Hospitals, Community Care Teams, and Recuperation:

Statewide Coordination to Identify, Monitor, and Care for the Homeless

Panelists

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Agenda

Overview of Homelessness in CT

Description of the Hospital Initiative

Role of Hospital Association & Policy Advocacy

Lessons from Middlesex County Community Care Team

Lessons from New Haven Community Care Team & Respite Program

Homelessness in CT

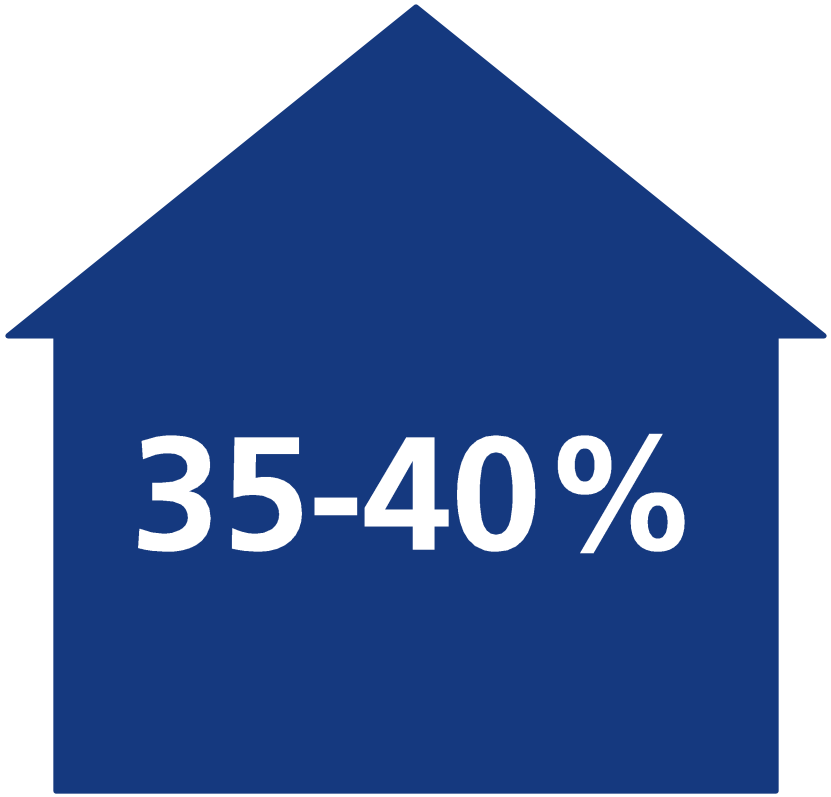
Based on 2014 Annual HMIS Data

People experienced homelessness in Connecticut during 2014.

People experienced chronic homelessness (homeless for a long time & have a disability).

Veterans experienced homelessness in Connecticut during 2014.

Homelessness & Health Care



Percent of frequent visitors to the emergency department experiencing homelessness or housing instability.

Opening Doors-CT Hospital Initiative

Goals:

1. Better identify individuals experiencing homelessness or housing instability
2. Reduce emergency department visits and inpatient readmissions
3. Improve care coordination upon discharge from inpatient and outpatient settings
4. Reduce costs for the medical and health care system

Opening Doors-CT Hospital Initiative

Led by:

Funded by:

Partners:

Hospital Initiative Fact Sheet

REACHING HOME
Ending Homelessness
a campaign of the Partnership for Strong Communities

Integrating Health Care & Housing:
Opening Doors-CT Hospital Initiative

Background

Homelessness and housing instability are associated with poor health outcomes, including high mortality and high rates of chronic illnesses. Often those experiencing homelessness or housing instability cycle in and out of hospital emergency departments (ED), costing the medical system millions of dollars each year.

Adults who are homeless represent 5% of the Medicaid population but are overrepresented in some types of care:

- 17% inpatient care
- 19% ED visits for adults with a primary behavioral health diagnosis
- 39% with 3+ inpatient medical detox episodes

Given these findings, hospitals have the potential to be a critical partner in interventions and care coordination for those experiencing homelessness. The Opening Doors-CT Hospital Initiative launched in 2014 as a collaboration between the Partnership for Strong Communities and the Connecticut Hospital Association. This project focuses on bridging the gap between hospitals and community providers, and better serving those who are homeless.

Target Population

Frequent visitors of hospital emergency departments (ED) and inpatient beds, also known as **super-utilizers**. Frequent visitors are those who have:

Visited an ED 7+ times in the past 6 months

Strategies

- Implement homelessness screener in emergency department electronic health records
- Establish **Community Care Teams (CCTs)** to improve care coordination between hospital staff and community providers
- Develop peer sharing across participating hospitals

Goals

1. Better identify individuals experiencing homelessness or housing instability
2. Reduce emergency department visits and inpatient readmissions
3. Improve care coordination upon discharge from inpatient and outpatient settings
4. Reduce costs for the medical and health care system

In Partnership With:

CHA Connecticut Hospital Association
Norwalk Hospital — Compassion. Expertise. Results.
Hartford Hospital
Saint Francis Hospital and Medical Center
Middlesex Hospital
Yale-New Haven Hospital

Funded by:

Connecticut Health Foundation — Changing Systems, Improving Lives.
Melville Charitable Trust

Opening Doors in Connecticut...
...to a Future Where **Everyone** Has a Home

PARTNERSHIP FOR STRONG COMMUNITIES
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Preliminary Findings

35-40%
Percent of frequent visitors experiencing homelessness or housing instability

7-69
Number of ED visits per frequent visitor in the past six months

34%
Percent of frequent visitors who visited 3 or more EDs during the previous six months

62%
Percent of frequent visitors who are male

Outcomes Tracked

- Demographics (age, race, gender)
- Health insurance
- % ED visits accounted for by frequent visitors
- Readmission rates to ED and inpatient care (7- and 30-day follow up)
- Connection to care (7- and 30-day follow up)
- Housing/homelessness status
- Medicaid claims data
- SF-12 physical and mental health scales
- Substance use

Lessons Learned

- Importance of peer sharing across Community Care Teams (CCTs)
- Extensive time needed to develop release of information
- Need for flexible care plans
- Movement of frequent visitors between hospitals
- Prevalence of substance use by frequent visitors
- Value of having the Administrative Service Organization (ASO) at the table

Next Steps

- Evaluate the initiative - both process and outcome
- Expand the model to other institutions
- Develop a predictive model to better identify and serve frequent visitors
- Expand respite care options across the state
- Develop a more comprehensive continuum of care for substance users
- Explore Medicaid payments for supportive housing services
- Develop a model for sustainability

Homelessness is unacceptable. Homelessness is solvable and preventable.
Homelessness is expensive. Invest in solutions.

PARTNERSHIP FOR STRONG COMMUNITIES 227 LAWRENCE STREET HARTFORD, CT 06106 860-244-0066 WWW.PSCHOUSING.ORG

Middlesex County Community Care Team: Care Management for Emergency Department ED Frequent Visitors

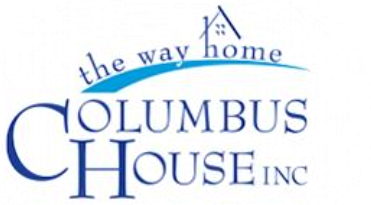
NATIONAL HEALTH CARE FOR THE HOMELESS

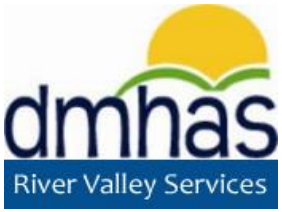
May 8, 2015

Terri DiPietro, MBA, OTR/L
Director, Outpatient Behavioral Health
Middlesex Hospital

The Smarter Choice for Care
MIDDLESEX HOSPITAL

A Community Collaboration





A National Crisis: Emergency Department Perspective

Fraying of behavioral health systems

↓

Increasing numbers of behavioral health patients (BHPs) without adequate inpatient or outpatient care

↓

BHPs wind up in EDs (our medical system's safety-net), often with long length of stay

↓

BHPs overwhelm EDs' capacity to care for all ED patients

↙ ↓ ↘

ED crowding

Decreased safety

Financial losses

A Closer Look…The Major Challenge of BH Super Users

This population does not get better with the traditional model of episodic care delivery

"Falling through the cracks"

Required: Care Coordination

Question Uncovered Along the Way:

How is the experience different for the homeless and those experiencing fragile housing?

