2022

Promoting Health By Strengthening Community Partnerships

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PROMOTING HEALTH BY STRENGTHENING COMMUNITY PARTNERSHIPS

TEAM MEMBERS

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Project Sponsors: Sheryl L. Garland, Chief of Health Impact, and Ryan L. Raisig, Associate Vice President for Coordinated Care and Continuum Integration, VCU Health System

PROJECT ABSTRACT

Social inequities, such as employment, living conditions, and food insecurity, can adversely affect health. Our project explores the efficient integration of social determinants of health into patient care. Social determinants of health are the conditions in the environments in which people live, work, and play that impact overall wellbeing and quality of life. We propose leveraging the VCU Health system to support already existing community partnerships to improve housing access and social assistance for vulnerable populations, specifically targeting Medicare and Medicaid beneficiaries. We will connect patients to community resources to reduce health disparities, improve health outcomes, and lower costs.

QUEST 2028

Virginia Commonwealth University (VCU) is physically tied to the city of Richmond and is strongly invested in the health and well-being of the surrounding communities. Additionally, they play a critical role in the economic development of the state and have the ability to create an infrastructure that builds successful communities and consequently improves population health outcomes.

[See Figure 1. VCU as an Anchor Institution]

VCU's role as an Anchor Institution aligns with its overall commitment to solving social and health inequities in partnership with communities (Quest, 2028, Theme 4). VCU can strengthen community partnerships and support community health by collaborating with existing organizations that improve the health outcomes of vulnerable populations in Richmond afflicted by housing. Levering existing resources and shared responsibility by investing in structural and social support can dramatically improve health outcomes for those with significant housing needs within Richmond's vulnerable populations. This will be achieved by providing access to housing and other social supports proven to reduce health disparities.

PROJECT GOALS

The overarching goal of this project is to expand and strengthen the existing collaboration and partnership between VCU and Virginia Supportive Housing (VSH). VSH is a nonprofit organization serving individuals experiencing homelessness in Virginia. Further, this project will contribute to VCU's mission to be an active participant in Richmond's collective urban and regional transformation by directly addressing the health outcomes of the community's most vulnerable population.

1. Quest 2028: Theme 4, Strategy 4.2 Partner with the Community - Collaboratively partner with the community to design and implement comprehensive health, education, and economic strategies that can scale to a state-wide approach

2. Strengthen mutually beneficial community partnerships to work to solve complex issues of housing instability in Richmond by piloting a housing program with VSH
3. Enhance health outcomes and overall well being of Richmond's community members by providing the resources to housing and wraparound services to individuals in need

PROJECT STRATEGIES

1. Collaborate with the VCU Health system to establish a streamlined-screening process that triages patients experiencing housing instability and interested in housing. We plan to capitalize on their existing social determinants of health screening process and connect the EPIC electronic health record (EHR) to the Housing Information System (HIS) that will directly connect patients to VSH.
2. Partner with VSH to increase housing supply with the aim of housing 350-400 people within five years. Using the Housing First approach, VSH provides residents with permanent affordable housing and wraparound supportive services. This approach works: 98% of VSH's residents and program participants remain stably housed. VSH is currently building a permanent supportive housing facility that is projected to be completed in 2024. For the immediate future, we plan to focus on revitalizing existing structures, such as motels and renovating single-family homes in low socioeconomic areas, to build up the community.
3. Participate in town hall and community meetings to ensure buy-in from the local government and residents when purchasing housing units
4. Assist in establishing additional funding from VCU Health System, payers (i.e., Medicare, Medicaid, Private Insurance), social impact bonds, and partnering with the state to establish Section 1115 Medicaid Demonstration waivers to build sustainability in the pilot project

ACTION STEPS

- Connect with Homeward to build out interoperability with EHR and HIS.
- Create new triage protocols to screen for housing instability in the emergency department (ED) and direct them to the most appropriate resources.
- Partner with the state to create a Section 1115 Medicaid Demonstration waiver that fits the unique needs of the patient population.
- Collaborate with Virginia Supportive Housing to purchase existing housing supply in the Northside area.
- Form contractual relationships with landlords that own apartments on Chamberlayne Avenue and owners of current motels.

