Housing is the Best Medicine

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Supportive Housing and the Social Determinants of Health

CSH

The Source for Housing Solutions

"The most appropriate question may not be how we can afford to pay for social determinants of health as a health intervention, but whether we can afford not to pay for social determinants of health as a health intervention."

- Dr. Kelly Doran, Bellevue Hospital, New York

Background

Every day doctors in America provide treatment to some of our sickest patients who live in shelters, institutional settings or unsafe housing. These patients often lack access to basic needs like transportation, nutritious food, heat, a steady income and social supports. Medicine and medical interventions alone will never resolve the complexity of issues that these patients face. Most will return to the clinic or hospital, again and again, with more serious and expensive problems. This reality is not lost on our strained health systems or physicians. However, until very recently, providers lacked the organizational framework, capacity and incentives to address the underlying causes of patients' poor health. With the recent implementation of the Affordable Care Act (ACA), the rise of Accountable Care Organizations and the general shift towards more integrated and holistic models of care, the health system is broadening their practices and investments outside the clinical setting to change the tide of health and health care costs in this country.

There is a growing recognition among health care professionals and policymakers that in order to achieve the "triple aim" of improving population health, improving health care delivery and reducing costs, the health system must take a broader approach to health care financing and delivery to include certain social services and supports. This new vision seeks to shift attention and dollars toward systematically addressing the social determinants of health that collectively have a greater impact on the health of a community than access to or quality of care[1]. Social determinants of health are the economic and social conditions that affect health outcomes and are the underlying, contributing factors of health inequities.[2] Examples include housing, educational attainment, employment and the environment.

> *The **social determinants of health** are the 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

Access to safe, quality, affordable housing - and the supports necessary to maintain that housing - constitute one of the most basic and powerful social determinants of health. In particular, for individuals and families trapped in a cycle of crisis and housing instability due to extreme poverty, trauma, violence, mental illness, addiction or other chronic health conditions, housing can entirely dictate their health and health trajectory. For these populations, housing is a necessary precursor of health. Supportive Housing, an evidence-based practice that combines permanent affordable housing with comprehensive and flexible support services, is increasingly recognized as a cost-effective health intervention for homeless and other extremely vulnerable populations.

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[1] Magnan S, Fisher E, Kindig D, Isham G, Wood D, Eustis M, Backstrom C and Leitz S, 2012. "Achieving Accountability for Health and Health Care." *Minnesota Medicine*. Available at: https://www.icsi.org/_asset/qj7tk6/Commentary---Magnan.pdf

[2] World Health Organization, Commission on Social Determinants of Health 2008. *Closing the gap in a generation: health equity through action on the social determinants of health.* Final report of the Commission on Social Determinants of Health. Available at: http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf

Supportive Housing – A Foundation for Health

Improving Health and Health Care Delivery

Supportive housing provides an essential platform for the delivery of services that lead to improved health and stability. First, at the most basic level, housing provides physical safety, protection and access to basic needs. A clean, dry, safe home reduces exposure to harsh weather, communicable diseases, infections, injury, harassment and violence; it provides a secure place to sleep and store food, clothing and medications; and it is essential to promoting personal hygiene and recuperation from illness.

Second, supportive housing improves access to quality health care both by providing a physical space for service delivery (e.g., in-home case management, nursing, ADL supports) as well as access to support staff that link tenants to community-based social, mental health, substance abuse and primary/specialty medical care services. In many communities, supportive housing serves as the locus of integrated health care efforts where providers have partnered with hospitals, clinics and community mental health centers to create multi-disciplinary care teams to deliver the full continuum of care for tenants with complex needs[3]. Several studies demonstrate that linking care management to supportive housing leads to improved health outcomes. A Denver study found that 50 percent of supportive housing residents experienced improved health status, 43 percent had better mental health outcomes and 15 percent reduced substance use[4]. In addition, a rigorous randomized control trial of a program in Chicago found that supportive housing residents with HIV/AIDS had much higher levels of survival with intact immunity compared to the usual care group (55% versus 34%) and significantly lower viral loads (34K versus 69K)[5].

What is Supportive Housing?

Supportive housing targets the most vulnerable people who need housing and service supports to remain stably housed and live healthy lives. In addition to individuals experiencing chronic homelessness, this includes people that are inappropriately placed in institutional care settings (nursing homes, state hospitals) due to a lack of affordable housing options and/or inadequate community-based care. Integrated models of supportive housing and health services, which have been proven effective in improving housing and health outcomes for this population, share a common set of guiding principles and Dimensions of Quality.