Middlesex County CCT History

- 1990s: Mental Illness Substance Abuse project through Rushford (grant funded by state); continuing care team for dual diagnosis; strong relationships were developed
- 2007: Middlesex County initiated the 10 Year Plan to End Homelessness; a component was the formation of a community care team → without a designated champion, the team was never formed
- 2008: Middlesex Hospital conducted a health assessment
- 2010: Community Care Team (CCT) was developed
  - Middlesex Hospital agreed to be the organizer
  - 4 core agencies: Middlesex Hospital, Gilead, Rushford, RVS
  - met on a monthly basis
  - barrier addressed: common Release of Information (ROI)
- 2012: CCT expanded to 9 agencies
- 2015: CCT expanded to 13 agencies

CCT Agency Members

- Middlesex Hospital
- River Valley Services
- Connecticut Valley Hospital (Merritt Hall)
- Rushford Center, Inc.
- The Connection, Inc
- St. Vincent de Paul Soup Kitchen
- Mercy Housing
- Columbus House
- Community Health Center
- Gilead Community Services, Inc.
- Advanced Behavioral Health
- Value Options, Connecticut
- Community Health Network

Case/care management agencies

CCT Guiding Principles

- **Objective**: To provide patient-centered care and improve outcomes by developing wrap-around services through multi-agency partnership and care planning
- **Core belief:** Community collaboration is necessary to improve health outcomes
- **Core understanding**: Psycho-social problems are community problems. No one entity alone can effectively improve outcomes for this population

CCT – Program Development

- Weekly meetings (1st meeting: March 27, 2012); for 1 hour
- Expansion of CCT Release of Information form (required for each patient)
- Developed process for patient selection
- DMHAS Grant Conversion extended/expanded Health Promotion Advocate (HPA) positions
  - only added labor resource (grant funded in 1st year by CHEFA; continued by DMHAS)
  - care coordination & case management
  - direct & indirect referrals to treatment
  - link between patient – ED – CCT – community services
  - does “check in” calls for those in community who are stabilized or still struggling

CCT Process

Patient Identification:

- ED visit threshold criteria (# of visits & behavioral diagnoses)
- Daily ED discharge reports (5+ visits in 6 months)
- Chair of Emergency Services dictates ED Care Plan for ROI to be signed
- Health Promotion Advocate referral
- CCT member referral

•Once ROI is signed, patient is added to CCT agenda

•Team meets on a weekly basis

•In year 1, utilization ranged from 12-80+ ED visits in past 12 months

•# of patients who have received CCT care planning to-date: **199**

CCT – Weekly Meeting Format

Typical CCT meeting: discuss 10-20 patients per meeting; weekly tracking minutes

Research:	Team members research patient histories and psycho-social backgrounds (prior to meetings)
Review:	Team members share histories and review: 1) Outpatient and inpatient utilization 2) Access to care issues: what's currently being provided, where there are gaps 3) Housing status & options 4) Insurance status; available resources based on insurance 5) Arrests; arraignment reports
Brainstorm:	**Team brainstorms** re: best care management strategy
Care Plan:	Team members collaboratively develop customized care plans, with goals for: 1) Treatment and/or stabilization (PECs and adjudication, if necessary) 2) Stable housing 3) State insurance redetermination 4) Case management 5) Linkage to primary care, psychiatrists, specialists, outpatient services 6) Wrap-around services and supports for post-treatment 7) After-care planning
Ongoing:	Long-term follow-up: team members follow-up, review progress and revise care plan as needed; *once on CCT agenda, always on CCT agenda*

What We Track & Measure

Impact Metrics:

- # of visits (ED & inpatient) pre- and post- intervention (snapshot in time)
- Cost/losses

Demographics:

- # of patients who have received care planning
- Diagnosis category
- Gender and age distribution
- Insurance status
- Housing status

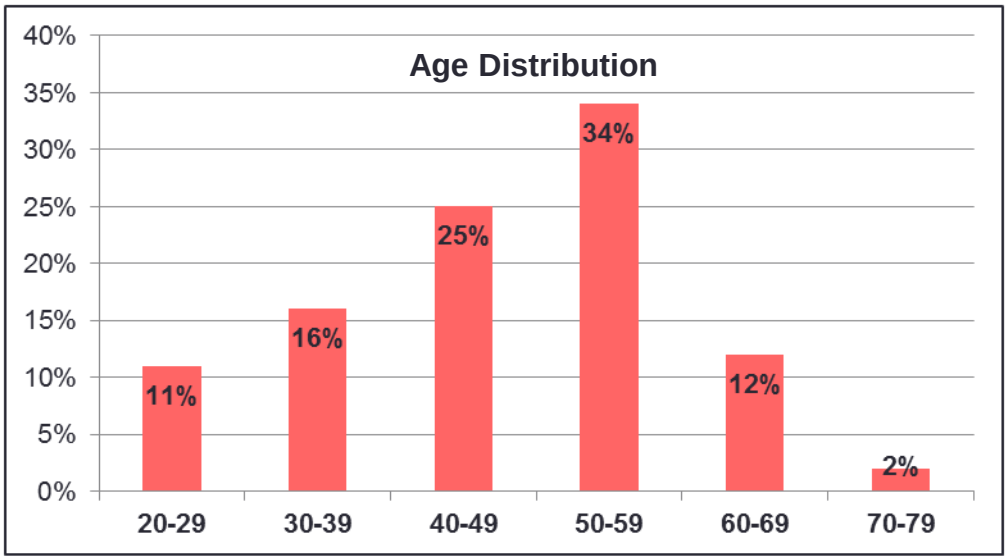
Community Care Team (CCT)

Complex high-risk and high-need ED "super user" patients with diagnoses of:

Dual Diagnosis	Chronic Mental Illness	Chronic Alcoholism	Other Drug Dependence
Coexisting severe mental illness and substance abuse disorders (primarily alcohol)	Most frequent dxs: bipolar; schizophrenia; schizoaffective; borderline personality	alcohol intoxication with/without suicidal ideation	Opioids; cocaine with/without suicidal ideation
43%	**29%**	**22%**	**6%**

- Dual: alcohol only → 45%
- Dual: other drugs → 28%
- Dual: alcohol & other drugs → 27%

What We Track & Measure



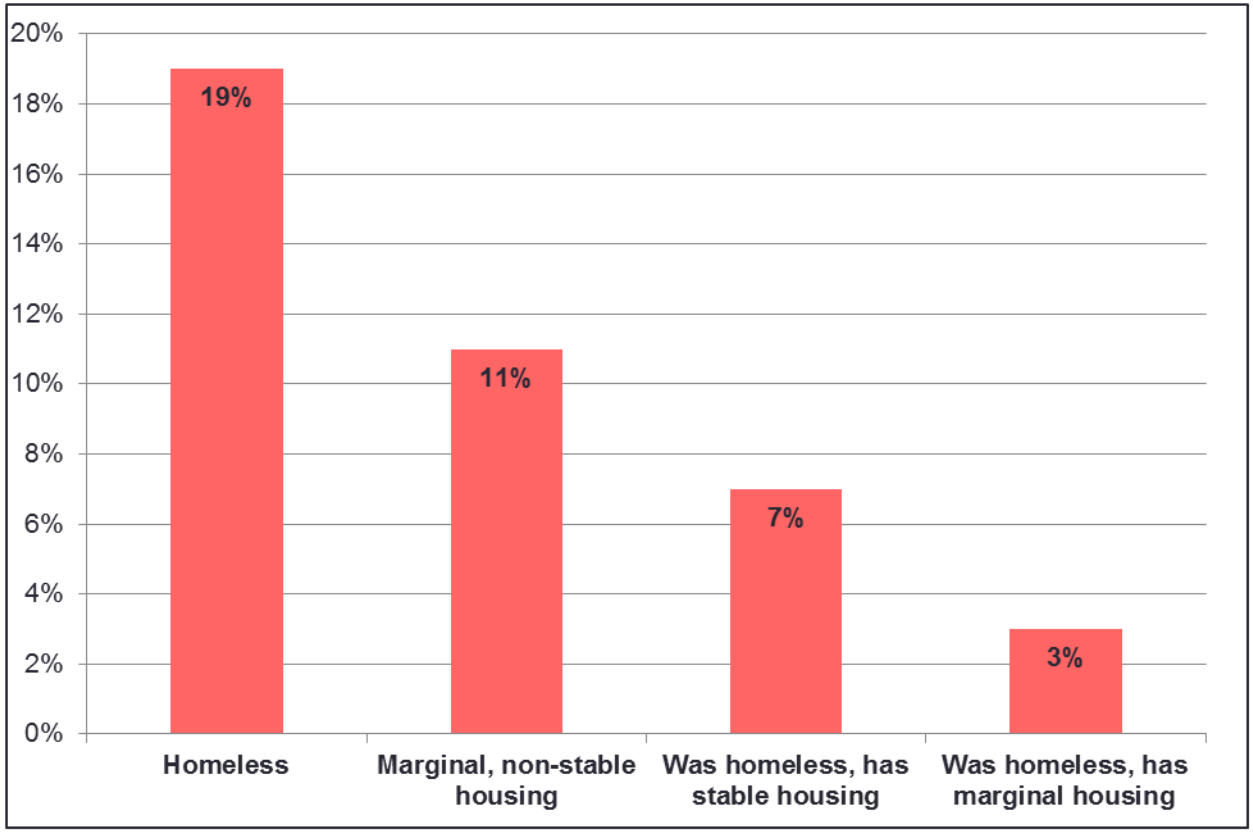
Gender:

- Female – 37%
- Male – 63%

Payor Status:

- Medicaid – 54%
- Medicare – 40%
- Managed Care – 4%
- Self-pay no insurance – 2%

