North Carolina Coalition to End Homelessness Hospitals Summit

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June 29, 2009

Overview of Presentation

- Who is CSH?
- What is Supportive Housing?
- How is Supportive Housing Financed?
- Enacting the Policies and Systems to Make Supportive Housing Available to
  - The New York/New York III Initiative
- Emerging and Innovative Models of Supportive Housing for People with Substance Abuse Issues

Corporation for Supportive Housing

CSH is a national non-profit organization that helps communities create permanent housing with services to prevent and end homelessness.

Since 1991, CSH has been advancing its mission by providing **advocacy**, **expertise**, **leadership**, and **financial resources** to make it easier to create and operate supportive housing.

CSH's Geographic Reach and Organization

- "Field" offices in 14 localities:
  - Rhode Island
  - Connecticut
  - New York
  - New Jersey
  - District of Columbia
  - Ohio
  - Illinois
  - Indiana
  - Minnesota
  - Texas
  - Michigan
  - Northern California
  - Los Angeles
  - San Diego

- CSH also provides targeted assistance to other communities and states through our Consulting Group

National Programs:

- Federal Policy
- Project Development and Finance
- Communications
- Innovations and Research

Accomplishments

Since inception in 1991, CSH has:

- Raised over $221 million from foundations, corporations, and government contracts to expand supportive housing nationwide.
- Leveraged $6.15 billion in federal, state, and local public and private sector financing.
- Committed over $200 million in targeted technical assistance, loans and grants to support the creation of 35,000 units of affordable and supportive housing.
- The units in operation have ended homelessness for at least 26,000 adults and children.

What is Supportive Housing?

Defining Supportive Housing

Supportive housing is
permanent, affordable housing
combined with
a range of **supportive services**
that help **people with special needs**
live stable and independent lives.

Essential Features

- **Housing**
  - **Permanent:** Not time limited, not transitional.
  - **Affordable:** To very low income people (due to financing with minimal to no conventional debt coupled with rent subsidies)
  - **Independent:** Tenant holds lease with normal rights and responsibilities.
- **Services**
  - **Flexible:** Responsive to tenants' needs. Focused on housing stability.
  - **Voluntary:** Participation not condition of tenancy

Basic Types of Supportive Housing

- **Single-site**:
  Apartment buildings exclusively or primarily housing individuals and/or families who are formerly homeless and/or have chronic health challenges.

- **Scattered-site**:
  Rent subsidized apartments leased in open market (scattered-site).

- **Integrated**:
  Apartment buildings with mixed tenancies, but with units set-aside for formerly homeless.

The "Support" in Supportive Housing is Flexible, Voluntary and Helps Tenants:

- Access to health care and counseling for chronic health and behavioral health conditions
- Get educational and vocational training
- Learn money management and life skills
- Work
- Achieve housing stability
- Socialize and connect with the wider world
- Be leaders in their community
- Pursue goals and interests

Supportive Housing is a Solution to Multiple Policy Problems

- In addition to increasing housing stability for people who are homeless, supportive housing is also a solution for:
  - Reducing incarceration rates for people with chronic health challenges
  - Improving family functioning and decreasing child welfare involvement
  - Promoting health, wellness, and access to recovery-oriented services and healthcare

And Supportive Housing Works for Tenants and the Taxpayers:

- ER visits down 57%[1]
- Emergency detox services down 85%[2]
- Incarceration rate down 50%[3]
- 50% increase in earned income
- 40% rise in rate of employment when employment services are provided
- More than 80% stay housed for at least one year[4]

[1] Supportive Housing and Its Impact on the Public Health Crisis of Homelessness, CSH, May 2000

[2] Analysis of the Anishinabe Wakaigun, September 1996-March 1998

[3] Making a Difference: Interim Status Report of the McKinney Research Demonstration Program for Homeless Mentally Ill Adults, 1994