- **Quality permanent and affordable housing**: Supportive housing is affordable rental housing with no artificial time limits on residency. Rent is adequately subsidized such that extremely low-income tenants can pay no more than 30% of their gross monthly income for rent.
- **Housing First**: Supportive housing provides individuals access to immediate, permanent, quality affordable housing in their own apartments or homes without any preconditions or requirements for sobriety or treatment compliance to maintain housing. Supportive housing tenants hold their own leases and have the same rights and responsibilities as any other tenant. Programs assertively engage tenants and offer services to maximize housing stability, including regularly communicating with property managers, advocating on behalf of tenants and mediating conflicts with landlords.
- **Comprehensive, Person-Centered Services**: Individuals in supportive housing have access to a comprehensive array of flexible services including housing stability supports, income and benefits support, coordinated health and behavioral health services, 24-hour crisis intervention, employment services, diet/nutrition counselors, and recovery/wellness peer support specialists. Services are provided as needed to ensure successful tenancy and to support the person's recovery and engagement in community life. Participation in support services is voluntary.
- **Community Integration**: Supportive housing focuses on maximizing tenant choice, self-sufficiency and community integration. Programs facilitate full integration into the community by providing direct assistance to tenants around employment, volunteer work, social activities and tenant-led community building activities.

Third, supportive housing provides a foundation for engaging tenants in managing their own care and promoting lifestyle changes that lead to good health.

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[3] Examples of enhanced models of supportive housing linked to coordinated health/behavioral health services from CSH's Social Innovation Fund grantees available at: http://www.csh.org/sifoverview

[4] Perlman, J. Parvensky, J. 2006. *Denver Housing First Collaborative Cost Benefit Analysis and Program Outcomes Report.* Available at: http://shnny.org/uploads/Supportive_Housing_in_Denver.pdf

[5] Sadowski, L., Kee, R, VanderWeele T, Buchanan, D 2009. "Effect of a Houising Case Management Program on Emergency Department Visits and Hospitalizations among Chronically Ill Homeless Adults." *Journal of the American Medical Association.* Vol 301(17):1771-1778

People with long histories of housing instability and multiple chronic physical and behavioral health conditions need more than medical care; they need support in mastering and sustaining habits and behaviors that lead to effective disease management and health-promoting lifestyles. Programs and services in supportive housing are designed to be person-centered, reduce or mitigate the impact of risky/unhealthy behaviors (alcohol/drug use, unprotected sex, smoking, etc.), help tenants establish healthy personal relationships and leisure activities, secure and maintain employment, and foster self-care behaviors that lead to wellness and recovery (e.g., eating regular meals, keeping appointments, attending AA/NA meetings and adhering to medication or treatment plans).

The Promise of Supportive Housing for Good Health

Maximizing Health Care Dollars

Over the years, community after community has illustrated that supportive housing not only improves outcomes but reduces health care costs when targeted at high-cost utilizers. The most recent evaluation report of Massachusetts' *Home and Healthy for Good Program*, which housed 766 chronically homeless individuals in supportive housing, showed that in the six months prior to housing, participants accumulated 1,812 emergency department visits, 3,163 overnight hospital stays, 847 ambulance rides and 2,494 detox stays. The estimated total cost per person for measured services – including Medicaid ($26,124), shelter ($5,723) and incarceration ($1,343) - amounted to $33,190 per year[6]. After one year in the program, the total per person costs for these same services fell to $8,603. With the cost of housing and services through the HHG program amounting to $15,468 per tenant, the total estimated return on investment to the state was $9,118 per person.

Similarly, the costs of keeping individuals inappropriately institutionalized in hospitals, nursing homes or other segregated settings are exorbitant and proving to be a significant driver of state budgets. There is a significant subset of individuals residing in nursing homes not because they have medical needs requiring this level care but because they lack a home to go to and are too ill or frail to recover on the streets or in a shelter. Still others may have a home but remain in nursing homes due to a lack of community-based services and supports that would enable them to live independently. A Kaiser Family Foundation report showed that nursing facility care costs an average of $62,750 per person per year whereas community-based care cost an average of $31,341 per year[7]. Findings from an evaluation of the New York/New York III Agreement - the largest supportive housing initiative for vulnerable, high-cost individuals in the country- demonstrate the great potential of supportive housing for this population. Among participants that were placed in supportive housing after being discharged from state-operated psychiatric facilities, net savings – including the costs of housing services and operating costs - amounted to approximately $77,425 per person per year, accruing mostly to the state[8].