Housing is an Issue

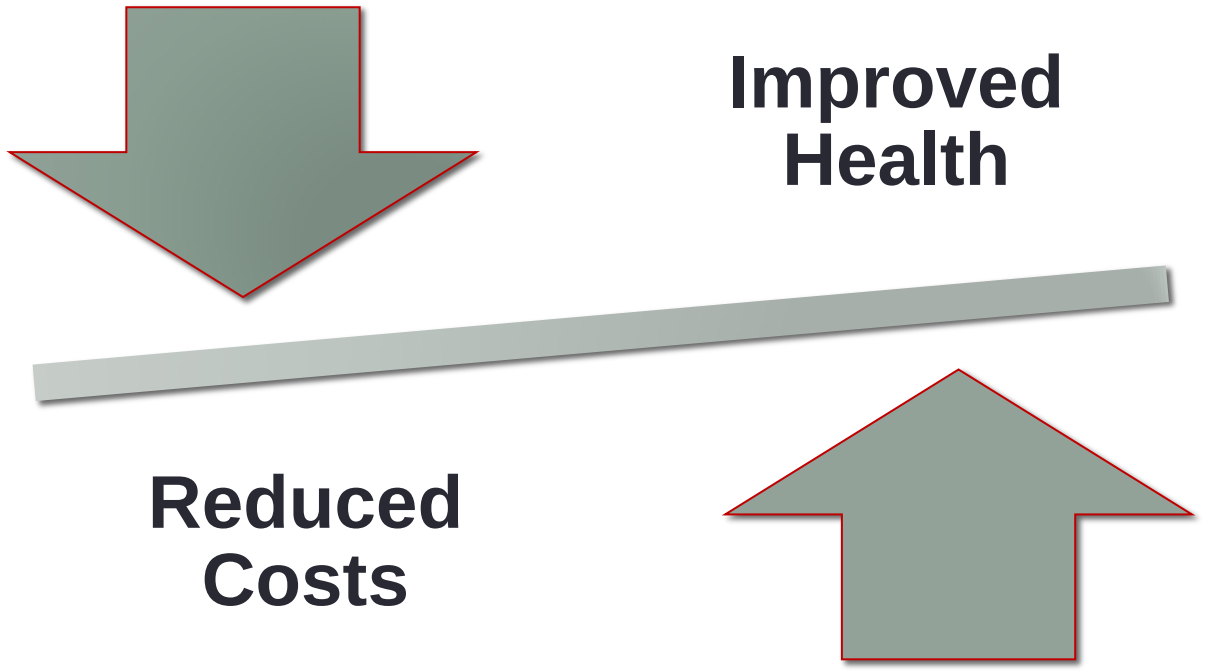


Total = 40%

CCT Patients who are Chronically Homeless – Common Traits

- Behavioral Health problems
- Disjointed care/lack of care coordination
- Poor primary care connections
- Lack of social network
- Noncompliance (with meds, follow-up/discharge instructions)
- Loneliness/hopelessness
- Use of ED as “home” → multiple ED & IP visits

Building Communities of Care as Partners in Practice



Cost Reductions

Hospital Cost Avoidance
All Claims

- 1142 reduction in visits x $1513.32 (average ED cost) = $1,728,205.99

Medicaid Claims Only
Savings Cost

- 640 reduction in visits x $915.66 (average ED cost) = $ 586,022.40

Additional Benefits

Patient:

- Improved quality of life:
  - Sobriety
  - Mental health stabilization
  - Reduced homelessness
  - Re-entry to workforce
  - Re-connection with family
  - Achievement of feelings of self-worth and respect
- Linkages to:
  - Primary care physicians, psychiatrists, specialists, etc.
  - Supportive housing
  - Appropriate outpatient services

Collaborative:

- Improved patient care
- Improved agency-specific care plans
  Improved inter-agency communication and relationships

Society:

- Increase in safety to all
- Reduction in Medicaid & Medicare expense

What Have We Learned?

1) This target population does not get better with the traditional model of care delivery

2) Chronically ill behavioral health patients consume a disproportionate amount of medical resources

3) Behavioral health chronic diseases require care coordination and customized treatment plans

4) Individualized care plans must have the ability to be flexible and evolve

5) Many agency providers were unaware of frequency of ED visits → communication allows for agency-specific care plans (a major part of CCT's success)

Questions?

Thank You!

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Healing the Homeless:

A Community Collaboration

Alison Cunningham
Executive Director
Columbus House, Inc.

Michael Ferry
Lead Social Worker
Yale New-Haven Hospital

Creating the Impetus for Change

- Ryan Greysen, MD – RWJ Scholar – 2010
  - 67% of the homeless stay in shelters
  - 21% saying with family/friends – "couch-surfing"
  - 11% consistently staying on the street
- Kelly Doran, MD – RWJ Scholar – 2012

  Studied 113 homeless individuals over 30 days
  - 50.8% were readmitted to inpatient care
  - 3.0% were readmitted to Observation
  - 75% of these readmissions occurred within 2 weeks
  - Only 18.7% of Medicaid patients readmitted during this time

Advocacy

- Kelly Doran, MD and then Senator Toni Harp of New Haven advocated for a Medical Respite program
- Respite was included first in a bill and later a budget signed by Governor Dannel Malloy in July of 2013
- Medical Respite Care opened on October 7, 2013
- Additional incentives for collaboration:
  - The need to reduce hospital readmissions
  - Profound reduction in medical reimbursement at state level

Formalizing Relationship

MEMORANDUM OF UNDERSTANDING

This MEMORANDUM OF UNDERSTANDING (this "MOU") is made and entered into as of February 6, 2015 by and between Columbus House, Inc., a Connecticut non-stock corporation ("Columbus House"), and Yale-New Haven Hospital, Inc., a Connecticut non-stock corporation ("YNHH"). Columbus House and YNHH are referred to in this MOU individually as a "Party" and collectively as the "Parties".

WHEREAS, the Parties mutually recognize the need for homeless individuals to receive recuperative care in a stable environment following hospitalization;

WHEREAS, Columbus House desires to establish and administer a medical respite program (the "Respite Program") that allows homeless individuals located in and around the area of New Haven, Connecticut to seek and receive temporary shelter at Columbus House's main shelter building at 586 Ella Grasso Boulevard, New Haven, Connecticut (the "Shelter") so that such individuals may receive recuperative care at the Shelter;

WHEREAS, YNHH desires to identify and refer patients requiring recuperative care who may be experiencing homelessness for admission to the Respite Program;

WHEREAS, the Parties wish to set forth the terms on which Columbus House will administer the Respite Program and WHEREAS,YNHH plans to refer patients to the Respite Program;

NOW, THEREFORE, the parties hereby agree as follows:

Medical Respite Program Columbus House

- Location: Third floor of Columbus House
- Number of Beds: 12
- Funding: Five-year pilot grant from the State of Connecticut
- Length of stay: Up to 30 days, with extensions permitted as needed
- Referrals: From Yale-New Haven and Veteran Administration Hospitals
- Staffing: 24-hour supervisory staff, Visiting nursing for medical care

Yale-New Haven Hospital

Columbus House, New Haven

Respite Patient's Room

Sensitizing Hospital Staff

- Training regarding homeless individuals and Medical Respite was provided to:
  - Social Workers
  - Care Managers
  - Physicians
  - Emergency Department staff
- Used to develop an appreciation of the unique needs and challenges faced by homeless individuals

Identifying Hospitalized Homeless Patients

- Patients disclose to staff:
  - Admissions
  - Physicians
  - Nursing
  - Social Work
- Documentation retrieved through software reports
  - Social Work

Eliciting Circumstances of Homelessness

"Where have you been living during the past two months?"

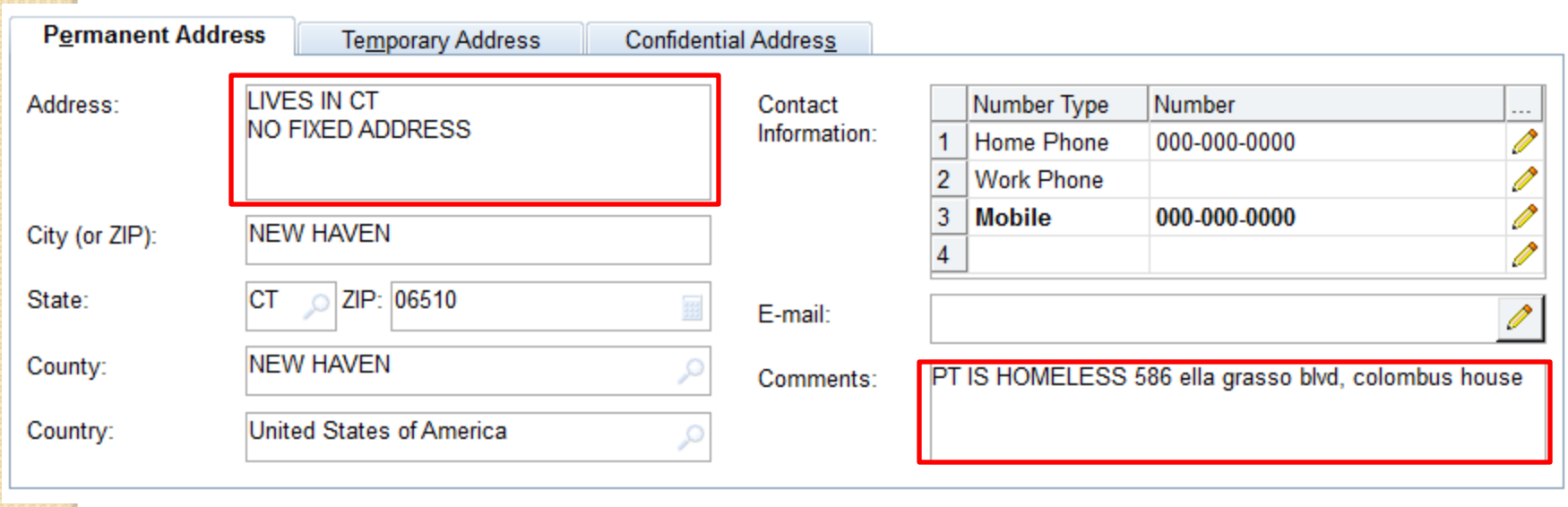
"Is this reliable housing that you own, rent, or stay in as part of a household?"

"Are you able to return and stay there following discharge?"

- If yes, "Are you able to receive a visiting nurse there?"
- If no, will this patient have a post-discharge medical need requiring respite?

