Health and Housing Partnerships: Overview of Opportunities and Challenges for Health Centers

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Introduction

Health and housing partnerships that can deliver coordinated care including needs assessment, housing search, and medical referrals and supports are critical to improve the quality of life for people with complex health conditions and experiencing homelessness or housing instability. These individuals, families, and youth experience the compounding effects of social and environmental stressors, such as poverty, trauma, and violence, in addition to personal health concerns, such as mental health conditions, substance use disorders, and chronic physical conditions. These factors are difficult to address when someone has limited resources, often resulting in poor health status and frequent and inappropriate use of emergency rooms, hospitals, and 911 systems.[1] Partnerships between health and housing system stakeholders are uniquely poised to address the social and health factors impacting quality of life for so-called "frequent users" of our communities' crisis and high cost resources. Health and housing partnerships can ultimately result in lower costs to the health system by providing an essential connection to preventive primary and behavioral health care in the community. However, these collaborations are not without challenges as the vastly different practice cultures of the health and housing sectors collide.

Supportive housing models, which bring together affordable housing and supportive services such as independent living skills and behavioral health counseling (see Addendum A for a full portfolio of supportive housing services) have proven to help individuals remain stably housed. In addition, supportive housing programs are increasingly documenting success by measuring improved resident health outcomes and lower costs to the health care system. These results are leading Health Center Program grantees, housing providers, service providers, and developers to explore more intentional partnerships that go beyond simply referring patients to each other. These partnerships can include multi-disciplinary, multi-agency case management and health care coordination teams that purposefully locate consumers in an apartment near a health center, and can go as far as co-location of a health center in a supportive housing building.[2]

CSH is a national leader in supportive housing and transforms how communities use housing solutions to improve the lives of the most vulnerable people. This paper describes the existing barriers health center grantees face as they target services to frequent users of other health systems and link them with housing. Our description of the barriers is based on what CSH has learned through years of creating supportive housing, with references to a range of papers documenting our work, combined with information gleaned from a recently performed needs assessment survey answered by health center staff and conducted through a National Cooperative Agreement (NCA) with the federal Department of Health and Human Services, Health Resources and Services Administration (HRSA). We believe it is important to articulate these issues so that over the next three years CSH can prioritize our work and measure progress as we improve health and housing coordination for the most vulnerable.

Developing Health Care Partnerships

To effectively serve individuals who are unstably housed, experiencing homelessness or residing in institutions (including jails/prisons, nursing homes, and mental health facilities), and are frequent users of emergency and inpatient health care services, it is important for health centers to consider partnering with their health system colleagues - hospitals, other behavioral health providers if not fully integrated, community-based social service providers, and health system payers, in addition to housing providers. The goal is to provide more intensive community-based support in meeting health care and self-management goals. The following describes the potential of these partnerships.

Hospital and health center partnerships aim to redirect patients to more appropriate primary care in order to reduce unnecessary utilization of emergency services and inpatient care. A starting point for health centers establishing partnerships with hospitals is to consider fostering stronger communication between them, often siloed medical entities. It can be valuable when differences in the practice culture between health centers and hospitals are navigated and mutual goals identified in order to build a strong working relationship. Additionally, it is key for hospitals and health centers to determine how best to identify patients who are frequent users with housing needs and share information. For example, while ICD codes[3] are available to identify homeless status, research indicates that hospitals are not consistently using this standardized code,[4,5,6] making it difficult to target outreach strategies.

Behavioral and primary health care integration is essential to providing comprehensive care to individuals who have co-occurring conditions. The importance of this integration is particularly true for people experiencing homelessness, cycling in and out of jails/prisons, and those residing in mental health institutional settings. Large percentages of these subpopulations – which often overlap – have either a mental health diagnosis, substance use disorder, or both, frequently coupled with physical health conditions. Partnerships across all levels of the primary and behavioral health care provider networks - funders, community agencies, and individual providers - ensure that people can access the comprehensive care they need, when they need it. Health centers can provide behavioral health services through partnering with behavioral health clinics or they can incorporate behavioral health providers on their staff. In either case, it is important for primary and behavioral care providers to establish clear, collaborative goals that address the "whole person" needs of the patient.[2, 7]

Community-based social service organizations, such as homeless service agencies, child welfare, and other case managers, are essential partners for health centers in providing services to frequent users of emergency and crisis care. These providers connect clients to non-medical services such as housing, health care benefits, public assistance, employment, child care, and education programs. Social service providers are able to build relationships with consumers; enabling them to better coordinate services and helping the consumer feel more comfortable seeking health services. In building trust, community-based service providers can get a better view of an individual's needs and seek to connect the individual with additional resources.

