Reducing Costs/Utilization of Homeless and High-Risk Populations

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About CSH

Advancing housing solutions that:

Improve lives of vulnerable people

Maximize public resources

Build strong, healthy communities

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Housing is Healthcare

- Homelessness = high risk for poor health
- Poor health = high risk for homelessness
- Homelessness complicates efforts to treat illnesses and injuries

Source: National Healthcare for the Homeless Council, "Housing is Health Care", 2011

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Housing is the Best Medicine

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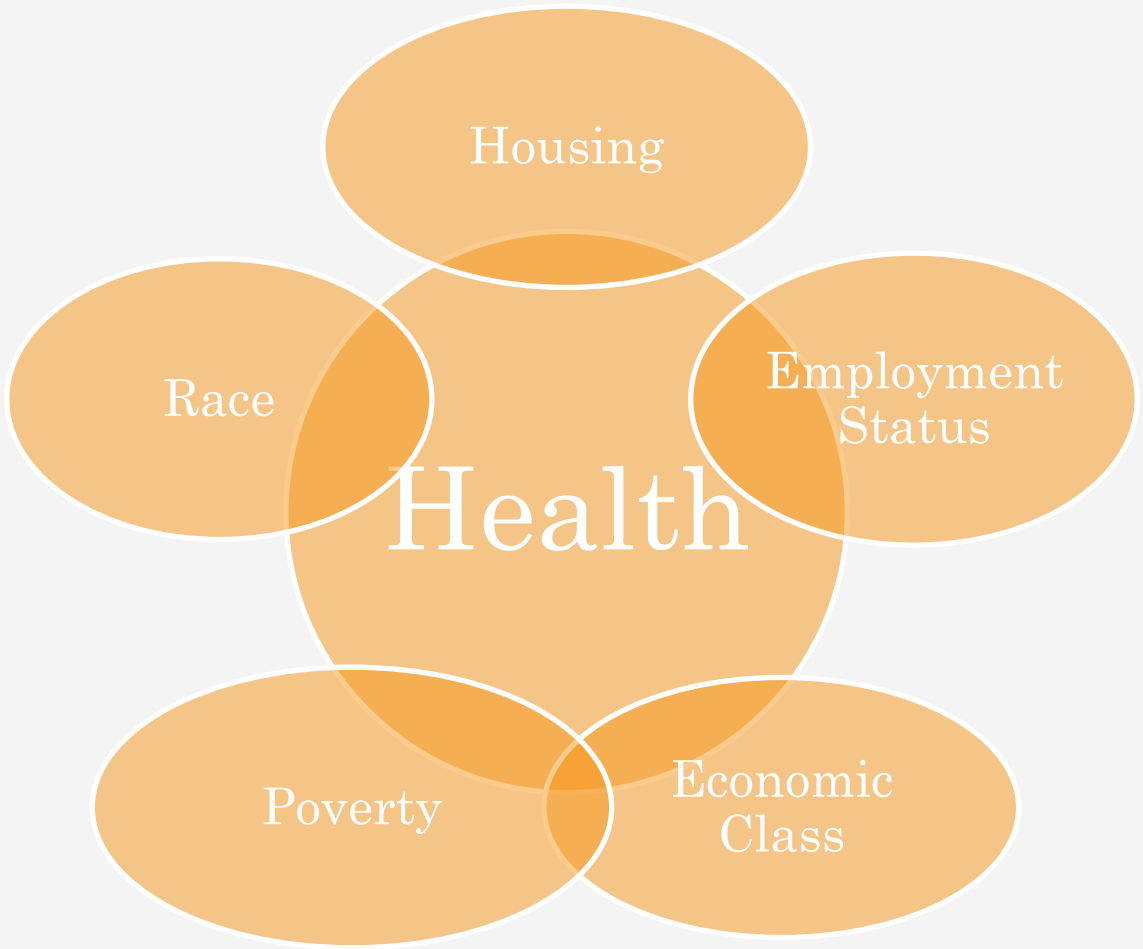
Social Determinants of Health



