

SHELTERFORCE

Health & Community Development

Addressing the Social Determinants of Health

Setting Aside Housing for Frequent Health-Care Users

By Amanda Abrams

WHEN THE UNIVERSITY OF Vermont Medical Center (UVMC) completed a community health assessment six or seven years ago, its staff learned that the lack of affordable, safe housing was the No. 1 issue in the area. But while the hospital's leaders acknowledged that finding, they weren't ready to address it. Providing housing, they felt, wasn't the hospital's job or mission.

Since then, the institution's mindset has radically shifted. UVMC partners with Champlain Housing Trust to run two renovated motels in Burlington, Vermont, which provide homes to formerly homeless

housing is perhaps the most influential. Housing insecurity can create and exacerbate a huge range of illnesses and symptoms. For hospitals and insurers, there can be major cost savings involved in focusing on housing because homeless people or those living in unsafe conditions are often the highest users of hospital services and can cost the system thousands of dollars in hospitalizations and emergency room visits.

Setting aside housing specifically for those who frequently use health care services makes sense on many levels—but it also raises questions about privacy and lining up who pays and who benefits.

and housing-insecure people with high medical needs. And the hospital's administrators are singing the praises of addressing high medical costs through housing.

Many hospitals and health care organizations around the country have gone through similar transformations. Less than a decade ago, most administrators and researchers would have asserted that housing was housing, and health was health: two distinct fields that overlap only in only superficial ways.

Today, of course, things have changed. There's a growing realization around the country that of all the social determinants of health,

Allocating funds to give some of those "frequent flyers" a reliable place to rest has proven consistently beneficial for everyone. And that includes community development organizations, which are often experts at housing development and are able to further their missions by partnering with deeper-pocketed health care groups.

The path there isn't always smooth, though. For many community development groups,

there are steep learning curves, different languages and cultures to be bridged, and technical challenges like data sharing and privacy to be ironed out.

But Champlain Housing Trust has had a relatively easy time—perhaps because UVMC wound up piggybacking on something the organization was already doing. Around 2013, the organization bought a motel and retrofitted it for homeless people, with space for case managers from a range of service providers.

“At the time, the hospital had a backlog of people in its ER, and had been asking the state to pay for a motel. They couldn’t discharge people because they couldn’t discharge them to a tent,” explains Chris Donnelly, the director

of community relations at Champlain Housing Trust. Eventually, Champlain Housing Trust offered to set aside a handful of rooms for those homeless patients—with full access to the on-site case managers—and the hospital contributed to the organization’s operating reserve in return. Patients stayed for roughly three weeks

until they were fully recovered, then they were discharged. The model wasn’t comprehensive: homeless patients went back to the streets, and others returned to housing that may have been substandard.

After a year or two, the hospital ran the numbers on the 100 patients who had stayed at the motel, comparing the average cost of treating each individual 120 days prior to the intervention to 120 days after the intervention. It turned out that UVMC saved more than \$10,000 per person, in-patient costs declined by 81 percent, and readmissions to the ER were way down.

“They saw that and said, ‘If we can save that much just helping people getting over the hump of being ill, what would it look like if we invested in more permanent housing?’” says Donnelly.

The hospital has since partnered with Champlain Housing Trust on the renovation of two more motels that provide on-site services. One, developed in 2016, has 19 small apartments for people with chronic illnesses. The

on-site services are paid in part by the medical center, and housing costs are covered by vouchers. The second was finished last year and has eight apartments: five are permanent units for chronically homeless people, and three are temporary “respite” units designed for those recovering from illness who don’t have a safe place to stay. UVMC, which selects patients for the respite units, paid for the property’s purchase and renovation, as well as for case management and operations. The residents of both projects are all UVMC patients: it is, after all, the only hospital in town. The hospital is tracking outcomes, but it’s too early to draw conclusions about cost savings at either project.

“The medical center kind of just got religion about this. They’re . . . really happy with the outcome,” says Donnelly.