Health system payers such as state Medicaid agencies, managed care organizations (MCOs), and health networks have a unique opportunity to support health and housing partnerships. First, payers can help to identify high cost users within their health systems in order to target appropriate interventions.[8] In addition, these organizations approve which health and support services are reimbursable and determine payment methodologies. As such, payers can support high impact, innovative interventions such as services in permanent supportive housing by broadening the scope of services eligible for reimbursement and providing payment incentives to providers for meeting quality-based outcomes. Health center leaders can provide important information about the health and housing needs of their patients in order to guide such decisions. Finally, supportive housing and health center stakeholders working together on initiatives aimed to improve access to home and community-based services or adherence to the *Olmstead*[9] decision ensure linkages are made to better enable people to be successfully integrated into the community.

<u>Identified Challenges to Partnership:</u>

- Incompatible data systems: Hospitals, behavioral health providers and health centers often cannot easily share patient data due to technological and/or legal (HIPAA) concerns, which is one of the basic necessities to partnership.
- Few hospitals and health care systems use ICD codes to track housing status making it difficult to identify homeless patients.
- Different practice models: Vulnerable patients often need mobile or in-home care to stay out of expensive emergency rooms and avoid lengthy in-patient hospital or institutional stays. Agencies are experimenting with

alternative practice models – flexible office hours, mobile vans, home visits – to meet patient needs but this requires a shift in regular practice.

- Lack of insurance (Medicaid) eligibility: In states that have not expanded Medicaid many of those with complex conditions do not have health insurance making it difficult for health system partners to find resources to more appropriately treat frequent users.
- Omission from payer decision making: Health center leaders can provide valuable information about the health care needs of vulnerable populations but are not often invited to participate in decision-making discussions with health care payers.

Services Financing

Creative use of health center resources, including funding, will support health centers in providing the full range of services needed by people with complex health conditions. The expansion of Medicaid in some states has improved revenue for many providers, yet it does not cover all services or may not adequately cover the cost of flexible, intensive, and often housing-based services.[10] Also, many traditional supportive housing providers are not Medicaid billing entities and do not have the infrastructure or certifications required to receive direct reimbursement. An effective strategy for health centers which have the expertise in billing Medicaid is to partner with supportive housing providers to deliver Medicaid billable services and allow housing entities to use their resources for non-Medicaid billable services and housing.

Comprehensive supportive housing services are often delivered by multiple entities with separate funding streams. Health centers and supportive housing providers, either working together or separately, frequently find it necessary to braid multiple funding sources such as HRSA and other federal grants, insurance payments, local and state funding, and philanthropic support to cover the cost of these services. Requirements for braided funding can be demanding since providers must report disparate outputs and outcomes for each service funded by each payer.[2, 7] Increasing the services that can be reimbursed by insurance, especially Medicaid, can reduce this burden and help stretch local and state funding further.

Identified Challenges for Services Financing:

- Medicaid does not cover all supportive housing services: There are limitations on the types of services that providers are able to bill for, such as housing-based services, and eligibility for some services is restricted to consumers with targeted conditions such as serious mental illness or a developmental disability.
- Health center reimbursement restrictions: Health centers face billing challenges when providing care to people living in permanent supportive housing. For example, services provided to residents who live outside of the health center's approved service area not reimbursable. Even when a resident lives within an approved service area, needed services such as case management and nursing care are generally not reimbursable alone.
- Billing structure: For services that are not billable under the Medicaid Prospective Payment System (PPS), health centers may be able to bill through other State Options such as a State Medicaid Behavioral Health Program. These programs may rely on a fee-for-service model, which is not conducive to serving individuals with complex needs. Each service must be billed separately and in 15-minute increments. When a provider serves an individual with multiple concerns, the extra time required to deliver quality care through various service interventions is not accounted for, resulting in an overall lower reimbursement.[2]
- Administrative burden: Multiple funding streams each require different reporting and some are only for specific services or populations.

