Executive summary

Eighty-two stakeholders, including members, local officials, senior executives from AmeriHealth Caritas, and experts in health care, housing, and violence prevention, assembled for the AmeriHealth Caritas Leadership Meeting, Health Is More Than Health Care: Maximizing the Value of America’s Investment in Medicaid, a one-day conference held on February 23, 2017, at the Hotel Monaco in Washington, D.C. The invitation-only meeting featured an intimate setting conducive to information exchange and strategy development.

The agenda focused on social determinants of health, such as stable housing and safe communities, and on the need for solutions that integrate efforts across sectors. Because the meeting was designed as an interactive working session, topical handouts and expert speakers provided a foundation for small-group discussion, which focused on developing strategies around four key topics:

- Social Determinants of Health: Individual and Community Health.
- HIV, Health Care, and Housing Delivery.
- Stabilizing Housing as a Health Care Initiative.
- Housing and Health Care: Violence Intervention.

The final session of the day focused on a summary and report-out of themes, ideas, and strategies that emerged throughout the meeting. Leveraging collective experience, the final report-out captured the many voices and varied experiences of attendees, including AmeriHealth Caritas members. AmeriHealth Caritas will use the identified strategies enumerated in this document to inform new program design and development.

“We believe we’ve started on a journey with key stakeholders and members of the community we serve and want to co-author some meaningful and effective solutions to some of the challenges we collectively face.”

— Karen Dale, Market President, AmeriHealth Caritas District of Columbia
Social determinants of health are societal, economic, and environmental factors that influence health but are, in some respects, outside the control of the health system.

**STRATEGY 1**

Invest in community health resources that complement the personal health activities of members, such as supporting efforts to increase consumer access to healthy options (e.g., fresh food and exercise) and investing in preventive care, including school-based prevention models (e.g., asthma and smoking prevention).

- **Many factors combine to affect the health of individuals and communities.** There is growing recognition that a broad range of social, economic, and environmental factors shape individuals’ opportunities and barriers to engage in healthy behaviors. While health care is essential to maintaining good health, research shows that health care alone is not a strong determinant of health outcomes. Despite annual health care expenditures projected to exceed $3 trillion, health outcomes in the United States continue to fall behind those in other developed countries. Although overall spending on social services and health care in the United States is comparable to other Western countries, the United States spends disproportionately less on social services and more on health care.

- **Social determinants have a significant impact on health outcomes.** Social determinants of health are “the structural determinants and conditions in which people are born, grow, live, work and age.” They include factors like socioeconomic status, education, the physical environment, employment, and social support networks, as well as access to health care.

  - **Housing is a key determinant of health.** Homelessness is a significant barrier to good health. Poor nutrition, inadequate hygiene, exposure to violence and weather-related illness and injury, increased risk of contracting communicable diseases, and the constant stress of housing instability all contribute to the health issues faced by homeless individuals and families. Without housing, simple cuts become infected, routine colds develop into pneumonia, and manageable chronic diseases such as hypertension, diabetes, and HIV become disabling, life-threatening, and costly conditions. Homeless persons die on average 30 years sooner than their housed counterparts.

  - **Violence has direct and indirect impacts on health.** The health consequences of violence can be immediate and acute, long-lasting and chronic, and/or fatal. In addition to the direct effects of physical injury, there can be indirect physical, mental, and emotional effects for victims and witnesses of violence. The observation of violence in childhood has been associated with higher levels of smoking, alcohol abuse, depression, and poor health in adulthood. Common long-term health consequences of violence against women include chronic pain syndromes; sexual and reproductive health complications; and a greater risk of adverse mental and behavioral health outcomes, including depression, anxiety, and post-traumatic stress disorder.
Session 1: The Social Determinants of Health

STRATEGY 2

Take a leadership role in establishing and building on multi-sector partnerships, including social services, housing, and health providers, to coordinate community health efforts; improve primary care delivery to individuals and family members; invest in opening family resource centers; and engage consumers where they are and learn from their lived experiences.

- **Personal health and community health are interconnected.** According to the Centers for Disease Control and Prevention, working at the community level to promote healthy living and prevent chronic disease brings the greatest health benefits to the greatest number of people in need. Community health care can complement personal health activities and address the social, economic, and environmental factors that may serve as barriers to individual health and wellness.

STRATEGY 3

Develop and use community-based care management teams (e.g., nurses, social workers, and community health workers) to provide in-home care for high utilizers with physical and behavioral health needs. This team will help provide behavioral health workers with training in strengths-based, trauma-informed care; facilitate connections to primary care providers; provide consumers with a bridge to telephonic care to manage health care needs; and include a “health conductor” role to address the social determinants of health with a focus on interventions, awareness, and changes that improve member health outcomes.

- **Addressing social determinants of health is important for achieving greater health equity.** The Department of Health and Human Services defines health disparities as “differences in health outcomes that are closely linked with social, economic, and environmental disadvantage.” This definition recognizes that health disparities are rooted in the social, economic, and environmental contexts in which people live. Achieving health equity will require addressing these social and environmental determinants through both broad population-based health care approaches and targeted health care approaches focused on communities experiencing the greatest disparities.

STRATEGY 4

Improve use of the Community Health Needs Assessment to identify and assess health needs of members, including the social determinants of health. This includes broadening the definition of health in the Community Health Needs Assessment to more successfully bridge gaps across sectors and bring various partners on board, and using funding from the Assessment to further invest in addressing social determinants of health.
The role of health care in addressing the social determinants of health

Two models of coordination to address population health and social determinants of health

The following visuals demonstrate two different models for structuring population health activities to address social determinants of health. Both take the form of a hub-and-spoke, where the hub allocates funding to and coordinates activities of spokes.

Health care-centric model

- In the health care-centric model, health care organizations at the hub would contract or manage health promotion activities and social service delivery by purchasing or contracting for these services from community organizations, providing the services themselves, or some combination of these approaches. Health care organizations may be motivated to take on the hub role given the financial risk for outcomes in accountable care and the need to collaborate to achieve improved outcomes in social determinants. Health care organizations also have expertise in structuring and managing contractual relationships with service providers. Additionally, many health care organizations are expanding the focus of their organizations to address the overall health of consumers, including social determinants of health, rather than focusing exclusively on the provision of health care services. For health care providers, accomplishing this goal of addressing a broader definition of “health” may include widening care coordination efforts to include social services.

