Making the Connection between Housing and Health

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CSH, The Source for Housing Solutions

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Agenda

- Welcome/Introductions
- Housing as a Social Determinant of Health
- Impact of Housing on Health
  - Health, Income and Housing Disparities
- Partnership
- Housing Vocabulary
- Emerging Models and Innovations
- Group Exercise: Housing and Health Planning!
1. Attendees can describe the impact of housing as a social determinant of health
2. Attendees have increased understanding of housing programs and the delivery system for supportive services
3. Attendees understand and can explain to others different models of health system partnership in housing interventions
Tell us about You
Share your name, organization, location and what you hope to get from this session
Center for Housing and Health: What We Do

- **Housing Programs**
  - Permanent Supportive Housing
  - Rapid Rehousing – Bridge
- **Citywide Outreach Coordination**
- **Better Health Through Housing**
  - Convener of Collaborative
CSH is a touchstone for new ideas and best practices and an influential advocate for supportive housing.
SOCIAL DETERMINANTS OF HEALTH

- environment
- access
- gender
- control of resources
- culture
- jobs
- racism
- colonization
- language
- education
- family
- housing
- school
- justice
- self-determination
-远离家乡
- much more
Why Housing Matters

- Poor health puts one at risk for homelessness
- Homelessness puts one at risk for poor health
- Unstable housing and homelessness complicate efforts to treat illnesses and injuries

Over 40% of people experiencing homelessness have a disability.

Source: National Healthcare for the Homeless Council, “Housing is Health Care”, 2011
https://www.hud.gov/offices/cpd/homeless/chronic.cfm
“...circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics.“

- World Health Organization

https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health
Housing = Health Care

• Social determinants of health are personal, social, economic and environmental factors that affect a wide range of health, functioning, and quality-of-life outcomes and risks.*

• Studies demonstrate that stabilized housing with services for vulnerable populations - those cycling through our communities’ crisis care systems – can positively impact health and quality of life outcomes, and achieve cost savings (avoidance) across the systems.**

*Healthy People 2020, Dept of Health and Human Services, 2010

**"Housing is the Best Medicine, CSH 2010."
## What Research Tells Us

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Case Study: UIC 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
Health Impacts

- Average age of death 42-52
- At significantly higher risk for violence
- Higher rates of substance use disorder, mental illness
- Increased use of crisis systems
- Mortality rate four to nine times higher than those who are not homeless
- ACE significantly related to homelessness
- Traumatic Brain Injury – research found lifetime prevalence was 53%
- Physical health conditions (cancer, heart disease) more likely to lead to death

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3969113
http://www.nhchc.org/PrematureMortalityFinal.pdf
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2553875/
https://www.cdc.gov/features/homelessness/
Maslow’s Hierarchy of Needs

Physiological: breathing, food, water, sex, sleep, homeostasis, excretion

Safety: security of: body, employment, resources, morality, the family, health, property

Love/belonging: friendship, family, sexual intimacy

Esteem: self-esteem, confidence, achievement, respect of others, respect by others

Self-actualization: morality, creativity, spontaneity, problem solving, lack of prejudice, acceptance of facts
Homelessness: Data and History
Why do people experience homelessness?
Housing is NOT an entitlement

- Three Out of Four Low-Income At-Risk Renters Do Not Receive Federal Rental Assistance

- The poorest renters face a far greater risk than other households of eviction, homelessness, and other hardship. With limited funds, federal rental assistance programs can only help 25 percent of these at-risk renters afford modest housing.

- Nearly 15.6 million at-risk renter households eligible for rental assistance do not receive it due to funding limitations. Sixty-three percent of these households have children or are headed by a person who is elderly or has disabilities.

- Federal rental assistance programs help over 5 million low-income households afford modest housing. Nearly 90 percent of these households have children, elderly or disabled people.