Communicating Housing Status through the Medical Record

From Admissions:



Communicating Housing Status through the Medical Record

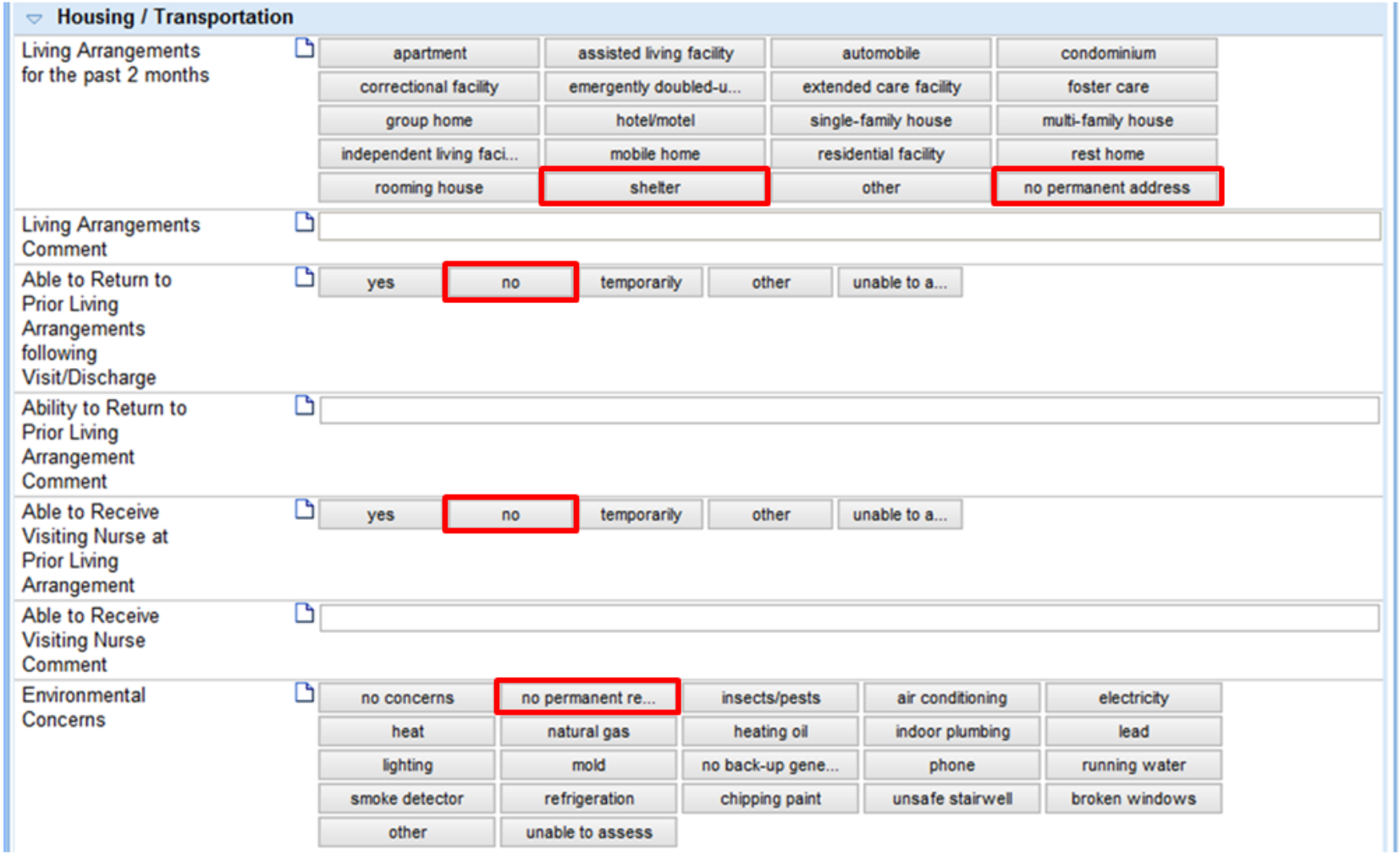
From Physicians:

Non-Hospital Problem List — Date Reviewed: **3/31/2014**

	ICD-9-CM	Priority	Class	Noted
Alcohol withdrawal	291.81			3/26/2014
Atrial fibrillation with rapid ventricular response	427.31			11/24/2013
Chronic pain syndrome	338.4			11/24/2013
Community acquired pneumonia	486			11/24/2013
Nicotine dependence	305.1			11/26/2013
Alcohol abuse	305.00			11/27/2013
Homelessness	V60.0			11/27/2013
Atrial fibrillation	427.31			2/4/2014
Atrial fibrillation with RVR	427.31			3/3/2014
Fibromyalgia	729.1			2/4/2014
Knee strain	844.8			3/3/2014
Hypertension	401.9			Unknown

Communicating Housing Status through the Medical Record

- From Nursing & Social Work



Housing / Transportation

Living Arrangements for the past 2 months	apartment	assisted living facility	automobile	condominium
	correctional facility	emergently doubled-u...	extended care facility	foster care
	group home	hotel/motel	single-family house	multi-family house
	independent living faci...	mobile home	residential facility	rest home
	rooming house	**shelter**	other	**no permanent address**
Living Arrangements Comment				
Able to Return to Prior Living Arrangements following Visit/Discharge	yes	**no**	temporarily	other	unable to a...
Ability to Return to Prior Living Arrangement Comment				
Able to Receive Visiting Nurse at Prior Living Arrangement	yes	**no**	temporarily	other	unable to a...
Able to Receive Visiting Nurse Comment				
Environmental Concerns	no concerns	**no permanent re...**	insects/pests	air conditioning	electricity
	heat	natural gas	heating oil	indoor plumbing	lead
	lighting	mold	no back-up gene...	phone	running water
	smoke detector	refrigeration	chipping paint	unsafe stairwell	broken windows
	other	unable to assess			

Establishing Communication

Release of Information

Yale-New Haven Hospital/Columbus House Medical Respite Care Program
Participation Agreement and Authorization for Access/Release of Information

PATIENT/CLIENT NAME: _____ DATE OF BIRTH: _____- _____- _____

YNHH Medical Record# _____ NAME OF FRIEND/NEXT-OF-KIN ETC. _____

ADDRESS/PHONE NUMBER (if applicable):_____ May I leave a message at this #? ☐ Yes ☐ No

This document authorizes Yale-New Haven Hospital (YNHH) and Columbus House Medical Respite Care Program to use, share and disclose protected health information (PHI) of the person named above with one another, as well as with other entities participating in the Medical Respite Care Program. These entities include, but are not limited to, Columbus House, YNHH and its Primary Care Center, Cornell Scott-Hill Health Center, Visiting Nurse Association of South Central Connecticut, Continuum of Care and The Apothecary (collectively the "Participants") for purposes of screening for participation in the program, as well as ongoing care and treatment.

I authorize YNHH, as well as the Participants named above, to release the information from my medical records as necessary and to obtain information from:

Columbus House Medical Respite Care Program, 586 Ella Grasso Boulevard, New Haven CT 06519 Phone: 203-401-4400

The person to be contacted at YNHH regarding medical questions or concerns is _____ Phone: _____
(name of social worker or care manager)

INFORMATION TO BE RELEASED OR OBTAINED (IN EITHER VERBAL OR WRITTEN FORM) may include:

☐ Relevant Social and Health History
☐ Medication Required Following Discharge
☐ Protected Health Information affecting home care needs
☐ Information related to necessary contact precautions

Collaboration

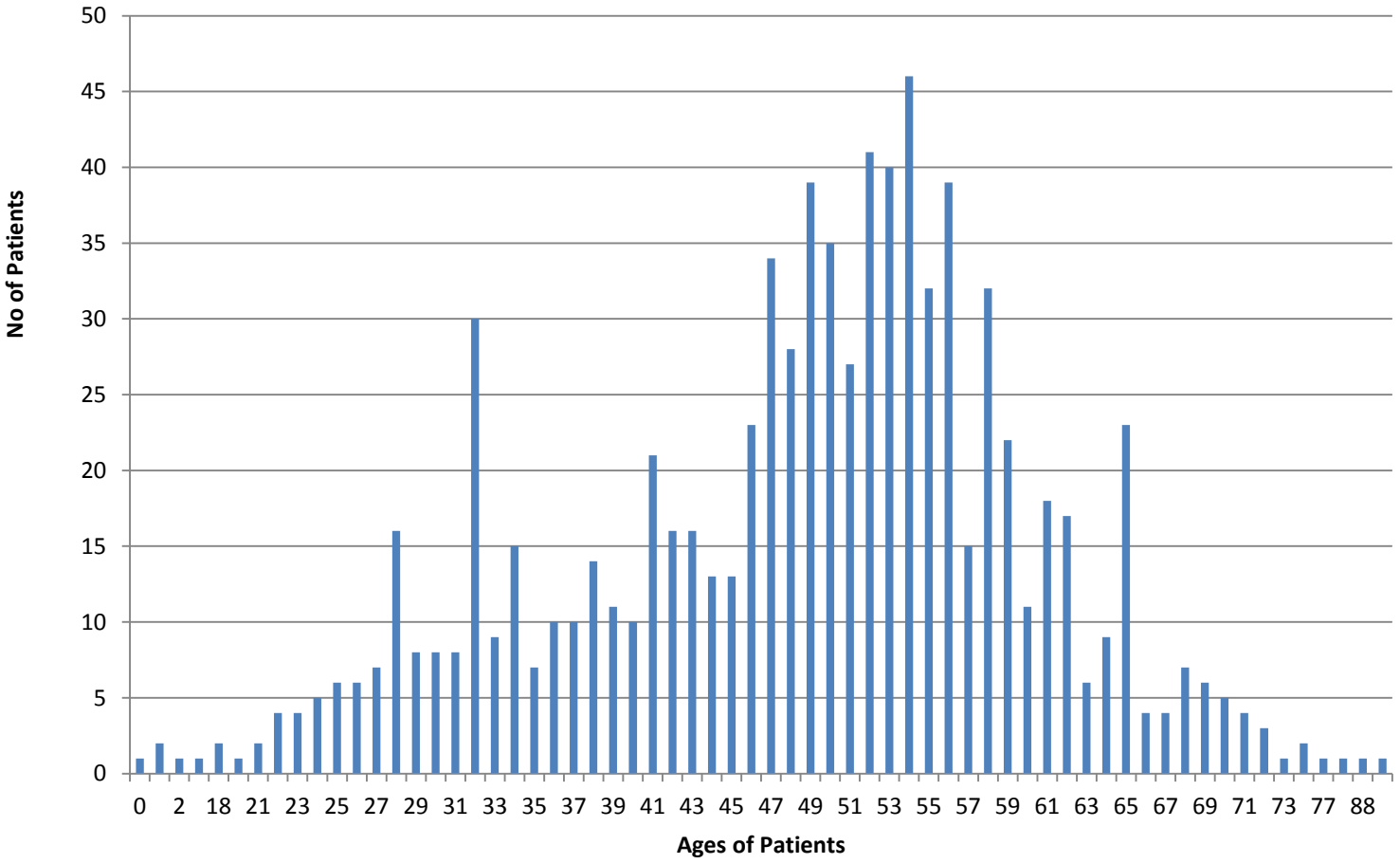
- Throughout the admission process
- Weekly Case Review meetings:
  - Social workers, care managers, physician, and pharmacy from Yale-New Haven Hospital
  - Staff from the Medical Respite Care program
  - Staff from the Cornell Scott-Hill Health Center and Primary Care Center, and
  - Staff from Continuum of Care and VNA of South Central CT
- Ongoing steering committee meetings to address systemic issues impacting the program and patient care

