Homelessness & Healthcare:
Community Connections and FUSE Pilot Project

2019 Michigan Campaign on Ending Homelessness Summit
Blue Water Convention Center - Port Huron, MI

CSH

Meet the Panelist

- Lindsey Bishop Gilmore, CSH
- Judy Kell, Mercy Health
- Lauren Valez, Avalon Housing
- Elizabeth Kelly, Hope, Inc.

CSH

Session Overview and Learning Objectives

This session will focus on models, best practices and lessons learned on coordinating housing and healthcare by exploring:

- Receptive Shelter model;
- Community Health project; and
- FUSE model.

Objectives:

- Better understand the connection between housing and healthcare
- Better understand how Community Health Workers can link housing and healthcare
- Better understand the FUSE model to prioritize for Supportive Housing.

CSH

About CSH

CSH

Advancing Housing Solutions That

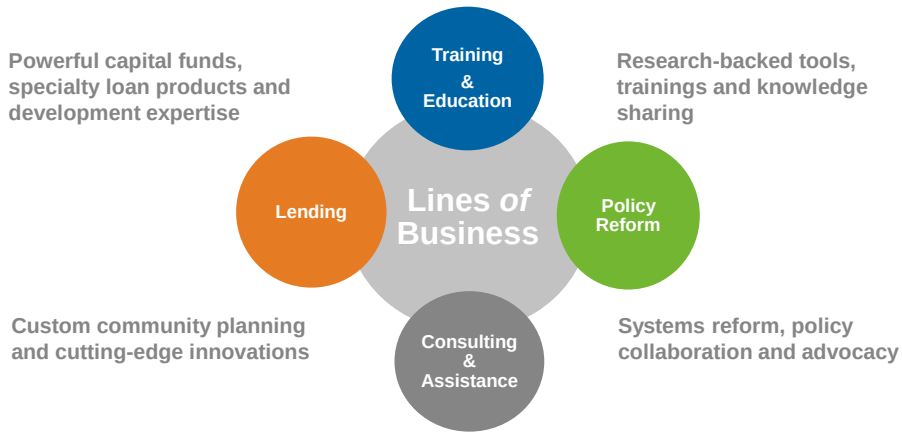
Improve lives of vulnerable people

Maximize public resources

Build strong, healthy communities

What We Do

CSH is a touchstone for new ideas and best practices, a collaborative and pragmatic community partner, and an influential advocate for supportive housing.



HOPE Recuperative Center

An Inpatient Hospital "Discharge to Home" Option for Those Who Are Homeless

"Discharge to Home"

- Recuperative care is acute and post acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets but are not ill enough to be in a hospital.

  National Healthcare for the Homeless Council

What is Recuperative Care?

The terms "**medical respite** care" and "**recuperative** care" are used interchangeably to describe the same service.

HOPE Helping Oakland's People Everyday

HOPE Recuperative

Treat and Street

Patients are sent back to the street with no way to change bandages, no access to bathroom facilities and discharged with no transportation back to the shelter. Emergency Depts become shelters.

HOPE Recuperative Care Center

Admission Criteria

- Patient must be able to perform activities of daily living independently (bathing, eating, dressing)
- Principal diagnosis must be medical
- Patient must be homeless with nowhere to go upon discharge
- HOPE does not accept patients with IVs, highly contagious diseases

HOPE Recuperative Goals

- Improve patient outcomes
- Promote the patient's human right to health and dignity
- Decrease hospital readmissions
- Connect patients with medical, mental health supports
- Connect patient with permanent housing

