RUTGERS

Connecting Health and Homeless Services for Medicaid Beneficiaries

Presentation to Monarch Housing Associates Conference

Housing as a Human Right: from Innovation to Impact

October 9, 2024

Acknowledgements

This project is supported by the **Robert Wood Johnson Foundation**. Project data were assembled under a grant from the **National Institute on Minority Health and Health Disparities** (R01MD01261).

The New Jersey **Division of Medical Assistance and Health Services** (Medicaid) and New Jersey **Housing and Mortgage Finance Agency** provided data essential to achieving our project goals.

We thank Rutgers colleagues Dan Treglia, John Palatucci, and Margaret Koller for their advice, insights, and support.

We are grateful our project **Steering Committee** members from the community, service organizations, and state agencies for their advice and guidance.

The content of this presentation is solely the responsibility of the authors and does not necessarily represent the official views of the Robert Wood Johnson Foundation, National Institutes of Health, the NJ Division of Medical Assistance and Health Services or the NJ Housing and Mortgage Finance Agency.

Our Team

RUTGERS HEALTH
Center for State Health Policy

Joel C. Cantor*
Michael Yedidia
Jolene Chou
Jose Nova
Joanna Chen

RUTGERS UNIVERSITY
School of Social Work

Emmy Tiderington*
Nora Sullivan

monarch
HOUSING ASSOCIATES

Taiisa Kelly
Nadine Azari

*Co-principal investigators

Project Overview

Goals

- Promote collaboration between homeless services and health care providers
- Engage policymakers and other stakeholders to reduce barriers to better care for people experiencing homelessness (PEH)

Study Activities

- Interviews to learn from **voices of PEH and health care challenges**
- Interviews to describe experiences of **people developing cross-sector programs**
- **Data visualizations** to identify opportunities to promote action to address homeless services gaps

Project Overview

Goals

- Promote collaboration between homeless services and health care providers
- Engage policymakers and other stakeholders to reduce barriers to better care for people experiencing homelessness (PEH)

Study Activities

- Interviews to learn from **voices of PEH and health care challenges**
- Interviews to describe experiences of **people developing cross-sector programs**
- **Data visualizations** to identify opportunities to promote action to address homeless services gaps

Findings

VOICES OF PEOPLE EXPERIENCING HOMELESSNES AND HEALTH CARE CHALLENGES

Data Collection

- N=23 interviews
- Conducted July 2023-February 2024
- Inclusion criteria: People who are experiencing or have recently experienced homelessness and have dealt with complex health needs within the healthcare system

Research Questions

1. What challenges do unhoused people with complex health needs experience when navigating services at the intersection of healthcare/housing?

2. What strategies do they identify for improving services at the intersection of healthcare/housing?

Challenges

- THEME 1 - Personal priorities not always aligned with system priorities/resources
  - "*My immediate concern was housing, not veterans' affairs. My immediate concern was housing, it wasn't my health. My health was secondary.*"
- THEME 2 - Cross-sector experiences occur, but seamless integration between housing/health systems has yet to be realized
  - "*I didn't expect them to even ask like, why are you asking [about healthcare?] when I need housing?*"
  - *Interviewer: In the housing service providers that you've been involved with, have you ever been asked whether you needed help with health care?*
    Interviewee: "That's more, yeah, that's more likely to happen."

Challenges

- THEME 3 – Programmatic and provider-related barriers to services and integration
  - *“It's just, you know, to make an appointment with a specialist in my insurance plan, I gotta schedule out a whole half a day or even a whole day for 10 minutes with the doctor, for him to write a prescription.”*
- THEME 4 - Some supports are positive but can’t solve systemic failures
  - *“How do you live on $700 with two children?”*
  - *“There's no way out of this loop of hospital and shelter, hospital and shelter.”*

Strategies

- THEME 1 – Modernizing and centralizing care
  - *“We are in 2023. We are still living in the 1990s on resources and paper and scanned in PDF.”*
  - *“I know people that have Section 8 housing vouchers, but they don't know who to talk to about getting the housing. And talk to one person and they'll give them the runaround and, you know, they give them numbers to another place.”*

- THEME 2 - Prioritizing hassle-free in-person care, with virtual options as needed
  - *“They really don't want you coming in there to social services. They want you to do everything over the phone and everything online.”*
  - *“Well, the thing is you have to go, you have to figure out a trip plan…I gotta schedule out a whole half a day or even a whole day for 10 minutes with the doctor, for him to write a prescription.”*

Strategies

- THEME 3 – Increased sensitivity from providers and other efforts to decrease stigma against service recipients
  - *“The staff really doesn't treat us good, but I feel like I'm an animal sometimes, the way they treat us, and the way that they talk to us.”*
  - *“They don't even want to give you medication. You just suffer because of your situation. If you're homeless, they really don't want to give you anything.”*
  - *“I get treated differently sometimes because of the fact that I am a black single mother, and I don't have the male counterpart to assist me.”*

