Bridging the Health and Housing Gap

The United States is on the cusp of a dramatic demographic shift. With baby boomers entering retirement, the American population aged 65 and older is expected to more than double by 2060. This unprecedented growth, coupled with the increasing number of people with disabilities and dementia, particularly amid a housing affordability crisis, will have profound public health and housing implications for the United States.

- **79M+**
  - The number of seniors living in the U.S. by 2035

- **38.8M**
  - Number of older adult households with a disability or dementia

- **70%**
  - Estimated number of older adults with a disability or dementia who will need long-term care

- **1/3**
  - Amount homelessness among seniors is expected to rise by 2020

The increase of seniors needing long-term care and the scarcity of alternative housing solutions raise the risk of institutions serving homeless older adults as a high-priced substitute for affordable housing.

Today, 1.4 million Americans reside in nursing homes. Two-thirds of these people receive Medicaid coverage. However, one study found that up to 1 in 5 of these seniors—up to 280,000 in all—could live in less-restrictive environments if they had affordable alternatives with wrap-around services. Because Medicaid covers nursing homes but often doesn’t cover House & Community Based Services (HCBS), these individuals are often forced to stay in high-cost nursing homes when they could be living in a community-integrated setting at far lower cost.

Additionally, even if their Medicaid plans does cover HCBS, there is an acute lack of available HCBS resources - many programs have caps or waiting lists for waivers - further compounding the problem. Many seniors in this situation find themselves caught in the gap between services provided by the U.S. Department of Housing and Urban Development (HUD) and Health and Human Services (HHS), and it often costs the United States taxpayers more as a result.

How Do We Address This Issue?

- Addressing the problem requires an effort that stretches beyond the traditional boundaries of health care—it requires a social, housing and whole-person care perspective.
- One major step in bridging the gap between the health & housing is further education and cross-training.
- Another gap to bridge surrounds data: it is imperative to find ways that HHS and HUD could share key data sets in a way that maintains patient privacy protections.
- We must not only invest in solutions to getting people out of institutions, but diverting them from the institutions in the first place. This includes investing in caregivers.
In the absence of strong federal health and housing partnerships, health plans have created innovative pilots to bridge the divide and provide solutions to individuals experiencing transitional homelessness. ACAP’s 61 health plan members are investing in innovations that directly address social determinants such as housing, even if they fall outside of the traditional bounds of Medicaid health benefits.

**Health Plan of San Mateo**
HPSM worked with the Institute on Aging and Brilliant Corners to launch the Community Care Settings Pilot (CCSP) to transition people living in nursing homes back to the community. The pilot taps into different housing sources tailored to a member’s circumstances and needs. It could range from assisted living to affordable housing to helping a member stay in their own home. A recent review indicated a reduction in costs of 46 percent for the six months after discharge compared with the six months prior to discharge. As of October 2017, CCSP has transitioned 192 people to the community. To date, just seven have returned to institutional care.

**Inland Empire Health Plan**
IEHP has partnered with the Institute on Aging and Brilliant Corners on an initiative to create a transition program to provide housing assistance for people who are willing and able to transition out of institutions and back into the community. With the help of IEHP’s Utilization Management transition of care team, the Managed Long-Term Services and Supports (MLTSS) case managers and community partners, IEHP successfully transitioned 570 members to the community between January 2016 and September 2017.

**CareSource**
In its home state of Ohio, CareSource has developed several programs to help transition members in institutions back to the community through funding from 1915(c) and 1915(i) waivers, as well as their own internal budget. CareSource is currently in the midst of developing an innovative permanent supportive housing model, targeting frail, older adults residing in nursing homes or long-term care rehabilitation centers, who could be living in lower level of care settings, as well as individuals living in sub-standard housing who are isolated from social services. CareSource is preliminarily reporting a one-third reduction in nursing home stays.

**Cardinal Innovations Healthcare**
By the year 2020, North Carolina plans to provide community-based supportive housing to 3,000 individuals who are unnecessarily segregated in, or at risk of being segregated in adult care homes. These 3,000 housing slots include housing vouchers, rental subsidies, tenancy support or transition support that will help these people transition to affordable housing. The Transition to Community Living Department includes peer support specialists to identify prospective members, a transition team, housing and employment specialists, and post-transition aides. As of October 2017, Cardinal Innovations has transitioned 469 individuals.