

The Partnership for Strong Communities is a statewide nonprofit policy and advocacy organization dedicated to ending homelessness and expanding affordable housing to strengthen Connecticut communities. To meet these goals, the Partnership staffs and manages two statewide campaigns – Reaching Home and HomeConnecticut.

In 2012, the Reaching Home Campaign launched the implementation of Opening Doors –CT, the statewide plan to prevent and end homelessness that follows the federal Opening Doors plan. Opening Doors-CT has engaged more than two hundred stakeholders, including government and community providers, healthcare providers, advocates and policymakers, to work collectively to meet the following core goals:

- Finishing the job of ending Veteran and chronic homelessness by the end of 2016
- Preventing and ending homelessness among families with children and youth by the end of 2022
- Setting a path to end all forms of homelessness

Connecticut is creating a system to end homelessness, and has made substantial headway for Veterans and the long term homelessness of people with disabilities (chronic homelessness).

Many of Medicaid's highest cost beneficiaries are individuals with complex and co-occurring health and behavioral health challenges experiencing homelessness and housing crisis.<sup>1</sup> For these individuals, homelessness exacerbates chronic illnesses by increasing exposure to trauma and high-risk behaviors and, in turn, results in social isolation and difficulties accessing the coordinated primary and behavioral health services needed to manage and expedite recovery. In this sense, homelessness serves as a virtual tri-morbidity, imposing additional ill-effects on health status in and of itself. A significant factor contributing to the growth in healthcare spending is the avoidable use of the most costly services by a small subset of individuals with complex health and behavioral challenges, and who, despite their repeated encounters with emergency and inpatient health care services, experience little or no progress in their health and clinical conditions. These individuals are often very poor, homeless or unstably housed, and often have multiple, co-occurring chronic medical conditions and behavioral health disorders.

Adequate housing is a significant determinant of health and health costs. Arguably, homelessness

coupled with frequent use of emergency health care services is a substantial driver of increased Medicaid spending in the state overall.

A key strategy employed by the Reaching Home Campaign for addressing chronic homelessness has been the creation/support of two innovative supportive housing programs in Connecticut, the Connecticut Collaborative on Re-Entry (CCR) and Connecticut Integrated Health and Housing Neighborhoods (CIHHN). CCR and CIHHN employ administrative data matches between the Homeless Management Information System and state agencies to target individuals who are cycling through homelessness, incarceration, and crisis medical and behavioral healthcare facilities. By providing these individuals with subsidized housing and intensive case management services, CCR and CIHHN have stabilized more than 250 people in housing, while simultaneously assisting them in improving health outcomes, reducing their utilization of crisis healthcare, and reducing returns to incarceration.

An additional strategy employed by the Reaching Home Campaign for addressing chronic homelessness is the Opening Doors-CT Hospital Initiative. The goal is to reduce the use of emergency departments as a source of primary health care for people experiencing homelessness, reduce readmissions, and improve their health outcomes.

The SIM has already begun to reshape aspects of our health care system, including service delivery, access, and financing, in ways that are creating unique opportunities to improve health outcomes for extremely vulnerable populations. With a substantial focus on expanded access and quality as core to achieving planned reductions in overall health care costs, there are opportunities at the state and local levels to test and implement new and more effective approaches to addressing the unmet health needs of persons who have not been well served by these systems. The Partnership for Strong Communities, through its Reaching Home Campaign recommends the following be considered when developing standards for Community and Clinical Integration Programs for Advanced Networks and Federally Qualified Health Centers:

**Align state and local strategies to support the goals of improved access to health care and effective use of appropriate types of health services**

1. Include data on homelessness/housing stability when identifying high need, high-cost users. Administrative data matches like those in CCR and CIHHN have demonstrated effectiveness in identifying persons with complex co-occurring medical, behavioral and social needs. Within any cohort of persons identified as frequent users of health care resources, the subset of those individuals experiencing literal homelessness (residing in shelter or in places not meant for human habitation, such as cars, parks, encampments, bridges) is likely to have significantly greater need and higher cost. In addition, while persons defined by HUD as “chronically homeless” are more likely to be disengaged from health services altogether and may not currently be frequent utilizers, their equally complex needs are likely to result in high costs when health crises do occur; targeting them for services also has potential to improve outcomes while preventing high costs.

**Maximize the use of existing and new health sector resources to address both the housing and service needs of extremely vulnerable populations**

1. Use the Community Health Worker model to expand and sustain the Patient Navigator workforce in supportive housing piloted by the CIHHN initiative. Patient Navigators provide intensive hands-on assistance to CIHHN tenants that go beyond traditional care coordination to provide the in-person supports they need to engage successfully in medical and behavioral healthcare.
2. Build collaborations between health, behavioral health and housing systems in order to ensure an integrated system of care.

**Implement housing-based approaches to align with the health reform goals of prevention, greater access, better quality and lower cost**

1. Expand and sustain existing supportive housing initiatives targeting high utilizers to meet identified needs across the state, including expanding administrative data matching to incorporate cross-system utilization as well as additional mainstream system utilization.
2. Establish (or expand) partnerships between housing organizations and healthcare agencies

(e.g. between a community health center and a housing authority) to integrate the health services at the housing site or make direct linkages to the community health center through the use of agreements.

2. Consider testing a medical respite model<sup>2</sup> directly linked to permanent supportive housing in one or more communities, through a partnership between a major hospital, a homeless service and housing provider, and state government. Target individuals who are chronically homeless and frequent users of hospital systems.

### **Use the Community Care Team (CCT) model**

Connecticut hospitals are teaming up with other community-based healthcare providers and providers of wraparound social services to establish a CCT or to engage in other related community care coordination initiatives. These regional multi-agency partnerships are often led by a community hospital, with active participation by local agencies, including mental health, substance abuse, federally qualified health centers (FQHCs), other medical services, city social services, housing authorities, religious organizations, shelters, vocational programs, and law enforcement. A CCT may also include representatives of Community Health Network of Connecticut and Beacon Health Options (formerly ValueOptions) Connecticut. The CCT meets either weekly or every other week, usually at the hospital, where members work collaboratively to identify patients based on the frequency of ED visits or referrals from other CCT members. These patients are complex, high risk, and high-need ED “super users” who are typically diagnosed with coexisting severe mental illness and substance abuse disorders, chronic mental illness, chronic alcoholism, or other drug dependence.

Thank you for the opportunity to provide comment on this draft from the Practice Transformation Task Force on Community and Clinical Integration Program Standards.

<sup>1</sup> Linkins, Karen W., Jennifer J. Brya, and Daniel W. Chandler. (2008) Frequent Users of Health Services Initiative: Final evaluation report. Oakland, CA: Corporation for Supportive Housing; and Raven, Maria C., Emily R. Carrier, Joshua Lee, John C. Billings, Mollie Marr, and Marc N. Gourevitch. 2010. Substance use treatment barriers for patients with frequent hospital admissions. *Journal of Substance Abuse Treatment*, 38, 22-30.

<sup>2</sup> Medical respite care is acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets but who are not ill enough to be hospitalized. Unlike “respite” for caregivers, “medical respite” is short-term residential care that allows homeless individuals the opportunity to rest in a safe environment while accessing medical care and other supportive services. These programs are housed in a variety of settings including freestanding facilities, homeless shelters, nursing homes, and transitional housing. Medical respite care meets the post-hospital recuperative care needs for people who are homeless while reducing public costs associated with frequent hospital utilization. Medical respite needs to be linked directly to permanent housing with services in order to ensure long term stability.