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Housing as a Social Determinant

- **The lack of housing itself dictates health outcomes for homeless, chronically ill populations.**
  - Lack of community based housing has a disproportionately negative impact on health and the health system vs. other social determinants of health

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Supportive Housing is the Foundation for Health

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Health Care Utilization

- **High levels of emergency department use**
  - Rates 8.5 times low-income but not homeless *(Hwang, et al. 2013)*
  - Homelessness prevalent among "super users" *(Doran, et al. 2013)*
- **High rates of hospitalizations**
  - Rates 4 times low-income but not homeless *(AJPH 2013)*
- **High health care spending**

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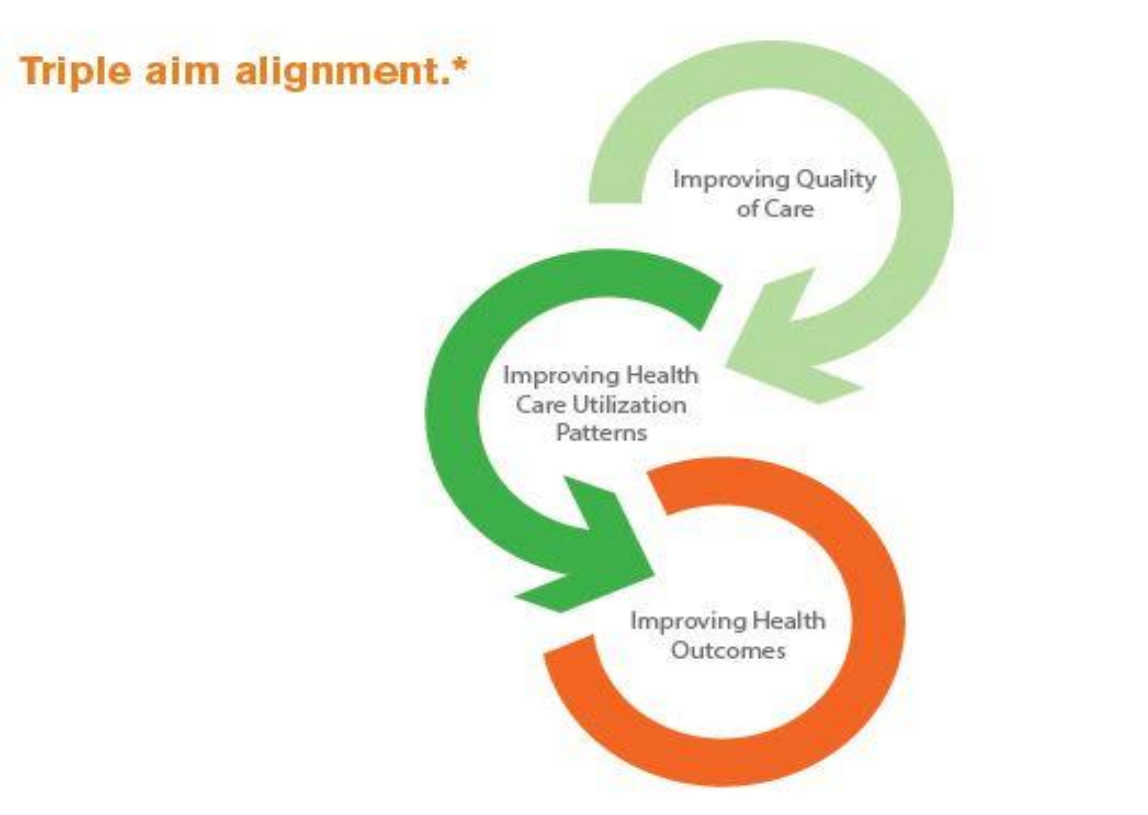
Intersection of Health and Housing



Source: UnitedHealthcare & Corporation for Supportive Housing Housing and Healthcare Webinar Series

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FUSE Problem Statement

- Local health providers recognized subset of homeless population utilizing disproportionate share of hospital/emergency care services.
- Target population difficult to engage and may not be captured in coordinated entry process.