Discussion
Voices of People Experiencing Homelessness

- Impacts of COVID-19 -- Tension between modernizing and returning to in-person services
- Services are most impactful when targeted to the individual and coming from capable, sensitive providers
- Systemic challenges both compromise service delivery and pit people against one another for services – cross-sector services should be designed with this in mind
- Further research is needed to identify specific gaps in different sectors

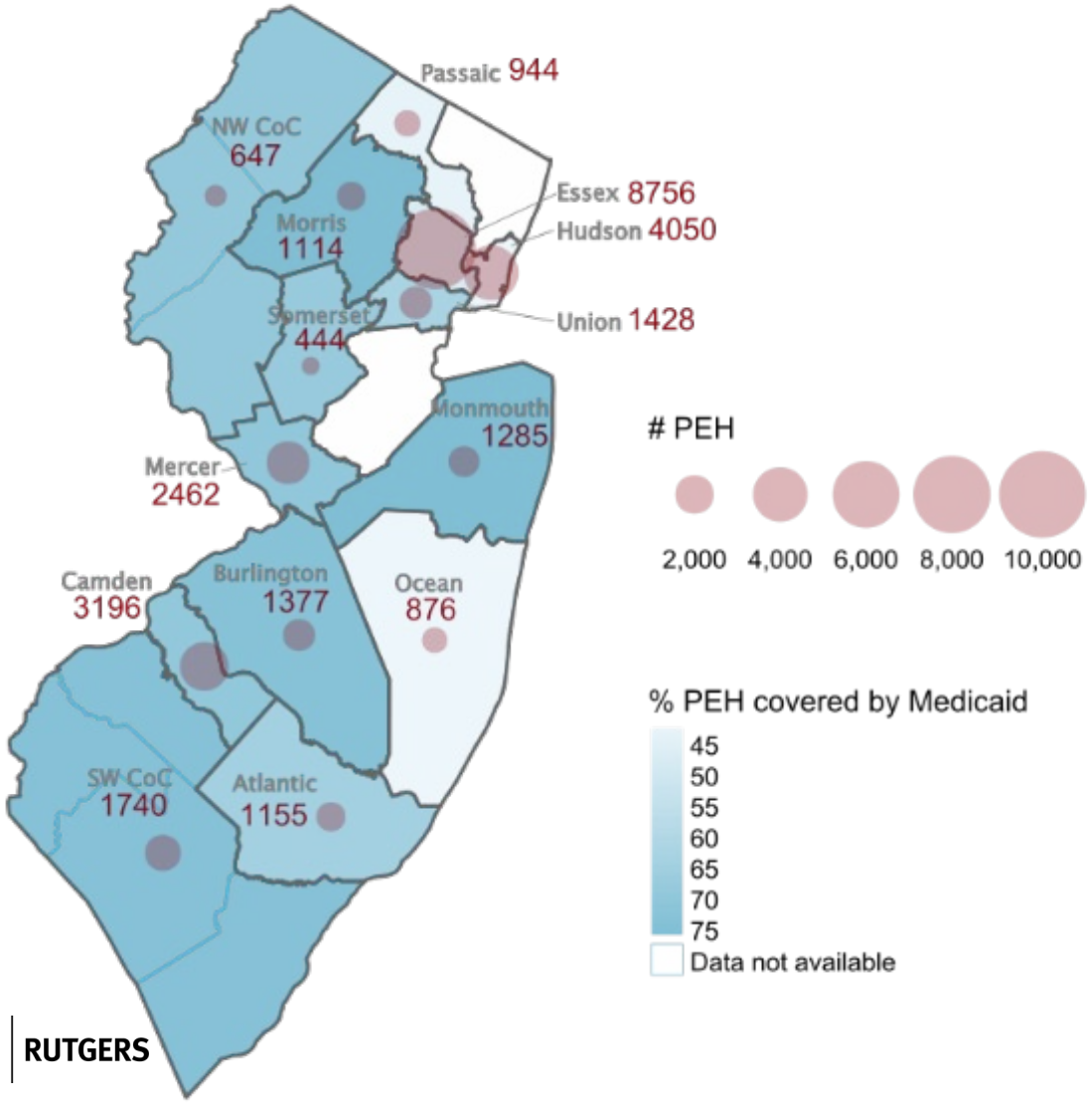
Findings

DATA VISUALIZATIONS

What We Did

- Link Homeless Management Information System (HMIS) data to Medicaid claims/encounter records for 2022
  - Client-level linkage
  - 19 of 21 counties (exclude Bergen and Middlesex Cos)
- Limit to adults, age 18+
- People experiencing homelessness (PEH) defined as users of any of five HMIS-recorded services during the year
  - Emergency shelter
  - Day shelter
  - Safe haven
  - Street outreach contact
  - Transitional housing
- Most analyses limited to Medicaid-enrolled PEH
- Data shown by modified HUD Continuums of Care (CoCs) & for selected hospitals
- Health measures drawn from Medicaid data