Using Data to Describe the Problem and Effectiveness of the Solution

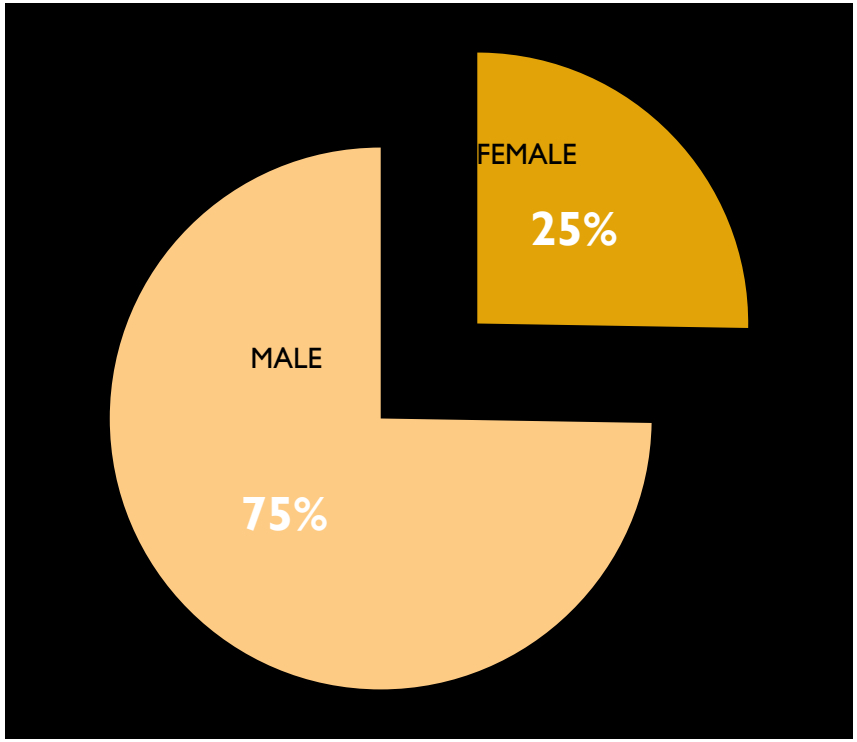
From October 1, 2013 to September 30, 2014:

- 804 patients were identified as homeless and screened (includes repeat patients)
- The above screenings resulted in 475 unique patients

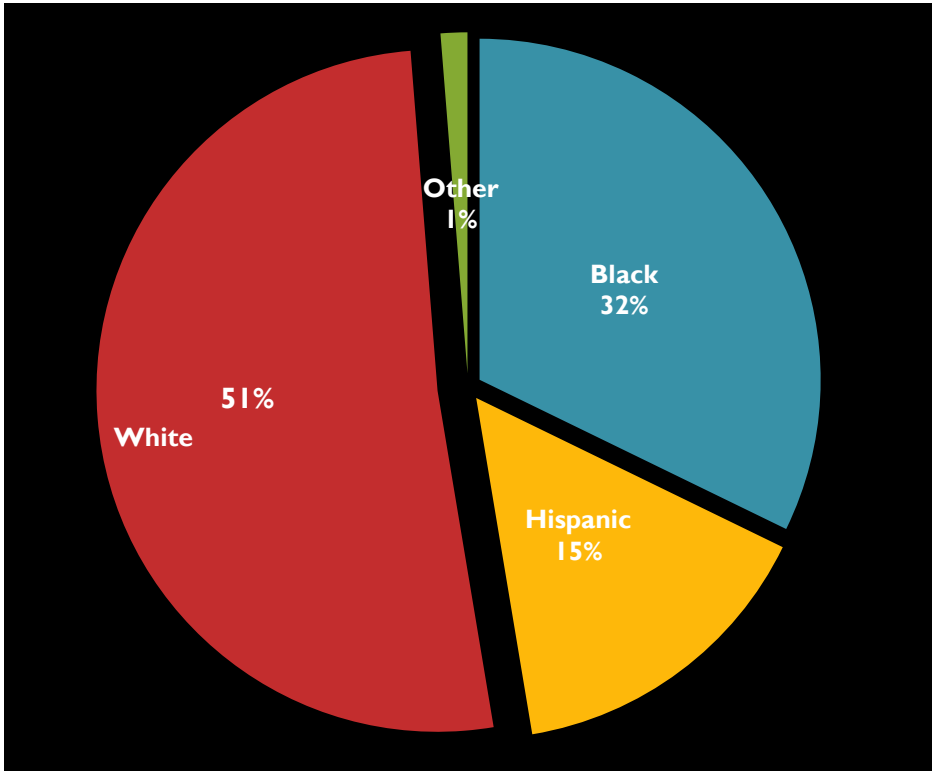
Average Age = 48.44 Years



Sex

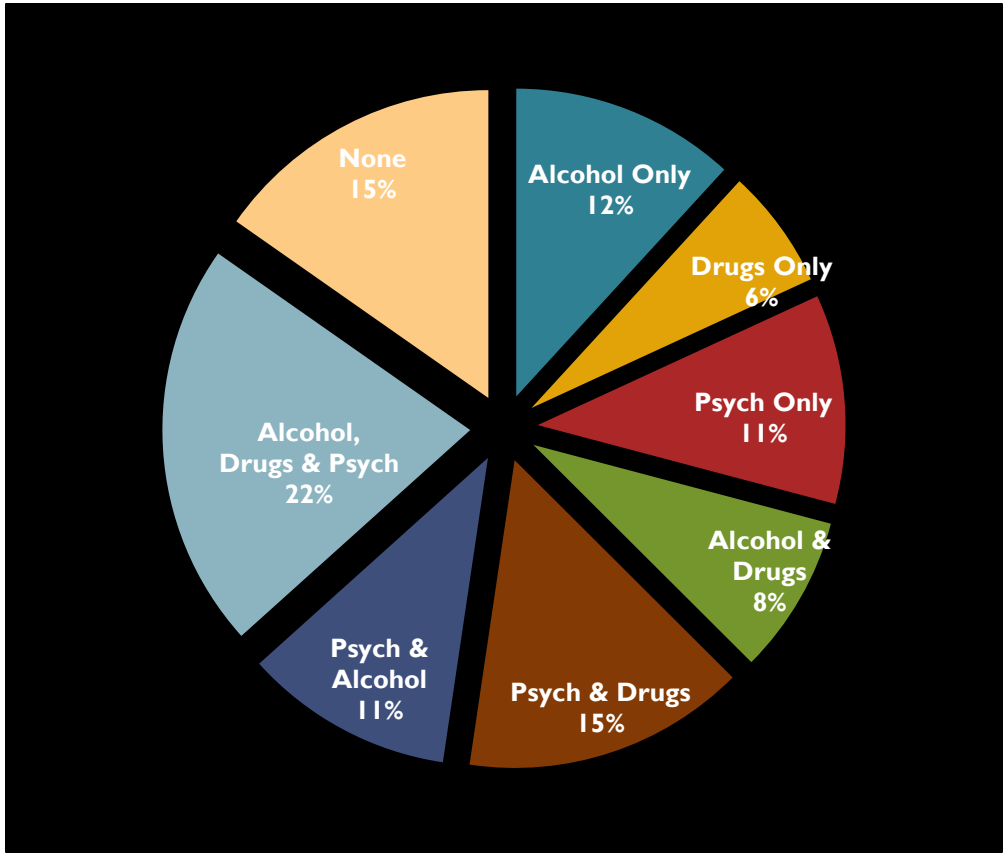


Race



Hospitalized Homeless Affected by Mental Health & Substance Abuse

- Patients assigned a mental health diagnosis, even if not currently experiencing symptoms= 58.2%
- Patients abusing alcohol: 52.5%
- Patients using illicit drugs: 50.9%
- Combining the alcohol & drug numbers, 84.7% of patients were actively abusing alcohol or using illicit drugs, while 15.3% were not misusing either.