The relationship has evolved, he says, and has slowly grown into one of trust and collaboration. The groups have advocated together at the state legislature for funding for the nonprofit, and Champlain Housing Trust testified on the hospital’s behalf before a state supervisory board when the hospital wanted to use surplus revenues for housing initiatives. “We work to solve each others’ needs.”

Most importantly, the residents of the three motels have seriously benefited. All are now connected to a primary care physician, and many are finally able to seek regular employment.

Finding the Best Partner

Champlain Housing Trust’s experience isn’t necessarily typical, says Sarah Norman, the director of healthy homes and communities at NeighborWorks America. “There are a lot of different partnership models, but health care partners are usually less likely to support actual bricks and sticks,” she explains. More often, they’ll pay for housing stability services or supportive services.

Funding from health care groups tends to come from one of three places: community benefit funds, investment dollars, and accountable care organizations, or health care services. But convincing hospitals and insurers that it’s worth their while to support housing for their frequent users isn’t always easy. Health care is complicated, and “the costs are incurred to multiple parts of the health care system,” says Norman. That is, the hospital may save a bit, but some of the savings may accrue to Medicaid or the criminal justice system—which means it may not be so obvious to the hospital that a big up-front investment will be beneficial.

But each health care group is different, says Megan Sandel, a Boston Medical Center (BMC) pediatrician who’s been focusing on the nexus of health and housing for two decades. “Not every hospital will serve a predominance of patients on Medicaid,” she says. “For some, it’s front and center; for others, it’s not make or break.”

The downside for community development organizations is that while nonprofit hospitals that care for the lowest-income people may feel like natural partners, they’re also the ones in the industry who tend to have the least money to give out.

Sandel—who points out that with 5 percent of housing-insecure patients using roughly 50 percent of a hospital’s resources, housing investments make sense—says that hospitals and other health care groups are still figuring out how to target those high users. “Do you have the analytic capacity if a houser sends you their address list—can you turn that into utilization patterns?” she asks. “Among our high-cost, high-need people, are we seeing common address patterns?” That is, can health care organizations take advantage of the data that housing groups are privy to?



Alicia Spradlin and her daughter Faith are residents of an integrated care housing community in Phoenix, which consists of set-aside apartments for UnitedHealthcare Community Plan members with complex socio-clinical needs.

“If you knew you had high-cost, high-need patients in a given concentrated area you are more likely to do housing [and] health collaborations there,” says Sandel, citing the Cincinnati Children’s Hospital and its work in an Avondale neighborhood as an example. The area had high levels of asthma hospitalizations and premature births and the hospital worked on housing partnerships with community-based organizations to reduce the incidence of those issues.

That might not make sense for every hospital, but mission-based institutions like BMC might be willing to invest in housing in neighborhoods that are home to many frequent users of health care services, without any guarantee that all of the project’s residents will be the hospital’s patients. And that’s particularly true if the hospital is mandated to fund community health initiatives in return for expansion approval.

“BMC’s housing investments are not tied specifically to our patients, which we did deliberately,” explains David Kibbe, a BMC spokesman. “The objective is to support healthy neighborhoods—and since many of our patients live in those same neighborhoods, we expect the hospital would see those positive outcomes reflected in our patient population as well.”

Navigating Privacy Issues

Data is key to everything a hospital does, which means that if it’s funding a housing development for patients, its administrators will want access to information about their health. And that can raise privacy issues.

Boston’s Codman Square Neighborhood Development Corporation has been grappling with some of those issues. Last December, the organization—thanks in part to Sandel’s advocacy—received \$800,000 from BMC over four years to rehabilitate 35 units of permanent, supportive housing. The organization had purchased the property two years earlier from bankruptcy and it came with existing low-income tenants who were considered high medical users.

So far, however, only about one-third of the residents have signed waivers that allow any of their personal information to be shared with BMC and other partners. That means the hospital doesn’t yet know how many of the residents are BMC patients. But getting those waivers will take effort and patience. “It’s not privacy—it’s more that you have to really work hard to develop relationships with [the tenants],” explains Gail Latimore, Codman Square’s executive director. “BMC definitely wants that information, but we still have a way to go.”

