THE BRONX HEALTH & HOUSING CONSORTIUM

CSH
The Source for Housing Solutions

Health Home/Homelessness White Paper
The Need for More Housing for People with Complex Needs
The Bronx Health and Housing Consortium and The Corporation for Supportive Housing

March 2014

1. Who We are and Our Collaboration

The Bronx Health and Housing Consortium organized in 2011 as a collaborative network of health, housing, social service, government agencies and the four Bronx Health Homes with the shared goal of streamlining participant access to quality health care and housing in the Bronx. The underlying premise is that shared housing and health care provider understanding is necessary to support high cost/high need populations who require intensive, coordinated services to achieve improved health outcomes. With the recent establishment of Health Homes to focus on high cost Medicaid populations, it became apparent that the homeless and unstably housed Health Home populations are significant drivers of high Medicaid costs. This is due to the lack of integrated, coordinated services including stable housing, for this targeted population. Consequently, the Consortium has been involved in several needs assessment projects to better understand the unstably housed/homeless population that it collectively serves and advocate appropriately for them.

The Corporation for Supportive Housing (CSH) is a national nonprofit organization and community development financial institution that helps communities create permanent housing with services to prevent and end homelessness. Founded in 1991, CSH advances its mission by providing advocacy, expertise, leadership, and financial resources to make it easier to create and operate supportive housing for people, including single adults, families with children, and young adults, who have extremely low incomes, disabling conditions, and/or face other significant challenges that place them at ongoing risk of homelessness. CSH is a member of the MRT Affordable Housing Workgroup.

We agreed to bring our respective skills and experience together and this needs assessment paper reflects our collaboration. Both organizations are interested in understanding the needs of Health Home participants to better serve them.

2. Our Needs Assessment Methodology: What we did

Together, we gathered and analyzed information from Bronx Health Homes. First, we asked the four Health Homes operating in the Bronx to report on the percentage of participants who answered Yes to a question “are you homeless” on the NYS Department of Health Functional Assessment form (FACT-HH6). The instructions that accompany the FACT define “having a home” as having one’s own residence that one has access to at any time. Thus, being in a shelter or “couch surfing” would be considered homeless.

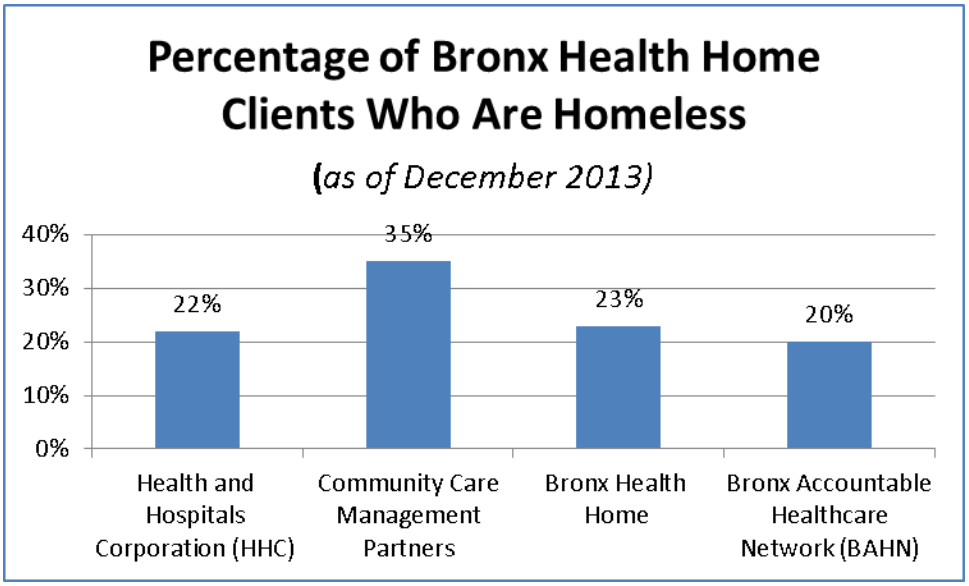
We also asked the Bronx Health Homes to provide data from a sample of their participants who are ‘homeless’ using the NYS definition above. Our sample was obtained from three Bronx Health Homes, including (Bronx Health Home (BHH) and Bronx Accountable Healthcare Network (BAHN) and included information from participants who agreed to share their

anonymized data. The **sample of 428 individuals** includes self-reported data about demographics, entitlements, diagnoses, utilization and housing situation. The data source documents are the Assessments used by the Health Homes and their partners. While the Assessment tools used by the three Bronx Health Homes are similar, they are not identical. As a result, we used data from questions that were worded almost identically on at least two of the three Assessments, making the actual sample size for each variable reported on slightly different.