Medical Factors Impacting the Hospitalized Homeless

(Includes repeat patients)

- Patients without a Primary Care Provider upon admission = 38.6%
- Average number of Emergency Department visits during the prior 365 days = 13.6
- Most common medical conditions upon admission:
  - Alcohol Intoxication/Withdrawal (18.2%)
  - Chest Pain (9.6%)
  - Diabetes (23.2%)
- Average inpatient length of stay = 7.0 Days
- Average number of medications prescribed at discharge = 6.7

Insurance Numbers…

(Includes repeat patients)

- Covered by Medicaid = 75.0%
- Covered by Medicare = 16.0%
- Covered by private insurance = 3.0%
- No insurance = 9.4%
- Patients with Medicare or Husky C and thus are either aged or disabled = 32.7%

Readmission Rates

Inpatient Readmission Type	All (age > 17) Medicaid	Homeless Medicaid Patients	Respite Medicaid Patients	Percent Difference in Readmission Rate for those Homeless Provided with Respite Services
30 day	18.6%	35.0%	25.0%	**28.6%**
14 day	12.0%	24.8%	12.5%	**49.6%**
7 day	7.6%	15.4%	7.1%	**53.9%**

Hospital Length of Stay

	Discharge Disposition		
	No Nursing Care Recommended	Required Home Nursing or Respite Care	Required Nursing Home Placement
All Medicaid (Age >17)	5.3 Days	6.4 Days	11.5 Days
Homeless (Age >17)	6.5 Days	10.2 Days	15.9 Days
Difference	1.2 Days	3.8 Days	4.4 Days

Possible Reasons for Higher Length of Stay for Homeless & Respite Patients:

- Sicker population
- Increased discharge preparation planning for the homeless implemented in April
- Evaluation by & communication with Columbus House for Respite patients
- Respite discharges are infrequent per staff, requiring re-learning each time
- Limited admission window for shelters

Disposition of the Hospitalized Homeless …

Out of 804 discharges (includes repeat patients):

- 85 patients were admitted to Medical Respite (10.5%)
- 54 patients went to a skilled nursing facility (because their needs were more than could be managed at Respite) (6.7%)
- 131 patients had family or friends willing to take them in (16.2%)
- 275 patients went to standard shelter services, due to not meeting criteria (typically due to lack of a medical need requiring recuperation) (34.2%)
- 92 patients declined respite or shelter services choosing the street instead (11.4%)
- 83 patients identified as homeless had a residence or acquired housing at discharge (10.3%)
- 72 patients went on to other forms of care, e.g. inpatient psychiatric or substance abuse treatment (8.9%)
- 12 patients could not be included, e.g. due to rapid discharge or demise (1.4%)

Applied for Respite, Not Admitted

Nine-Month Sample: 25 Patients

Secured own housing:	6 pts,	24%
Went to nursing home:	5 pts,	20%
Non-compliance issues:	4 pts,	16%
Chronic conditions only:	3 pts,	12%
Left before Respite eval:	3 pts,	12%
No home nursing needs:	2 pts,	8%
Left against medical advice:	2 pts,	8%

Additional Community Collaborations

Project Night Time, 2014

- A seasonal program that guides homeless visitors to the Emergency Department (who are not injured or ill) to services more appropriate to their needs.
  - Organized through a collaboration between the hospital and local shelters, including Columbus House
  - Homeless individuals are asked for their name, date of birth, and prior location of residence
  - Provided with transportation when necessary
  - Dropped the number of people situated in the YNHH waiting room dramatically

100-Days Program

- Begun in April of 2014
- Brought many community agencies together on many levels
- Furthered the efforts to share information
- coordinated efforts to survey the homeless and provide housing

Coordinated Access Network (CAN)

- Launched January 25, 2015
- Multi-agency collaboration by housing agencies - with hospital input
  - Homeless individuals are assisted in calling InfoLine (211) and are scheduled for an intake interview
  - If eligible, they are guided to the nearest shelter bed
  - Standardizes the emergency shelter process

Overnight Winter Warming Center, 2015

- A follow-up program to provide the homeless with an overnight walk-in location to stay out of the winter weather
  - Organized by a collaboration of many local agencies including YNHH and Columbus House
  - January 15 to March 15, chairs & tables only
  - 30 to 35 visitors per night, police and case manager presence, no concerning incidents
  - Greatly reduced visitors to our Emergency Departments

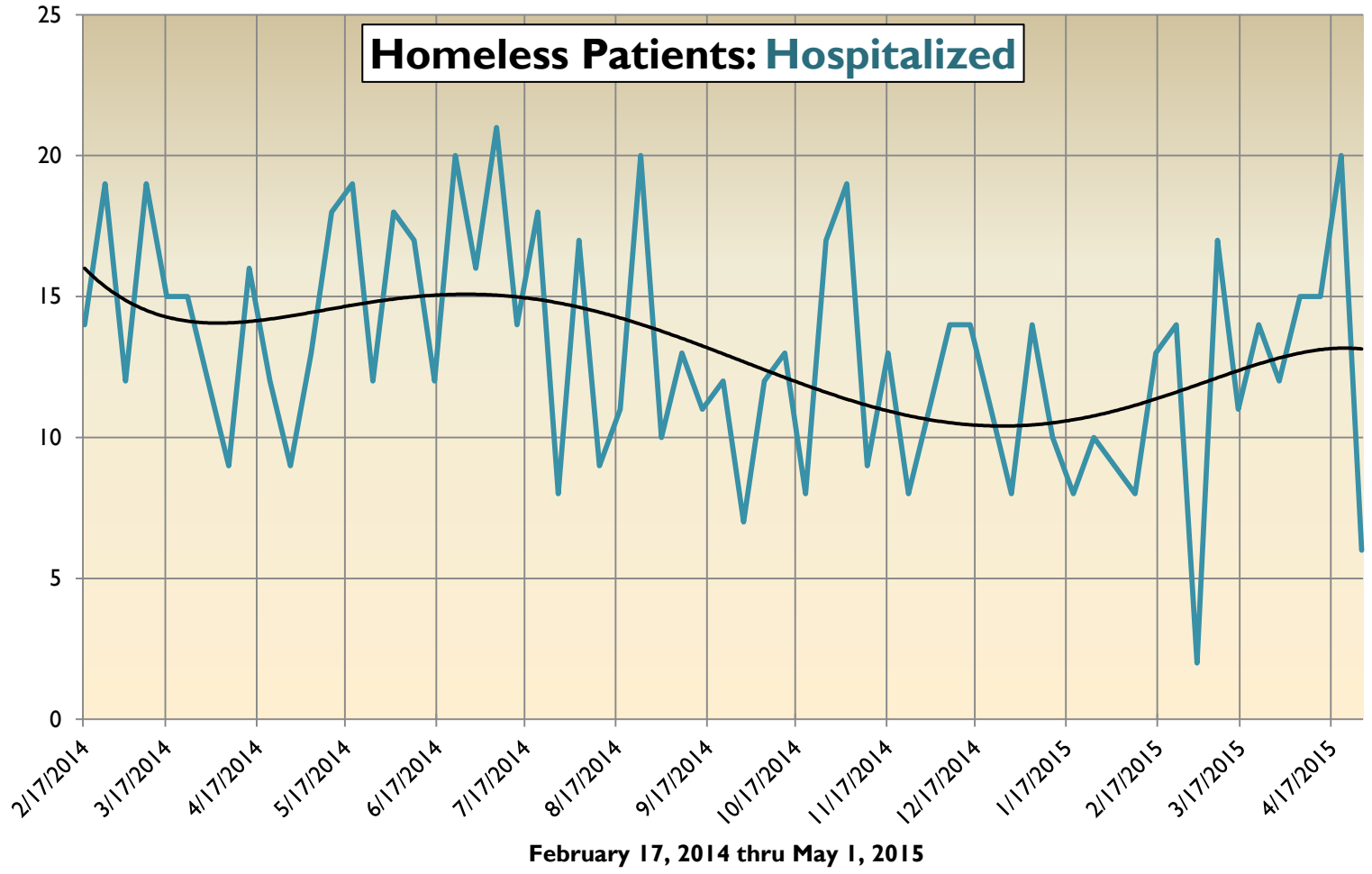
Brandeis Innovation Study

- Five Respite programs across the U.S.
- Evaluating each program for the purpose to determining whether Respite should be covered by federally-funded insurances
  - ED visits
  - Length of stay
  - Readmission rate
  - Diagnoses, treatments
  - Charges, costs, reimbursements