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[6] Massachusetts Housing and Shelter Alliance, 2014. *Home and Healthy for Good June 2014 Progress Report.* Available at: http://www.mhsa.net/matriarch/documents/June%202014%20HHG%20Report.pdf

[7] Kaiser Commission on Medicaid and the Uninsured, October 2011. *Medicaid's Long-Term Care Users: Spending Patterns Across Institutional and Community-based Settings.* Available at: http://www.kff.org/medicaid/7576.cfm

[8] Levanon-Seligson A, Lim S, Singh T, Laganis E, Stazesky E, Donahue S, Lanzara C, Harris TG, Marsik T, Greene CM, Lipton FR, Myers R, Kaparti AM, *New York/New York III Supportive Housing Evaluation: Interim Utilization and Cost Analysis.* A report from the New York City Department of Health and Mental Hygiene in collaboration with the New York City Human Resources Administration and the New York State Office of Mental Health. Available at: http://shnny.org/images/uploads/NY-NY-III-Interim-Report.pdf

These analyses confirm similar findings from more than 30 studies nationwide that show how supportive housing, by addressing critical social determinants of health for the most vulnerable populations, can significantly reduce costs while simultaneously improving health and other quality of life outcomes.

Building Healthy Communities

Building healthy communities requires that we create a continuum of high quality, affordable housing options that support the social, economic and physical needs of all residents. Affordable housing is a powerful public health intervention that has been shown to positively impact the health of entire communities and improve overall health equity. Supportive housing is a critical part of this housing continuum and plays a particularly important role in addressing health disparities as it represents a critical point of services for many people with no or extremely low-incomes and living with chronic health conditions[9]. Those entering supportive housing tend to have high morbidity and mortality rates and carry a significant disease burden based on multiple and significant risk categories (homeless, serious mental illness, addiction, etc.) that exacerbate known health disparities. For example, homelessness and serious mental illness are associated with increased risk for obesity, cardiovascular disease, diabetes, HIV/AIDS, hypertension and other chronic medical conditions due to factors such as sedentary lifestyles, risky behaviors, poor diet, lack of exercise, and metabolic alterations attributable to psychiatric medications. Thus, due largely to *preventable* medical conditions, these sub-populations tend to die at a much younger age (20 – 25 years earlier) compared to the general population[10]. By improving health and wellness among some of the poorest and sickest individuals among us, supportive housing may contribute to reductions in the health gap within and across communities.

> *"There's a lot of information in an address…it tells me about your income, your education, the health amenities you have access to and employment opportunities you can access. I can pretty much predict your life expectancy by where you live."*
>
> *Anthony Iton, MD, JD, MPH*

Affordable housing also plays a key role in neighborhood-based strategies to transform the built environment in ways that promote greater integration, public safety, physical activity, and increased access to critical social services and resources. Supportive housing providers are disproportionately located in underserved communities and often rehabilitate abandoned or unsightly buildings or develop units on blighted blocks, which contribute to neighborhood renewal and increased property values for surrounding areas[11]. Community integration is also one of the core Dimensions of Quality in supportive housing. The design, construction, appearance, physical integrity, and maintenance of the housing units should provide an environment that is attractive, safe, sustainable, functional, and conducive to promoting tenants' health, stability and community integration. Furthermore, supportive housing developments often attract or directly bring critical services to resource-barren neighborhoods. Many supportive housing developments are increasingly featuring on-site or direct linkages to gym facilities, after-school programs, recreational spaces, food pantries, recovery support groups and full-service health clinics that benefit the larger community. Another growing trend is the development of projects that provide high quality affordable housing to a mix of tenants that promote greater socio-economic integration. By impacting local services, resources and the built environment in ways that contribute to improved health, healthier lifestyles and greater health equity, supportive housing can be a catalyst for building healthy communities.

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[9] Henwood, BF, Cabassa LJ, Craig CM, Padgett DK. 2013 "Permanent Supportive Housing: Addressing Homelessness and Health Disparities?" *American Journal of Public Health* 2013 Dec; Vol. 103 Supplement 2:S188-92

[10] National Association of State Mental Health Directors, Medical Directors Council, 2006. *Morbidity and Mortality in People with Serious Mental Illness*, Technical Report. Available at: http://www.nasmhpd.org/docs/publications/MDCdocs/Mortality%20and%20Morbidity%20Final%20Report%208.18.08.pdf

[11] Econsult Corporation, 2007. Project H.O.M.E.'s Economic and Fiscal Impact on Philadelphia's Neighborhoods. A report submitted to Project H.O.M.E. Available at: http://shnny.org/uploads/Project_HOME.pdf

