

# HEALING HANDS



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## Hard to Reach: Rural Homelessness & Health Care

*This issue of Healing Hands examines obstacles to health care encountered by people who first experience homelessness in small communities and remote rural areas of the United States. The following articles briefly explain the causes of rural homelessness and how unstably housed people in rural areas differ from their urban counterparts. In addition, they highlight strategies that homeless service providers are using to meet the challenges these clients present, and recommendations to improve service access and reduce rural homelessness. Information presented here is excerpted from a more comprehensive analysis of these issues, to be published soon by the National Health Care for the Homeless Council with support from the Bureau of Primary Health Care.*

In sparsely populated areas across America, growing numbers of economic refugees are struggling to meet the basic human need for shelter. Their struggle is mostly hidden from public view. Some live in makeshift shelters far from developed areas — in mountain hollows, forest campgrounds, desert canyons, and farmers' fields. In desperation, large numbers move from relative to friend to casual acquaintance, until their only option is sleeping in a vehicle or dilapidated structure on the edge of private land. Proud people with a long tradition of self-reliance, the rural homeless are reluctant to seek help, are far from established support services, and hard to reach.

Homelessness in rural America has received far less attention than urban homelessness. Larger numbers of visibly homeless persons in metropolitan areas have caused some to conclude that homelessness is primarily an urban problem. On the contrary, it is also a serious and growing problem in rural communities throughout the United States. In some rural counties, the incidence of homelessness per 1,000 population is proportionately comparable to or greater than that in New York City, Los Angeles, and Washington, DC.<sup>1</sup> For small towns with few health and social services, the burden of homelessness is particularly heavy but difficult to document.

According to the most recent national data, 9% of surveyed homeless clients live in rural areas, 21% are in suburban areas, and 71% reside in central cities.<sup>2</sup> These data exclude rural homeless persons who did



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not or could not access targeted homeless assistance services. Homeless shelters are virtually nonexistent in rural communities, and most health and social services accessible to indigent persons are located in areas with larger and denser populations.<sup>3,4</sup> Less than 5% of McKinney funds go to rural communities, which often lack staff and resources necessary to compete for federal grants.<sup>4</sup> Only nine Health Care for the Homeless grantees currently serve significant numbers of clients in rural areas, although homeless clients served by many HCH projects have rural origins.

**Homeless:** an individual without permanent housing who lives on the streets; in a shelter, mission, or single-room occupancy facility; in an abandoned building, vehicle or other place not intended for human habitation; or "doubled-up" temporarily with a series of relatives, friends or extended family members. Fundamental to homelessness is an unstable living situation. (based on the BPHC definition used in its guidance to HCH grantees)

**Rural:** a nonmetropolitan area of less than 50,000 population. Rural communities are of four types: *rural adjacent* – contiguous to or within a metropolitan (urban) area of 50,000 population or more, *rural nonadjacent* – not contiguous to a metropolitan area, *urbanized rural* – with a population of 25,000 or more and not adjacent to a metropolitan area, or *frontier* – fewer than six people per square mile. (NRHA, 1994, based on 1990 Census definitions used by most researchers cited here)

**CAUSES OF RURAL HOMELESSNESS** Wherever it occurs, homelessness is inextricably linked to poverty. The same trends are responsible for the growth of homelessness in both rural and urban areas: falling incomes from low-wage, seasonal or temporary jobs; rising rents; and severe shortages of low-cost housing.<sup>4</sup> Rural areas in which the prevalence of homelessness is especially high include:

- Agricultural regions with a history of persistent poverty that are economically dependent on declining extractive industries such as mining, timber or fishing;
- Economic growth areas that attract more job seekers than can be absorbed and/or higher income residents who drive up taxes and living expenses, including housing costs;
- Areas in which changing economic conditions have resulted in fewer employment opportunities, such as a lower demand for farm labor due to mechanized and corporate farming, or a shrinking service sector from declining populations;
- Communities located on major transportation routes that attract transient people without resources, looking for work.<sup>3</sup>

When rural residents lose permanent housing, they typically use three strategies to cope with homelessness:<sup>3</sup>

- *Move in* with a series of relatives and friends until they wear out their welcome;
- *Move out* of housing intended for continuous habitation into abandoned shacks, vehicles, or other temporary shelter on private property, in Forest Service campgrounds, or other remote areas; or
- *Move on* to more urbanized areas in search of jobs, services, and personal contacts, often beginning the cycle anew.