Intensive Case Management Model

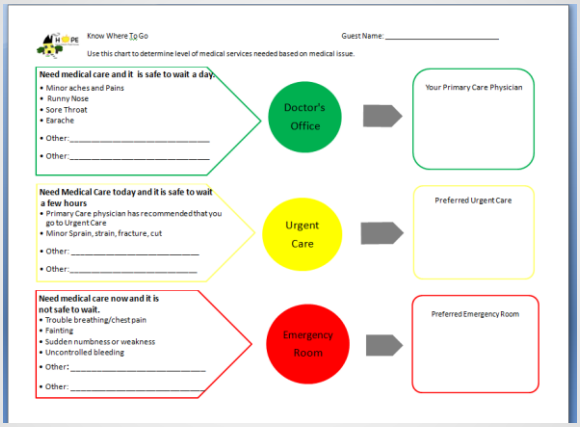
Role of HOPE's Service Navigator

- Helps guests obtain **vital documents**
- Assists guests in achieving housing goals
- Assistance with applying for benefits, housing, and securing income
- Referrals to partner agencies

Role of HOPE Nursing

- Patient education
- Care coordination
  - Ensure guest is receiving proper follow up post hospitalization
- Serve as liaison between guest and healthcare providers

Know Where to Go


Know Where To Go

Guest Name: _____

Use this chart to determine level of medical services needed based on medical issue.

Need medical care and it is safe to wait a day.
- Minor aches and Pains
- Runny Nose
- Sore Throat
- Earache
- Other: _____
- Other: _____

Doctor's Office → Your Primary Care Physician

Need Medical Care today and it is safe to wait a few hours
- Primary Care physician has recommended that you go to Urgent Care
- Minor Sprain, strain, fracture, cut
- Other: _____
- Other: _____

Urgent Care → Preferred Urgent Care

Need medical care now and it is not safe to wait.
- Trouble breathing/chest pain
- Fainting
- Sudden numbness or weakness
- Uncontrolled bleeding
- Other: _____
- Other: _____

Emergency Room → Preferred Emergency Room

Example of Patient Medical Education

- CHW, CNAs, RN/BSN, EMT, BSW, & MSW
- Staff training—AED, CPR, Naloxone, trauma informed, mental health first aid, de-escalation

Service Coordinators

Recuperative guests tend to be complex and are usually prioritized higher on the coordinated entry housing prioritization list

Housing Prioritization

Community Partners

- Coordinated care and lower hospital readmissions
- Housing as healthcare
- Network of support follows patient—mental health, public health and housing case managers

Recuperative Care—Better Care at Lower Costs

- 15 Beds
- Average length of stay—42 days
- Top patient issues

-Post surgical
-Uncontrolled chronic illnesses
-Cancer
-Catastrophic incident/hit by car/car accident

HOPE Recuperative Overview

HOPE Recuperative Care Center

- Launched Oct 2015; 10 bed pilot
- Expanded in April 2018; 15 beds
- CY 2019:
  - 74 total served as of 8/31/2019
  - 66 Positive exit destination

HOPE Recuperative Statistics

- 90% of exited guests have been positively discharged to stable housing
- 95% connected with community mental health services
- 100% connected with public health nursing services
- 98% connected to primary care, health insurance supports such as CHW and Complex Care Mgrs.

- Only 2% of Recuperative guests were readmitted to the hospital during their stay. Most hospital admissions were for different reasons than the original hospitalization

HOPE Recuperative Outcomes

- Sample size =69 but only 35 completed both entry/exit surveys
- 50% had repeated homeless episodes
- 87% had health insurance on entry to Recuperative

Study Conducted by Jason Wasserman, PhD Professor at OUWB School of Medicine

Data Collected

- VI SPDAT
- Trust in healthcare providers
- Social support
- TBI
- EOB cost comparison 2 month prior and 2 months in Recup
- Entry/Exit Surveys conducted

What We Learned

- Trust in healthcare providers increased slightly while trust in informal healthcare sources decreased
- Mean support increased significantly in all 4 domains—emotional/informational, tangible, affection and positive social interaction—likely due to health information, compassion/caring of staff and connection with life changing resources at Recuperative
- Incidence of TBI was 42% which is notably higher than that of the general population and higher than incidence rate of 9.3% among active duty military personnel

