miriam's kitchen

Stephen C. Taylor, Commissioner
D.C. Department of Insurance, Securities and Banking
810 First Street, NE, Suite 701
Washington, D.C. 20002

July 14, 2016

Dear Commissioner Taylor:

Thank you for the opportunity to submit public comments to inform a community health reinvestment plan for the CareFirst $56 million excess surplus from 2011. As you explore how to invest these much-needed dollars into community health programs and services, we urge you to consider the following recommendations on how the surplus could be used to address the urgent health care needs of individuals experiencing chronic homelessness in Washington, D.C.

On any given night in the District, there are **1,500 individuals** experiencing chronic homelessness, which means they have been **homeless repeatedly or for years and struggle with a long-term health condition**. The average age of this population is in the mid-50s, while life expectancy is only in the early 60s. People are dying of treatable and preventable diseases because they do not have the stable housing and supports needed to improve their lives. As such, we respectfully request that a portion of the $56 million surplus be dedicated to activities that will help DC residents improve their health and well-being through housing.

1) Permanent Supportive Housing (PSH) - $20.8 million

Research and experience show that, for individuals experiencing chronic homelessness, **housing is health care**. Current efforts underway to leverage Medicaid to pay for supportive housing services in the District underscore a growing consensus that PSH is critical to improving health outcomes for people experiencing chronic homelessness. In addition, by allowing individuals the stability to address their chronic health conditions, PSH decreases the burden currently placed on DC emergency services to address the health needs of this vulnerable population. A recent study by the Advisory Board Company shows that paying for PSH for D.C.'s most vulnerable residents for an entire year could save the District nearly $19 million in emergency services such as emergency room visits and in-patient psychiatric stays (attached).

While DC's FY17 budget funds PSH for 425 individuals, there are projected to be at least 650 additional D.C. residents in need of this life-saving intervention. As such, we request that **$20.8 million** of the excess surplus be allocated to the **D.C. Department of Human Services for the purposes of providing PSH** to meet this urgent need. This amount would cover the start-up costs of providing PSH over a **2-year period**, after which, the District could reinvest cost-savings from the Health Home 2 (HH2) benefit into PSH subsidies to cover part of the cost moving forward.

2) Project management staff to end chronic and veteran homelessness - $250,000

The District's plan to end homelessness, *Homeward DC,* outlines two major benchmarks: ending veteran homelessness by 2015 and ending chronic homelessness by 2017. While DC did not end veteran homelessness entirely by the end of 2015, we are close to reaching functional zero. We know what works to end veteran and chronic homelessness and these deadlines are critical to securing the resources and political will necessary to achieve these goals. However, reaching these two goals requires a full-time project manager to track progress and address obstacles that impede progress. A project manager would work with the Coordinated Assessment and Housing Placement System (CAHP) staff to manage work towards these two major benchmarks. This position should be based within The Community Partnership (TCP), which already manages D.C.'s CAHP process, but lacks the capacity to both oversee the CAHP process, and track, monitor, and troubleshoot D.C.'s progress towards the benchmarks. We recommend that **$250,000 be allocated to The Community Partnership for the purposes of hiring one FTE** for this purpose and providing any **additional consulting and training** necessary for the position.

3) Landlord Partnership Fund and staff to coordinate Landlord outreach - $1 million

In recent years, D.C. has implemented a Coordinated Assessment and Housing Placement (CAHP) system that reflects national best practices and has streamlined the process by which individuals experiencing homelessness are matched to housing. Despite this progress, vulnerable D.C. residents still face significant barriers to housing. The D.C. Interagency Council on Homelessness (DC ICH) has identified several ways in which the District could address these barriers by strategically engaging landlords. However, these efforts require dedicated staffing and resources.

a) Landlord Partnership Fund

Efforts are currently underway within the D.C. Department of Human Services (DHS) to develop a **Landlord Partnership Fund**, which would incentivize landlords to relax screening criteria for people who are experiencing homelessness and have rental barriers. We request that up to $1 million be allocated to D.C. DHS for a one-time endowment to "capitalize" the fund and cover the administration of the fund.

b) Funding for Dedicated Staffing to Manage City-wide Landlord Outreach Efforts

While DHS and service providers are working together to improve landlord outreach, efforts fall short of their potential because of limited resources to coordinate and scale-up the work. There is a need for a city-wide approach with consistent branding, marketing strategies, coordinated requests to landlord partners about how to participate, and outreach strategies that span from individual meetings to larger events.