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Root Causes

Root Causes of Cycling In and Out of Emergency Services

- Presumptive diagnosis/labeling
- Trauma/injury
- Poor health work-ups
- Medication non-compliance
- Self medicating
- Chronic medical conditions
- Exacerbation of chronic disease
- Substance use
- Primary care system not responsive to population/issues

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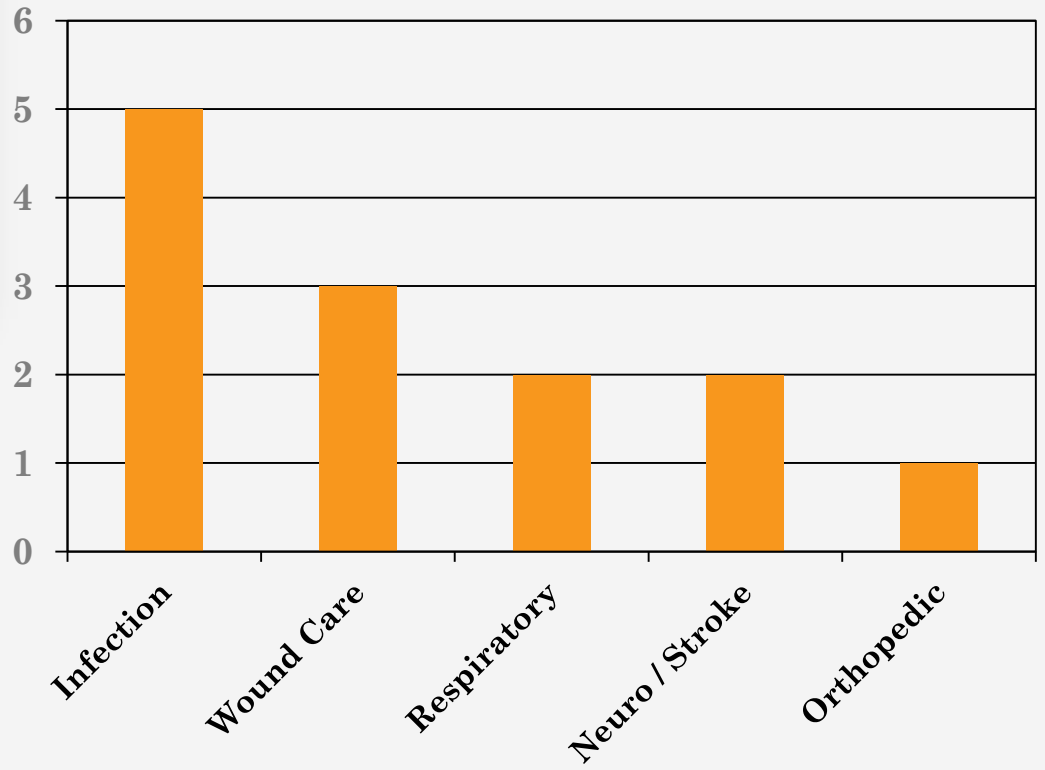
Acute Illness / Injury



Most patients had one or more acute conditions that were addressed at the Medical Respite Center.

