BETTER HEALTH THROUGH HOUSING

Center for Housing & Health

Better Health Through Housing: A Collaboration Between Supportive Housing Providers and the Health Care Sector

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2018 Housing First Partner's Conference

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Objectives

- **Attendees will understand the impact of Housing First on the healthcare landscape**
- **Attendees will understand the benefits of collaboration between the health care sector and supportive housing.**
- **Attendees will understand how supportive housing impacts health care costs.**
- **Identify ways to improve coordination between the health care and housing sectors.**

Housing First in Health Care

- **Foreign Concept**
- **Medical providers are prescriptive**
  - ***Treatment = Positive Health Outcomes***
- **Housing after Compliance**
  - ***Treatment to stabilize prior to housing***

Client Story

Case Study: UI Health Hospital Utilization for 83 days

- **$70K expense / $20K payment**
- **55 ER Visits**
- **13 Inpatient Admissions:**
  - ***8 Psych***
  - ***5 Internal Medicine***
- **Procedures**
  - ***18 ECG***
  - ***22 X-ray***

Eligibility

Who can participate?

- Chronically Homeless (HUD)
- Disability Condition
- High healthcare costs
- Referred by Hospital or Managed Care Organization (MCO)

Client Support

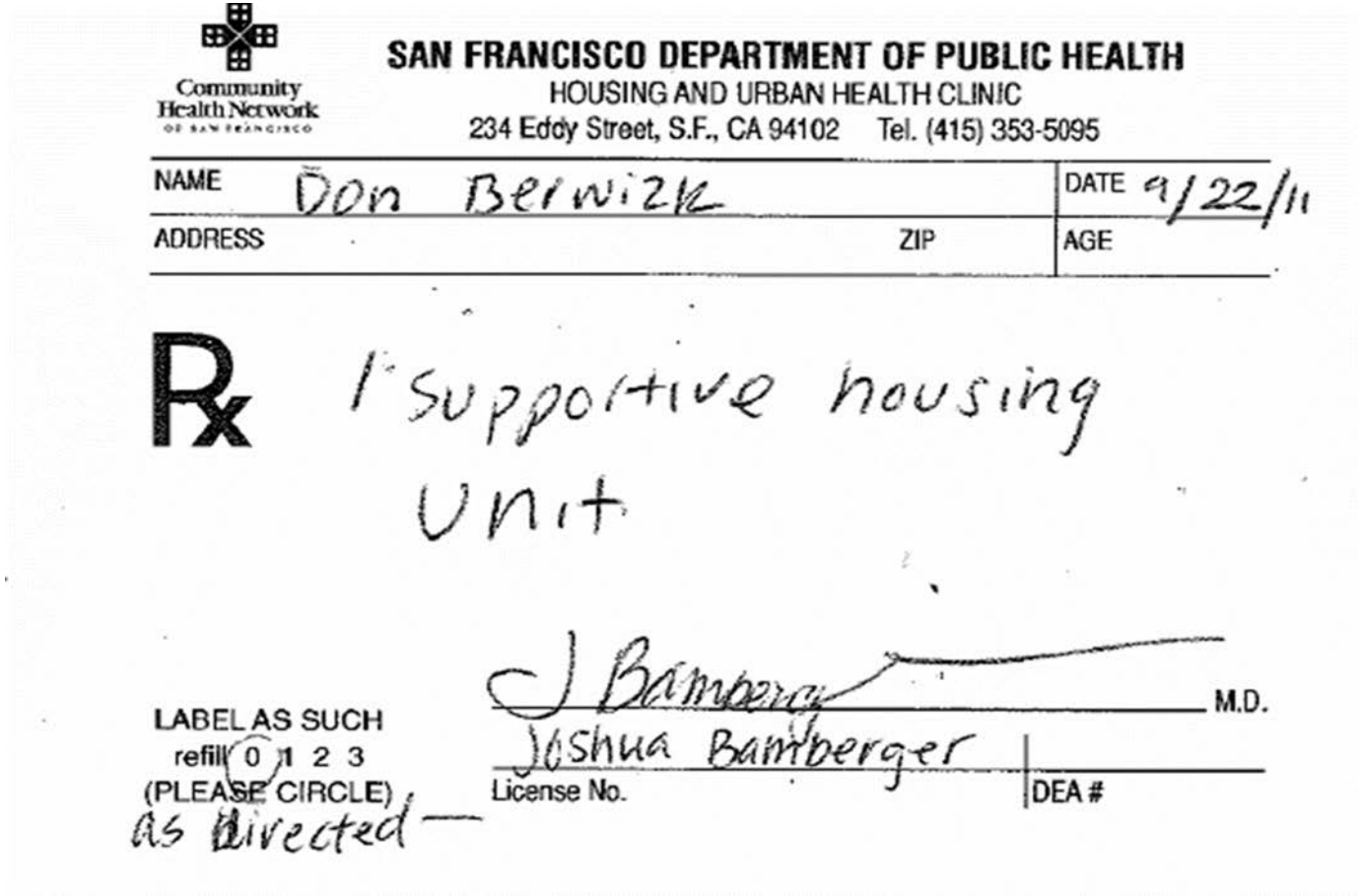
Practice Harm Reduction

- Healthcare choices
- Medication adherence
- Doctor Appointments

Liaise between Client & Health Team

- Accompany to appointments
- Relationship with Care Coordinator

Housing is Health Care!



Community Health Network of San Francisco

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH
HOUSING AND URBAN HEALTH CLINIC
234 Eddy Street, S.F., CA 94102 Tel. (415) 353-5095

NAME Don Berwick DATE 9/22/11
ADDRESS ZIP AGE

℞ 1 supportive housing unit

LABEL AS SUCH
refill 0 1 2 3
(PLEASE CIRCLE)
as directed

J Bamberger M.D.
Joshua Bamberger
License No. DEA #

A Chicago Area Supportive Housing Collaborative

- Established in November 2014
- Partnering and negotiating with Medicaid MCOs and hospital systems
- Representing 30 Supportive Housing organizations
- Portfolio: 70% of units in Chicago / County

Initial Projects

University of Illinois at Chicago (UI Health)

- 25 frequent visitors of the Emergency Department
- Housed in HUD funded units by BHH partner agencies

Chronic Homeless Project (CHP)

- 15 people from Lake Shore Drive Encampments who receive medical care at local FQHC
- Housed in HUD funded units by BHH partner agencies