STRATEGY 5

Use a hub-and-spoke approach to address the social determinants of health, centralized around the mayor's office, with spokes for community functions, such as the fire department, police department, Department of Education, and Housing Authority.
The public health and/or philanthropy-centric model offers an alternative vision in which health care organizations would take on the role of a spoke alongside other community actors, leaving another organization to take up the hub position. In some communities, this coordinating role could be played by the local government. In other communities, cross-sector collaborations among a range of different organizations may be explored, with the potential for local foundations or organizations to take the lead in communities.

“There is only one assumption you should make for every patient: Everybody wants to be healthy. We have started looking not just at who the patient is, but what conditions they return to at home.

We need to create environments that give people the capacity to be healthy. People cannot be healthy unless they are safe.”

— Kathleen Reeves, Senior Associate Dean of the Office of Health Equity, Diversity, and Inclusion at the Lewis Katz School of Medicine at Temple University
Both hub-and-spoke models are currently in practice in the United States:

- In Baltimore, Maryland, Bon Secours Health System has taken on a hub role to coordinate population health efforts, focusing on increasing the stock of affordable housing in its neighborhood and helping coordinate the efforts of other organizations to increase access to education, job training, and community activities.
- Nationwide Children's Hospital, in Columbus, Ohio, has served as a hub organization in developing a Healthy Neighborhoods, Healthy Families network to address underlying health disparities in the Southside neighborhood adjacent to the hospital.
- In Spartanburg, South Carolina, a local family foundation, the Mary Black Foundation, has taken the lead in a large community health investment project and has coordinated work among health care organizations, local government, non-profits, and local businesses to improve community health.
- Some local public health departments have used Affordable Care Act-mandated community health needs assessments as runways to longer-term collaboration among health systems and community partners.

Emerging efforts to integrate social and environmental needs into the health care system

STRATEGY 6
Expand use of Medicaid to encompass housing as a health need by leveraging Medicaid to pay for outreach and housing support services and maximizing the use of the State Innovation Models (SIM) initiative to address social determinants of health.

STRATEGY 7
Identify data and common languages used across the health care system (e.g., hospitals, federally qualified health centers [FQHCs], and providers) and standardize data collection.
Medicaid delivery and payment reforms: Given Medicaid’s longstanding role serving a diverse population with complex needs, a number of Medicaid delivery and payment reform initiatives include a focus on linking health care and social needs.

- **Colorado** and **Oregon** are both implementing Medicaid payment and delivery models that provide care through regional entities. Coordinated care organizations (CCOs) in Oregon and regional care collaborative organizations (RCCOs) in Colorado focus on integration of physical, behavioral, and social services as well as community engagement and collaboration.

- **Medicaid programs** are addressing broader factors influencing health through the health homes option established by the Affordable Care Act. Health home services include comprehensive care management, care coordination, health promotion, comprehensive transitional care, patient and family support, and referrals to community and social support services.

**STRATEGY 8**

Build relationships with care providers and others who can intervene seamlessly and quickly to meet member behavioral health needs and other care needs as they emerge.

**STRATEGY 9**

Use a standardized tool to assess the demographics of communities and needs of members by adopting the Protocol for Responding to and Assessing Patients’ Assets, Risks, and Experiences (PRAPARE) to assess members for select social determinants of health and develop interventions for members based on assessment results.

“Coverage gains under the [Affordable Care Act] provided a strong foundation for moving beyond health care to improve health and advance health equity. This is a new avenue to connect with individuals and address their health needs.”

— Samantha Artiga, Director of the Disparities Policy Project at the Henry J. Kaiser Family Foundation and Associate Director for the Foundation’s Program on Medicaid and the Uninsured
• **Health plan efforts**: Given that social determinants have such a significant impact on health outcomes and health status, managed care plans have incentive to help their members address their broader needs. Some plans have developed specific programs or initiatives to address those needs.

  - In Los Angeles, the LA Care Health Plan opened Family Resource Centers in underserved areas of Los Angeles County. The centers help enrollees understand their benefits and identify available providers. They also offer health screenings and free classes on topics such as parenting, asthma, and health management. For the broader community, they help individuals obtain health insurance coverage, provide free health classes, and connect individuals with community organizations and services.²⁴

### STRATEGY 10

Create more opportunities like AmeriHealth Caritas’ Health Is More Than Health Care meeting for cross sector discussion and planning, supported by individual follow-up meetings to improve coordination of existing cross-sector forums, task forces, and work groups to continue identifying strategies, move forward on action steps, and track progress; bring in alternative partners who might be willing to give back to the communities they impact (e.g., developers and businesses); and partner with local leaders to give voice to community needs.
Session 1: The Social Determinants of Health


Social Determinants of Health
Session 1

Despite having significantly higher health care spending than comparably wealthy and sizable countries, the United States lags behind in several measures of health outcomes:

**Life expectancy**
Life expectancy at birth in years, 2013

<table>
<thead>
<tr>
<th>Country</th>
<th>Life Expectancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Japan</td>
<td>83.4</td>
</tr>
<tr>
<td>Switzerland</td>
<td>82.9</td>
</tr>
<tr>
<td>France</td>
<td>82.3</td>
</tr>
<tr>
<td>Australia</td>
<td>82.2</td>
</tr>
<tr>
<td>Sweden</td>
<td>82.0</td>
</tr>
<tr>
<td>Comparable country average</td>
<td>81.8</td>
</tr>
<tr>
<td>Canada</td>
<td>81.5</td>
</tr>
<tr>
<td>Netherlands</td>
<td>81.4</td>
</tr>
<tr>
<td>Austria</td>
<td>81.2</td>
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<tr>
<td>United Kingdom</td>
<td>81.1</td>
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<tr>
<td>Germany</td>
<td>80.9</td>
</tr>
<tr>
<td>Belgium</td>
<td>80.7</td>
</tr>
<tr>
<td>United States</td>
<td>78.8</td>
</tr>
</tbody>
</table>

**Mortality**
Age-adjusted major causes of mortality per 100,000 population, in years, 2010

**Disease burden rates**
Age standardized disability adjusted life year (DALY) rate per 100,000 population, 2010
Racial gap in life expectancy
Despite national improvement in decreasing the black-white life expectancy gap between 1990 and 2009, the racial gap in D.C. remained dramatically more unequal than in every other state.

