A Hear from Your Peers Webinar - Effective Coordination between Hospitals and CoC Homeless Assistance Providers Results in Improved Residential Stability and Reduced Costs

Webinar Format

Our Webinar Format:

Speakers will present for 12 minutes. Following all the speakers we will have approximately 25 minutes for Questions and Answers.

How to ask questions:

Question Box: You may enter your question into the question box at any time during the presentation. We will read questions aloud and answer some after each speaker and then during the allotted Q&A session.

Follow up questions:

Contact information will be provided after each presentation and at the close of the webinar.

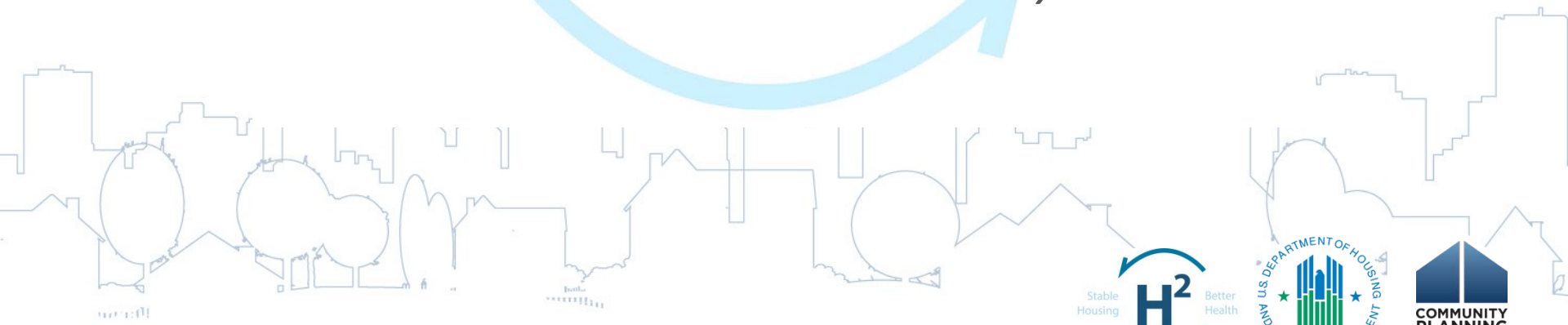
Materials:

Slides presented during the webinar will be made available after the webinar. For those who registered, copies will be emailed. For those participating at a later date, copies will be made available on the HUD Exchange.

H² Housing and Healthcare Technical Assistance

Roula K. Sweis, M.A., Psy.D, Supervisory Program Advisor, Office of the Assistant Secretary for CPD

H²: Housing and Healthcare TA - A Federal Partnership between HUD and HHS focused on *improving program participant access and effective utilization of mainstream healthcare services at the systems level*.



Today's Presenters

- Roula K. Sweis, Supervisory Program Advisor, Office of the Assistant Secretary for CPD
- Lisa Bahadosingh, Community Liaison for Regional Initiatives, Fairfield County, CT
- Joyce Platz, Executive Director, Residential Services, St. Vincent's Hospital, Bridgeport, CT
- Corrin Buchanan, Program Manager, Housing for Health, LA County Health Services, Los Angeles, CA
- Lynn Kovich, Senior Consultant, Technical Assistance Collaborative, Boston, MA

Fairfield County, Connecticut

Activities Focused on the Integration of Healthcare and Housing

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H^2 Action Planning: March 18-19, 2015

- **Target Population**: People who are experiencing homelessness and/or who are living with HIV/AIDs who have difficulty accessing and maintaining consistent healthcare as well as stable housing with a focus on active substance users and/or those with persistent mental illness
- **Goals**:
  - Fill key gaps in housing, treatment, and services to improve health and housing outcomes
  - Facilitate expanded system and service level integration and coordination of care
  - Enhance data quality, analysis and sharing to improve client outcomes and system efficiency
  - Secure stable Funding to support provision of integrated housing and health and behavioral health services and treatment

Fairfield Co. Progress to Date

- Elicited feedback from Health and Housing Stability Committee
- Worked with consultants to pare down the plan and make edits based on changes within our community
- Plan was reviewed with the Coordinating Council of our CoC to get buy in and approval
- Made revisions and worked to identify priorities
- Plan was circulated to participants on 9/30/15
- Current implementation of the plan:
  - Convening meetings with key mental health and substance abuse treatment providers to discuss barriers and problem solve to achieve improved access and retention
  - Set up a Fairfield County Funding Collaborative
  - Increasing capacity to address data gaps
  - Ongoing efforts to secure funding for patient navigators
  - Adding substance abuse peer specialists to CCTs
  - Engaging key stakeholders invested in the successful execution of the plan