Homeless Service Users and Medicaid Enrollment Across CoCs



CoC	County	# PEH	PEH Covered by Medicaid #	PEH Covered by Medicaid %
NJ-509	Morris	1114	845	75.9%
NJ-508	Monmouth	1285	971	75.6%
NJ-503/512	SW CoC [2]	1740	1274	73.2%
NJ-502	Burlington	1377	1005	73.0%
NJ-514	Mercer	2462	1717	69.7%
NJ-503C	Camden	3196	2217	69.4%
NJ-516	NW CoC [3]	647	447	69.1%
NJ-513	Somerset	444	301	67.8%
NJ-500	Atlantic	1155	742	64.2%
NJ-515	Union	1428	890	62.3%
NJ-504	Essex	8756	4186	47.8%
NJ-511	Passaic	944	404	42.8%
NJ-506	Hudson	4050	1665	41.1%
NJ-510	Ocean	876	358	40.9%
All CoCs [1]		29540	17022	All CoCs: 57.8%

[1] Excludes Bergen and Middlesex counties
[2] SW CoC includes Gloucester, Salem, Cumberland, and Cape May counties
[3] NW CoC includes Warren, Sussex, Hunterdon counties

RUTGERS

Prevalence of Behavioral Health and Other Chronic Condition Diagnoses, per 1,000 PEH

CoC*	Serious mental illness (SMI)	Substance use disorder (SUD)	3+ non-BH chronic conditions
Burlington	200	252	75
Mercer	391	476	101
SW CoC[2]	412	478	106
Somerset	455	488	59
Union	378	407	130
Hudson	422	483	124
Passaic	435	485	121
NW CoC[3]	467	498	109
Essex	472	516	114
Monmouth	491	530	128
Ocean	634	608	108
Morris	536	578	124
Camden	497	544	159
Atlantic	598	675	142
All CoCs[1]	449	500	119

Top quartile (lowest)*
2nd quartile
3rd quartile
Bottom quartile (lowest)

*Shorted by highest to lowest mean rank for individual measures

[1] Excludes Bergen and Middlesex counties

[2] NW CoC includes Warren, Sussex, Hunterdon counties

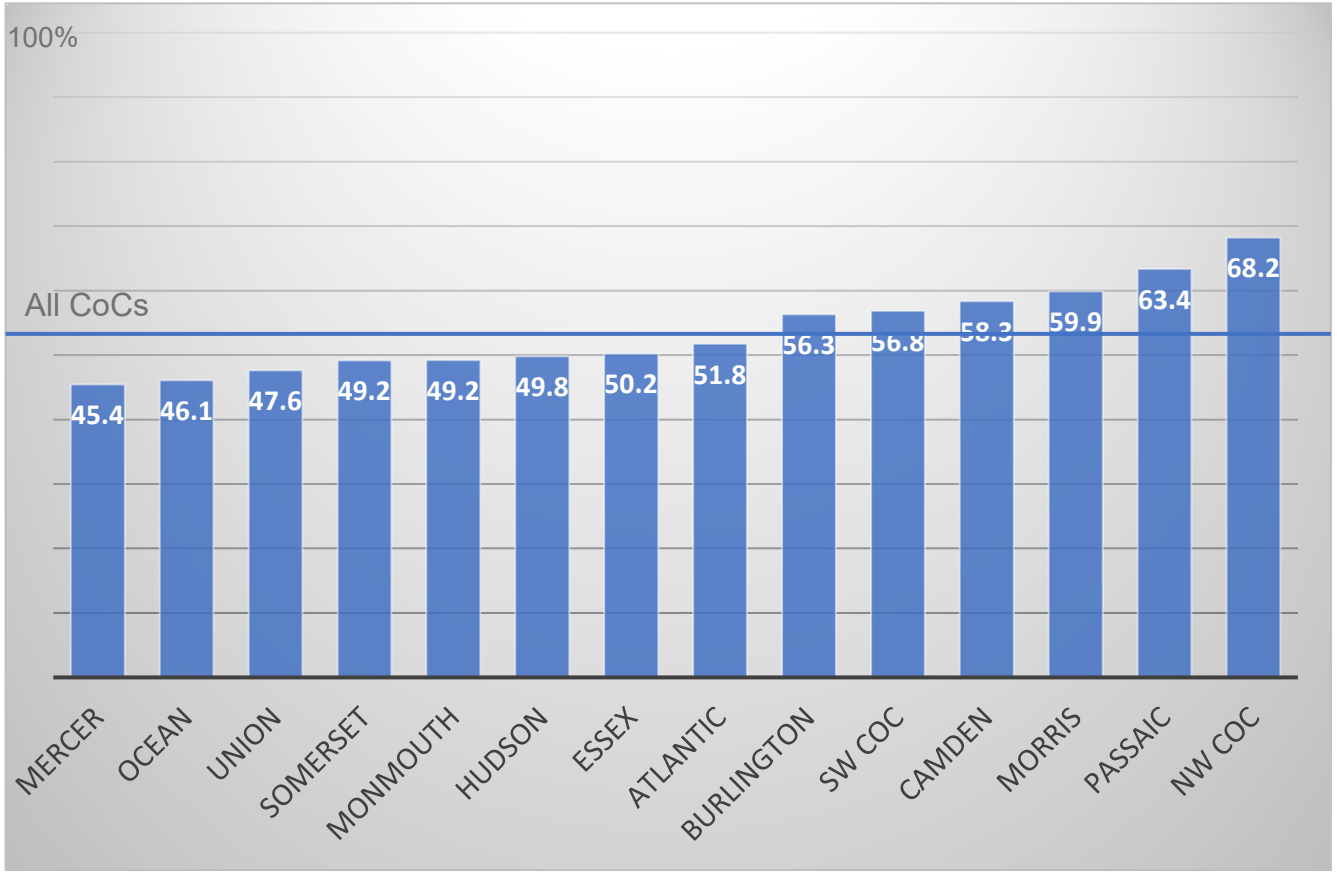
[3] SW CoC includes Gloucester, Salem, Cumberland, and Cape May counties

