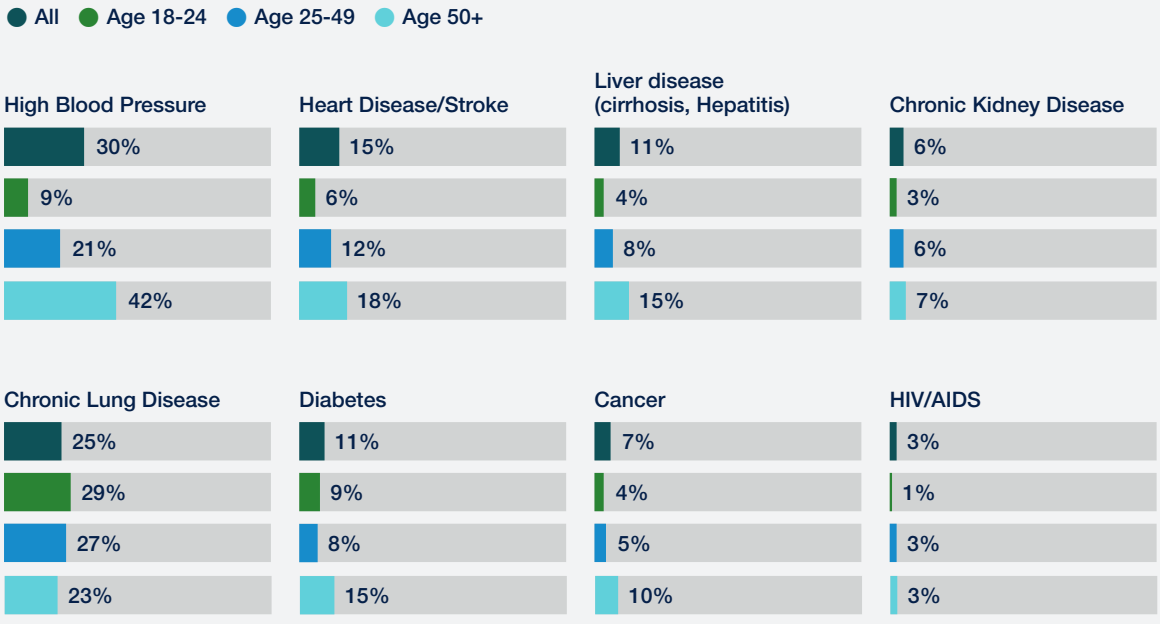
> *"I kept getting sick because I am not used to such filth. And then to the bathroom. And then to every morning eating cold cereal. See, my health does not require that."*

"I have diabetes and high blood pressure and a horrible lumbar problem and sciatica and pain all day and can't quite talk as well as I used to."

The most common illnesses were hypertension (high blood pressure) (30%); lung disease, including chronic obstructive pulmonary disease, emphysema, or asthma (25%), and heart disease or stroke (coronary artery disease, past heart attack or stroke, and congestive heart failure) (15%). The high proportion of people experiencing homelessness with these conditions demonstrates the need for strategies that integrate healthcare and housing and other supports. The aging of the homeless population will further increase the burden of chronic disease.

During the COVID pandemic, the Project Roomkey program used hotel rooms to provide non-congregate shelter to those who were at the highest risk of severe consequences of COVID, including older adults, pregnant women, and people who had medical conditions that placed them at high risk of severe consequences of COVID (e.g., immunocompromising conditions, diabetes, and severe chronic kidney disease). The intent was to decrease the risk of death amongst those at the highest risk by

FIGURE 3 Chronic Conditions Among People Experiencing Homelessness



removing them from high-risk places. While there was an effort to find housing for people as the program wound down, many returned to living either in congregate shelters or unsheltered settings. As a participant who had been in Project Roomkey said:

"I stayed at a motel program they had running during COVID. People that were high risk of catching the virus, they put us in a motel program. I was there for the year and a half it was running...I have Graves' disease, so I have no immune system... It was nice being off the streets. It was real nice having a shower and a roof over my head. After eight years, it was real nice. I didn't expect to have to come back out here, especially being almost 60 years old. It's rough out here. It's rough."