### RURAL VS. URBAN HOMELESSNESS

Homeless people in rural areas of the United States differ significantly from those living in metropolitan areas in a number of respects. According to national averages, they tend to be somewhat older — most are between ages 35 and 44, and significantly fewer are under age 35.<sup>2</sup> In general, there are lower proportions of African Americans and higher proportions of Native Americans among rural homeless residents.<sup>2</sup> Nevertheless, because the ethnic distribution of homeless people tends to mirror the distribution of poor people in a given location,<sup>6</sup> low-income people lacking stable housing are predominantly white in Appalachia and rural areas of the Northeast and upper Midwest, black in the Mississippi Delta, Native American in areas close to Indian Reservations, and Hispanic in parts of the country that attract migrant labor.

There is less socioeconomic diversity in rural America, where more traditional values and bias against ethnic minorities can magnify the stigmatization of homeless individuals.<sup>7</sup> A 'blame the victim' mentality may be more prevalent in small towns, where residents place a high value on individuality and self-sufficiency, and tend to attribute

homelessness to individual failure rather than to structural problems.<sup>1</sup> Although rural communities pride themselves on "taking care of their own," economic pressures in recent years from rising unemployment, falling incomes, and continued decline in low-cost housing have made it increasingly difficult for informal support systems to manage the burden of a growing rural homeless population.<sup>4,5</sup>

Rural homeless clients are less educated but more likely than urban clients to be working, albeit at part-time, short-term or seasonal jobs without benefits. Geographic isolation and lack of transportation often block their access to better jobs and health services in more urbanized areas. Larger extended families compensate somewhat for the scarcity of temporary shelters in rural communities, where a higher proportion of residents who lose permanent housing "double up" or "couch surf" with a series of friends and relatives.<sup>4,6</sup> While homelessness is therefore more "hidden" in rural America, it is also less anonymous, increasing the difficulty of preserving client confidentiality.<sup>5</sup>

### HOW RURAL HOMELESS CLIENTS DIFFER FROM THEIR URBAN COUNTERPARTS:

- more than twice as likely to be high school drop-outs (64%)
- more likely to be employed, less likely to have jobs lasting at least three months
- higher median income during the past month, half as likely to have no income
- more likely to receive cash assistance from friends, less likely to receive it from the government
- experience shorter and fewer episodes of homelessness during their lifetime
- at least twice as likely to be living in private housing with family or friends (45%)
- less likely to sleep on the streets or in other places unintended for human habitation (16%)
- less likely to report having a mental health or drug problem during the past year
- six times more likely to report having an alcohol-only problem during the past year
- less likely to have been physically or sexually abused before age 18
- more likely to be without any health insurance (63%), less likely to be on Medicaid (25%)
- have less access to medical care
- have the highest rates of incarceration: 67% have been in juvenile detention, jail or prison.

*National Survey of Homeless Assistance Providers & Clients, 1996*

The reported health status of rural US residents in general is worse than that of urban residents.<sup>9</sup> Among the most notable discrepancies are these: In most rural counties, adults are 20% more likely to die from heart disease; death rates among men with chronic obstructive pulmonary disease are 30% higher, attesting to the high prevalence of smoking in rural areas; and suicide rates are nearly 80% greater for males age 15 and older.<sup>10</sup> Rural residents get less professional medical attention than residents of metropolitan areas; more of them lack health insurance, and fewer physicians practice in rural areas.<sup>9</sup> The supply of specialists and dentists decreases markedly as urbanization decreases, in all regions of the United States.<sup>10</sup> Few statistical analyses are available comparing the health status of rural and urban homeless populations. Nevertheless, clinicians report that similar health problems seen in both rural and urban clients are more advanced in their rural homeless patients, who have had little or no health care and present with more untreated, chronic health problems.

