# Untangling the Safety-Net:
## Advancing Health Equity through Housing-Health Partnerships

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# Learning Objectives

- Discuss root causes and systemic drivers of homelessness
- Understand the impact of homelessness on health outcomes and the evidence for supportive housing as a health intervention
- Describe opportunities for improving health through cross-sector partnerships

All photos, stories and quotes shared with permission from community partners. Names and details of cases changed to protect confidentiality.

# Carla's Story: A Tangled Safety Net

- 45 y.o. F with PMH of HTN, obesity and umbilical hernia
- Relocated to Denver and working as pastry chef
- Prolonged hospitalization for complications of incarcerated hernia, sepsis, multiple surgeries
- No income, evicted
- Discharged from Denver-area hospital to shelter
- Newly homeless on streets and in shelters

*“They had 3 months to find me some place to go. There is no reason why I should have been on the street with my belly cut from here to here and all this stuff. You know? And a huge open wound.”*

# Definitions

- Homeless Person: **“someone who lacks a fixed, regular, and adequate nighttime residence and who lives in a shelter, or a place not designed for human habitation”** (McKinney Homeless Assistance Act)
- Expanded to include: **“people at imminent risk of housing loss within the next two weeks and people fleeing from domestic violence with inadequate resources to obtain other permanent housing” (**Homelessness Emergency Assistance and Rapid Transition to Housing (HEARTH) Act)
- A “chronically homeless” person is defined by the US Department of Housing and Urban Development (HUD) as **“an individual with a disabling condition who has been either continuously homeless for at least one year or homeless at least four times in the past three years”**
- “Housing insecurity” encompasses literal homelessness and a broad range of unstable housing situations

Photo courtesy Cathy Alderman

*“We are a very complicated and diverse population of people… And I think that is the more critical point. The system isn't being really respectful and responsive or sensitive to our diversity.”*

# Denominating the Homeless population

**United States:**

- **500,000+ people** experienced literal homelessness on a single night in Jan 2020
- 2018 HUD AHAR- 1.4 Million people HMIS sheltered count vs. 500k+ PIT estimates

**Colorado:**

- **9846 people** experienced literal homelessness on a single night in January 2020 (PIT)
- **23,000+ students** identified as experiencing homelessness, doubled up or unstably housed in 2018-2019 school year
- **53,000 + individuals covered by CO Medicaid** were without stable housing in 2019

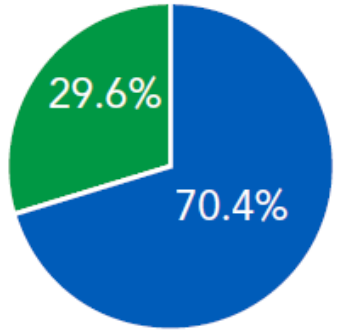
# Point in Time Data

## COLORADO

**2.4%**
change from 2019

**-30.8%**
change from 2007

**17.1** in every **10,000**
people were experiencing homelessness




Total Homeless, 2020
**9,846**

### Estimates of Homelessness

**7,579** individuals

**2,267** people in families with children

**562** unaccompanied homeless youth

**1,044** veterans

**2,834** chronically homeless individuals

# Metro Denver 2020

## By The Numbers

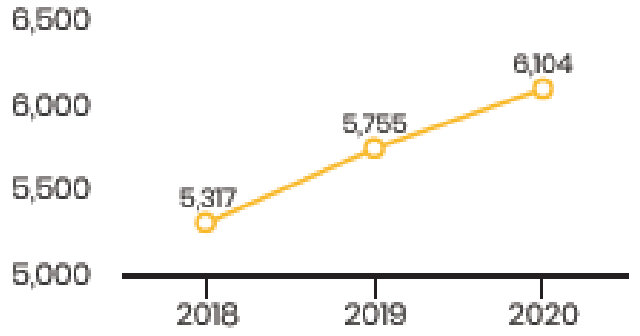
Total Count

**6,104**

**Data**

*Provided by MDHI Point-in-Time Survey conducted January 27th, 2020. For more information visit here.*

## Number of Literally Homeless




## Populations

**627** **Veterans**
*People self-reporting service in the U.S. Military*

**420** **Families**
*Households with at least one adult and one child under 18 years old; there were a total of 1446 people in these households*

**278** **Unaccompanied Youth**
*Persons under age 25 who are not accompanied by a parent or guardian and are not a parenting youth*

**759** **Fleeing Domestic Violence**
*People actively fleeing a situation of domestic or interpersonal violence*

## Where People Stayed

**1561** Unsheltered

**2911** Emergency Shelter

*Emergency Shelter Beds Available* 3561

** of those 3561 beds, 264 beds are for Severe Weather Shelter only*

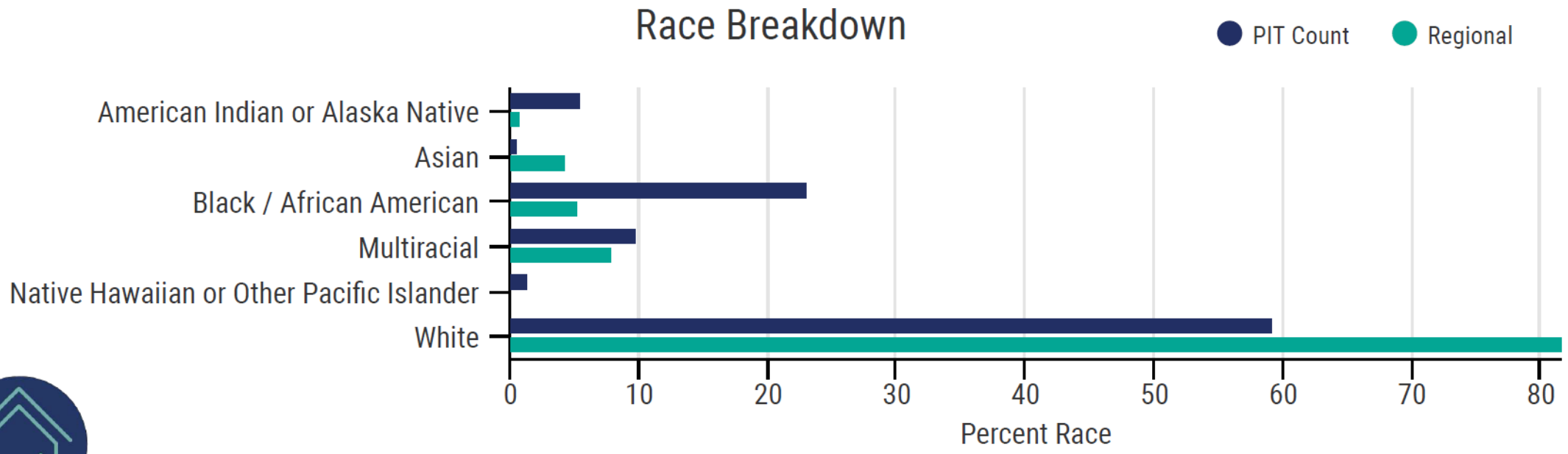
** motel vouchers counted as ES but not available capacity in the HIC*

**1582** Transitional Housing

*Transitional Housing Beds Available* 2202

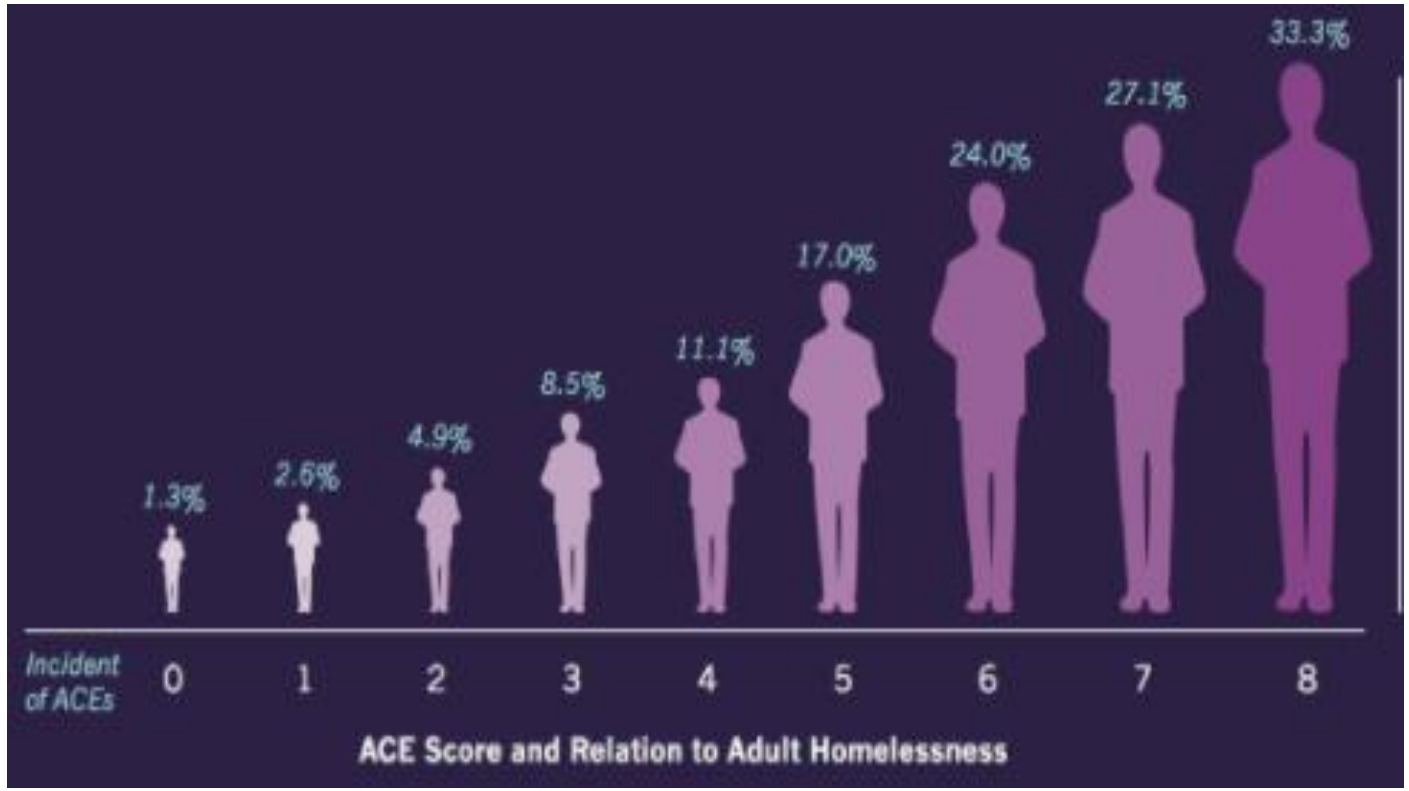
Where some unsheltered PEH in Denver live…

