

“Better Health through Housing” — The UIC Experiment

Affordable and supportive housing can drive significant cost savings and improved health outcomes.

The chronically homeless represent less than 20% of all those homeless at any point in time, but they account for 80% or more of the cost of all services rendered to homeless people. The challenges they face – lack of primary care, medication adherence, food insecurity, exposure, assault – lead to a higher incidence of mental illness, physical trauma, skin diseases, and chronic health. Without a stable place to live, and with higher rates of behavioral and physical health issues, homeless people tend to seek service in the most expensive public facilities.

Some estimate that the average annual cost for a frequent-flyer homeless ED patient is \$44,000 and that 80% of those visits could be treated in a primary care setting. Homeless patients also spend an average of four extra days in an inpatient setting, at an average extra cost of \$2,500 per stay.¹ For institutions in urban settings with a large homeless population, these costs can add up quickly. It is often health systems that shoulder the cost. Significantly, of all the homeless patients sampled in 2016 at UIC, 32% were in the top decile of the most expensive patients. The costs for top-decile homeless patients ranged from \$51,000 to \$533,000 – from 7 times to 76 times the average UI Health patient cost (\$6,947).

Policymakers and care providers are exploring **Housing First** programs as a way of tackling the problem closer to the root by offering permanent housing with few to no treatment preconditions, behavioral contingencies, or barriers.

The UIC pilot

UI Health, the health system at the University of Illinois at Chicago, conducted a Housing First pilot in 2015-17, partnering with the Center for Housing and Health, a community agency focused on affordable and supportive housing. The pilot, called Better Health through Housing (BHH), brought together three single-room occupancy hotels to serve as “bridge units” so that individuals could be immediately housed and a pool of 125 one-bedroom apartments scattered throughout the north, west and south sides of Chicago. Twenty-eight supportive housing providers were responsible for case management that helped to transition patients in permanent supportive placement in the housing pool.



Following the Housing First model, BHH residents were not required to undergo psychiatric treatment or maintain sobriety prior to obtaining housing. Vulnerable clients can more easily engage in services and address their chronic medical conditions once they are no longer dealing with the chaos of homelessness. Supportive case management helps participants learn how to do daily activities and assists them in dealing with medical appointments, paying bills, and other tasks.



Photo: Better Health through Housing

The BHH experience

Of 60+ patients ages 28-63 reviewed by the panel, 27 were referred into the program, including 17 who were chronically ill.

Participants in the BHH cohort had the same utilization characteristics as seen in patients with serious mental illness and the chronically homeless, but did not have SMI as the primary disabling condition. Rather, the cohort had high rates of head and neck cancer, and neurocognitive impairments – such as traumatic brain Injuries and intellectual developmental disabilities – as their primary disabling condition.

Of the 27 patients in the cohort, 16 were justice involved, and four had felony convictions that presented challenges in securing housing.

Key findings

- [A strong business case is emerging](#) – The medical center saw a 21% cost reduction for 17 homeless patients housed; and subtracting one outlier with a costly terminal illness would make that a 67% reduction.
- [Chronic homelessness is a dangerous health condition](#) – Of the 60+ patients screened, roughly 75% had three or more chronic conditions. These included cancers, schizophrenia, bipolar, depression, anxiety, substance abuse and neurocognitive disorder or intellectual disability.
- [The homeless are often invisible in health care](#) – While 48 homeless ER patients were known to UIC in 2015, by January 2017 over 1,300 patients had been identified as homeless, including 45% of the top frequent ER visitors.
- [The homeless have exorbitant health care costs](#) – Almost a third of the homeless patients were in the top 10% for cost, with costs ranging from seven times to 76 times that of the average UIC patient.

Housing led to:

21%
cost reduction for 17
chronically homeless
patients (including one
outlier in hospice care)

67%
cost reduction for the
remaining 16 patients

A potential win-win for providers and payors

UI Health's experience with the BHH pilot underscores the key fact that fragmented, uncoordinated silos shift costs to the most expensive public facilities. The housing approach to health has been explored by the Healthy Chicago Hospital Collaborative and the city's Department of Public Health; other hospitals in the Chicago area are now considering starting similar housing programs.

In the current environment – with more states moving their Medicaid populations into capitated managed care models, payors moving to value-and outcome-based reimbursement models, and recent CMS guidance that unlocks the potential to use federal Medicaid matching funds for housing supports and services – healthcare stakeholders should be seriously considering how to integrate housing into the healthcare delivery system. To do so most effectively, understanding the characteristics of the homeless population, as well as other high-utilizer populations of public systems, is vital and would allow for projects like the BHH pilot to be replicated and expanded across public systems for the highest possible impact.

Sources:

1. <http://www.greendoors.org/facts/cost.php>
2. <http://hospital.uillinois.edu/about-ui-health/community-commitment/better-health-through-housing>