Despite their quantitative and qualitative differences, homeless people in rural and urban locations share many of the same health risks. Exposure to the elements, environmental pollutants, infectious disease, frequently overcrowded living conditions, and chronic stress inherent in finding food and shelter increase their risk for poor health.

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## Health Problems & Access Barriers

To put flesh on the bones of rural homelessness, we asked service providers in a variety of rural settings to describe the clinical conditions that seem to distinguish their rural homeless clients from others, and to specify obstacles that prevent these individuals from obtaining the services they need.

**HEALTH PROBLEMS** Clinicians we consulted specified the following health conditions as most frequently seen in their rural homeless clients:

- *mental health and substance abuse problems* – PTSD; drug use varies by region and population (alcohol, methamphetamine and prescription drugs most often mentioned)
- *chronic medical conditions* – hypertension, heart disease, diabetes, obesity, COPD, asthma
- *infectious diseases* – hepatitis C, respiratory and intestinal infections; much less TB and HIV/AIDS than in urban areas
- *disabilities* – secondary to mental illness, occupational injuries & trauma
- *skin problems* – foot lesions, frostbite, poison oak

Though familiar to most homeless health care providers, these problems are often more advanced and complicated in homeless persons from remote rural areas, as the following example illustrates:

**Clinica Sierra Vista Homeless Program**, based in Bakersfield, California, is one of the few Health Care for the Homeless projects serving a large rural population. Although the HCH clinic is located in a metropolitan area, its mobile health care unit goes all over Kern County, spanning 8,000 square miles of mountains, desert and agricultural land, much of it sparsely settled. Unemployment rates in some communities are as high as 20–30%.

The HCH outreach team serves several distinctive groups of rural clients, says homeless coordinator **Marie Aylward-Wall, MSN, PHN**. Among them are 40,000 mostly Hispanic *migrant farm workers* who come to the area during harvest season, May – October. Most live in orchards and fields or along canal banks; some live in more urban areas, doubled up in motels. These undocumented immigrants are very skittish about receiving services, says Aylward-Wall. One Sunday, the mobile outreach team found a 47-year-old diabetic farm worker living in the desert with gangrene up to his knee. They transported him to the emergency room, where his leg had to be amputated.

Most *homeless families* live in small agricultural towns or more urbanized areas with support services. The county puts up hundreds of farm workers' families in a welfare motel, often

Lack of a permanent address complicates their access to entitlements. Financial and transportation barriers, prejudice and stereotyping limit their access to mainstream health services. The geography of homelessness may vary, but its consequences are remarkably the same. ■

6–8 people to a room. Pockets of homeless families also live in more remote areas. In one isolated place in the desert they discovered 250 farm worker families, living in shacks and trailers with no electricity or water, 110 miles (a 4.5 hour drive) from Bakersfield.

HCH clinicians also found a 33-year-old undocumented pregnant woman in the desert, living in her car with two children. She was pre-eclamptic with extremely high blood pressure, a medical emergency. They were unable to save the baby, but without their help, the woman and her other two children would also have been lost. "This woman wasn't far from a rural clinic, but she knew she wasn't welcome there," recalls Aylward-Wall. "She was entitled to Emergency Medicaid but didn't know it."

At least 600–700 *Vietnam veterans* are estimated to be living in the desert and mountains. The HCH serves about 350 of them at any given time. "This is the hardest group to reach and the most reticent," says Aylward-Wall. Many of these clients have untreated posttraumatic stress disorder with overlying drug problems. Already on drugs when they returned from the war, they have been self-medicating ever since. A number of these individuals have advanced diabetes and hypertension. Bad foot lesions are often seen in untreated diabetic alcoholics. Hepatitis C is also very common

among homeless veterans. “In those we have tested, the average prevalence of HCV is 60–65%, compared to 30% in their other homeless clients,” she reports.

