Improving Health Care and Housing Outcomes Through Cross System Coordination

Partnering with Homeless Assistance Programs and Mainstream Health Care Providers

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HomeBase / The Center for Common Concerns

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Advancing Solutions to Homelessness

Overview

- Need for coordination and integration across housing and health care systems to improve health outcomes and housing stability
- Strategies to foster and facilitate partnerships among HCH programs, housing and homeless assistance agencies, and health care providers
- Examples of existing innovative partnerships between HCH programs and homeless assistance agencies

Connection Between Housing & Health Care Needs

- Housing is a Key Determinant of Health
- Homelessness is Correlated with High Health Costs
- Housing Linked with Health Care and Support Services Improves Health Outcomes and Reduces Health Care Costs

Housing is a Key Determinant of Health

People Experiencing Homelessness are at Greater Risk for Poor Health

- Contact with communicable diseases and infections, exposure to extreme weather, malnutrition, stress, lack of running water to maintain cleanliness, and lack of refrigeration for medication
- High rates of infectious and acute illnesses (skin diseases, TB, pneumonia, asthma); chronic diseases (diabetes, hypertension, HIV/AIDS, cardiovascular disease); poor mental health and/or substance abuse; and being victims of violence.
- Mortality rate 3-4 times higher than for the general population

Homeless-ness is Correlated with High Health Costs

- High proportion of complex health needs and co-occurring health and behavioral health disorders increases the number, intensity, and scope of the services needed.
- Homelessness inhibits the long-term, consistent care needed for many of these conditions, aggravating the conditions and making them more dangerous and more costly.
- Homelessness also increases the likelihood of avoidable, repeated use of the emergency room, inpatient treatment, and crisis services.

Homeless-ness is Correlated with High Health Costs

Strong evidence base:

- CA study: **45%** of high utilizers of ERs are people experiencing homelessness
- NYC study: Homeless people with SMI utilized over **$40,000/year** on average in publicly funded shelters, hospitals, ERs, prisons, jails, and outpatient care
- FL study: each chronically homeless individual cost state **$31,065/yr** in in-patient hospitalizations, ER fees, incarceration and other systems.
- Phila. study: Top 20% of chronically homeless individuals with substance abuse issues cost City approx. **$22,000/year per person** in behavioral health services, prison, jail, and homeless services.

Housing Linked with Health Care Improves Health Outcomes and Reduces Costs

Research and experience repeatedly document that housing linked with health care and supportive services results in:

- reductions in costs for hospitalization, emergency room visits, crisis services, shelter, jail, and detox
- higher rates of housing stability and retention; and
- improved health and recovery

Housing Linked with Health Care Improves Health Outcomes and Reduces Costs

- Illinois PSH program: **39% reduction** in total cost of services two years after housing. Mainstream services costs decreased by almost **$5,000 per person**.
- Denver analysis of PSH residents: **34% fewer** ER visits, **40% fewer** inpatient visits, **82% fewer** detox visits, and **76% fewer** incarceration days.
- Chicago Housing for Health Partnership study: Each 100 chronically homeless individuals housed will **save $1M** in public funds/year **($630,000/year** for each 100 short term homeless individuals).

H^2: Federal Initiative to Improve Housing and Health Integration

- HUD + Federal Agency Partners
- Housing-Health Integration Action Planning Sessions to address:
  - HUD Homeless Assistance funds going toward services that could be funded by mainstream programs
  - Lack of coordination between housing and health care providers

Housing-Health Integration Action Planning Sessions

- 1.5-day facilitated planning sessions to create action plan to increase cross-systems coordination and integration
- Mix of stakeholders: housing assistance, health care, and supportive service providers
- Knowledge exchange across homeless assistance and health care systems, including review of case studies and best practices
- Facilitated breakout discussions to elicit strategies and action steps

Housing-Health Integration Action Planning Sessions

- 20 sessions around the country: CT, FL, GA, HI, ID, IL, MI, MT, NC, ND, NM, NV, NY, PA,TN, TX, UT, VA, WI, WV
- About half in states with expanded Medicaid
- Some state-wide; some city- or county-focused
- Rural and urban communities represented

Housing-Health Integration Action Planning Sessions

Lessons Learned / Common Themes

- Homeless or formerly homeless individuals are not effectively accessing health care, even when enrolled in Medicaid or other insurance.
- Lack of knowledge of health care resources available to homeless clients and vice versa.
- Lack of knowledge of how to access resources; ensure client engagement.
- Lack of accessible behavioral health services (often due to long wait times for appointments).
- Lack of transportation/ability to get to health appointments from shelters or permanent housing.