# PEH are disproportionately BIPOC



# Situational Barriers to Housing Stability

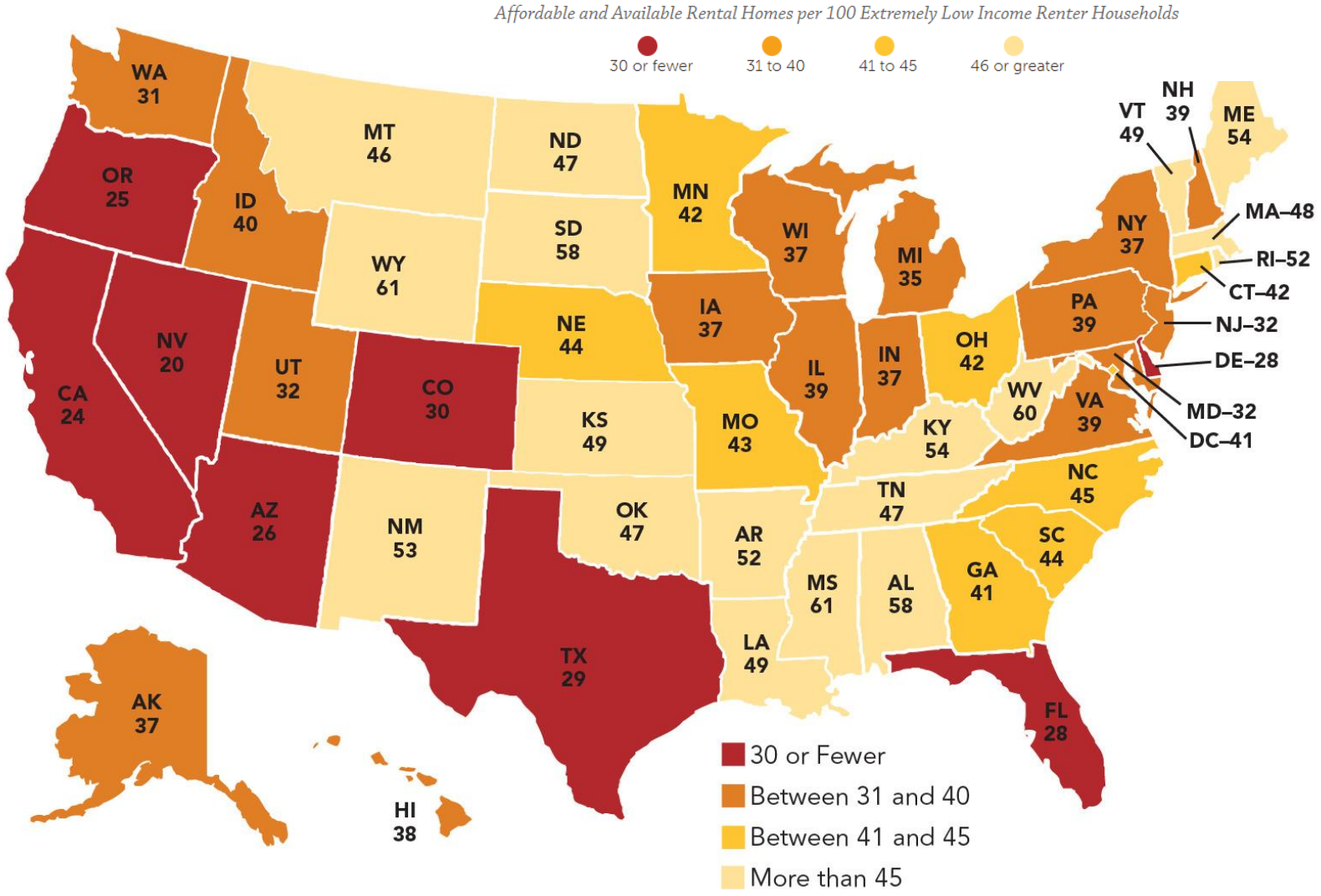
- Unexpected medical expenses
- Physical and mental health disabilities
- Job and wage loss
- Substance Use
- Eviction
- Trauma and violence



# A Wicked Problem

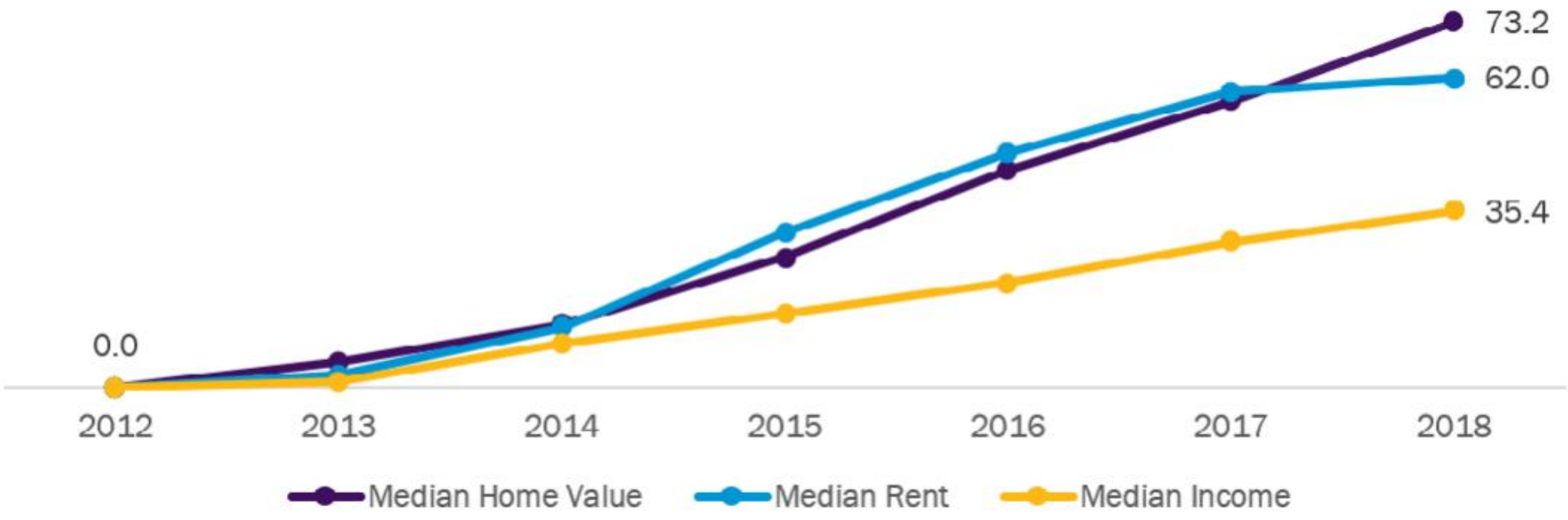
- Generational poverty
- Systemic/institutional racism
- Criminal legal system
- Limited job opportunities
- Jobs lacking living wages
- Affordable housing shortage

# The Gap: A Shortage of Affordable Homes




Note: Extremely low income (ELI) renter households have incomes at or below the poverty level or 30% of the area median income. Source: NLIHC tabulations of 2019 ACS PUMS Data.

# Percent Increase in Median Home Value, Rent and Median Income, Denver




Source: U.S. Census Bureau, American Community Survey 1-year estimates, 2012-2018.
Note: Data are for Denver County.