**ACCESS BARRIERS** Despite the severity and complexity of their health problems, access to health care for homeless people in rural areas is seriously limited by three primary obstacles: lack of transportation, lack of health insurance, and unavailable or inaccessible health services — particularly specialty care, mental health services, and substance abuse treatment.

These access barriers are not unique to rural homeless people, but they are more severe.

**Transportation** Limited or no access to public or private transportation makes health care access virtually impossible for many homeless rural residents. Severe geographic barriers, such as mountainous terrain or vast distances from available services, exacerbate this problem. “Many rural areas don’t even have buses,” notes **Jan Wilson, FNP**, homeless health care coordinator at **Valley Health Systems, Inc., Huntington, West Virginia**. “Even if you are only ten miles away from a health center and don’t have a car, that’s a serious barrier.”

**Secondary & Tertiary Care** An insufficient provider network exacerbates this problem, says Wilson. Even where primary health care is available there is a scarcity of specialists. Many local hospitals have closed because of lower Medicare reimbursements and fewer patients who are eligible for Medicaid following welfare reform.

**Health Insurance** Even where it exists, specialty care may not be available to patients without health insurance. “Single homeless adults aged 30–55 fall through the cracks in Wisconsin,” says **Mary Clay Santineau** of **Starting Point**, in **Chippewa Falls, Wisconsin**. “Most aren’t eligible for Medicaid, and general medical assistance, in the few counties that offer it, isn’t enough to help,” she says. “The only clinic in Chippewa County that sees clients on a sliding scale is so full that it turns away one-third of the people seeking services. Many families need \$70–\$80 medications to treat ADHD, diabetes or mental



*Migrant farm workers' children pose in front of the Clinica Sierra Vista mobile health van at High Vista, a family camp in the Mohave Desert.*

illness, but can’t afford them; so they get off their medications, crash and burn, and can’t maintain regular housing.”

**Alcohol & Drug Treatment** Lack of available and adequate substance abuse treatment is another serious barrier, adds Wilson. “There aren’t enough medical detox beds for indigent patients, even for those who want treatment, which often lasts only 24 hours.” The only clients able to get long-term substance abuse treatment are those willing to wait as long as a month who haven’t been in treatment too many times before, she says.

In Idaho, substance abuse treatment has gone backwards, according to **Kevin McTeague** of **Terry Reilly Health Services** in **Boise**. “Idaho has lost its detox centers,” he says. “Some state-funded, inpatient and outpatient substance abuse treatment is accessible to homeless people, but these funds are badly managed with poor tracking. There is evidence that available money isn’t being used, despite a significant demand for services.” Detox beds aren’t being used because practitioners can’t get patients past managed care gatekeepers into treatment, explains McTeague. “Treatment on demand is a critical element for homeless persons with substance abuse problems.”

Except for one AA group in town, there is no substance abuse treatment or therapy available for homeless people in **Beatty, Nevada**, says **Brian Lane, PA**, of **Beatty Medical Center**. “We deal with addictions through crisis management alone,” he says. Mentally ill clients must be referred to the HCH project in Las Vegas, 120 miles away.

Most often, they are referred to the ER at the nearest hospital, also in Las Vegas. “If an emergency occurs, we use a volunteer ambulance service; if it’s a real emergency, we can get a helicopter from Vegas,” says Lane.

**Mental Health Care** is virtually nonexistent in rural southwestern Tennessee, except for that provided by community mental health centers, says **Minnie Bommer, Children and Family Services, Covington, Tennessee**. “Not many low-income people go to CMHCs except those mandated to go because of

disruptive behavior.” Psychiatric referrals and psychotropic medications are hard to come by, even for clients who qualify for TennCare, Tennessee’s Medicaid managed care program, because psychiatrists are in short supply and few will accept TennCare enrollees.