Key Takeaways

- High rates of SMI, SUD and multiple chronic conditions in all CoCs.
- Wide variation across CoCs in SMI (2.2-fold), SUD (1.7-fold) and multiple chronic conditions (1.7-fold).
- CoCs high in one type of morbidity tend be high the other two.

RUTGERS

Percentage of PEH with at Least One Primary Visit



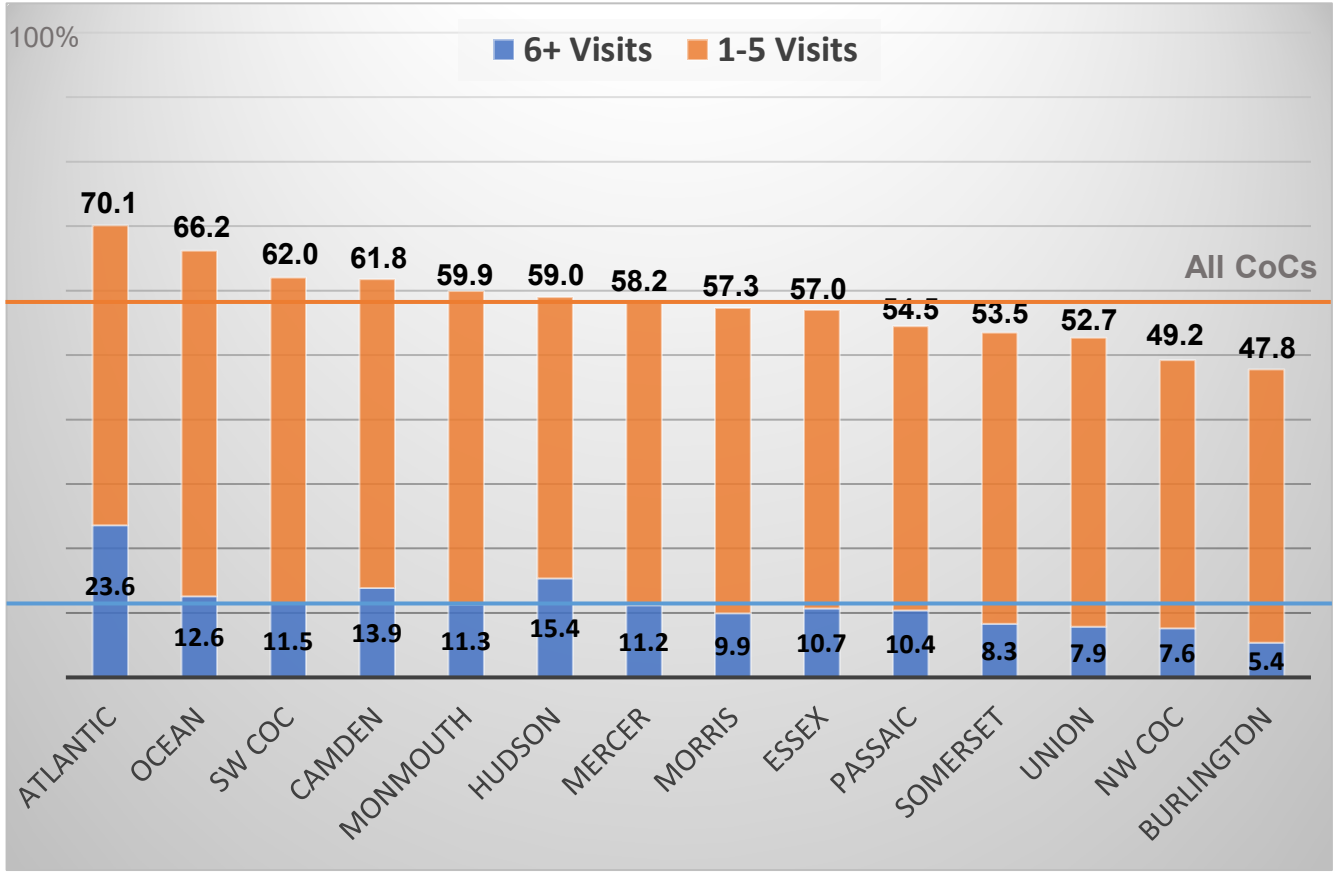
Excludes Bergen and Middlesex counties
NW CoC includes Warren, Sussex, Hunterdon counties
SW CoC includes Gloucester, Salem, Cumberland, and Cape May counties

