EXECUTIVE SUMMARY

# HEALTHY INVESTMENT

*How Health Care Stakeholders Are Linking Housing with Health*

WISCONSIN POLICY FORUM

Private sector health care stakeholders in Milwaukee County – including health systems, community health centers, and insurers – have increasingly invested in housing supports and programming to address the shelter-related issues facing their patients and members. Still, despite this growing public and private sector emphasis on addressing housing as a key social determinant of health (SDOH), there has been little analysis of these efforts.

This report seeks to provide such an analysis. Authored jointly by the Wisconsin Policy Forum (WPF) and IMPACT Planning and Evaluation, it describes the landscape of health care-related housing initiatives and supports that are offered to low-income individuals in Milwaukee County. The report provides both a detailed analysis of an initiative created by Milwaukee Health Care Partnership (MHCP) members called *Housing is Health*, as well as a broader assessment of the full landscape of health care-sponsored housing support initiatives in Milwaukee. We also offer a brief scan of how health care stakeholders are investing in housing supports in other communities across the country.

## Housing is Health

MHCP was created in 2007 to coordinate and expand the efforts of regional health systems, federally qualified health centers (FQHCs), and local and state government health agencies to improve health outcomes for low-income and underserved populations. In 2019, MHCP members piloted *Housing is Health* (HIH) and have expanded the program in subsequent years.

The program works with hospitals and primary care providers throughout the county to identify individuals who are homeless or at imminent risk of homelessness when they present in health care settings and connect them through a shared process with supports to help them achieve housing stability. The intent is not only to produce an obvious immediate benefit to the individuals who are served, but also to improve their longer-term health outcomes and reduce their future avoidable emergency department visits and inpatient stays through stable housing.

HIH specifically seeks to serve individuals or families who are deemed "literally homeless" or considered at "imminent risk of homelessness" as defined by the federal Department of Housing and Urban Development (HUD). When an individual who is homeless or shows housing vulnerability presents at a participating hospital inpatient facility, emergency room, or safety net clinic, staff administer one of two different screening questionnaires to understand the individual's basic housing needs. If the individual screens positively, then a referral is made to Coordinated Entry (CE), a standardized process that is used to assess persons who are homeless and prioritize them for appropriate interventions and supports.

HIH supports a dedicated staff person at IMPACT, a local social services agency that is the lead agency for CE in the county. Ideally, the CE staff person is able to identify a community-based housing program that both meets the referred individual's needs and has an opening. If that is not possible, then a referral likely will be made to a HIH-funded housing navigator employed by the Milwaukee County Housing Division (MCHD), who can perform housing navigation, identify possible housing subsidies available through HIH or other sources, and continue the search for solutions.