Service Delivery Models

Critical to the delivery of care to the frequent user population is staff that is well-trained to handle and manage a high degree of complexity. Staff must be able to negotiate the range of physical, behavioral, and social challenges that patients present when they seek care at health centers. Skill sets that address high-risk behaviors such as provision of trauma-informed care, in addition to motivational interviewing, harm reduction strategies, and de-escalation techniques are critical to serving the frequent user population. Knowledge related to social determinants of health and ability to work collaboratively with other sectors is also an important prerequisite for delivering adequate care. It may take years to establish a strong provider/patient relationship; staff trained in homeless health care may be better equipped to establish rapport with consumers who may be reluctant to engage in care.[2]

Multi-disciplinary teams can be effective in assisting individuals who have a wide-range of physical, behavioral, and social needs. These multi-disciplinary teams leverage resources and staff from multiple agencies and draw upon team members' areas of expertise to provide more comprehensive and holistic care. Additionally, such teams can allow multiple agencies to work from the same care plan with clearly defined roles thus reducing fragmentation and duplication of care. Working as part of a multi-disciplinary, sometimes multi-agency, care team can break down communication silos between health and housing.[2] Providers are still learning what the right mix of staff delivering primary and specialty healthcare is needed for which populations.[2] Many providers prefer a team inclusive of licensed staff in order to bill insurers and increase quality of care but costs may be a concern preventing those highly trained and licensed personnel from engaging in off-site team work. Over time, as clients require less services a team approach may not be needed. As the demand to save money grows, it is important to understand at what point cost reductions compromise care.

Health centers co-located in single-site supportive housing can also be an effective way to provide services to high need consumers, and can reduce the burden of transportation to access health care on residents/patients. Hours of operation and level of staff will vary depending on utilization trends and health center service site (e.g. New Access Point vs. established health center site). Co-located health centers may be open fewer hours and have fewer staff and resources than a stand-alone health center. However, residents are informed of regular hours and encouraged to seek support from health center staff when on-site. Additionally, staff providing care in co-located sites often offer reminders and check in on residents to ensure that their health needs are being met which in turn supports housing stability. Co-located health centers and supportive housing may be created through renovation of existing space or may require new construction.[2] In either case, it is essential that the health facility be constructed in a self-contained space that meets local zoning and building codes, and any state healthcare facility requirements.

Mobile clinics are also used widely with supportive housing to provide a range of primary, behavioral health, and general case management services. Mobile clinics can provide care at multiple locations and are often less expensive than building a co-located health center. A mobile clinic may not have the capacity to provide comprehensive services to the same degree as a stand-alone health center, but is able to reach more people who face barriers to getting to the off-site appointments.

<u>Identified Challenges for Services Delivery:</u>

- Funding team-oriented care: Highly trained teams with licensed providers may be cost-prohibitive.
- Determining appropriate level of care: Not all individuals will need the same level and intensity of care. Health centers will need to assess how to deliver the most appropriate level of care to each individual.
- Health center location: To maximize resources, it is important for health centers to continually assess patient needs to determine whether a stand-alone health center, co-located health center/new access point, or mobile clinic are best for the community and what mix is necessary to have the best impact. Additionally, patient engagement with co-located health centers and/or mobile clinics can vary greatly month to month, which requires strategic budget decisions on how to best use deployed resources.

ENGAGING THE HOUSING SECTOR

Partnering with housing providers is essential to the long-term health stability of people with complex health conditions and experiencing homelessness or housing instability. When living on the streets, health care is often neglected in order to address more pressing priorities such as getting shelter and food for the day. Once housing is attained, patients can focus on issues that are less immediate or pressing such as keeping appointments, taking and safely storing medications, eating more nutritious food, and making other adjustments to improve their overall health (i.e., smoking cessation or regular counseling).