Informed consent is key, says Steve Miff, president and CEO of PCCI, which connects heavy users of Dallas’s Parkland Hospital with key services. His organization lives and dies by data, and takes a multi-pronged approach to consent. That means there are several layers to the information the group asks for, as well as several levels of access for employees of PCCI and service providers. “It’s critically important” to carefully structure how data is shared, says Miff, “and it’s the right thing to do.”

But data isn’t the only challenge that Codman Square is facing. The organization had initially hoped to prioritize men of color—one of its target populations—in the building, but that idea raised fair housing alarms. Instead, it will figure out how to provide support for a group of residents with deep needs, which isn’t something the team has done much of.

“We’re going to have to learn with our partners; they’re giving us a sense of how best to access and tap into services like housing

stabilization and case management,” says Latimore.

The good part is that the funding from BMC has helped Codman Square leverage another \$3 million in pre-development capital—and that’s important because the entire development could cost as much as \$5 million. “BMC will help us with not only dollars, but also being able to map out a plan for this property from a social services perspective,” says Latimore. “Their money is helping us build those relationships.”

Health Care Groups Taking the Lead

Not infrequently, health care groups drive the partnership. In Minnesota’s Twin Cities, Health Partners, an insurer that also administers hospitals and clinics, approached Common Bond Communities, which runs several low-income properties in St. Paul. The health care group has a clinic nearby and was interested in sending a community health worker to educate residents about their medical options—preventive care, primary care, and after-hours sites—to offset the high rate of ER use and hospitalizations.

Health Partners used ZIP code analysis to identify 230 members of its network who lived in one particular building. The community health worker eventually met with 150 of them in repeated interactions. “[The community health worker] was thought of as part of the community, and Common Bond supported her presence,” says Tom von Sternberg, senior medical director of geriatrics, home care, hospice, and case management for Health Partners. “Our evidence shows that after those interactions over six months, we saw an increase in primary care, a decrease in hospitalization rates and ER usage, and an increase in satisfaction.”

But not everyone who lived in the complex was insured by Health Partners, and this made for a slightly sticky situation since the insurer was only assisting its customers. The company did provide newborn

‘If we can save that much just helping people getting over the hump of being ill, what would it look like if we invested in more permanent housing?’

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screenings to any family with a newborn in the building, but ultimately, says von Sternberg, “we haven’t solved that yet.”

In New Jersey, the Camden Coalition of Healthcare Providers has also pushed to find housing for frequent hospital users.

“We were enrolling people who were homeless, and realized there was a gap in the system,” says LaTonya Oliver, a clinical manager for the Camden Coalition. “We’d meet them at the hospital, then they’d be discharged. We weren’t able to engage with patients when they were discharged home.”

The result, in 2015, was the coalition’s Housing First initiative, which uses housing vouchers from the state to get those homeless patients immediately into long-term shelter. The group has several partners—Volunteers of America, South Jersey Behavioral Health Resources, and Saint Joseph’s Carpenter Society—that provide wraparound services and help rent out apartments.

“Once they’re housed, other things come up as they’re in a position to be more stable,” explains Victor Murray, the coalition’s director for care management. “We’re still in connection with the patient—we’re still very involved even though we’re not directly providing care.” The coalition has found that Housing First participants’ use of emergency room and inpatient services drops more than 60 percent once they’re housed.

Two Big Hitters Collaborating

In Phoenix, Arizona, the partnership between United Healthcare and Chicanos Por La Causa is perhaps the most well-known example of a successful effort to get heavy health care users into homes. Classic because the players are powerhouses, the funding is major, and the relationship was built gradually upon successful projects.

The two groups—one a division of the largest insurer in the U.S., the other the biggest community development group in Arizona—first met around 2012 and collaborated on a community service center. Their partnership on that project grew over the next few years, and the relationship deepened.