Nationally, the life expectancy gap decreased by 2.2 years. In D.C., the life expectancy gap increased by 0.3 years.

Income inequality
Percent of population age 15+ reporting good health by income quintile, 2013

Americans with lower incomes are less likely to report being in good health than those with high incomes. The least healthy American counties also tend to have higher rates of unemployment and lower graduation rates.
Data sources

Life expectancy

Mortality

Disease burden rates

Racial gap in life expectancy

Income inequality
Growing evidence base for stabilizing housing as a health care initiative

**STRATEGY 1**
Invest in improved data systems and increase the use of data to measure client health outcomes as related to housing availability and conditions.

- **People experiencing homelessness are at greater risk for poor health.** They have high rates of infectious and acute illnesses (skin diseases, tuberculosis, pneumonia, asthma), chronic diseases (diabetes, hypertension, HIV/AIDS, cardiovascular disease), poor mental health and/or substance use disorders, and experiencing violence. In addition, the mortality rate among the homeless population is three to four times higher than for the general population.¹

**STRATEGY 2**
Establish a timely referral and transportation process for members using the emergency room for nonemergent care needs to receive more immediate and appropriate care at nearby lower cost clinics; set up routing procedures with emergency services to provide this less costly alternative as a first option for members with nonemergent care needs; and increase awareness and utilization of preventive care as a first option.

- **People experiencing homelessness are less likely to prioritize routine medical care.** Multiple competing demands in daily life, such as food and shelter, make prioritizing routine medical care difficult or unlikely. When their unmanaged symptoms trigger urgent events, or when they are injured, people experiencing homelessness seek care in emergency rooms four times more frequently than the U.S. average.²

**STRATEGY 3**
Review the assessment tools in use in the District of Columbia’s coordinated entry system for connecting homeless or at-risk individuals to housing and services; consider the current weighting of health care issues, including primary care needs, and recommend changes to the tool as necessary; and identify opportunities for AmeriHealth Caritas to connect members to the coordinated entry system.

- **Unstable housing is a significant contributor to frequent hospitalizations and emergency room visits.** Leading diagnoses for general medical hospitalizations of people experiencing homelessness indicated poor care of injuries and problems in managing chronic conditions. Simple regimens such as diet, exercise, and insulin use for a diabetic patient may be insurmountable obstacles for a person experiencing homelessness. Conventional medical intervention models alone are unlikely to reduce frequent hospitalizations and emergency room visits for people experiencing homelessness.³
• **Health issues are likely to increase as the homeless population ages.** In studies across the country, there appears to be a clear upward trend in the proportion of persons ages 50 – 64 among the homeless population. Rates of chronic health conditions and the potential for extended stays in nursing homes increase with age.

**STRATEGY 4**

Work with Continuum of Care outreach teams, emergency shelters, Health Care for the Homeless clinics, food pantries, soup kitchens, and the entire spectrum of emergency services to have frontline health care workers on site to meet immediate medical needs and make connections for continued care.

**STRATEGY 5**

Partner with local affordable housing providers and homeless housing programs to identify members with health care needs, provide access to immediate care options, and connect members to long-term care options including primary and preventive care.

• **Permanent supportive housing reduces health system costs.** Studies have shown that stable housing with adequate support helps reduce the prevalence of substance use disorders, the use of acute care services, and health care expenditures.

  - Thirty-seven homeless men and women in Asheville, North Carolina, over a three-year period, cost the city and county over $800,000 each year, including $120,000 for emergency medical services and $425,000 in hospitalization costs.

  - A 2014 New Mexico study found a 13 percent decrease in emergency room costs and 83.8 percent decrease in hospital inpatient costs after study group members were housed for a year, compared to the prior year.

  - A two-year study in Boise, Idaho, led to an estimate that homeless services for one person experiencing chronic homelessness in Boise for one year ranges from $40,000 to $85,000, including case management, police intervention, incarceration, paramedic care, fire department services, emergency room care, hospital care, and shelter services.

**STRATEGY 6**

Engage with researchers to pilot programs and investigate innovative health care and housing solutions for members, identify approaches that can be implemented nationwide, and work to create place-based solutions and respond to the needs of specific localities and populations.

• **The District of Columbia’s managed care organizations (MCOs) fail to keep costs down.** The Department of Health Care Finance released the fiscal year 2014 MCO performance report of health care utilization and spending for three of the District’s four Medicaid health plans, including AmeriHealth Caritas.

  - Three-fifths of emergency room visits by D.C. Medicaid recipients were for basic care, and a large portion were avoidable.

  - Emergency room use for low-acuity illnesses and potentially avoidable hospital admissions and readmissions cost the MCOs more than $34 million in one year.
Case studies

**STRATEGY 7**

Participate in housing, health, and service provider partnerships; focus partnerships around stabilizing the highest cost and highest use members; and utilize partnerships to coordinate treatment, training, navigation, and service delivery across systems of care.

**Minnesota: Coordinating with MCOs to increase permanent supportive housing capacity**

The health plan Medica has subcontracted with Hearth Connection Inc., a nonprofit, intermediary organization that provides administrative support, fiscal oversight, and research to a network of supportive housing providers, to conduct a demonstration project targeting Medica’s 88 highest-cost users of Medicaid. Medica decided to address the needs of their Medicaid enrollees who experience long-term homelessness, manage chronic conditions, and frequently use health systems. Medica created an algorithm to identify all 88 enrollees to be targeted by the project. Once Medica staff identified potential enrollees for the demonstration, they collaborated with Hearth Connection, which locates each enrollee and determines his or her eligibility for the program, including whether the person is homeless. If the enrollee is eligible, Hearth Connection facilitates payment for services and housing (using existing U.S. Department of Housing and Urban Development and state voucher program resources) and conducts staff training for both Medica providers and supportive housing providers on issues such as case management and care coordination integration, navigating the health system, and understanding supportive housing. Medica pays for supportive housing services, coordinates care, and evaluates the project. Foundations and other funders have funded an evaluation study and assisted Hearth Connection in covering its administrative costs.

**STRATEGY 8**

Support efforts to increase local public and private investments in housing resources for individuals experiencing homelessness, including local housing trust fund programs, social impact bonds, and tax credits.

