Health Care for the Homeless

Delivering “whole person” care

Kevin Lindamood, President & CEO

July 30, 2018
History of Health Care for the Homeless

• One of 19 original Robert Wood Johnson Foundation projects
• Leveraging resources to deliver integrated care
• Medicaid expansion and health reform
• Current strategic direction
  • 100% access
  • Sustainable business models
  • Improved health outcomes
Behavioral Health System Collaborations

Evolution of engagement

• Mental health outreach
• Addiction treatment programs
• SSI/SSDI Outreach, Access & Recovery (SOAR)
  – Clinic based
  – Community collaborations
  – Statewide training
• SOAR housing collaboration
Housing is Health Care

- Current supportive housing work
- Growing recognition of housing/health connection
- Preliminary health system data
- Medicaid supportive housing waiver
  - Assistance in Community Integration Services
  - 300 Statewide; 100 in Baltimore
  - Recent request to double
BEYOND BEDS: 100% HOUSING

Practical Lessons from Health Care for the Homeless

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Senior Director of Policy
July 30, 2018
HCH PROGRAMS NATIONALLY

300 programs, 2,000 locations, ~1 million patients

FQHCs (and others) with comprehensive care

Integrated care model focused on **access** for most vulnerable
HOMELESSNESS IN THE U.S.

• 553,742 homeless on a single night in Jan 2017—of these, 20% report an SMI (111,902) (this is a conservative estimate)

• 1.4 million use shelters/housing programs over the course of a year (this is a conservative estimate)

• Mental health ↔ homelessness

• Homeless services system may not serve vulnerable populations well
HOUSING IN THE U.S.

- Homelessness is the result of extreme poverty & lack of housing
- Only 1 in 4 low-income people who qualify for housing assistance are able to receive it
- 8.3 million households pay more than ½ their income toward rent
- 28% of low-income renters couldn’t pay full rent in last 3 months
- 3.7 million evictions in 2017

Great resource on state-level housing costs:
National Low Income Housing Coalition report:
Out of Reach: The High Cost of Housing
WHY THIS ISSUE FOR SMHAs?

• More frequent use of high-end services (inpatient, emergency, outpatient, etc.) = high costs & poor outcomes

• Harder to achieve (or retain) recovery without housing; poorer health & increased mortality

• Identified as a priority by ISMICC (and others in the field)

• SMHAs have influence over funding & services, Medicaid & other health programs, hospital protocols & contractual requirements for community providers

• SMHAs have relationships across health care, housing, education, labor, social services & criminal justice

• SMHAs have a voice with Governors & legislators
HEALTH CARE

- Expand **Medicaid** & ensure assertive outreach/enrollment
- Promote Medicaid **waivers** to cover more services
- Support **integrated care** models
- Promote **harm reduction** and **trauma-informed** approaches
- Implement **EBPs** like ACT and CTI
HEALTH CARE

- Improve & standardize institutional **discharge processes**
- Promote **medical respite care** programs as a discharge option
- Increase community **capacity** along continuum of care
- Ask about housing status and **code Z59.0** in patient records
- Increase **workforce development** and **training**
HOUSING

- Promote supportive **housing** programs
- Allocate funding for **rental assistance** directly to providers
- Consider unused **state property** for homeless services/housing
- Partner with state housing authorities to develop a **housing plan**
- **Advocate** for additional affordable housing—at the lowest income levels—at federal, state & local levels
INCOME & SUPPORT SERVICES

- Support **SOAR** programs
- Support **rep payee** services
- Promote supported **employment** programs
- Advocate for **higher SSI benefits** (or a state supplement)

- Support street **outreach** and intensive **case management**
- Develop **peer specialists**, CHWs and other support roles
CRIMINAL JUSTICE & CHILDREN/YOUTH

• Increase **diversion** activities
• Ensure coordinated, high-quality care while in detention
• Improve **discharge** policies

• Promote **school-based clinics** that can screen & treat early
• Increase **capacity** in the system for children/youth services
• Link support services to the **entire family**
FINAL THOUGHTS

• Need for leadership and vision

• Need for a “champion” for population that is not often the priority

• Everyone will have different opportunities to pursue solutions

• Ending homelessness goes beyond “cost-effectiveness” and “more efficient systems” this is a moral imperative