In 2016, staff from Chicanos Por La Causa approached the insurer with a much bigger ask than in the past. “We looked at what they were currently investing in and wanted to invest in, and we presented them with an opportunity,” says

Pedro Cons, Chicanos Por La Causa’s executive vice president of integrated health services. “We knew that decreasing utilization was a big thing for them, and we think housing is health care, and so we suggested” that United Healthcare lend Chicanos \$20 million at a low interest rate.

Instead of being shocked, the insurer said yes, and the amount was later raised to \$22 million. The funding was used to acquire and rehabilitate a dilapidated 500-unit building in Phoenix. The strategy was to rent out 80 percent of the units at market rate, and the returns from those apartments would subsidize the other 20 percent, which would be available to low-income residents who were heavy health care users. Those residents would be given supportive services that would connect them to resources and track their progress.


Because United Healthcare completely funded the project, it was able to mandate that all of those residents be clients of the insurer, and it chose them. Had the project utilized public money, that practice would have raised fair housing concerns.

“It’s been working phenomenally,” says Cons. “From an operational business standpoint, the site is doing what it needs to be doing to support the subsidy.” The project is also demonstrating the impact housing has on health care; United Health has seen a drop in emergency room visits among residents in the subsidized units, measured by pre- and post-intervention utilization rates.

It hasn’t been 100 percent smooth sailing, however. “What’s been a challenge is that we speak different languages. We had to learn each other’s languages fairly quickly. Our culture is different too,” says Cons. For example, he said, the insurer tended to move much faster than the nonprofit, and consistently maintained certain business practices. “Every single meeting, they’d have a [written] agenda. And every one of our conversations was done on their [phone] line,” explains Cons. “On the positive side, our financing speaks the same language as their financing.”

Part of United Healthcare’s attraction may have been Chicanos Por La Causa’s track record, says Cons. The organization has been in the real estate business for over 30 years and currently has 3,500 multifamily units in its portfolio, as well as 500,000 square feet of commercial space. It was recently awarded \$137 million—one of the largest grants in the country—from the federal Neighborhood Stabilization Program 2 program, and has already deployed another \$300 million in NSP funding.

Partnering with an insurer to develop housing works best in an area where the insurance company has a large market share, as United Healthcare does in Arizona. “Here in Arizona, one in every three individuals is insured by them. They have a pretty significant presence—50,000 members in a five-mile radius—so it’s a critical mass,” says Cons.

That may have simplified some elements of the project; not every partnership between a health care institution and a community development group is quite so straightforward. And the practice of collaborating to provide housing for high utilizers of health care services is still new, which means there are lots of uncertainties and issues that remain to be addressed. But just about all of the groups involved in these partnerships say they pay off across the board, and are worth pursuing. 

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RESOURCES

“Financial Metrics Won’t Tell the Full Picture,” by Kimberly Latimer-Nelligan. *Shelterforce*, Feb. 13, 2018. bit.ly/SF189LatimerNelligan

A Prescription for Electricity

By Rachel Blake

WHEN WAS THE LAST time you lost power in your house? How many seconds did it take before your mind started to race? *Where is the flashlight? How will I cook dinner? Will I have to throw out all the groceries in the fridge? How do I keep the kids warm? How long will this last?*

Last fall's hurricanes affected thousands of Americans and forced them to live without electricity and other essential services for months in some cases. In Puerto Rico, the health and death tolls are

housing was a challenge for many patients, but after doing some site visits, she came to the realization that utility access was a key piece of that challenge.

Hernández is one of a small number of researchers who are looking at the effects of energy insecurity on low-income populations. She is both elevating the issue and giving us

In most states, a person can avoid or delay utility service termination if the shut-off would significantly harm their health. But the process is complicated—and delays can be deadly.

still being tallied. A little digging reveals that the island's problems are intense—especially for people who have chronic illnesses. A resident of Puerto Rico recently told *The Guardian*, “There are people I know still dying from having no electricity, people who need medical machines in hospitals.”