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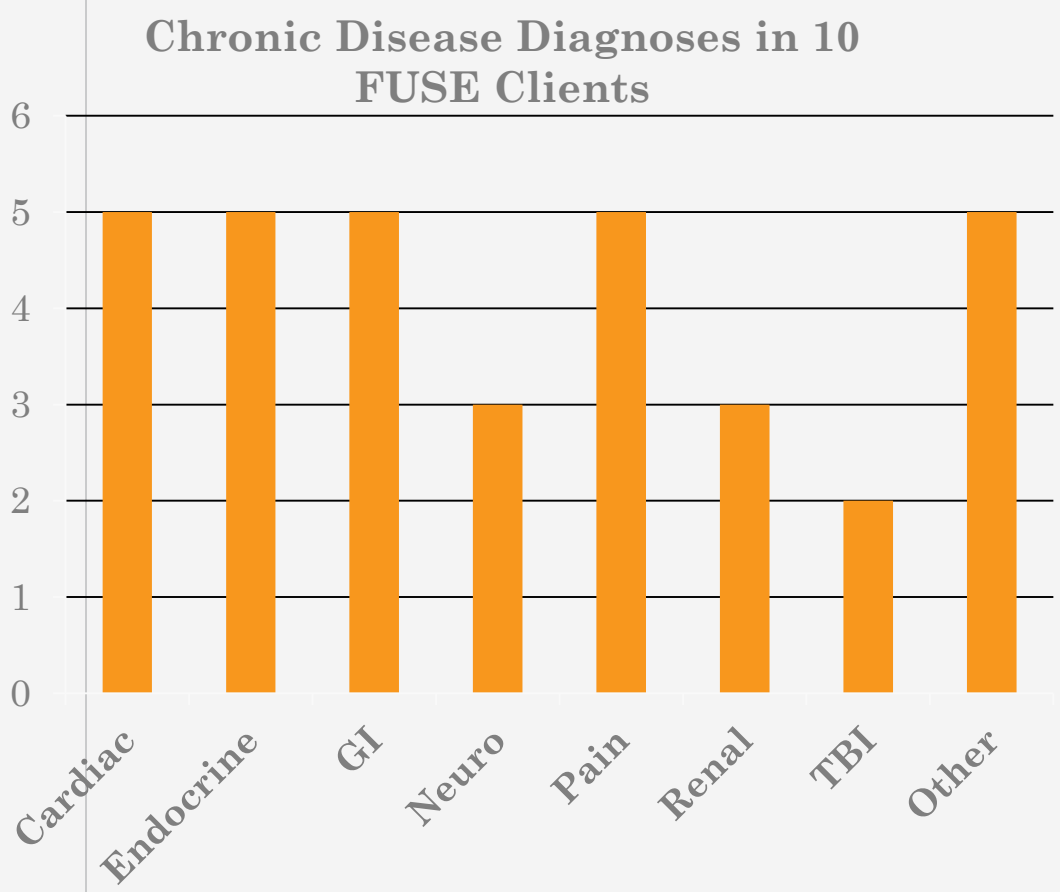
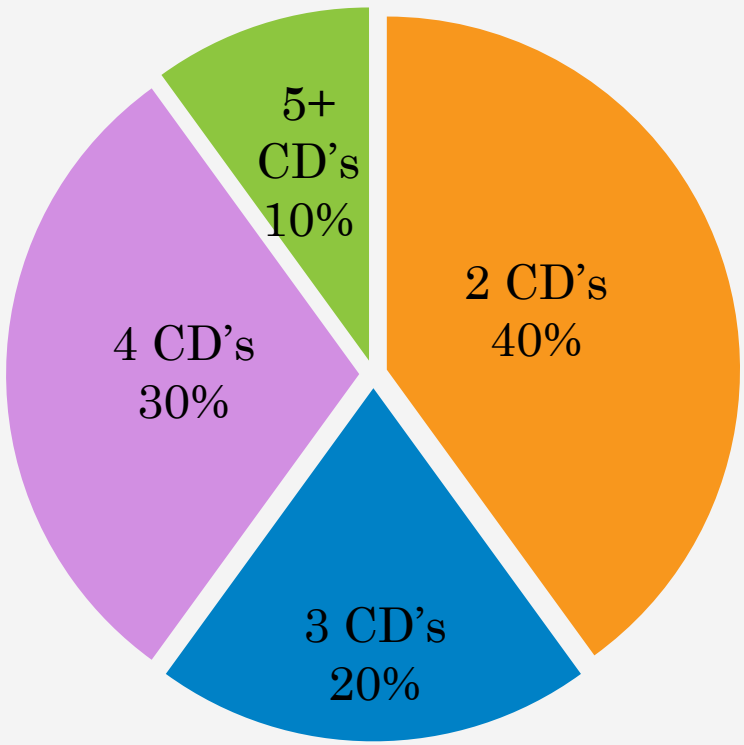
Prevalence of Chronic Disease





Number of FUSE Clients w/ Multiple Chronic Disease Diagnoses

FUSE clients evaluated and stabilized at CTC had multiple chronic disease diagnoses. The majority had 3 or more.

