INNOVATIVE TREATMENT, HOUSING, AND SERVICE PARTNERSHIPS TO LINK HOUSING WITH HEALTH AND HUMAN SERVICES

The information in this document is intended to provide housing, health care, and social service providers with ideas for innovative, cross-system partnerships and coordination. The following topics are covered:

- Connection Between Homelessness and Health Outcomes
- Housing and Service Providers in Partnership
- Healthcare for the Homeless Programs as Housing Programs
- Housing Navigators
- Housing Transition and Support Services
- Managed Care Strategies

Connection Between Homelessness and Health Outcomes

- Homeless adults are more likely to suffer from chronic medical conditions and to suffer complications from their illnesses due to lack of housing stability and regular, uninterrupted treatment.[1]
- Chronically homeless people tend to frequently use emergency services, crisis response, and public safety systems.[2]
- For those with complex chronic health conditions, homelessness or housing instability is among the most significant barriers to health care access, resulting in excessive use of emergency departments, inpatient treatment, and crises services.[3]
- Numerous studies have shown the correlation between homelessness and high health care costs:
    - A 2010 HUD study found that in Kalamazoo, Medicaid costs for children in a cohort of homeless families were 26% higher than the statewide average Medicaid cost for children; Medicaid costs for adults were 78% higher than the statewide average.[4]
    - A 2004 analysis of Duval County conservatively estimated taxpayers pay $35,000,000 a year on providing services for the homeless, including healthcare system costs such as emergency rooms, untreated illnesses, unreimbursed expenses, ambulance service, and crisis stabilization units.[5]
    - A Philadelphia study found that the top 20% of individuals experiencing chronic homelessness plus substance abuse cost the City approximately $22,000 per person per year in behavioral health services, prison, jail, and homeless services.[6]

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[1] http://www.cdc.gov/features/homelessness/ and Kaiser Commission on Medicaid and the Uninsured, "Medicaid Coverage and Care for the Homeless Population: Key Lessons to Consider for the 2014 Medicaid Expansion", September 2012, available at: http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8355.pdf

[2] National Alliance to End Homelessness, "Chronic Homelessness," 2015, http://www.endhomelessness.org/pages/chronic_homelessness.

[3] Deborah Canavan Theile, "Creating a Medicaid Supportive Housing Services Benefit: A Framework for Washington and Other States," *The Corporation for Supportive Housing for Washington Low Income Housing Alliance,* August 2014: 10, http://wliha.org/sites/default/files/FINAL%20Creating%20a%20Medicaid%20Supportive%20Housing%20Services%20Benefit.pdf.

[4] U.S. Department of Housing and Urban Development, "Costs Associated with First-Time Homelessness for Families and Individuals," March 2010, https://www.huduser.gov/publications/pdf/Costs_Homeless.pdf.

[5] Ability Housing, "Home is Where Our Heart Is," 2007 Annual Report, http://abilityhousing.org/docs/AH_07AnnualReport.pdf.

[6] Stephen R. Poulin, Marcella Maguire, Stephen Metraux, and Dennis P. Culhane. "Service Use and Costs for Persons Experiencing Chronic Homelessness in Philadelphia: A Population-Based Study" *Psychiatric Services* 61.11 (2010): 1093-1098.

- A Clarke county study released in February 2007 found that Athens hospitals, which are required to treat everyone regardless of ability to pay, spent at least $12.4 million in 2005 caring for the homeless, an average of almost $20,000 per homeless patient.[7]
- According to a University of Texas two-year survey of homeless individuals, each person costs the taxpayers $14,480 per year across public systems, primarily for overnight jail.[8]
- A New York study found that homeless patients are six times more likely than patients with stable housing to name an emergency department as their usual source of care or to report no usual source of care.[9]
- A 2012 study in Los Angeles found the estimated average annual public cost for 10th decile patients living in permanent supportive housing was $63,808. These public costs included jail, probation, emergency medical services, and hospitalization.[10]
- 37 homeless men and women in Asheville, North Carolina, over a three-year period, cost the City and County over $800,000 each year. The total costs included $120,000 for 280 episodes of EMS services, and $425,000 in hospitalization costs.[11]
- A study conducted by West Virginia University (WVU) and the West Virginia Coalition to End Homelessness found that 267 persons experiencing homelessness who received care at WVU Ruby Memorial Hospital over a one-year period incurred $5,979,463 in service costs, including 785 emergency department visits totaling $1,128,036 in care costs and 257 inpatient stays totaling $3,743,699 in care costs.[12]
- California study: Approximately 45% of high utilizers of emergency departments are homeless.[13]
- Hawaii study: The rate of psychiatric hospitalization of homeless people was over 100 times higher than for a non-homeless cohort.[14]
- AmeriHealth Washington D.C. member costs: A data query of 48 homeless members, listing a shelter as address in 2014, found that 54% had behavioral health issues; 19% made frequent use of the emergency room; 62.5% had costs significantly higher than average per member per year cost of $3,307.[15]
- In 2009, the emergency department of St. Patrick Hospital in Missoula, MT was visited by 514 people identified as homeless. These individuals accounted for 1,219 separate visits to the ER and were provided with $3,028,359 in charity care. Three years later in 2012, the cost was closer to $4,000,000.[16]

