A Health Needs Assessment Among Milwaukee's Homeless

Joshua Matzke, MD; Bryan Johnston, MD; Thomas Schneider, BS; David Nelson, PhD

ABSTRACT

Background: This project aims to assess the needs and barriers to care from the people experiencing homelessness in a large Midwestern city from their perspective.

Methods: This survey was advised by those with lived experience of homelessness and those who work in the space. Surveys were disseminated during outreach around the city of Milwaukee, Wisconsin. Data were transcribed, reviewed, and analyzed.

Results: Results indicated that 68% of participants perceive their health as "poor" or "fair." Fifty-five percent indicated they had primary care, and 64% reported possessing active health care insurance. There were many perceived barriers to care, including lack of transportation, money, and inadequate clinic hours.

Conclusions: Survey results indicate that the needs and barriers to care for those experiencing homelessness are broad and complex and should be factored in when considering solutions and aiming to provide more equitable care.

BACKGROUND

Homelessness can result from an array of reasons, including unemployment, substance abuse, and a lack of affordable housing, which results in a broad range of needs in this population. Each January, the US Department of Housing and Urban Development (HUD) completes its annual Point-in-Time Count of all those experiencing homelessness on a single night.[1] In January 2019, there were 567,715 people experiencing homelessness in the United States, of which 4,538 were in Wisconsin and 885 were in Milwaukee County.[1]

People experiencing homelessness often find themselves in scenarios where health needs compete with their immediate needs, like food and housing.[2] As a result, they both underutilize primary care and present at a late stage of disease.[3] This has led to mortality rates among homeless adults that are 3 or more times greater than the general population.[4] Although resources for this population have improved over the last decade, additional resources are still needed.[5] Community-wide needs assessments in Milwaukee have been completed by health systems and the county, but none are specific to people experiencing homelessness.[6] Ake et al published a needs assessment in 2018 that focused on a population of homeless pregnant women in Milwaukee, to help establish a program of care to improve the health outcomes of newborns and their mothers.[7] A health assessment among Milwaukee's general homeless population is necessary to identify the needs of all those experiencing homelessness in the city. This study sought to identify gaps in current care and resources from the perspective of people experiencing homelessness to influence possible solutions needed to improve health equity and access, health outcomes, and perceived health in this population.

METHODS

Survey Design

A survey tool was developed in collaboration with a group of 7 key informants with current or past personal experience with homelessness and those who work closely in the space. An important component of this study was to obtain input from those experiencing unsheltered homelessness, a population often missed by study

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Author Affiliations: Medical College of Wisconsin, Milwaukee, Wisconsin (Matzke, Schneider); Department of Family and Community Medicine, Medical College of Wisconsin, Milwaukee, Wisconsin (Johnston, Nelson).

Corresponding Author: Joshua Matzke, 732 S 103 St, West Allis, WI 53214; email jmatzke@mcw.edu.

Table 1. Responses to Health Needs Assessment Among Milwaukee's Homeless

Variable	%
Race (N=77)	
Non-Latinx White	52
Non-Latinx African American	26
Latinx	22
Sex (N=77)	
Male	61
Female	39
Overall how do you feel your health is? (N=77)	
Poor	48
Fair	25
Good	23
Very good	4
Excellent	0
Do you have a primary care physician or clinic you regularly visit? (N=77)	
Yes	58
No	42
Do you have a dentist you regularly visit? (N=77)	
Yes	12
No	88
Do you use any mental health counseling services, including substance use counseling? (N=77)	
Yes	17
No	83
Do you have health insurance? (N=77)	
Yes	64
No	36
Who is your insurance provider? (N=77)	
BadgerCare or Medicaid	80
Private	4
Medicare	16
Do you have access to harm reduction (clean needles, Narcan, etc)? (N=64)	
Yes	31
No	69
In the past year, have you had unprotected sex? (N=58)	
Yes	59
No	41
(For females) In the past year, have you been pregnant or been worried about becoming pregnant? (N=30)	
Yes	37
No	63
Age (N=77)	
18–25	6
26–35	20
36–45	29
46–55	25
56–65	14
66–75	6
(For females) Are you currently using birth control? (N=30)	
Yes	30
No	70
I don't know/unsure	0
Do you have any chronic illnesses you are prescribed medicines for? (diabetes, high blood pressure, heart disease, asthma, etc) (N=61)	
Yes	61
No	39
Do you have a mental health diagnosis? (N=54)	
Yes	35
No	65
Within the past 12 months, did you worry that your food would run out before you got money to buy more? (N=77)	
Never	0
Rarely	6
Sometimes	22
Fairly often	38
Frequently	34
How often does anyone, including family, threaten you with harm? (N=77)	
Never	88
Rarely	8
Sometimes	4
Fairly often	0
Frequently	0
Where do you usually sleep? (N=77)	
Shelter	20
Outside	45
Car	12
Couch or friends	18
Own place	5

teams due to inconvenience. The final survey focused on assessing perceived health status, health resource utilization, and perceived barriers to accessing care. It received Institutional Review Board (PRO00036564) approval on August 11, 2020.

Procedures

This project was conducted in partnership with StreetLife Communities, a nonprofit organization engaged in homeless outreach throughout Milwaukee. Research team members joined StreetLife to conduct surveys during their longstanding outreach programming, including a weekly city gathering and well-established biweekly routes visiting major outdoor encampments and informal gathering places. Voluntary participation and data privacy were explained, and verbal consent was obtained prior to the administration of each survey. Participants completed the paper survey, and collected surveys were stored by the student investigator prior to data analyzation.

