Slowing the Revolving Door

Hospitals and Homeless Services Collaboration to Disrupt the Hospital-Homeless Cycle

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Pedro

"Take a look at your high-utilizer list…What story is it telling?"

Pat Belair, RN

Senior Vice President—Ambulatory Services and Strategy

SBH Health System

- ***BronxWorks*** helps individuals and families improve their economic and social well-being. From toddlers to seniors, we feed, shelter, teach, and support our neighbors to build a stronger community.
- As a result of the efforts of the BronxWorks Adult Homeless Services Department, there has been a more than 50% decline in the number of chronic street homeless people on Bronx streets over the past decade

- ***SBH Health System*** is committed to improving the health and wellness of our community and is dedicated to providing the highest quality care in a compassionate, comprehensive and safe environment where the patient always comes first, regardless of their ability to pay.
- SBH Health System includes St. Barnabas Hospital, SBH Ambulatory Care Center, SBH Hemodialysis Center, SBH Behavioral Health, and Southern Medical Group

Agenda

- Health and Homelessness Landscape in the Bronx
- Beginning a Collaboration
- Building a Toolkit
  - Tools for Data Collection
  - Tools for Individual and Systemic Interventions
- Toolkit in Motion
  - Case Presentation
- Best Practices and Scalability
- Future Directions
- Q&A

Health and Homelessness Landscape in the Bronx

BronxWorks | SBH Health System

#Not62

See New York City Department of Health. (2016, March 16). *New partners join #Not62 campaign in response to Bronx County health ranking* [Press release]. Retrieved from https://www1.nyc.gov/site/doh/about/press/pr2016/pr015-16.page

Opioid Overdoses

- More New Yorkers die from overdose than from homicides, suicides, and motor vehicle crashes combined.[1]
- There were 308 overdose deaths among Bronx residents during 2016, accounting for one-quarter (26%) of all deaths among New York City (NYC) residents.[1]
  - Fentanyl was involved in nearly half during second half of 2016 (less than 5% before 2015)[2]
- Drug-related deaths accounted for 33% of deaths among people experiencing homelessness in FY 17.[3]
  - Nearly twice the number of deaths due to heart disease[2]
  - 161% increase since FY 07[2]

[1] Li, W., Huynh, M., Lee, E., Lasner-Frater, L., Castro, A., Kelley, D.,…Van Wye, G. (2016, March). *Summary of vital statistics, 2014: The City of New York*. Retrieved from http://www1.nyc.gov/assets/doh/downloads/pdf/vs/2014sum.pdf

[2] Li, W., Huynh, M., Lee, E., Lasner-Frater, L., Castro, A., Kelley, D.,…Van Wye, G. (2016, March). *Summary of vital statistics, 2014: The City of New York*. Retrieved from http://www1.nyc.gov/assets/doh/downloads/pdf/vs/2014sum.pdf

[3] New York City Department of Health and Mental Hygiene, Bureau of Vital Statistics, & New York City Department of Homeless Services. (2018). *Twelfth annual report on homeless deaths (July 1, 2016-June 30, 2017)*. New York, NY: Author

Scope of the Issue

Homeless Outreach Population Estimate (HOPE)

- 3,892 “unsheltered” individuals on February 6, 2017 (estimate)

Source: New York City Department of Homeless Services. (n.d.), *HOPE: The NYC street survey—2017 Results.* Retrieved from https://www1.nyc.gov/assets/dhs/downloads/pdf/hope-2017-results.pdf

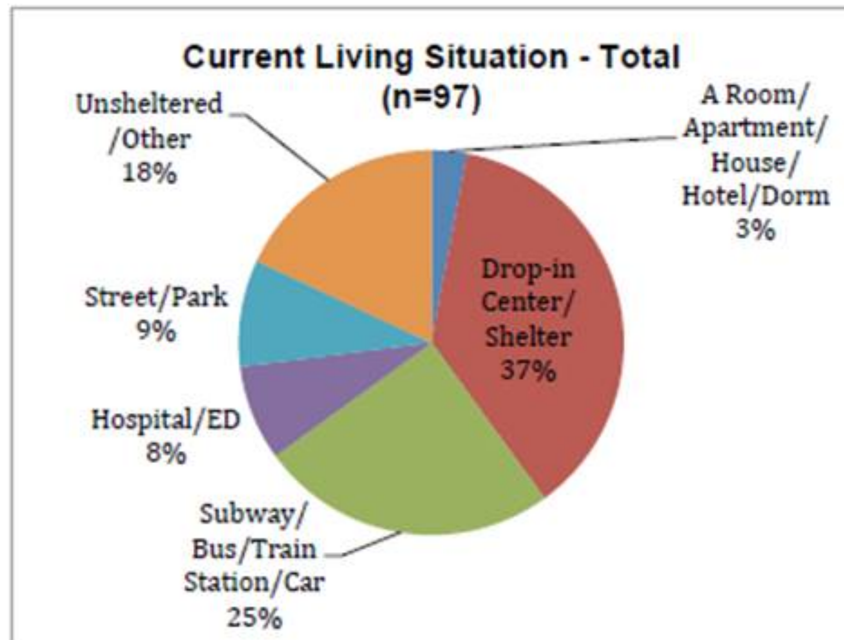
Overnight Shelter Census on 3/19/18

Men	11,122
Women	4,153
Single Adults	15,275
Total Shelter Census (including Adult Families and Families with Children)	60,355

See https://www1.nyc.gov/assets/dhs/downloads/pdf/dailyreport.pdf for daily shelter census