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[7] "Cost Analysis of Medical Services to Homeless Persons" (2007) Athens-Clarke County Dept. of Human and Economic Development, as cited in "Addressing Homelessness through Collaboration," State Housing Trust Fund Annual Report, January 1, 2008, http://www.dca.state.ga.us/housing/specialneeds/publications/2008HTFAnnualReport.pdf.

[8] National Alliance to End Homelessness, "Cost of Homelessness," http://www.endhomelessness.org/pages/cost_of_homelessness.

[9] California Department of Health Care Services Webinar, "Medi-Cal Managed Care Plans and Homeless Members," October 1, 2014. Available at: https://www.youtube.com/watch?v=32xyeUzTqys&feature=player_embedded

[10] "Getting Home: Outcomes from Housing High Cost Homeless Hospital Patients," Conrad N. Hilton Foundation, UniHealth Foundation, the Corporation for National and Community Service, the Corporation for Supportive Housing, and the Economic Roundtable, *http://www.csh.org/wp-content/uploads/2013/09/Getting_Home_2013.pdf*

[11] From National Academy for State Health Policy, "Chronic Homeless and High Users of Health Services" available at http://nashp.org/sites/default/files/chronic_homelessness.pdf?q=Files/chronic_homelessness.pdf

[12] David Parker, "An inexpensive, interdisciplinary, methodology to conduct an impact study of homeless persons on hospital based services," as cited in the West Virginia Interagency Council on Homelessness 2014 Report, available at: http://www.wvcommerce.org/App_Media/assets/download/ndrc/WVICH_Progress_Report_2014.pdf.

[13] Linkins, Brya, & Chandler, 2008, available at: http://www.aidschicago.org/pdf/2009/hhrpn/FUHCS/1FrequentUsersofHealthServicesInitiative-FinalEvaluation.pdf.

[14] National Alliance to End Homelessness, "Cost of Homelessness," 2015, http://www.endhomelessness.org/pages/cost_of_homelessness.

[15] Testimony of Karen Dale, RN, MSN, "FY 2016 Budget Hearing," AmeriHealth District of Columbia, Before the Council of the District of Columbia Committee on Health and Human Services, April 24, 2015: 4.

[16] Missoula Reaching Home Workgroup, "Reaching Home: Missoula's 10-Year Plan to End Homelessness 2012-2022," October 2012: 11, http://www.ci.missoula.mt.us/DocumentCenter/View/21013

- As of 2009, Billings estimated each homeless person cost the city over $15,000 per year in public services, with an estimated cost of $115,000 to serve each chronically homeless individual per year. With nearly 2,400 people experiencing homelessness in Billings each year, costs exceed $54 million annually.[17]
- A rough estimate for the total annual cost of homelessness in Flathead County in 2013 was in the multi-million dollar range.[18]
- The Minnesota Supportive Housing and Managed Care Pilot program found that homeless single adults with highly complex needs such as medical problems, mental illness, chemical dependency, and traumatic experiences used an average of $13,954 per year in services prior to entering permanent supportive housing.[19]
- A study in Maine found that rural homelessness costs the state $18,623 per person, including costly emergency room services and behavioral health costs.[20]

Housing and Service Providers in Partnership

- Innovative yet common form of Permanent Supportive Housing (PSH)
- Many of these arrangements involve agencies on the service side that are not Medicaid providers, but some examples of partnerships involve a service partner with some capacity to use Medicaid financing.

Examples

Central City Concern (Portland)[21]

- Permanent Supportive Housing provider has clinic, patient centered medical home, primary care and mental health team on-site.
- Coordinated with housing through Supportive Housing Healthcare Coordinator, who:
  - Develops care coordination that connects housing and health services
  - Identifies high needs residents with gaps in health care support
  - Conducts needs assessment at intake to identify health issues
  - Streamlines referral process to connect housing residents to health care
  - Obtains signed releases at outset of process
- Housing information is contained in medical records.
- Housing residents who are clinic patients have electronic medical records updated.