On the mainland, we can (thankfully) expect that our hospitals will have electricity. But, for people who deal with chronic illnesses at home, there is no guarantee the power will stay on. A significant amount of academic and government research has shown how to identify people who require electric-powered medical devices and help them during power outages. What gets less attention is how to help those same people when they are unable to pay their utility bills and face termination of service. Recent estimates suggest that at least 685,000 people in the United States use medical devices that require electricity.

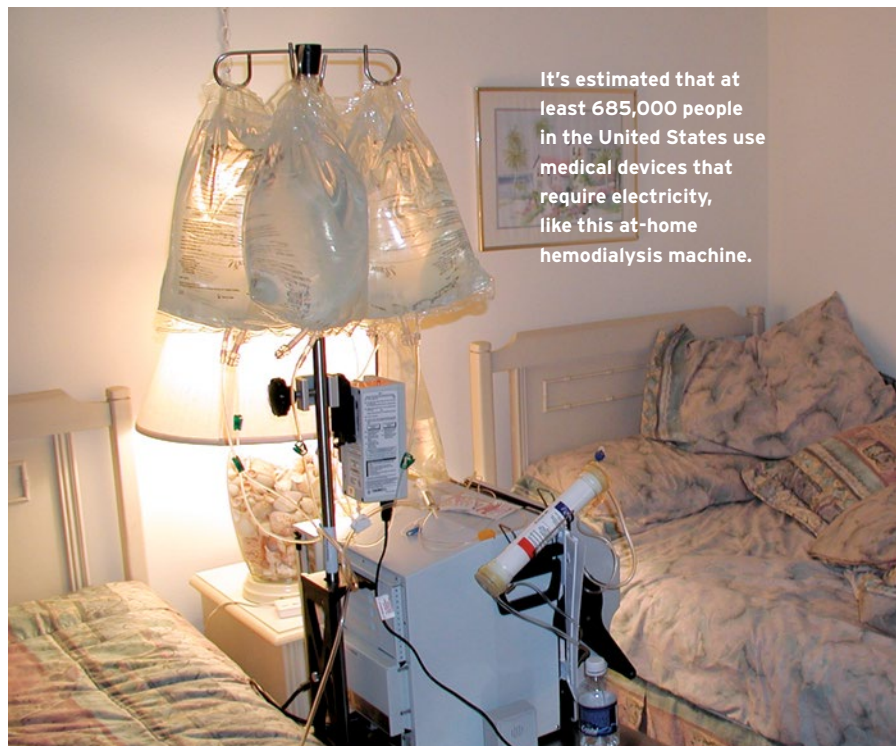
Social Determinants of Health

The social determinants of health (SDOH) are all of the factors in a person's life that affect their health, but are not strictly medical. These factors include housing and neighborhood conditions, education, employment, social supports, and more. Professionals in these fields and health researchers have documented the impact of social factors on health outcomes, and they work outside traditional professional boundaries to learn how other systems work, and to do what it takes to help their patients address complex needs. In addition, lawyers and medical professionals who work together in medical-legal partnerships respond to the overlapping needs.

Diana Hernández, assistant professor at Columbia University's Mailman School of Public Health, has done extensive research on the importance of having access to utilities. Her journey to this work came from participating in a medical-legal partnership in Boston. Hernández says

the language we need to better understand the challenges and opportunities. Complementing the rule of thumb that a household should not spend more than 10 percent of its income on utilities, Hernández defines energy insecurity as, “an inability to adequately meet basic household energy needs.” According to her research, an estimated 16 million low-income households in the United States struggle with energy insecurity.

Hernández has developed a conceptual framework for understanding the three dimensions of energy insecurity. *Economic energy insecurity* refers the financial



It's estimated that at least 685,000 people in the United States use medical devices that require electricity, like this at-home hemodialysis machine.

hardship associated with paying for utilities and managing on a limited budget; *physical energy insecurity* refers to the physical deficiencies and inefficiencies that may arise from not being able to maintain and upgrade the mechanical elements related to energy, like functional heating and cooling systems, poor insulation, and dated appliances; and *behavioral energy insecurity* refers to the variety of strategies people resort to as they deal with the consequences of economic and physical energy insecurity. These lead to adverse social, health, and environmental consequences such as thermal discomfort, the disruption of family routines, and psychosocial stress.