Cities like Seattle, Denver, and Atlanta that are the most successful at landlord outreach have dedicated staffing to managing landlord outreach efforts, stewarding landlord relationships, managing landlord risk mitigation funds, coordinating the matching of housing providers and landlord partners and their units, and coordinating the work of housing specialists embedded in programs across the city.[i]

Identifying dedicated funding to provide staffing for this landlord outreach management/coordination function would significantly improve the capacity of housing programs to work within the existing housing market. Dedicated landlord outreach staffing could be managed by a community provider (either funded through philanthropy or contracted

through government funding) or directly by the DC government. As such, we request **$150,000 be made available as a grant for a nonprofit to hire 1-3 FTEs to manage the city-wide landlord outreach efforts.**

Thank you for the opportunity to submit recommendations. Should you have any questions about this request, please do not hesitate to contact me at **lara@miriamskitchen.org or 202-452-8926 x 242**. We look forward to working with you to address the long-term health needs of D.C.'s most vulnerable residents.

Sincerely,

Lara Pukatch
Director of Advocacy
Miriam's Kitchen

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[i] (See USICH "Risk Mitigation Funds Community Profiles" for more detailed information on risk mitigation funds and the landlord outreach management staffing supporting them.

the Way HOME
Ending Chronic Homelessness in DC

The cost of chronic homelessness in Washington, D.C.

On a given night in the District, approximately 1,800 individuals and 130 families are chronically homeless - they have been homeless repeatedly or for years and have at least one—and sometimes many—disabling conditions. These are some of our most vulnerable residents.

The research is clear—chronic homelessness has a high human and financial cost.

The good news is that there are proven solutions—like Permanent Supportive Housing (PSH)—that save lives and reduce costs.

Human cost of chronic homelessness

Because of the immediacy of life on the streets, appointments made for next week are easily forgotten and rarely kept, leading to episodic encounters with the health care system after wounds have festered or illnesses have grown more severe[1].

- Dr. Levy and Dr. O'Connell

People who are chronically homeless are dying young of preventable and manageable diseases.

- People who experience chronic homelessness die 4-9 times younger than the general population.[2]
- The average age of someone who is chronically homeless is in the 50s and average life expectancy is 61, compared to the U.S. average of 79.[3, 4]

A recent analysis of self-reported health conditions from 828 of the most vulnerable chronically homeless individuals in the District reveals that people who are chronically homeless suffer from[5]:

Financial cost of chronic homelessness

Chronic homelessness is costly. Without the stability of a home people who are chronically homeless are living in a state of crisis, moving from one emergency service to the next.

Permanent Supportive Housing is a proven intervention that couples affordable housing and supportive services, provides the stability needed for people to recover at a much lower cost than letting someone remain homeless.

It is estimated that in just one year's time, DC's 828 most vulnerable chronically homeless individuals had[6]:

4,702 E.R. visits

2,544 ambulance rides to the hospital

2,346 police interactions

2,154 hospitalizations in an inpatient setting

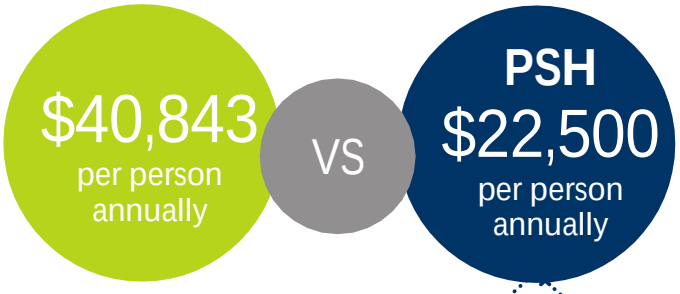
1,696 uses of a crisis service (suicide prevention)

This costs a minimum of

19 MILLION

in emergency services per year

Of this group, the most vulnerable 50% cost an average of $40,843 per person annually, while solutions like PSH cost $22,500.