Pathways (Washington, D.C.)[22]

- Permanent supportive housing program with adjacent clinic
- Integrated Health team (HealthWorks) with nurse practitioner, medical assistant, peer health specialist, nutritionist
- Nurses on the ACT team get appointments with primary care doctors
- Set-aside appointments at partner FQHC

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[17] City of Billings Mayor's Committee on Homelessness Community Development Division, "Welcome Home Billings," October 2009: 5, http://www.ci.billings.mt.us/DocumentCenter/Home/View/4985

[18] Flathead Homelessness Interagency Resource and Education, "Finding the Way Home: Five-Year Plan to Address Homelessness (2014-2019)," 2014: 13, http://flatheadhealth.org/wp-content/uploads/2015/01/5-Year-Plan-to-Address-Homelessness.pdf

[19] The National Center on Family Homelessness, "The Minnesota Supportive Housing and Managed Care Pilot: Evaluation Summary," March 2009, http://www.air.org/sites/default/files/downloads/report/Evaluation-Minnesota-Supportive-Housing-and-Managed-Care-Pilot-2009.pdf

[20] State of Maine, "Cost of Rural Homelessness: Rural Permanent Supportive Housing Cost Analysis," May 2009, http://www.portlandmaine.gov/DocumentCenter/Home/View/2274

[21] Central City Concern, "Central City Concern Supportive Housing," PowerPoint, presented at National Alliance to End Homelessness Conference, July 2012. Available at: http://www.centralcityconcern.org/research/.

[22] Pathways to Housing D.C., "Housing First," 2015, https://www.pathwaystohousingdc.org/housing-first.

- SAMHSA grant has been used over last five years to integrate primary care into behavioral health care
- Created Wellness suite with a medical assistant in the agency waiting room to interact with people, directing them to the adjacent clinic

Chicago[23]

- Heartland Health Outreach (a Health Center) collaborates with Mercy Housing Lakefront to provide on-site health clinics in PSH
- Links tenants seen in those housing-based clinics to Heartland Health Outreach's main clinic for ongoing care and treatment.
- These services are Medicaid-reimbursable if clients are enrolled in Medicaid.

Los Angeles[24]

- A Community of Friends (a housing provider) has arrangements with various providers of Medicaid-reimbursable and county-funded mental health services for supports to tenants in its many buildings.
- Skid Row Housing Trust has arrangements with JWCH's Center for Community Health and Los Angeles Christian Health Center (both Health Centers) as well as Exodus Recovery and LAMP (mental health providers), among others, to serve its tenants.

Health Care for the Homeless Programs as Housing Programs

Case Study: Family Health Centers, Inc. (Louisville, KY)[25]

- Health Care for the Homeless program (Phoenix Health Center) with Permanent Supportive Housing vouchers under Housing First
- HCH Director runs the Coordinated Assessment system for the CoC
- Full-time SOAR worker, mental health therapist, and two social service workers that provide substance abuse counseling, referral, and case management
- Peer Support Program – provides residents with one-on-one mentoring
- PSH residents receive medical, dental, and behavioral health services through Phoenix Health Center

Housing Navigators

Housing navigators work as "brokers," providing options for individual patients to community health workers or social workers for them to discuss with clients.

Case Study: Hennepin Health (MN)[26]

Background:

- Housing navigators (employed by the county's Human Services and Public Health Department) play a broker role: They do not work directly with clients. Instead, they work with the social workers and community health workers who are part of clinical teams.

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[23] ASPE, "Medicaid and Permanent Supportive Housing for Chronically Homeless Individuals: Emerging Practices from the Field, "August 2014, available at: http://aspe.hhs.gov/daltcp/reports/2014/EmergPrac.pdf.

[24] ASPE, "Medicaid and Permanent Supportive Housing for Chronically Homeless Individuals: Emerging Practices from the Field," August 2014, available at: http://aspe.hhs.gov/daltcp/reports/2014/EmergPrac.pdf.

[25] Connie Campos, "Grantee Spotlight: Family Health Centers, Inc.", U.S. Substance Abuse and Mental Health Administration, Homeless Resource Center, 2013, http://homeless.samhsa.gov/resource/grantee-spotlight-family-health-centers-inc-55979.aspx.

[26] State of Minnesota, "Reform 2020: Pathways to Independence- Section 1115 Waiver Proposal," resubmitted to CMS November 21, 2012: 58-59. https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6535E-ENG.

- Clinical teams and housing navigators use a "tiering system" to target assistance to the most vulnerable patients who are homeless or unable to return to a safe and stable living situation.
- The goal is to focus on those whose lack of housing contributes to escalating medical costs.

