BETTER HEALTH THROUGH HOUSING

a healthcare & housing collaborative

Lessons Learned

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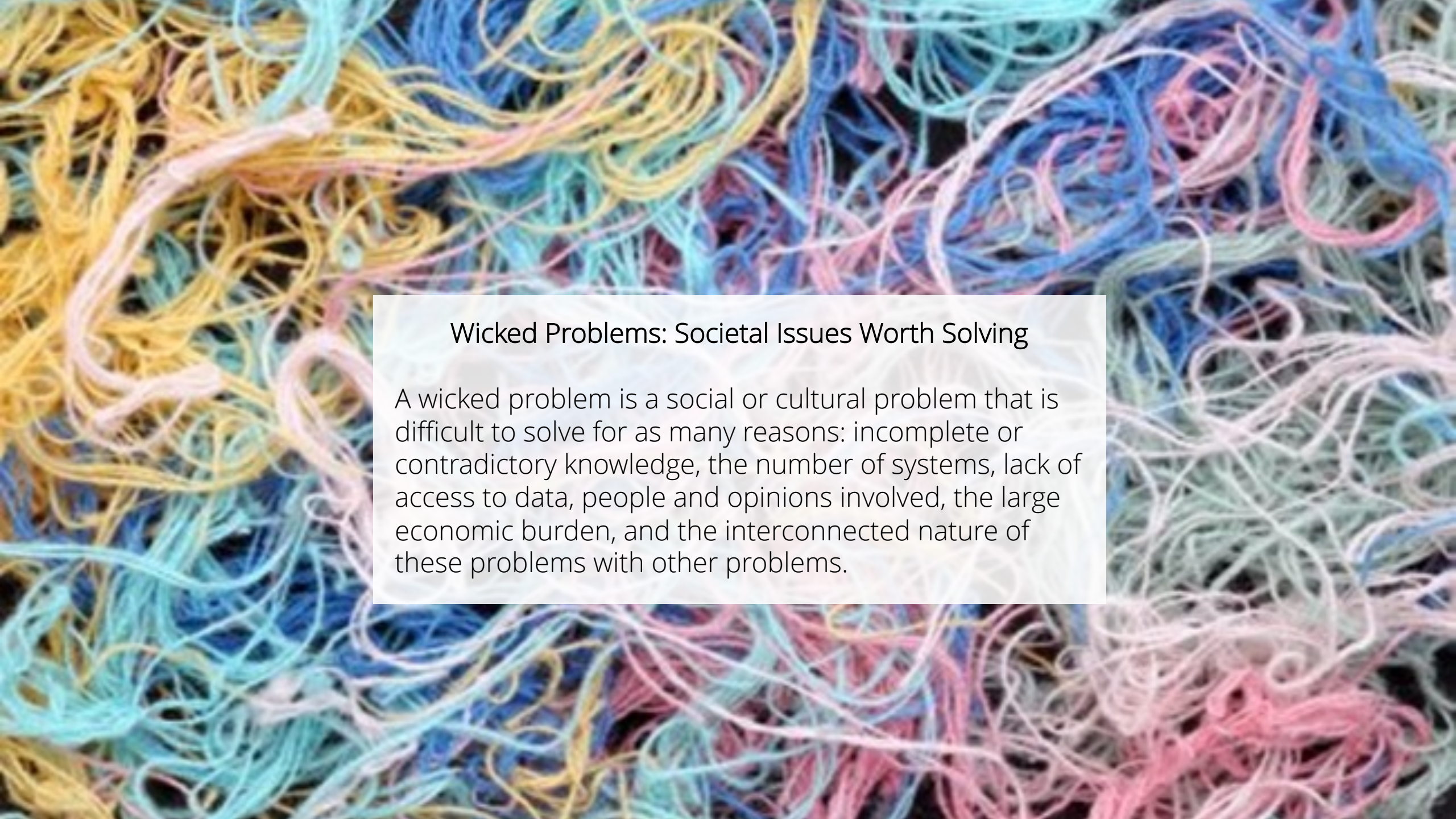
HH Center for Housing & Health

UI Health Emergency Medicine | UIC

“Homelessness is a failure of systems, not people”