OUTCOMES

Our objective is to strengthen the collaboration between VCU and VSH to help support the unhoused population and improve health outcomes for Richmond's most vulnerable populations. The strength of the partnership can be measured by tracking both the number of referrals and individuals housed over time.

From the hospital side, VCU can use Medicaid claims data to evaluate reduction in readmission rates using the Hospital-Wide All Cause Unplanned Readmission measure and monitor improvement in chronic conditions overtime.

Additionally, the hospital inpatient quality reporting program includes health equity measures, such as screening for social drivers of health and patients who screened positive for social drivers. We could leverage those measures to help monitor the screening process within the ED. We will evaluate the screening and hospital utilization measure to track progress over time. Indeed, data support that health care utilization and cost will reduce over time when a population's health is effectively managed. Subsequently, we anticipate hospital cost savings by reducing unnecessary emergency department utilization and providing wrap-around social supports.

VSH can track the number of referrals received and housed from VCU. Once housed, VCU can use its research resources to track quality of life and health outcomes over time. The data collection will help validate expanding the model to serve a greater portion of the Richmond community.

Performance metrics include frequencies and length of visits to the ED by recurrent unhoused individuals. We hope to achieve the following outcome metrics:

1. Transform patient care experience, which will be observed by an:
    a. Enhance culturally competent communication between care partners and patients to improve patient-centered care and patient-provider understanding
    b. Improvement in the patient quality of life
2. Improve health outcomes as demonstrated by a(n):
    a. Reduction in chronic conditions
    b. Increase in referrals to community-based organizations
    c. Increase in use of preventative health care services
3. Decrease unnecessary health care utilization within one year as shown by a:
    a. Reduction in 30-day readmissions
    b. Reductions in ED visits
    c. Decrease in use of emergency detoxification services

SUSTAINABILITY

The long-term sustainability of this project relies on VCU's ongoing commitment to the following:

1. Partnerships
    a. Maintaining a positive and mutually beneficial partnership between VCU and VSH.
2. Funding
    a. In order to create long lasting sustainability, VCU must be willing to invest $6.65 million, annually over the next two years.
    b. Grant efforts (e.g., applying, securing, maintaining), funding from payers, social impact bonds, and Section 1115 Medicaid Demonstration waivers.
        i. California's Whole Person Care Act demonstrates how Medicaid 1115 waivers can successfully fund comprehensive care coordination that result in better health outcomes and lower health care utilization.
3. Staffing
    a. Maintaining a multidisciplinary well staffed team to manage the program, including social workers and community health workers.
4. Outcomes
    a. Data collection must occur in order to measure the success of this project in both the short term and long-term.
    b. Oregon's Bud Clark Commons provides a sustainable model of how housing vulnerable populations improves health outcomes, decreases health care utilization, and provides hospital cost savings.

FINANCING AND RESOURCES

The project's overall success depends on VCU's willingness to invest in financial and human resources. RVA Eviction Lab, at the L. Douglas Wilder School of Government and Affairs, focuses on eviction data and has used its research to inform policy decisions and respond to the community's needs. Their data suggests that the Northside area is one of the areas with the highest eviction rate in the Greater Richmond area and, therefore, is a priority area for economic investment to improve the built environment. Eviction increases the likelihood of housing instability. The data also highlight how housing instability correlates with other social determinants of health such as education, which then impacts the community.This is a pivotal moment for VCU to

contribute to the rebuilding of a historically disinvested area and create a new narrative of how health begins where we live.

[See Figure 2. Eviction Rates by Richmond Public Elementary, 2016]

VSH has the resources to purchase and manage the housing units such as single-family homes, motels, and partner with apartment complexes. VCU's financial role can be primarily around covering rent in the apartment complexes. VSH has implemented a similar partnership between hospitals and apartment complexes in the Norfolk region. VCU can also use its resources to initiate a relationship with the Virginia Department of Medical Assistance to mirror a successful Section 1115 waiver demonstration.