# BIPOC renters are disproportionately cost-burdened

20% of Black households

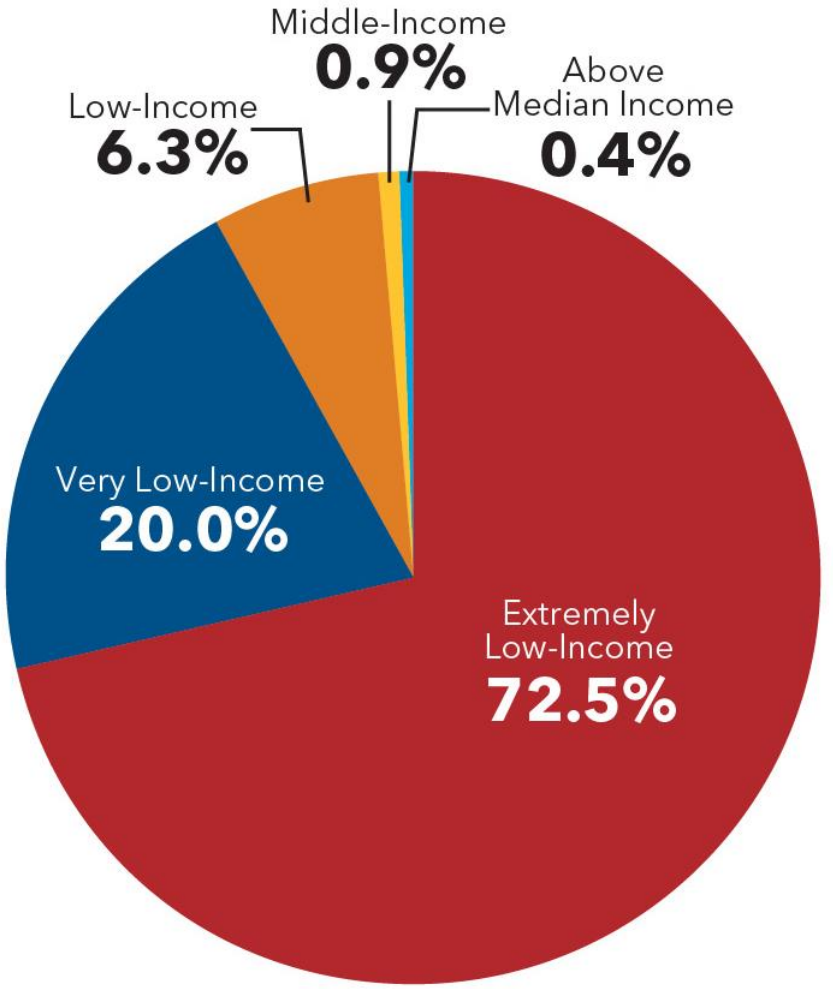
18% of AI/AN households

14% Latino households

vs.

6% White households

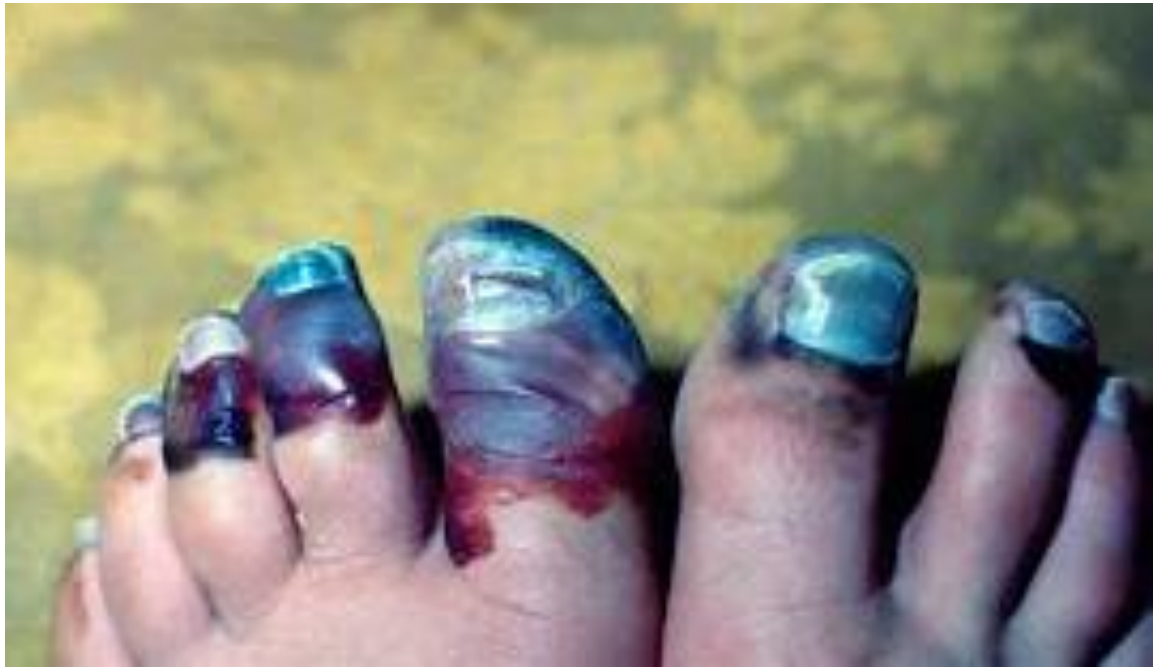
## FIGURE 6: SEVERELY HOUSING COST-BURDENED RENTERS BY INCOME, 2019




Source: NLIHC tabulations of 2019 ACS

# Homelessness and Health Inequities

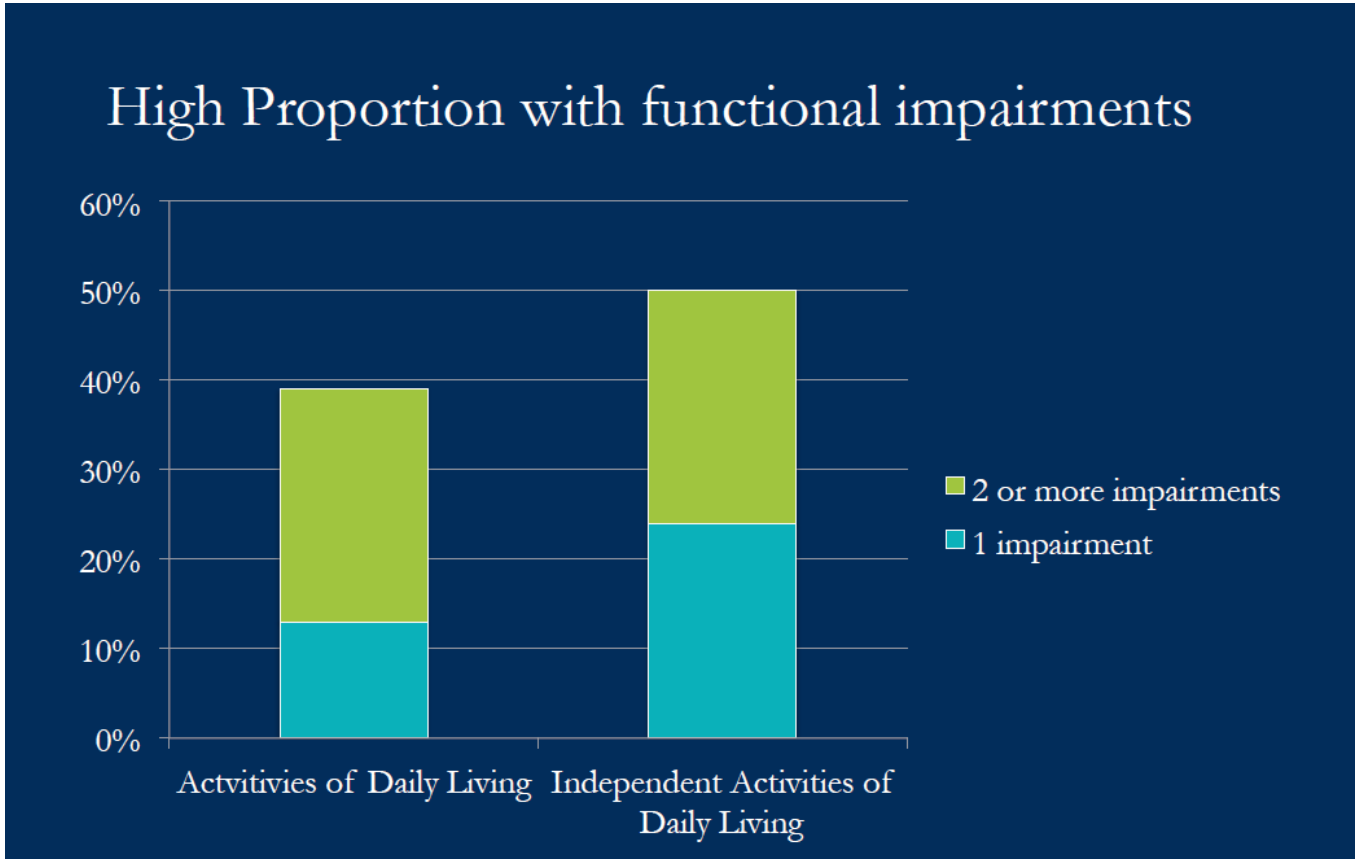
- Large burden of both acute and chronic disease
- High rates of mental health and SUD conditions
- Infections- HIV, HCV, TB, COVID-19 and others
- Environmental exposure
- Increased Mortality
  - Risk of death 2 to 5 times higher than general population
  - attributable to infections, chronic heart disease, SUD and unintentional injuries
- Decreased life expectancy
  - Chronically homeless PEH have a median life expectancy that is nearly 30 years shorter than the average U.S. life



Fazel S, Geddes JR, Kushel M.Lancet 2014
Baggett TP et al. JAMA Intern Med. 2013

# Aging of the Homeless Population

- Brown et al studied 350 homeless adults aged 50+ in a variety of living environments
- Geriatric conditions were common, and the **prevalence of these conditions was higher than that seen in housed adults 20 years older.**
  - Almost 40% had difficulty performing ADLs
  - 33% reported any falls in the past 6 months
  - 26% had cognitive impairment
  - 45% had vision impairment
  - 48% had incontinence.