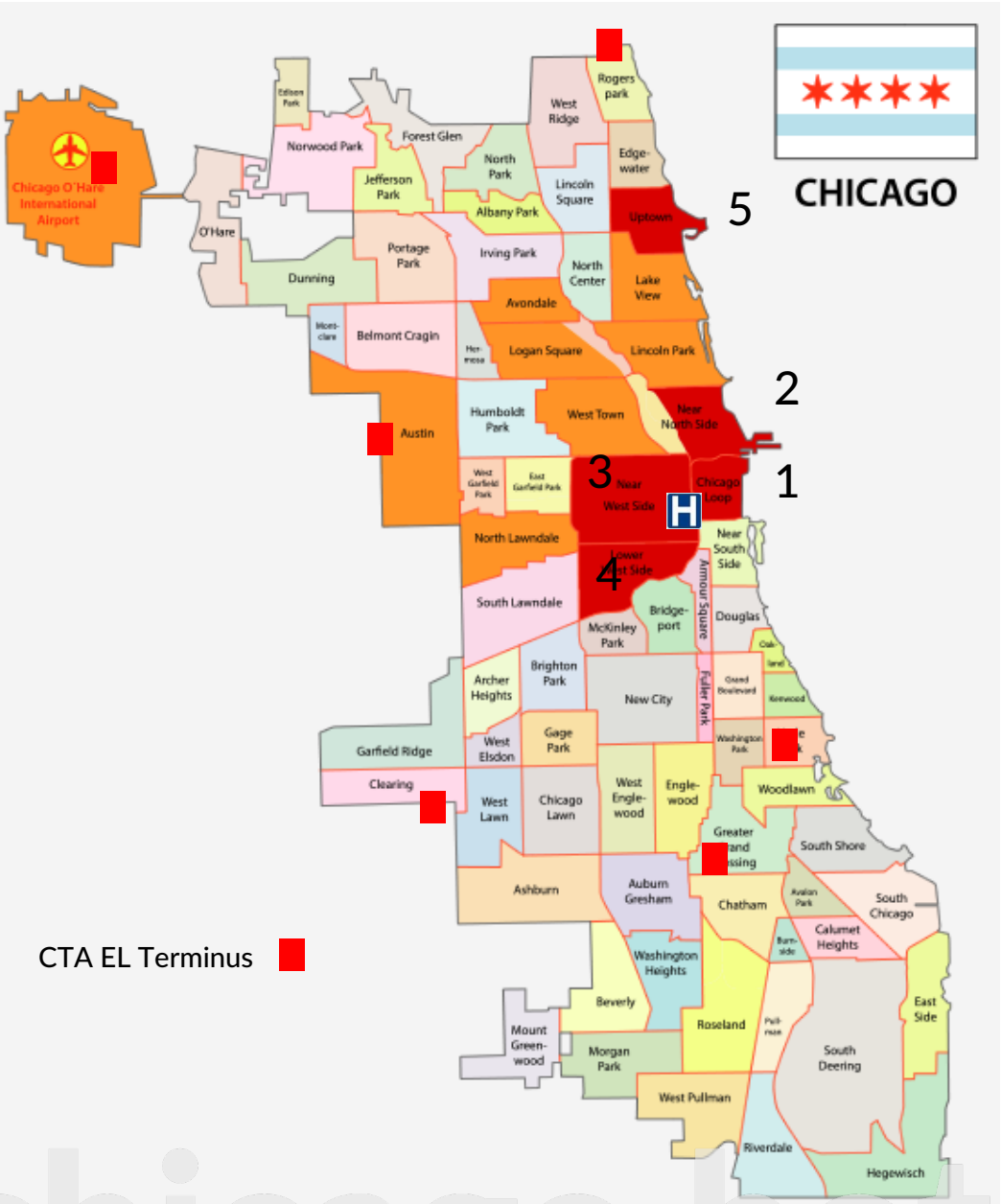
Ed Stellon, Executive Director
Heartland Healthcare



Wicked Problems: Societal Issues Worth Solving

A wicked problem is a social or cultural problem that is difficult to solve for as many reasons: incomplete or contradictory knowledge, the number of systems, lack of access to data, people and opinions involved, the large economic burden, and the interconnected nature of these problems with other problems.