**Massachusetts: State-funded housing-first program**

Home & Healthy for Good (HHG) is a permanent supportive housing program for chronically homeless individuals. HHG is run by the Massachusetts Housing and Shelter Alliance (MHSA) and is funded by the state of Massachusetts. The program piloted in 2006 and 2007 and received increased budget allocations in subsequent years. The budget allocation for HHG is flexible: funding can be used for housing subsidies, supportive services, or both. In fiscal year 2017, MHSA entered into a contract with the Department of Housing and Community Development (DHCD) to continue to administer the HHG program throughout Massachusetts. Seventeen homeless service providers now participate in the program as agencies subcontracted by MHSA.

MassHealth (Medicaid) analysts reviewed billing claims data in March 2009 for 96 HHG participants who had Medicaid eligibility in both the year prior to and the year after
Care is the heart of our work moving into housing. MassHealth provided MHSA with actual Medicaid costs for these participants, which serve as the basis for cost savings estimates. (See: “Average public service usage per Home & Healthy for Good tenant” graphic on page 6).

Texas: Expanding access to affordable housing
The definition of “health-related factors” must be broadened as health plans seek innovative solutions to the nation’s health problems. For example, UnitedHealthcare invested $11.7 million, using low-income housing tax credits, in Austin’s Capital Studios community, which opened at the end of 2014 and provides low-income and homeless housing. The insurer made this investment assuming that having access to housing will help vulnerable patients stay healthy and out of the hospital, ultimately lowering health care costs.

Philadelphia: Cost savings reinvested into supportive housing
The City of Philadelphia operates a nonprofit behavioral health managed care organization called Community Behavioral Health (CBH). Recognizing the need for supportive housing investment, CBH partners with the city’s housing agency and utilizes both Medicaid and city-designated funding to finance services and housing for supportive housing residents. If a participant is deemed eligible, specifically if they are chronically homeless, CBH offers a set of services delivered by community-based homeless service providers. CBH cost savings become city revenue largely reinvested into supportive housing in the form of rental assistance and other funds for supportive housing.

California: MCO plans to integrate housing
San Francisco Health Plan has incorporated a community-based case management program for members identified as high utilizers

“The conversation around housing and health care takes understanding from both fields...We all need to understand the social determinants of health, and we all need to do more for [our clients] with complex needs.”

— Peggy Bailey, Director of the Health Integration Project at the Center on Budget and Policy Priorities
of inpatient and emergency room services and who require management in the community for long-term psychosocial interventions. Among other services, Care Coordinators provide psychosocial interventions that connect members to basic needs (such as food and clothing), social support, transportation, and other community resources. San Francisco Health Plan is focused on integrating housing into the case management model. The MCO is currently developing a program to staff city clinics with housing navigators.

California: LA’s 10th Decile Project
The 10th Decile Project brings together health centers, hospitals, and homeless service providers to connect frequent users of emergency health services to housing and appropriate health care through intensive case management. This initiative targets the top 10 percent highest-cost, highest-need homeless individuals in Los Angeles County. This is a data-driven process, using a triage tool for identification. This model has resulted in improved housing stability and health outcomes and a significant reduction in per-person cost to the health care system. After accounting for 10th Decile Project costs, emergency room costs were reduced by 67 percent, and inpatient costs were reduced by 85 percent.


3 Ibid.


11 Ibid.

12 Ibid.


Stabilizing Housing as a Health Care Initiative
Session 2

Average public service usage per Home & Healthy for Good tenant

Permanent supportive housing reduces health care costs

For chronically homeless individuals who are housed:
- One-third fewer inpatient hospital stays.
- One-fourth fewer emergency room visits.
- One-fifth more primary care visits.

$1 million savings in public funds per year for every 100 housed chronically homeless individuals.

District of Columbia 2016 Homeless Census: 8,350 people

Adults with disabilities

- Chronic substance abuse (CSA): 19.2%
- Severe mental illness (SMI): 20.4%
- Dual diagnosis (CSA and SMI): 10.7%
- Chronic health problems: 10.8%
- Living with HIV/AIDS: 2.1%

Median age
- 52 years: Unaccompanied homeless persons
- 27 years: Adults in homeless families
Data sources

**Average public service usage per Home & Healthy for Good tenant**
Massachusetts Housing and Shelter Alliance, “Home & Healthy for Good Progress Report” (January 2015).

**Permanent supportive housing reduces health care costs**
AIDS Chicago, “Studies on Supportive Housing Yield Results for Health of Homeless and Cost Savings” (2012).

**District of Columbia 2016 Homeless Census**
HIV/AIDS and homelessness are intricately related

**STRATEGY 1**

Utilize local data to demonstrate the link between HIV, housing, and health care, and engage in cross-system advocacy efforts to improve health care and housing options for people living with HIV/AIDS.

- **HIV/AIDS is correlated with homelessness.** Many domiciled individuals face the threat of homelessness once they or someone in their family becomes infected with HIV/AIDS. Additionally, people experiencing homelessness are at risk of contracting HIV due to the prevalence of high-risk behaviors such as injection drug use, unsafe sex, and “survival sex” (i.e., the exchange of sex for food, shelter, or money).¹

**STRATEGY 2**

Strengthen HIV treatment, prevention, and intervention services available at shelters and other emergency services locations; utilize mobile vans in the city for instant testing, supported by follow-up case management; and develop a resource map of HIV housing and health care resources in D.C. to assist health care providers in making connections and referrals.

- **Homeless populations have higher rates of infection.** The homeless population has a median rate of HIV prevalence at least three times higher — 3.4 percent versus 1 percent — than the general population. Even higher rates (8.5 percent to 62 percent) have been found in various subpopulations.²
  - The death rate among people living with HIV (PLWH) experiencing homelessness is five times the death rate for housed PLWH.³

**STRATEGY 3**

Work with the D.C. Department of Health to identify where HIV is at its highest levels among members, non-members, and persons at risk of homelessness; heighten outreach and resource-directed housing and health care efforts; reduce HIV-related disparities in communities at high risk of infection by hiring staff from overrepresented communities; and partner with community-based organizations that specialize in serving overrepresented communities.