Sources: CBPP analysis of the 2013 American Housing Survey; 2015 HUD administrative data; FY2015 McKinney-Vento Permanent Supportive Housing bed counts; 2015-2016 Housing Opportunities for Persons with AIDS grantee performance profiles; and the USDA FY2015 Multi-Family Fair Housing Occupancy Report
In Illinois, the Fair Market Rent (FMR) for a two-bedroom apartment is $1,085. In order to afford this level of rent and utilities — without paying more than 30% of income on housing — a household must earn $3,617 monthly or $43,406 annually. Assuming a 40-hour work week, 52 weeks per year, this level of income translates into an hourly Housing Wage of:

**Facts about Illinois:**

<table>
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<tr>
<th>State Facts</th>
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<tr>
<td>Minimum Wage</td>
<td>$8.25</td>
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<tr>
<td>Average Renter Wage</td>
<td>$16.32</td>
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<tr>
<td>2-Bedroom Housing Wage</td>
<td>$20.87</td>
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<tr>
<td>Number of Renter Households</td>
<td>1,608,683</td>
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<td>Percent Renters</td>
<td>34%</td>
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**Most Expensive Areas:**

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<th>Housing Wage</th>
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<td>Chicago-Joliet-Naperville HMFCA</td>
<td>$23.69</td>
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<tr>
<td>Kendall County</td>
<td>$21.15</td>
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<tr>
<td>Grundy County</td>
<td>$19.92</td>
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<tr>
<td>DeKalb County</td>
<td>$17.85</td>
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<tr>
<td>Kankakee County</td>
<td>$17.29</td>
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* Ranked from Highest to Lowest 2-Bedroom Housing Wage

ILLINOIS

- Living wage Cook County: $12.56 ($26,124 annual)
- Living Wage Marion County $9.50 ($19,760 annual)
- Minimum Wage: $8.25 ($17,160 annual)
- Federal Poverty Level $12,060
- Social Security Income $8,808 ($735/Month)
  - 8.3% of those 18-64 live with a disability
  - 35.5% of those 65 and up live with a disability

Illinois Department of Public Health Center for Minority Health Services
US Dept. of Health and Human Services
https://aspe.hhs.gov/poverty-guidelines
http://livingwage.mit.edu/states/17/locations
ILLINOIS
Income Disparities by Race


Note: Darker Color Illinois, Lighter Color United States
Structural Racism and Housing

- Redlining lasted from 1934 to 1968
- Not only are communities of color still impacted by redlining of decades past, it continues to occur today
  - Ex. Associated Bank in Wisconsin settled with HUD over discriminatory lending. Settlement includes $200M in home loans in minority census tracts, $10M in down payment assistance
  - Segregation occurs throughout the state, majority of communities are segregated at moderate to high levels

- https://www.theatlantic.com/business/archive/2014/05/the-racist-housing-policy-that-made-your-neighborhood/371439/
- https://igpa.uillinois.edu/sites/igpa.uillinois.edu/files/reports/IR09-Ch4-Segregation.pdf
People experience homelessness because they can’t afford housing.

We have an affordable housing problem in the US.
Health and Homelessness
Goals

Health Care

- **Triple Aim**
  - Better quality of care
  - Better experience of care
  - Lower costs
- **Population Health**
- **Health Equity**
- **Value Based Payments**
- **Delivery System Reform**

Housing

- **End Homelessness**
- **Expand Opportunity**
- **Community Development**
- **Safer more livable neighborhoods**
- **Alternative to institutional settings**
The U.S. is an anomaly in health and social spending patterns

- Health expenditures as % of GDP
- Social service expenditures as % of GDP

Source: OECD
The Wrong Pocket Problem

- Understanding SDOH creates the wrong pocket problem. We know what works to improve health, but we can’t use health care funding to assist with
  - Food
  - Housing
  - Education

We need new partners to address these issues
Where did we start?

- “The last time I checked my textbooks, the specific therapy for malnutrition was in fact, food.”

  - Jack Geiger, 1965

The Strongest Health Care Intervention for Frequent Users
Are we speaking the same language?
Who pays for Housing?

- **Mainstream Resources**
  - HUD
  - Local Housing Authorities

- **Innovation in the Health Care Sector**
  - Hospitals
  - Managed Care Organizations
Housing Speak

- **Housing and Urban Development (HUD):** Federal Agency that provides funding for affordable housing, public housing, supportive housing, and temporary housing (shelters or transition housing).

- **Continuum of Care (COC):** HUD requires communities to collaborate and is designed to promote communitywide commitment to the goal of ending homelessness.