[4] See note 1 above

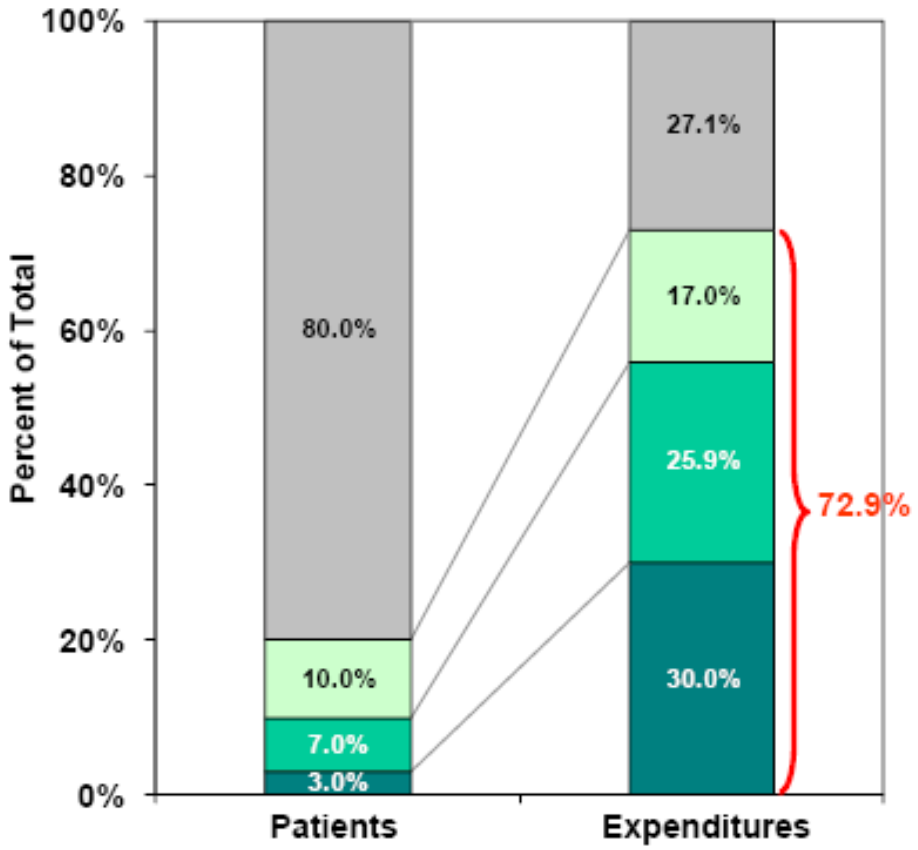
The Need for Supportive Housing and Health Partnerships

Individuals Inappropriately Placed in Inpatient and Long-Term Care

- Patient "holdovers" - Homeless individuals who enter emergency care and require hospitalization get stuck in inpatient settings long after their care

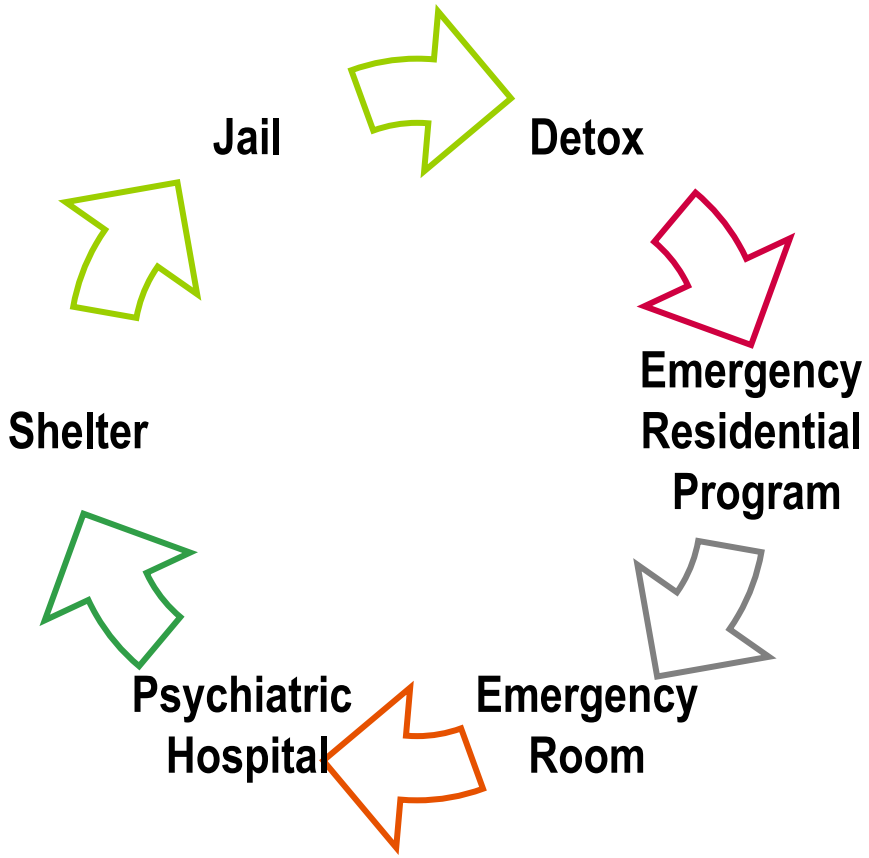
- "Olmstead" victims – Individuals with disabilities (usually mental illness) who are inappropriately placed into nursing homes or long-term care hospitals despite their right to most integrated, least restrictive settings per *Olmstead v. LC*