Key Takeaways

- Room to improve Primary Care access in all CoCs.
- Highest region (NW CoC) has primary care visit rate 1.5 times greater than lowest region (Mercer Co).

RUTGERS

Percentage of PEH with Emergency Department (ED) Visits, Any and Frequent Utilization



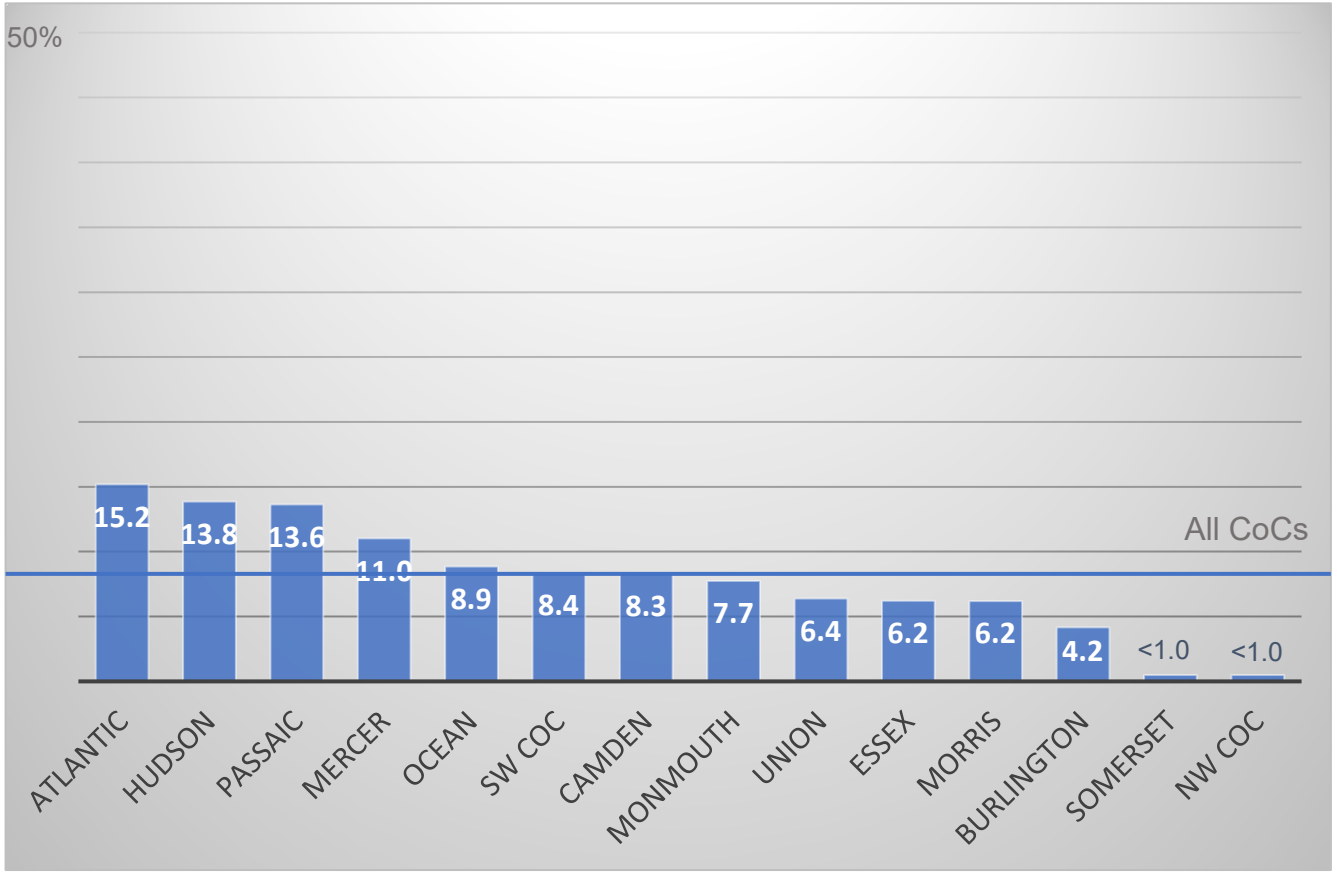
Excludes Bergen and Middlesex counties
NW CoC includes Warren, Sussex, Hunterdon counties
SW CoC includes Gloucester, Salem, Cumberland, and Cape May counties