Recently Started Projects

UI Health 2.0

- Referring a second cohort of 25 patients

Swedish Covenant Hospital

- Referring 10 frequent visitors from the Emergency Department
- Project Impact

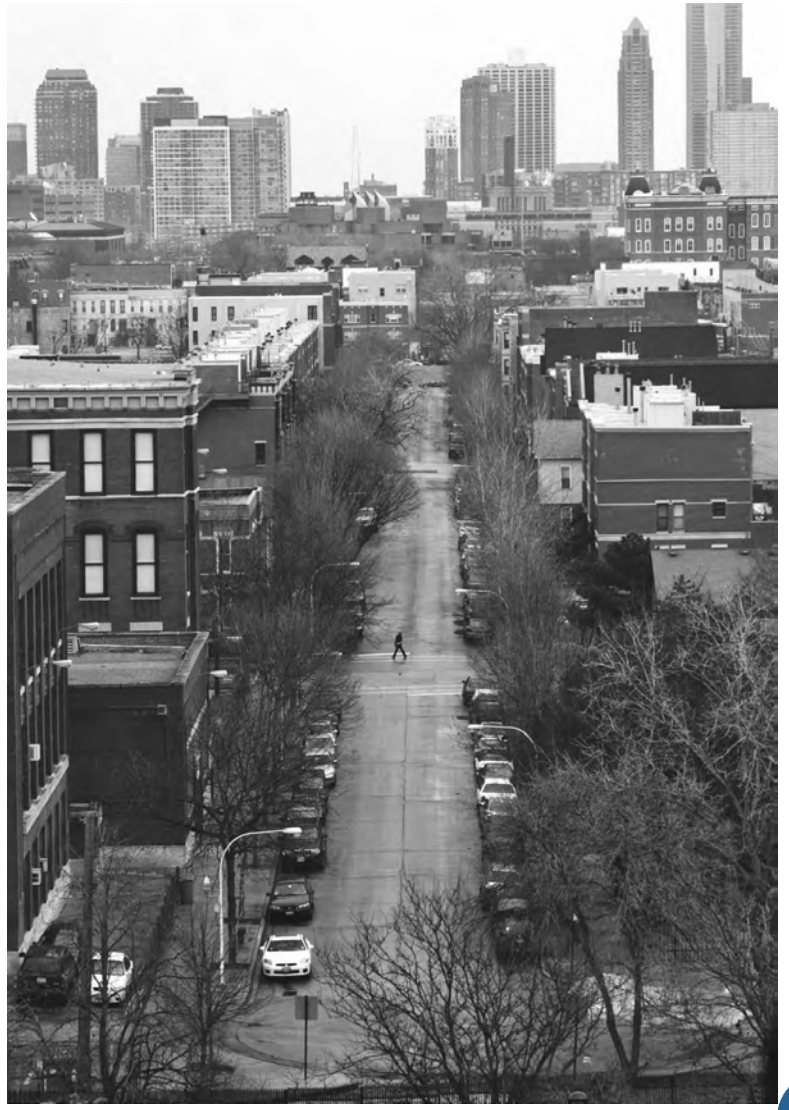
IL Managed Care Organization (MCO)

- Contract to house 50 of their highest cost members