Hospital Use in the Bronx

Hospital HOPE Count Results



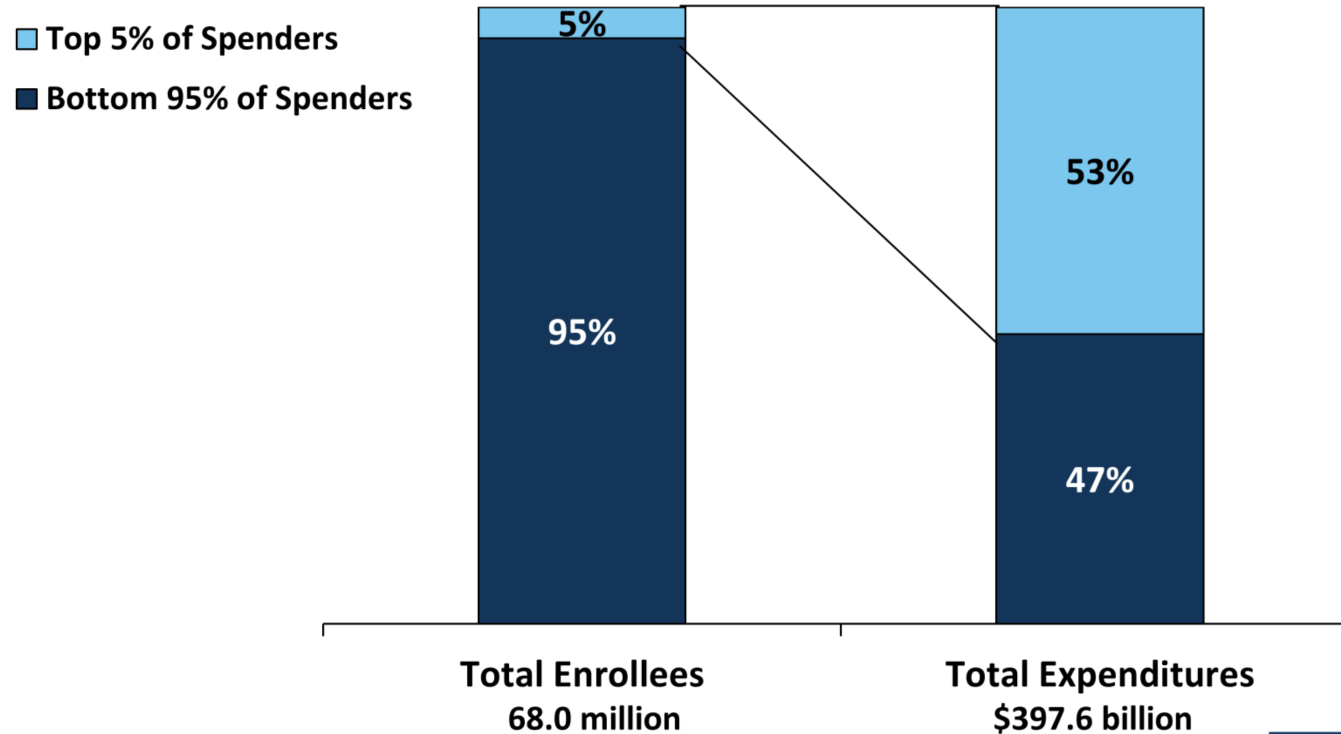
Hospital	# Homeless
Lincoln	13
St. Barnabas	13
Bronx Lebanon	10
Jacobi	8
Montefiore (3 locations)	6
North Central Bronx	4
Bronx VA	0
TOTAL	54

154 participants citywide

55% (n=108) had no medical care outside ED

Source: Bronx Health & Housing Consortium. (2018). *2018 Hospital homeless count: Results and report*. Bronx, NY: Author.

Top 5% of Enrollees Accounted for More than Half of Medicaid Spending, FY 2011



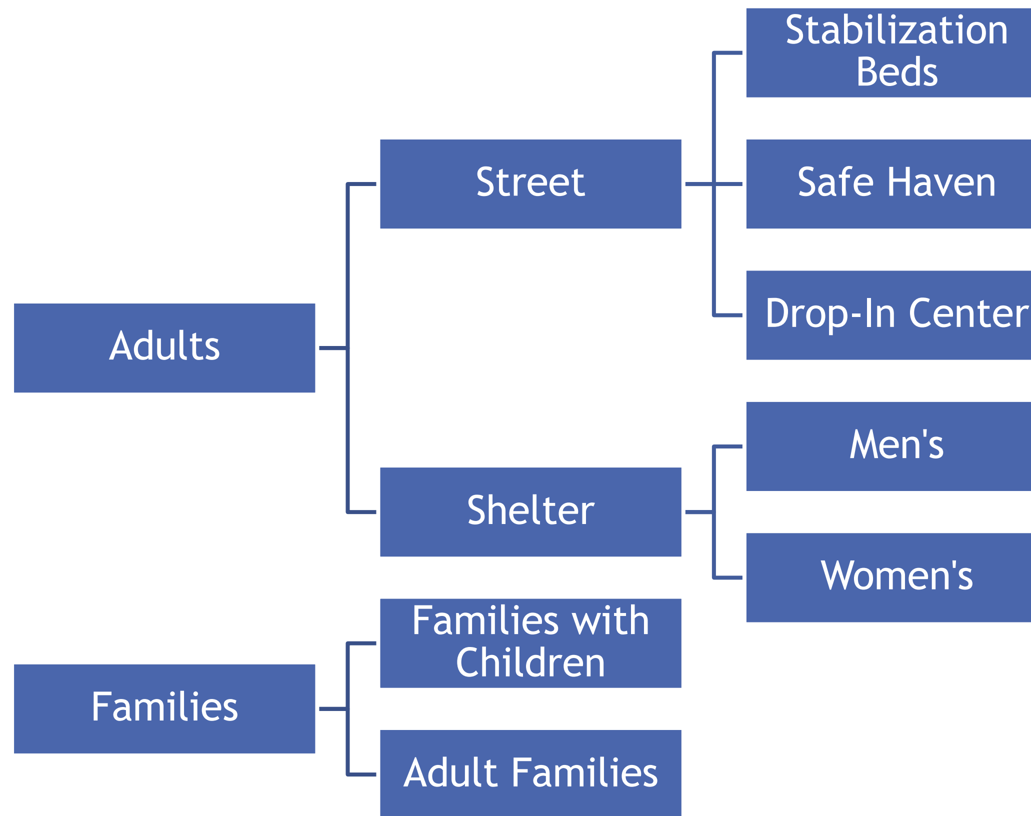
SOURCE: KCMU/Urban Institute estimates based on data from FY 2011 MSIS and CMS-64. MSIS FY 2010 data were used for FL, KS, ME, MD, MT, NM, NJ, OK, TX, and UT, but adjusted to 2011 CMS-64.