- **Housing with health care stabilizes health conditions.** Permanent supportive housing (PSH) — affordable housing linked with comprehensive health and support services — serves people with severe and complex needs, including those who have been chronically homeless and people living with HIV/AIDS (PLWHA). Research and experience repeatedly document that PSH results in reductions in costs for hospitalization, emergency room visits, crisis services, shelter, jail, and detox; high rates of housing stability and retention; improved health and recovery; and sustained viral suppression⁴ for PLWHA.⁵
  - The Housing and Health Study conducted by the Centers for Disease Control and Prevention (CDC) in partnership with the U.S. Department of Housing and Urban Development’s (HUD) Office of HIV/AIDS Housing to assess the impact of Housing Opportunities for People with AIDS (HOPWA)⁶ housing vouchers found that persons who continued to experience homelessness throughout the duration of the study were significantly less likely to reach viral suppression than those who did not report homelessness.⁷
• **Medical practices for PLWHA have improved, but there is still a long way to go.** Today, fewer people are being diagnosed with HIV, most people living with HIV are aware of their status, and more Americans with HIV are getting the care they need than ever before. But, minority groups are still disproportionately affected. For example, in 2013, the rate of black males living with an HIV diagnosis was 2.8 times that of white males. In 2013, the rate of black females living with an HIV diagnosis was 27.4 times that of white females.

• **Implementing new initiatives in the face of new challenges.** While the United States has made great strides in understanding and developing treatments for HIV, we still face an epidemic that must be addressed in innovative ways. In July 2016, President Obama signed into law provisions that modernize the HOPWA funding formula to only consider living persons diagnosed with HIV, rather than the cumulative number of cases. Recent efforts in Washington, D.C., also reflect a new approach to fighting the epidemic. As city officials and advocates in the District recognize the heart of the HIV crisis shifting from deaths caused by AIDS to lack of affordable housing for PLWHA, they are moving their focus toward housing and other social factors.

  - In March 2016, Channing Wickham, Executive Director of the Washington AIDS Partnership, articulated his concerns regarding new challenges in the HIV epidemic: "HIV is no longer a new and exciting issue, and it’s frustrating because... D.C. is turning a corner in terms of its prevention efforts. So now is not the time to slow down or budge, but the resources are diminishing. And that’s the challenge.”

  - In December 2016, Mayor Muriel Bowser announced the 90/90/90/50 Plan to end the HIV epidemic in D.C. by 2020. The directives in the plan include:

    › Examine adding performance measures to future contracts with managed care organizations (MCOs) to enhance treatment adherence, viral load suppression, and funding for support services—especially housing.

    › Examine the need for expanded funding for affordable housing for people living with HIV.

    › Promote use of HOPWA funding for capital development to create new units of affordable housing for people living with HIV.

    › Ensure that people living with HIV who access low-barrier shelters in D.C. receive accommodations that will allow them to manage their condition.
Case studies

**STRATEGY 6**

Utilize a community support model to establish a network of providers for the provision of holistic primary care, housing, supportive services, and case management.

**New York: Housing Works Community Healthcare, The Undetectables**

The Undetectables is a superhero-themed, incentive-based program run by Housing Works that aims to help people with HIV achieve and maintain viral suppression. Housing Works is a health center and advocacy organization that partners with a network of providers to offer holistic primary care, case management, and supportive services. The Undetectables was launched in 2014 using a community support model, with the goal of getting 80 percent or more HIV+ Housing Works clients to take medication consistently and thus have undetectable levels of HIV virus in their blood (i.e., to achieve viral suppression). At periodic points, clients would have financial incentives to achieve “undetectable” status. The program has been very successful and has been adopted by six more organizations in New York City.

- In August 2015, there were 610 active “Undetectable” participants with an overall 80 percent retention rate at 18 months.

- Among these participants, 83 percent were virally suppressed, 15 percent undetectable, and 2 percent unknown.

- Among these participants who were also housing clients in the program, 85 percent were virally suppressed.

**STRATEGY 7**

Invest in the full spectrum of housing and services for people living with HIV/AIDS, including subsidies, units, on-site services, and independent housing; create designated staff positions to foster treatment adherence and provide health care counseling and health classes for members with HIV/AIDS; and increase the number of housing navigators connected to health care providers.

**Missouri: Doorways**

Doorways provides affordable, secure housing and services for PLWHA. The program is successful because they recognize that a one-size-fits-all model does not work for this population. Doorways offers a full spectrum of housing so that clients can get their needs met in the environment best suited for their improved health. Different housing programs they operate include: emergency housing and rent subsidies, housing and services for rural communities, independent living apartment units in the city, rental assistance for homeless single parents with HIV/AIDS, and permanent supportive housing.

- In 2016, there were 668 total clients enrolled in one of their housing programs funded by HOPWA, 78 percent of whom were retained in care and reached viral suppression.

“The HOPWA Program was designed to respond to the housing needs emerging from the HIV/AIDS crisis in the early 1990s. Over the past 25 years, the needs of people living with HIV/AIDS have changed, and so has the HOPWA program.

Today, the HOPWA program funds program planning, development, outreach, and case management, in addition to housing — support is customizable to community need.”

— Rita Flegel, Director of the Office of HIV/AIDS Housing at HUD

Session 3: HIV, Health Care, and Housing Delivery
New York: HIV Special Needs Plans (SNPs)
A Special Needs Plan (SNP) is a health plan that covers all the same services covered by other Medicaid health plans, plus special services for people living with HIV/AIDS. Designed to meet the needs of the HIV community, these plans are offered as an alternative to regular Medicaid managed care plans. SNPs provide access to: coordinated care from HIV experienced primary care providers, treatment adherence services to help in the management of medications and side effects, and HIV prevention and risk-reduction education including counseling and health classes. Three SNPs are currently operating in New York State.15 A study that evaluated SNP cost and usage impacts indicated, “The HIV SNP program’s impacts have been highly favorable along every dimension assessed. The program’s care integration model appears to effectively manage enrollees’ health, achieves massive inpatient cost savings, and provides overall savings to the Medicaid program.”16

U.S. Department of Health and Human Services: Ryan White HIV/AIDS Program17
The Health Resources and Services Administration’s (HRSA’s) Ryan White HIV/AIDS Program authorizes funding to address the unmet care and treatment needs of persons living with HIV/AIDS who are unable to pay for appropriate HIV/AIDS health care. The program works with cities, states, and local community-based organizations to provide HIV care and treatment services to more than a half-million people each year. The majority of Ryan White HIV/AIDS Program funds support primary medical care and essential support services. A smaller portion is used to fund technical assistance, clinical training, and the development of innovative models of care. The program serves as an important source of ongoing access to HIV medication that can enable people living with HIV to live close to normal lifespans.