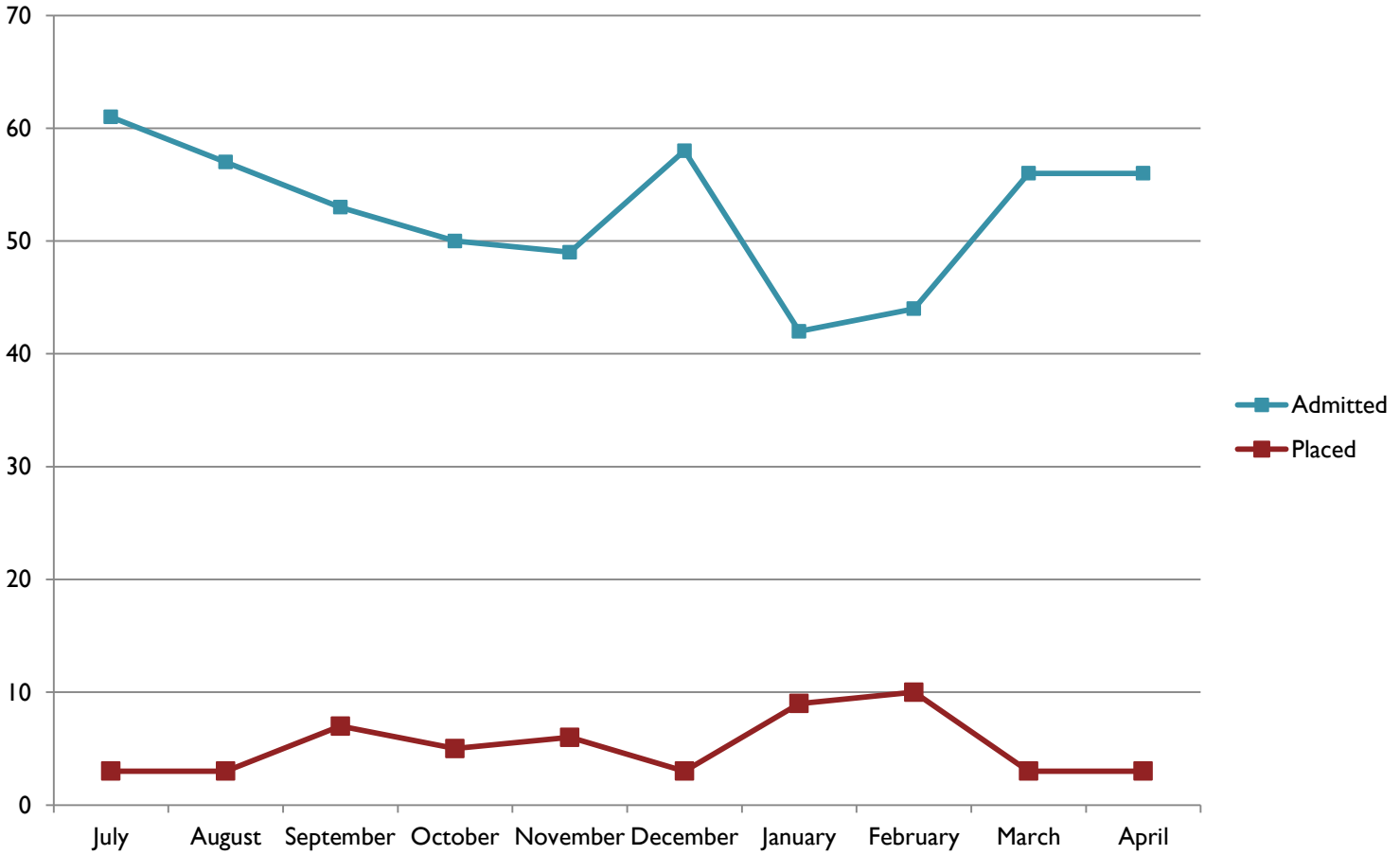
South Central Community Care Team

- Led by Value Options
- Established in August 2014
- Meets weekly on Thursday afternoons
- Address the needs of frequent visitors (7x in past 6 months) to the ED with behavioral health problems
- Additional meeting now established for those with primarily substance abuse difficulties

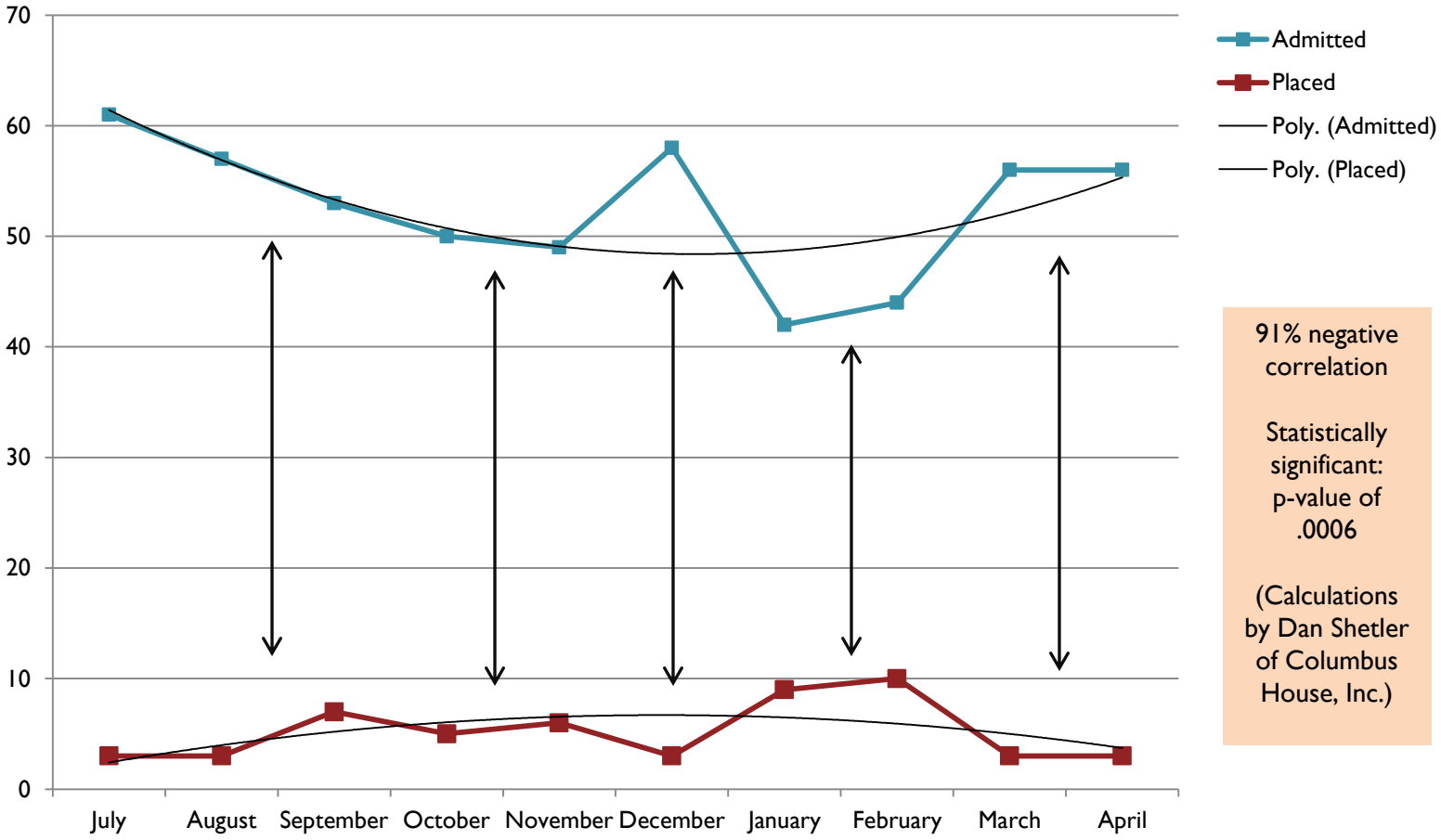
Hospitalized Homeless Patients



Hospitalized Homeless and Housing Placements



Hospitalized Homeless and Housing Placements (w/ Guides)



91% negative correlation

Statistically significant: p-value of .0006

(Calculations by Dan Shetler of Columbus House, Inc.)

Conclusions

- Advocacy makes a difference
- Training counts
- Collaborative relationships work!
- Data can make your case
- Multiple approaches may be needed
- Housing is its own form of health care!

Supporting Documents

Example Releases of Information
Agency Contact Information

Coordinated Access Network ROI

[Organization logo]

Greater New Haven Case Confrencing
AUTHORIZATION FOR RELEASE OF INFORMATION

This authorization is voluntary. The information you authorize us to disclose may be subject to re-disclosure by the recipient and if the person or organization authorized to receive the information is not a health plan or health care provider, the information may no longer be protected by Federal privacy regulations. We may not condition your receipt of treatment, payment, enrollment, or eligibility for benefits on completion of this authorization.

NAME (LAST, FIRST): _____ **DATE OF BIRTH:**_____

I hereby authorize the agencies listed below to exchange the indicated information for the purpose of ensuring effective coordination of services. (With one or more of the other agencies)

Initial each type of information to release:

☐ Medical ☐ Mental Health/Psychiatric ☐ Criminal Record ☐ HIV/AIDS
☐ Housing ☐ Alcohol and/or drug abuse ☐ Other: _____
☐ All of the above

Agencies covered by the terms and conditions of this authorization are:

Fellowship Place, Inc.
Connecticut Mental Health Center
Liberty Community Services, Inc.
Continuum Home Health
Columbus House, Inc.
Cornell Scott Hill Health Center
The Connection, Inc.
Easter Seals Goodwill Industries Rehabilitation Center, Inc.
Leeway, Inc.
New Haven Legal Assistance Association
City of New Haven
VNA South Central Consultant
New Reach
Yale-New Haven Hospital
Youth Continuum, Inc.
Christian Community Action
Yale School of Medicine
Continuum of Care, Inc.
Connecticut Court Support Services Division
Emergency Shelter Management Services
Connecticut Department of Correction
Connecticut State Dept. of Mental Health and Addiction Services
AIDS Project New Haven
Community Solutions
Veterans Service Administration
Marrakech, Inc.
Beth-El Center, Inc.
BHCare
Connecticut Health Network
Spooner, Inc.

I understand that some or all of my information may be protected under Federal regulations (42 C.F.R. Part 2) and/or Connecticut state law and cannot be further disclosed without my written consent. I further understand that this authorization will expire one year from the date I sign the authorization. I may revoke this authorization in writing at any time; however, any revocation will not be effective retroactively for information disclosures that have already occurred.

Client Signature:_____ **Date:**_____

_____
Print Name

Note: If you are a legal guardian or representative, you must attach a copy of your legal authorization to represent the member and complete the following:

Signature of Guardian/Representative: _____

Print: _____ Date: _____

Legal Authority: _____

NOTICE TO RECIPIENT OF INFORMATION

All or a portion of this information may have been disclosed to you from records protected by Federal and/or Connecticut state law which prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law(s). A general authorization for the release of medical or other information is NOT sufficient for this purpose. In addition, Federal rules (42 C.F.R. Part 2) restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

100-Day Campaign ROI

Yale-New Haven Health System

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NAME (LAST, FIRST): _____ **DATE OF BIRTH:** _____

I hereby authorize the agencies listed below to disclose information from one year ago to present and exchange the indicated information for the purpose of ensuring effective coordination of services related to 100,000 Homes Campaign.