Project Budget

	Item Description	Justification	Cost
1.	Supportive Services	Health monitoring (physical and mental), Social workers, Caregivers	$ 5,000,000
2.	Property Management	Share of the maintenance and management of rental/housing properties	$ 150,000
3.	Property Purchase	2719 Chamberlayne Ave	$ 530,000
		4910 Chamberlayne Ave	$ 395,000
		2712 Chamberlayne Ave	$ 895,000
4.	Other General Cost	Supplies, Recreation, Travel, Utilities, Management Staff Salary, Enhanced Technology	$ 500,000
		Total:	**$ 7,470,000**

RECOMMENDATIONS

Based on our research and conversations with a variety of stakeholders, we recommend the following action items:

- Create a **universal screening process** involving an inpatient social work team to streamline the process, the identification and mobilization of resources, and the discharge planning.
- Strengthening the **connections** between VCU Health EHR (EPIC), VSH, and Homeward to create a smooth and secure transition of vulnerable patients with housing needs to the appropriate supportive housing resources.
- **Partner** with the State of Virginia to scale the project state-wide.

FINAL PITCH

Housing instability is a growing problem, and this public health issue has impacted Richmond. Research shows that stable housing is a critically important part of social determinants of health. When unhoused people are properly selected for housing interventions, there are improvements in both health outcomes and a reduction in health care cost. The bottom line is ***housing is healthcare***, and VCU has the opportunity to create lasting impact on the Richmond community in a profound way by investing in supportive housing for the community's most vulnerable citizens. By partnering with Virginia Supportive Housing, VCU can directly increase the supply of supportive housing units by contributing financially to the purchase of new properties. VCU can sustain these supportive housing properties over time by providing financial assistance to cover the cost of rent for individuals living in these properties, while VSH manages the properties. Finally, VCU should work to improve the screening and referral process to ensure a more streamlined process for individuals in need of supportive housing that utilize the VCU Health's ED.

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VCU RVA EVICTION LAB, Center for Urban and Regional Analysis

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See Figure 1. VCU as an Anchor Institution

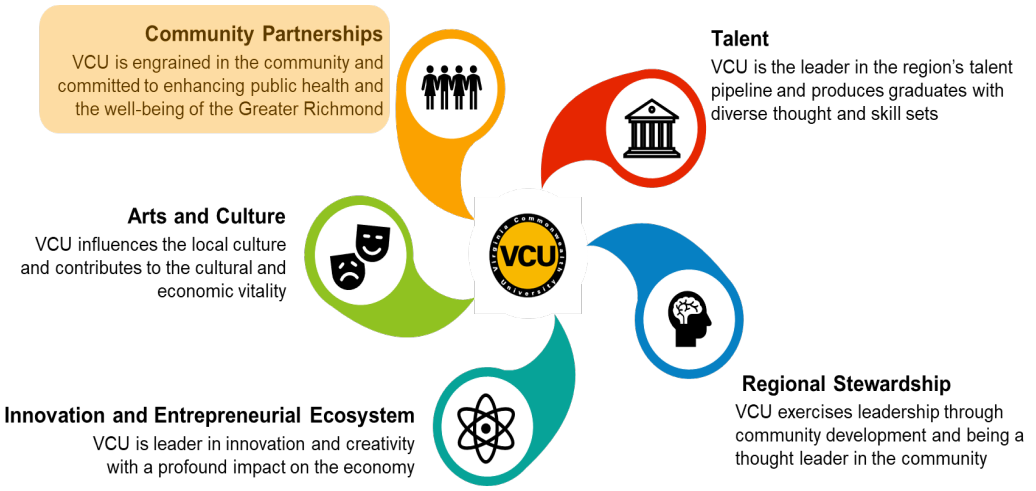
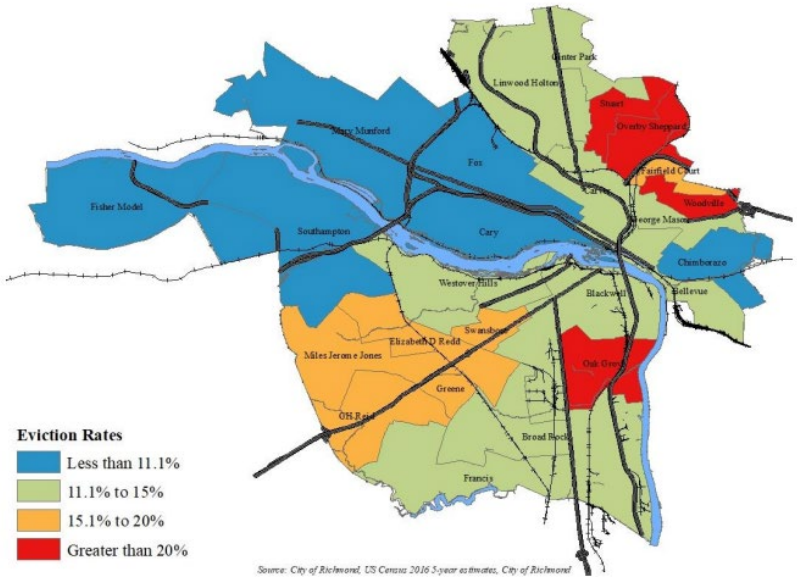