Right to Shelter

- *Callahan v. Carey* (1981)
  - "The City defendants shall provide shelter and board to each homeless man who applies for it provided that (a) the man meets the need standard to qualify for the home relief program established in New York State; or (b) the man by reason to physical, mental or social dysfunction is in need of temporary shelter."
- See also *Eldredge v. Koch* (1983) and *McCain v. Koch* (1983)

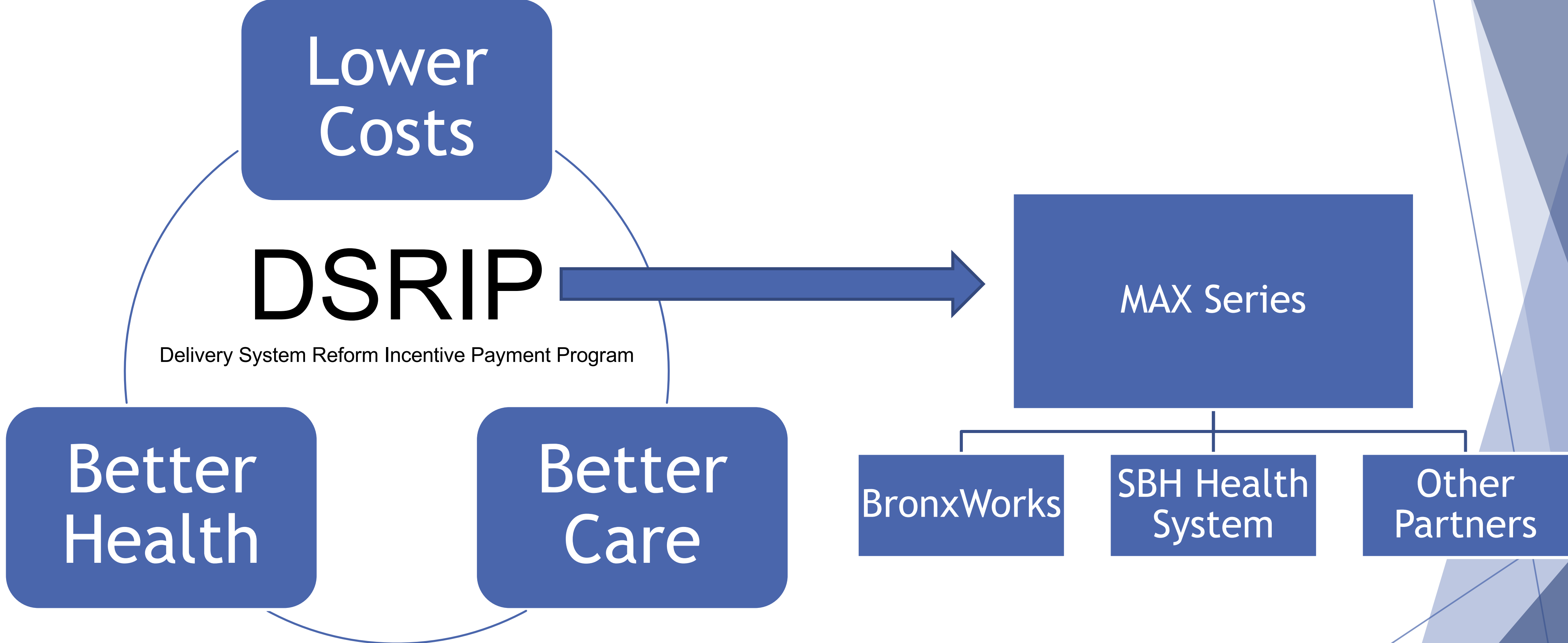
Source (including full text of consent decree): *The Callahan consent decree: Establishing a legal right to shelter for homeless individuals in New York City*. (n.d.). Retrieved from http://www.coalitionforthehomeless.org/wp-content/uploads/2014/08/CallahanConsentDecree.pdf

NYC Homeless Services System



Beginning a Collaboration

Medicaid Accelerated eXchange (MAX Series)



See https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_workshops/docs/2017-jan-jul_imp_care_for_high_utilizers.pdf

DOH MAX Series- Managing Care of Super Utilizers

“Our mission is to create a sustainable and collaborative system that reduces unnecessary ED visits by identifying people with substance abuse and homelessness and connecting them to alternative resources that meet their basic needs.”

MAX Methodology

- Structured program of interdisciplinary teams aimed to accelerate redesign and improvement
- Define the “target population”
- Form “Action Teams” to include administrative staff who can directly enact change and can be directly accountable for implementation
- “Identify today’s SUs(super utilizers)” – define the “super utilizer” by analyzing last year’s data
- “Assess SU needs” – view recurrent utilization as a symptom of unmet needs and identify the “driver of utilization” – not the primary diagnosis, not the chief complaint but the HUMAN
- “Do something different”- engage the patient, on site, now
- Follow up to ensure stability – use care plans
- Measure to drive implementation and results

Building a Toolkit

Tools for Data Collection

BronxWorks | SBH Health System

Business Associate Agreement

- An agreement between BronxWorks and SBH allowing SBH to share PHI to help coordinate care and reduce unnecessary healthcare utilization by shared, or potentially shared, clients/patients
- "Business Associate" is a term defined by HIPAA Privacy Rule
- "A 'business associate' is a person or entity, other than a member of the workforce of a covered entity, who performs functions or activities on behalf of, or provides certain services to, a covered entity that involve access by the business associate to protected health information."

Source: U.S. Department of Health and Human Services Office for Civil Rights. (2013, January 25). *Business associate contracts*. Retrieved from https://www.hhs.gov/hipaa/for-professionals/covered-entities/sample-business-associate-agreement-provisions/index.html

ED Utilization Data

- The top 50 super-utilizers (SUs) of St. Barnabas ED made up:

  0.6% of ED patient population

  2.74% of ED visits

  3195 ED visits

  (11/2014-10/2015)

- Before MAX series (5/2015-10/2015):

  Average of **267** ED visits/month

- After MAX series (11/2015-6/2016):