Preventing one inpatient hospitalization at **$2,596/DAY**[8] could pay for over **43 DAYS OF PSH**

Case Study
Ricky, 51 years old

For some, the financial and human costs are much higher. Ricky is 51 years old and has struggled with schizophrenia for most of his life. His mental illness has made it difficult to hold on to jobs in retail and security, getting ongoing primary care, and taking medication for underlying health issues. He often goes to the E.R. because he needs a warm safe place to sleep for the night. In one year alone, Ricky:

- Took the ambulance 134 times to the hospital
- Had four inpatient hospital stays
- Used mental health crisis services 12 times

This represents $208,908 in medical costs alone.

Fortunately, in February, Ricky moved into Permanent Supportive Housing, where he receives affordable housing and the support needed to recover.

PSH only cost $22,500 a year and drastically reduces the use of other emergency services.

Although Ricky has a long road ahead, he now has a place to call his own

[1] Levy, B, and O'Connell, J. (2004). "Health Care for Homeless Persons," *The New England Journal of Medicine*; 350:2329-2332.

[2] U.S. Interagency Council on Homelessness (2010). *Supplemental Document to the Federal Strategic Plan to Prevent and End Homelessness*, June 2010. http://usich.gov/resources/uploads/asset_library/BkgrdPap_ChronicHomelessness.pdf

[3] Culhane, D., and Byrne, T. (2010). *Ending Chronic Homelessness: Cost-Effective Opportunities for Interagency Collaboration*. http://works.bepress.com/cgi/viewcontent.cgi?article=1093&context=dennis_culhane

[4] Center for Disease Control (2013) *Life Expectancy*. http://www.cdc.gov/nchs/fastats/life-expectancy.htm

[5] Miriam's Kitchen Analysis of DC Coordinated Entry System data

[6] Ibid.

[7] Advisory Board Company. "Uncovering the Health Care and Police Costs of Chronic Homelessness in the District: Advisory Board Analysis for Miriam's Kitchen."

[8] Kaiser Family Foundation (2012). *Hospital Adjusted Expenses per Inpatient Day*. http://kff.org/other/state-indicator/expenses-per-inpatient-day/

The Advisory Board Company | Advisory Board Fellowship

Uncovering the Health Care and Police Costs of Chronic Homelessness in the District

Advisory Board Analysis for Miriam's Kitchen

Uncovering the Costs of Chronic Homelessness

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The Impact of Chronic Homelessness: Costs of Highest Utilizer

The Advisory Board team was asked to determine the cost of providing five discrete services to the chronically homeless population in Washington D.C.