According to Hernández, “energy insecurity acts as a mediator in the poor housing to poor health continuum.” The negative health impacts of energy insecurity are staggering. According to the American Academy of Pediatrics, “Children are less able to regulate their body temperature

compared with adults. As a result, children are more likely to develop significant health effects when they are exposed to environmental temperature extremes.”

Children who live in energy insecure homes are hospitalized more often and they have more developmental problems than their peers. There

is also evidence that energy insecurity contributes to chronic stress and increased mental health disorders. It can also lead to involuntary displacement, which adds another layer of cost and disruption.

And, as with housing conditions and poverty more broadly, some populations are more at risk for energy insecurity. Closeness to the poverty line, race, and immigration status are all linked to increased rates of energy insecurity, according to the National Center for Children in Poverty. In addition, racial segregation has been linked to worse housing conditions and increased risk of not being able to afford utilities.

Energy Insecurity for Chronically Ill, Low-Income Households

While there are significant harmful effects from energy insecurity for all who experience it, the risks to those who are seriously or chronically ill can be extreme. People who need to refrigerate medicines, and those who are vulnerable to temperature extremes could

be considered energy dependent. Many people rely on electricity-powered medical devices, like ventilators, nebulizers, oxygen concentrators, and dialysis machines.

There is no national database or comprehensive estimate of the number of people who use electricity-dependent medical devices at home. One 2012 estimate suggests that nearly 400,000 people with employer-sponsored insurance were using ventilators at home. A 2009 article estimated that 2 million people use home oxygen machines, and cited a number of other devices that require electricity to operate—IV and nutrition pumps, CPAP breathing masks, and heart pumps.

While the exact numbers are unknown, what is clear is that the number of people using electricity-dependent medical devices at home has been increasing, and is expected to continue to rise. “The aging of the U.S. population and shifts toward shorter hospital stays continue to make home health care more common. With these trends, a significant number of medical devices, including infusion pumps, ventilators, and wound care therapies, are now being used in the home,” according to the Center for Devices and Radiological Health and the U.S. Food and Drug Administration.

The Financial Impact of Cancer

Families who have been affected by cancer are at risk of losing their jobs while they are also trying to pay the extremely high costs of treating the condition. According to a report on the financial impacts of cancer on families, *Family Reach*, “Cancer patients and their families pay about \$4 billion a year for out-of-pocket costs associated with treatment, and the financial effects on families can be toxic.” High costs associated with cancer treatment have “wide-ranging social and clinical consequences including reduced quality of life, increased psychosocial hardship, poorer treatment adherence, and decreased survival,” according to *Family Reach*.

A study released in 2017 found that of breast cancer patients, those who were low-wage workers were the most likely to lose their jobs during cancer treatment. “Between 20 and 30 percent of women diagnosed with breast cancer will lose their jobs . . . endangering their financial security as well as their insurance coverage. But the risk is heavily biased: Poor women are four times more likely to be jobless by the end of treatment than their better-off peers,” according to Stat. Only 60 percent of low-income, Medicaid-insured breast cancer survivors were still employed three years later. In addition, “immigrant and minority workers are less likely to be employed in accommodating settings or to have benefits such as a sick leave.” Perhaps not coincidentally, African-American women tend to have worse breast cancer outcomes than other racial groups.

Medical Certificates: A Safety Valve?

The National Consumer Law Center has created summaries of state provisions that either delay or prohibit utility termination for people who are sick. A review of the summaries shows that most states have some medical certificate process. The provisions are broadly similar, with significant differences in the details.

Most states delay termination of utilities for a household when a medical professional can tell the utility company that a member of that household either has a serious medical condition, or that terminating the utilities will significantly affect their health. Several states also provide protections for households with young children.