Interpreting the Language: Housing vs. Health Care

Project Design

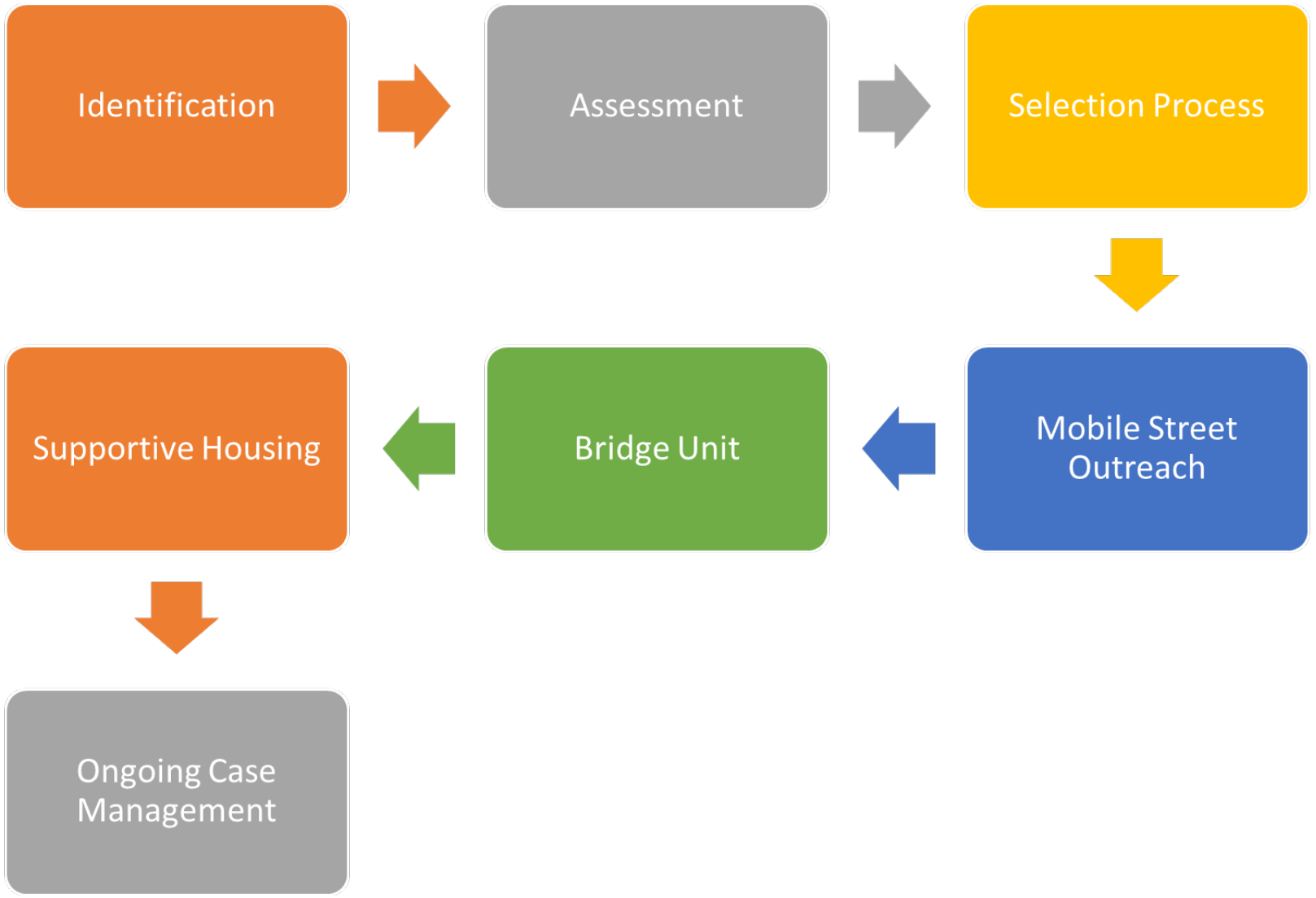
- **Supportive Housing Units**
- **Housing Case Managers**
- **Project Coordinator**
- **Eligibility criteria:**
  - ***1) HUD Chronic Homelessness***
  - ***2) Disabling Condition***
  - ***3) Frequent User of Healthcare Services***