We also asked the Health Homes to provide sample Case Studies that illustrate how Care Coordinators address housing issues. A total of 13 cases were submitted by two Health Homes (Bronx Health Home and Bronx Accountable Healthcare Network).

3. What We Found from the Data

3.1 At the annual Bronx Health & Housing Consortium meeting in December 2013, the four Bronx Health Homes reported the percentage of enrollees who answered "Yes" to the NYS Assessment form question "Are you Homeless?"



The Health and Hospitals Corporation (HHC) reported 22% of Health Home enrollees across the City were homeless. The Community Care Management Partners reported 35% of their city-wide Health Home enrollees (2,549 of 7,284) were homeless. **Looking specifically at Bronx Health Homes, we see similarly high numbers of homeless Health Homes members, which is particularly concerning given that very few MRT-funded supportive housing beds have been allocated to the Bronx.** The Bronx Health Home reported 23% (590 of 2,565) were homeless, and the Bronx Accountable Healthcare Network reported 20% (523 of 2,651). We do not have specific data for HHC, but the city-wide Community Care Management Partners found 2,549 of their 7,284 enrollees were homeless. **Therefore, if we use Bronx only data to estimate the percentage of homeless Health Home members, 21% (1,113/5216) of Bronx Health Home enrollees are self-reported homeless.** These are significant numbers.
At the same Consortium meeting, the NYS Department of Health reported 7,743 people enrolled in Bronx Health Homes. Thus 21% of 7,743 translates to **1,626 Bronx Health Home participants living in homeless/unstably housed conditions**. Even if the actual need for units is half this figure, there is a need for over 800 units in the Bronx for

Health Home participants. **Last year, there were about 50 MRT funded beds (22 OMH and about 30 OASAS) allocated to the Bronx, all scatter site and for single adults.**

3.2 **From our Health Home sample data-Demographics. This sample is from self-reported assessment data.**

3.2.1 Median age=48

3.2.2 Gender - 42% Female, 58% Male

3.2.3 Age - 14% over 60; 6% over 65

3.2.4 Family composition—28% are not single. (n= 351)

In this sample, 15% have children under 18 years of age living with them and 9% are two-adult households. The other 4% have children over 18 years of age living with them (and no children under 18). So, of the 1,626 units needed above, 28% of them should not be single or 'shared with other singles' units.

3.2.5 Current living arrangements (n=374)

30% live with friends or family—This is a very unstable situation for many Health Home participants as they are often 'evicted' from these arrangements.

28% live in rental apartments on their own. They reported they were at-risk of losing their housing or unstable situations.

22% live in shelters

7% live in ¾ housing

6% live in SROs

3% live in public housing

2% live in residential facilities

2% are 'homeless'

3.2.6 Military- 1% reported they had served in the military. This means few can benefit from VA housing.

3.2.7 Incarceration (n=106)

9% have history of incarceration. Housing options are limited for formerly incarcerated individuals.

3.2.8 SSI/SSD (n=171)

At least **40% have SSI or SSD or both.** Thus there is high need for housing for people with disabilities.

3.2.9 Public Assistance-about 40% receive this public benefit

3.2.10 Substance Abuse (drugs and alcohol)- Over a third report current or past substance abuse. Some supportive housing is dedicated to people who are current and/or past substance abusers. Some of these units are only available to people who are currently under treatment by that organization. Thus, people receiving service from a trusted provider will be placed in a position of choosing potential housing and a *new* service provider or continuing with their current services.

3.2.11 Multiple medical and mental health diagnoses - 55% have at least 2 mental health and 2 physical health self-reported diagnoses. We understand that these data usually under-represent mental health diagnoses as it is based on self-reporting. This population, with such complex conditions, often requires specialized housing and health care support.

4. What We Learned from Case Studies

As a part of this study, we gathered 13 case examples. Care Coordinators were asked to select cases that illustrate the difficulties Health Homes face in

supporting participants with housing needs. The qualitative data obtained provided a better picture of the care coordination challenges faced by homeless and unstably housed Health Home participants and their Care Coordinators. This qualitative data helped to contextualize what we surmised from the quantitative data.