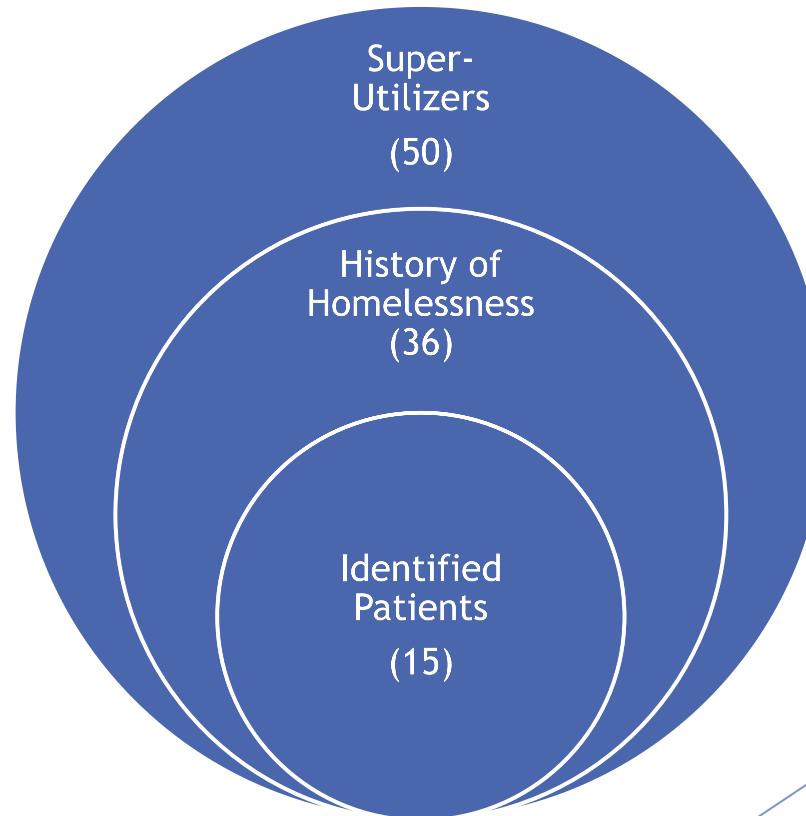
  Average of **166** ED visits/month

Defining a Cohort

- Homeless?
- Familiarity with neighborhood?
- Substance use?
- Methadone patients?
- Use patterns?
  - Time of day

Refining the Cohort

- Top 50 Treat and Release Super-utilizers
  - Analyze use pattern and diagnoses for chronic disease and/or housing issue
- For housing issues, clarify:
  - Street homeless
  - Shelter
  - Unstably housed
- Identify subset of SUs known to BronxWorks Adult Homeless Services to focus intervention



Hospital Needs Assessment/ Screening Tool

Emergency Department Psychosocial Needs Screening

1. Do you have access to food, water, shelter and medication (if needed) everyday? ❑ Yes ❑ No,
   If No, please specify.

   When was your last meal?
   Do you know when and where you will eat next? ❑ Yes ❑ No
   Where did you spend the last five nights?
2. Have you ever had any symptoms such as feeling sad or nervous, hearing voices, having thoughts of killing yourself? ❑ No ❑ Yes If Yes, please specify:

   Have you ever been hospitalized in a psychiatric hospital or received psychiatric treatment in a clinic?
   ❑ No ❑ Yes

   Do you receive treatment in a psychiatric clinic now? ❑ No ❑ Yes If Yes, where?______________________
3. Have you ever had difficulties with alcohol or drugs? ❑ No ❑ Yes If Yes, which one?

   If Yes, When was the last use?

   Do you receive treatment in an alcohol or drug program now? ❑ No ❑ Yes
   If Yes, which one? ____
4. Are you experiencing any significant problems such as family, illness, legal?❑ No❑ Yes
   If Yes, please specify:
5. Do you have a worker who calls or visits you?❑ No ❑ Yes If Yes, please provide contact information:
   ____
6. Are you currently connected to a homeless shelter or have you been to a shelter in the past? ❑ No❑ Yes
   If Yes, please specify:
7. Considering everything you told me about your situation, what can we help you with?

____

8. Best contact number to reach: ____

Referrals made:

❑ Emergency Shelter	❑ Transitional Housing	❑Emergency Assistance (rent/utilities)
❑ Mental Health	❑ Substance Abuse Treatment	❑ HealthHome
❑ Food Assistance	❑ Medication Assistance	❑ Case Management
❑ Clothing Assistance	❑ Childcare assistance	❑ Transportation Assistance
❑ Case Management	❑ Housing Placement Services	❑ Life Skills Training
❑ Outpatient Detox	❑ Transportation Assistance	❑ Parachute Program
❑ Other______________________________		

Name:______________________ Signature:______________________ Date:______________

Building a Toolkit

Tools for Intervention with Hospital and Client/Patient

BronxWorks | SBH Health System

Flagging/Developing a “Go Team”

- What happens when someone on the “list” walks through the door?
  - Security and Registrar have list of super-utilizers
- Change is made one person at a time.