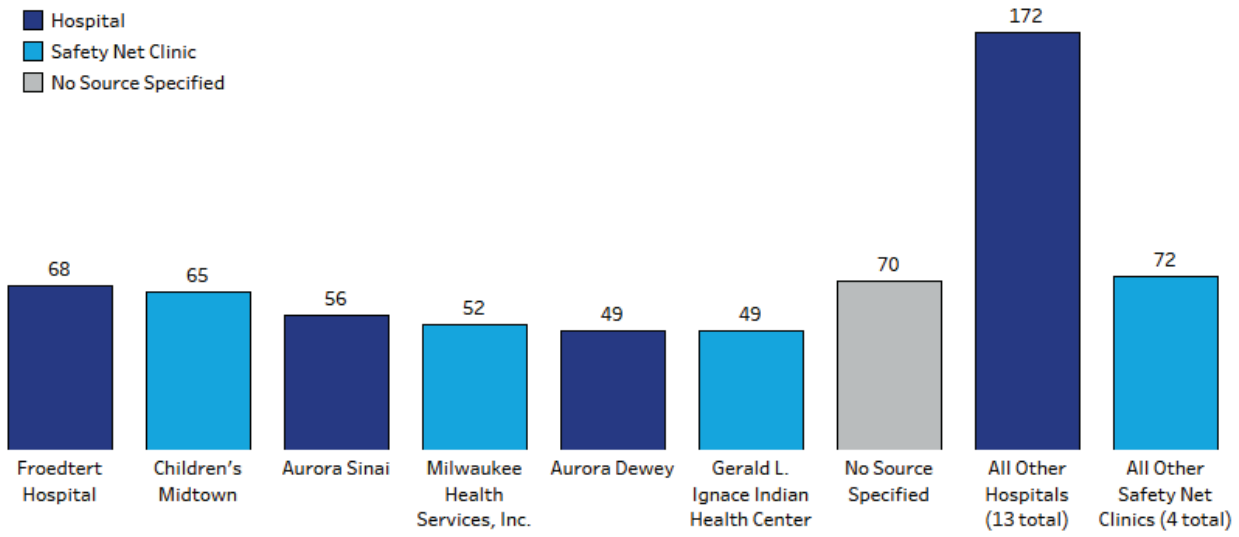
HIH pays for the equivalent of one full-time Health System Liaison at IMPACT to administer CE for HIH referrals and another at MCHD to provide housing navigation and case management services to HIH participants. The combined contribution for the two positions in 2022 was $130,000. The program also budgets $125,000 annually for the HIH Flexible Housing Subsidy, which can be used to provide direct financial support for HIH participants for purposes like security deposits and rent payments.

Since its inception in 2019, HIH has grown substantially. For the first year, referrals happened only at the hospital locations of the three MHCP adult health system members: Ascension Wisconsin, Aurora Health Care, and Froedtert ThedaCare Health Inc. In 2020, the program was expanded to primary care for the first time at Children's Wisconsin Midtown Clinic.

In 2022, HIH expanded further to the five FQHCs that are located in Milwaukee County (Gerald L. Ignace Indian Health Center, Milwaukee Health Services Inc., Outreach Community Health Centers, Progressive Community Health Centers, and Sixteenth Street Community Health Centers) as well as to the largest free clinic serving the uninsured, Bread of Healing Clinic. According to data from MHCP, after fewer than 100 referrals to CE in 2019, the program grew to nearly 300 referrals in both 2020 and 2021. Then, after the expansion to the FQHCs and clinics, referrals more than doubled to 653 in 2022. According to IMPACT, the agency assessed 6,980 households through CE in 2022, of which approximately 40% (2,770) were literally homeless while others were households experiencing housing insecurity. This means that HIH referrals accounted for slightly less than 10% of the total.

Six entities accounted for a majority of the 653 HIH referrals in 2022, as shown in **Figure 1**. The majority of referrals (52.8%) came from a hospital setting, while a smaller amount (36.4%) came from clinics.

**Figure 1: Number of Housing is Health Referrals Made to Coordinated Entry, 2022 Data**




Source: Milwaukee Health Care Partnership

There were 142 clients who received initial permanent housing as a result of their participation in HIH in 2022. In other words, of 653 individuals who were referred to CE from a health care setting in 2022, a little more than one-fifth (21.7%) achieved a housing placement that was deemed "permanent" by the participating agency or program.

There is no benchmark to determine whether that number or percentage of placements constitutes "success." Still, given the myriad housing challenges facing HIH participants and the challenges that public sector and community-based entities have faced in attempting to secure a sufficient supply of appropriate housing options and resources for vulnerable individuals in Milwaukee County, **an initiative that placed 142 individuals in permanent housing in 2022 certainly appears to be one that is making a positive contribution to efforts to combat homelessness in the county.**

**Takeaways**

HIH's focus on proactively identifying individuals with severe housing challenges when they appear in health care settings is praised by health care social workers, who say **the program adds a layer of expertise about housing challenges that they do not possess and that it frees up their time to address patients with other needs**.