High Utilizers of Health Services with Poor Health Outcomes



- In nearly every community, there exists a subset of individuals who consume a disproportionate amount of health services with no improvements to health outcomes
- Billings' (2006) analysis of NYC Medicaid claims data found that:
  - 20% of adult disabled patients subject to mandatory managed care account for 73% of costs
  - 3% of patients accounting for 30% of all costs for adult disabled patients

The Institutional Circuit of Homelessness and Crisis



- High utilization of crisis services in one public system is often part of a larger "institutional circuit" (Hopper and colleagues, 1997)
- Institutional circuit pattern:
  - Indicates complex, co-occurring social, health and behavioral health problems
  - Reflects failure of mainstream systems of care to adequately address needs
  - Demands more comprehensive intervention encompassing housing, intensive case management, and access to responsive health care

Supportive Housing and Health Care – Best Practices and Outcomes

San Francisco, CA
Direct Access to Housing (DAH)

- Program takes people who have concurrent mental health, substance abuse and mental health conditions directly from streets into permanent housing. All are high users of public health system.
- FQHC (HCH grantee) provides on-site primary health care, mental health and other support activities to the 600 tenants; billed through Medicaid and HRSA
- Weekly case coordination with all service providers of tenants
- Positive outcomes:
  - 58% reduction in ER use
  - 57% reduction in inpatient episodes
  - Decrease in number of days per psychiatric hospitalization

Portland, OR - Central City Concern's Community Engagement Program

- Scattered-site supportive housing linked to ACT teams for chronically homeless adults with co-occurring mental illness and substance abuse
- Provides wrap-around support and peer recovery model (including consumer-run drop-in center)
- Evaluation findings:
  - Tenants had average of 3.7 years homeless and used $42,075 in emergency services annually
  - After 1 yr, service utilization decreased to $17,199, with housing and services that cost $9,870 (Total cost of $27,069)
  - Total annual cost savings per person: $15,006

Portland, OR – Central City Concern's Recuperative Care Program

- Supportive and transitional housing for homeless patients of area hospitals
- CCC offers beds (through housing) and a medical home with its FQHC clinic
- Since its inception in 2005, the RCP has:
  - Served more than 540 people;
  - Had a successful discharge rate (full recovery and completion of care) of 76%; and
  - Discharged 77% of all participants to stable housing

Seattle, WA – DESC's 1811 Eastlake Avenue

- Supportive housing for 75 homeless alcoholics who are high users of detox, treatment, health and corrections
- Tenants identified through pre-generated list of high Medicaid-funded crisis services
- Evaluation demonstrates that six months after placement, the project resulted in a 63% reduction in costs associated with use of crisis alcohol services (detox)

Seattle, WA
Plymouth on Stewart

- 87 units – 40 PSH
- 20 specifically for health services
  - 14 units for high utilizers of Medical Respite/emergency room services
  - 6 for high utilizers of the Sobering Center/chemical dependency services.
- Service partner is Health Care for the Homeless – FQHC clinic

Frequent Users of Health Services Initiative (FUHSI) - California

- Local hospitals and service providers collaborated in the development and implementation of more responsive systems of care to address unmet needs, produce better outcomes, and reduce unnecessary use of emergency services.

- 6 year demonstration project in 6 sites in California – Programs and Interventions diverse, almost all included linkages to housing

  Alameda County – Project RESPECT
  Los Angeles County – Project Improving Access to Care
  Sacramento County – The Care Connection
  Santa Clara County – New Directions
  Santa Cruz County – Project Connect
  Tulare County – The Bridge

FUHSI - California

- On average FUHSI participants experienced:
  - 8.9 ED visits each annually, with average annual charges of $13,000 per patient
  - 1.3 hospital admissions annually
  - 5.8 inpatient days each, with average annual charges of $45,000 per patient