HUD HIV Housing Care Continuum Initiative18
HUD’s Office of HIV/AIDS Housing, the National AID Housing Coalition, and Collaborative Solutions, Inc., developed a Technical Assistance (TA) initiative focused on increasing the capacity of HOPWA grantees to create HIV Housing Care Continuums19 in their communities. These continuums were designed to demonstrate the proportion of HOPWA beneficiaries engaged at each stage of HIV care.20 The continuum model outlines the stages of HIV care that people with HIV go through from initial diagnosis to achieving the goal of viral suppression. As part of this collaborative initiative, a series of regional meetings was held that brought together HOPWA grantees, Ryan White providers, and health department staff to create community strategies for developing and implementing HIV Housing Care Continuums. Regional meetings took place in Chicago, Illinois; Washington, D.C.; Atlanta, Georgia; and Portland, Oregon.

STRATEGY 8

Coordinate care with HIV-experienced primary care providers and treatment adherence services using state-of-the-art assessment tools and treatment protocols; improve mechanisms to monitor and report on consumer health outcomes, such as treatment adherence; and support data collection and data-sharing efforts to track utilization of housing and health care services for members living with HIV/AIDS (all in compliance with applicable privacy laws).

STRATEGY 9

Develop a coordinated care system to support LGBTQ transition-age youth who have complex needs (e.g., HIV, housing, mental health, food security, medication management) through partnerships and expanded capacity (e.g., mental health services, group homes).

STRATEGY 10

Facilitate a broader, deeper level of convening, specifically focused on people living with HIV/AIDS, with a focus on breaking down silos and improving discharge planning for this population.
Communities that developed HIV Housing Care Continuums were able to:

- Illustrate overall engagement in care and treatment for PLWHA
- Benchmark against national and other community-level continuums
- Identify successes and gaps in care and treatment for HOPWA participants
- Improve health outcomes for PLWHA by enhancing programs
- Inform policymakers on program development
- Align with national initiatives.

An HIV Housing Care Continuum webinar series and accompanying workbook have been developed to share the information and resources presented at the regional meetings to a broader audience of HOPWA grantees and providers.

The webinars and workbook were designed to help HOPWA grantees develop strategies in their own communities to:

- Improve their ability to measure client health outcomes
- Create the strategic partnerships necessary to build a local HIV Housing Care Continuum
- Utilize local data to benefit clients by demonstrating the link between housing and health and engaging in cross-system advocacy efforts.

Local Strategies for Using Your HIV Care Continuum

Rusty Bennett, CEO of Collaborative Solutions Inc., spoke on housing, homelessness, and health for people living with HIV/AIDS. As part of HUD’s HIV Housing Care Continuum Initiative, Collaborative Solutions Inc. developed an HIV Housing Care Continuum Implementation Workbook. The Workbook highlights the following strategies for using your HIV Care Continuum at the local level:

- Support the use of surveillance data to identify people out of care and link them to and engage them in care.
- Use your Continuum as a tool for sharing progress towards addressing the epidemic in your community.
- Research new approaches to help people stay in care and adhere to their medication through structural interventions, such as housing.
- Employ your Continuum as a program planning tool to determine where improvements are most needed and target resources accordingly in your agency.
- Develop an education campaign to help health care providers integrate simple prevention approaches into routine care for people living with HIV, as well as advocate for increasing HIV testing.
- Utilize your Continuum as a community planning tool to galvanize the community to address the gaps and needs of PLWHA in your community.
Session 3: HIV, Health Care, and Housing Delivery

4 Viral suppression means that HIV is undetectable in lab tests.
6 HOPWA refers to the Housing Opportunities for Persons with AIDS Program, a federal program dedicated to the housing needs of people living with HIV/AIDS.
9 Ibid.
19 Sometimes also referred to as the HIV treatment cascade.
HIV, Health Care, and Housing Delivery
Session 3

Housing with health care stabilizes health conditions
A study of 6,558 cases of persons diagnosed with AIDS who survived five years

| Participants in supportive housing | 81% |
| Participants without housing      | 67% |

HIV/AIDS is correlated with homelessness
In a service needs survey conducted in 2015, 21.8% of HIV+ respondents indicated that they were homeless at some point in the year prior.

PLWHA in Washington, D.C., who retained health care in 2014

| HOPWA clients | 93% |
| All PLWHA     | 73% |

A study of HIV+ persons who achieved viral suppression, 2014

| Stably housed | 84.4% |
| Unstably housed | 45% |
Medical practices for PLWHA have improved

Over half of PLWHA were virally suppressed in 2016.

In 2016, three in four persons diagnosed with HIV were linked to care within one month.

In D.C., the number of new HIV diagnoses dropped by 72% in eight years.

Minority groups in D.C. are disproportionately affected

The rate of black males living with an HIV diagnosis is 2.8 times white males.

The rate of Hispanic males living with an HIV diagnosis is 1.4 times white males.

The rate of Hispanic females living with an HIV diagnosis is 6.4 times white females.

The rate of black females living with an HIV diagnosis is 27.4 times white females.
Data sources

**HIV/AIDS is Correlated with Homelessness**

**Housing with Health Care Stabilizes Health Conditions**


**Medical Practices for PLWHA Have Improved**


**Minority Groups in D.C. Are Disproportionately Affected**
Violence is a major public health issue. Like an epidemic, violence spreads from person to person, but it can be successfully contained with fast and appropriate treatment.

**STRATEGY 1**

Collect and utilize data on the effectiveness of anti-violence programs and on the cost savings to the health care system of treating and preventing violence by working with researchers to map violence in D.C. and demonstrate on a local level that violence behaves like an infectious disease.

- **Violence behaves like an epidemic.** The most important predictor of violence is whether someone was recently exposed to intense violence in his or her neighborhood or home. Like smallpox, influenza, tuberculosis, and malaria, violent attitudes and behaviors spread from person to person. Violence “causes something of itself to be communicated, causing another person to take on some of the same characteristics.”¹ One reason that violence often begets violence is that trauma “causes dysregulation in the limbic system and prefrontal cortex leading to hypervigilance and hostile attribution to perceived insults,” which can make people more likely to draw a weapon in response to ordinary low-level social conflicts. Notably, violence spreads across categories: Domestic violence can increase the risk of gang violence, and vice versa.