Year 1 Outcome Study

20 Patient Sample Where EOB Cost Data Was Available

- Total ED Cost Change--$187,532*
  *calculated as cost 60 days post entry minus cost 60 days prior to entry
- Total Inpatient Cost Associated with ED visit change--$55,589**
  ** calculated as cost 60 days post entry minus cost 60 days prior to entry
- Total Outpatient Costs--$13,415.32 ***
  ***Calculated at cost 60 days post entry minus cost 60 days prior to entry

ECONOMIC IMPACT OF RECUPERATIVE CARE

Pathways to Better Health of the Lakeshore – Muskegon HUB
October, 2019

Bringing health capacity to the community through partnerships, coalitions and hospital community benefit programs.

HEALTH PROJECT

A COMMUNITY BENEFIT MINISTRY OF MERCY HEALTH

HEALTH PROJECT

A COMMUNITY BENEFIT MINISTRY OF MERCY HEALTH

- *The Health Project is the Community Benefit Ministry of Mercy Health Muskegon*
- *An inclusive, community-based, decision-making, non-profit agency committed to improving the health of the community and the delivery of health care in Muskegon County and the surrounding West Michigan region since 1992*

~~Healthcare is Changing~~ Healthcare has CHANGED

- Vulnerable populations have to be met in their own environment
- Significant needs require *out-of-the-box* thinking
- People live in environments that don't support them
- Care coordination across multiple health and social service
- Community Health Needs Assessment – can help define the needs of the community and how we address those needs

Community Health Workers

Are **indigenous to the community** in which they work. Assist clients with navigating a complex healthcare system and **accompany** clients through treatment, monitoring social service needs, and helping them **overcome obstacles** to their own health and **ability to follow treatment** from the medical community. **Advocate** for vulnerable individuals and communities

Levels of Engagement

Tier A: Partially Integrated CHW

- CHWs partner with key staff at clinic, physician office or community agency and are knowledgeable about support personnel with whom to coordinate patient care

Tier B: Integrated CHW

- Specific CHWs are dedicated to the clinic or practice for a designated number of hours per week and see patients at the practice
- Clinics typically serve a larger volume of practice patients

Tier C: CHW Integrated into Community HUB

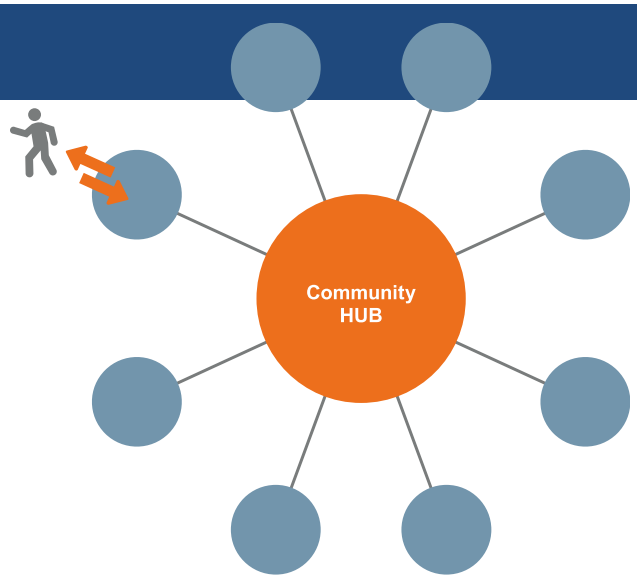
- Community HUB accepts referrals from physicians, community partners and others
- Assigns the CHW to the patient based upon the need of the patient and the expertise of the CHW to manage those specific needs