- Additionally:
  - 65% chronic illness (diabetes, cardiovascular disease, chronic pain, cirrhosis & other liver disease, asthma & other respiratory disease, seizures, Hepatitis C, and HIV)
    - Small number of people with HIV were frequent ED users in communities where supportive housing is available to them
  - 53% substance use issues (alcohol, methamphetamines, crack/cocaine, heroin, prescription drugs)
  - 45% homeless, living on the streets
  - 32% mental illness (Axis I and II)
  - 36% have 3+ of these presenting conditions

Outcomes: Hospital Utilization & Charges

Frequent Users of Health Services Initiative (CA)

	1 Year PRE	2 Years POST		% DIFFERENCE
ED Visits (Mean)	10.9	4.5		**59% decrease**
ED Charges	$2,093,247	$952,770		**55% decrease**
Inpatient Admissions	283	82		**69% decrease**
Cumulative Inpatient Days	1,266	365		**71% decrease**
Inpatient Admission Charges	$9,905,168	$2,824,710		**72% decrease**

Other Research & Evaluation Findings Regarding Supportive Housing and Health Care

Frequent Users – Additional Data

- A study by San Francisco General Hospital found that half of study participants had 5 to 11 ED visits per year and half had more than 12 visits
- A study of chronically homeless inebriates by the University of California, San Diego Medical Center found that 15 people had 417 visits to the emergency department; one had 87 visits
- A Washington State study of Medicaid patients identified 198 individuals that averaged 45.5 ED visits in a year, a total of 9,000 visits

How much does that cost?

- *FUHSI* found that each frequent user averaged $58,000 a year in hospital charges ($13,000 related to ED visits, $45,000 related to inpatient days)
- A San Francisco General Hospital study found that total hospital costs per frequent user averaged $23,000 per year
- A study of chronically homeless inebriates by the University of California, San Diego Medical Center found that 15 individuals averaged $100,000 each in medical charges

NY/NY Cost Study

The Impact of Supportive Housing for Homeless Persons with Severe Mental Illness on Use of Public Services in New York City

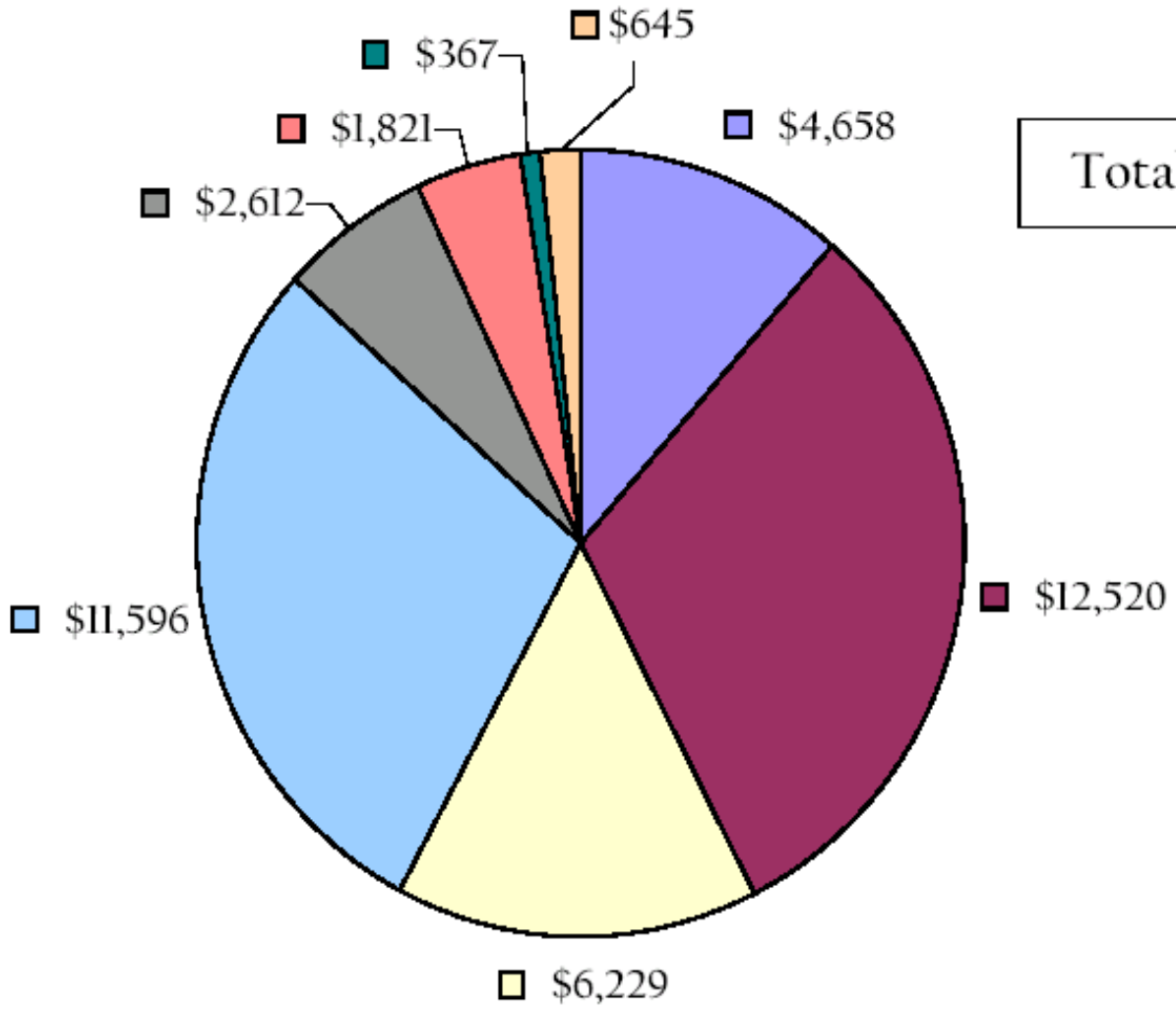
- Agreement between NY State and NY City in 1991
- Funded capital, operating, and service costs for 3,600 supportive housing units in NYC
- Placement recipients must have an SMI diagnosis & a record of homelessness
- Data available on 4,679 NY/NY placement records between 1989-97 - Studied use of resources 2 years before and 2 years after housing placement
- Performed by Dennis Culhane, Ph.D., Stephen Metraux, M.A., and Trevor Hadley, Ph.D., Center for Mental Health Policy & Services Research, University of Pennsylvania