Initial each type of information to release:

_____Medical _____Mental Health/Psychiatric _____Criminal Record _____HIV/AIDS
_____Housing _____Alcohol and/or drug abuse _____Other: _____
_____All of the above

Agencies covered by the terms and conditions of this authorization are:

AIDS Project New Haven
APT Foundation
City of New Haven
Columbus House, Inc.
Community Services Network
Community Solutions
Connecticut Behavioral Health Partnership/Value Options
Connecticut Court Support Services Division
Connecticut Dept. of Corrections
Connecticut Dept. of Mental Health and Addiction Services
Connecticut Mental Health Center
Continuum of Care
Continuum Home Health
Cornell Scott-Hill Health Center
Easter Seals Goodwill Industries
Emergency Shelter Management Services
Fellowship
Leeway New Haven
Liberty Community Services, Inc.
Marrakech, Inc.
New Haven Correctional Center
New Haven Home Recovery
New Haven Legal Assistance Association
Ryan White Program
The Connection, Inc.
Veterans Service Administration
VNA of South Central Connecticut
Yale-New Haven Hospital
Yale School of Medicine
Youth Continuum

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Print Name:

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F7705

F7705 (N 05/14)

Medical Respite ROI

Yale-New Haven Hospital/Columbus House Medical Respite Care Program
Participation Agreement and Authorization for Access/Release of Information

PATIENT/CLIENT NAME: _____ DATE OF BIRTH: ____-____-____

YNHH Medical Record# _____ NAME OF FRIEND/NEXT-OF-KIN ETC. _____

ADDRESS/PHONE NUMBER (if applicable):_____ May I leave a message at this #? ☐ Yes ☐ No

This document authorizes Yale-New Haven Hospital (YNHH) and Columbus House Medical Respite Care Program to use, share and disclose protected health information (PHI) of the person named above with one another, as well as with other entities participating in the Medical Respite Care Program. These entities include, but are not limited to, Columbus House, YNHH and its Primary Care Center, Cornell Scott-Hill Health Center, Visiting Nurse Association of South Central Connecticut, Continuum of Care and The Apothecary (collectively the "Participants") for purposes of screening for participation in the program, as well as ongoing care and treatment.

I authorize YNHH, as well as the Participants named above, to release the information from my medical records as necessary and to obtain information from:

Columbus House Medical Respite Care Program, 586 Ella Grasso Boulevard, New Haven CT 06519 Phone: 203-401-4400

The person to be contacted at YNHH regarding medical questions or concerns is _____ Phone: _____
(name of social worker or care manager)

INFORMATION TO BE RELEASED OR OBTAINED (IN EITHER VERBAL OR WRITTEN FORM) may include:

☐ Relevant Social and Health History
☐ Medication Required Following Discharge
☐ Protected Health Information affecting home care needs
☐ Information related to necessary contact precautions

1. I understand that this authorization will expire one year after I have signed this form, or other date as specified: ___/___/____
2. If I change my mind about allowing YNHH and Columbus House Medical Respite Care Program to share my information, I will tell YNHH and Columbus House in writing. This change will be effective on the date the organization receives it but will not affect anything that has already happened.
3. I understand that information used or disclosed as part of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by privacy regulations.
4. I understand that I am not required to sign this form in order to receive treatment or payment for my care.
5. I understand that information to be released or obtained may include mental health information in accordance with CGS 52-146(d), substance abuse treatment information in accordance with 42 CFR 2.1-2.67, and/or HIV/AIDS-related information except as below:

☐ No Mental Health ☐ No Substance Abuse treatment information ☐ No HIV/AIDS information

_____ _____ _____
Patient Signature Date Time

_____
Print Name

_____ _____ _____
Parent/Legal Guardian/Authorized Person Date Time

_____
Relationship to Patient

PATIENT MAY RECEIVE A COPY OF THIS FORM AFTER SIGNING
(White - YNHH Medical Record, Yellow - Columbus House MR Program, Pink - Patient)

F7589

F7589 (Rev. 02/14)

Questions?

Keep In Touch!

Partnership for Strong Communities

www.pschousing.org

@pschousing

Connecticut Hospital Association

www.chime.org

@cthosp

Keep In Touch

Middlesex Hospital
www.middlesexhospital.org

Columbus House, Inc.
www.columbushouse.org
@columbushouseCT

Yale-New Haven Hospital
www.ynhh.org
@YNHH

REACHING HOME
Ending Homelessness
a campaign of the Partnership for Strong Communities

Integrating Health Care & Housing:
Opening Doors-CT Hospital Initiative

Background

Homelessness and housing instability are associated with poor health outcomes, including high mortality and high rates of chronic illnesses. Often those experiencing homelessness or housing instability cycle in and out of hospital emergency departments (ED), costing the medical system millions of dollars each year.

Adults who are homeless represent 5% of the Medicaid population but are overrepresented in some types of care:

- 17% inpatient care
- 19% ED visits for adults with a primary behavioral health diagnosis
- 39% with 3+ inpatient medical detox episodes

Given these findings, hospitals have the potential to be a critical partner in interventions and care coordination for those experiencing homelessness. The Opening Doors-CT Hospital Initiative launched in 2014 as a collaboration between the Partnership for Strong Communities and the Connecticut Hospital Association. This project focuses on bridging the gap between hospitals and community providers, and better serving those who are homeless.

Target Population

Frequent visitors of hospital emergency departments (ED) and inpatient beds, also known as **super-utilizers**. Frequent visitors are those who have:

Visited an ED 7+ times in the past 6 months

Strategies

- Implement homelessness screener in emergency department electronic health records
- Establish **Community Care Teams (CCTs)** to improve care coordination between hospital staff and community providers
- Develop peer sharing across participating hospitals

Goals

1. Better identify individuals experiencing homelessness or housing instability
2. Reduce emergency department visits and inpatient readmissions
3. Improve care coordination upon discharge from inpatient and outpatient settings
4. Reduce costs for the medical and health care system

In Partnership With:

CHA Connecticut Hospital Association
Norwalk Hospital — Compassion. Expertise. Results.
Hartford Hospital
Saint Francis Hospital and Medical Center
Middlesex Hospital
Yale-New Haven Hospital

Funded by:

Connecticut Health Foundation — Changing Systems, Improving Lives.
Melville Charitable Trust

Opening Doors in Connecticut...

...to a Future Where **Everyone** Has a Home

PARTNERSHIP FOR STRONG COMMUNITIES

FOR MORE INFORMATION, CONTACT:
ALICIA WOODSBY, EXECUTIVE DIRECTOR
ALICIA@PSCHOUSING.ORG

PARTNERSHIP FOR STRONG COMMUNITIES
860.244.0066
WWW.PSCHOUSING.ORG

REACHING HOME
Ending Homelessness
a campaign of the Partnership for Strong Communities

Integrating Health Care & Housing:
Opening Doors-CT Hospital Initiative

Preliminary Findings

35-40%

Percent of frequent visitors experiencing homelessness or housing instability

7-69

Number of ED visits per frequent visitor in the past six months

34%

Percent of frequent visitors who visited 3 or more EDs during the previous six months

62%

Percent of frequent visitors who are male

Outcomes Tracked

- Demographics (age, race, gender)
- Health insurance
- % ED visits accounted for by frequent visitors
- Readmission rates to ED and inpatient care (7- and 30-day follow up)
- Connection to care (7- and 30-day follow up)
- Housing/homelessness status
- Medicaid claims data
- SF-12 physical and mental health scales
- Substance use

Lessons Learned

- Importance of peer sharing across Community Care Teams (CCTs)
- Extensive time needed to develop release of information
- Need for flexible care plans
- Movement of frequent visitors between hospitals
- Prevalence of substance use by frequent visitors
- Value of having the Administrative Service Organization (ASO) at the table

Next Steps

- Evaluate the initiative - both process and outcome
- Expand the model to other institutions
- Develop a predictive model to better identify and serve frequent visitors
- Expand respite care options across the state
- Develop a more comprehensive continuum of care for substance users
- Explore Medicaid payments for supportive housing services
- Develop a model for sustainability

Homelessness is unacceptable. Homelessness is solvable and preventable.
Homelessness is expensive. Invest in solutions.

PARTNERSHIP FOR STRONG COMMUNITIES 227 LAWRENCE STREET HARTFORD, CT 06106 860-244-0066 WWW.PSCHOUSING.ORG

[Organization logo]

Greater New Haven Case Confrencing
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Christian Community Action
Yale School of Medicine
Continuum of Care, Inc.
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Yale-New Haven Health System

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_____Medical _____Mental Health/Psychiatric _____Criminal Record _____HIV/AIDS

_____Housing _____Alcohol and/or drug abuse _____Other: _____

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F7705

Yale-New Haven Hospital/Columbus House Medical Respite Care Program
Participation Agreement and Authorization for Access/Release of Information

PATIENT/CLIENT NAME: _____ DATE OF BIRTH: ____- ____- ____

YNHH Medical Record# _____ NAME OF FRIEND/NEXT-OF-KIN ETC. _____

ADDRESS/PHONE NUMBER (if applicable):_____ May I leave a message at this #? ☐ Yes ☐ No

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_____ _____ _____
Patient Signature Date Time

_____
Print Name

_____ _____ _____
Parent/Legal Guardian/Authorized Person Date Time

_____
Relationship to Patient

PATIENT MAY RECEIVE A COPY OF THIS FORM AFTER SIGNING
(White - YNHH Medical Record, Yellow - Columbus House MR Program, Pink - Patient)


F7589