Process:

- Community health workers and social workers who make referrals gather information about patients and then work with the housing navigators to identify options that offer the best fit for each individual in terms of eligibility, needs, and preferences.
- Housing navigators know about all of the housing options in the county, and they know which programs use a housing-first approach and which have rules about sobriety. Options include emergency or short-term options as well as permanent supportive housing.
- Housing navigators track information about housing program characteristics, including application procedures and vacancies, and then offer up to three options for the community health workers or social workers to discuss with their clients.
- Community health workers or social workers are responsible for helping clients follow through to complete applications and get into housing.
- If client is rejected by a suggested housing provider, navigators try to find other options.
- Housing navigators also provide information that community health workers can use to follow up on their own to assist other patients who have lower levels of need.

Housing Transition and Support Services

- Enable participants who are transitioning into a PSH unit, including persons who were homeless or transitioning from institutions, to secure their own housing; or
- Provide assistance continuously thereafter including at any time the participant's housing is placed at risk (e.g., eviction, loss of roommate or income).

Case Study: Louisiana[27]

Background:

- Interventions are included in two Home and Community Based Services (HCBS) Waiver programs and in the state's Medicaid 1915(i) program, which includes:
    - Community Psychiatric Treatment and Support (CPST)
    - Combined case management and direct services intervention, and
    - ACT services for persons with serious mental illness, including those with co-occurring substance abuse disorders.
- Identical housing support interventions in state's CABHI grant, their Access to Recovery (ATR) program, and their CDBG funded housing support services.
- Nearly 3,000 households are now served. Persons who were homeless at the time of referral to supportive housing have been major beneficiaries of this service.
- The Louisiana Department of Health and Hospitals (DHH) manages the program in partnership with the Louisiana Housing Corporation and local CoC designated agencies.
- Providers are certified as PSH providers to deliver these services, and receive ongoing training and coaching to help them meet Medicaid requirements and address challenges.

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[27] Deborah Canavan Thiele, The Corporation for Supportive Housing, "Creating a Medicaid Supportive Housing Services Benefit: A Framework for Washington and Other States," August 2014, http://www.csh.org/wp-content/uploads/2014/08/Creating_Medicaid_Supportive_Housing_Servcies_Benefit_WashingtonState.pdf and ASPE, "Medicaid and Permanent Supportive Housing for Chronically Homeless Individuals: Emerging Practices from the Field," August 2014, available at: http://aspe.hhs.gov/daltcp/reports/2014/EmergPrac.pdf.

Medicaid Services Included:

- Housing assessment identifying the participant's preferences related to housing and needs for support to:
  - Maintain housing
  - Budget for housing/living expenses
  - Obtain/access sources of income necessary for rent, home management, and establishing credit
  - Understand and meet obligations of tenancy
- Assistance locating, securing, and maintaining housing
- Development of an individualized housing support plan based upon a housing assessment that includes short-term and long-term measurable goals, an approach to meeting each goal, where other provider(s) or services may be required to meet the goal
- Participation in development of the Plan of Care
- Individual supportive counseling and assistance with daily living skills development
- Looking for alternatives to housing if PSH is unavailable
- Assistance with landlord negotiations
- Intervention and help requesting assistance from Crisis Intervention Services if a participant's housing is placed at risk (e.g., eviction, loss of roommate or income)

Managed Care Strategies[28]

Managed care organizations (MCOs) may pay for services on a fee-for-service basis. However, in recent years, states have moved away from just using a straight fee-for-service payment for many of the health care services covered by Medicaid, relying instead on Medicaid managed care approaches to organizing payment and delivery of medical and/or behavioral health services for growing numbers of Medicaid beneficiaries.

Strategies for MCOs to Effectively Serve Homeless People

1. Target resources to those with greatest needs. Develop methods for identifying the highest need/highest cost beneficiaries, which will typically include people who are chronically homeless or have ongoing housing stability problems. Target intensive care management and housing stabilization services for this population.
2. Develop innovative funding strategies for funding the care management and housing stabilization services needed by people who are chronically homeless or at-risk. This includes using funds included in their capitated payment to fund specialized care management or coordination and essential services that are difficult to fund under a fee-for-service system. (This may require State and CMS approvals.)
3. Reinvest a portion of profits on an annual basis (cost-savings after covering risk and contingency) into housing and other services needed to stabilize the population, and hopefully, allow more cost-savings to be incurred. This is particularly important as a strategy to fund additional PSH, respite housing, and other housing needed by the target population.
4. Establish partnerships with a range of agencies serving the target population in order to coordinate (not duplicate) resources and support robust and effective interventions that

[28] Information from: ASPE's Medicaid and Permanent Supportive Housing for Chronically Homeless Individuals: Emerging Practices from the Field (mostly Chapter 6), available at: http://aspe.hhs.gov/daltcp/reports/2014/EmergPrac.pdf and CSH's Integrating Housing in State Medicaid Policy, http://www.csh.org/wp-content/uploads/2014/04/State_Health_Reform_Summary.pdf.

effectively stabilize individuals served. This includes homeless housing and service providers who have expertise with the population.