NY/NY Research Question

How do NY/NY housing placements affect the use of:

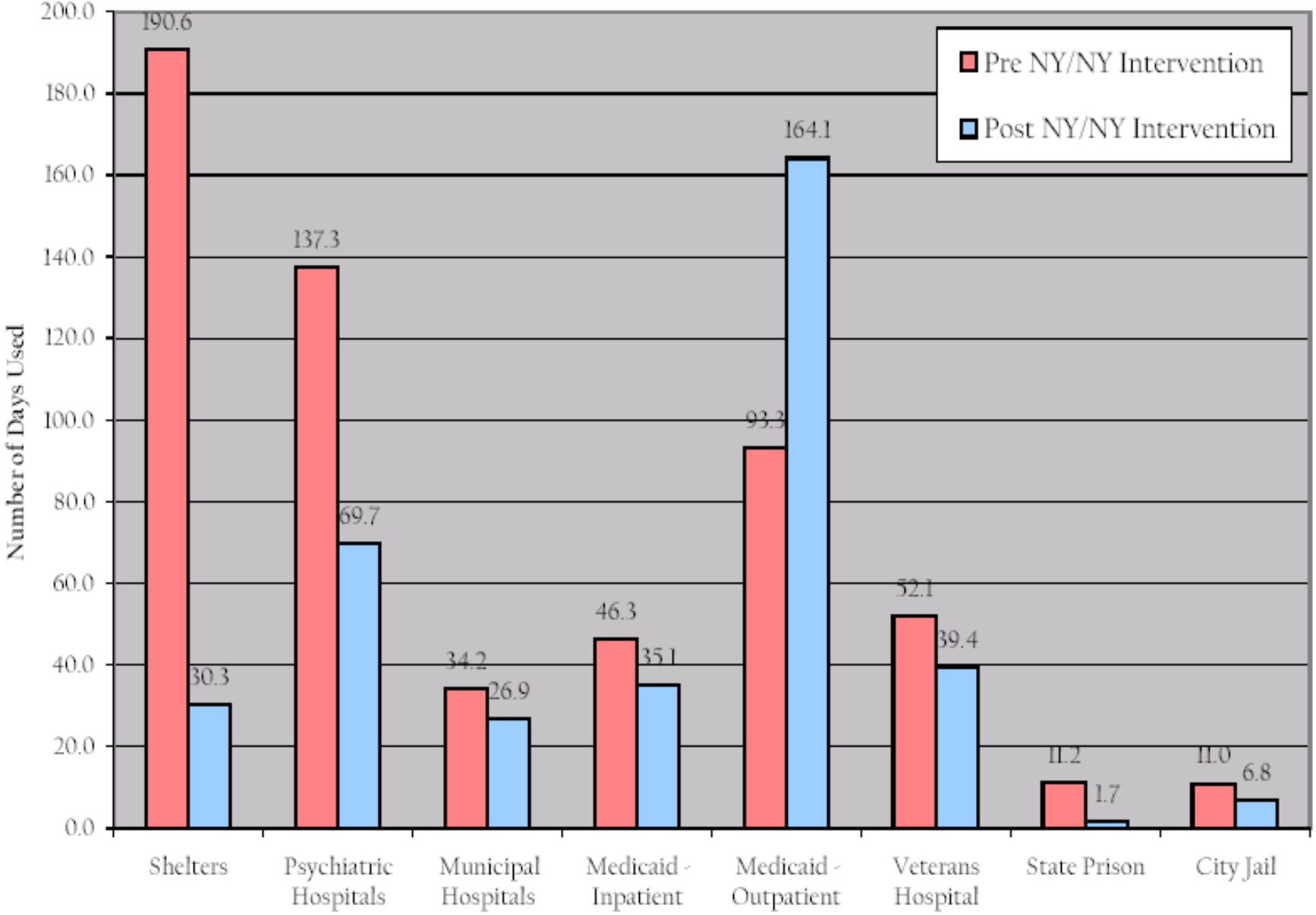
- City shelters
- State psychiatric hospitals
- State Medicaid services
- City hospitals (HHC)
- Veterans Administration hospitals
- State prisons
- City jails