32

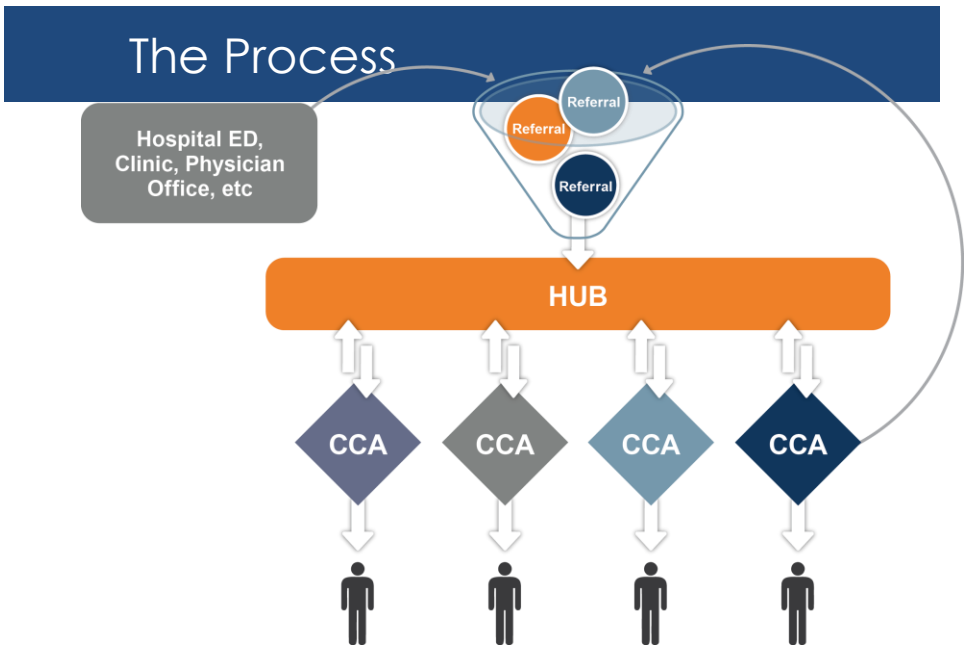
The Hub.

Administrative support ensures quality, customer service and timely assignment of referral

Clinical Oversight coordinates community-based care with medical plan of care for coordinated treatment and chronic disease management

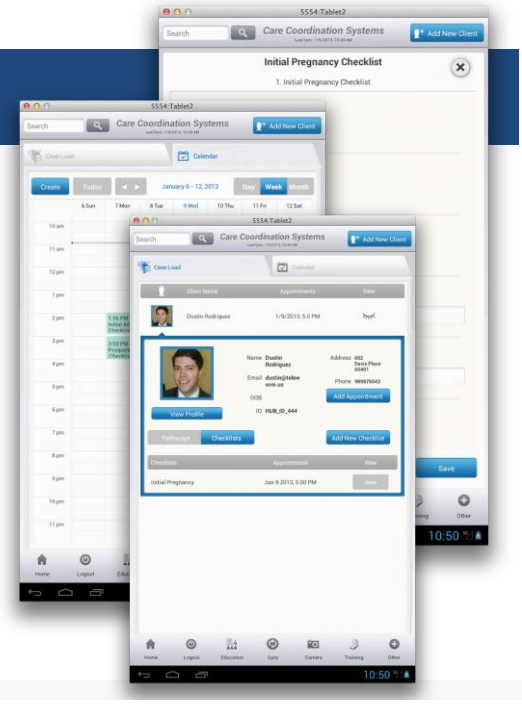


The Process



Our Tools.

- **Checklists** assess eligibility and identify access to care, financial issues and health improvement barriers
- **Pathways** work through barriers; provide documentation and ***accountability*** for the patient, agency and health system



Sample Pathways

- Medical Home
- Medical Referral
- Health Coverage
- Social Service
- Transportation
- Pregnancy
- Smoking Cessation

Clinical Supervision

- The Community Health Workers are under the clinical supervision of the RN and MSW based in the HUB
- Provides oversight and guidance to the community health workers
- Evaluates performance of community health workers
- Recommends duty assignments
- Plans continuing education for community health workers
- Signs off on documentation and work of CHWs