- **Housing First:** an approach to quickly and successfully connect individuals and families experiencing homelessness to permanent housing without preconditions and barriers to entry, such as sobriety, treatment or service participation requirements.

- **Harm reduction:** strategies and ideas aimed at reducing negative consequences associated with a behavior (drugs, alcohol, seat belts).

https://www.huduser.gov/portal/glossary/glossary_all.html
Funding

- HUD
- HOPWA
- Tax Credits
- Foundation giving
- Health Care Partnerships
Factors that create cross sector possibilities

Public Health

• Community Assessments
• Safety net systems
• Ensuring community health outcomes
• Including housing in strategic plans
• Role as a convener

Health Care

• Value Based Payment
• Medicaid Expansion
• 1115 Waiver that covers foundational community supports

Housing

• Coordinated Entry
• Housing First
• Targeting and Prioritization
• Lack of resources
Potential Reasons for Partnering

- Identify potential clients through data sharing
- Access to and funding for services
- Understand target populations’ health and service needs
- Access to potential engagement sites
- Improve health outcomes through coordination
- Advance resident stability and recovery
The Right Structure

Referrals

Care Coordination

Co-Location

Full Service Integration
Types of Partnerships

**Referrals**
- Client referrals to preferred services
- Client initiated
- Partners retain autonomy and operations are independent; resources generally not shared
- **Low collaboration**

**Care Coordination**
- Client Centered joint care plans
- May include centralized intake
- Client initiated with strong transition supports
- Organizations operate independently but may share resources and funding
- **Moderate to high collaboration, with cross-training and frequent communication**

**Co-Location**
- Health center operates satellite or full center on-site at supportive housing or shelter
- Wrap-around care housed in a site that tenants access for various services
- Partners operate jointly, but may retain autonomy
- Can be incorporated into existing site, mobile services or new joint site
- **High collaboration**

**Full Service Integration**
- Single point of entry, integrated assessment
- Joint case planning/managem ent
- Wrap-around care that may be brought to where it is most accessible to the client
- Partners may have independent or joint operations
- **Very high collaboration, with integrated resources, service delivery and sometimes funding**
EXAMPLES
Type of Organization:
Federally Qualified Health Center

Project Basics:
- Acquisition and renovation of 50,000 SF building in South of Market/Tenderloin Neighborhood for relocation and expansion of services.
- Modern medical campus providing comprehensive and integrated medical, dental, mental health, and other enabling services, including benefits enrollment and Housing Resource Center.

Health/Housing Partnership:
- Critical need: 70%-80% of patients are homeless or in unstable housing situations.
- Extensive housing referral services provided through partnerships with 12 core housing providers (to hopefully continue to expand).
- CSH provided TA to help expand and strengthen connections with housing providers.
- Partnerships have evolved and HR360 is providing on-site serves to nearby housing developments.

Community Demographics:
- 11.79% Poverty Rate
- Family Income: 69.83% of AMI
- Unemployment Rate 2.3%
- District 6: 58% of City’s Homeless

Projected Community Impact:
- 16 new FTE permanent jobs/79 retained
- 183 construction jobs
- 8,100 patients to be served per year, of which 5,300 will be new
- LEED-Gold Certified
The Women’s Home (“TWH”)  
WholeLife Service Center-Houston, TX  
(Closed & Under Construction)

**Type of Organization:**  
Behavioral Health and Housing Provider

**Project Basics:**
- 30,000 SF shared use medical and social service facility:
  - 6,400 SF leased to Spring Branch Community Health Center to provide medical & behavioral health services.
  - Partnerships with YMCA, DePelchin Children’s Center, & Memorial Assistance Ministries to provide after school programs, counseling, and adult education/workforce development programs.
- Adjacent to 87-unit supportive housing project with 25 units for homeless individuals & within two blocks of an 84-unit supportive housing project for families, with 40 units dedicated to homeless families.

**Community Demographics:**
- 43.2% Poverty Rate
- Family Income: 46.48% of AMI
- Unemployment Rate 7.0%
- Medically Underserved Area

**Projected Community Impact:**
- 44 new permanent jobs/23 retained
- 46 construction jobs paying Davis Bacon wages
- 2,600 people to be served per year
- LEED-Silver Certified

**Health/Housing Partnership:**
- Same target service area with established referral relationship.
- Partnership grew from a comprehensive community needs assessment completed by TWH.