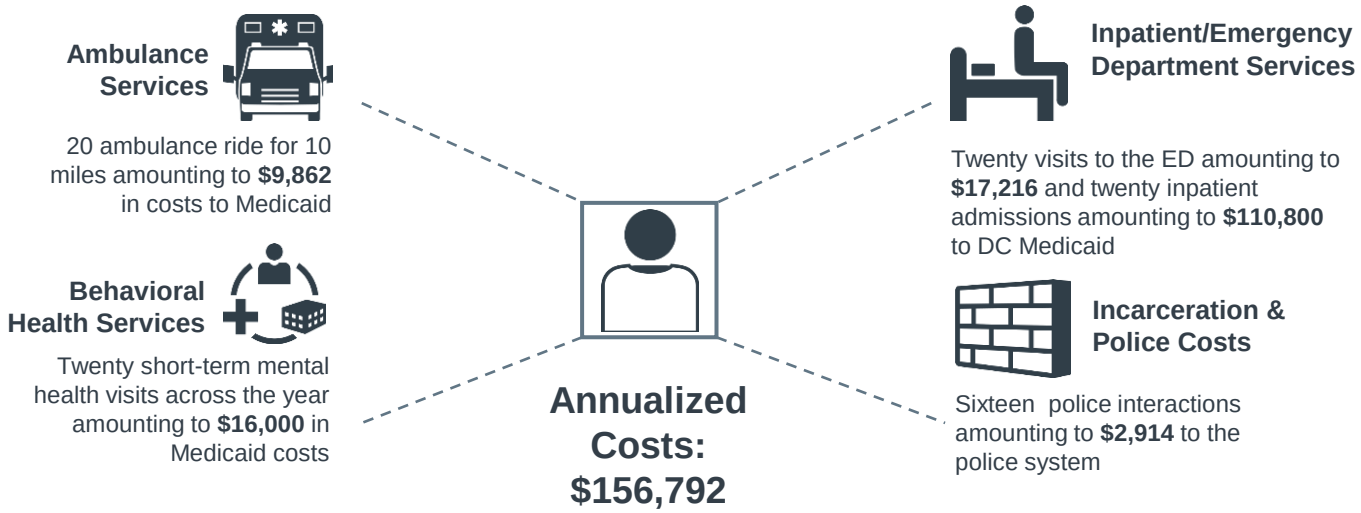
The graphic to the right illustrates the overall cost of those services, based on average annual utilization data. Just adding these four services totals over $156,792 in annual costs.

Inpatient services and the emergency department comprise the majority of overall costs.

An important note about these costs. They are not comprehensive. These costs do not include other potentially more expensive items pertaining to inpatient admissions, physician visits, or support provided by other community organizations. They are limited to health care services and interactions with the police department.

The utilization data for this analysis is based on a survey of the chronically homeless conducted across six months as part of the Coordinated Entry System. The overall numbers here are annualized across the year.

Potential Annual Utilization of Highest Homeless Utilizer of Health Care Services



Costs Add Up Quickly

- Utilization data for homeless individual based on interviews with health care service providers and literature search
- Total costs for three categories requested by Miriam's Kitchen: emergency services, behavioral health, and incarceration could amount to $80,140 annually

Category	Annualized Utilization
Ambulance	20 uses
Inpatient admissions	20
Emergency Department	20 visits
Behavioral Health	20 visits
Incarceration	16 police interactions

The Impact of Chronic Homelessness: Costs of Highest Utilizers

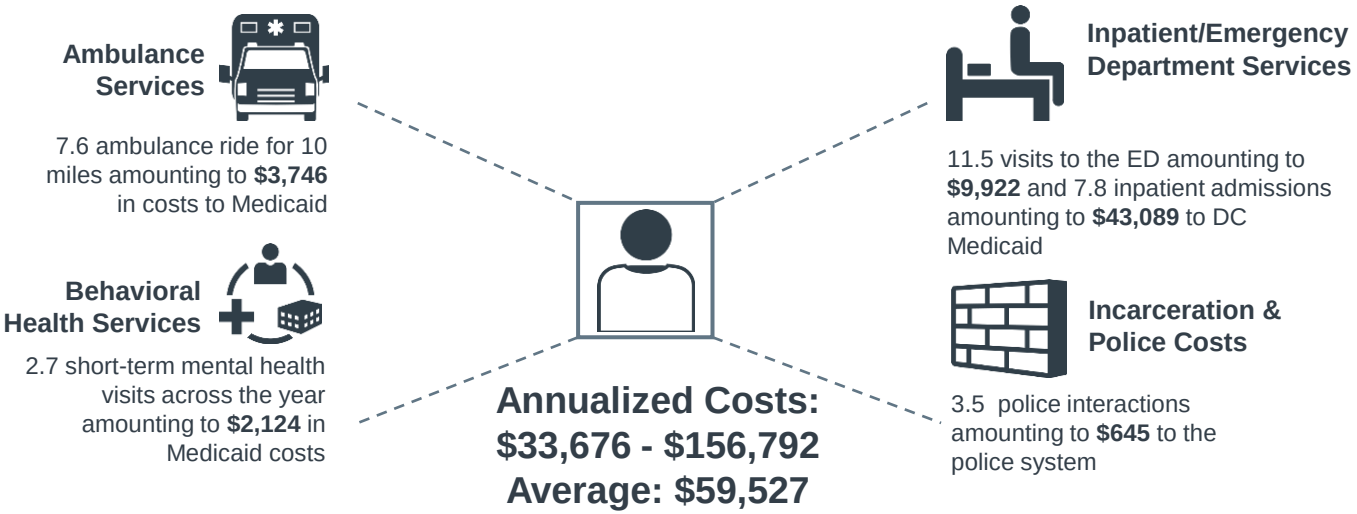
The Advisory Board team was asked to determine the cost of providing five discrete services to the chronically homeless population in Washington D.C.

