CSH SIF Classic

Developing housing and health care solutions for vulnerable populations
Homelessness and High-Cost Use of Crisis Health Services

Problem... Subset of individuals who cycle between multiple crisis systems, use a disproportionate share of healthcare costs and are systematically excluded from interventions that may benefit them

- Lack of care coordination and connection to primary/preventive services, which leads to frequent use of crisis health services
- High costs and poor outcomes for individuals... multiple arrests, risky behaviors, unmanaged chronic conditions
- Funding and policymaking in “silos” prevents the provision of integrated solutions that address health, social, and housing needs at once

Solution... Supportive Housing as a Platform for a Coordinate Service Delivery System

- Population demands a more comprehensive intervention: targeted housing, enhanced outreach and engagement, intensive case management
- Use data to identify and target cohort
- Builds integration with health care improving health access, improve health outcomes and better utilizes public resources
Tenants are homeless, have complex health conditions and not well connected to a medical home.

Supportive Housing

- Prioritization and Placement in Housing
- Troubleshooting of Housing Problems / Lease Violations

Stable housing creates platform for confronting health needs and receiving care.

Care Management and Patient-Centered Health Home

- Engagement and Rapport Building
- Motivational Enhancement & Empowerment
- Care Management and Coordination
- Coordinated Primary/Behavioral Health Care

Health status improves, use of crisis health services decreases, use of preventive care increases, and public costs lowered or offset.
Why Target Frequent Users?

Homelessness with Complex Needs and High Costs

- Subset of individuals who cycle between multiple crisis systems and are systematically excluded from interventions that may benefit them.
- Poor outcomes for individuals… multiple arrests, risky behaviors, unmanaged chronic conditions
- High costs with little positive results

Opportunity for Coordinated Service Delivery System with In Supportive Housing

- Population demands a more comprehensive intervention: targeted housing, enhanced outreach and engagement, intensive case management, and access to health care
- Use data to identify and target cohort
- Builds integration with health care improving health access and outcomes while lowering costs

Blue Print for Systems Change and Scaling

- Develop a services financing model that benefits all systems
- Diversify funding for services and reinvest savings from health/CJ system into housing and/or housing based services
- Increase capacity of housing and services interventions to end chronic homelessness!
Researchers from NYU’s School’s of Medicine and Education are completing a cross-site, multi-method evaluation to measure the impact on health and housing stability, use of crisis health services and Medicaid and other public costs.

**Key Research Questions**

- Is it possible to effectively target and engage the kinds of homeless high utilizers for whom this program was intended and provide them with the type of supportive housing that was thought likely to be effective?
- If so, would we see impacts on health care utilization – that is reductions beyond what likely would have happened even without the program? What about impacts on shelter use and jail time?
- Would these impacts prove sufficient to cover the costs of the program?

**Methods:**

- Site visits
- Participant Survey Data
- Administrative health, homelessness and jail utilization data
Adapting Supportive Housing as a Health Care Intervention

- Data Driven Targeting
- Assertive Outreach and Housing First
- Patient Navigation/Health Care Coordination
- Clinical Partnerships with Health Care Providers

SUPPORTIVE HOUSING
SIF uses 2 types of data driven targeting:

- Match identified administrative data from HMIS and health system (Medicaid/hospital) to generate list of priority individuals
  - Engaged only those on the list who meet threshold criteria
  - Criteria can be adjusted based on local characteristics and need

- Point of Care: Use de-identified administrative data to develop predictive algorithms
  - Able to identify and engage high utilizers in multiple systems (hospitals) and make direct referrals to housing
  - In LA, the 10th Decile Triage tool is used in 14 hospital systems
<table>
<thead>
<tr>
<th>Lead Organization</th>
<th>Tenderloin Neighborhood Development Corporation</th>
<th>AIDS Connecticut</th>
<th>Housing Works, HHCLA, Acencia, OPCC</th>
<th>Avalon Housing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target Geography</td>
<td>San Francisco, CA</td>
<td>Connecticut (statewide)</td>
<td>Los Angeles County, CA</td>
<td>Washtenaw County/Ann Arbor, MI</td>
</tr>
<tr>
<td>Number of Individuals</td>
<td>172</td>
<td>160</td>
<td>107</td>
<td>110</td>
</tr>
<tr>
<td>Data Driven Approach to Client Identification</td>
<td>Analysis of ED/hospitals records &amp; top 200 users of county health plan services</td>
<td>Data match between Medicaid and HMIS to identify top 10% highest users</td>
<td>Predictive algorithm to identify highest decile of costs of crisis health service use</td>
<td>County health plan data analysis to identify highest cost users</td>
</tr>
<tr>
<td>Outreach and Recruitment</td>
<td>In-reaching into hospitals and emergency rooms</td>
<td>In-reaching into hospitals and shelters</td>
<td>Hospital-based screening</td>
<td>In-reaching into emergency rooms and hospitals</td>
</tr>
<tr>
<td>Housing Model</td>
<td>Single-site supportive housing building (with onsite FQHC)</td>
<td>Scattered-site and single-site</td>
<td>Single-site and scattered-site</td>
<td>Scattered-site</td>
</tr>
<tr>
<td>Primary and Behavioral Health Services</td>
<td>City of San Francisco Housing and Urban Health FQHC</td>
<td>Five regional partnerships between FQHCs and LMHAs</td>
<td>Several FQHCs</td>
<td>University of Michigan Hospital and Packard Health</td>
</tr>
<tr>
<td>Integration of Health and Housing</td>
<td>Integrated services team between TNDC and HUH</td>
<td>FQHC-based patient navigators/boundary spanners</td>
<td>Patient navigators/system coordinators</td>
<td>Integrated Housing and Health Care Team</td>
</tr>
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</table>
Kelly Cullan Community Center
Target: 172