An estimated 16 million low-income households in the United States struggle with energy insecurity.

The broad contours of the process are also similar across the country:

- The utility customer has to talk with their medical provider to get a certificate.
- The medical professional has to have a process in place for handling these requests.
- The medical professional has to notify the utility company, which has to receive the notification.
- The utility company has to do the right thing.

Simple? Only on paper. This requires at least four steps and three different people to do the right thing, often in a short time. Handoffs are hard enough when people are on the same team. When they are at different organizations with different

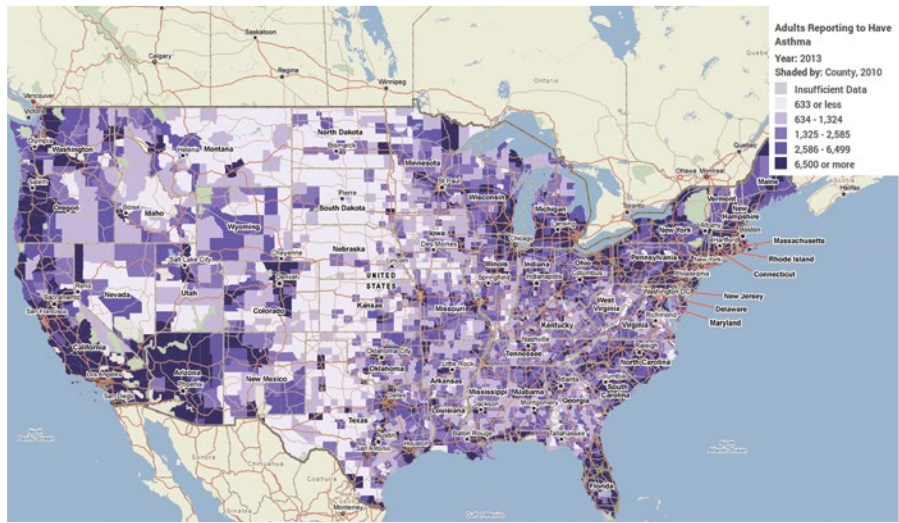
priorities and motivations, it can become extremely difficult. A utility customer may be too sick or preoccupied to take immediate steps to avoid service cutoff. Medical professionals may neglect to send the certificate. The utility company may not receive the request. The person assigned the case at the utility company may not be familiar enough with the rules to do the right thing.

For instance, in 2015 a Michigan man died of hypothermia in his home after his utilities were shut off. He may have been eligible for medical-related assistance, but allegedly did not file the appropriate paperwork. That same year, a Texas man died after the electricity in his home was shut off and he was unable to use his oxygen concentrator. He had a past-due balance of less than \$130. In 2017, a Pennsylvania man fought to keep the electricity on for his wife's life-sustaining equipment. Eventually, anonymous donors helped the family pay the balance of the overdue utility bill.

In Pennsylvania, a medical professional must submit certification that shows their patient has a medical need in order keep their utilities connected. If the person pays the new monthly bill (existing past-due amounts are not required to be paid during this period) the certificate can be renewed for another 30 days. It does not matter what your condition is—a person who has cancer and is undergoing chemotherapy, or someone on a ventilator, must still file for a new certificate every 30 days.

Data gathered from the 2017 Medical Certificate Reports of the 10 largest utility companies in Pennsylvania indicate that approximately 70,000 medical certificates were issued in 2017. Each of these 70,000 certificates could be a new request or a renewal—we simply don't know. In addition to not knowing how many households get medical certificates in a year, we also don't have a good sense of the number of households that are eligible for this service. Getting a better handle on both of these elements would improve our ability to understand how the current system works and where there may be gaps. However, the limited quantitative data coupled with anecdotal reports suggests that medical certificates are underutilized across Pennsylvania.

