DOWNTOWN WOMEN'S CENTER
Homelessness ends here.

HEALTH HOME CONNECT

Improving the Health of Aging Homeless Individuals through the Coordinated Entry System and the Affordable Care Act

Amy Turk, LCSW, Chief Program Officer

INTRODUCTION

Homeless adults often have compounding healthcare needs that are largely unmet by existing social and healthcare systems – a problem made progressively worse by the increasing numbers of aging homeless individuals.[i] With a life expectancy in the low 60s, older adults who have spent multiple years homeless disproportionately use emergency healthcare services because of complex health problems and a lack of housing.[ii] Extensive bodies of research demonstrate the considerable cost-effectiveness of Permanent Supportive Housing (PSH) as a solution to homelessness among older adults.[iii] This solution is essential, not only because the problem is a national tragedy, but also because it makes economic sense – the publicly funded health costs of street homelessness far exceed the cost of PSH by as much as 70 percent per person annually.[iv]

Singularly, the healthcare, housing, and homeless services systems are challenged to meet the needs of homeless older adults, but the passage of the Affordable Care Act (ACA) and additional changes required by the US Department of Housing and Urban Department (HUD) provide opportunities for improvement, including reductions in fragmentation of healthcare provision and streamlined access to housing.

BACKGROUND

Nationwide, on any given night, 578,424 individuals are without a home and, among those, approximately 12% are older adults.[v] The toll that homelessness takes on an individual's health is profoundly displayed in early mortality rates. **People without homes have a life expectancy 30 years shorter than that of the general housed population.**[vi] A lack of adequate health and housing support increases the likelihood that homeless individuals in their 50s and 60s will live with health conditions typically not seen in housed populations until their 70s and 80s. These complex health problems are devastating to the individuals and costly to our public systems. However, the Economic Roundtable noted that when homeless individuals who most frequently use Medicaid services are provided with PSH, costs to public and hospital services decrease by an average of 75% – from $68,808 when homeless to $16,913 after placement in subsidized housing.[vii]

> "THE HOMELESS POPULATION is aging. We see it in the community, in the practices that serve this population, and in the data. Trying to provide healthcare without housing is an oxymoron. How do you really provide adequate healthcare for those who lack one of the most fundamental elements of health – adequate housing? As more individuals living at low incomes now have access to Medicaid through the ACA, we need to ensure that we have a simple, streamlined approach to identifying those with housing needs and that we are addressing the critical fact that inadequate housing units exist. This is a community issue and needs a collective approach to ensure that homeless individuals receive both healthcare and housing."
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> – DR. DAVID LABBY
> *Chief Medical Officer, Health Share of Oregon*

In June 2010, the Obama Administration released *Opening Doors: The Federal Strategic Plan to Prevent and End Homelessness*, in which HUD and its federal partners set goals to end Veteran and chronic homelessness by 2015. To this end, HUD has mandated that each Continuum of Care[viii] that receives HUD funding create a Coordinated Entry System (CES), through which individuals are prioritized for housing based on factors such as their

healthcare needs and length of time experiencing homelessness. While CESs are making substantial strides toward streamlining housing placements, they are also an untapped opportunity to include linkages to healthcare.

The timing of the HUD-mandated CES dovetails well with the significant opportunity to improve access to health insurance for low-income and homeless populations since the ACA Medicaid expansion allows low-income adults (with incomes up to 138% of the federal poverty level) in 28 states to now qualify for health coverage.[ix] This significant shift in access to insurance creates the opportunity for individuals to shift from costly emergency healthcare to preventative and primary healthcare services.

TERESA MCDONALD BECAME HOMELESS TWO YEARS AGO. After 36 years of employment, she was laid off from her work as a youth program worker through the Los Angeles Unified School District. At the age of 56, without employer provided health insurance and a home, Teresa's use of Emergency Rooms increased. Teresa recalls using Emergency Rooms to help her treat chronic pain due to a work injury, gout, and heart problems on ten occasions.

When Teresa started using the services at the **Downtown Women's Center**, she was quickly enrolled into Medicaid and moved into housing through the Coordinated Entry System. With the help of a Benefits Specialist, Teresa's new linkage to Medicaid and Permanent Supportive Housing decreased her need for emergency healthcare by 70% in the last year.