The fact that 142 HIH participants received a permanent housing placement in 2022 is not an insignificant accomplishment. However, **an important next step for the program will be to learn more about the individuals who receive an initial referral to CE but are *not* placed** (of whom there were more than 500 in 2022), as well as to become knowledgeable about the permanency of these initial placements by tracking participants for some period of time after their successful engagement with the initiative.

From a bigger picture perspective, **our review of HIH yields the not-so-surprising insight that gaps in the county's larger affordable housing and homelessness prevention landscape hamper the initiative's potential**.

## The Broader Housing and Health Landscape

We also provide an overview of the broader landscape of services and supports provided by local health care entities to low-income Milwaukee County residents to support their housing needs. Our definition of such entities is broadened from the HIH model to include not only hospitals and community-based clinics, but also insurers and specialty providers. Our analysis was primarily developed through key informant interviews conducted by IMPACT Planning and Evaluation staff.

While the underlying philosophy for housing programs and services offered by these health care entities generally was attributed by interviewees to a recognition of housing as a SDOH, the motivations behind those services varied somewhat across the type of organization offering them. For example:

- In addition to reducing homelessness and improving health, **Health Maintenance Organizations (HMOs) were more likely to identify adherence to Medicaid contract provisions and cost containment** as key motivations for addressing members' housing needs.
- **Hospital systems were more likely to point to the frequent and often unnecessary use of emergency department and inpatient resources** by homeless individuals, with housing services becoming a means to alleviate the strain on these hospital resources.
- Among interviewees representing **FQHCs and specialty providers, housing services were most commonly seen as mission-driven** and contributing to their broader set of offerings to holistically address the needs of their patients and the communities they serve.

Health care entities that are involved with HIH often also provide their own additional housing services, including to individuals who do not meet the program's eligibility criteria. Entities that are not connected to HIH have separately developed diverse approaches to implementing their housing services. **Table 1** provides a brief snapshot of the elements involved in the approaches of each of the health care entities we interviewed that are not connected to the HIH program.

Table 1: Summary of Approaches of Non-HIH Entities

| Entity | Patients Served | Housing Services | | | | | Staffing | | | | | | Financial Supports | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Screening/ Assessment | Direct Referrals to Services | Navigation (in-house) | Navigation (through MCHD) | Case Management | Housing Navigator(s) | Case Manager(s) | Resource Specialist(s) | Medical | Behavioral Health | Peer Support | Small One-Time Payments | Short Term Rental Assistance | Long Term Rental Assistance |
| **Molina** | Medicaid members with high service utilization and housing insecurity | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | | ✓ | ✓ | |
| **Anthem/Elevance (Fresh Start Housing Program)** | Medicaid members with high service utilization and housing insecurity | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | | ✓ | ✓ | |
| **UnitedHealthcare (UHC)** | Medicaid members with housing insecurity | ✓ | ✓ | | | ✓ | | ✓ | ✓ | ✓ | ✓ | | Indirect community investments (no direct support to patients) | | |
| **Chorus Community Health Plans (CCHP)** | Medicaid members with housing insecurity | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | | ✓ | ✓ | |
| **Vivent Health** | People with HIV/AIDS and housing insecurity | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ Financial assistance through: Ryan White & HOPWA programs | ✓ | ✓ |
| **Milwaukee VA Medical Center (Homeless Prevention Program)** | Veterans with housing insecurity | ✓ | ✓ | ✓ | | ✓ | | ✓ | | ✓ | ✓ | ✓ | Assistance accessing financial support through: HUD-VASH, WDVA-VHRP, and other community-based providers | | |

## Takeaways

Regardless of the approach to service delivery or specific services offered, interviewees representing local health care entities **all noted the importance of having dedicated, knowledgeable, and well-connected staff working on the housing needs of their clients, with those involved in HIH or with navigators situated at MCHD extolling the benefits of having them centralized within the larger system.** Interviewees also were clear that no services to which they were referring their patients were sufficient to meet those patients' housing needs without financial resources provided by their organizations or through public benefit programs such as Section 8.