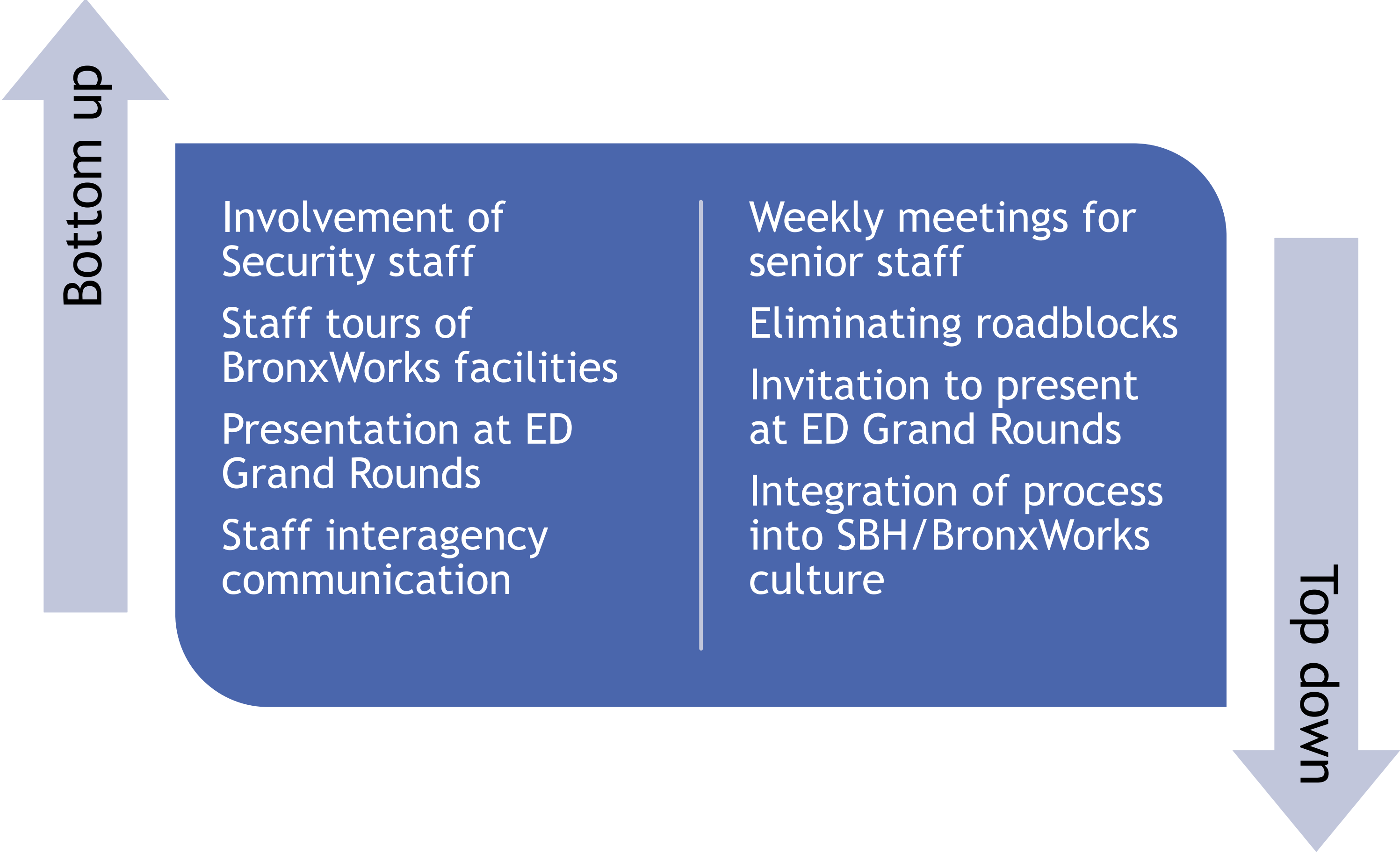
Homeless Outreach in ED

- 24/7/365 outreach team goes into hospitals to engage individuals experiencing homelessness who are using the ED as shelter
- Offer transport to more appropriate shelter
- Repeated engagements
- Connection to services

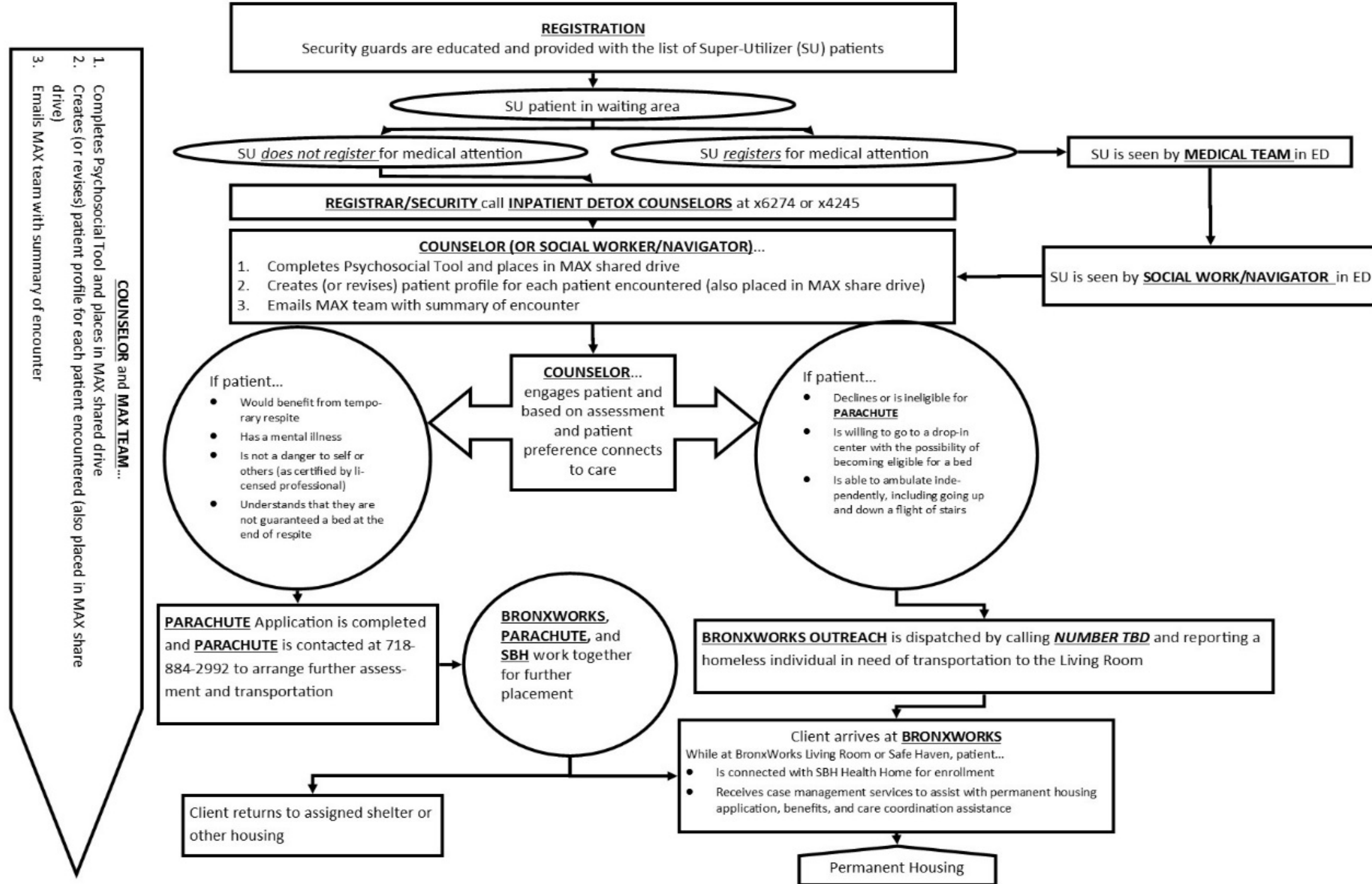
Identifying Stakeholders

- Those who can say "No."
  - Patients/Clients
  - Line staff (social workers, residents, RNs)
  - Supervisory staff (supervisors, attendings)
  - Administration (leadership, legal)

Generating Buy-in from All Stakeholders



Systems/Process Mapping



Interdisciplinary Patient Profile Extraction Tool

Template – Multidisciplinary Meeting/ Plan of Care

MRN:

History:

Meds:

Clinic visits:

ED visits:

Med Admissions:

Psychosocial issues:

Care Plan:

ED:

Ambulatory Clinics:

- **Medicine:**
- **Specialty:**

Health Home/Patient Navigator:

Inpatient:

Centralized Interdisciplinary Care Plan

Service/ Department	Representative	Plan	Outcome	Follow up
Emergency Department				
Inpatient Psychiatry				
Outpatient Psychiatric Provider				
Medicine				
Care Coordinator				
Shelter				