Linking the CES as an access point to Medicaid is an important connection to make as HUD, the U.S. Department of Health and Human Services, and the Centers for Medicare and Medicaid Services (CMS) implement these system changes. Given the significant challenge in providing outreach and information about Medicaid enrollment to homeless individuals, who typically lack consistent contact information, the CES can act as a mechanism to identify qualifying applicants and streamline enrollment for this otherwise challenging to reach population.

BRINGING TOGETHER ACA & HUD COORDINATED ENTRY SYSTEMS: A CASE STUDY AT DWC

In 2013, the Downtown Women's Center (DWC), a pioneering PSH provider for women in Los Angeles, noted that the CES, through which it was linking individuals to housing, could also be the same entry system for access to healthcare. In response, DWC spearheaded the Health Home Connect Project (HHC) to address the specific healthcare needs of chronically homeless women over the age of 55, identified by the CES as particularly vulnerable. Through HHC, once an individual is placed on the CES for housing, she is also prioritized for healthcare enrollment and linkage to a Medical Home by the DWC Benefits Specialist. Interventions then include enrollment in Medicaid; linkage to a Medical Home (i.e., Primary Care Physician); education regarding new benefits; extensive patient navigation, including transportation; advocacy for specialty care; and follow-up services to document emergency healthcare usage. Results have demonstrated a 41% decrease in unnecessary emergency healthcare usage among 40 women enrolled in the project's first year. Conservatively, the HHC saved local County hospitals $120,000 in avoided inpatient Medicaid costs.[x]

ADDITIONAL OPPORTUNITIES

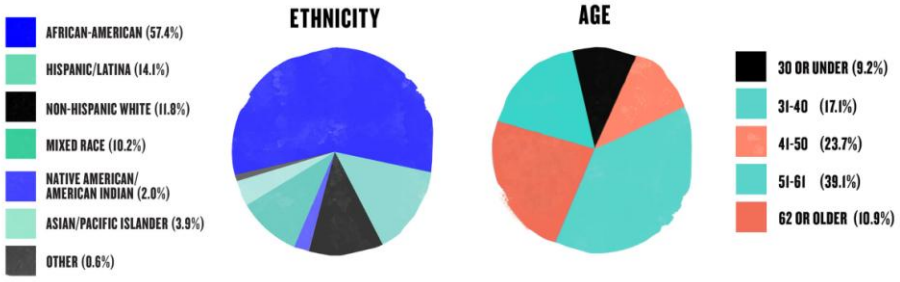
Homeless services and managed care providers now have the opportunity to create multidisciplinary team-based models of service delivery for reducing fragmentation of care, improving health outcomes, and decreasing unnecessary use of emergency healthcare services.[xi] As more homeless individuals are enrolled into managed care, it is increasingly important to address not only immediate health concerns, but also to provide adequate services to address social determinates of health, such as income, housing, nutrition, and social connectedness.

"IN MY DAILY PRACTICE as an Emergency Medicine Physician, I see the devastating impacts of homelessness on the health of our older adults. Without housing, my patients will never heal. If I could prescribe housing, that would be my first 'medicine' of choice. I would then not only be able to save lives, I would save my hospital a significant amount of money."

– DR. KEVIN BIESE
Emergency Medicine Physician, University of North Carolina at Chapel Hill

Examples of new partnerships can be demonstrated in states with approved CMS Health Home State Plan Amendments.[xii'xiii] Made possible through Section 2703 of the ACA, the *Health Home Option for Enrollees with Chronic Conditions* allows states to apply for enhanced federal funding for services provided to beneficiaries who are chronically homeless and frequently use hospital services. This new funding source is a promising avenue by which to improve health outcomes while also reducing Medicaid costs.[xiv] While Health Homes have the promise of creating a new benefit to fund services in housing, California and other states are also proposing paying for operating and services costs through a Medicaid Section 1115 Waiver. Both Health Homes and 1115 Waivers, which include Medicaid-funded housing supports, are significant policy shifts, changing the way special needs housing projects are operated and financed. As demonstrated in DWC's HHC pilot, the CES can serve as an entry and engagement tool for outreach to beneficiaries who will qualify for Health Homes and new support services through 1115 Waivers.

