Healthcare and Public Housing National Symposium

“The connection between health and the dwelling of the population is one of the most important that exists”. *Florence Nightingale*

Cited in Lowry, S. - British Medical Journal, 1991, 303, 838-840

Who can focus on immunizations with eviction notices on the door?

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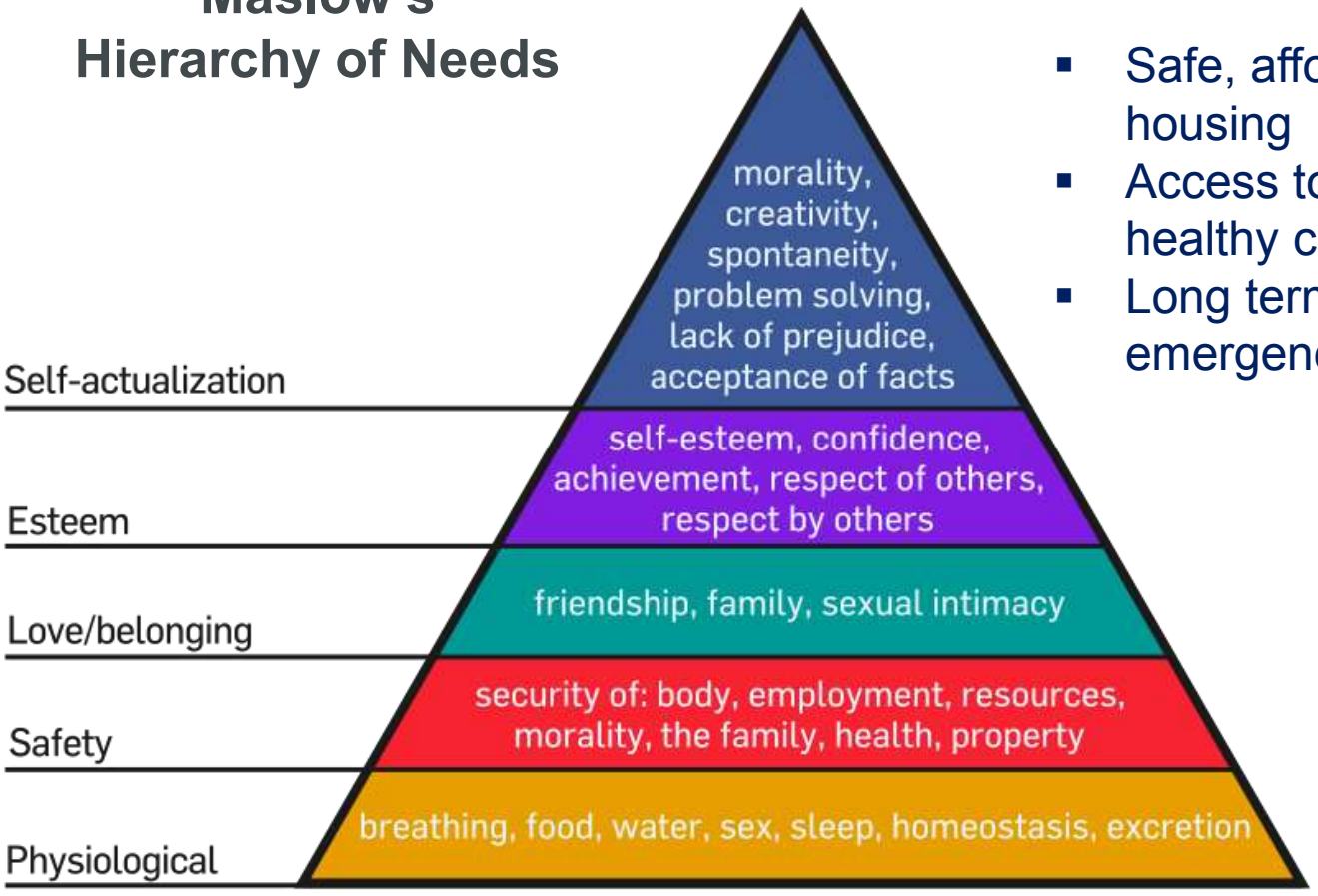
Maslow's Hierarchy of Needs



- Safe, affordable, integrated housing
- Access to services to make healthy choices
- Long term and transition and emergency housing needs

We need to ensure ***The Basics*** are covered

Our Patient-Centered Care Model

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Creating and delivering a care model that reflects a broad spectrum of need.

- **Patient centered** solutions, not disease focused
- **Integration** of medical, behavioral and social care
  - **Mix of services will be more community-based** and include social agencies, **housing**, transportation and more
- Leverage the resources of Complex Case Management, Health Homes and other types of integrated care organizations and multi-disciplinary teams to reduce costs and improve outcomes

Potential UHC Focus Areas

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Policy & Program Design Advocacy	Best Practices Incorporating in Plans of Care (Clinical)	Best Practices in Delivering Housing Assistance	Pilot Focus
• Benefit Inclusion • Housing First • Provider/Landlord Considerations • Coordination with agencies, developers, landlords, supportive housing providers • Housing Incentives • Finance Investment considerations: Tax Credits, Social Impact Bonds and others	• Assessments • Person Centeredness • Training Programs for Care Coordinators • Housing Coordinators • Work with Homeless and Supportive Housing Providers • Incorporate resident managers/social workers in care team	• Understanding housing landscape-public, vouchers, supportive, special programs • Build relationships with supportive housing providers • Build relationships with homeless coalitions • Support capacity building as possible • Support transition and respite programs	• Homeless/Supportive Housing • Healthcare for the Homeless Collaborations • Homeless Coalitions • MFP – SMI and Supportive Housing • Site based disease management • Mixed Use services – health home/housing/social services