Address Obstacles/Drivers of Utilization

Component/ Need	Responsible Party	Plan	Outcome	Comments

Examples of "Outside the Box" Drivers

- Anxiety about unknown/undiagnosed health condition
  - Somatic symptoms of undertreated anxiety?
- Ties to the area (with no other shelter options)
- Close to "spot"
  - Using EMS/Non-emergency transport as "taxi"
- Fear of being alone
- Interpersonal conflict
  - Fight with significant other/relative
- "Not my night"
  - Doubled up

Toolkit in Motion

Pedro

- 51-year-old Hispanic male
- Limited social support
- Mental illness
- Substance abuse
- Street homeless
- Known to SBH since 2007
- Average ED visits (2008-2010) 35/year

Emergency Department Psychosocial Needs Screenii

1. Do you have access to food, water, shelter and medication (If needed) everyday? ☐ Yes ☑ No,
   If No, please specify: Currently living in the streets, no place to eat or drink water.
   When was your last meal? earlier in the Day
   Do you know when and where you will eat next? ☐ Yes ☑ No
   Where did you spend the last five nights? in the street

2. Have you ever had any symptoms such as feeling sad or nervous, hearing voices, having thoughts of killing yourself? ☐ No ☑ Yes If Yes, please specify: I hear voices telling me to kill myself I am very depressed

   Have you ever been hospitalized in a psychiatric hospital or received psychiatric treatment in a clinic? ☐ No ☑ Yes

   Do you receive treatment in a psychiatric clinic now? ☑ No ☐ Yes If Yes, where?

3. Have you ever had difficulties with alcohol or drugs? ☐ No ☑ Yes If Yes, which one?
   If Yes, When was the last use? Crack Cocaine earlier in the day
   Do you receive treatment in an alcohol or drug program now? ☑ No ☐ Yes
   If Yes, which one?

4. Are you experiencing any significant problems such as family, illness, legal? ☐ No ☑ Yes
   If Yes, please specify: not getting along with sister

5. Do you have a worker who calls or visits you? ☑ No ☐ Yes If Yes, please provide contact information:

6. Are you currently connected to a homeless shelter or have you been to a shelter in the past? ☑ No ☐ Yes
   If Yes, please specify:

7. Considering everything you told me about your situation, what can we help you with?
   Housing, rehab, psychiatric reason

8. Best contact number to reach: nephew

Referrals made:

- ☐ Emergency Shelter
- ☐ Mental Health
- ☐ Food Assistance
- ☐ Clothing Assistance
- ☐ Case Management
- ☐ Outpatient Detox
- ☐ Other
- ☐ Transitional Housing
- ☐ Substance Abuse Treatment
- ☐ Medication Assistance
- ☐ Childcare assistance
- ☐ Housing Placement Services
- ☐ Transportation Assistance
- ☐ Emergency Assistance (rent/utilities)
- ☐ HealthHome
- ☐ Case Management
- ☐ Transportation Assistance
- ☐ Life Skills Training
- ☐ Parachute Program

Pedro at SBH 2016

Visits

ED	184*
IP Psych	0
IP Detox	2

*Sometimes 3x/day
**Few times patient absconded

Chief Complaint/Triage Note

- "stopped EMS and reported had drank and had seizures"
- "reported wanting to kill himself"
- "I caught 20 seizures"
- "my stomach hurts"
- "my feet hurt"

Pedro at SBH 2017

Visits

ED	23*
IP Psych	1
IP Detox	0

*21 from 1/1/17-7/1/17; 2 from 7/1/17-12/31/17

Inpatient Psychiatric Admission for 1 week in September 2017 for agitated, combative, bizarre behavior at the shelter

Chief Complaint/Triage Note

- "my legs are swollen and hurt"
- "he said he had a seizure today"
- "my kidney hurts"
- "per EMS found on the floor, intoxicated"
- "I had a seizure and fell down, I hit my head"

Pedro at SBH 2018
(up to 5/1/2018)

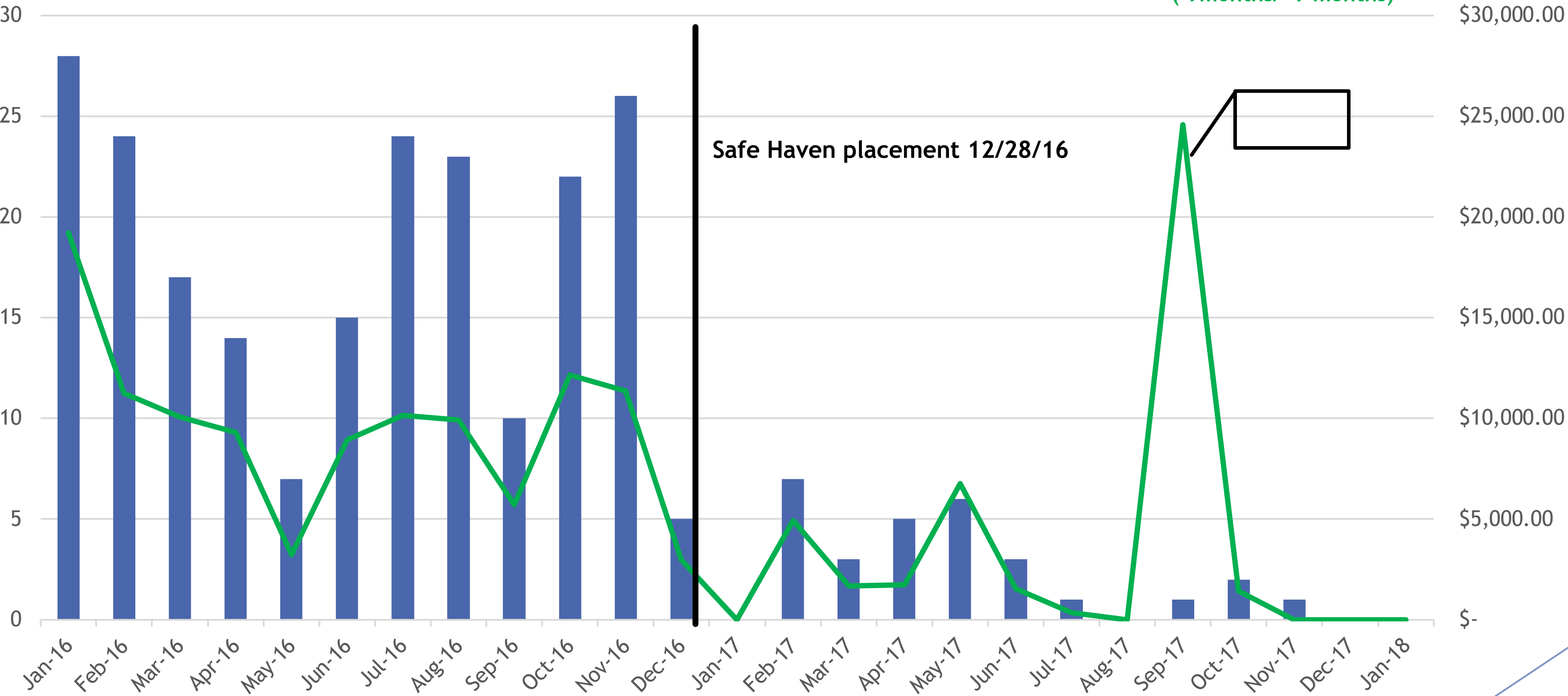
Visits

ED	1
IP Psych	0
IP Detox	0

Chief Complaint/Triage Note

- "talking to himself"
- Cooperative and calm
- Discharged after overnight observation and coordination of care with ACT and Bronx Works