**STRATEGY 2**

Serve as an incubator for anti-violence community programs and investors in anti-violence initiatives; shift the focus of investment to violence prevention; work with medical schools to include violence interventions in their curricula; and connect with and support the National Network of Hospital-Based Violence Intervention Programs.

- **Homeless populations are at higher risk of violence.** The experience of homelessness deprives people of a safe place that they can use to withdraw from conflicts. When “activities of daily life” such as sleeping and urinating are criminalized, people experiencing homelessness may also be unable to get help from law enforcement.
  
  - The highest rates of violence against the homeless population are found in Florida and California, which also have some of the most severe anti-camping, anti-panhandling, and anti-foodsharing laws. Laws that effectively criminalize homelessness send a message to the general public that “homeless people do not matter and are not worthy of living in our city.”²
  
  - The National Coalition for the Homeless has documented 1,437 reported acts of violence against homeless individuals in the last 15 years. Three hundred and seventy five of the victims died as a result of the attacks.
  
  - Violence against people in unstable housing situations is common and multidimensional. A recent study of homeless families in three types of housing programs found that 93 percent of mothers experienced at least one trauma, and 81 percent experienced multiple traumatic events. Violent victimization was the most common traumatic experience; 70 percent reported being physically assaulted by a family member or someone they knew.
• **Violence is a major public health issue.** Direct and indirect exposure to violence not only results in huge immediate health care costs, but also predisposes people to develop chronic illnesses like cancer, heart disease, and diabetes. Violence is one of the leading causes of death for anyone under the age of 45, and it is the single most common cause of death among African American men.³
  
  – **Gunshot wounds occupy much of the attention of local emergency rooms.** Almost 720 shooting victims are taken to Baltimore area emergency rooms each year. Fifteen percent of them die in the emergency room.⁴
  
  – **Violent environments weaken people’s resistance to chronic diseases.** Exposure to multiple forms of violence as a child is associated with a 2.2 times greater risk of heart disease, 2.4 times greater risk of stroke, and 3.9 times greater risk of lung disease.⁵

**STRATEGY 4**

Create mediator and community health worker positions to de-escalate and prevent violence throughout the community, including in both housing and health care settings.

• **We know how to “cure” violence.** Several American cities have decided to treat violence as a public health issue by swiftly deploying large numbers of trained mediators to de-escalate and prevent outbreaks of violence whenever violence is reported. These programs have been dramatically successful in reducing the frequency of shootings and homicides in the communities where they have been deployed.⁶ The Johns Hopkins Center for the Prevention of Youth Violence, an Academic Center of Excellence founded by the CDC in 2000, collaborates with community organizations and residents on a “multisectoral public health framework,” including school-based prevention programs that “prevent violence and bullying and promote safe and supportive environments.”⁷

**STRATEGY 5**

Collaborate with community organizations and residents to develop a multi-sectorial public health framework to prevent and treat violence by standardizing the best practice response to violence among related systems (hospitals, health centers, schools, law enforcement, etc.) and investing in school-based violence prevention programs.
# Health Care Strategies for Preventing and Ending the Transmission of Violence

Shannon Cosgrove, Director of Health Policy at Cure Violence, spoke on preventing the transmission of violence as a health issue. Cosgrove highlighted the following strategies for the health care system to prevent and end the transmission of violence:

- Develop common understanding and language among health and community groups, leaders, and sectors to greatly elevate violence as a health issue.
- Increase policies to support health approaches to violence prevention.
- Change practices to increase the utilization of health and community solutions to violence prevention.
- Examine opportunities for the health approach to advance racial and health equity.
- Develop additional multi-sector partnerships and coalitions to strengthen the movement and its relationship to community, criminal justice reform, and racial equity.

## Strategies for hospitals, doctors, nurses, and other health professionals

- Implement measures to properly detect and treat violence.
- Conduct assessments of the types, severity, and amount of violence treated.
- Identify available resources in community.
- Assess potential and prevention of potential retaliations with prevention professionals.
- Provide treatment and follow-up for victims and their families suffering the trauma of violence.
- Integrate with community outreach.

## Strategies for universities and schools of public health

- Conduct research on impact and methods of violence.
- Develop curriculum and train local leaders.
- Hold forums to disseminate and advance the evidence.

## Strategies for communities affected by violence

- Implement community health worker strategies.
- Link to health departments and other government agencies to manage programs that treat violence as a health issue.
- Hold systems accountable and ensure work is community led.

## Strategies for state, county, and city health departments

- Implement epidemic control programs.
- Assess and analyze data from hospitals, police, etc.
- Identify and disseminate evidence-based strategies.
- Lead social marketing efforts to change norms.
- Assess impact of strategies and refine practices.
- Hold systems accountable and create incentives.

## Strategies for insurers

- Reimburse prevention professionals.
- Hire staff to work with victims and families inside and outside of health systems.
- Train all staff in trauma-informed care and create accountability metrics.
- Conduct case reviews.
- Lead the perspective transformation by leading campaigns.
- Partner with local leaders to invest.
AmeriHealth Caritas Leadership Meeting February 23, 2017

Case studies

**STRATEGY 6**

Provide training for all staff positions in the health care system (receptionist, case manager, Care Coordinator, doctor, nurse, etc.) on addressing violence as a health issue, trauma-informed care and accountability metrics, mitigation and de-escalation tactics, and addressing stigma and discrimination when providing care to victims of violence.

**STRATEGY 7**

Leverage Medicaid for helping prevent and cure violence by advocating with local Medicaid agencies to ensure violence prevention is a covered service; helping schools bill Medicaid for reimbursement of school-based health services; partnering with Medicaid outreach to conduct enrollment at jails, prisons, and youth corrections facilities; and working to ensure Medicaid and related benefits are seamlessly reinstated for recently released institutionalized or incarcerated members.