Chicago: Homelessness

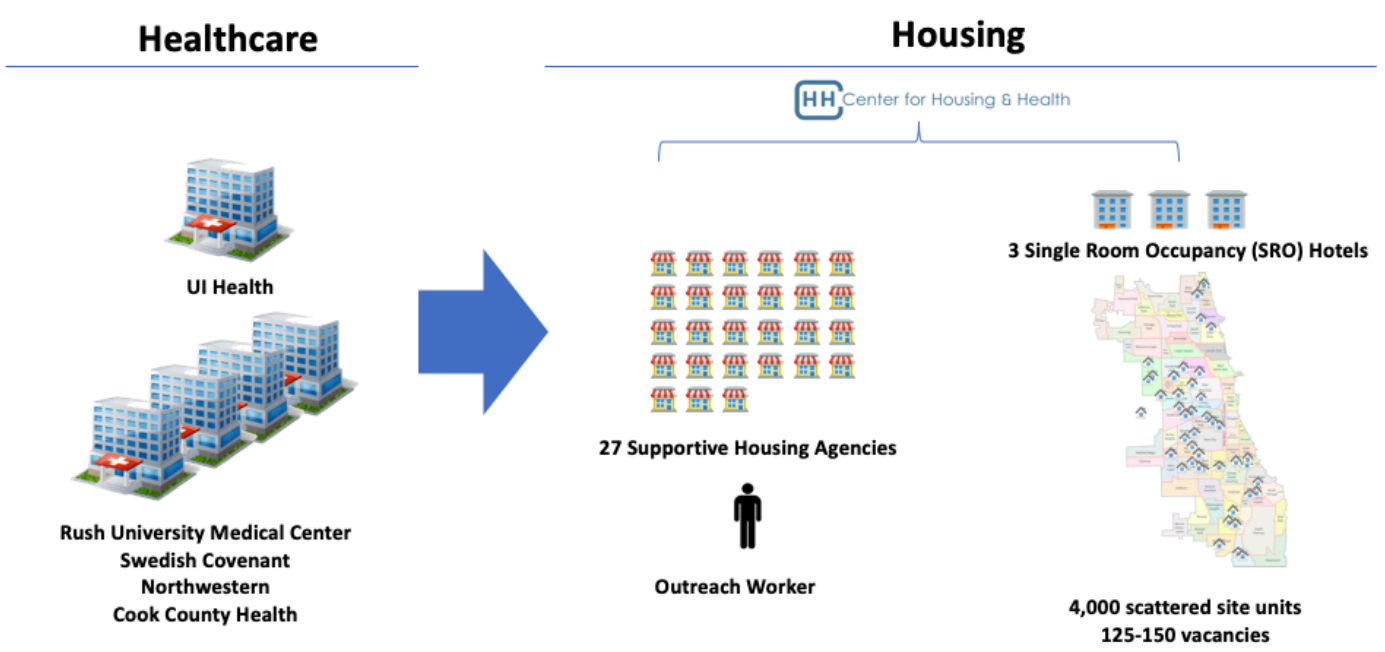


Chicago's unsheltered rate has remained constant for 5 years: ~1,500

Source: Chicago Department of Family and Support Services (DFSS), Annual Point In Time Count (7/17)

Center for Housing & Health

A model that makes it easy for hospitals to refer their patients into supportive housing



27 Supportive Housing Partners

Housing Forward
Chicago House
H.O.W.
Debra's Place
Sarah's Circle
Bobby E Wright
Thresholds
Heartland Alliance
More…

Outcomes

First Cohort (n=26)

47%
Housing Retention (8 of 17 survivors)

- 21%
Reduction in Healthcare Costs

- 57%
Drop-in Hospital Utilization

- 67%
Drop-in Emergency Department Utilization

34%
Mortality Rate

All Patients (n=59)

63%
Housing Retention (8 of 17 survivors)

0%*
Reduction in Healthcare Costs

- 30.3%
Drop-in Inpatient Utilization

- 34.8%
Drop-in Emergency Department Utilization

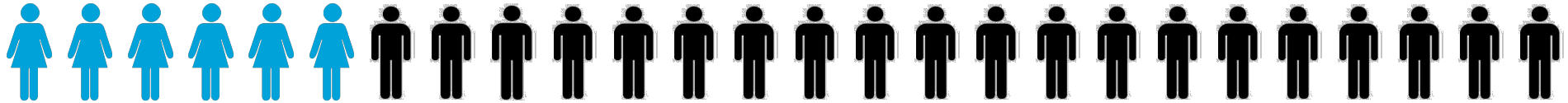
+ 16.3%
Increase in Outpatient Utilization

22%
Mortality Rate

47% HOUSING RETENTION RATE

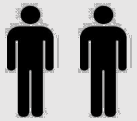
Reasons for Program Discharge – first cohort