Community Health Worker Training

- Muskegon and Grand Rapids Community Colleges use the Michigan Community Health Workers Alliance curriculum to teach the core competencies to community health workers. The CHWs also receive 8 hours of college credit for the 16 week course at MCC
- CHWs apply for and receive National Provider Identification Numbers
- CHWs receive training in the Pathways model as well as 150 hours of annual training in such areas as CPR/First Aid, Mental Health First Aid, Tobacco Cessation, Motivational Interviewing, QPR (suicide prevention), Michigan Benefits Access & MI Bridges Navigation Training, Asthma Management and other chronic disease management
- CHWs also receive training to become certified as Medicare counselors and in other area such as Social Security benefits and Advanced Care Planning
- Some CHWs are also recovery coaches as well as Certified Addiction Specialists

Community Partnerships

- 8 Care Coordinating Agencies –deploy health workers
  - Community enCompass – HARA
  - Mission for Area People
  - Health Project
  - Senior Resources of West Michigan
  - Affinia Network
  - Every Woman's Place
  - Hackley Community Care
  - Pioneer Resources
- Contracts with MATS and local cab companies to transport clients to physician appointments
- HUB Manager is also the Muskegon County Homeless Continuum of Care Coordinator
- Michigan Works – Training Funds
- CHWs are stationed at the Muskegon Rescue Mission on a weekly basis
- Relationship with CHIR for Referral Specialists as part of Community Clinical Linkages
- CHW stationed at Oakridge and Fruitport Public School

CHWs Embedded in Practices

Community Health Workers Embedded in Practices

- Mercy Health Physician Partners - Fruitport Family Medicine
- Mercy Health Physician Partners - Geriatrics
- Mercy Life Counseling – mental health and substance abuse counseling
- Mercy Health Physician Partners – Women's Comprehensive Health
- McClees Clinic – HIV/AIDS Clinic

Pathways to Better Health of the Lakeshore Participants

9,824 Patients– since January 31, 2013

40% 60 years or older

42% Housing Issues

Top Five Diagnoses		
2013 – June, 2017	July 1, 2017 – June 30, 2018	July 1, 2018 - present
Hypertension	Hypertension	Hypertension
Depression	Depression	Depression
Diabetes	Anxiety	Anxiety
High Cholesterol	Arthritis	High Cholesterol
COPD	Chronic Pain	Diabetes

Counties Served: Muskegon, Oceana, western Newaygo, southern Mason and northern Ottawa Counties; working to begin providing services in Kent County

Muskegon Offices – 2 in downtown Muskegon

565 W. Western and 1200 Ransom

Oceana Office - Shelby

Referrals: Great Lakes Health Connect, email, fax, phone

Most Frequently Initiated Social Service Pathways

- Transportation
- Housing
- Food/WIC
- Clothing
- Utilities
- Financial
- Medication
- Legal
- Education
- Employment

- 10 Number of Months – where behavior change is seen

- Client information is provided to referring entities, PCP/other providers with a signed ROI through a dashboard as well as a closing letter describing services provided. CCS (the software) is now interfacing (pushing data) into the Clarke System (an electronic record of social services provided by the Community Benefit Ministry – Muskegon Community Health Project.

Pathways to Better Health Programs

CURRENT PROGRAMS

- Healthy Pregnancy – High Risk Mothers

  Reduce the incidence of low birth weight babies from high risk mothers by linking Moms to medical and social influencers of care

- Healthy Futures – High Risk Students – Oakridge and Fruitport School Districts

  Link students and families to the social influencers of care in a high risk schools

- Chronic Disease

  Link adults 18 years or older with one or more chronic diseases who are either enrolled or eligible for Medicaid and Medicare. Working with a small number of commercial insurance patients with one or more chronic diseases as well

- Muskegon County Senior Millage

  CHWs paid for completed Pathways for services to seniors

  Navigation Services – CHW stationed at municipal and neighborhood association offices

Pathways to Better Health Programs

Current Programs

- Prescription for Health - Partnership with Urban Farm, FQHC and MSU Extension

  CHW links clients to social influencers & medical care as well as to healthy food and cooking classes through a prescription from a physician at a FQHC or primary care practice.