California: Opening violent leaders’ minds with travel and fellowships. Richmond, California, was once ranked as the sixth-deadliest city in America for gun violence, averaging about 32 homicides per year, i.e., over eight times the national average. After decades of failing to make progress against crime using traditional methods, Richmond turned to consultant Devone Boggan to implement a creative new approach: Boggan and his team of data scientists attempt to identify the 50 people in Richmond who are most likely to commit acts of violence. These people are then targeted with positive reinforcement, including job training and assistance with GEDs and driver’s licenses. More controversially, the program also offers its potentially violent clients a small monthly stipend (ranging between $300 and $1,000) for successfully completing the program’s goals. Finally, Mr. Boggan himself “personally takes pairs of young men who consider each other enemies in the context of Richmond outside the city in the hopes that they will resolve their differences.” As he put it, “It’s hard to be in South Africa, on Robben Island, in Mandela’s prison cell, with your enemy from Richmond and that not have a life-changing impact.” The Harvard Political Review credits Mr. Boggan’s Office of Neighborhood Safety with a 76 percent reduction in firearm homicides since the program’s 2007 implementation.

**STRATEGY 8**

Partner with the new D.C. Office of Neighborhood Safety and Engagement (ONSE), with a focus on the health care needs of program participants, by ensuring hospitals, managed care organizations, and health care providers are connected to ONSE and to the Deputy Mayor’s violence prevention networks and crisis teams and work with a Community Crime Prevention Team to connect with members with unmet housing, health, and safety needs.

District of Columbia: A new Office of Neighborhood Safety and Engagement (ONSE). In February 2016, the DC Council “voted unanimously to approve a comprehensive public safety omnibus bill,” which includes funding for “a new Office of Neighborhood Engagement to identify teenagers and young adults at the highest risk for committing or being a victim of violent crimes.” The new Office will be explicitly modeled after the successful program in Richmond, California, providing a stipend in exchange for participation in “life planning, trauma-informed therapy, and mentorship.” The program will also establish a Community Crime Prevention Team to connect police officers with mental health clinicians and housing outreach specialists from the Department of Behavioral health and Human Services to better serve people who are “in regular contact with the police due to unmet healthcare and housing needs.” Although Mayor Muriel Bowser is skeptical of the program and would prefer a more traditional tough-on-crime approach, Professor Daniel Webster of the Johns Hopkins School of Public Health calls the model “intriguing,” noting that “ex-convicts face immediate financial needs after release, including housing and often renewed commitments to child support, but have limited employment prospects to meet those obligations.” Hopefully, the ONSE will help Washington, D.C., residents meet those obligations and break the cycle of violence.
STRATEGY 9

Start the conversation among partners about a standardized response to identifying, preventing, and curing violence; provide education to providers on available resources and methods to prevent and treat violence, establish safety interventions, and provide culturally-competent, trauma-informed care for patients affected by violence; develop standardized assessment tools and protocols to identify the type, severity, and amount of violence experienced by members; utilize the Adverse Childhood Experience (ACE) questionnaire as an assessment tool in schools, community centers, and among providers; code patient records consistently to track violence; and conduct individual member case reviews with a violence-conscious lens.


13. Ibid.

Housing and Health Care: Violence Interventions
Session 4

Public health approaches to preventing violence

**Chicago**
Districts in Chicago targeted by CeaseFire Chicago (now Cure Violence) experienced a 31% reduction in homicides.

**Baltimore**
The Safe Streets program was associated with 40 fewer shooting incidents during 112 cumulative months of intervention in Baltimore.

**Minneapolis**
Minneapolis documented a 40% drop in juvenile crime in its most violent neighborhoods within two years of implementing its approach Blueprint for Action.

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A recent study of mothers experiencing homelessness found that...

- **93%** experienced at least one trauma.
- **82%** experienced trauma in adulthood.
- **81%** experienced multiple traumatic events.
- **91%** experienced trauma in both childhood and adulthood.
- **79%** experienced trauma in childhood.
Violence prevention as a health issue

1981
CDC epidemiologists begin one of the first collaborative efforts with law enforcement to investigate a series of child murders in Georgia.

1992
CDC receives its first congressional appropriations for youth violence prevention.

2000
CDC receives a congressional appropriation to establish 10 National Academic Centers of Excellence for Youth Violence Prevention.

2007
CDC publishes a study that estimated the medical and productivity-related costs of violence in the United States exceed $70 billion each year.

2013
President Obama releases his plan directing CDC and other scientific agencies to conduct research into the causes and prevention of gun violence in Now Is The Time.
Data sources

Violence Clusters Like an Epidemic


Public Health Approaches to Preventing Violence


Violence Prevention as a Health Issue

Barbara DiPietro, Senior Director of Policy at the National Health Care for the Homeless Council, spoke on the intersection of health, housing, and homelessness at the Health Is More Than Health Care meeting. DiPietro highlighted six strategies for improving the delivery of health care to individuals experiencing homelessness:

**STRATEGIES**

1. **Invest in support staff to engage members in systems of care.**
   Support staff, including outreach staff, case managers, behavioral health consultants, peer support specialists, and community health workers, are vital for engaging members in an appropriate venue of care. Roles for support staff include engaging members in the emergency room, providing documentation support, assisting in care coordination, helping schedule transportation and appointment arrangements, and facilitating referrals.

2. **Reimburse for medical respite services.**
   Medical respite reduces length of stay and readmission for individuals experiencing housing instability, resulting in better health outcomes.

3. **Reimburse for supportive housing services.**
   Managed care plans can invest in case management supports and wraparound services to ensure that housing solutions for members are stable and successful.

4. **Re-evaluate prior authorization policies.**
   To remove barriers to care, health care providers must re-evaluate how, when, and under what conditions prior authorizations are required. This includes taking steps to streamline referrals and re-evaluating the onus on providers to secure referrals.

5. **Incentivize health care providers to document homelessness using ICD-10 code Z.59.0.**
   The ICD-10 code for homelessness, Z.59.0, is currently under-utilized by health care providers. Incentivizing providers to document homelessness via ICD-10 code Z.59.0 would improve the ability of providers and managed care plans to identify and locate members experiencing homelessness and provide appropriate housing supports.

6. **Implement technology that facilitates expanded access to care.**
   Health care providers should engage with alternative methods of communication and service delivery for individuals experiencing homelessness. Mobile technologies, such as electronic consultation services with specialists, allow providers to serve vulnerable populations who are unlikely to self-present at a medical clinic.