Fostering Hospital & CoC Collaboration

Building Housing and Healthcare Systems that Work Together

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Framing the Problem

- Fairfield County's fragmented behavioral health system
- Hospital EDs are serving increased numbers of behavioral health patients without adequate inpatient or outpatient care
- This population doesn't get better with traditional model of episodic care delivery
- High Medicaid costs, high cost to hospitals
- ED crowding, decreased safety and financial losses to the hospital

The Solution: Community Care Teams

- A group of community stakeholders came together to identify a high needs population, discuss their cases, and formulate plans in order to improve the quality and access to care, improve the health of a population and reduce excessive services.
- Model started in Middlesex, CT in 2010
- Since then it has been replicated in Bridgeport, Danbury, Norwalk & Stamford

Community Care Teams (CCT) & the Homeless Continuum of Care (CoC)

- Opening Doors Fairfield County
  - Health and Housing Stability Workgroup
- Activities to promote and support CCTs
  - H^2 Action Planning Sessions
  - CCT Forum
  - Regional CCT Leadership Meeting (quarterly)
  - Substance Abuse Forum

Patient Demographics

- Gender: 40% female, 60% male
- 35% homeless or at risk
- 60% with substance abuse
- 50% with psychiatric diagnosis
- 40% with both
- Payer mix:
  - 65% Medicaid
  - 30% Medicare or dually eligible
  - 4% Uninsured
  - 1% Commercial

CoC has a vested interest in supporting the CCT Teams

* Based on Norwalk and Danbury CCTs, but

Community Care Team Meetings

Goals

- Assist vulnerable populations including those with unstable housing, social problems and chronic medical, mental health or substance abuse issues by connecting them to needed services
- Reduce ED utilization
- Reduce hospital admissions
- Reduce costs
- Improve health outcomes
- Improve housing stability

Outcomes (as of 9/30/15)

Norwalk CCT: 170+ Care Plans
>45 assisted with housing
>30% reduction in ED utilization

Norwalk Super-user team: 70+ Care Plans
23% reduction in ED Utilization

Danbury: 46 Care Plans
>10 assisted with housing
>25% reduction in ED utilization (point in time)

And other successes:

- Communication improves care
- Better understanding of issues
- Getting providers in the room talking to each other has benefits beyond individual cases

Challenges

- Staffing – Patient navigation
- Outreach and direct line staff who can take responsibility for each individual
- Substance Abuse: inadequate resources
- ED as the safety net
  - EMTALA
- Incentives: doctors, hospitals, drug companies
- Culture changes: watching costs rather than enhancing revenue
- Liability fears: drive excessive testing, treatment

St. Vincent's Medical Center Bridgeport, CT

- 473-bed community teaching hospital with Level II trauma Center; part of Ascension Health, the nation's largest Catholic Hospital System
- Multi-faceted resources, including 92 in-patient beds, psychiatric emergency room, 2 out-patient psychiatric clinics and 142 units of permanent supportive housing
- Bridgeport is CT's largest city, with significant disparity in socio-economic status and home to 50,000 people below poverty level and 300+ homeless any given night
- In CT, fewer than 15% of Medicaid recipients account for more than 60% of the costs for healthcare
- Issues: fragmented behavior and medical healthcare systems, poor access, long wait times, and severely limited public transportation system

Greater Bridgeport's Community Care Team

- Innovative model brings together 2 local hospitals and other community representatives to facilitate care coordination for shared patients/high utilizers of ED
- Maximizes partnerships/integration across the healthcare continuum, including outreach services, homeless services, case management, housing, legal services and substance abuse treatment
- Primary goals: (1) reduce ED costs/frequency of use; (2) increase residential stability/homelessness prevention
- All providers collaborate on a Care Plan, which is client driven; and an "owner" is identified to drive the plan
- Utilizes a Patient Navigator who serves as the "support hub" with the client in implementing the plan

Bridgeport-specific Elements

- What St. Vincent's brings to the table:
  - Mission-driven institution with 24/7 access
  - Central point of the community
  - Hospital-based resources, including housing vouchers
- The target population is frequent users of ER services with serious mental illness, chronic substance abuse or dually diagnosed many of whom have co-occurring complex health needs and who are experiencing homelessness or housing instability
- Greatest Challenges: ongoing outreach and engagement; substance abuse services
- Targets: to serve 30-50 people annually, reduce public services & ER expenditures, improve health outcomes, and increase client adherence to Community Care plans