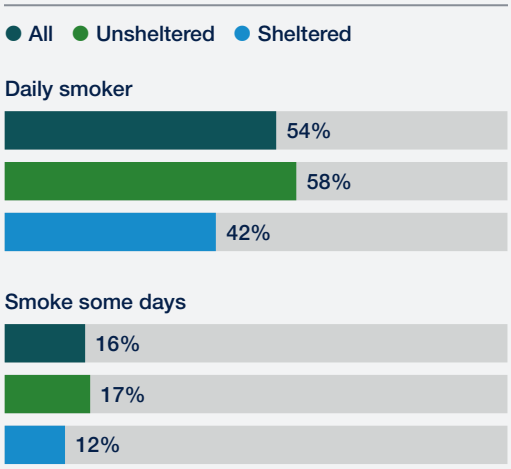
TOBACCO USE

People experiencing homelessness have high rates of tobacco use.[3] There are many reasons for this, including targeting advertising toward low-income communities, the high stress of homelessness, and low quit rates (i.e. likelihood of stopping use once started). Helping people stop smoking is a major focus for people who access primary care, where there are many effective strategies to help people quit (or reduce) smoking. As we discuss below, people experiencing homelessness have minimal access to primary care and they have limited access to these services.

> *"Sometimes I wish I never started smoking cigarettes. Seeing my mother going through what she went through. My mother died because she had lung cancer and throat cancer from smoking cigarettes. And now I wish I never started smoking."*

We found widespread tobacco use: 70% were current smokers, and 10% were former smokers. Over half (54%) smoked daily. The low proportion of those who had stopped smoking, compared to those who had ever smoked, reflects the difficulty of quitting while experiencing homelessness. People who were unsheltered were more likely to smoke than those who were sheltered. This could be a result of smoking bans in shelters, greater access to smoking cessation in shelters, or the increased stress of living in unsheltered settings.

FIGURE 4 Tobacco Use Among People Experiencing Homelessness by Shelter Status



Visit our website for more information on tobacco use and homelessness.

FUNCTIONAL IMPAIRMENTS AND DISABILITY

Functional status—the ability to carry out daily living activities (e.g., bathing, toileting) and to walk are important to health. These reflect one's overall health—and the environment in which a person lives. For example, if someone has limited ability to stand from a seated position, but lives in a home with a raised toilet seat and grab bars in the bathroom, they will be less likely to say they have difficulty using the toilet than someone who lives outside and must walk a distance to a portable toilet. Having access to healthcare could help someone improve their functional status. For instance, they may have better control of their chronic diseases, or work with a physical or occupational therapist. Those with the ability to make changes in their home environment would help improve one's functional status, for instance, by adding grab bars to one's bathroom. But people experiencing homelessness face significant barriers. Many have lived difficult lives that harmed their health, and they live in dangerous environments

where they are more likely to be injured. At the same time, they have poor access to healthcare and face limited control of their environment to make necessary adjustments to their impairments. Thus, it is not surprising that they have poor functional status.

To assess participants' functional status, we asked them about the five standard "activities of daily living (ADL):" dressing, bathing, toileting, transferring (getting up from one's bed or chair), and eating. Limitations in activities of daily living—particularly three or more—are associated with increased risk of hospitalization and mortality. Having three or more limitations in ADLs is an indicator that one may need nursing home care.

Among homeless adults in our study, over a third (34%) reported at least one limitation in ADLs: 12% reported 1, 6% reported 2, and 16% reported 3 or more. As in the general community, disabilities increased with age. Among those 50 and older, 43% reported at least one ADL limitation. The most common ADL limitations were transferring, dressing, and bathing (24%, 22% and 17% respectively).