IN THE YEARS SINCE the launch of the **Downtown Women's Needs Assessment**, conducted every three years since 2001, there has been a demographic shift toward older women on Skid Row in Los Angeles, as reflected in the increase in mean and median ages, as well as in the growing percentages of women who are 51 and older. When compared to census data for LA County, these numbers show that women on Skid Row are disproportionately more likely to be women of color, and half are over the age of 51.



RECOMMENDATIONS

Nationwide, HUD Continuum of Care administrators should encourage homeless services providers to extend the use of the CES not only for access to housing, but also for access to Medicaid enrollment. Additionally, as states look to apply for Health Home State Plan Amendments and 1115 Medicaid Waivers, managed care providers should look to community-based organizations – with expertise in providing services to homeless populations – as uniquely qualified partners to provide outreach and

engagement, case management, and patient navigation services to Medicaid beneficiaries. It is further recommended that managed care providers and PSH providers partner to leverage expertise and decrease gaps in services frequently experienced by homeless individuals as they navigate access to needed housing and healthcare and address other social determinants of health. **The Health Home Connect Project piloted at DWC has shown that the coordination of tools available through the HUD Coordinated Entry System and ACA can streamline access to healthcare as well as housing for homeless individuals, reducing fragmentation in service provision, costs to our public systems, and the unnecessary suffering of the most vulnerable in our society.**

PROJECT DIRECTOR/AUTHOR BIO

Amy Turk, LCSW, is Chief Program Officer at the Downtown Women Center. In this role, Amy oversees DWC's Permanent Supportive Housing, Day Center, Medical and Mental Health Clinic, and Education and Job-Readiness programming for 4000 homeless and extremely low-income women annually. Amy has worked in the non-profit sector since 1998 specializing in providing services for survivors of domestic violence; adults living with mental illness, experiencing homelessness, and recovering from substance abuse; and families of children with special needs. Amy received a Master's in Social Work from California State University, Los Angeles in 2009 and a Bachelor's degree in Sociology from Pepperdine University. Amy launched the Health Home Connect Project at DWC after noting opportunities, made possible through the ACA, for innovative work between community-based organizations and traditional healthcare systems to improve coordination of care for older adults experiencing homelessness.

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[ii] Culhane, D., Metraux., D., Byrne, T., et. al. (2013). The Age Structure of Contemporary Homelessness: Evidence and Implicatio ns for Public Policy. *The Society for the Psychological Study of Social Issues*, Vol. 13, No. 1, pp.228-244

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[v] National Alliance to End Homelessness (2013). Retrieved 12/28/14 from http://www.endhomelessness.org/pages/about_homelessness

[vi] O'Connell, J.J. (2005). *Premature Mortality in Homeless Populations: A Review of the Literature.* National Healthcare for the Homeless Council. Retrieved 1/10/15 from http://www.nhchc.org/2013/01/council-responds-to-jama-homeless-mortality-report/

[vii] Flaming, D., Burns, P. (2013). *Getting Home: Outcomes from Housing High Cost Homeless Hospital Patients.* Economic Roundtable. Retrieved 1/10/15 from http://www.economicrt.org/summaries/Getting_Home.html

[viii] According to HUD, a Continuum of Care is "a community plan to organize and deliver housing and services to meet the specific needs of people who are homeless as they move to stable housing and maximize self-sufficiency. It includes action steps to end homelessness and prevent a return to homelessness." In most cities, a government entity takes the lead for the Continuum of Care acting as a Jurisdictional Body and overseeing the Service Delivery System of HUD programs.

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[xii] As of December 2014, 16 states have 30 approved state plan amendments to implement Medicaid Health Homes. Retrieved 1/10/2015 from http://www.chcs.org/resource/medicaid-health-homes-implementation-update/

[xiii] Additional information about states with approved state plan amendments. Retrieved 1/10/2015 from http://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/hh-spa-at-a-glance-3-19-14.pdf

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