- Diabetes Prevention Program – the Muskegon YMCA is the vendor providing the service through a CDC grant awarded to Trinity Health/Muskegon Community Health Project. Patients living in Muskegon, Oceana, Barry, Ionia and Ottawa counties can attend the DPP Program at no cost as the costs are covered by the grant. Physicians may send referrals directly to the YMCA from Great Lakes Health Connect of through Athena

Funding Sources

- Community Benefit – Mercy Health
- Senior Millage – Muskegon County
- Insurance Companies
- Center for Disease Control
- SIM/CHIR Funding

Healthy Mama = Healthy Baby

Multiple Chronic Disease | High-Risk Pregnancy | Parolees | At-Risk Students

- In a study conducted by Grand Valley State, of 95 infants born in the program, only 12 were born at low birth weight (13%).
- For patients enrolled in their first (or early second) trimester, birth outcomes **exceeded their Medicaid peers** and were brought to the **same level of that of commercial insurance** patients.
- Program cost per **completed patient** varied from $301.93 - $388.29
- $2,431 avoided per patient with delivery of a healthy birth weight baby
- Savings of $2,086 **per** participant.

Pathways Program using Community Health Workers Return on Investment

Michigan Public Health Institute Analysis

Chronic Disease Program

Muskegon Subset (n= 2,726)

- ED visits dropped after 6 months in program for all patients (Medicare, Medicaid, Dual)
- Hospitalizations decreased after 9 months in program for Duals
- All three groups showed sharp declines in readmission after 3-6 months in program. Only Medicare patients maintained that trend beyond six months

Community Impact

Making a Difference - Every Day.

"I have a rare blood clot disorder, and I was lost."

"…we build trust, and knock down barriers when other agencies may not have the time or resources to dedicate to one individual like we do."
Dave, CHW

48

Questions?

LIKE us on Facebook

Follow us on Twitter @MuskHealthProj

Call or **Write** 231.672.3304 | Judith.Kell@mercyhealth.com

AVALON HOUSING

*Avalon's mission is to build healthy, safe and inclusive supportive housing communities as a **long-term** solution to homelessness.*

- Housing First
- Enhanced Property Management
- Community Building
- Scattered Site/Single Site
- Serving Families and Singles

Trauma Informed. Harm reduction oriented.

AVALON HOUSING

What are people asking for?

"Supportive Housing is Healthcare"

- Do any you have a formal partnership with your local health system(s)?
- Are any of you doing data matching or receiving data matched referrals?
- Are any of you leveraging Medicaid?

https://youtu.be/lzc1LhBTWcI

AVALON HOUSING

CSH Social Innovation Fund
FUSE (Frequent Users Systems Engagement)

- Lead Agency

Avalon Housing

- Housing

Avalon Housing
Ann Arbor Housing Commission
Shelter Association of Washtenaw Co.
Michigan Ability Partners
Washtenaw Housing Alliance

- Hospitals

UMHS
St. Joseph Mercy Hospital

- Integrated Health
  - Packard Health
  - Washtenaw Public Health
  - Washtenaw Health Initiative
  - CMH and PATH

Backpack Medicine

- House Calls
- Co-located clinic

AVALON HOUSING

FUSE Program Goals

- Serve 100+ homeless frequent users of emergency health services using data driven targeting
- Create cross-system partnerships to improve health care delivery for patients with complex needs
- Improve health outcomes for frequent users
- Reduce health care costs associated with frequent users