Total Project Cost - $10,700,000  
CSH NMTC Financing - $9,000,000
Central City Concern ("CCC")
Eastside Health Center-Portland, OR
(Potential CSH NMTC Investment)

Type of Organization:
Fully Integrated FQHC, Behavioral Health, & Housing Provider

Project Basics:
- New 40,000 FQHC providing primary and acute medical care, mental health services, substance use recovery programs.
- 51 respite care beds to serve those that are homeless and exhibit acute medical conditions.
- Co-located with 124 substance use disorder units, of which 90 units will be fully subsidized, and 34 will be affordable at or below 30% of AMI, with lengths of stay up to two years.

Health/Housing Partnership:
- CCC owns and manages 1,700 units of housing and several medical clinics.
- Extensive partnership and programs with area hospitals and managed care organizations to help finance capital cost and operations.
- Part of CORE (Center for Outcomes Research and Education) study of effect of housing on cost and access to services.

Community Demographics:
- 17.0% Poverty Rate
- Family Income: 64.56% of AMI
- Unemployment Rate 7.4%
- Located in Enterprise Zone & Neighborhood Stabilization Target Area

Projected Community Impact:
- 65 new FTE permanent jobs/22 retained
- 100 construction jobs
- 3,000 patients to be served per year, all of which are new

Total Project Cost- $23,000,000
Potential CSH NMTC Financing- $14,000,000
The 10th Decile Project

People experiencing homelessness who are the top 10% highest-cost, highest-need individuals in Los Angeles County.

Service Approach:

- **Collaboration**
  - Hospitals, FQHCs, homeless services
- **10th Decile triage tool**
  - Highest-cost, highest-need 10% of homeless individuals
- **Health Home**
  - Intensive case management/care coordination
- **Permanent Supportive Housing**
  - Housing navigation

The Glue: Intensive Case Management

i.e., Care Coordination + Housing Navigation

Partners:

- 5 Homeless Service Providers
- 7 Health Centers & Behavioral Health Providers
- 15 Hospitals

Outcomes:

- 51% Screened are Enrolled
- 47% in Housed in 6 months
- 98% in Housed two years
- Average Cost Reduction of $54,106 to the Public Sector
- Emergency Room Visits Reduced by 71%
- Hospital Admissions Reduced by 84%
- Inpatient Days Reduced by 80%
People experiencing chronic homelessness who are frequent users of the hospital system and have high hospital expenditures.

Service Approach:

1. Coordinated Entry
2. Prioritization
3. Housing Location

Partners:
- Health Care Center for the Homeless
- Homeless Services Network (CoC)
- Florida Hospital
- Local Law Enforcement
- City of Orlando/Orange County

Outcomes:
- 106 Housed, 100% Retention
- 127 Engaged
- 100% of landlords have 24 hour access to Housing Specialist
- 85.7% maintain or reduce hospitalizations
- 100% maintain or increase income
- 90% reduced incarcerations
Washtenaw County: FUSE

Individuals with very low income, a diagnosed behavioral health condition, 1+ chronic conditions, experiencing homeless or in persistent housing crisis, and are a high utilizer of health services.

Service Approach:

- Referrals
- Data Match
- Identify & Locate Participant; Housing Navigation
- Outreach Coordinator
- Housing
- Intensive Case Management
- Health System Coordination

Partners:
- Avalon Housing
- 2 Hospital Partners
- Washtenaw Community Mental Health Center
- Washtenaw Health Initiative
- Packard Health
- Washtenaw Public Health & Washtenaw Housing Alliance
- Ann Arbor Housing Commission
- Michigan Ability Partners and Shelter Association of Washtenaw County

Outcomes:
- 81% Housing Retention
- 87% Enrolled in Primary Care
- Reduction in Inappropriate ER and Hospital Usage
- Improved Quality of Life
- Improved Systems Level Coordination
Two Models of Data Use with High Utilizer Interventions

High utilizer population is defined, looking at frequency of use across multiple systems.