Figure 2. Eviction Rates by Richmond Public Elementary, 2016



Health Starts at Home

Team Think Tank

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Outline

Vision: QUEST 2028

Theme 4: Thriving Communities for All People

VCU will strengthen community partnerships and support community health by collaborating with existing organizations that support the improvement of the health outcomes of vulnerable populations in Richmond. This will be achieved by providing access to housing and other social supports proven to reduce health disparities.

Goals

1. Partner with the Community – Collaboratively partner with the community to design and implement comprehensive health, education and economic strategies
   (Quest 2028, **Theme 4: Strategy 4.2.**)

Goals

2. Strengthen mutually beneficial community partnerships between VCU and Virginia Supportive Housing to work to solve complex issues of housing instability in Richmond
3. Enhance public health/well-being by providing housing and wraparound services to individuals in need

Social Determinants of Health

Housing as a Social Determinant of Health

Stable and Secure

- Free from hazards (e.g., Lead paint, asbestos, Mold)
- Safe neighborhood
- Long-term affordability

Housing as a Social Determinant of Health

High Opportunity

- Access to high performing schools
- Proximity to public transportation, clinics, grocery stores, libraries, parks, etc.
- Community based needs: fitness centers, playgrounds, offices

Housing as a Social Determinant of Health

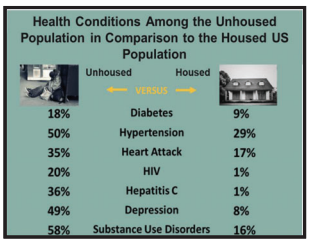
Service Enriched

- Social and mental wellness center
- Suitable for seniors citizens and people with special needs

Health Conditions Among the Unhoused Population

Chronic health conditions such as high blood pressure, diabetes, and asthma worsen because there is no safe place to store medications properly.

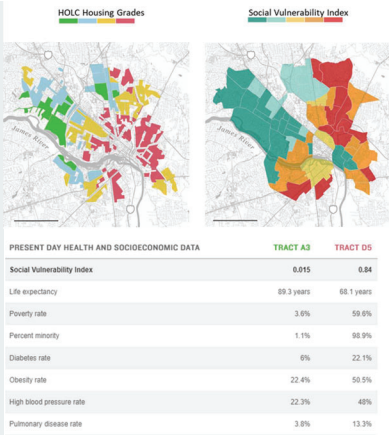
Maintaining a healthy diet is difficult in soup kitchens and shelters as the meals are usually high in salt, sugars, and starch (making for affordable, filling meals but lacking nutritional content).



Source: Health Center Patient Survey (HCPS) 2009

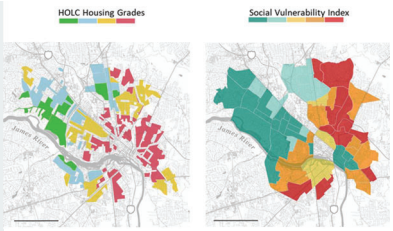
History of Housing in Richmond

- Richmond has the second highest eviction rate
- High Eviction Rates are disproportionately found in minority communities that were historically redlined



History of Housing in Richmond

- Disinvestment in redlined communities systematically shape characteristics of the environment that impact health