Collaboration between health care and housing entities is necessary for successful implementation of supportive housing programs aiming to serve this population. The range of potential housing collaboration partners, with access to affordable housing resources, may include non-profit organizations that own and operate supportive housing, public housing authorities with both housing units and rental subsidies, and private multi-family apartment owners working with community service agencies. Health centers can be working with housing providers to help staff understand and effectively respond to patient needs related to their physical or behavioral health. When patients neglect tenant responsibilities and risk losing their housing, it is important that issues are handled collaboratively and housing and health care providers work together to determine the best course of action that will address concerns without resorting to eviction. Strategic approaches to collaboration that physically brings health and housing partners together on a regular basis have worked well. In addition to having a housing case manager participate in care teams, some permanent supportive housing programs station housing case managers next to a co-located clinic so that staff have frequent and regular communication. Alternatively, many health and housing providers schedule weekly team meetings for case conferencing. Such collaborations ensure that health and housing providers work toward mutual goals to better support residents of supportive housing. Moreover, such collaborations can lead to improved programming, helping to shape new policies and eligibility criteria to improve quality and access to supportive housing.[11]

A major challenge to supportive housing initiatives is the shortage of affordable housing. Federal housing subsidy resources (such as Section 8 and public housing) are stagnant. Local housing authorities administer voucher programs and have developed ways to target this limited resource to high need populations such as veterans, families, seniors, and single adults who are deemed most vulnerable as demonstrated through an unified assessment. Also, state and local rental assistance programs are being created to advance local goals such as to end veteran homelessness, house the most vulnerable, target frequent users, and end family homelessness. Health centers have "something to offer" housing authorities (and other housing providers). Linkages to primary and behavioral health care can have a positive impact on housing stability. Health and housing case conferencing to meet the needs of mutual consumers is an efficient allocation of resources for both comprehensive services and housing rent subsidies.

<u>Identified Challenges for Housing Access:</u>

- Accessing affordable housing: Many communities have affordable housing deficits and long voucher waiting lists. Based on data contained in a recently released report, *Worst Case Housing Need, 2015 Report to Congress* from the U.S. Department of Housing and Urban Development, "Only 65 affordable units are available per 100 very low-income renters, and only 39 units are available per 100 extremely low-income renters."[12] Continued attention needs to be focused on forging the relationships that build on the respective expertise of the sectors, without creating unproductive or damaging competition.

Other Key Challenges

There are other obstacles to partnership between the housing and health systems as it relates to serving those who frequently and inappropriately use the health care system. These obstacles include restrictive housing eligibility policies that exclude many high need, high cost populations, limited options for data sharing, confusion related to coordinated entry, and limited capacity to serve the large number of people in need of supportive services.

Often, high need populations face barriers to qualifying for housing such as substance use, corrections involvement, and past evictions. Individuals who have a substance use disorder may have difficulty obtaining housing if sobriety is a criterion and may have past evictions resulting from possession or use of illicit substances. Past evictions and interactions with the justice system create barriers to obtaining housing as individuals may not be able to pass landlord screenings or criminal background checks.[8] Moreover, people who have spent time in a correctional facility often find it difficult to obtain employment and other sources of income, making housing stability more of a challenge.[13] Housing First[14] strategies have been successful at treating substance use disorders and other health concerns that could lead to unstable housing and homelessness.

Currently, data is not easily shared between housing, health care and other system providers. With multiple electronic systems and reporting requirements, in addition to separate billing systems for health and housing providers, there is a need to better coordinate data systems to identify consumers engaged in both housing and health services. In the development and implementation of a coordinated data system, there must be consciousness of HIPAA confidentiality requirements, which often are a barrier to sharing data between multiple systems.[2]

Another key challenge is the HUD-mandated coordinated housing access or entry systems developed among the local homeless providers.[15] The goal of coordinated access is to help all safety net providers understand local housing availability and streamline the process for accessing housing units. Communities are performing uniform assessments to make sure the most vulnerable are first to access supportive housing and other housing models. While this coordinated assessment helps create a more formal and prioritized system, it can be confusing for those outside the traditional homeless system to understand how to get their clients access to housing. Other systems such as re-entry programs for ex-offenders and those leaving institutional care (nursing homes, group living residences, and schools for those with developmental disabilities) may also need access to supportive housing but may not be tied into coordinated entry initiatives.

Finally, overall there is a provider capacity gap. Even in states that have expanded Medicaid eligibility, many individuals experiencing homelessness or housing instability now have access to insurance coverage and providers have seen a corresponding increase in the number of individuals enrolled in Medicaid. While this has resulted in many health centers reporting increased revenue, the increased coverage has led to some limited capacity and availability of providers, resulting in issues accessing services.[16] As high cost systems (such as hospitals, institutional care, and jails) seek to redirect their clients to community-based supports, these capacity issues could be further exacerbated.