Permanent Supportive Housing

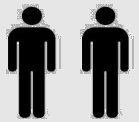


34% — **Deceased**

35% — **Severe Mental Illness**

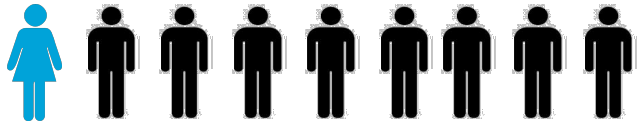


Intellectual Disability



Re-incarcerated

Discharged



34% — **Remain in Housing**

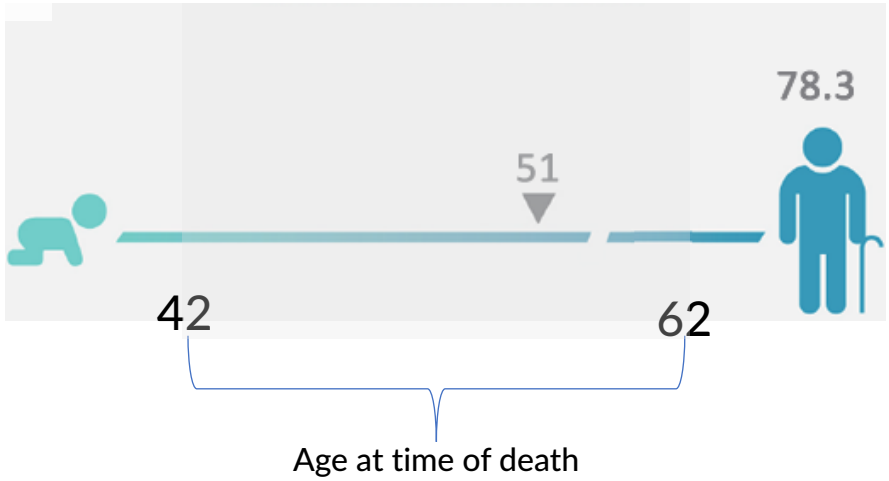
* 47% Housing Retention

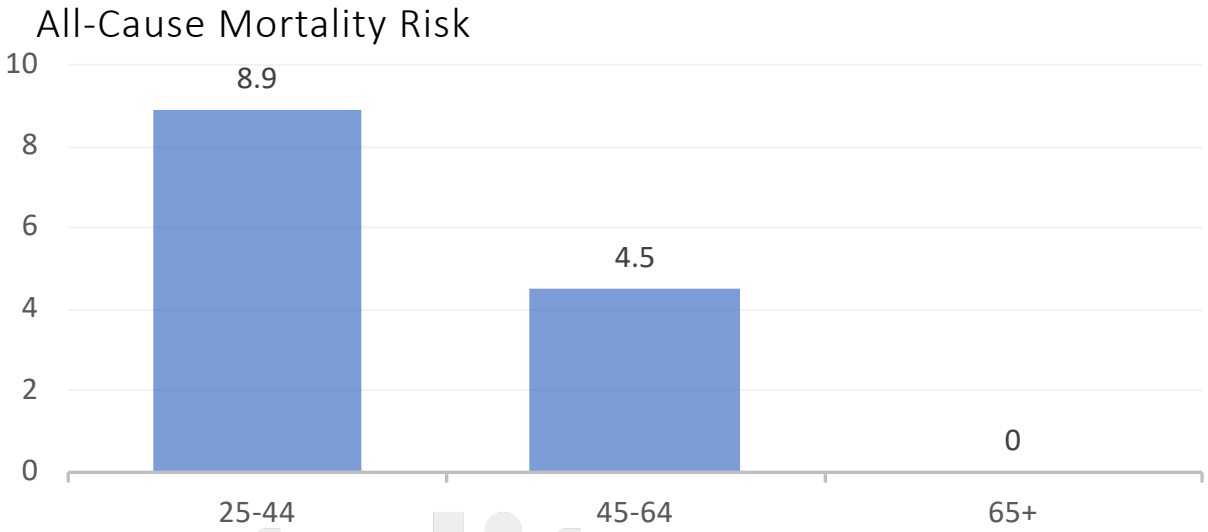
Lesson #1:

Homelessness is a dangerous health condition

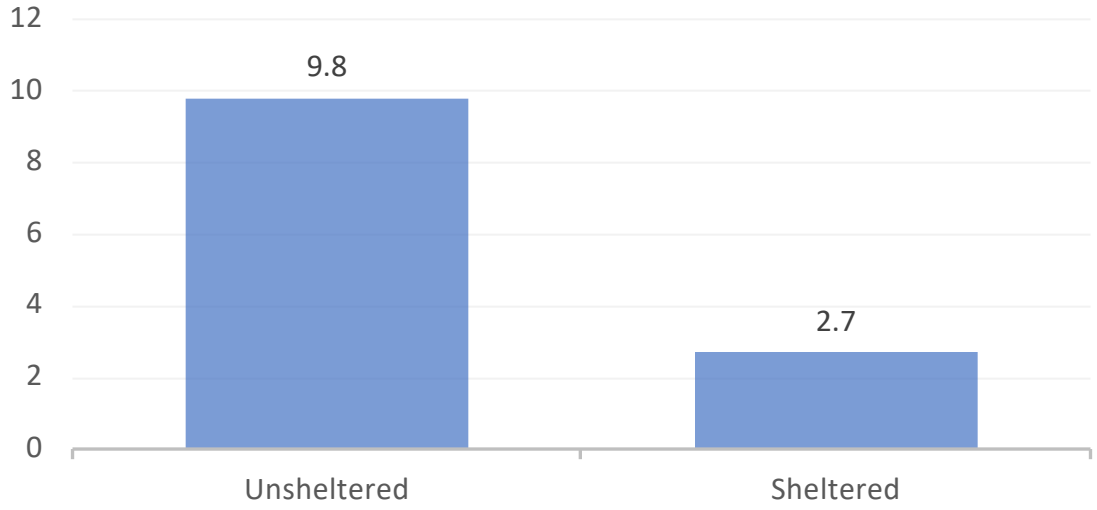
Life Expectancy

- The average life expectancy is 27.3 years less than the average American





Unsheltered Mortality Rate – 3.6x higher than all homeless



mortality

Source: Baggett TP, Hwang SW, O'Connell JJ, Porneala BC, Stringfellow EJ, Orav EJ, Singer DE, Rigotti NA. Mortality among homeless adults in Boston: Shifts in causes of death over a 15-year period. *JAMA Intern Med.* 2013 Feb 11; 173(3): 189-195.