In addition, customers don't always understand their options. Social service providers in Pennsylvania have reported that utility companies have given them incorrect information about how medical certificates work. For instance, a provider for families affected by



An estimate of the number of adults in the U.S. who are affected by asthma. One hospital in North Philadelphia requires that medical certificates be written upon request for people who have asthma, chronic medical conditions like heart disease, diabetes, as well as a multitude of other conditions.

cancer in Pennsylvania works with a utility company that limits medical certificates to one per year for a period of 60 days. Similarly, a social worker from central Pennsylvania said another utility company imposes a lifetime limit for medical certificates. In Philadelphia, a utility company told customers that they are limited to three medical certificates for the life of their accounts. A medical-legal partnership in suburban Philadelphia said there are recurring issues with utility company representatives providing incorrect information to their clients, including limits on medical certificate utilization that do not exist and failing to tell customers that they can pay their current monthly amount and renew the certificate for another month.

Another significant challenge is the wide variation in how medical professionals respond to requests for medical certificates. There are at least three large medical systems in Pennsylvania that have instructed staff members not to write medical certificates. It is unclear why these medical systems made that choice. The wide latitude given to medical professionals concerning when they should complete a medical certificate is a challenge. The deference to medical professionals is appropriate, but the lack of definition can create conflict or paralysis. One model for how to address the ambiguity is for medical providers to create an internal list of conditions for which medical certificates are appropriate. This model has been employed at St. Christopher's Hospital for Children in North Philadelphia, the site of a medical-legal partnership with a doctor who has a strong interest in the social determinants of health. The

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hospital instituted a screening process to uncover utility issues that families might have, and adopted standardized criteria for writing medical certificates. Conditions for which medical certificates should be written upon request include asthma; having a child under the age of 2 in the home; chronic medical conditions like heart disease, diabetes, immunodeficiency and/or chronic immunosuppressive, oncology conditions, and sickle cell disease; special-needs patients; and acute conditions that lead to temporary disabilities (such as pneumonia).


Advocates at The Utility Reform Network (TURN) in California, are working to change the law there—in part to loosen the requirements about who can make a certification. TURN has raised the issue of lack of access to a doctor. In California, only one in five people have regular access to a doctor.

What Are Housers to Do?

There are already untold numbers of low-income people who have chronic illnesses and live at home. A nontrivial number of them likely struggle with energy insecurity. While most states have some policies in place to help customers avoid termination of utility services, the protections do not appear adequate. Given that we are expecting an increase in the number of elderly people in the United States at the same time that federal and state health initiatives are working to keep people out of institutions and in the community, this problem will only continue to grow.

There is undoubtedly a cost element driving much of what is happening in the medical world—especially in Medicaid. There are many reasons for allowing people to live at home, rather than in institutional settings. But the focus shouldn't solely be about a hospital's cost savings. For instance, according to a 2012 report in *Respiratory Health*, "the preferred location for long-term mechanical ventilation is in the home, because costs are reduced (hospital costs \$21,570, home care costs \$7,050, dollar savings per patient, per month \$14,520)." How much household labor is given for "free" that would have been provided by a medical professional in an institutional setting? What does it cost a household to operate a ventilator at home?

Medicaid won't pay for utilities, though customers can sometimes get funds for a utility deposit, at least in Pennsylvania. Given the push to keep people with serious conditions living in their own community, including large numbers who are reliant on medical devices, and the expected increase in the number of elderly in the country, it seems like now is a good time to revisit the issue.

Housers can help move the needle. Make utilities a key part of the discussion when you talk about housing and housing affordability, especially when you talk to health partners. Utilities are, after all, part of housing affordability. 

To comment on this article, go to bit.ly/SF191Blake or write to letters@shelterforce.org.

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RESOURCES

Lights Out in the Cold: Reforming Utility Shut-Off Policies as if Human Rights Matter, by Marcus Franklin and Caroline Kurtz. NAACP Environmental and Climate Justice Program, March 2017 bit.ly/2M5rRfl

"A Look at a Medical, Legal Aid Partnership in New Orleans," by Katy Reckdahl. *Shelterforce*, April 25, 2017 bit.ly/2pvPPbL