The graphic to the right illustrates the overall cost of those services, based on sample utilization data. Just adding these five services totals over $59,527 in average annual costs.

As noted earlier, these costs are not comprehensive and are limited to health care services and interactions with the police department.

The utilization data for this analysis is based on a survey of the chronically homeless conducted across six months Coordinated Entry System. The overall numbers here are annualized across the year.

Potential Annual Utilization of Top 10% Highest Homeless Utilizers of Health Care Services



Costs Add Up Quickly

- Utilization data for homeless individual based on interviews with health care service providers and literature search
- Total costs for three categories requested by Miriam's Kitchen: emergency services, behavioral health, and incarceration could amount to $80,140 annually

Category	Annualized Utilization
Ambulance	7.6 uses
Inpatient admissions	7.8
Emergency Department	11.5 visits
Behavioral Health	2.7 visits
Incarceration	3.5 police interactions

Summary of Costs

Emergency/Acute Care Services	Cost of Services
Transportation (Ambulance)	$460 - $767 per ride[1]
Emergency Department	$861-$1017 per visit
Inpatient stay	$5,540 per stay

Behavioral Health Services	Program	Cost of Behavioral Health Services	Time Needed for Services	Frequency of Services
Short-term services	CPEP	$800 per encounter billed to Medicaid	17-18hrs per visit	1.25-1.3 visits per person annually
Medium-term services	Crisis Beds	$340 per day	10-14 days per visit	Typically one-off encounters
Long-term services	St. Elizabeth's Hospital	$850 per day	2-4 months	Typically one-off encounters

Incarceration	Cost of Service	Average Length of Incarceration	Frequency of Incarceration	Service Type
Local Washington D.C Jails	$182.40 per inmate per day	• 109 days for males • 56 days for females	19% of all inmates were re-incarcerated after one year	Local Washington D.C Jails

1) Assumes 5 mile distance covered.

Ambulance Services

There are three types of ambulance services contracted by the D.C. local government.

Basic (BLS): These services are provided to patients requiring "basic life support." BLS includes minimal or basic treatment and vital signs monitoring. In some cases, oxygen may also be given. Reasons for BLS transport are usually considered "non-life threatening."

Advanced (ALS): These services typically require life support in the ambulance.

Advanced 2 (ALS 2): These ambulance services are usually provided in cases where the patient's condition is considered "immediately life threatening."

Ambulance services are paid at a flat fee, billed out by DC government to the individual or their insurer for each ambulance service.

Ambulance Type	Unit Cost ($ per encounter)
Basic (BLS)	• $428 per ride • $6.55 per mile surcharge
Advanced (ALS)	• $508 per ride • $6.55 per mile surcharge
Advanced 2 (ALS 2)	• $735 per ride • $6.55 per mile surcharge

Homeless Utilization of Ambulance Services

20%	Proportion of high-volume ambulance users who are homeless	5	Number of ambulance rides needed to qualify as a high utilizer	196	Number of ambulance services used by highest utilizer

Emergency/Inpatient Visits

Emergency department costs are defined as the charge to an individual for a defined set of services provided in the emergency room. Those charges are then covered by the individual in the form of copays or by a public or private insurer to greater or lesser degrees.