FIGURE 5 Prevalence of Specific Activity of Daily Living Limitations by Age

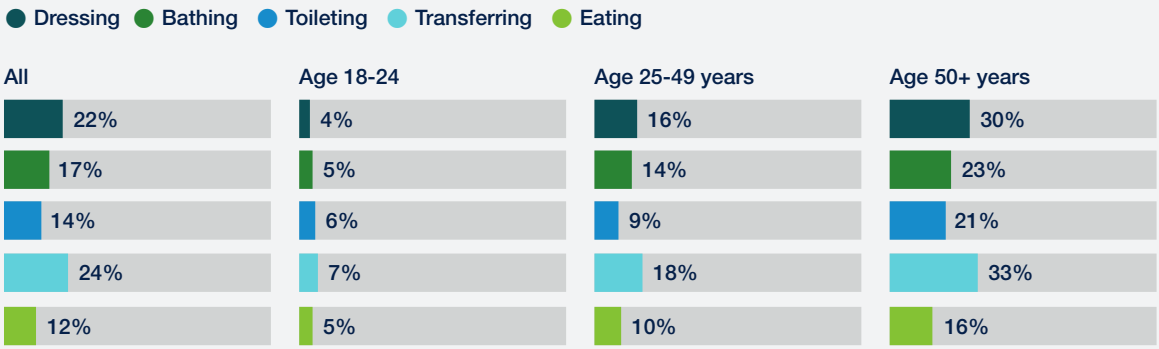
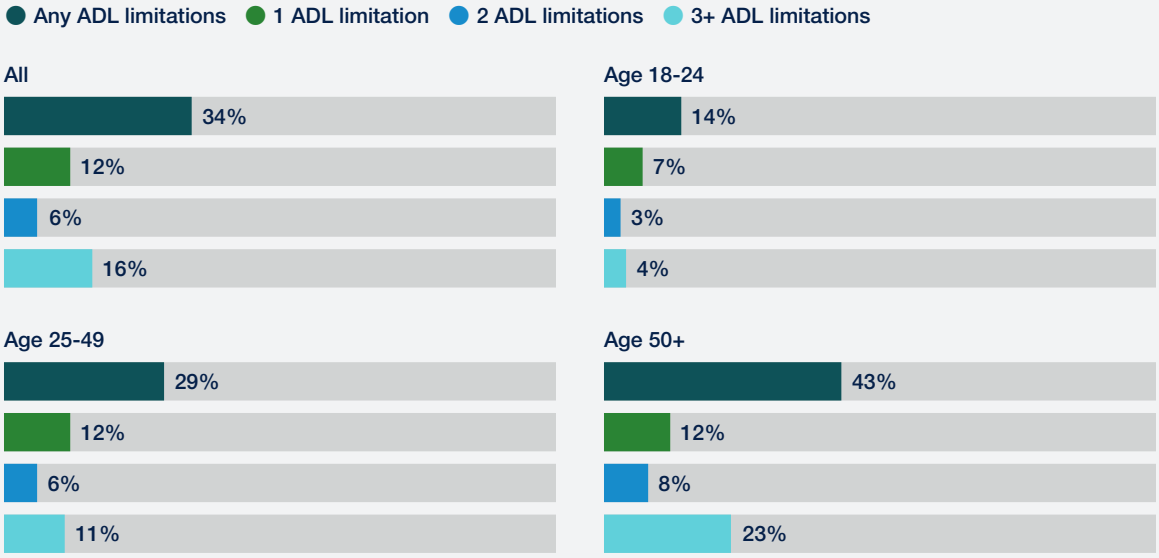


FIGURE 6 Prevalence of Numbers of Activity of Daily Living (ADL) Limitations by Age



MOBILITY

We asked whether participants had difficulty walking across a room due to physical, emotional, or memory problems. Nearly a quarter (22%) did. This, too, increased with age. Among those 18-24, 18% did, 25-49, 15% did, and 50 and older, 32% did.

If we consider mobility one of the activities of daily living limitations (as some do), 37% of the homeless population (46% of those 50 or over) had either one of the five ADL limitations or mobility limitation. To put our findings on activities of daily living in context, in 2018, 16.5% of older adults (age 65 and over) in the general population had a limitation in either one of the five ADLs or mobility.[4]

People with mobility limitations can improve their function by using a mobility device, such as a cane or wheelchair. Among homeless adults, 20% reported using one. Among those 50 and older, 32% did. Despite Medicaid providing coverage for mobility aids, many participants struggled to obtain them. Participants who had acquired equipment expressed how often it broke, was lost, stolen, or thrown away. This was particularly true for those living in unsheltered settings, where there was higher risk of damage or loss due to exposure to the elements, limited protection against theft, and frequent loss during encampment "sweeps" or forced displacements.

> *"I had buddies had to come, literally pick me up and carry me to the bathroom so I could use the bathroom. I couldn't even walk."*

Participants who faced mobility difficulties or other disabilities, such as loss of vision, faced additional challenges managing their experience of homelessness. Many relied on friends or family who themselves were struggling to get by. Participants didn't want to be a burden on others who were struggling themselves. Others found themselves relying on their faith. As one participant described: "And God knew what He was doing. He took my sight from me. Because, if I can't see a person the minute before they walk up on me, if I want to deal with them or not, I can't do it. I'm just like stuck…a blind man walking. You know, and God been keeping me safe."

Functional and mobility impairments worsened people's experience of homelessness and left them stuck in homelessness (and frequently, unsheltered homelessness). As one participant explained: "I was trying to rent a room; the doors are not wide enough for the wheelchairs that I had. They're not wheelchair accessible." The difficult terrain that people experiencing unsheltered homelessness faced in their day-to-day life worsened their impairments and complicated the use of mobility aids. Shelters were poorly equipped for those with mobility or other functional limitations. We heard from participants that they were unable to access shelter because shelters could not accommodate their needs (not being accessible to wheelchair users, only having mats on the floor or top bunk beds available for sleeping). Turned away by shelters, participants were forced to sleep outside. And these very disabilities—that made some people ineligible for shelter and made surviving unsheltered environments so difficult—presented barriers to regaining housing. In surveys, 24% of people noted that they couldn't find housing that meets their needs due to physical disability. Among those who report either an ADL or a mobility impairment, 66% did.