**Managed Care** is a huge barrier for homeless people, particularly transients, agrees **Edith Iwan, CN**, of the **Western New Mexico Group**, which serves the tiny town of **Thoreau**. She recounts the experience of a Native American family that brought a two-month-old baby to the clinic last winter with respiratory syncytial virus, contracted from an older sibling. The baby had stopped eating, started to lose weight, and needed oxygen

#### **ACCESS BARRIERS FOR RURAL HOMELESS CLIENTS:**

- Lack of transportation
- Lack of health insurance and other entitlements
- Inaccessible/ inadequate mental health & substance abuse services, dental care, TB/HCV screening and treatment
- Limited access to secondary & tertiary care: few specialists accepting indigent patients, hospital closures
- Limited access to medications
- Language and cultural barriers
- Primary care access barriers: managed care, copayments
- Other barriers impacting health care access:
  - Lack of temporary shelter beds
  - Lack of respite/recuperative care
  - Lack of childcare
  - Community resistance to homeless service centers
  - Criminalization of homelessness

and medical care. Getting it was a logistical nightmare, even though the child was on Medicaid, because the family had moved around so much and didn't understand how

to access the managed care system. The baby ended up in the only available hospital, 30 miles away, after clinic staff had struggled to locate needed service providers within the

appropriate managed care network. Native Americans (but not other homeless people) have since been exempted from Medicaid managed care in New Mexico. ■

## How Rural Service Providers Are Coping

Homeless assistance models in rural communities vary according to their size and distance from urbanized areas. In rural areas large enough to support health and social services, strategies include *community partnerships* linking formal and informal support systems, *multiservice centers*, and a *hub-and-spoke model* of outreach to, and referrals from, outlying rural and urban communities in one or more counties. In remote rural communities with only minimal capacity to provide services, two strategies are most frequently used: *mobile health outreach* and, as a last resort, “*Greyhound referrals*” — providing the price of a bus ticket to cities with established homeless services.

**COMMUNITY PARTNERSHIPS** The SKYCAP program in Hazard, Kentucky, provides case management for sheltered and unsheltered homeless people in Perry and Harlan counties, where much of the land is vertical. Three organizations coordinate a voluntary network of more than 80 agencies and service providers through a management information system that tracks social services, housing status, and clinical and environmental factors that affect the health of people who are homeless and at risk of homelessness. The database currently contains information about more than 3,000 clients. These efforts have resulted in a streamlined system of homelessness intervention and prevention, says Gerry Roll, executive director of Hazard-Perry County Community Ministries, Inc., one of the program's three co-sponsors. “We are learning from the mistakes made in urban areas for the last 20 years about how to prevent increases in homelessness.” There is evidence that their work is paying off. The number of homeless people in Hazard has decreased by 68% since 1993.

**MULTISERVICE CENTERS** Access to behavioral health services is fairly good for clients served by the Homeless HealthCare program in Burlington, Vermont. One-third of HCH clients are from rural areas throughout the state. All mental health, substance abuse, case management, and primary care services are coordinated at a single point of access. The program has been particularly successful at integrating services for individuals with co-occurring mental health and substance abuse disorders, says director Paul Dragon. A *pro bono* network of private practitioners provides mental health services. To reach more homeless people, the project is expanding its services to smaller clinics and health centers within Burlington, and developing expansion sites around the state.

**HUB & SPOKE MODEL** Montana is an entirely rural state, large parts of which are frontier areas. The Yellowstone City-County Health Department's HCH project in Billings and its sub-grantees in Helena, Butte, and Missoula exemplify an interesting hub-and-spoke service model. Besides serving homeless people who migrate to these

cities from outlying areas, the project uses a mobile van to reach out to unsheltered persons in remote areas without HCH services. All towns with homeless health care projects have specialists within their provider network, says HCH project manager Lori Hartford, RN. “Few specialists refuse referrals, regardless of a client's ability to pay. There is lots of community support for providing care to homeless people in Montana, where the media play an important part in educating the public about client needs and often participate in solving problems associated with homelessness.” Overlapping responsibilities among public health workers at community health centers, health departments and HCH, Indian, and migrant health services foster a high degree of collaboration and service integration not often seen in more urban areas, says Hartford.