The Cost of Homelessness in New York City

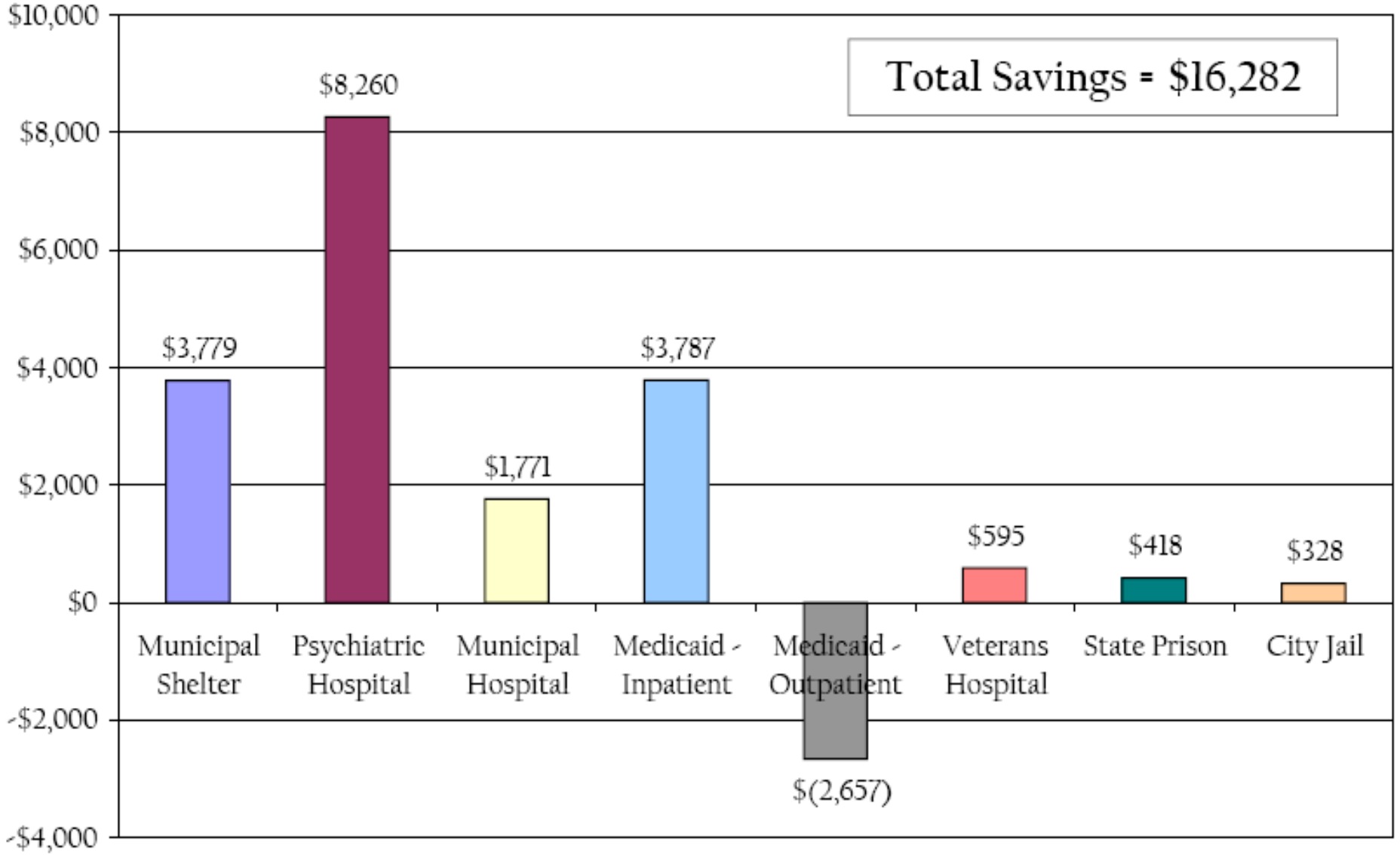


Cost figures based on emergency services utilization of individual