Improving Health Care and Housing Outcomes Through Cross System Coordination

Partnering with Homeless Assistance Programs and Mainstream Health Care Providers
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.
Homelessness 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.
Homelessness 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.
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
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.
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
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 H² Implementation Team, including leading effort to get housing questions integrated in health system
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 H² Implementation Team (Work Group Leader)
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?
Gillian Morshedi, HomeBase

gillian@homebasecccc.org

415-788-7961 ext. 301