Opportunities for Engagement

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Multi-Family complex (TANF/CHIP)	•Healthy Living programs to complex – Healthy Hound, Eat4Health, etc. •Improve health/wellbeing •Crisis housing •Site based disease management •EPSDT – site based
Elderly/Disability (DSNP/MME/ABD)	•Establish aging in place services •Support Greenhouse projects – SNF transformation •Site based Chronic Disease management •PSH
ID/DD	•Group and supervised housing •Housing changes as population ages •Supportive services, in home services •Self determination support
PSH (ABD/LTSS/DSNP/ID/SMI)	•Funding •Clinical model impact / MFP support/homeless support •Ensure most vulnerable, hardest to reach successful •Strong cost reduction opportunities
Homeless	• Location services, clinical model impact • Housing capacity • Housing First – Harm reduction
Foster Kids	•Preparing for aging out- housing, finance training •Specialized housing – emancipated •Homeless services

Needs Assessment: Chronically Homeless

Austin currently has 1877 members on an Unable to Locate list. Some of those members may be in the HMIS database and may be chronically homeless and highly vulnerable and will meet priority housing being supported by City of Austin and Foundation Communities requirements for prioritization.

The top 25 UTL members generated over $2, 137, 364 in costs. Total costs for everyone on UTL list was over $6,000,0000. In addition, these members negatively impacted quality outcomes putting 5% premium withholds at risk.

FOUNDATION COMMUNITIES
creating housing where families succeed

ECHO

"I think about homelessness as a community problem that sits at the vortex of where a number of community problems converge such as affordable housing , unemployment, access to affordable health care, family violence, mental health problems and substance abuse and addictions"
Cal Streeter, ECHO Board Members & 100 Homes Volunteer

In addition to the direct impact on individuals and families who are without a home, enormous costs accrue to our society in general from the problem of homelessness. These costs are incurred in the areas of medical treatment, hospitalization, police intervention, incarceration, the provision of emergency shelters, and other areas. In fact, nearly $103 million is spent annually on chronically homeless individuals in our community. National Alliance to End Homelessness

Executive Summary - Houston

Opportunity: Project Based Section 8 housing for seniors and people with disabilities funded for renovations to include opening an FQHC on ground floor that will serve as health home and behavioral health home in zip code that is underserved. United has more than 1000 Medicaid members in zip code. Project will include access to social services, supportive housing services and acute and behavioral health services.

Membership in ZIP 77022	
Star Plus	673
STAR	206
CHIP	73
DSNP	234
Total	1,186

Improve access to acute and behavioral health services in geography. Provide supportive housing services to most vulnerable to ensure ability to successfully live as independent as possible in the community. Provide housing for homeless members and/or members in institutions wishing to live in community.

Build a relationship with Christian Church Homes – property manager of Woodlands Christian Towers in Houston TX. Work with them to place MFP or members who are unstably housed in their supportive housing site. As renovations occur in 2015 and FQHC is built, develop health home with Behavioral Services to underserved market.

The Integrated Service Model in which the services are offered on-site at the housing project is most often used with projects serving tenants with high intensity service need. Although services are voluntary, the staff actively engages clients on a regular basis. The health care services are provided in a satellite FQHC clinic operating within the housing facility. The satellite clinic is linked to a “full service” clinic operated by the FQHC and, generally, is no more than 5-10 miles away.

Housing Appendix

The High Hurdle of Income:
Housing versus Healthcare Example

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Comparison of Federal Poverty Level (FPL*) versus Area Median Family Income (AMFI*): Houston-Baytown-Sugar Land HUD MSA

# in Family	U.S. HHSC FPL $*	U.S. HUD 2014 AMFI $**	AMFI as % of FPL	U.S. HUD Low Income Limit _AMFI @ 80% in $	E/B	U.S. HUD Very Low Income Limit_ AMFI @ 50% in $	G/B	U.S. HUD Extremely Low Income Limit_ AMFI @ 30% in $	I/B
A	B	C	D	E	F	G	H	I	J
1	11,670	46,688	400%	37,350	320%	23,350	200%	14,000	120%
4	23,850	66,600	279%	53,300	223%	33,300	140%	20,000	84%
8	40,090	88,000	220%	70,400	176%	44,000	110%	26,400	66%

*FPL-Refer: http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-02-07-2014.pdf

**2014 AMFI with effect from 12/18/2013. Refer: www.huduser.org

Resources

[1] The State of Housing in America in the 21st Century: A Disability Perspective. National Council on Disability. January 19, 2010.

[2] Nardone, M., Cho, R., and Moses, K. Medicaid-Financed Services in Supportive Housing for High-Need Homeless Beneficiaries: The Business Case. Center for Health Care Strategies, Inc. Policy Brief. June 2012.

[3] The Medicaid and CHIP Payment and Access Commission. Report to the Congress on Medicaid and CHIP. March 2012.

[4]Strategies to Reduce Costs and Improve Care for High-Utilizing Medicaid Patients: Reflections from Pioneering Programs. Center for Health Care Strategies, Inc. October 2013.