Partner Agencies
TNDC, SF Department of Health, SF Health Plan, Lutheran Social Services, YMCA

- Co-located FQHC and Supportive Housing
- Housing first approach with assertive outreach and engagement
- Intensive case management, comprehensive needs assessment and individualized service planning
- Housing stabilization, retention, and eviction prevention
- Nurse case management and medication adherence assistance
- Coordinated primary and behavioral health care
- Community building and social activities

State of CT
Target: 160

Administrative data match b/w Medicaid and HMIS to identify the target population

Non-profit Housing & Service Providers
- Columbus House, New Haven
- Journey Home, Hartford
- New London Homeless Hospitality Center
- Supportive Housing WORKS, Bridgeport

Integrated Health Partners:
Community Health Network of CT, ValueOptions, FQHCs and Local Mental Health Authorities

Housing Resources:
Governor’s office allocated 150 Rental Assistance Program vouchers
Successful public/private partnership with $13 million in match funds raised

47% engaged at hospital or health clinic

719 people housed

89% housing retention rate

92% report being connected to primary health care services
What are we learning so far…

1. Data driven targeting is effective in **defining and locating** the highest utilizers with complex needs. Integrating data to see people beyond our “own” system.

2. Forging new institutional and cross-agency partnerships…
   - Leveraged housing resources including 150 state vouchers from CT and set-aside of units from Ann Arbor Housing Commission.
   - Cross system case conferencing and Interagency Steering Committee to monitor progress and overcome system barriers in real time.
   - *Avoid duplication or temptation to build from scratch… leverage the strengths of the right system/agency/staff to play the right role (SH and health)*
   - Aligning priorities: health systems focus on super utilizers homeless system focus on ending chronic homelessness.

3. Effective engagement requires housing first approach, flexibility and partnerships
   - Intensive Service Model and Small Case Loads: 10:1
   - **The Role of the Patient navigator is Key**… Relationships that extend beyond housing and health care…
   - Coping with complex health issues and even death (13 people have died across all sites).

4. Role of community context and resources in program implementation and impact

5. Impact of supportive housing as a health care intervention for those with greatest cost and complex chronic conditions.
Early Evaluation Results

Administrative data shows high utilization at baseline:

In the year prior…
• Average hospitalizations: 2.3
• Average number of hospital days: 21.4 (> 30 in CT, ~9 in MI, and ~ 12 in SF)
• Average ED visits: 9.3
• High average costs of healthcare

  ~ $30,000 in MI and SF
  ~ $60,000 in CT

In the 12 month follow up period:
• SF: reduction in hospital days (-5) and number of medical hospitalizations (-1)
• CT: reduction in hospitalizations (-1.1) and a cost reduction of $15,583
Key Takeaways…

• It is possible to develop and deliver a medically-oriented supportive housing program targeted at homeless individuals who are high utilizers of health care, but it is difficult. Program implementation and capacity for impact are both influenced by local context and state policy.

• This program can reduce utilization of shelters and costly health care, primarily through reduced hospitalizations, and especially for those who were mostly costly at baseline. These reductions can substantially offset program costs.

• While the program was associated with reduced costs and utilization and improvements in self-reported quality of life and access to care, many participants were still likely experiencing deep and complex health problems one year into the program.
Sustaining and scaling take both practice and policy reform

Utilizing both state and federal resources, engaging health systems, MCOs, Medicaid directors to discuss role housing can play in reducing healthcare costs

<table>
<thead>
<tr>
<th>California</th>
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<tbody>
<tr>
<td>• Increased <strong>investments</strong> for health and housing integration:</td>
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<td>• LA County Healthcare investments by DHS, MCOs, DHCS for integrated services:</td>
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<tr>
<td>• Whole Person Care (Medi-Cal waiver); L.A. Care investment in Flexible Housing Subsidy Pool;</td>
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<tr>
<td>• Health Home</td>
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<tr>
<td>• LA County Homelessness Initiative:</td>
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<td>• Measure H funding and Proposition HHH</td>
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<table>
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<tr>
<th>Connecticut</th>
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<tr>
<td>• Continued state investment through housing vouchers and DMHAS service dollars</td>
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<tr>
<td>• 1915i Policy Development</td>
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<tr>
<td>• Hospital Engagement/Community Care Teams (CCT)</td>
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<td>• Medicaid Institute for SH Agencies</td>
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<thead>
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<th>Washtenaw</th>
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<tr>
<td>• Lead Agency Transitioned to Medicaid Biller</td>
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<tr>
<td>• Integration of FUSE into CA</td>
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<td>• Engagement of State and Interagency Committee</td>
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<tr>
<th>Evaluation</th>
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<tbody>
<tr>
<td>• Closer look at changes in hospitalization (funded)</td>
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<tr>
<td>• Quality of care</td>
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<tr>
<td>• Jail data</td>
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<tr>
<td>• Mortality</td>
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## Scaling with PFS and Common Elements

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Partners</strong></td>
<td>identify a concrete problem/goal and a proven solution.</td>
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<tr>
<td><strong>Data</strong></td>
<td>is used to understand and identify a target population and targeted outcomes are identified.</td>
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<tr>
<td><strong>Intervention</strong></td>
<td>is designed that will meet the needs of the target population and achieve the targeted outcomes.</td>
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<tr>
<td><strong>Resources and funding</strong></td>
<td>are identified to implement.</td>
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<tr>
<td><strong>Proven, high capacity housing and service providers</strong></td>
<td>are identified.</td>
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<tr>
<td><strong>Eligibility, enrollment and evaluation strategies</strong></td>
<td>are designed and implemented.</td>
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<tr>
<td><strong>Implementation</strong></td>
<td>occurs and adjustments are made along the way.</td>
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