Pedro’s Utilization (Inpatient and ED)



Super-utilizers Evaluation Process

- Stop the revolving door of ED visits with brief evaluation and rapid disposition
- Assess immediate aspects of care: medical or psychiatric
- Admit patient (medicine or psychiatry) for evaluation/management and an in-depth assessment of needs and challenges
- Organize multidisciplinary team meeting early in the admission

Toolkit in Motion

Mr. W

Interdisciplinary Patient Profile

MRN

History: 21y/o male h/o bipolar disorder, h/o suicidal attempts (last 7/15), asthma admission for hypoglycemia work up as prior work up incomplete. Patient also c/o feeling depressed. Recently admitted to ICU 12/26 but eloped. Multiple ED visits this year (84 visits) for depression/dizziness/ hypoglycemia..

Patient presently admitted and being seen by endocrine for work up for recurrent hypoglycemia.

No h/o diabetes mellitus

***Patient has a diagnosis of Hyperammonemic hyperinsulinemic hypoglycemia requiring diazoxide PO as treatment . He is non compliant because of the taste. Pharmacy reviewing to mix meds to lessen harshness of the flavor.*

Meds: Zoloft 50mg daily, Seroquel 400mg bid, Albuterol MDI PRN
h/o +tobacco/+PCP/+heroin/ +cocaine/ +THC – No IVDU

Labs: Utox on 12/30 - +benzodiazepine

PCP: None

Clinic visits: 5/11 – Dr. M.

ED visits: 12/22, 12/17, 12/14, 10/27, 9/30, 9/15, 8/30, 8/28, 8/27, 8/26, 8/21, 8/19, 8/18, 8/16, 8/6, 7/23, 7/14, 7/10, 7/7, 7/3, 7/1, 6/25, 6/22, 6/20, 6/16, 6/12, 6/11, 6/10, 6/8, 6/6, 6/5, 6/4, 6/3, 5/16, 5/15, 5/13, 5/11, 5/7, 5/5, 5/4, 4/25, 3/13, 2/23

41 additional ED visits with second MRN – **total 84 visits in 2015 to the ED**

Med Admissions: 12/26 – still admitted
12/26-12/27 - AMA
6/7-6/8 – AMA

Psychosocial issues: Patient homeless. Educated till 11th grade, unemployed. Estranged from family.
Aunt died 3 years ago and has been homeless since.
Pt was institutionalized at Queens Childrens and was also at Leakee Watts with h/o aggressive behavior.

Insurance: United Healthcare HMO, Medicaid (active)