Key Takeaways

- In most CoCs, over half of PEH visited an ED at least once.
- Atlantic Co. stands out as having the highest frequent ED use rate, nearly 1 in 4 PEH.
- Atlantic, the highest region, had an overall ED visit rate 1.5 times higher than Burlington, the lowest region.
- Hudson, Camden, and Ocean also have above average frequent ED use rates.

RUTGERS

Percentage of PEH ED Users with a Shelter Admission or Street Outreach Contact* within 72 Hours



Excludes Bergen and Middlesex counties
NW CoC includes Warren, Sussex, Hunterdon counties
SW CoC includes Gloucester, Salem, Cumberland, and Cape May counties

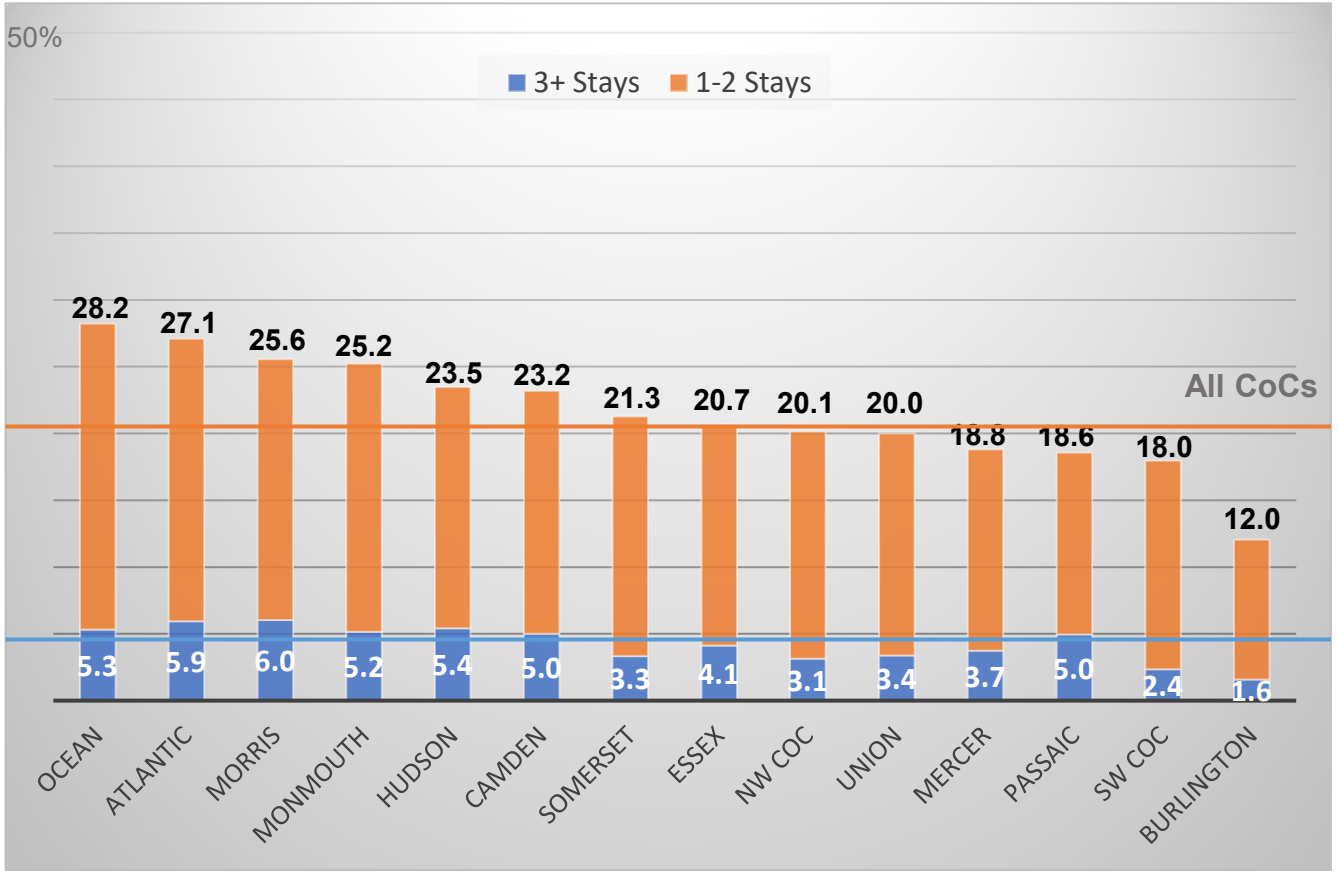
Key Takeaways

- Wide variation in the share of ED users returning to homeless services across CoCs.