There is no one specific reimbursement for an ED visit; rather Medicaid (as well as Medicare and all other insurers) group services together along with the location ER and a level to approximate the “cost” of an average ED visit.

At this time the Data team at the DC Dept. of Healthcare Finance is pulling the average cost of an ED visit for calendar year 2013.

We have used national data as a proxy here. The first data point represents average cost of ED services for all people under 65 with public coverage (Medicaid, Tricare etc…) The second is mean expense for all people including those with no coverage up to the FPL.

Emergency Department Usage	Definition	Cost of Services
CDC National Data for ED Usage	Mean expense under 65 years with public coverage	$861per visit
CDC National Data for ED Usage	Mean expense (by income) regardless of coverage below 100% of Federal Poverty Level	$1017 per visit
Inpatient visits	Average payment of an inpatient stay in FY 2013, following an ED visit	$5540 per stay

Behavioral Health

The Washington D.C. Department of Behavioral Health (DBH) serves a population of 18,000 individuals per year. The department estimates that 23% of the population utilizing behavioral health services are homeless.

About 3,000 use the Comprehensive Psychiatric Emergency Program (CPEP). Crisis beds and St. Elizabeth's represent a very small portion of the remainder (only a few hundred per year).Community hospitals account for the bulk of the mental health services to the overall population.

Short Term: CPEP (comprehensive psychiatric emergency program) mostly involuntary services . CPEP decides whether they need admission to community hospital. On average, 25-30% of patients per month are admitted.

Medium Term: Crisis Stabilization Beds are available for a small percentage of patients that represent only voluntary admission from community hospitals.

Longer Term: Patients with the most severe behavioral health needs are transferred to St. Elizabeth's hospital.

Service Type	Program	Cost of Behavioral Health Services	Time Needed for Services	Frequency of Services
Short-term	Comprehensive Psychiatric Emergency Program (CPEP) stay (Department of Behavioral Health or DBH)	$800 per encounter billed to Medicaid	17-18hrs per visit	1.25-1.3 visits per person annually
Medium-term	Short term mental health visit (crisis stabilization post acute-care discharge)	$340 per day	10-14 days per visit	Typically one-off encounters
Long-term	St. Elizabeth's Hospital institutionalization (DBH)	$850 per day	2-4 months	Typically one-off encounters

Incarceration Costs

Incarceration is defined as the costs for temporary housing for the chronically homeless in Washington D.C. jails.

For FY 2014 (October 1, 2013 – May 31,2014), the DC Department of Corrections incarcerated 371 homeless individuals. Annualized across the year, that would amount to 557 individuals per year.

Service Type	Cost of Service	Average Length of Incarceration	Frequency of Incarceration
Local Washington D.C Jails	$182.40 per inmate per day	• 109 days for males • 56 days for females	19% of all inmates were re-incarcerated after one year

Cost Data Sources

The Advisory Board project team would like to thank the individuals listed at right for their assistance in providing cost data for the categories requested by Miriam's Kitchen.

Sources		Contact Information
Ambulance Costs	Sarah Roque (DC FEMS) Andy Beaton	andrew.beaton@dc.gov
Inpatient and Emergency Services	Claudia Schlosberg (DC Department of Finance) Katherine Rogers (Director of Data Team) John Wedeles (Data Lead)	John.Wedeles2@dc.gov
Behavioral Health	Stephen Baron, the Director of the Department of Behavioral Health	Steve.Baron@dc.gov
Incarceration	Sylvia Lane; Government and Public Affairs Coordinator, DC Department of Corrections	sylvia.lane2@dc.gov

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