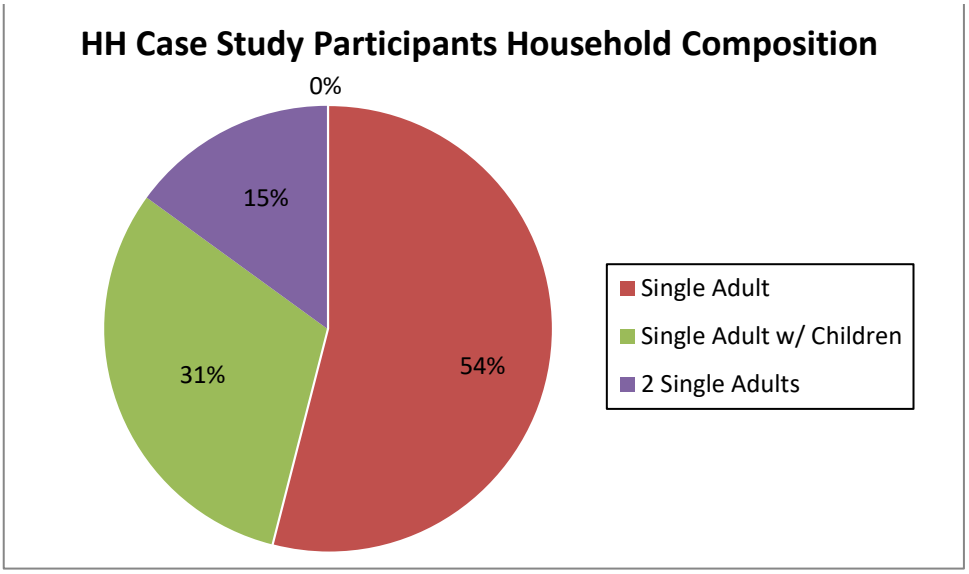
4.1 About the Health Home Case Study Participants:

1.1.1.1. Median age = 44

1.1.1.2. Gender - 54% male, 46% female

1.1.1.3. Disabilities - 67% have a physical disability, 58% have a serious mental illness (SMI)

1.1.1.4. Over a third (36%) who responded to the question were formerly incarcerated



1.1.1.5. Household composition - more than half (54%) are single adults, 31% are single adults with children and 15% are 2 single adults.

1.1.1.6. A majority (62%) receive SSI, followed by food stamps (54%),

4.2 The respondents' median income is $749.

4.3 Some of the demographic data from these cases differs from the broad quantitative sample discussed in Section 3 above. Incarceration history (35% qualitative vs. 9% quantitative) and household composition (46% qualitative vs. 28% quantitative are not singles) differed significantly, probably because Care Coordinators selected difficult cases and had more conversations with these participants that gave them more information than the self-assessments used to collect the quantitative data. Other factors, such as median age and gender differences remained similar. What may be important for future research is to determine whether high-need frequent users with more complicated circumstances may have higher criminal justice involvement and other risk factors that require a more intensive, expensive care management intervention. Research is needed to determine what characteristics individuals with complicated cases share to better target extra resources to this already high-need, high-user population.

4.4 Gaps and barriers identified:

4.4.1 Scarce affordable housing options for individuals with limited fixed incomes. In several cases, the Health Home participants with compromising physical disabilities are not eligible for 2010e supportive housing and may not be able to afford the rent if they were accepted into a housing program due to their very limited fixed income. The case study group had a median income of $749, which in most cases is not enough to provide for housing and living expenses. Some people are being 'evicted' by family and friends and not able to support their own unit. Others live in unsafe conditions such as rat infested rooms. Additionally, most of the homeless respondents were either on NYC Housing Authority's (NYCHA) waiting lists or found ineligible for various reasons (i.e. income, incarceration history etc.). In fact, one Health Home participant had a NYCHA apartment but is unable to reside there due to his mental health instability. Affordable housing options are not available on a scale to match need.

4.4.2 Current Health Home system falls short in meeting the housing needs of Health Home participants with families. Almost half of the respondents in this sample are living with family members - either with children and/or spouse. However most of the MRT supportive housing units and a significant proportion of the NY/NYIII housing units (NYC supportive housing initiative) are dedicated to single adults living in single room occupancies; therefore, many Health Home families would NOT be eligible.

4.4.3 Housing providers with additional eligibility criteria serve as barriers to accessing care/housing. In some examples, Health Home participants did not meet the eligibility criteria for available disability-dedicated housing units, largely in part due to the requirement that participants participate in treatment programs. In one case, the Health Home participant with a substance use disorder was currently receiving treatment in one community setting but recent acceptance into a housing program would require him to transfer treatment programs. This does not work for the participant as he feels that his current program provides critical social supports from both the staff and fellow patients.

4.4.4 Limited housing options for individuals with past criminal justice involvement. Several housing programs have restrictions for individuals previously incarcerated, creating barriers to ending homelessness for these individuals.