- Atlantic, Hudson, Passaic and Mercer have over 10% of PEH ED users returning to a homeless service within 72 hours.

*About 90% shelter, 10% street outreach

RUTGERS

Percentage of PEH with Hospital Inpatient Stays, Any and Frequent Utilization



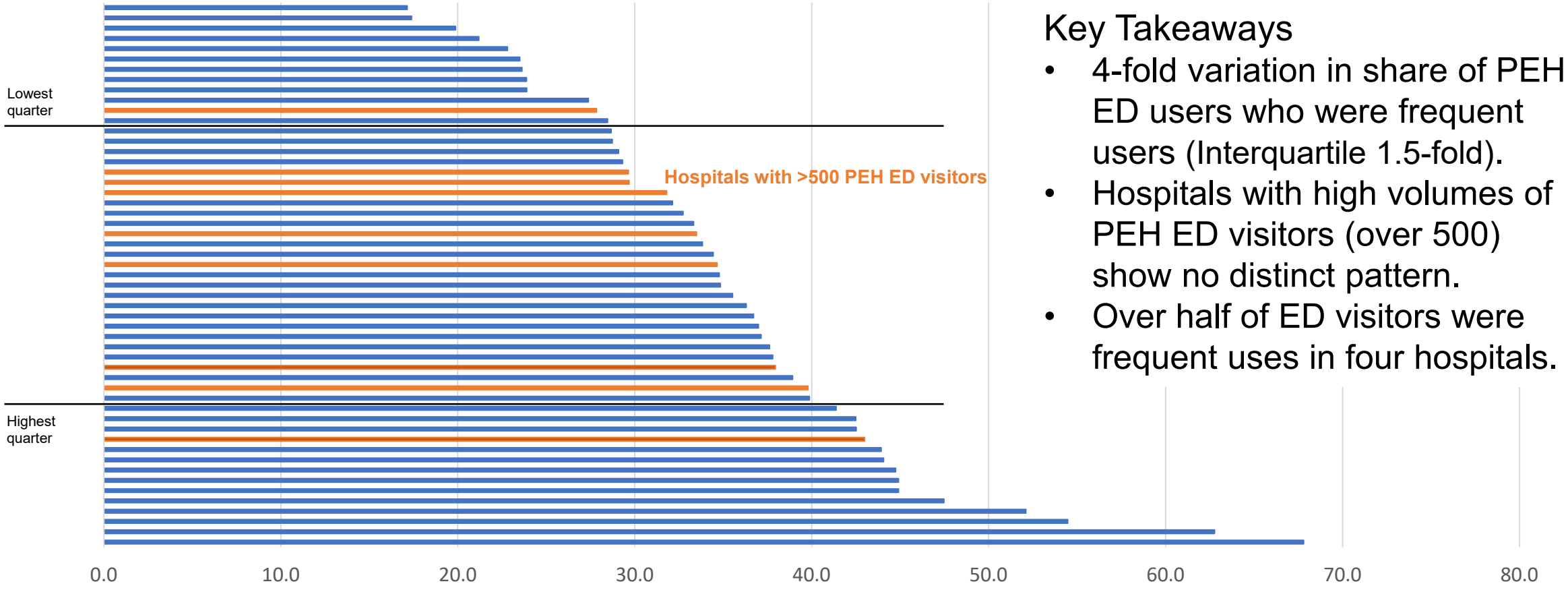
Excludes Bergen and Middlesex counties
NW CoC includes Warren, Sussex, Hunterdon counties
SW CoC includes Gloucester, Salem, Cumberland, and Cape May counties

Key Takeaways

- One in five or more PEH are hospitalized at least once across most CoCs.
- Hospitalization rates vary two-fold across CoCs (1.5-fold excluding Burlington).
- 1 in 20 or more PEH were hospitalized frequently (3+ stays) in about half of the CoCs.