Advancing Housing as Health Care

Efforts to bring supportive housing to scale as a health care solution for some of the most vulnerable and costly patients raise new opportunities and challenges for both the supportive housing industry and health systems. National health reform initiatives, including the ACA, are creating unprecedented opportunities for integration between health and housing systems. New health care delivery approaches such as Medicaid Health Homes and Accountable Care Organizations that emphasize care coordination, high-touch services, a focus on whole-person health outcomes and moving from fee-for-service to bundled payment rates are a perfect fit with supportive housing. Health care financing systems – including Medicaid, Medicare and private payers – are exploring innovative payment models that incentivize greater collaboration between health, housing and social service sectors and elevate the health system's ability to address the social determinants of health.

These system and culture changes are generating tremendous energy and innovation on the frontlines of health service delivery. Providers and care management organizations are beginning to recognize housing and other social factors as critical components of patient health and taking responsibility for addressing them either directly or through better collaboration with community-based agencies. CSH is involved in a number of innovative health/housing partnerships that are expanding across the country. In our Social Innovation Fund Initiative, supportive housing providers, health and behavioral health systems are coming together by forming cross-agency care teams to serve the most challenging, high-cost, multi-system users. These models often feature patient-centered medical homes, multi-agency case consultation forums, formalized data sharing agreements, protocols for regular communication and information sharing, co-location of staff/services and coordinated funding strategies. In addition, there are a number of supportive housing providers working in formal partnership with, or directly operating, Federally Qualified Health Centers (FQHC) or mobile health service teams to serve individuals with complex health issues. These efforts are giving rise to a new workforce of community health workers, care coordinators and patient navigators serving at the intersection of health, housing and social services.

Despite remarkable progress and a compelling business case, these integrated health and housing models have not yet been systematically adopted as a health care solution for high-need, high-cost patients and still remain on the periphery of health care delivery and financing systems. Bringing these models to scale will require important changes in both practice and policy across housing and health sectors.

Key Strategies for the Road Ahead

Improve Medicaid Reimbursement for Housing Support Services

One determining factor for advancing supportive housing as a mainstream health care intervention is whether and how states and private plans use their health dollars to pay for housing-based support services. In many states, especially for individuals without serious mental illness or a developmental disability, housing-based services are not Medicaid benefits and are therefore not reimbursable. In states that do cover housing-based services, usually through waivers or demonstration programs, critical services like outreach and in-reach (into jails, shelters, hospitals) services, pre-tenancy supports (housing navigation, lease-up, move-in, etc.) and housing stability supports (eviction prevention, voucher re-certification support, landlord-tenant mediation, etc.) are excluded. For this target population, outreach and housing supports are just as critical as medication management or other medical services for supporting good health outcomes. CSH is working with state Medicaid agencies across the country to create a comprehensive supportive housing services package and reimbursement model that aligns with the entire continuum of care this population requires.

Increase Housing Availability

In addition to services, in order to meet the growing demand for supportive housing, more investment is also needed to pay for housing – including rental subsidies and the capital costs of development. While the concept of health plans paying for housing may sound far-fetched, the fact is that they already do in the form of nursing facilities and other expensive and restrictive settings. Studies show that, when targeted at chronically homeless individuals or those in institutional settings with consistently high (at least 2+ years) and modifiable costs across public systems (jails, hospitals, shelters, etc.), the cost

of providing services and housing could yield a net positive return for states[12][13][14]. Placing their bet on these findings, the state of New York, as part of their larger Medicaid Redesign efforts, is re-investing state Medicaid savings into supportive housing. Over the past three years, approximately $252 million has been invested into supportive housing for high-cost/high-need patients. These investments cover capital, operating and services funding. More states should be encouraged to pursue these types of experiments through Medicaid waivers or demonstration programs to build the evidence base for these models and guide the development of best practices in this work going forward.

While the clinical and fiscal benefits of housing to Medicaid are now well established, there needs to be clearly defined limits and parameters for investing health dollars toward housing. Federal, state and local housing entities need to leverage their resources to pick up the long-term costs of housing for this population. Recognizing the critical role of housing for improving health outcomes and reducing public costs, the federal Department of Housing and Urban Development (HUD), as well as state and local governments, should increase and target investments toward expanding the supply of housing for high-cost utilizers and create policies that incentivize Continuum of Care entities to do the same. Some resources that HUD can bring to the table for these purposes include the Housing Opportunities for People With Aids (HOPWA) vouchers, 811 vouchers for non-elderly disabled, McKinney vouchers, Special Purpose Vouchers and mainstream Housing Choice vouchers. In addition, through technical assistance and policy changes, HUD can encourage Public Housing Authorities (PHA) to use a portion of their capital financing to create supportive housing projects or require set-asides of PSH units targeted at chronically homeless high utilizers. PHAs can also amend annual administrative plans to increase access to or target vouchers for special needs populations. At the state level, changes to state Qualified Allocation Plans can also be made that either require or encourage the designation of tax credit awards to create supportive housing units for vulnerable populations. States and local housing and service agencies can also create their own housing subsidy programs to build housing or dedicate vouchers for high utilizers, as they are doing in New York, Connecticut and Michigan.