Key Elements

- Mobile Street Outreach Team
- Housing First & Harm Reduction
- Intensive Case Management
- System Integration Team (SIT) Meetings
- Health Coordination

Project Process and Flow



Outreach

- Location
- Determines eligibility
- Connects to Bridge unit (SROs)

Housing Case Managers

- Diverse backgrounds in education & experience
- Offer Intensive 1:1
- Provide additional resources

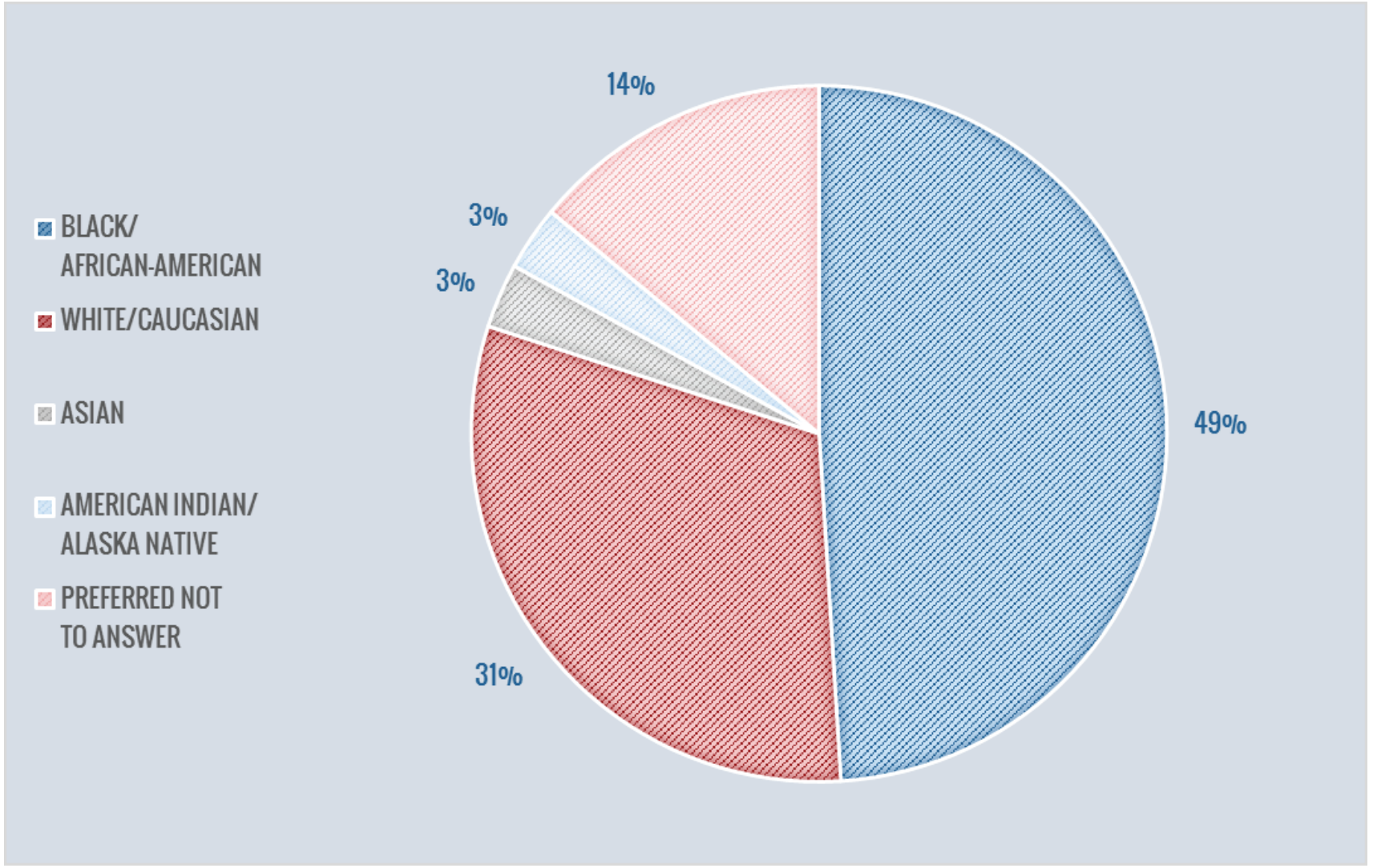
System Integration Team (SIT)

- Bi-weekly meetings
- Hospital clinical staff attendance
- Trouble shooting and brainstorming
- Trainings & Education