PRESENT DAY HEALTH AND SOCIOECONOMIC DATA	TRACT A3	TRACT D5
Social Vulnerability Index	0.015	0.84
Life expectancy	89.3 years	68.1 years
Poverty rate	3.6%	59.6%
Percent minority	1.1%	98.9%
Diabetes rate	6%	22.1%
Obesity rate	22.4%	50.5%
High blood pressure rate	22.3%	48%
Pulmonary disease rate	3.8%	13.3%

VCU as an Anchor Institution

Community Engagement Strategy

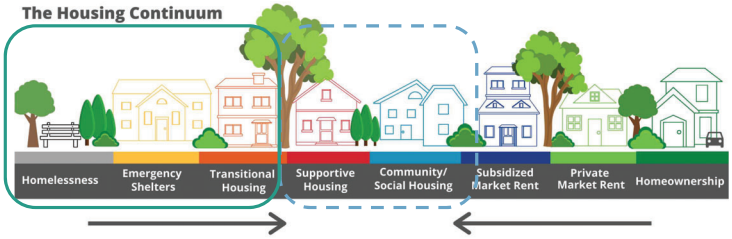
Process

Leverage existing screening process to refer to Virginia Supportive Housing

Supply

Collaborate with VSH and expand existing housing supply

Housing Spectrum



Action Steps

Connect	Create	Partner	Collaborate	Form
Connect with Homeward to build out interoperability with Electronic Health Records (EHR) and Homeward Community Information System (HCIS)	Create new triage protocols to screen for housing instability	Partner with the State to create a Section 1115 Medicaid Demonstration Waiver to meet the needs of the patient population	Collaborate with Virginia Supportive Housing to purchase existing housing supply in the Northside area.	Form contractual relationships with landlords that own apartments on Chamberlayne Avenue and owners of current motels

Outcomes

- From the **Hospital side**, VCU can use claims data to evaluate reduction in readmission rates using the Hospital-Wide All Cause Unplanned Readmission measure. We could evaluate the screening and hospital utilization measure to track progress over time. It will be equally important to track cost savings over time.

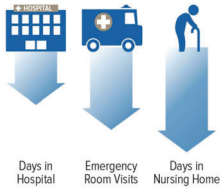
Outcomes

- **Virginia Supportive Housing** can track the number of referrals received and housed from VCU. Once housed, VCU can use their research sources to track quality of life and health outcomes over time. The data collection will help validate expanding the model to serve a greater portion of the Richmond community.

Outcomes

Primary Outcomes:

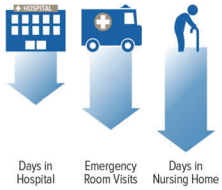
- Improve Patient Health Outcomes
  - Improvement in chronic conditions
- Decrease Unnecessary health care utilization within 1 year
  - Reduction in 30 day readmissions
  - Reductions in ED visit
- Increase in referrals to Community based organizations.



Outcomes

Secondary outcome:

- Transform Patient Care Experience
  - Transforming communication between care partners and patients to improve coordinated and patient centered care



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Recommendations

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Recommendations

- Strengthening the **connections** between VCU Health EHR (EPIC), VSH and Homeward to create a smooth and secure transition of vulnerable patients with housing needs to the appropriate supportive housing resource

Recommendations

- **Partnering** with the State of Virginia to scale the project state-wide

Final pitch

- Evictions are a severe form of housing insecurity and Richmond has the **second highest eviction** rate in the nation.
- Research studies have shown **improvement in health outcomes** and **reduction in health care costs** with properly selected housing interventions for low-income people.
- We propose that VCU partner with **community organizations** to address the issue of housing insecurity that can have a positive impact on overall **community health** and reduce health care costs in this vulnerable population.

Acknowledgements

Sheryl Garland, Chief of Health Impact, VCU Health System & Executive Director, VCU Office of Health Equity

Ryan Raisig, Associate Vice President, Coordinated Care and Continuum Integration, VCU Health System

Allison Bogdanovic, Executive Director, Virginia Supportive Housing

Kimberly Lewis, Director of Outreach and Administration, Virginia Coordinated Care, VCU Health System

Barbara Smith, Vice President Community Health and Innovation, VCU Health System

Nick Langlie, Former GEHLI project mate, Team Think Tank