4.4.5 Care Coordinators are not housing specialists and have limited time and other resources to dedicate towards finding housing for their participants. Navigating through the various housing options that may be available to eligible Health Home participants is a time-consuming and sometimes exhaustive process - even for those who are familiar with the various housing options available. After an application is sent to a housing provider, the follow-up can be extensive. One Health Home Care Coordinator reported placing over 100 calls for one participant in a matter of months, another reached out to over 300 contacts over the span of a year for one participant. Health Home Care Coordinators have very limited resources to dedicate to the necessary, yet time-consuming, process of researching, identifying, referring and following up with housing providers. As Health Homes continue to expand and enroll new participants, this administrative burden will only escalate.

4.4.6 Agency funding requirements were found to be rigid and not aligned with real-life situations as well as not cost-effective. In one example, a Health Home participant seeking housing through HASA came across several barriers due to HASA's regulations. HASA will only approve $1,100 for an apartment, which limited her options in the Bronx. In addition, broker's fees must be paid in full and HASA will only cover half that amount. The participant is unable to afford the other half; however HASA would pay for her to stay in shelter - a far more costly option. Another participant lost a place in line for an apartment due to repeated hospitalizations. Some Health Home participants need

medications management or financial management support, which are not provided by all 2010e supportive housing providers. Thus the pool of available housing for them is even more limited.

4.4.7 Inability to place participants into housing may negatively impact participant & Health Home relationships. Several Health Home Care Coordinators noted frustration in trying to find housing for their participants after exhausting all resources known to them. Many "reached a dead-end" in trying to find appropriate and available housing for their participant(s). This inability to address the housing needs of participants may negatively impact the relationship between participants and their Care Coordinator and trusting their Care Coordinator's ability to help them in general. Care Coordinators and Health Home participants are left frustrated by current housing availability.

4.4.8 Current system limitations. One Care Coordinator noted placing 20 calls to PATH that were unanswered. Another Care Coordinator noted that senior housing had long waiting lists which left the Health Home participant on a couch in an 'unhealthy' environment. Several Health Home participants are on NYCHA waiting lists for years and Care Coordinators cannot identify other options.

4.4.9 Pressures on Care Coordination. The absence of supportive housing that participants need means that the services usually provided by supportive housing case managers must be provided by the Health Homes. When in supportive housing, case manager and Care Coordinators can work together to ensure that all the participant's needs are being met.

5. Conclusions—Policy Implications

5.1 Health Home participants have serious housing needs. Over twenty percent of all Bronx Health Home participants are unstably housed/homeless. This need is not currently being met by MRT, NYNY III or any other source of safe, affordable housing.

5.2 NY needs broader housing eligibility criteria for those who are high utilizers of Medicaid resources and other public resources (public assistance, criminal justice, shelter, etc.). A new NY/NY agreement should target people who are in this high utilizing category.

5.3 Units need to be larger so that families as well as single adults can access the housing. We estimate that about 28% of the units needed to house Bronx Health Home participants who are in family households (with other adults and/or children).

5.4 NY needs a centralized (can be statewide or regional, e.g. NYC and Upstate) housing assessment tool. Health Home Care Coordinators cannot make dozens or even hundreds of calls to identify which housing is appropriate and then available for their participants. A centralized clearing house for Health Homes that match participants with available housing for which they are eligible, based on this shared tool, is needed. MRT funds and other sources should be used to provide housing available through this mechanism.

5.5 Health Homes have elderly populations that need other care/support. Six percent (6%) of the Bronx Health Homes enrollees are over age 65. If we assume a total of 7,743 Health Home participants in the Bronx, then 465 older people have specialized housing needs. In order to keep them out of costly nursing and adult homes, special supportive housing for the aging must be made available.

5.6 Other cases show the need for medications management, financial management (to avoid evictions) and other services that are not available from all supportive housing providers. In some cases, the Care Coordinators may be able to refer out for these services, but in other cases they cannot. We need more resources within supportive

housing and housing specialist positions to support this population to have better health outcomes and decreased resource utilization over time.

5.7 We found 40% of members in this study were receiving either SSI or SSD; case studied members had even higher numbers for whom accessible housing was the only option – and difficult to identify. Although it is not clear how many of these Health Home participants require housing that is physically accessible, this is clearly an issue. New housing associated with Health Homes and in the general pipeline must include units that are accessible to physically disabled participants. Handicapped 'adaptable units' are inadequate—units that are truly accessible and available are needed now. Current supportive housing with 'adaptable units' should be funded to become *accessible* upon turnover and offered to individuals who are physically disabled.

5.8 While scatter-site supportive housing units bring units on-line quickly, more congregate housing is necessary for participants with intense need. This is especially true as people often have co-occurring mental and physical diagnoses.

5.9 Health Home participants with housing needs and complex conditions require more resources for effective Care Coordination.

Since housing needs are basic and we know that Health Home participants often do not address their health needs until their housing is stable, we need to focus on responding to the need for stable housing for this population as soon as possible.