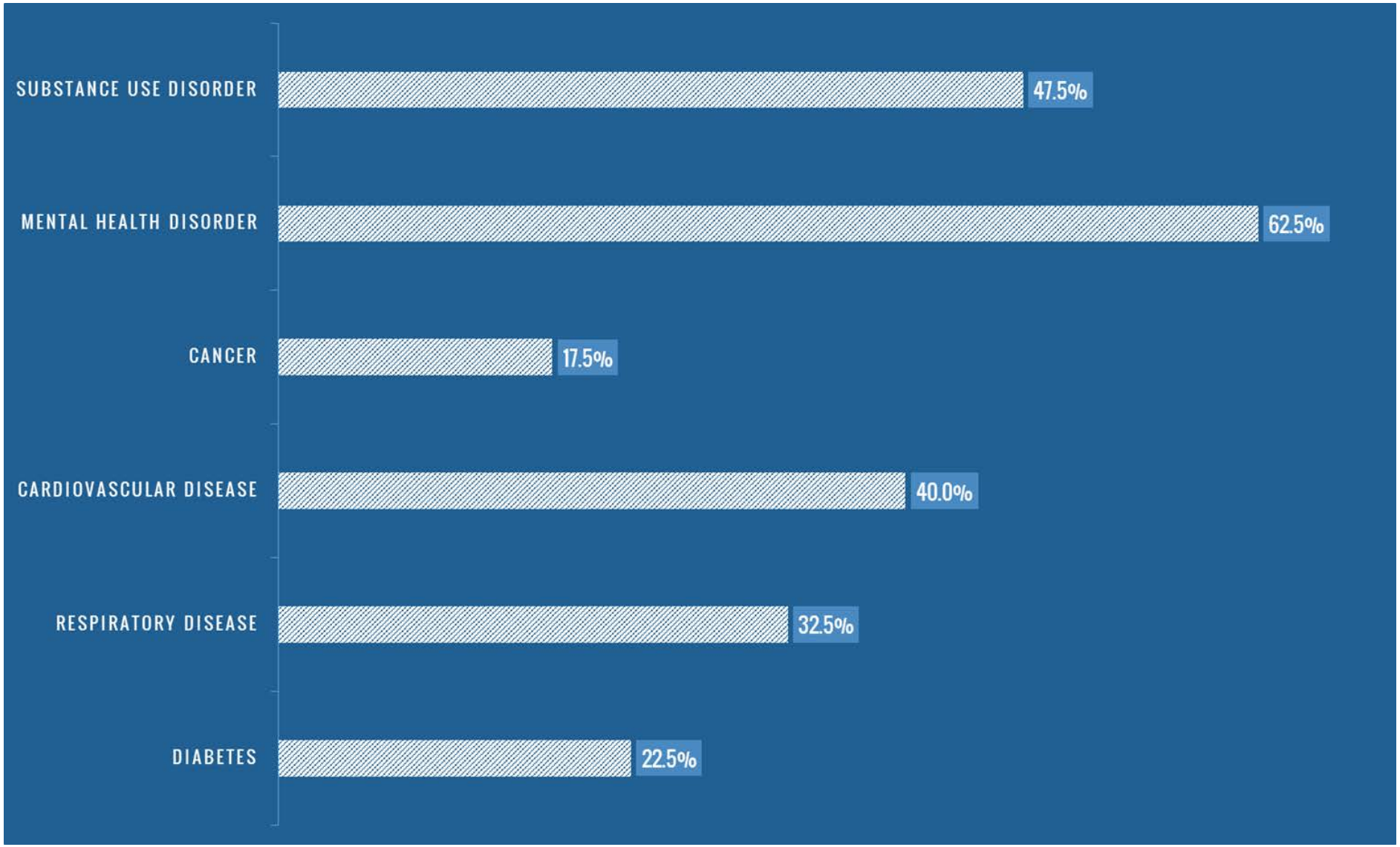
Health Coordination

- Work closely with MCO Care Coordinators
- Focus on medication and appointment adherence
- Communicate with hospital staff

Client Demographics



Chronic Health Conditions



Utilization Outcomes

62% Decrease in Emergency Room Visits

60% Decrease in Inpatient Days

26% Decrease in Hospital Costs

Benefits for MCOs & Hospitals

- Work closely with MCO Care Coordinators
- Focus on medication and appointment adherence
- Communicate with hospital staff
- Helps MCOs meet HEDIS and other quality measures

Benefits for Housing Providers

- **Flexibility in filling units**
- **Per Member Per Month (PMPM)**
- **Access to information typically not available to housing providers**

Benefits for Program Participants

- Housing needs are met
- Improved health literacy
- Extended support network

Successes

- Coordination between multiple partners
- Housing stability
- Opportunities for replication

Challenges

- **UI Health Outcomes**
  - 21 Housed
    - 11 still housed – 50% retention rate

- **Chronic Homeless Project Outcomes**
  - 15 Housed
    - 13 still housed – 87% retention rate

Lessons Learned

- Acuity of participant illness
- Time to housing
- Transition into permanent housing
- LOCUS to screen potential referrals

Models Integrating Housing with Health Care

Central City Concern

- **Collaboration with 6 local health care organizations investing $21.5 million in housing**
- **Set to create 382 new housing units and a health center in Portland**
- **Priority populations include people designated as medically fragile, in recovery from substance use and mental health disorders, families, and people needing support to participate in the workforce.**


The Future
NEXT EXIT

Questions & Dialogue