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**REFERRALS ELSEWHERE** Ed Friedman, PA, is the sole health care provider in Redfield, Iowa, population 833. A doctor visits his clinic once a week. Homeless people come there for medical services if they don't have transportation; if they do, they go 25 miles to Perry or 35 miles to Des Moines. Friedman faxes EKGs to a consulting cardiologist, but doesn't use telemedicine because the clinic isn't big enough to justify the cost. If his clients need a specialist, he just tries to help them find transportation to more urban areas.

**MOBILE OUTREACH** Wendy Ring, MD, is medical director and administrator of the Mobile Medical Office in Blue Lake, California, which serves homeless people all over Humboldt County. The van is 39 feet long, includes two exam rooms, an office lab, a dispensary for medications, and medical records — just like a stationary clinic, but smaller. In addition to providing medical services, they have a needle exchange program. Clients see a doctor every time they come in to exchange needles. Physicians screen them for HCV, HIV, TB, STDs, and mental illness. Ring maintains good electronic communications with other providers. “You can do a lot to connect people up to services with a laptop computer, a phone and a fax from a mobile unit,” she says.

**HOMELESSNESS PREVENTION** Dr. Ring and her colleagues also deliver comprehensive medical care at school-based clinics.

“Adolescence is the age to begin homelessness prevention,” she advises. “You can’t intervene as easily with younger children without parental permission, and parents often resist interventions because they are fearful of losing their child to state custody. Pregnancy prevention and substance abuse prevention are key.” School-based clin-

ics also foster early identification of mental illness, which often emerges in adolescence. Early intervention can prevent cognitive impairment and encounters with the criminal justice system that can limit employment options and treatment access, explains Ring, who was formerly a Medical Director at Albuquerque HCH. ■

#### RECOMMENDATIONS FROM RURAL SERVICE PROVIDERS

- **Transportation assistance:** Refurbish used cars for homeless people. Need more information about how rural areas are addressing transportation problems.
- **Temporary shelters** as alternative to costly motels. Provide services for homeless women in domestic violence shelters.
- **Basic health & social services:** School-based clinics and service centers for women. Improve responsiveness of rural mainstream professionals to homeless people. Interagency collaboration & service coordination within/among rural counties.
- **Behavioral health care:** Improve responsiveness of CMHCs to homeless people. Follow American Society of Addiction Medicine substance abuse treatment guidelines. Track use of frequently abused prescription drugs (e.g., OxyContin).
- **Specialty care:** Expand Medicaid eligibility. Mandate universal coverage. Limit fees for specialty care. Prohibit "cherry-picking" by mainstream providers and private insurance carriers.
- **Homelessness prevention:** Advocate for a living wage, affordable housing. Educate adolescents in school-based clinics.
- **Entitlement assistance:** Educate homeless clients about Medicaid requirements and enrollment procedures.
- **Medicaid policy changes:** Restore eligibility for disabling substance abuse disorders. Exempt homeless people from managed care. Provide presumptive Medicaid eligibility for homeless persons.
- **Outreach services:** Use community networks and indigenous workers to facilitate homeless outreach in remote areas.
- **Decentralized rural health services:** Establish permanent clinic sites in remote areas (e.g., Quonset huts in Guatemala)
- **Cultural competency:** Provide an interpreter at every clinic site serving persons with limited English proficiency. Focus on clients' immediate and perceived needs. Educate faith-based service providers about the needs of homeless people.
- **Increased federal & state funding to rural areas** for dental care, integrated mental health/substance abuse services, services to undocumented immigrants, hepatitis C treatment and follow-up care.
- **Closer HUD/HHS collaboration:** Integrate housing & health care. Guarantee maintenance of transitional housing services. Give lower-income applicants priority for Section 8 housing; maintain stable rental fees over an extended period.

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