"When you're disabled, that's not a good thing for you. And especially when you're homeless, those two things don't combine. That's bad and bad. And it just makes your ability get housing that much harder."

SUMMARY

There is a clear cycle between poor physical health and homelessness. Those in poor health—often due to a lifetime marked by trauma, physically demanding and often dangerous work, difficult living conditions, and poor access to healthcare—are at heightened risk of homelessness. Once homeless, people's health continues to worsen. Those with poor health face particular difficulty navigating the brutal landscape of options: access to an already limited number of shelters is more restricted, and life in unsheltered settings is dangerous and difficult. Necessities, such as canes and wheelchairs, get lost, damaged, stolen, or thrown away, further worsening daily functioning. These very disabilities trap people in cycles of homelessness, unable to escape. As the population of people experiencing homelessness continues to age, these problems will only worsen.

Healthcare Access and Utilization

All people need and deserve access to high-quality healthcare. Those with extensive health problems, like adults experiencing homelessness, need it even more, but people who experience homelessness face a barrage of barriers to accessing care.

Accessing healthcare requires multiple steps: insurance to pay for the services, knowledge of where the services are and how to access them, the time and resources (including transportation) to get there, an ability to navigate complex appointment schedules, and the belief that once there, you will be treated with dignity and respect. Once someone receives healthcare, obtaining and adhering to suggested treatment regimens is even more complex. People need to be able to understand the recommended plan, trust their healthcare provider, and have the resources to follow suggestions. When treatment plans include medications, people must have a way to pay for them, transportation to a pharmacy, the ability to navigate pharmacy hours (and to feel welcome in the pharmacy), a place to store medication, and the ability to remember to take medications (often several times a day). Healthcare recommendations frequently include recommendations about diet (which require access to appropriate and timely food), exercise, and sleep. Other recommendations relate to follow-up care, such as tests (that need to be scheduled and attended), and visits with specialists. One participant shared that she was forced to stop treatment after becoming homeless "...I'm waiting for the back, sports and spine doctor... I was getting treatment for it before I moved out here, and then, they had to stop it because I moved out here."

It is not hard to imagine how many of the challenges people experiencing homelessness face interfere in their accessing needed healthcare.

"Well, I don't get as much treatment as I would if I was housed. I don't really, even when I start taking my medication and sometimes it's interrupted because somebody stole it or might ruin it or something I don't have it, you know?"

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> *"Well, during all this stuff, when I was losing my place and lost my job. But just going through the physical stuff again really threw my mental, I think, and stress and not being able to do anything about it*
>
> *…Because how do you make a phone call? How do you get to a doctor appointment when you don't have a car anymore, like you don't even have a penny in your pocket?"*

INSURANCE

We found that most California adults experiencing homelessness reported having health insurance (83%), primarily Medi-Cal (California's Medicaid program). Currently, all Californians living in extreme poverty are eligible for Medicaid coverage, although new restrictions placed by the current Federal administration will lead to a reduction in eligibility and coverage.[5] At the time of the study, California was rolling out access to a group that had previously not been eligible—recent immigrants and undocumented adults. Thus, while a small proportion of those in the study would not have met eligibility criteria, most did. Not all who meet the criteria are aware or able to enroll. People experiencing homelessness face many barriers to accessing health insurance, including a lack of paperwork (such as an ID) or not knowing where to enroll. People without insurance (even if they are eligible) may avoid healthcare, worrying about cost.

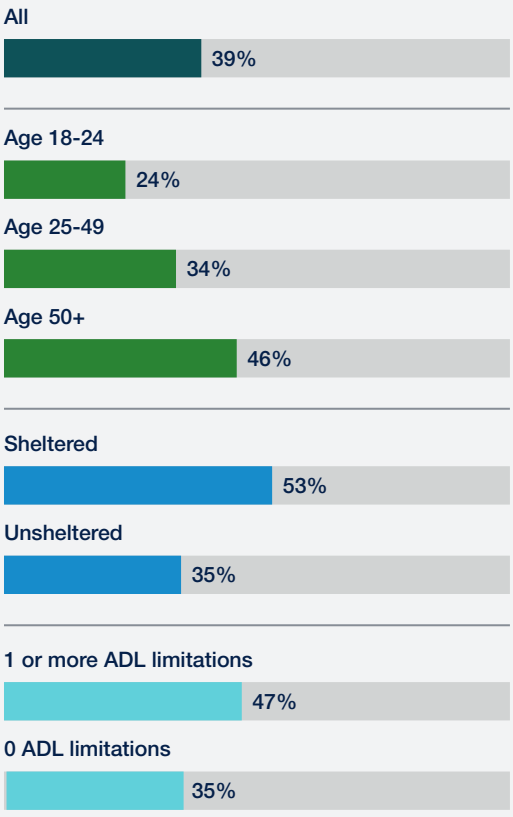
Younger adults were more likely to report being uninsured than older adults. Over one-third (35%) of homeless adults aged 18-24 reported being uninsured, compared to 18% of those aged 25-49 and 14% of those 50 and older.