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Intervention

- Engagement
- Diagnosis/Medical Stabilization
- Supportive Housing

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Case Study – Stephen

- History of morbid obesity, hypertension, kidney disease and blood clots in legs
- Admitted to hospital with new episode of leg infection requiring surgery
- Developed blood clots in both lungs, requiring blood thinning medications
- Had to go back to surgery again, large wounds in legs couldn't be closed and had to heal slowly
- Recovery complicated by depression
- Discharged after wounds healed to Permanent Supportive Housing as part of FUSE project

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FUSE Evaluation/Outcomes

- **Data**
  - Self Sufficiency Matrix
  - Hospital Financial Data
  - Jail Data

- **Results**
  - 47.2% Reduction Inpatient Days
  - 36.6% Reduction Inpatient Costs

  - 73% Reduction ER Visits
  - 74.7% Reduction ER Costs

  - 100% Reduction Jail Days

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Identification

What we did	What we learned
Compiled hospital cost data	Multi sources difficult to access and compile
Cross-referenced health data with HMIS	Labor intensive
Refined targeted- user list	List needs to be larger than target number
Attempted to leverage hospital information systems to flag targeted individuals	Hospital information systems (finance, intake) don't speak to each other; no functional ability to flag individuals
MOU/ROI to share identified clients w/ Continuum of Care	Link w/ Continuum health services to share information

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Success in Housing

- Prioritizing housing supports in terms of medical needs
- Ownership of health navigation responsibility
- Alignment with local health resources – FQHC's, CHC's, HCH, Behavioral Health, etc.
- Importance of immediate placement – bridge housing may be necessary
- Clients may be too ill for direct placement in PSH

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mercy maricopa integrated care

Addressing The Housing Needs of Individuals and Families Across the Service Delivery System