Goals

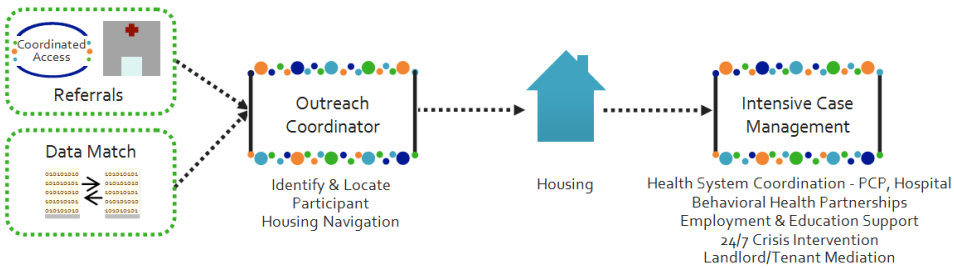
Participant Level:

Improve Physical and Mental Health	Decrease Mortality Rates	Reduce Substance Use	Reduce Medical and Psychiatric Inpatient Admissions and Hospital Days
Reduce Homelessness & Increase Housing Stability	Reduce Emergency Room Utilization	Reduce Utilization of Detox Facilities, Shelters, Jails, etc.	

System Level:

Increase Visibility, Awareness, & Understanding	Reduce Public & Private Health Care Costs	Break Down Systemic Barriers to Coordinating Care	Engage Local and State Level Policymakers to Stimulate System Changes that Work Toward Sustaining & Disseminating the Model of Care
Break Down Barriers to Rapid Access to Housing	Integrate Affordable Housing Resources with Health Care System	Build Solid Base for Supportive Housing's Effectiveness	

Approach



FUSE Demographic

- 70% chronic health condition
- 76% mental health condition
- 71% SUD
- 49% tri-morbid

*average age: 48 years old

Health Indicators (1 year post housing)

- 60% rate health as fair/poor
- 1 in 5 experience a medical problem every day in past month
- Half report difficulty walking or climbing stairs

Access to Health Care

Baseline	1 year follow up
ED as main source of care: 58%	ED as main source of care: 31%
Needed but could not find a dentist: 76%	Needed but could not find a dentist: 32%

Mental Health and Social Support

Baseline	1 year follow up
Frequent Loneliness: 48%	Frequent Loneliness: 34%
Feeling Life is Unstable: 57%	Feeling Life is Unstable: 12%
Life is Organized: 24%	Life is Organized: 75%

Client Satisfaction

High levels of satisfaction were reported with:

- Ease contacting social worker
- Choice of when to see social worker
- Choice over whether or not to take meds
- Proximity to shopping, public transport, etc.
- Independence in daily life
- Condition and affordability of the apartment

90% housing retention rate

Cost Impact

- *The most expensive quartile of participants reduced their costs by approximately $6,000 per person. While these reductions were not statistically significant, they suggest that:*
  - The highest of the high cost utilizers may benefit most from the care coordination approach of supportive housing.
  - Supportive housing may play a vital role as a care coordination model for individuals with complex health care conditions experiencing homelessness.
- *The lowest quartile of participants increased their costs by approximately $4,000 per person. This may have been due to the fact that they gained access to the care they needed.*

"No Health = No Justice"

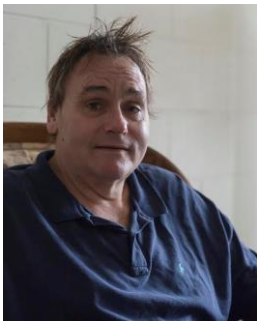
- 65-85% incarcerated individuals have SUD/MH d/o
- RESIST a siloed approach
- Track race explicit data/outcomes
- Educate your health systems on what your doing about racial equity

AVALON HOUSING

SUSTAINABILITY and NEXT STEPS

- ✓ State Innovation Model
- ✓ Financial Support from Health Systems
- ✓ Expansion of FUSE Model
- ✓ Coordinated Entry – LIHTC

Success Story



AVALON HOUSING

Thank you!

Questions?

Please contact Lauren Velez

lvelez@avalonhousing.org

Q & A

CSH

THANK YOU!

CSH

stay connected

csh.org