USE OF PRIMARY CARE

Having a primary care provider is key to receiving high-quality care, including preventive care (e.g., timely vaccinations and cancer screenings), chronic disease management, and management of tobacco, alcohol, and drug use problems. Emergency departments, while a critically important part of the healthcare system, are not intended to provide ongoing care. Numerous studies show that having access to primary care is associated with improved health outcomes. Federally Qualified Health Centers and other safety-net clinics offer primary care, social services, and short-term behavioral healthcare. They facilitate access to specialty care, including medical and surgical specialties and specialty mental healthcare.

Despite a widespread system of Federally Qualified Health Centers and other clinics throughout California that offer low-barrier primary care to individuals who are uninsured or insured by Medicaid, only 52% of adults experiencing homelessness reported having a regular place for care (other than the emergency department). Even fewer (39%) reported having a specific primary care provider (such as a physician, nurse practitioner or physician associate) to manage their care. Those who were sheltered were more likely to report having a PCP (53%) than those who were unsheltered (35%). Older adults were more likely to report having a PCP than younger adults, as did participants who reported a limitation in activities of daily living.

FIGURE 7 Proportion of Homeless Adults Who Reported Having a Primary Care Provider



Increasingly, there is a recognition of the many barriers that individuals experiencing homelessness face. To get to a clinic, people must be aware of its services and location, have access to transportation, and have a way to contact the clinic. If they are unsheltered, they must have a place to store their belongings. These barriers may be insurmountable. One participant described how difficult it was to get help accessing care: "Or for transportation like to my appointments or to pick up my prescriptions or anything for that matter—they never, it would always be a no. No, we don't help with that."

With this the increased awareness of serious health problems faced by people experiencing homelessness, there has been an increased emphasis and development of programs that allow clinicians to meet people experiencing homelessness where they are—whether that be in a shelter or in unsheltered settings. Federally Qualified Health Centers and others have established satellite clinics in homeless shelters to serve individuals who stay in shelters. Care delivered in unsheltered settings is known as street medicine. Street medicine includes medical and psychiatric care, providing treatment for mental health conditions and other chronic diseases, addiction care, wound care, nursing care, care for minor acute illnesses, case management and social services, and other services. Recent changes in Medicaid have made billing for services delivered by street medicine teams easier. A small group of participants reported that their regular source of healthcare is through either street medicine or shelter-based healthcare provider: 6% of all adults experiencing homeless adults reported this (12% of those who reported having a regular place for care).

"Just started talking with other homeless people, you know, where do I go for this. And then, one day, a nurse and a couple other social workers – I was by the water. Come up to me like, "Hey, you know, here's a bus pass... If you can make it up here, there's a free doctor's office..." I was like, "Do they have a rehab program?" ..."Because, you know, I don't want to do this. Like I want to stop doing this stuff. [drugs]" And they were like, "Yeah. You know, we can help you get into all that."

During our research, we saw street medicine teams providing medical and nursing care to people living in encampments or to those staying in homeless shelters. We heard from participants that they wished there were more available.

Even without a PCP, many people received care from outpatient clinics and doctors' offices. In the prior six months, 49% visited a non-ED ambulatory care setting; 61% had done so in the prior year. Visits in the prior six months were more common among those who were sheltered (61%) compared to those who were unsheltered (46%), and among people with ADL difficulties (57%) compared to those without (46%). We do not know whether these visits reflected street medicine visits, unscheduled or scheduled visits to outpatient providers.

UNMET HEALTHCARE NEEDS

Despite the use of outpatient non-ED care, many participants reported having unmet needs for medical care, meaning they needed medical care in the prior six months but were unable to obtain it. Among all adults experiencing homelessness, 22% reported an unmet healthcare need, increasing with age: 14% of those ages 18-24, 21% of those aged 25-49, and 25% of those age 50 and older reported unmet healthcare needs. Cisgender men and women were equally likely to report inability to access healthcare (21% versus 25%).

Those with one or more chronic diseases and those with one or more ADL difficulties were more likely to report unmet need than those without. There are many reasons for unmet healthcare needs. In addition to lacking information about available healthcare, transportation, a way to communicate with clinics to schedule appointments or receive reminders, there are several other reasons participants could not access care. Some simply could not prioritize healthcare when faced with so many other competing demands for their time.