- Develop identification tool based on data and predictive characteristics from the initial high utilizer population.
- If assessed as likely high utilizer, individual given high priority for housing/services.
- Data matching used to identify individual high utilizers or priority population.
- Upon location and engagement, individual is connected to housing/services.
People experiencing chronic homelessness with three or more emergency department visits, and are identified and prioritized through coordinated access.

**Service Approach:**

- Call Center
- Outreach Team
- Assessment Hub
- Coordinated Access System
- Prioritized based on VI Score
- Assessment by Clinical Team
- Clinical Case Manager
- Community Health Worker
- RN

**Partners:**

- Health Care for the Homeless – Houston
- SEARCH Homeless Services
- New Hope Housing, Inc.

**Outcomes:**

- Reduction in Inappropriate, Non-emergency, ED Use
- Meaningful Difference in Health Functional Status
- Clinically Significant Response in Overall Depression Scores
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
University of Illinois at Chicago (UI Health)

- 25 frequent visitors of the Emergency Department
- Located and housed 22 patients
- Housed in HUD funded units by BHH partner agencies
**Chronic Homeless Pilot**

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

- Began July 1st
- Referring 10 frequent visitors from the Emergency Department
- Project Impact
Systems Integration Team Meetings

- Bi-weekly meetings
- Hospital clinical staff attendance
- Trouble shooting and brainstorming
- Trainings & Education
- **IL Managed Care Organization (MCO)**
  - Contract to house 50 of their highest cost members
  - Value-based Contract
  - Status to be determined due to IL RFP announcement
Outcomes and Challenges

- **UI Health Outcomes**
  - 22 Housed
    - 12 still housed – 54% retention rate

- **Chronic Homeless Pilot Outcomes**
  - 15 served
    - 15 still housed – 100% retention rate
Creating Partnerships: Identifying the Right Fit

What were the key decisions that pushed you to your partnership(s)?
What do you want to know about the housing market and demand in your community?
What barriers to you anticipate?
What assumptions are in play that might need to be adapted?
What resources do you have? What are needed?
The Future

NEXT EXIT
Innovative Strategies

**Flexible Subsidy Pool**
- Combines public, private, foundation and health care investments to create a funding pool for housing subsidies
- Can be a solution for populations that are not eligible for traditional subsidies
- Strategy for adding new units of supportive housing

**New Integrated Developments**
- Partner with Developers, complex projects usually involved braided funding resources
- Long term developments, deeply affordable
- Healthcare and/or Services Partnerships

**Housing Tenancy Supports**
- Medicaid reimbursable pre-tenancy and tenancy supports
- Pending in IL via 1115 Waiver
- Medicaid reimbursable if someone has dx of Severe Mental Illness

**Linkage to Coordinated Entry**
- Connecting to the system created for supportive housing access
Local Opportunity: Coordinated Entry System

Chicago Coordinated Entry System Map

Initial Engagement

Assessment

Persons Experiencing Homelessness

Coordinated Entry Assessment
Access Points for assessment are site-based, call center, or mobile outreach workers

persons at Risk of Homelessness

Call 311 and ask for short-term help

Intervention

Diversion Path:
Short term help and/or resources for housing

Crisis Path:
Shelter, DV Shelter, Human Trafficking

Parallel System Path:
VA, AFC

Match to Housing Solution Using System Prioritization

Housing Solution

Family Reunification, Stabilize in Current Housing
Low-Cost Market-Rate Housing
Subsidized Affordable Housing

Rapid Re-Housing
Supportive Housing
Permanent Housing with short-term supports
Interim or Transitional Housing

For more info and to sign up for the newsletter go to:
www.csh.org/chicagoces
Innovative Strategies

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Innovative Strategies

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- Medicaid reimbursable pre-tenancy and tenancy supports
- Pending in IL via 1115 Waiver
- Medicaid reimbursable if someone has dx of Severe Mental Illness or/and Substance Use Disorder
Resources

CSH Health Outcomes Literature Review

Health Centers and Coordinated Entry

Medical Respite and Supportive Housing

Health Outcomes and data measures

CSH FUSE Guide
http://www.csh.org/fuseRC

CSH Health and Housing Partnership Guide

CSH Health and Housing Partnerships Online Tutorial