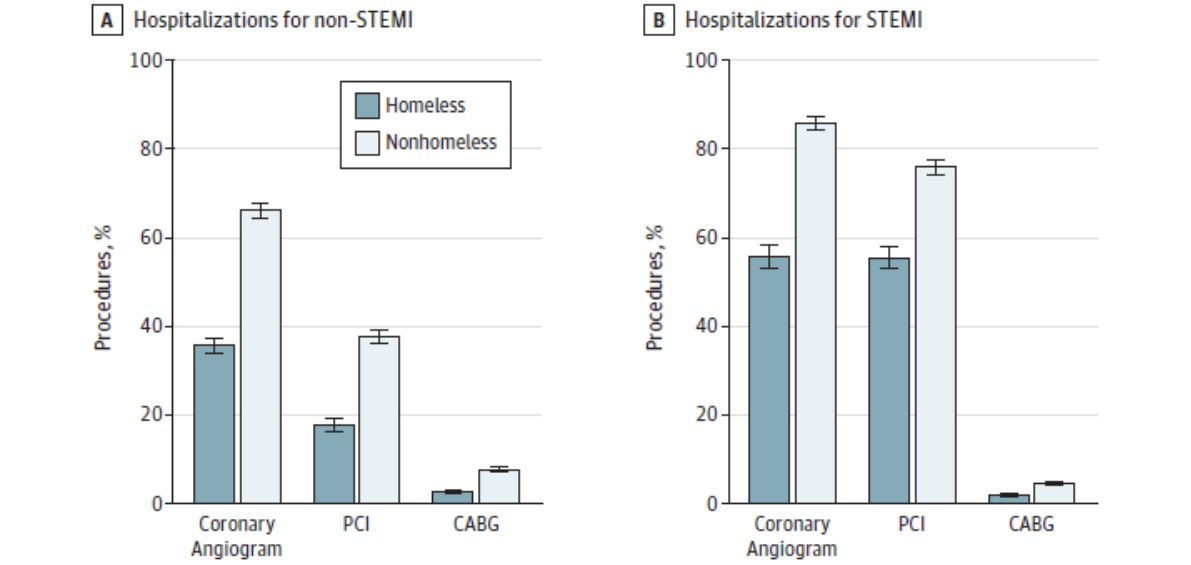



Brown RT et al. Geriatric Conditions in a Population-Based Sample of Older Homeless Adults. Gerontologist. 2017 Aug 1;57(4):757-766.

# Healthcare Utilization Patterns and Care Disparities in PEH

- Decreased utilization of primary care
- Higher ED and hospital utilization and costs
  - Longer Length of Stay
  - More 30-day readmissions
- Higher inpatient mortality and disparities in-hospital care disparities

Figure 3. Risk-Standardized Diagnostic and Therapeutic Procedure Rates for Homeless and Nonhomeless Adults Hospitalized for Non-ST-Elevation Myocardial Infarction (non-STEMI) and ST-Elevation Myocardial Infarction (STEMI)



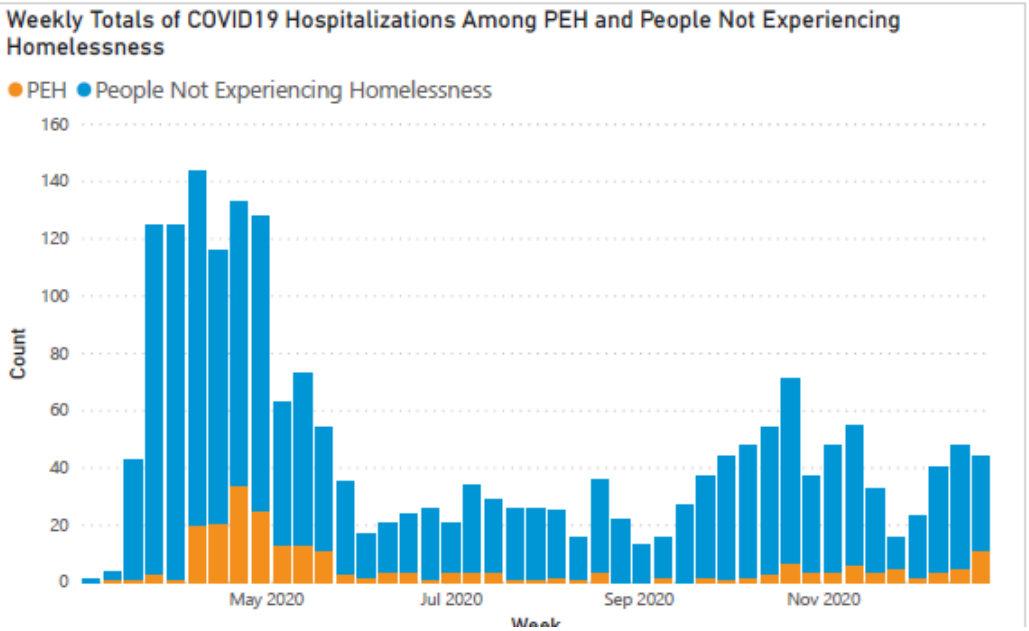

Wadhera RK et al. JAMA Int Med, 2020

Wadhera RK, et al. Med Care, 2019
Rinehart DJ, et al. Med Care, 2018
Saab D., et al. J Gen Intern Med, 2016
Morrison DS, Intern Journ Epid, 2009

# PEH = Triple the Risk of hospitalization

## COVID-19 Hospitalizations Among PEH Compared to the General Population

| Percent of Cases in PEH (out of all COVID19 cases) | Percent of cases in PEH that have been hospitalized (out of all cases in PEH) | Percent of cases not in PEH that have been hospitalized (out of all cases in people not experiencing homelessness) |
|---|---|---|
| 2% | 28% | 9% |




**Take Aways**

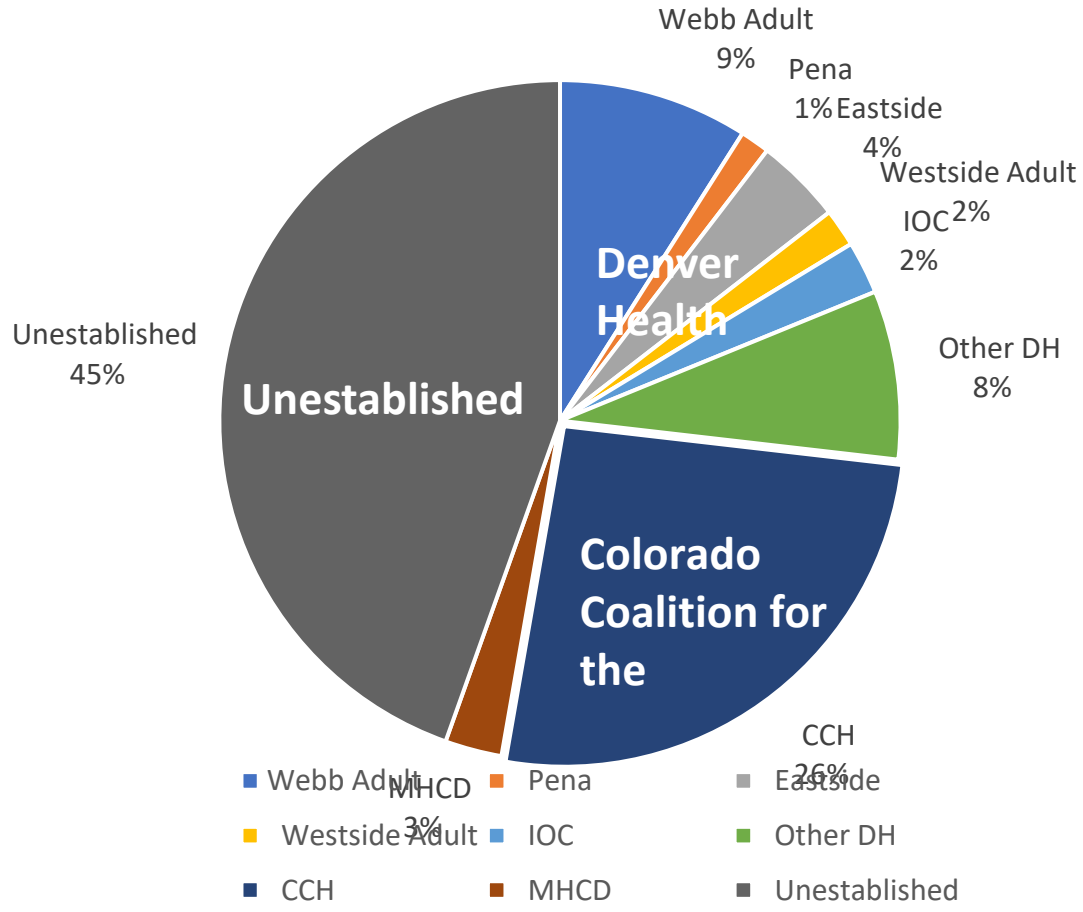
- Out of all COVID19 cases, 2% are in the population experiencing homelessness.

- Out of all cases in PEH, 28% have been hospitalized, compared with 9% of cases hospitalized in the general population.