> *"I need to schedule an appointment because they told me that I have breast cancer...I couldn't charge my phone. So I'd have to take it into [drop in center]... when you're focusing on that, and then, trying to keep [stuff] clean, it escapes my mind that I need to call to make the appointment with the doctor."*

Those living in encampments feared leaving their spot, knowing that doing so could cause their belongings to be stolen or removed as part of a "encampment sweep." Others noted that they couldn't bring all their belongings with them to the clinic, without a place to store them.

"You go away for the – if you go to a doctor's appointment, you come back and everything's gone... I just came back after 16 days. I got bit by a spider, and it got infected. I had four surgeries and two blood transfusions... I came back, and my tent and everything was robbed... so I started over again. It's hard if you try going to a doctor's appointments and you try getting things set up, and they rob you blind."

Some living in shelters feared being delayed at clinics and missing deadlines to return to the shelter for the night, thus losing their spot. Still others faced the stigma of going to an appointment without having clean clothes or the opportunity to bathe, feeling shame and embarrassment. And others reported that they felt judged or discriminated against when they received care. Others, had lost trust in the medical establishment, and faced the hidden barrier of medical mistrust.

As one participant explained: "I don't really go to the doctor all that much because I feel that the doctors only know so much, like I feel that you should know your body well enough to know what's wrong ... unless there's stuff that like you can't know the answer to, and then you go to the doctor, but I don't believe in going ... on a regular basis because from my experience they like to pump you full of antibiotics and then eventually they won't work no more."

UNMET MEDICATION NEEDS

Almost a quarter (22%) reported unmet need for medication, defined as being unable to fill medication prescribed by a doctor in the last six months. Among people with an ADL disability, 32% reported this. This could be because they lacked transportation to a pharmacy, awareness of where and when pharmacies were open, or faced stigma when going to pharmacies. Some participants noted that they didn't feel comfortable going to pharmacies, where they were followed or treated as if they were there to steal. Feedback from our Lived Expertise Advisory Board underscored this concern: When we considered offering pharmacy gift cards to study participants, board members cautioned that many people experiencing homelessness feel unwelcome in these settings.[6] Others noted that they lacked insurance coverage for their medications or could not afford a co-payment. Patients with Medi-Cal, which insured most participants, should have minimal co-payments, and yet even small ones could be a barrier. And while insurance should cover most needed medication, there are often issues obtaining insurance coverage. Sometimes, clinicians do not know which medications are on "formulary" and require some communication with pharmacies to work this out, leading to delays. But, for people experiencing homelessness, many of whom didn't have telephones or a way to reach out to their clinicians to let them know that their medication wasn't covered, these delays could have severe consequences, cutting them off from lifesaving medications. Others noted that they didn't have the identification needed to show their insurance coverage, or to be able to receive certain medications. As one participant whose clinician had prescribed buprenorphine, a form of medication to treat opioid use disorder, which has been shown to reduce the risk of death by half, shared:

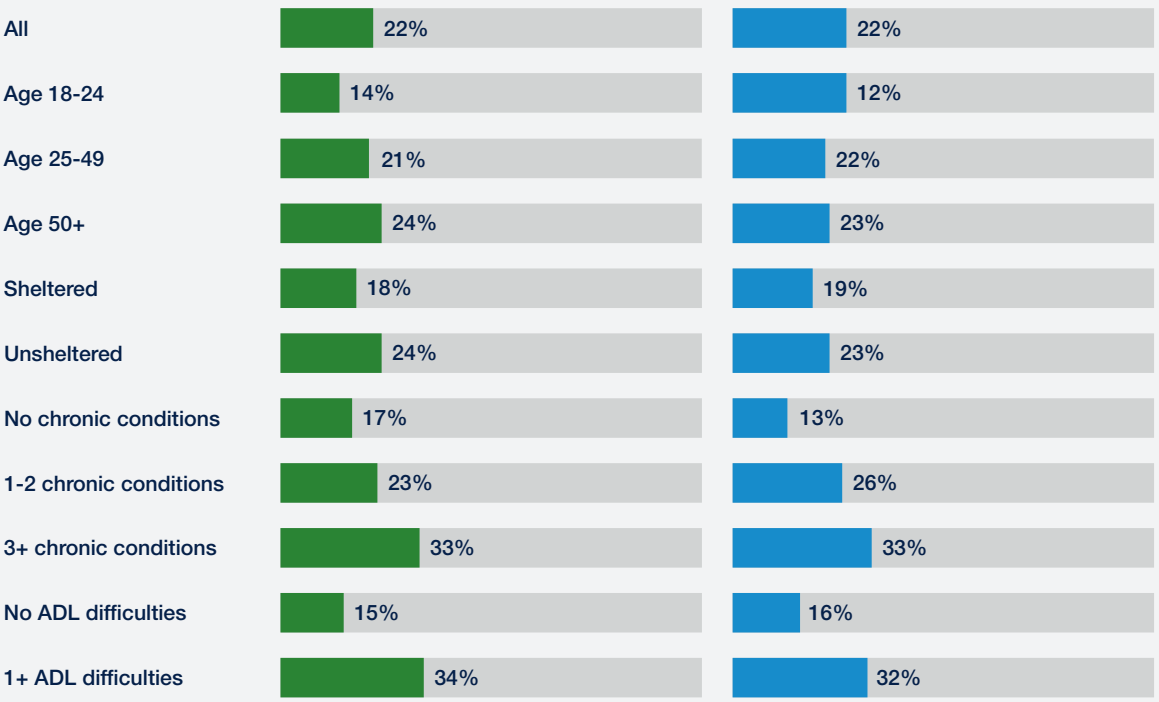
> *"So they gave me a two-week supply [buprenorphine], plus Narcan...It costs $176." ...You need your ID to pick this medication up...So I can't even pick up the medication that the doctor's office is offering me because my wallet was stolen."*