**Overwhelmingly, the lack of shelter space and permanent, quality affordable housing in Milwaukee County was the biggest challenge identified during our interviews**, with representatives lamenting that services like housing navigation and case management mean little if there is no housing to

which clients can be directed. Furthermore, those patients with unique circumstances that make them ineligible for benefits or undesirable to landlords or shelter providers become nearly impossible to house.

In addition to the scarcity seen in the physical housing environment, **the lack of data and information infrastructure across the county was seen as a significant barrier to improving, expanding, and sustaining health care-related housing services**. While some larger systems have electronic medical records and other data systems that allow them to track services and longer-term outcomes, smaller providers reported that their inability to follow their patients along their housing journeys impacts the care they provide and can lead to patients cycling back to experiencing housing instability.

## Health Care and Housing in Other Metro Areas

The final step in our research was a broad national scan that sought to identify examples from other metro areas in which health care entities are playing a role in providing housing supports to their patients. We found a variety of strategies, many of which are similar to those taking place in Milwaukee County, but others that were distinct. Some attempt to help individuals better navigate their housing and health care systems while others try to influence the systems directly, including with "bricks and mortar" investments in new housing facilities.

The housing-related health care programs we identified can be categorized into four categories, as summarized below:

- **Affordable housing** is when a hospital or medical provider directly supports the construction of affordable housing units, thereby helping to meet the general demand for such housing with increased supply. The units supported by health care entities may have restrictions such as only being available to low-income renters or to senior citizens, or they may be placed strategically near a hospital or other affordable amenities.

- **Supportive housing** programs expand beyond affordability by also providing onsite services to residents. These may include a range of social services that are not necessarily new to the participants but are conveniently located within or near the housing units in order to increase usage. Often, the services relate to physical and mental health care. Some supportive housing programs we identified provide temporary respite care for patients who are homeless and no longer need the acute care provided by a hospital, but cannot yet be discharged without some form of housing identified.

- **Rental assistance** programs offer assistance that may be financial, administrative, or a combination of both. An example of administrative assistance is a program that acts as a mediator between renters and landlords, guaranteeing that the housing is adequate and meeting basic needs as well as ensuring that the rent is paid on time and in full.

- **System navigation** programs employ professionals with knowledge of local community programs. Participants in these programs get information about housing programs for which they qualify as well as direct help in the application processes.

**Table 2** summarizes the programs and initiatives we have identified that show how health care organizations in other metro areas are investing in housing supports. Many of these programs began

in the mid-2010s. Consequently, there is not much research available with results and outcomes data – though there are plenty of anecdotes expressing the improved health care outcomes for those who have received housing aid.

Table 2: Summary of Programs and Initiatives in Other Cities

| Program | Location | Type | Description |
|---|---|---|---|
| 655 Broadway | Denver, CO | Affordable Housing, Supportive Housing | Converted office building to affordable housing and medical respite housing. Set to open in 2024. |
| McAuley Park | Atlanta, GA | Affordable Housing, Supportive Housing | Mixed-use housing complex of 170 units. Extension of Mercy Care Health Clinic. |
| Better Health Through Housing | Chicago, IL | Supportive Housing | Hospitals identify frequent ER utilizers and refer them to collaborating housing agencies. |
| Columbus House | New Haven, CT | Supportive Housing | Medical respite care for up to 12 individuals since 2013. |
| Housing with Dignity | Sacramento, CA | Supportive Housing | Medical respite care for up to 24 patients followed by placement in more permanent housing. |
| Flexible Housing Pool | Chicago, IL | Rental Assistance | Coordinates agreements and rental payments between participants and approved landlords. |
| Housing Prescriptions | Boston, MA | Rental Assistance, System Navigation | Participants identified as high ER utilizers given housing prioritization and other aid. |
| Passport by Molina | Louisville, KY | System Navigation | Assist patients with permanent housing application process. |
| Homeless Initiative | Cleveland, OH | System Navigation | Hospital screens patients for homelessness so they can better meet their needs. |
| Coming Home | Middlesex County, NJ | System Navigation, Rental Assistance | Hospitals refer patients with needs that will affect their health outcomes to funded social workers. |