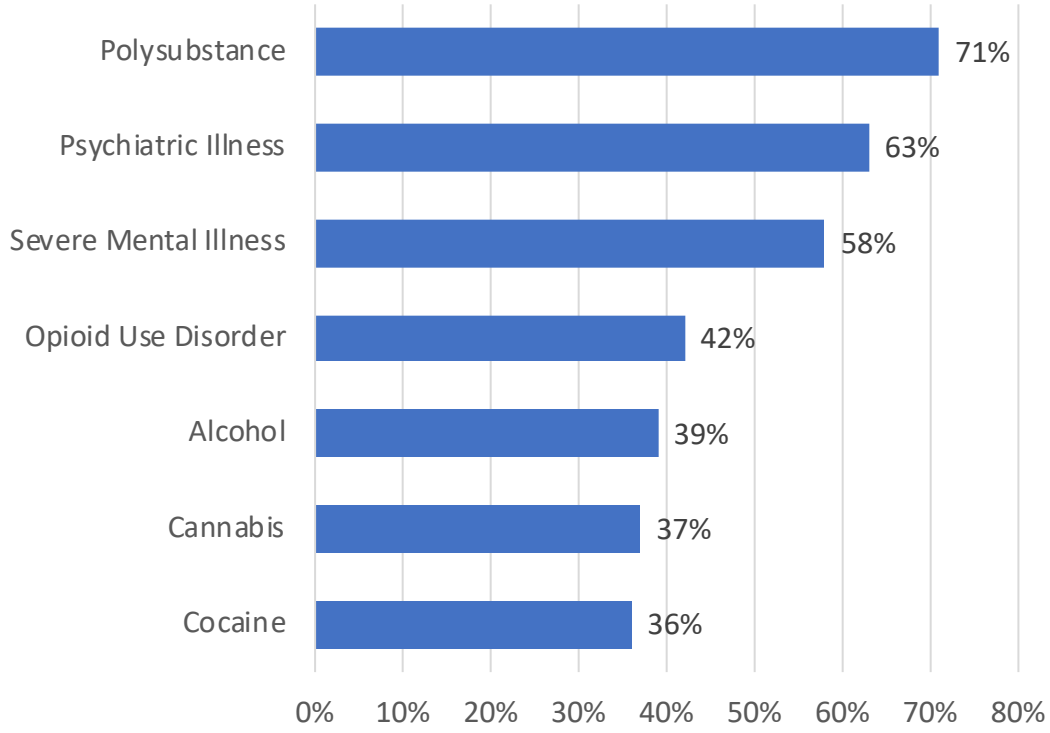
Tri-morbidity: the complex nature of chronically homeless patients

25x the rate of sheltered homeless

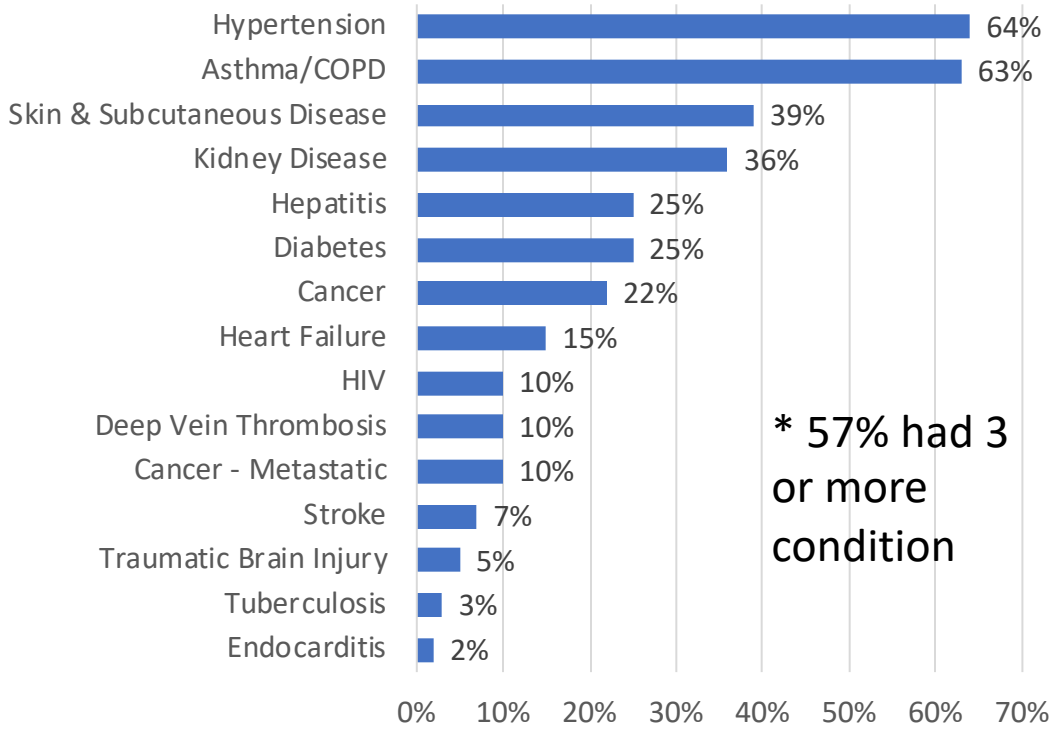
Trimorbidity is the combination of:

- Complex Chronic Condition(s)
- Substance Use Disorder
- Severe Mental Illness

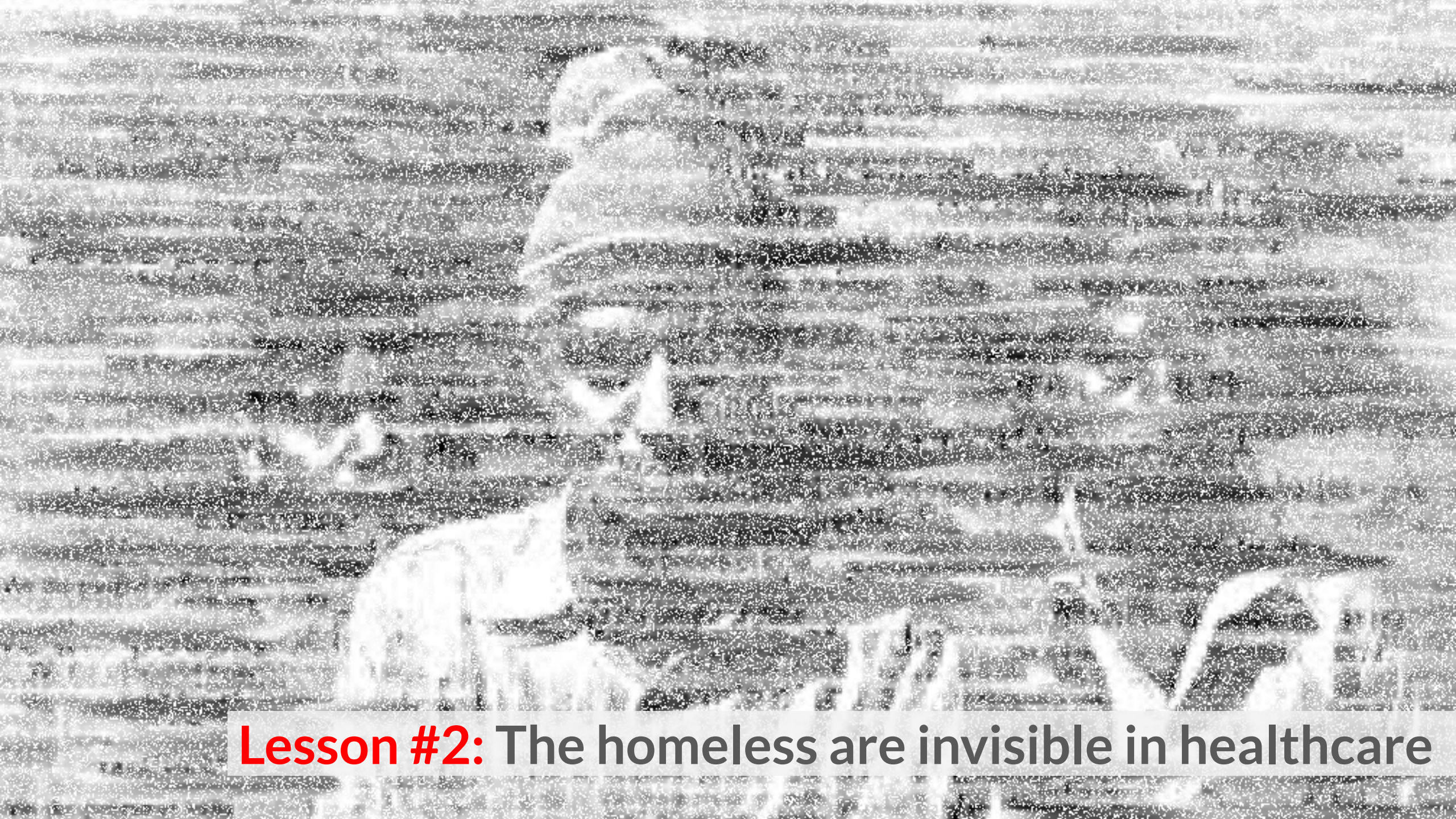
Psychiatric Illness & Substance Use Disorders