homeless person with serious mental illness

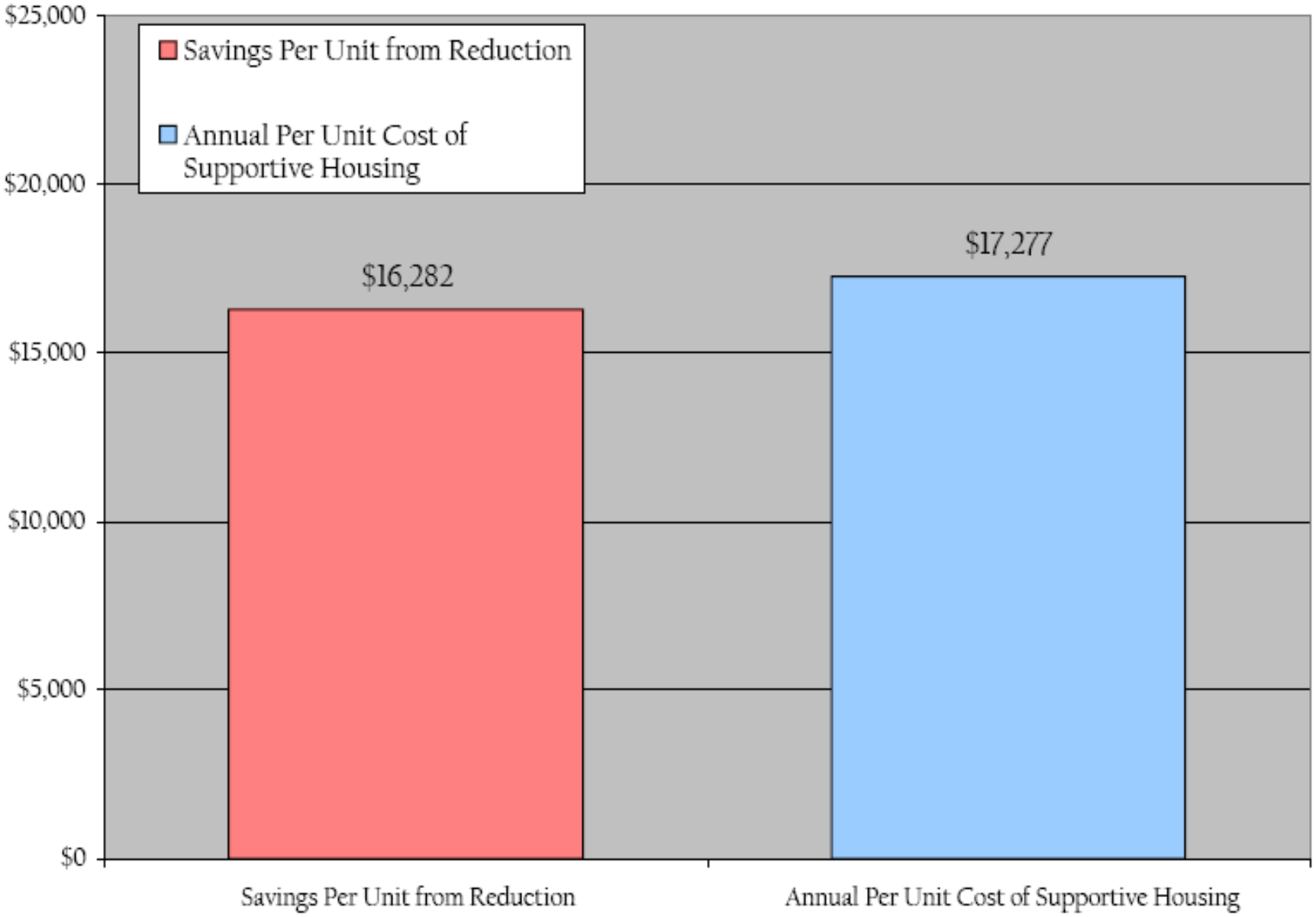
Reduction in Average Services Utilization in Days for NY/NY Placements