*Data Source: Denver Health and Hospital Authority RedCap database*

# Partnership Beyond the Hospital Walls

- Establish community-academic partnership
- Funding from CCTSI to establish a community-academic partnership to:
  - Better understand community needs and priorities related to hospital care and care transitions
  - Develop a shared vision for meaningful improvement



# Themes from the CAP

Trauma experienced through homelessness and through emergency and hospital care is pervasive

Substantial gaps in care and  a lack of integration and coordination of care transitions

Social isolation and limited support during hospitalization and after discharge contribute to poor health outcomes

Hospitalization is a missed opportunity for interventions to address vulnerability

## 2018

CAP identified  opportunities and priorities to improve care

Formal partnership to improve clinical care and data sharing

## 2019

LEAN Strategic Planning: Housing and Specialty Care

Transitions of Care and Respite partnership launched

## 2020

Center for Healthcare Strategies Rising Risk Group

Home to Health Medicaid  Housing PilotCOVID-19- Denver Joint Task Force

## 2021

Joint funded research- RWJF

EHR Interoperability/Care Transitions Partnership

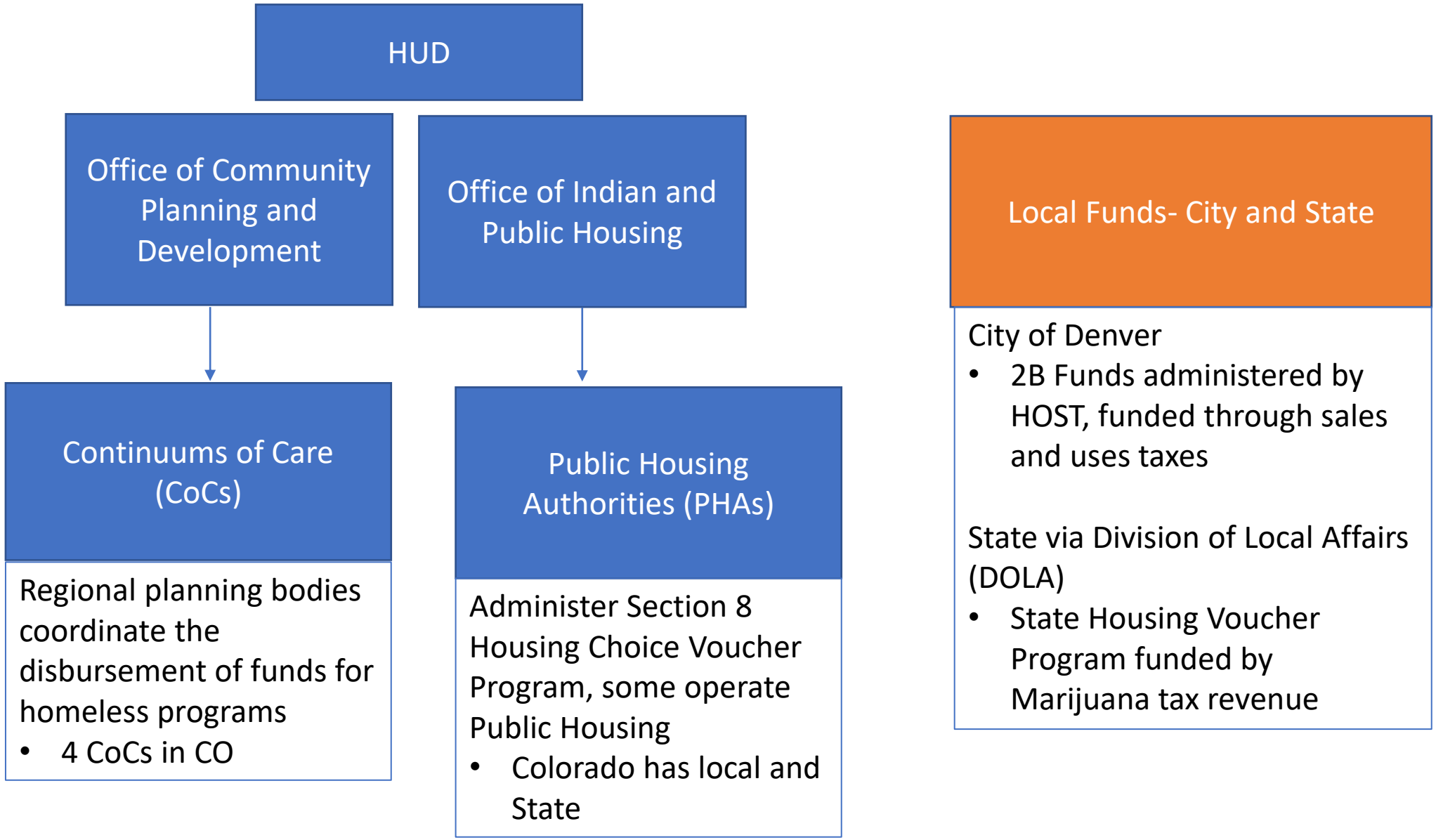
SIPPRA Housing Project

# Carla's Story: Foundation for Health

- Multiple rehospitalizations
- Case Manager at Colorado Coalition
- Medicaid and disability
- Housed through scattered-site voucher program
- Engages in SUD treatment

*"Clean and sober we have a lot of emotions that you have to deal with… And when you are high you don't do emotions. So once you come off, you get bombarded. And it is overwhelming. And that makes you realize how you now can feel now. But that also causes more trauma…".*

# Housing Funding Streams



# Impact of Supportive Housing on Housing Stability

- Several RCTs have shown that PEH who are chronically-ill and receive PSH via Housing First model spend significantly fewer days homeless than those who receive usual care.
  - Pathways Housing First was compared to a treatment-first model among PEH with a dual mental health and substance abuse diagnosis in New York City. Housing First model proved superior; those randomized to PSH were housed sooner and spent more days in stable housing than those randomized to housing contingent on first achieving sobriety.
  - The Canadian At Home/Chez Soi study- those randomize to scattered site housing plus intensive CM spent 33-49% more days in stable housing (Steriopoulos et al. 2015)
  - RCT in Chicago- Chronically-ill PEH randomized to housing plus CM following recovery from hospitalization had 62 more days per year in stable housing (Basu et al, 2012).

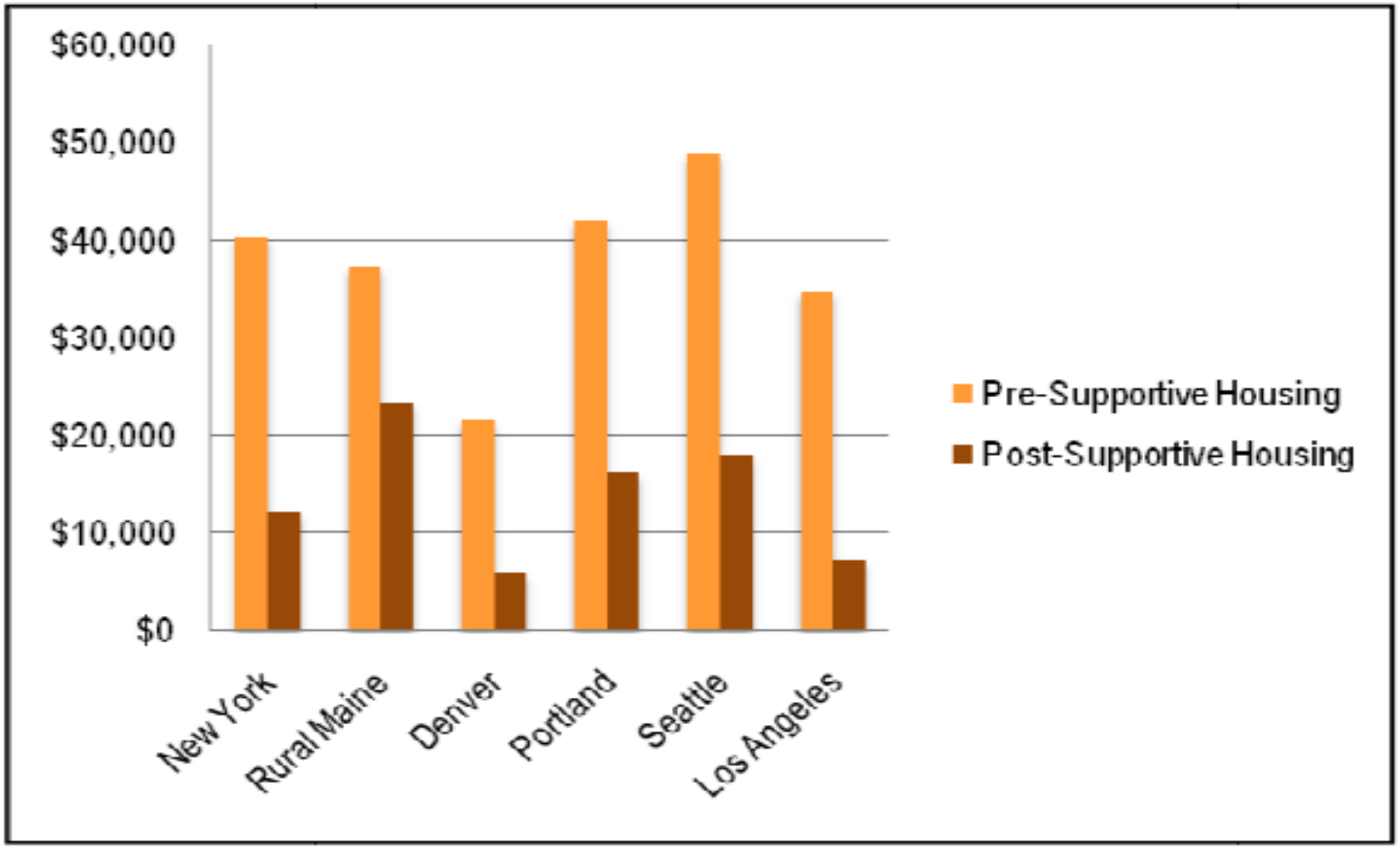
# Housing is necessary but not sufficient for health

Provision of PSH reduces ED and hospitalizations and costs in high needs populations

PSH improves HIV outcomes, well-being and QOL from a variety of different measures and study designs.