Buprenorphine is available for coverage on almost all Medicaid formularies, due to Federal legislation, in recognition of its effectiveness in combating opioid use disorders. But, despite this, there are often issues with prescriptions. Among people with good access to care, working telephones, and longstanding relationships with their physicians, insurance coverage for medications can be difficult to navigate. For people experiencing homelessness who typically have none of these things, the consequences can be deadly.

USE OF EMERGENCY DEPARTMENTS AND INPATIENT HOSPITALIZATIONS

With poor health, dangerous environmental conditions, and poor access to care, it is unsurprising that people experiencing homelessness had high use of high use of emergency departments and hospitals.. Over a third, or 37% of all adults experiencing homelessness in our study reported having visited an emergency department (without being admitted to the hospital) in the prior six months; 17% reported one visit, 11% reported two, and 9% reported three or more. There were no clear differences based on age, shelter status, or having ADL disabilities. "Treat and release" (ED visits without resultant hospitalizations) can result from non-life-threatening injuries, poorly controlled chronic diseases, or acute illnesses that progressed due to lack of access to care, or minor issues for which participants were unable to access other care providers; our data cannot distinguish between these. Emergency departments, which are always open, accessible by ambulance, and do not turn people away due to lack of insurance. They serve as a critical part of the healthcare continuum for all, particularly for those facing homelessness.

FIGURE 9 Unmet Healthcare and Medication Needs Among People Experiencing Homelessness



The high use of the ED by people experiencing homelessness suggests the need both to design solutions that allow people experiencing homelessness to avoid unnecessary ED visits and simultaneously to ensure that ED providers have the resources they need to provide care outside their normal role for people experiencing homelessness. There are multiple efforts to do just that. For instance, there is an increased recognition of the importance of alternative destinations for care for people experiencing homelessness and others who may not need the ED but are frequently brought there. For example, sobering centers offer an alternative destination for people who exhibit public intoxication but meet criteria to stay at a non-ED location safely. Staffed by nurses, social workers, and others, sobering centers provide a safe place to "sober up," an opportunity to be engaged in or referred to substance use treatment, and a way to avoid people using the emergency department unnecessarily.[7]

Because many people experiencing homelessness will only encounter the healthcare system via the emergency department, ED providers have a critical role to play in addressing the health consequences of homelessness. Increasingly, EDs are being recognized as important intervention points for people experiencing homelessness. In California, EDs are required to provide a discharge plan (outlining referral to services and plan for follow-up) for patients experiencing homelessness. Under the same legislation, EDs are required to provide screening for common infectious diseases and other services. Many EDs now provide enhanced social work services for PEH, vaccinations, and start people on medication for opioid use disorder and alcohol use disorder.

Inpatient hospitalizations for physical health conditions were common. One fifth (21%) of all adults experiencing homelessness reported a hospitalization for a physical health condition in the prior six months; 12% reported one and 9% reported two or more. This high rate reflects several realities. First, people experiencing homelessness are extremely medically vulnerable, having conditions that increase their risk of severe illnesses and injuries that require hospitalization. Second, they often lack access to both preventive care and early intervention for acute illnesses, allowing conditions that might ordinarily be treated in outpatient settings, to worsen to the point that they require hospitalization. Third, clinicians lower admission thresholds for people experiencing homelessness, recognizing that they lack the resources or environment to adhere to treatment plans or return quickly for care should things worsen. Thus, some people with conditions that might normally be treated in outpatient settings were admitted to the hospital. Counteracting this is the fact that people experiencing homelessness do not get many elective treatments that might lead to hospitalization but improve health. For instance, people experiencing homelessness are less likely to receive treatments such as a hip replacement, coronary artery bypass operation, or non-emergent heart valve replacement. These often result in hospitalization. As a result, the high level of hospitalization may understate the true effect of homelessness on hospitalization rates.