Chronic Disease & Injury



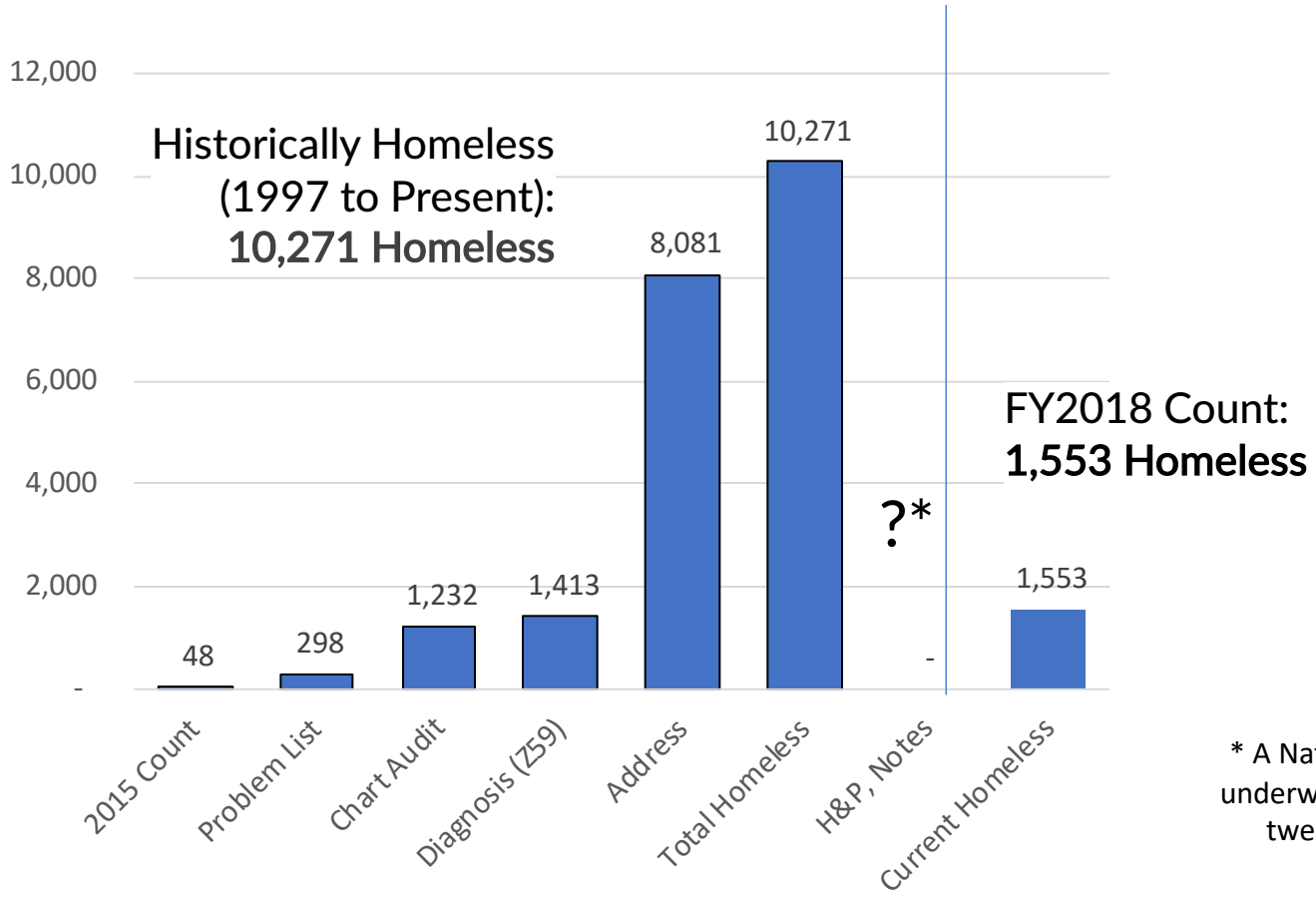
All BHH Patients (n=59) November 2015 to present