National Academy Press, 2018. Permanent Supportive Housing: Evaluating the Evidence for Improving Health Outcomes Among People Experiencing Chronic Homelessness (2018)

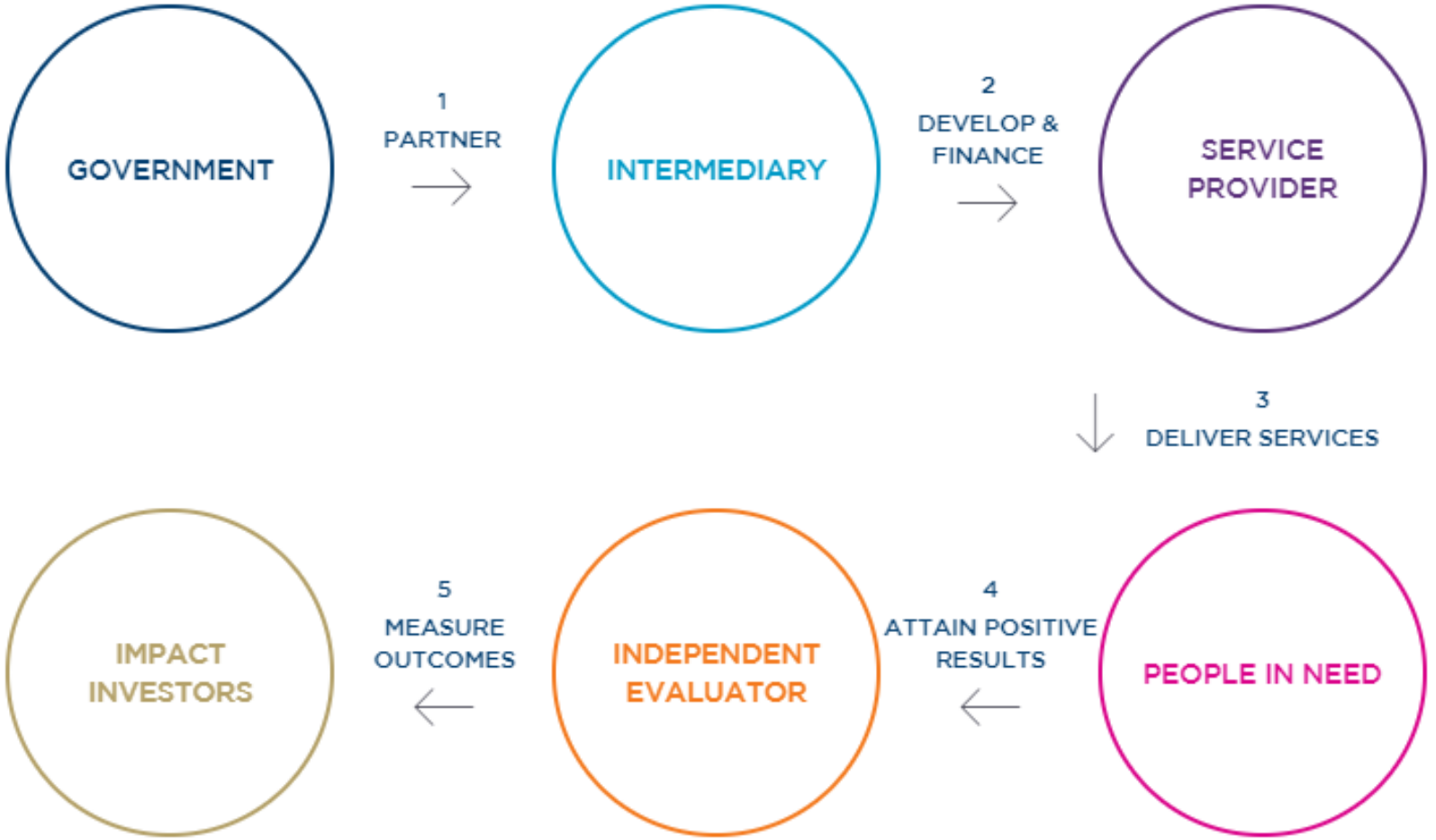
# Impact of Supportive Housing Public Service Costs




**Per-Person Annualized Cost of Public Services Before and After Entering Supportive Housing**

Corporation for Supportive Housing, 2020

# Social Impact Bonds: Pay for Success

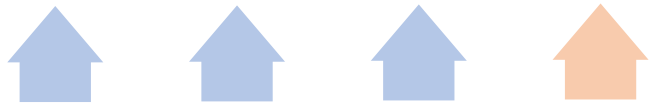



[Social Impact Bond (SIB) Financing: A Pay for Success Strategy - Social Finance]

# Denver's Social Impact Bond (SIB)

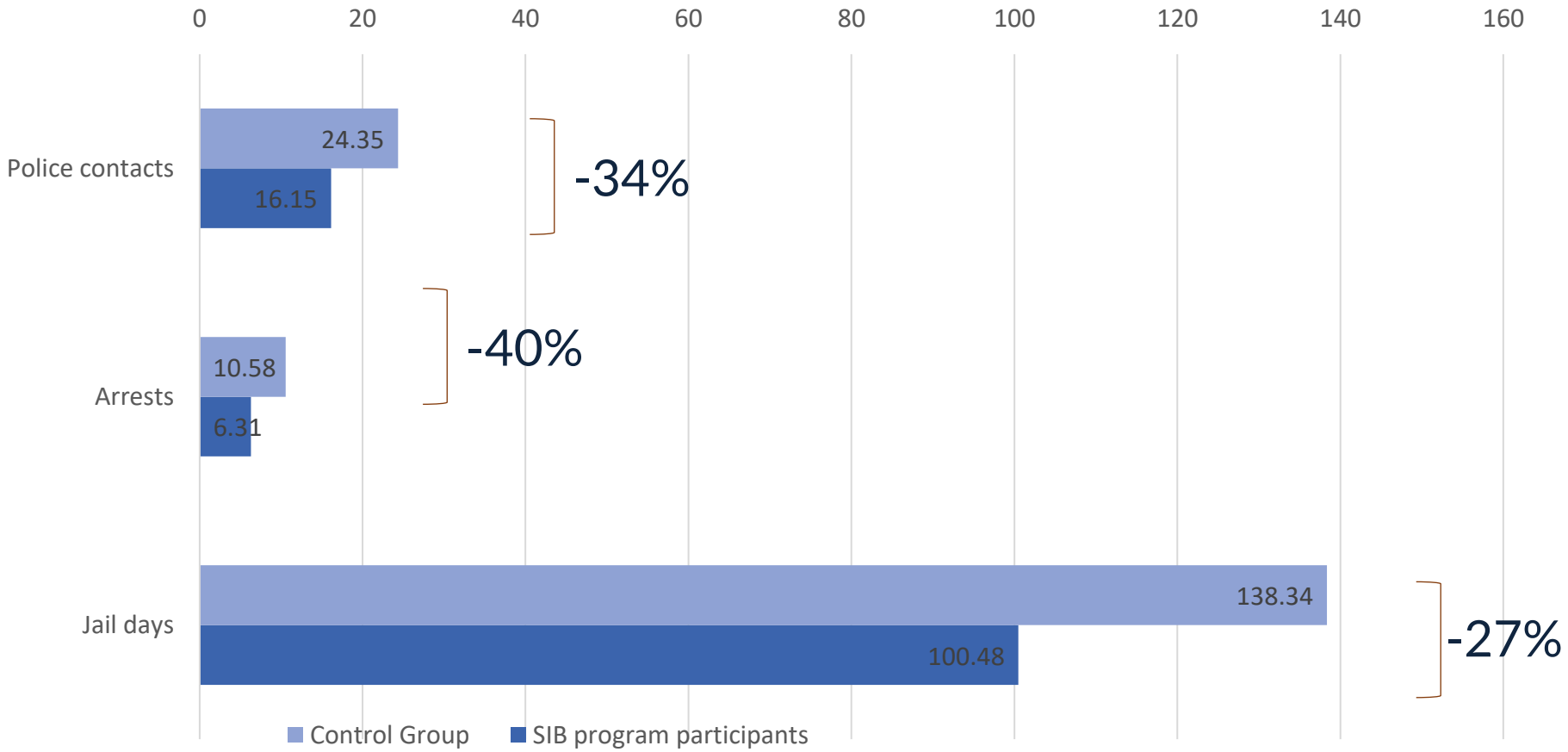
| | |
|---|---|
| **Goals** | Address the underlying causes of homelessness, including mental illness and SUD, reduce costs in the criminal justice and emergency health systems through housing and supportive case management services |
| **Project Dates** | 2016-2021 |
| **Target Population** | PEH who frequently use Denver's emergency services in police, jail, the courts and EDs (250 of which cost $7 million per year) |
| **Outcomes Funding** | $8.6 initial investment across 8 investors; $11.4M max repayment |
| **Outcome Payor** | City of Denver |
| **PFS Funding Use** | Services, limited housing related costs |
| **Service Model** | Modified Assertive Community Treatment (ACT) |
| **Evaluation** | RCT led by Urban Institute, paid for by City of Denver |
| **Success metrics** | Stable housing + jail day reduction |