Tad D. Gary, MEd, MA, CRC, LPC
Chief Clinical Officer

Brief Overview of Housing Services and Supports

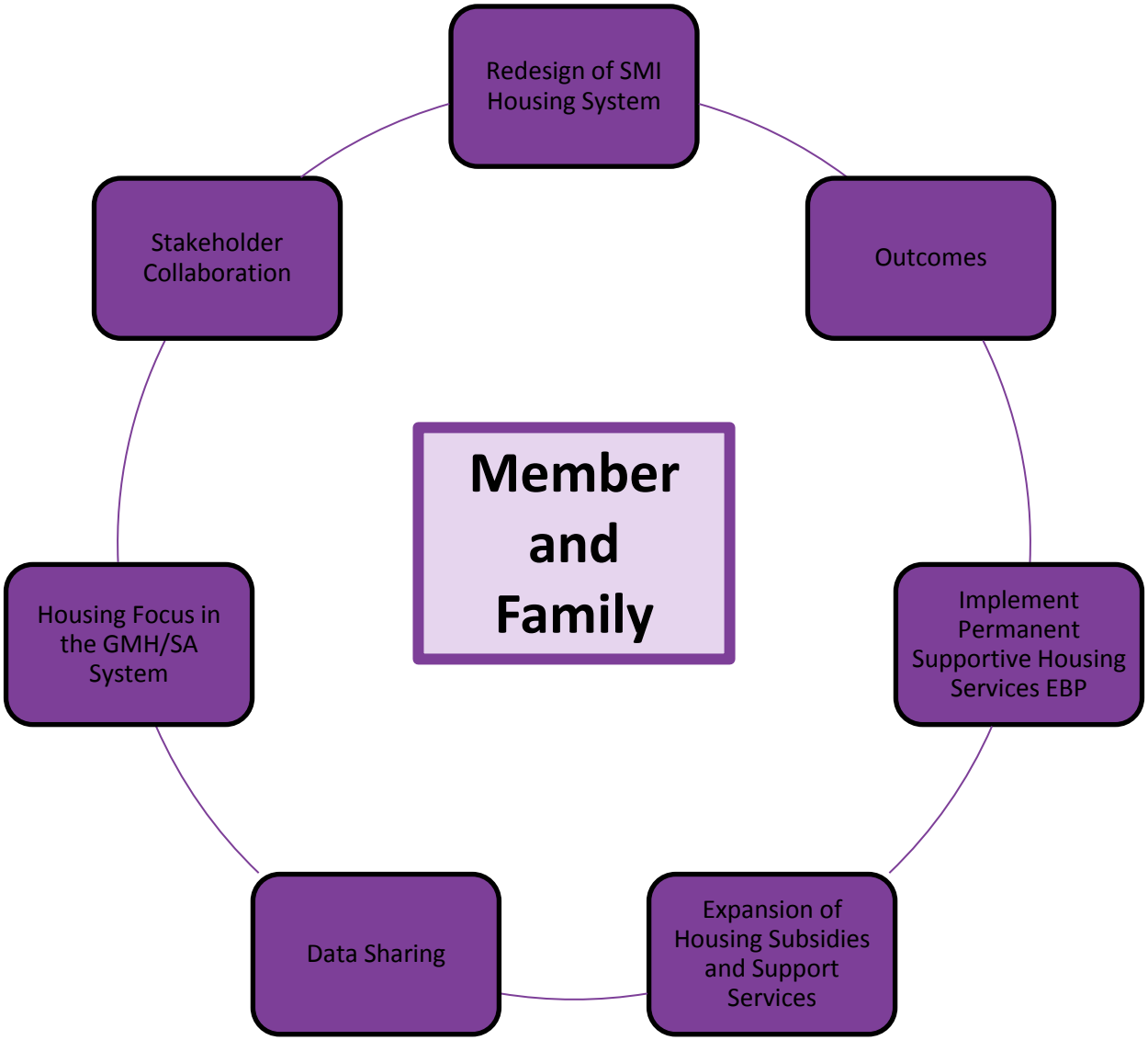
Housing Subsidies

- Covering the Costs of Rents

Housing Support Services

- *Covered Support Services* (e.g. navigation, case management, Independent Living Skills, and etc.)
- *Flex Funds* (e.g. utility start-up, deposits, housing supplies and etc.)

Housing Strategic Plan Activities



Housing Strategic Plan Activities

- **Redesign of the SMI Housing System**
  - Consultation with WICHE to facilitate process and develop comprehensive plan
  - Assess gaps in the system, current programs and ease of access to services and supports

- **Expansion of Housing Subsidies and Support Services**
  - Expanded the Scattered Site PSH program by 700 new subsidies
  - 200 additional PSH Services were provided to members in their own home in the community who needed additional support
  - Mercy Maricopa implemented the Temporary Housing Assistance Program

Housing Strategic Plan

- **Implementing Permanent Supportive Housing (PSH) Services Evidence Based Practice (EBP)**
  - Consistent review of PSH activities
  - Improvement plan to assist providers in implementing PSH EBP

- **GMH/SA Focus**
  - Collaborations with community partners to increase housing options for members that are viewed as high cost/high need and homeless
  - New partnerships to provide PSH services to support GMH/SA members in accessing and maintaining housing