After hospitalization, many people experiencing homelessness were discharged back to the conditions in which they had been before, threatening their health. Participants discussed how challenging it was to be discharged back to unsheltered situations where they faced the same risks as they had prior to their hospitalization.

Some participants were discharged to recuperative care facilities (sometimes known as Medical Respite or respite care). Recuperative care provides a place to recover for people experiencing homelessness who are too sick to remain in unsheltered environments or routine homeless shelters, but who do not qualify for either hospital or skilled nursing facilities. There are a variety of models for recuperative care: some are shelters where people can stay throughout the day (unlike most shelters) and receive food and basic nursing and medical care. Others provide more enhanced care, with physicians, nurse practitioners and physician assistants, along with nurses, licensed clinical social workers and case managers providing an array of health, mental health, social work, and case management services. One participant explained how their partner's experience with respite care helped him get housing: "My boyfriend was [in the shelter], and, unfortunately, he was having heart problems, so, when he left here, he went to the hospital for a heart attack. They gave him a defibrillator. From there, they sent him to the [medical respite program], which is like a medical shelter. And after

that, you know, he got his [Medicaid] and his housing navigator, and then they gave him a place really quick, but, you know, he had to go through all that. Within three months after going to the [medical respite], they got him a place."

For more information on healthcare access and utilization, see our recent article in *JAMA Health Forum* Health Care Access and Use Among Adults Experiencing Homelessness.

SUMMARY

People experiencing homelessness face constant threats to their health. Having lived difficult lives without access to healthy environments, they have poorer health than adults in the general population. This is accentuated by their homelessness, where they face constant threats to their health and have difficulty accessing care. Many are living outdoors, in their cars, or in homeless shelters managing complex chronic conditions and facing disabilities. As the homeless population ages, these burdens deepen. Unable to access regular healthcare to get preventive health checks, management of chronic illness, and care for urgent problems—and facing difficulty filling prescriptions—they rely on high-cost emergency care. We see the damage to people's lives reflected in high rates of emergency department use and high hospitalization rates—but the real toll is born by people who are homeless—facing disability and disease without access to the care they need. There are many efforts underway to improve care—including the work of Federally Qualified Health Centers and other of our safety net care system, street medicine teams who bring healthcare to where people are—even under extraordinary conditions, and the lifechanging work of recuperative care programs. The expansion of Medicaid in California to fund these lifesaving efforts is promising—but itself is facing threats from changes in Federal policy. Homelessness has many costs—but none as serious as the threats to health experienced by those facing it. A moral society would do everything in its power to grant people the safety and security of home—and provide dignified, high-quality healthcare to all who need it.

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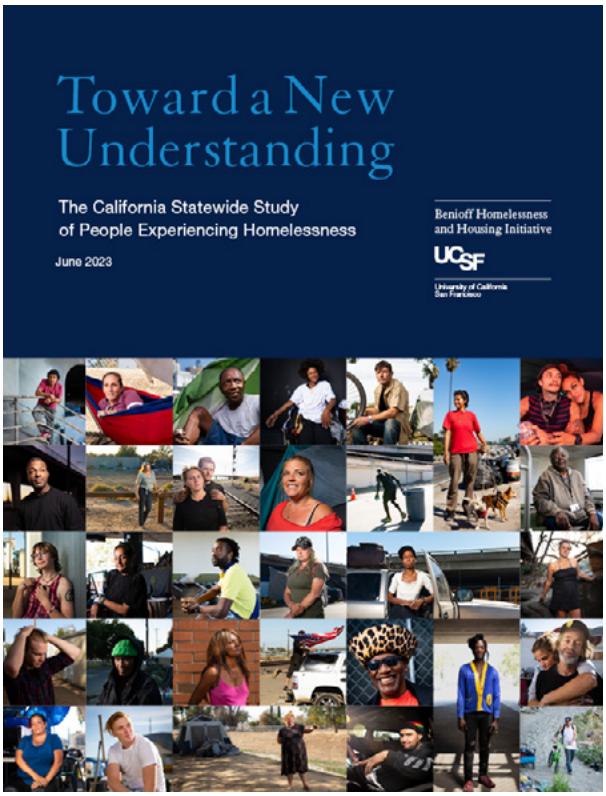
For a full list of contributors, please visit homelessness.ucsf.edu/CASPEH.

To access the full report of the California Statewide Study of People Experiencing Homelessness, click here or scan the QR code below.



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