# When people experiencing homelessness were offered housing, most took it and stayed long term

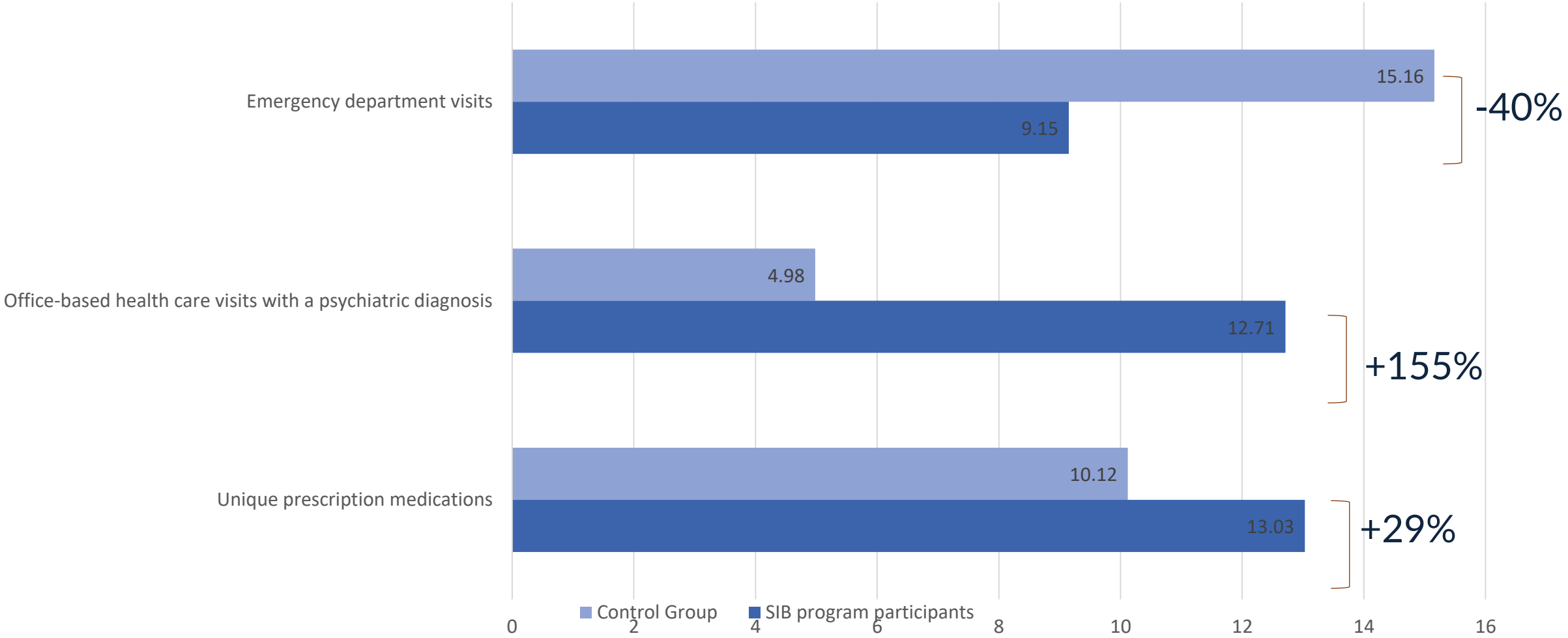


After three years in the supportive housing program, **77 percent stable housing**

# People in supportive housing had **fewer interactions with the criminal justice system** than people receiving usual services.



# People in supportive housing **used less emergency health care and received more office-based care** than people receiving usual services



# Social Impact Partnership to Pay for Results Act (SIPPRA)

**U.S. Department of the Treasury**
Office of Public Affairs

**Press Release:** **FOR IMMEDIATE RELEASE**
September 14, 2021

**Contact:** John Rizzo; Press@Treasury.gov

**Treasury Announces Social Impact Partnership to Pay for Results Act (SIPPRA) Project Grant for City and County of Denver, Colorado**

WASHINGTON — The U.S. Department of the Treasury announced that it has offered the City and County of Denver, Colorado (Denver) a Social Impact Partnership to Pay for Results Act (SIPPRA) Project grant in the amount of $5,512,000 and a SIPPRA Independent Evaluator grant in the amount of $826,800 for its Housing to Health (H2H) program, a permanent supportive housing program designed to reduce homelessness and increase housing stability. Once the grants are accepted by Denver through its legislative and executive process, Denver will be the second entity awarded funding under the SIPPRA program. Denver expects to present the offered SIPPRA grants to the City Council in early October.

# Leveraging Medicaid to fund supportive housing initiatives

- A large proportion of PEH have Medicaid
- States are experimenting that PSH for people with complex medical needs can improve individual and population health while reducing costs through a number of policy mechanisms
  - Home and Community-based Services (HCBS) authorities, Section 1915 waivers
  - Sections 115 Waivers- gives states authority to test new strategies
  - Section 1945 Health Home State Plan Amendments
  - Managed Care Programs

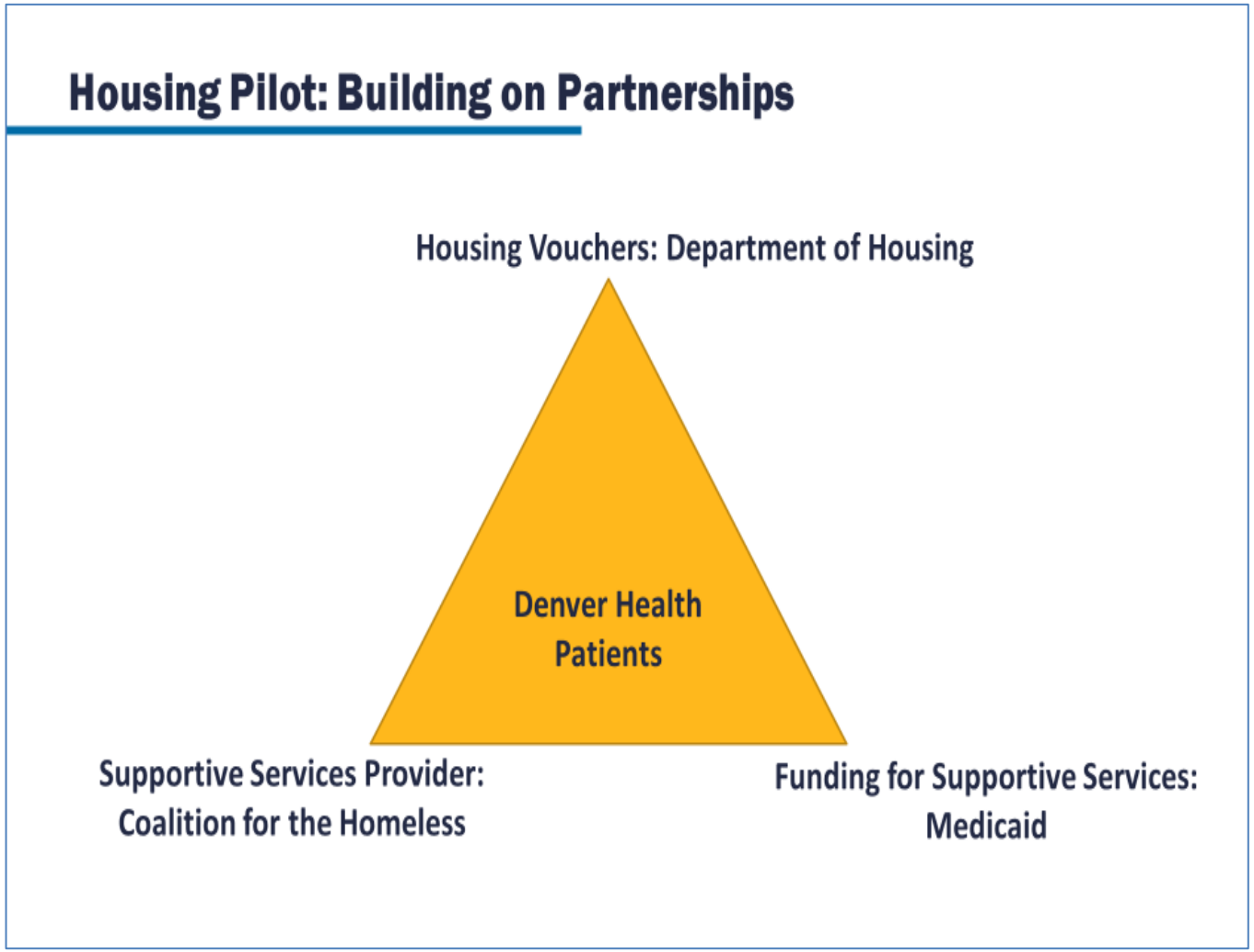
https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf
Corporation for Supportive Housing Policy Brief: Medicaid & Housing Services, August 2021