Practical Examples[29]

Facilitate Homeless Enrollment and Access to Care

This involves taking steps to ease the transition and facilitate continuity of care (if they had care before) for newly enrolled homeless clients, including ensuring that procedures are in place for quickly making changes in provider assignment and for facilitating access to the most appropriate care providers for people who are homeless, supportive housing tenants, and people with behavioral health disorders. It also involves taking steps to increase MCO organizational capacity and cultural competence to help newly enrolled homeless beneficiaries.

Reach Out to Organizations with Experience Working with Homeless People

Contract with organizations such as homeless service agencies and those providing PSH or services to clients in PSH in order to provide key services (care coordination, targeted case management (TCM), behavioral health care, or other services) that support ongoing health and wellness.

Case Study: Minnesota Special Needs Basic Care Plans

- Minnesota state legislation enacted in 2011 requires that Medicaid recipients with disabilities be assigned to a Special Needs Basic Care health plan
- Plans are responsible for:
    - Covering both health and behavioral health services;
    - Completing comprehensive health assessments and providing care coordination services to help patients get care from primary care providers, specialists, and other health care services; and
    - A benefit package that includes targeted case management services for people with serious mental illness.
- To fulfill their responsibilities, some plans work with mental health service providers, including those who deliver TCM services in PSH, to establish contracts and share training and other resources.
- Medica, one of the Special Needs Care Plans, shares its care management tools (such as assessment instruments, care plans, and information systems) with the plan's vendors.
    - Medica recognizes that some of these partner organizations have a background in social services but less capacity or experience with medical issues.
    - Therefore, Medica nurses and nurse practitioners are available to these partners to provide clinical consultations or do home visits as needed.
- **Outcome**: Data shows a large increase in the number of mental health clients who have seen their primary care providers and had physical exams.

Use a Tiering System

Match people with the most appropriate level of care based on the complexity of their health and social needs. This should be linked to a tiered reimbursement rate that pays more for care provided to people with complex health needs and histories of high service utilization and costs (e.g. those who are homeless and have multiple ER visits, hospital admissions and/or detox stays).

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[29] Information from: ASPE's Medicaid and Permanent Supportive Housing for Chronically Homeless Individuals: Emerging Practices from the Field (mostly Chapter 6), available at: http://aspe.hhs.gov/daltcp/reports/2014/EmergPrac.pdf and CSH's Integrating Housing in State Medicaid Policy, http://www.csh.org/wp-content/uploads/2014/04/State_Health_Reform_Summary.pdf.

Incorporate a “Super-Utilizer” Program

Create a program that identifies high-need/high-cost members and targets evidence-based interventions to meet their needs, including Housing First, PSH, and intensive service supports.

Case Study: Minnesota

- The State’s contract with the Special Needs Basic Care Plans allow the MCOs to provide “in lieu of” services—meaning some services that are not defined in the state Medicaid plan but “make sense” because of the needs of members and the potential to achieve cost offsets.
- Representatives of Medica (one of the MCOs participating in managed care in Minnesota) are initially focusing on providing these services to members who are experiencing homelessness and/or making frequent use of hospital care or other health services.

Reinvest a Share of Cost Savings

Use a share of "annual" cost savings for “re-investment” back into supportive housing and other key programs and services, such as care coordination, housing navigation, and recuperative care/medical respite/bridge housing programs.

Case Study: Community Behavioral Health in Philadelphia

- The City of Philadelphia operates a not-for-profit behavioral health managed care organization called Community Behavioral Health (CBH).
- CBH partners with the city’s housing agencies and the Department of Behavioral Health, utilizing both Medicaid and city designated funding to finance services and housing for supportive housing residents based on their contract with the Pennsylvania Department of Human Services (Medicaid agency).
- If a participant is deemed eligible for Medicaid, CBH offers a set of services that community-based homeless service providers deliver.
- CBH cost savings become city revenue after risk and contingency obligations are made. CBH may request those funds be allocated to supporting one-time expenditures based on their state approved housing plan.
- Investments can be made for capital, rental assistance, contingency funds and one-time services and administrative costs.