Overall, this broad national scan identifies several examples in which health care organizations in other metro areas have come to a similar conclusion as many of those in Milwaukee County, i.e. that investments in housing supports for frequent users of their services have the potential to produce better health care outcomes for participants and lower health care costs going forward. One difference is the decision by some to invest more heavily in broader affordable housing and homelessness prevention efforts in their communities, whether by directly investing in bricks and mortar or in larger housing programs. This may provide important food for thought for health care leaders in Milwaukee County, where the lack of quality affordable housing units is one of the key challenges identified by stakeholders.

## Insights and Conclusion

We find, overall, that the efforts conducted as part of HIH and by other health care entities show both similarities and differences; that they are widely praised by those “on the ground” who are directly involved with housing navigation, referral, and placement services; and that they might benefit from

a more formalized structure as well as from collective action on the larger systemic housing issues facing the community. The following four insights stand out:

- **Greater standardization among health care stakeholders might be helpful.** Given that several stakeholders are supporting housing navigator positions at MCHD, it may make sense to minimally develop common standards and desired outcomes for those navigation services. An even more ambitious step would be to consider creating and jointly paying for a pool of housing navigators at MCHD to collectively serve all participating health care stakeholders. Similarly, given that most lean on some type of direct financial assistance to address the housing needs of patients or clients, stakeholders could give consideration to sharing their experiences regarding dollar amounts, lengths of time, and efficacy or perhaps developing common standards.

- **Expansion to other vulnerable populations could be a next step**. Stakeholders could explore whether individuals who have pressing, but not immediate housing needs should be served by some of the strategies cited in this report – or perhaps served by different strategies that they could jointly develop. Expansion discussions might also include consideration of medical respite facilities similar to those that have been financed by health care stakeholders in other communities or initiated on a small scale in Milwaukee County by the Salvation Army. Milwaukee County appears to lack sufficient options for homeless patients who are ready for hospital discharge but still could benefit from some support while they recover from the health ailment that caused their hospitalization.

- **Data and communications gaps should be addressed**. In particular, improved tracking and reporting on the housing journeys of patients past the point of their initial placement and on outcomes associated with direct financial assistance would seem to be essential. With regard to the former, such data gathering would minimally shed light on whether placements resulting from the initiative are long-lasting and also could reveal whether they have resulted in reduced emergency room and clinic visits and produced other positive health care outcomes. Enhanced data gathering on direct financial assistance for housing could include the specific types and amounts of assistance provided, the characteristics of the individuals who receive such assistance, the lengths of time for which assistance is offered, and outcomes.

- **System-level solutions are needed**. Our many interviewees attested almost unanimously that the success of existing health care-related housing initiatives is significantly limited by the broader housing challenges facing the Milwaukee community. In particular, they cited a lack of both immediate shelter beds and quality permanent housing to serve individuals with complex conditions and histories. Milwaukee's health systems and insurers might take note of some of the examples we provide from other cities, where health care stakeholders are financially involved in the development of affordable and supportive housing units, helping to pay for case management or other supports in those units, and helping to construct respite facilities designed to serve as a bridge for homeless individuals between inpatient care and their move to independent permanent housing.

There is little question that each of the stakeholders addressed by this report would benefit from being able to better and more expansively address the housing needs of their patients and clients. Taking the next steps with some level of collaboration could leverage best practices, reduce costs, ensure that investments in expanded and new initiatives occur strategically and effectively, and achieve the ultimate goal of creating a healthier community.