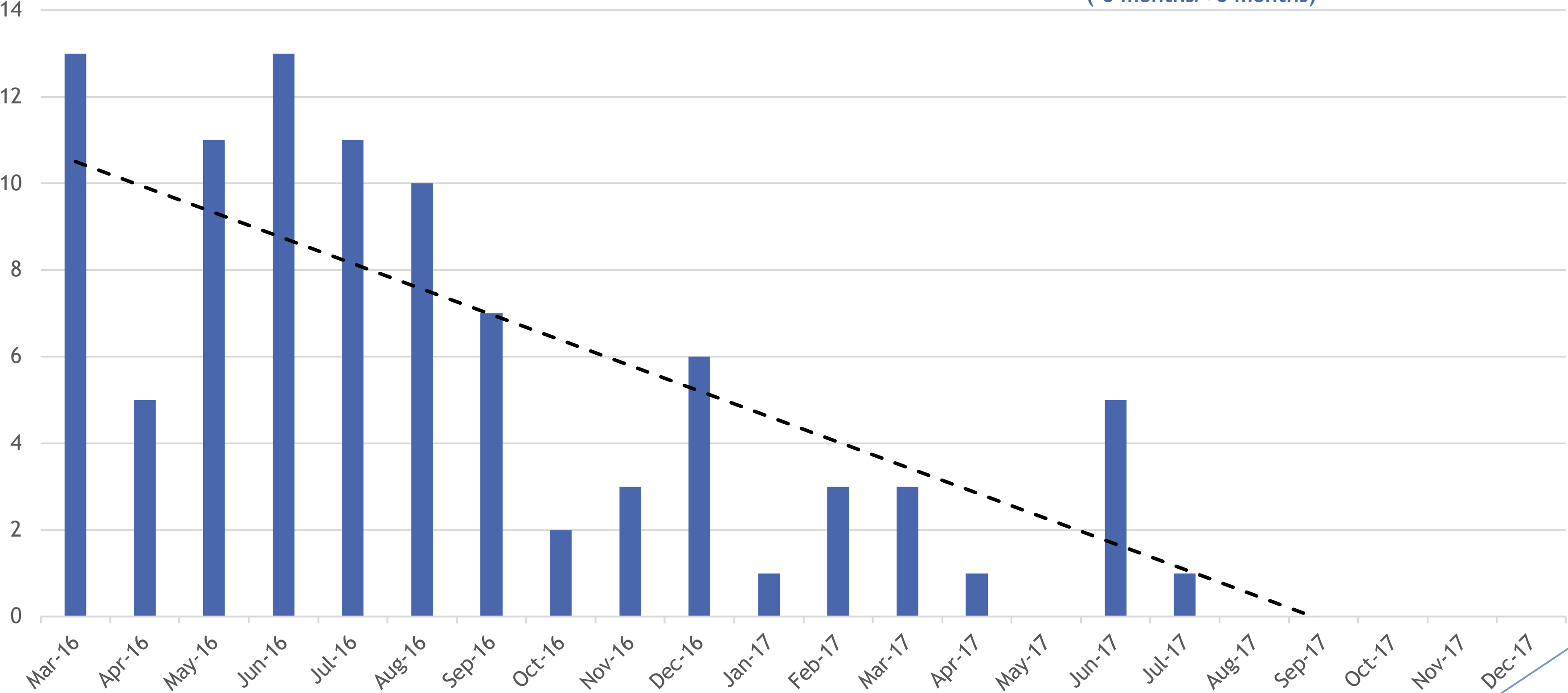
Centralized Interdisciplinary Care Plan

Service/ Department	Representative	Plan	Outcome	Follow up
Emergency Department	A.B	Patient diagnosed with Hyperammonemic hyperinsulinemic hypoglycemia requiring diazoxide PO as treatment	He is non compliant because of the taste. Pharmacy reviewing to mix meds to lessen harshness of the flavor.	If patient returns to the ED with symptoms of hypoglycemia – endocrinology to be consulted
Case Management from insurance company	C.D.	C.D. will follow up on authorization with insurance company (United HealthCare)		
Outpatient provider	E.F.	Early Medicine clinic appointment to be made	Consider endocrinology appt on the same day	
Shelter/Bronx Works	G.H.	Seen by J.B. from Bronx Works	Patient to be assigned to a room at Safe Haven	
Patient Navigator/ Health Home Program	I.J.	Referral made and navigator assigned	Contact made	

Level of Detail

Component/need	Responsible party	Plan	Outcome	Comments
Clothing	M.L.	Clean clothes closet	Secured pants/sweater	Need for shoes
Cell. Phone	M.L.	Verify property	Checked No SIM card	Purchased
Transportation	M.L.	Pick up by shelter staff	Confirmed	None
Medication delivery	L.T.	Eprescribe 1 day in advance	Available on the unit	
Insurance	G.O.	Call and inquire if patient has Case Manager	Contacted and discussed plan	
Medicine	M.K.	Obtain early medicine clinic appt. on the day of discharge		

Emergency Department Utilization (Ms. J)



Best Practices and Scalability

Toolkit of Best Practices

BronxWorks | SBH Health System

Review of Toolkit

Data Gathering

- Business Associate Agreement
- Utilization Data
- Define Cohort
- Data Match
- Refine Cohort
- Hospital Screener

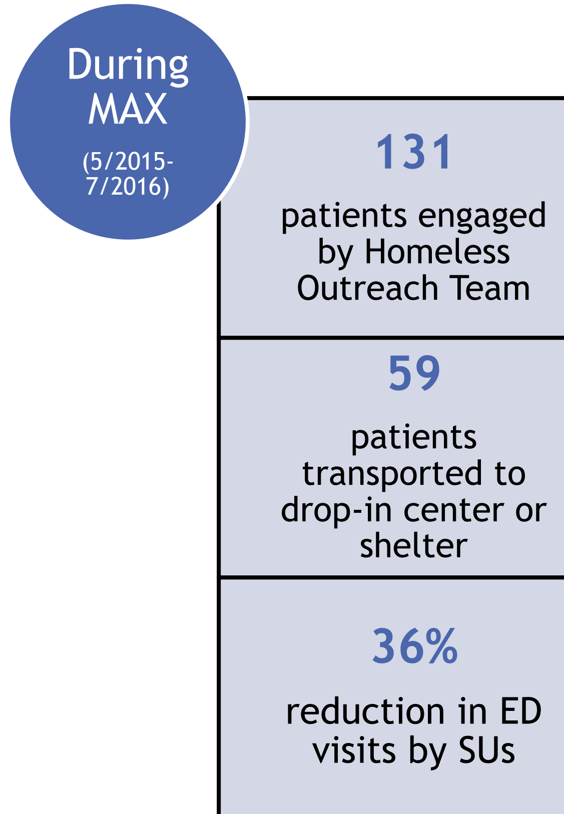
Intervention

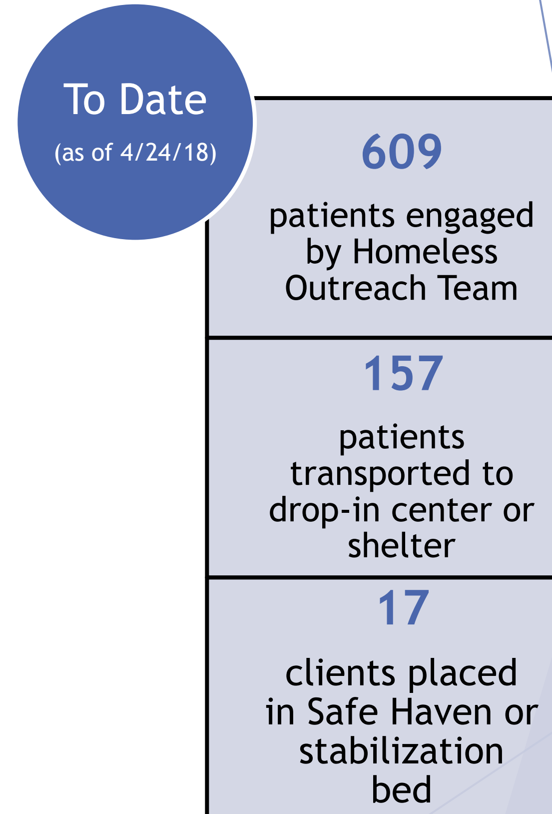
- Systems/Process Mapping
- Flagging/Developing a “Go Team”
- Homeless Outreach in ED
- Identify Stakeholders
- Generate Buy-in
- Interdisciplinary Patient Profile
- Centralized Care Plan
- Address Obstacles/Drivers of Utilization

Results

During MAX series (11/2015-6/2016):

- **5** patients engaged in BronxWorks services
  - 3 placed in the Safe Haven
  - 2 placed on Drop-In Center caseload
- Connected patients had **10.33 fewer ED visits**/month since Safe Haven engagement (90.7% reduction)
- Connecting these 3 patients to services was **projected to prevent 124 ED visits annually**





Looking to the Future

Broadening the Scope

Building on Past Successes

- Expanding best practices in care coordination to other hospitals
- Partnering with SBH Health System to build permanent supportive housing near hospital
- Embedding Housing Coordinators in Hospital EDs to supplement existing social work staff and focus on unique issues for people who are unstably housed or experiencing homelessness
- ED Navigators hired by hospitals for further care coordination
- Exploring options for medical respite in NYC
  - Possible site identified for respite program
- Testifying before NYC City Council on health care for individuals experiencing homelessness and opiod overdoses

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