# What types of Housing Related Services can be funded by Medicaid?

- Pre-tenancy Services
  - tenant screening/assessment to identify preferences and barriers related to successful tenancy
  - housing application assistance and housing search
  - ensuring that housing units are safe and move-in ready
  - assisting in arranging for and supporting move-in (e.g., transportation and moving expenses).
- Tenancy sustaining services
  - identifying and addressing behaviors that may jeopardize housing (e.g., lease violations)
  - education on the role, rights, and responsibilities of the tenant and landlord
  - individualized case management and care coordination

https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf

# Medicaid Supportive Housing Partnership




- Describe and better understand the health and social needs of unhoused Medicaid members at risk for poor health outcomes and avoidable healthcare utilization
- Gather preliminary data on the feasibility and scalability of the pilot approach to inform broader Medicaid policy discussions
- Gain experience with stakeholder engagement and patient-centered measurements to inform future larger scale evaluations

# Lessons Learned

- Necessity of adapting methods for collaboration, clarification, and integration between departments/teams/agencies
- Addressing barriers to data sharing in larger-scale evaluation
- Need for levels of care within Housing First with services delivered based on client need→ Project HOPE

# Colorado Medicaid Demonstration Project

- With ARPA funding HCPF will operationalize funding for supportive housing for 500 PEH with serious mental illness

Health First COLORADO™
Colorado's Medicaid Program

# The Role of Hospitals and Health Systems in Housing



VIEWPOINT

## Investing in Housing for Health Improves Both Mission and Margin

**Megan Sandel, MD, MPH**
Department of Pediatrics, Boston Medical Center, Boston, Massachusetts.

**Matthew Desmond, PhD**
Department of

**During the last 20 years,** low-income families have had their incomes plateau or decline as their housing costs soared. Public aid has not been expanded to meet the growing need: only 1 in 4 households that qualify for housing assistance receives it. As a result, today most renting households below the federal poverty line spend more than half of their income on housing costs, and 1 in 4 spends more than 70% of its income on rent and utility costs alone.[1] Rent-burdened families not only have

### Housing Is Similar to Drug Prescription

Recognizing residential insecurity as a cause of preventable hospitalization, some hospitals and health systems have developed permanent, supportive housing models to reduce health care utilization among chronically homeless people.[7] The Camden Coalition of Healthcare Providers in New Jersey and the Hennepin County Health Center in Minnesota use housing vouchers to reduce health care costs; health care organiza-

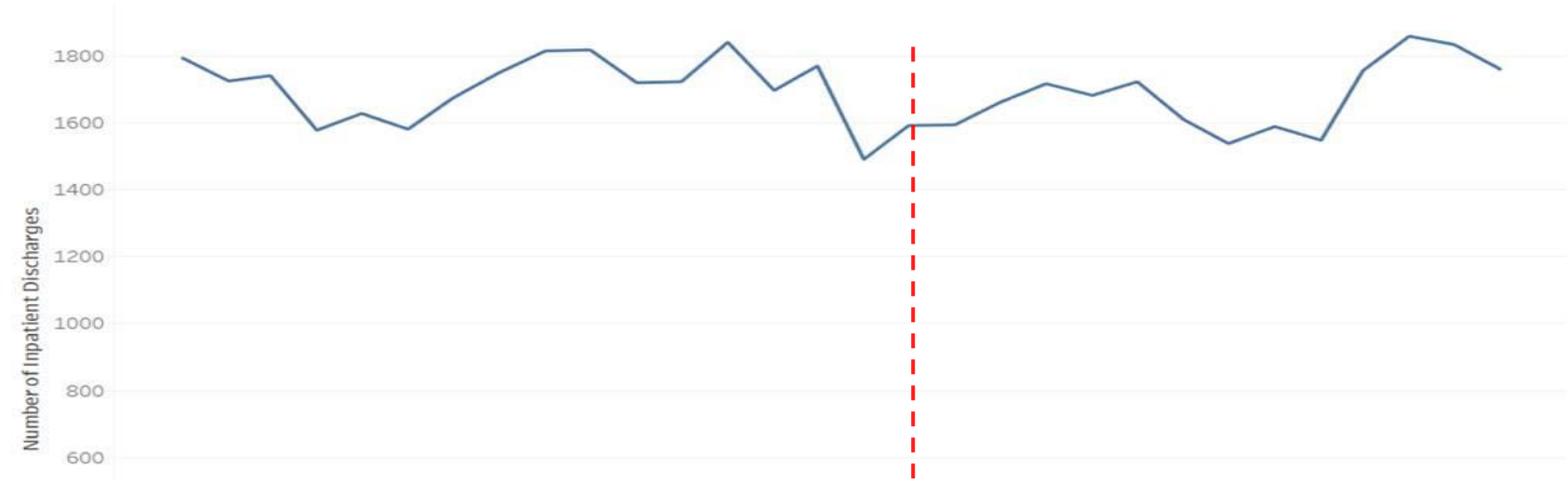
# Transitional Housing Partnership with Denver Housing Authority (DHA)

- 110 Senior Disabled Affordable housing
  - Denver Health will lease 14 SRO units for patients transitioning out of Denver Health hospital
  - On-site DH Case Manager will work with residential service coordinator
  - Goals to decrease avoidable LOS and decrease homelessness through connection to longer-term housing supports

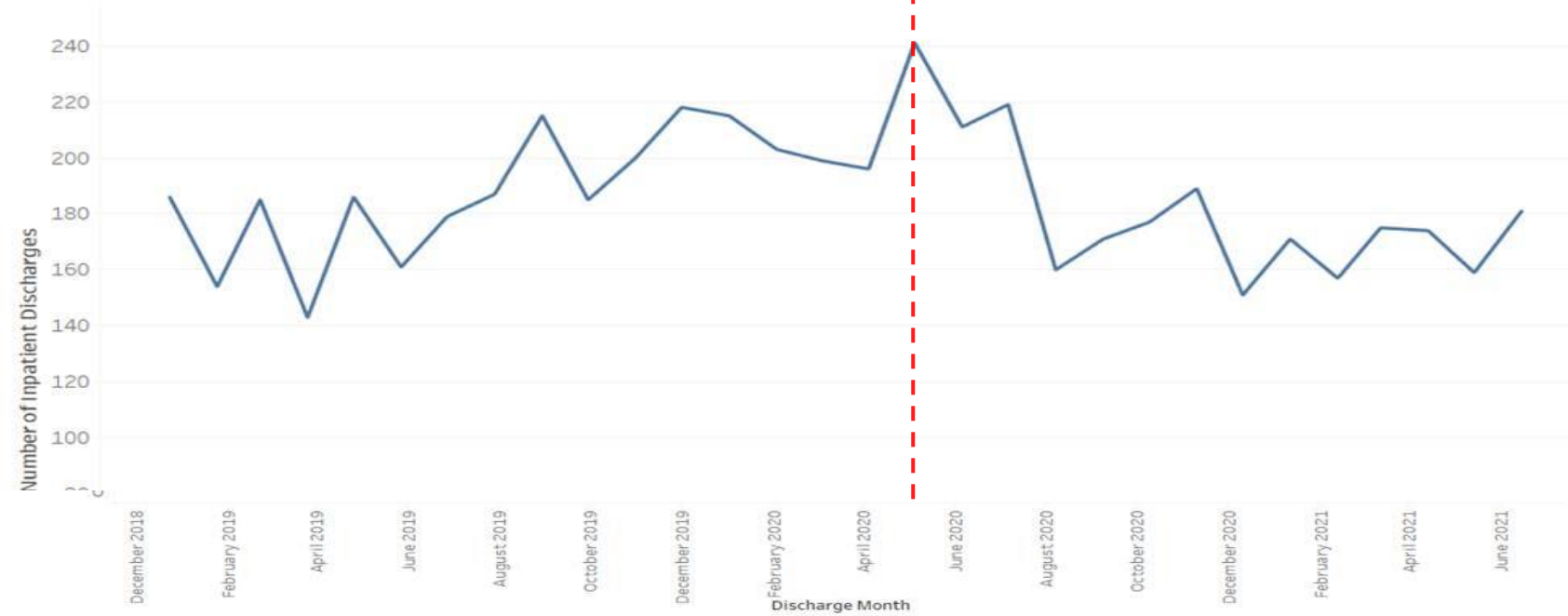
# Denver's COVID-19 Strategic Response in PEH

- Shelter de-densification and implementation of preventative measures
- Isolation and recuperative care for PEH 3,000 PEH with confirmed or suspected COVID-19
- Temporary housing for >1500 elderly medically vulnerable PEH
- Surveillance testing and outbreak mitigation in shelters and encampments
- Low-barrier vaccination and medical care
- Ongoing advocacy for funding and resources

## Non-Homeless Inpatient Hospitalizations Per Month at Denver Health




## Homeless Inpatient Hospitalizations Per Month at Denver Health



DENVER HEALTH
est. 1860

COLORADO VILLAGE COLLABORATIVE

# Safe Outdoor Spaces


More at coloradovillagecollaborative.org/safe-outdoor-space

# Carla’s Story

- Raising her son and baking again!

# Thank You

Thank you to all those individuals who are experiencing homelessness who have taught me so much and to the many community partners and agencies working to address health equity.

Questions?

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