Housing Strategic Plan Activities

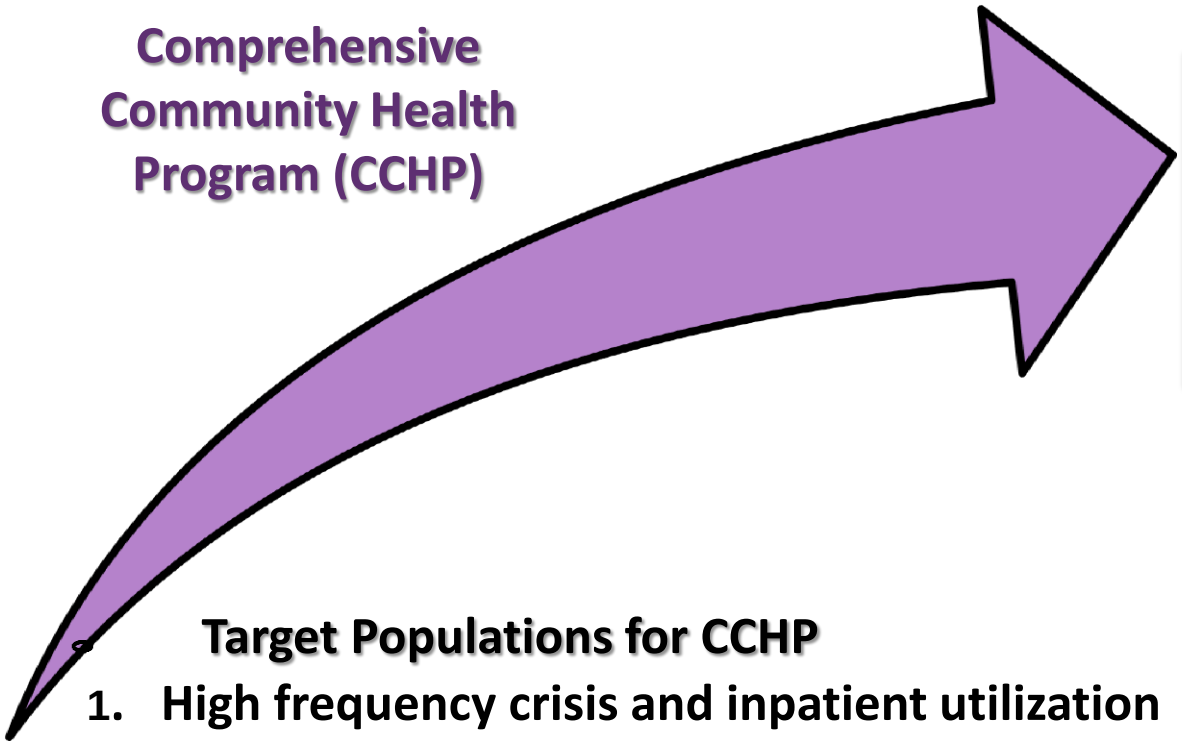
- **Stakeholder collaboration**
  - Collaboration with community providers, such as the Housing Continuum of Care and Valley of the Sun United Way
  - Leverage housing subsidies and matching covered support services
  - Implement the VI-SPDAT within Mercy Maricopa and support service providers to assist in determining needed housing intervention
  - Participate in the Community-Wide coordinated entry process

- **Data sharing**
  - Develop and/or enhance data sharing agreements with stakeholders

- **Outcomes**
  - Defined outcomes
  - Value-based contracting

GMH/SA Innovative Network Expansion Programs

Comprehensive Community Health Program (CCHP)



Program Goal:
Keep members healthy and stabilized by managing the full spectrum of care and addressing members and families social determinants of health

Target Populations for CCHP

1. **High frequency crisis and inpatient utilization**
2. **High risk of recidivism due to untreated behavioral health concerns**
3. **Frequent or potential interactions with emergency first responders**
4. **Inadequate or at risk living environments**
5. **Lack of social supports**
6. **Chronic medical conditions**

Comprehensive Community Health Program (CCHP)

CCHIP and Housing

Housing Subsidies /Start up Funding

Permanent Supportive Housing Program Partners:

- La Frontera EMPACT
- Community Bridges
- City of Phoenix
- United Way

Target Population:

- Chronically Homeless Population

Number of members housed since 4/1/15:

- 107

Number of members in process of being housed since 4/1/15:

- 77

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Thank You