

## **Hennepin Health- Housing Navigation Services**

Since 2012, housing has consistently been identified as a top barrier to improving the health of Hennepin Health's members. Acknowledging the link between housing instability and expensive health care utilization, Hennepin Health began to include housing interventions in its approach to care coordination and service integration. Through care coordination efforts, this health reform initiative strives to improve quality of care and patient experience while lowering overall costs. Interventions to address housing instability include the Hennepin Health Social Services Navigation Team and Hennepin Health's partnerships with the Minneapolis Public Housing Authority and the Hennepin County's Heading Home Hennepin initiative.

The social service navigation focuses on finding housing for homeless members or those with unstable housing. They complete the Life Style Overview document and a housing referral form and work in conjunction with the clinic care coordination staff to find housing options to meet the member's need. By partnering with the Minneapolis Public Housing Authority (MPHA), Hennepin Health leases up to eight interim housing units from MPHA in the Elliot Twins building in Minneapolis' Elliot Park neighborhood. The units are reserved for Hennepin Health members who are homeless and either in inpatient care or have recently discharged from inpatient care. Members identified with high risk for hospital re-admission due to lack of housing and social supports receive up to 90 days of housing. While there, they receive in-home nursing and/or case management support services to address their medical or mental health needs. The social service navigation team then assists the member with securing longer-term supportive housing placement. The partnership with Hennepin County's Human Services and Public Health Department (HSPHD) is another way to reduce housing instability. Their involvement ranges from contracts with shelter and group residential housing providers to large-scale efforts to address homelessness via efforts such as Heading Home Hennepin, a 10-year plan to end homelessness in Minneapolis and Hennepin County by 2016. Heading Home Hennepin connects with over 120 local nonprofit organizations, government agencies, businesses, faith-based alliances and concerned citizens allowing Hennepin Health to have access to multiple housing resources.

### **Rationale**

As outlined in the Minnesota HIV Epidemiological Profile – General Minnesota Demographics report, homelessness is also seen as a social determinant of health. In 2012, an estimated 10,214 people were homeless in Minnesota. According to the 2012 Wilder Homelessness Survey, this number has increased by 10 percent since 2009 with the largest reported increase among persons age 55 years and older (48% increase). Despite this increase of homelessness

among older people, persons age 21 and under still account for the largest proportion of homelessness (46%).

According to the Wilder 2012 Minnesota Homeless Study, Hennepin County had 4,316 homeless individuals which was an increase of nearly 7% from 2009 when 4,035 individuals were homeless. As reported in the Housing + Health Innovations in the Field (National Housing Conference, Center for Housing Policy (June 2015) Hennepin Health serves over 10,000 members. Approximately 30 to 50 percent of this population has unstable housing or is homeless or living in a homeless shelter.

### Objectives

Housing has consistently been identified as a barrier to improving the health of Hennepin Health's members. Utilizing care coordination to address the social determinants of health that drive health care utilization, this initiative strives to improve quality of care while lowering overall costs.

### Methodology

According to Hennepin Health's Housing Navigation Results Summary (June 2015), when primary care clinic-based care coordination teams identify that a medically complex or frequently-hospitalized member is experiencing homelessness or is precariously housed, they make a referral to Hennepin Health's social service navigators. The navigators assess each member's situation and match them to available supportive housing options.

The results are determined by comparing the rate at which 123 members who were housed through housing navigation from 2012 through mid-2014 who used the emergency department, the psychiatric emergency department, were admitted to an inpatient hospital, and used outpatient clinic visits prior to and following their housing placement. Utilization rates are reported on a per 1000 member month basis, and the pre-and post-periods are each 12 months in duration. To be included in the evaluation, members needed a minimum of three months in both the pre and post periods. All outcomes are calculated from the electronic health record data.

### Findings

Hennepin Health members housed through housing navigation services saw significant reductions in acute care utilization following placement as demonstrated in Table 2 below.

Table 2: Members housed through Housing Navigation Services

Activity	12 Months Pre-Housing	12 Months Post-Housing	% Change
Inpatient Admissions/1000	33.2	27.8	-16.27%
ED Visits/1000	151.1	98.9	-34.55%
Psychiatric ED Visits/1000	14.9	12.2	-18.12%
Outpatient Visits/1000	4140	5008	20.97%

Of the 123 members who were housed through housing navigation from 2012 through mid-2014, the results are as follows:

- Members were admitted to a hospital 16% less often after placement in housing.
- Members visited the ED 35% less often after placement in housing.
- Members visited the psychiatric ED 18% less often after placement in housing.
- Members received outpatient clinic visits 21% more often after the placement in housing.

In 2014, there were 55 referrals for housing with 26 members (47.27%) being housed through social service navigation services.

#### Conclusions

The social service navigation team members attend case consultations and team meetings throughout partner locations and are integral to the quality of care coordination throughout service transitions. Hennepin Health members housed through housing navigation services saw significant reductions in acute care utilization following placement which in turn led to reduced associated health care costs. There may be limitations with the data. Given that participants are prioritized for housing due to medical complexity and high utilization, some of the observed reductions may be explained by a natural regression to the mean. Results are unadjusted observations and may not be repeatable or generalizable.

Housing needs for a subset of Hennepin Health’s members may continue to be difficult for members who use drugs, alcohol and/or have a felony conviction as this can exclude them from several housing options such as subsidized housing (“Section 8”). Even with these challenges, Hennepin Health’s social services navigation team and clinic care coordination staff continue to influence the HSPHD’s extensive housing network to find members an immediate bed for the night, short-term housing options and long-term rentals while also influencing the development

of new housing that meets the needs of its members.

### Recommendations

Families experiencing homelessness are under significant stress and often live in a day-to-day survival state which can have an impact on family and child health. One way Hennepin Health can address the needs of homeless families is through its partnership with HSPHD's Healthcare for the Homeless clinics at People Serving People and Mary's Place, two family shelters located in downtown Minneapolis and at YouthLink, a drop-in center for homeless youth. All of these clinics share Hennepin Health's EPIC health record, which lends itself to seamless care coordination between primary care clinics and social service programs.

One pilot program at People Serving People is a grant-funded initiative to provide prenatal support and education services. The prenatal classes are held in the shelter to build peer support and a sense of community among homeless pregnant women, and provide them with an opportunity to share their experiences. Holding classes at the shelter also increases access, and eliminates barriers such as transportation and child care.

Recommendations include providing housing and social service navigation to families that are at high risk due to medical fragility and complexity.

### Sustainability

Programs such as this do not have a sustainable funding source, despite their potential for future cost savings. Hennepin Health's financial and governance structure allows flexibility to support such programs as part of the health benefit and reinvestment into the system.

Hennepin Health has funded a reinvestment initiative for Employment Pays Housing Navigation. The project provides a .75 full time equivalent (FTE) employee to provide housing navigation to employed clients wishing to use HOME vouchers to find a suburban landlord to rent an apartment from.

There are challenges for sustaining the activity as there are not enough Group Residential Housing (GRH) beds and other affordable housing units available to meet the demand among Hennepin Health members. There is also a shortage of units with supportive services for individuals with complex needs. Another challenge in addressing the housing needs of Hennepin Health members is the difficulty of investing in permanent affordable housing for its members as people go on and off the health plan frequently and once off the health plan, they would no longer be eligible for housing.