Savings from Reduction in Services Utilization Per NY/NY Housing Unit



Savings and Costs of NY/NY Supportive Housing



Supportive Housing Increases Impact Of Multidisciplinary Care

- Homeless frequent users receiving services and connected to permanent housing
  - Reduced average ED visits 34%
  - Reduced average inpatient days 27%
  - Reduced average inpatient charges 27%

- Homeless frequent users receiving services but NOT connected to permanent housing
  - Reduced average ED visits 12%
  - ***Increased*** average inpatient days 26%
  - ***Increased*** average inpatient charges 49%

Emerging Lessons and Key Elements for Supportive Housing & Health Care

Target population identification strategies

- Administrative data match driven strategies (1811 Eastlake)
- Strategies involving case knowledge of referring entities (FUHSI, RCP)
- Consider overlap with frequent users of other systems (i.e., homeless shelters, jails, etc.)

Client engagement

- One of the most significant challenges is client/tenant recruitment. Effective engagement strategies are key:
  - Partnerships between institutional settings of care and supportive housing/community based care
  - Importance of “in-reach” by supportive housing providers and community based services
  - Seek clients in broad array of settings (hospital, shelters, jails, treatment programs, etc.)
  - Persistence recruitment and repeated engagement to establishing trust / overcoming aversion to services
  - Competency and skills to distinguish between “service resistance” and behavioral adaptations to long-term homelessness and institutionalization
  - “Low-demand” orientation and client-centered approach reduces resistance

Supportive services

- Case management as foundation for engagement and relationship building
- Benefits/health insurance advocacy and enrollment
- Service coordination and systems navigation/advocacy critical for multi-occurring issues and lack of integrated care
  - FQHC partnerships
- Services approach focused on helping tenants achieve successful tenancy, and improve health outcomes
  - Housing as foundation for improved health

Housing

- Housing may be single site, integrated, scattered/clustered site
- Services on site or nearby and linked to medical home
- Accessible, particularly for a medically fragile population
- Innovative design features tailored to chronically ill populations

Interagency Collaboration

- Effective program planning – Multiple sectors bring broader expertise and deeper bench
- Initiative resources/funding – Blended funding is essential for supportive housing and health care
- Implementation – Success of initiative contingent upon case conferencing and “fix it” committees to troubleshoot client and system barriers
- Services integration – Services need to be coordinated between supportive housing, clinics, hospitals, treatment programs, public benefits systems, etc.
- Program sustainability – Diversification of partners and funding increases the chance for continued support

Advancing Partnerships

Advancing Supportive Housing and Hospital Partnerships

- Target population definition and identification
- Initiative/program design (including housing/services model and client recruitment and referral process)
- Partnership formation – engaging with policy makers from housing and community based health services systems

Advancing Supportive Housing and Hospital Partnerships (cont'd)

- Identifying and tapping housing opportunities
  - Consider units that "turn over" within existing inventory of housing
  - Tap into development pipeline of new housing units
  - Pursue new housing development and creation strategies

- Financing possibilities
  - Explore usual sources (HUD McKinney, Section 8, HOME, tax credits, supportive housing capital, state mental health services funding)
  - Medicaid (Rehab Option, 1115 waiver, etc.)
  - New resources including new federal grants and stimulus funding
  - Local opportunities
  - Foundations and philanthropy as "pump primer"
  - Reinvestment of funds currently used to pay for traditional services to new supportive housing

Roles for Hospitals

- Initiation of data match/analysis to identify and call attention to problem
- Leadership to mobilize attention and political will
- Role in financing through reinvestment
- Direct role in development or service provision
- Outcomes/performance measurement

For More Information

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