Integrate Systems and Break Down Silos

Aside from significant shifts in policy, there is a need to improve and streamline practices across housing and health systems in order to achieve effective integration. Cross-system integration remains a significant challenge due to silo-ed funding streams, bureaucratic barriers to data/information sharing, conflicting or incongruent accountability and outcome measures, and lack of coordination between organizations within the health and housing sectors. In order to overcome these challenges, we can start by broadening performance measures and realigning incentive systems in ways that facilitate stronger collaboration and a sense of mutual accountability between health and housing systems. On the health side, this means continuing the move away from provider-based fee-for-service reimbursement structures and toward bundled rates, global capitation and pay-for-performance models that emphasize quality over volume of care and reward comprehensive care approaches that lead to improved patient satisfaction and health outcomes. Such changes should encourage health providers to incorporate and treat housing and other social factors as "vital signs", or indicators of patient health in screening and discharge protocols, as well as outcomes to measure program/provider performance.

On the supportive housing side this means taking a broader and more intentional approach toward improving health and building healthy communities. Housing systems need to do a better job of coordinating resources and funding streams to create a continuum of housing and services – including supportive housing, rapid rehousing, emergency shelter, medical respite and affordable housing - that meet both the demand and the broad spectrum of need among high utilizers of health services. Supportive housing is an intensive model of care that should be prioritized for the most costly and medically vulnerable individuals. The recent federal HEARTH Act mandates that all communities receiving HUD funding for homeless populations develop system-wide prioritization and targeting standards for allocating housing resources. These efforts should help move housing systems in the right direction.

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[12] Aidala, A, McAllister W, Yomogida M, Shubert V. *Frequent Utilizers Service Enhancement "FUSE" Iniatiative. New York City FUSE II Evaluation Report.* Available at: http://www.csh.org/wp-content/uploads/2014/01/FUSE-Eval-Report-Final_Linked.pdf

[13] Levanon-Seligson et. al. 2014

[14] Larimer ME1, Malone DK, Garner MD, Atkins DC, Burlingham B, Lonczak HS, Tanzer K, Ginzler J, Clifasefi SL, Hobson WG, Marlatt GA, 2009. "Health care and public service use and costs before and after provision of housing for chronically homeless persons with severe alcohol problems" *Journal of the American Medical Association* Vol. 301(13):1349-57.

Create Health-Oriented Performance Measures for Supportive Housing

Finally, to advance supportive housing as a health care solution, housing providers will need to adopt health-focused performance measures that incentivize better coordination with health systems. We need to identify, design and test enhanced models of supportive housing that integrate targeted clinical or health promotion interventions that increase patient engagement and improve self-care behaviors and disease management (Wellness Self-Management, Stanford Chronic Disease Self-Management Model, peer support models, etc.). While several studies document the impact of supportive housing on housing stability, substance abuse, mental health symptoms, and reduced use of crisis health services, research on the impact of supportive housing on physical health outcomes (obesity, cardiovascular health, disease management) and health-promoting behaviors (exercise, diet, smoking cessation, medication/treatment adherence, socialization, sobriety) is less clear and relatively sparse. Work toward this goal could be supported through stronger partnerships with researchers in medicine, psychology and public health to create a collaborative research agenda that incorporates health and community health measures into evaluations of supportive housing programs.

Conclusion

The high public costs and poor health outcomes associated with homelessness and inappropriate institutionalization is an issue that health care systems can no longer afford to ignore. Two decades of research on supportive housing and practical experience have taught us that a comprehensive view of health necessarily includes housing and other social factors. At the national level, the Affordable Care Act is an important step forward in aligning our health care financing and delivery systems with this vision. This landmark legislation provides a unique window of opportunity to bring supportive housing to scale as a health care solution for the most complex and costly patients. With this framework in place, the next step is to work with our state partners and local health and housing systems to build the capacity, resources and political will to achieve the full promise of these reforms.