RUTGERS

Percentage of PEH with at Least One ED Visit Who Made Frequent (6 or more) Visits



Key Takeaways

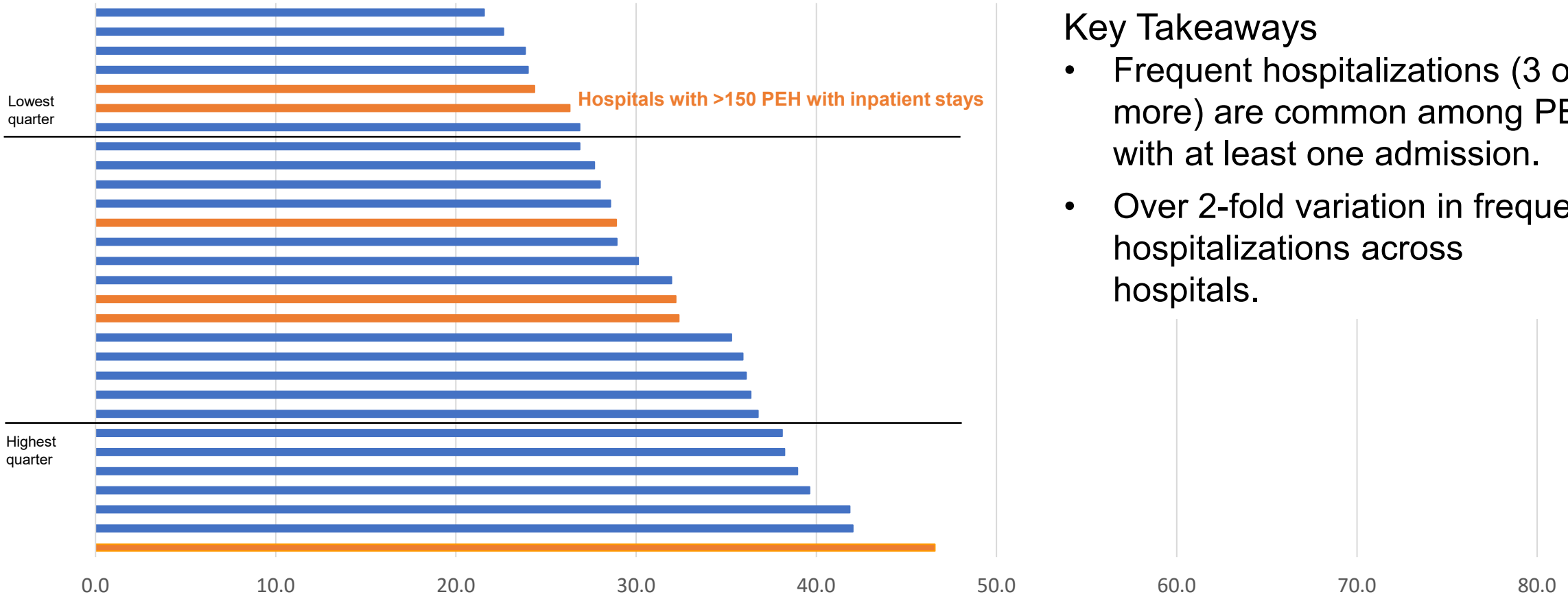
- 4-fold variation in share of PEH ED users who were frequent users (Interquartile 1.5-fold).
- Hospitals with high volumes of PEH ED visitors (over 500) show no distinct pattern.
- Over half of ED visitors were frequent uses in four hospitals.

Excludes hospitals located in Bergen and Middlesex counties
The number of PEH with any ED visits in the facilities in the chart range from about 35 to 1,200.

RUTGERS

Percentage of Hospitalized PEH who Had 3+ Stays

Hospitals with admissions of at least 30 PEH



Key Takeaways

- Frequent hospitalizations (3 or more) are common among PEH with at least one admission.
- Over 2-fold variation in frequent hospitalizations across hospitals.

Excludes hospitals located in Bergen and Middlesex counties

The number of PEH hospitalized at least once in facilities represented in the chart ranges from about 35 to 400.

RUTGERS

Discussion
Medicaid-Homeless Services Data Visualizations

- Very high and widely varying rates of poor outcomes
  - Frequent ED and inpatient use
  - Return to homeless services after health care encounter
  - Gaps in primary care
- Outcomes may not reflect “performance” of hospitals and community organizations, many other factors may influence outcomes
  - Client/case mix
  - Service mix (e.g., more street outreach → higher rates of return to homeless services)
- Still – high rates of poor outcomes underscore opportunities for health and homeless services organizations to collaborate for better outcomes for Medicaid-enrolled PEH

Additional Analyses Underway

- Use of **community-based mental health and substance use services** among PEH with relevant conditions
- Additional **hospital-level metrics**, e.g., 30-day readmissions, return to ED, spending on inpatient and ED services for PEH
- **Compare HMIS and Medicaid** identification of developmental disabilities and mental health and substance use disorders among PEH, and Medicaid coding of homelessness (ICD-10 code Z59.0)