Conclusion

Partnering with other entities can be challenging for health centers. As discussed above, the challenges involve greater need for systemic coordination, limited resources, complex billing structures to cover the comprehensive health care and supportive service delivery costs, and gaps in community capacity to meet the affordable housing needs of both the general population and especially the target population of "frequent users." Braiding of resources to cover the costs of comprehensive health care and supportive service costs creates high administrative burden on health centers and other providers to address the reporting requirements of each funding stream. And certainly, in states that have not expanded Medicaid, many "frequent users" remain uninsured, which further exacerbates the effort to identify resources to provide appropriate care.

While these challenges are complex, they are not insurmountable. CSH is actively working to address these challenges by providing technical assistance and training to health centers to help them improve services and housing coordination for "frequent users" through a three year cooperative agreement with the Health Resources and Services Administration. As part of this effort, CSH shares best practices and assists in the development of new solutions to these challenges. CSH sees the importance for extensive collaboration between HUD and HHS that can help meet the needs of vulnerable individuals and families. Current CSH initiatives have demonstrated effective ways to share data between health and housing providers to target resources, as well as yielding lessons learned regarding collecting health outcome information in housing settings. The core tenet of CSH's cooperative agreement to provide technical assistance for health centers is to advance innovative solutions that have been developed by states and communities tackling these issues.

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Contact Information

For more information on CSH's HRSA Training and Technical Assistance Program, please visit www.csh.org/hrsata, or email CSHHRSA@csh.org.

HRSA Disclaimer

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Addendum A

SUPPORTIVE HOUSING SERVICES - 2015

Housing-Based Services and Supports for Residents	
▪ **Assessment** o Services intake o Assessment-identifying client need o Gathering documents for eligibility determination o Arranging for further testing and evaluation o Conducting reassessments o Documenting assessment activities ▪ **Service Plan Development** o Service Plan Development with client o Writing service plan o Determining who should provide services o Obtaining signatures o Update and review service plan o Documenting service plan development ▪ **Referral, Monitoring, Follow-up** o Referrals to other ancillary services o Referral and related activities o Assist in connecting to services o Coordination of services identified in service plan o Monitoring and evaluation o Documenting referral, monitoring and follow-up o Personal advocacy ▪ **Medication management/monitoring** o Harm Reduction strategies o Substance abuse counseling o Peer counseling, mentoring o Education about mental illness o Psychotropic medication education o Recovery readiness o Relapse prevention ▪ **Routine medical supports, medication management, vision, dental, HIV/AIDS services** o Medication set-up o Medication coordination o HIV/AIDS/STD education o End of life planning ▪ **Entitlement assistance/benefits counseling** o Entitlement and benefits counseling o Application for income and food assistance o Application for health benefits, including Medical Assistance and specific programs funded through Medical Assistance o Referral to legal advocacy and assistance with appeals o Budgeting and financial education ▪ **Transportation** o Transportation - non-medical o Care manager accompaniment on appointments	▪ **New tenant orientation/move-in assistance** o Finding housing o Applying for housing o Landlord advocacy o Securing household supplies, furniture o Tenancy supports o Eviction prevention ▪ **Outreach and in-reach services** o Identifying and engaging with un-served, under-served individuals, and poorly-served individuals o Connecting individuals with mainstream services ▪ **Independent living skills training** o Nutrition education o Cooking/meal prep o Personal hygiene and self-care o Housekeeping o Apartment safety o Using public transportation ▪ **Job Skills training/education** o School connections o Access to Social Support o Truancy intervention o Access to academic support o Opportunities/access to GED, post-secondary training o Supported employment o Childcare (connect people to resources) ▪ **Domestic Violence intervention** o Domestic Abuse Services o Crisis planning, intervention o Child Protection assessment, follow-up o Referral to Legal Advocacy o Training in personal and household safety o Crisis intervention-clinic based or mobile crisis ▪ **Support groups Self-determination/Life satisfaction** o Grief counseling o Development of recovery plans o Group therapy o Recreation o Social Support o Community involvement/integration o Parenting supports and mentoring o Peer monitoring/support o Conflict resolution/mediation training ▪ **Respite Care** ▪ **Individual counseling** ▪ **Discharge planning** ▪ **Reengagement**

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