RESULTS

A total of 77 surveys were disseminated, of which 61 were fully completed. Questions from the survey and results are shown in Table 1. The demographics of this project included 52% non-Latinx White respondents, 26% non-Latinx African American respondents, and 22% Latinx respondents. This is of note, as only 19% of Milwaukee's population identifies as Latinx. The most common age group was 36 to 45 and 61% were men. Overall perceived health in study participants was poor. Participants were asked to indicate how often they utilized health services in the last 12 months (Table 2); this revealed that emergency departments (ED) were the highest utilized health resource, and 43% of respondents accessed an ED at least 4 times. Only 13% of respondents saw a dentist and 23% saw a mental health provider. Fifty-five percent of respondents had a primary care physician, and 64% had active health care insurance.

Using a Likert scale, participants were given a list of barriers and asked to rate the perceived level of impact each had on accessing care or resources (Table 3). Transportation was the most common barrier, as 85% of respondents indicated that it was a significant factor—4 or 5 on the scale—in preventing them from accessing resources. Another 74% and 69%, respectively, described inadequate clinic hours and money as significant barriers, while 30% perceived disrespectful care as one of their barriers to care. Thirty-nine percent indicated that substance use hindered their access. Tobacco/cigarettes and alcohol were the most common substances used (77% and 68%, respectively) on at least a weekly basis. Thirty percent of participants said they use opiates/heroin on a weekly basis and 18% on a daily basis. Additional results regarding barriers to care, including food security and housing, are shown in Table 1.

DISCUSSION

As expected, there were wide variations in health resource utiliza-

tion. Specifically, reported ED utilization was very high in this study compared to the general population.[4] One participant presented to an ED 122 times in 2020, most often for anxiety and frostbite. Meanwhile, only 6.5% of the general population used an ED twice or more in 2017.[8] Individuals who experience homelessness not only have higher rates of hospital admission, but they also have longer stays once admitted—at least 2 days longer for acute admissions.[9]

While primary care access was reported more than expected, many still lacked consistent care. A lack of regular primary care may contribute to the overutilization of EDs, leading to poor outcomes and experiences for both patients and clinicians. Many homeless patients relying on seeing different clinicians in acute settings are denied access to the patient-provider relationship and continuity of care that are essential for solutions to their complex health challenges—not just acute issues.

The ability to address health concerns also is hindered by perceived barriers. Respondents often suggested that even if they were able to schedule an appointment to see their primary care physician, transportation was a significant barrier. If they did not have money for a bus and the weather was not amenable to walking, they were unable to attend their appointment. Inadequate clinic hours also were frequently indicated as a barrier to accessing care, which suggests that either clinics truly do not have hours that align with this population's availability or that there is a lack of familiarity with available clinics and primary care coordination.

A common theme was lack of awareness regarding access and resources. It is often forgotten that many resources are designed from the lens of privilege or by those who have few barriers, which makes it easier to overlook the logistics that may be involved for those who face these barriers to care. For example, many respondents were unaware of clean needle exchanges in Milwaukee or conveyed they had heard about them but did not know how to access them. A similar sentiment was found regarding housing. While not formally collected during the survey process, many survey respondents and other people experiencing homelessness indicated awareness of the centralized 2-1-1 resource used to seek housing resources, but lack of a cell phone or poor experiences in the past were common barriers to successful connection.

There certainly is a connection between these barriers and overall health status. As a result of the barriers and lack of resources or access to services, nearly half of the respondents perceived their health as poor. Sixty-one percent endorsed having 1 or more chronic health conditions, which is a 9% higher prevalence than the noninstitutionalized adult US civilian rate.[10] These data alone suggest that this cohort requires more resources per capita to help manage chronic disease than the general population. Addressing this issue will require research, policy, and resources for health services. Steps that can be taken might include primary care coordination, multidisciplinary teams performing regular outreach, improved food and housing stability screening and resources, and harm reduction resources.

Table 2. Health Services Utilized in the Last 12 Months (N = 77)

Health Resource	0	1–3	4–6	7–9	≥10
Emergency department	18	26	22	8	3
Mental health provider	59	12	6	0	0
Dental	67	10	0	0	0
Urgent care	40	19	15	3	0
Primary care provider	35	33	9	0	0
Free clinic	61	16	0	0	0
Overnight hospital stay	38	35	4	0	0

Table 3. Likert Scale of Perceived Barriers to Accessing Health Resources (N = 61)

Barrier	1	2	3	4	5
Inadequate hours	7	0	9	8	37
Money	4	1	14	10	32
Transportation	6	0	3	10	42
Substance use	31	1	5	9	15
Safety	51	6	3	1	0
Language barrier	53	0	7	0	1
Ability to read or write	45	5	7	4	0
Housing	15	a7	20	6	13
Child care	41	6	5	5	4
No mailing address	57	0	0	0	4
Disrespectful care	36	4	3	6	12

1 = not a barrier; 5 = significant barrier.

Improving access, resources, and awareness of resources will be vital to improving the overall health and well-being of people experiencing homelessness in the future.

Limitations of this study include participants being excluded if they were unable to read and complete the English survey, as no Spanish speaking translators were available. Another limitation was that the participants included were those who gather at a community lot each Saturday, along with those encountered during street outreach by StreetLife Communities. While this outreach method covers commonly utilized unsheltered sites of habitation in the Milwaukee area, it does not encompass the entire homeless population. There are certainly pockets of extreme poverty and homelessness that are undiscovered and not included in this project. Additionally, the survey was independently completed by participants, so data were unable to be verified. Independent completion also may have led to confusion on some wording of questions. For example, 5% of respondents indicated they owned a place to sleep, although they were homeless.

CONCLUSIONS

Those presently and at risk for homelessness make up some of the most vulnerable members of our community. Not only is this population sicker than those more stably housed, but they die sooner. In addition to access to care, the other social determinants of health need to be considered as solutions are discussed. Only when we address the entire system will we begin to see progress to eradicate the issues of homelessness.

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