Housing-Health Integration Action Planning Sessions

Lessons Learned / Common Themes

- Lack of cross-system coordination (or even awareness) with respect to shared clients, resulting in missing knowledge about client history and needs and/or duplication of efforts
- Lack of data-sharing (especially across systems) with respect to shared client base
- Need to partner housing/homeless assistance providers with hospitals and/or managed care organizations
- Opportunities for linking HCH and other FQHCs, ERs/hospitals, and other health care providers to Homeless Services Coordinated Entry System

Opportunities for HCH Programs

- As more people experiencing or exiting homelessness gain health care coverage, there is a greater need for education and coordination to ensure effective access to health care that ultimately reduces avoidable system costs.
- HCH programs are in a unique position to form mutually beneficial partnerships with homeless assistance agencies and help bridge the gap between the mostly siloed housing and health care systems.
- Goal is to create a truly coordinated continuum of housing, health, and supportive services to improve housing and health outcomes for people experiencing homelessness and lower costs/burdens on all systems.

Opportunities for HCH Programs

- Build relationships with CoC/Homeless/Housing System
  - Learn about housing needs of your community generally and how to better identify needs of individual patients
  - Learn about resources available to your patients
  - Work together to make decisions about new clinics (including locations, services needed)
- Become part of Coordinated Entry System
- Form strategic partnerships with individual housing providers/agencies
- Request funding for transportation; implement loan repayment/scholarship programs for medically underserved communities
- Consider opening clinics and/or recuperative care facilities at shelters or permanent housing sites
- Consider operating shelter and/or permanent housing

HCH Program Snapshot

Albuquerque Health Care for the Homeless

- Includes an emergency shelter for families in crisis
- Runs a motel voucher program that lodges people who are homeless who require shelter during recuperation.
- Links to a range of homeless service providers, including shelters, meal sites, transitional housing programs, clothing banks, social service organizations, job training/employment, and educational support services
- Vital part of NM H^2 Implementation Team, including leading effort to get housing questions integrated in health system

HCH Program Snapshot

Jacksonville: Sulzbacher Center for the Homeless

- Operates an emergency shelter, and provides food, clothing, child care and employment services.
- Operates over 100 HUD-funded, scattered-site housing programs targeted to specific homeless populations.
- On-site: 20-bed Recuperative Care Unit (funded by hospital)
- Participates in program with Sheriff's Office, County Prosecutors Office, and County Public Defenders to divert homeless people with the frequent misdemeanor arrests from jail directly to housing
- Part of FL H^2 Implementation Team (Work Group Leader)

HCH Program Snapshot

Louisville: Phoenix Health Center

- Operates a Housing First Permanent Supportive Housing voucher program. Residents receive medical, dental, and behavioral health services through the HCH.
- Full-time SOAR worker, mental health therapist, and two social service workers that provide substance abuse counseling, referral, and case management.
- HCH Director runs the Coordinated Entry System for the Homeless Continuum of Care

Opportunities for HCH Programs

- Bridge gap between homeless/housing system and mainstream health care system:
  - Evidence shows need and potential for cost savings (studies, pilot programs, CHNAs) but some mainstream health care providers remain hesitant
  - Need intermediary partners that speak the same language, can more easily share data, have experience working with the homeless population

Homeless-Health Partnership Examples

- Managed care organizations contracting with Homeless Continuum of Care to identify and outreach to members
- Hospitals funding affordable/homeless housing as a result of Community Health Needs Assessments
- Hospitals and managed care organizations partnering with Homeless Continuum of Care on frequent utilizer pilot programs: funding, participating in case conferencing, measuring outcomes

Discussion

- What have you tried in your community?
- What's working? What's not?
- What barriers and obstacles are you finding?
- What strategies and opportunities are you interested in pursuing?
- Questions?

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