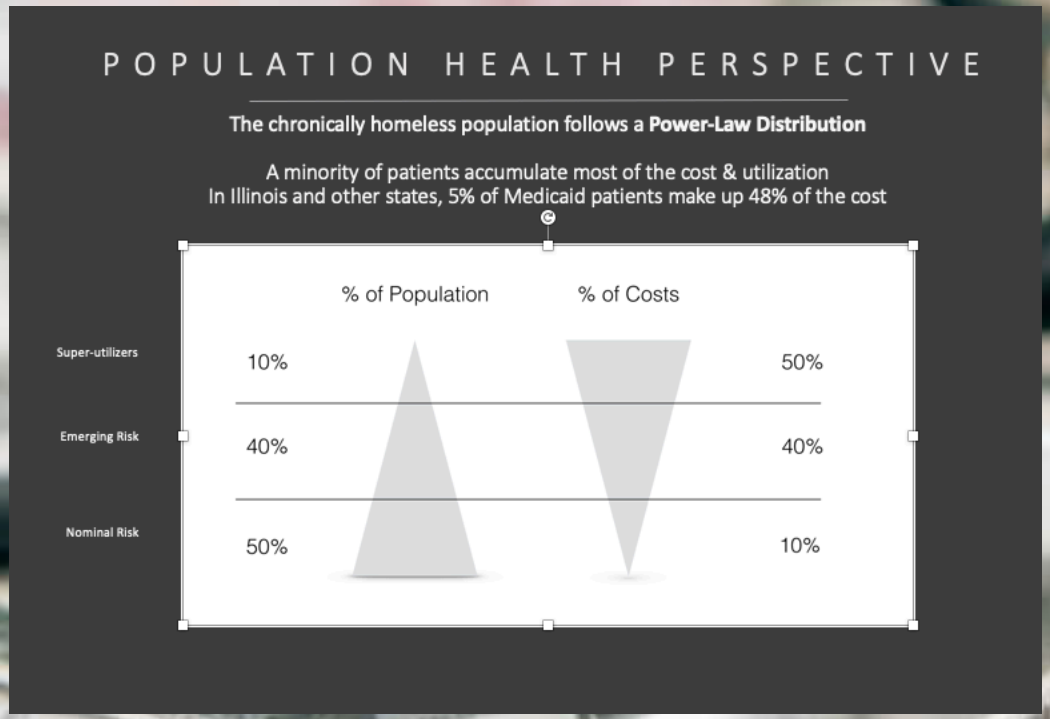
Lesson #2: The homeless are invisible in healthcare

Homelessness is significantly underreported

In 2015, less than 100 homeless patients had been identified by ED & Psych staff interviews.



* A Natural Language Processing (NLP) project is currently underway in order to identify homeless patients from over twenty million clinical notes. Preliminary results will be reported in the Spring of 2020.



from **The New Yorker**

February 13, 2006
DEPT. OF SOCIAL SERVICES

Million-Dollar Murray

Why problems like homelessness may be easier to solve than to manage.

by Malcolm Gladwell

1.

Murray Barr was a bear of a man, an ex-marine, six feet tall and heavyset, and when he fell down—which he did nearly every day—it could take two or three grown men to pick him up. He had straight black hair and olive skin. On the street, they called him Smokey. He was missing most of his teeth. He had a wonderful smile. People loved Murray.

His chosen drink was vodka. Beer he called "horse piss." On the streets of downtown Reno, where he lived, he could buy a two-hundred-and-fifty-millilitre bottle of cheap vodka for a dollar-fifty. If he was flush, he could go for the seven-hundred-and-fifty-millilitre bottle, and if he was broke he could always do what many of the other homeless people of Reno did, which is to walk through the casinos and finish off the half-empty glasses of liquor left at the gaming tables.

"If he was on a runner, we could pick him up several times a day," Patrick O'Bryan, who is a bicycle cop in downtown Reno, said. "And he's gone on some amazing runners. He would get picked up, get detoxed, then get back out a couple of hours later and start up again. A lot of the guys on the streets who've been drinking, they get so angry. They are so incredibly abrasive, so violent, so abusive. Murray was such a character and had such a great sense of humor that we somehow got past that. Even when he was abusive, we'd say, 'Murray, you know you love us,' and he'd say, 'I know'—and go back to swearing at us."

"I've been a police officer for fifteen years," O'Bryan's partner, Steve Johns, said. "I picked up Murray my whole career. Literally."

Johns and O'Bryan pleaded with Murray to quit drinking. A few years ago, he was assigned to a treatment program in which he was under the equivalent of house arrest, and he thrived. He got a job and worked hard. But then the program ended. "Once he graduated out, he had no one to report to, and he needed that," O'Bryan said. "I don't know whether it was his military background. I suspect that it was. He was a good cook. One time, he accumulated savings of over six thousand dollars. Showed up for work religiously. Did everything he was supposed to do. They said, 'Congratulations,' and put him back on the street. He spent that six thousand in a week or so."

Often, he was too intoxicated for the drunk tank at the jail, and he'd get sent to the emergency room at either Saint Mary's or Washoe Medical Center. Marla Johns, who was a social worker in the emergency room at Saint Mary's, saw him several times a week. "The ambulance would bring him in. We would sober him up, so he would be sober enough

Lesson #3: Many homeless have excessive cost & utilization

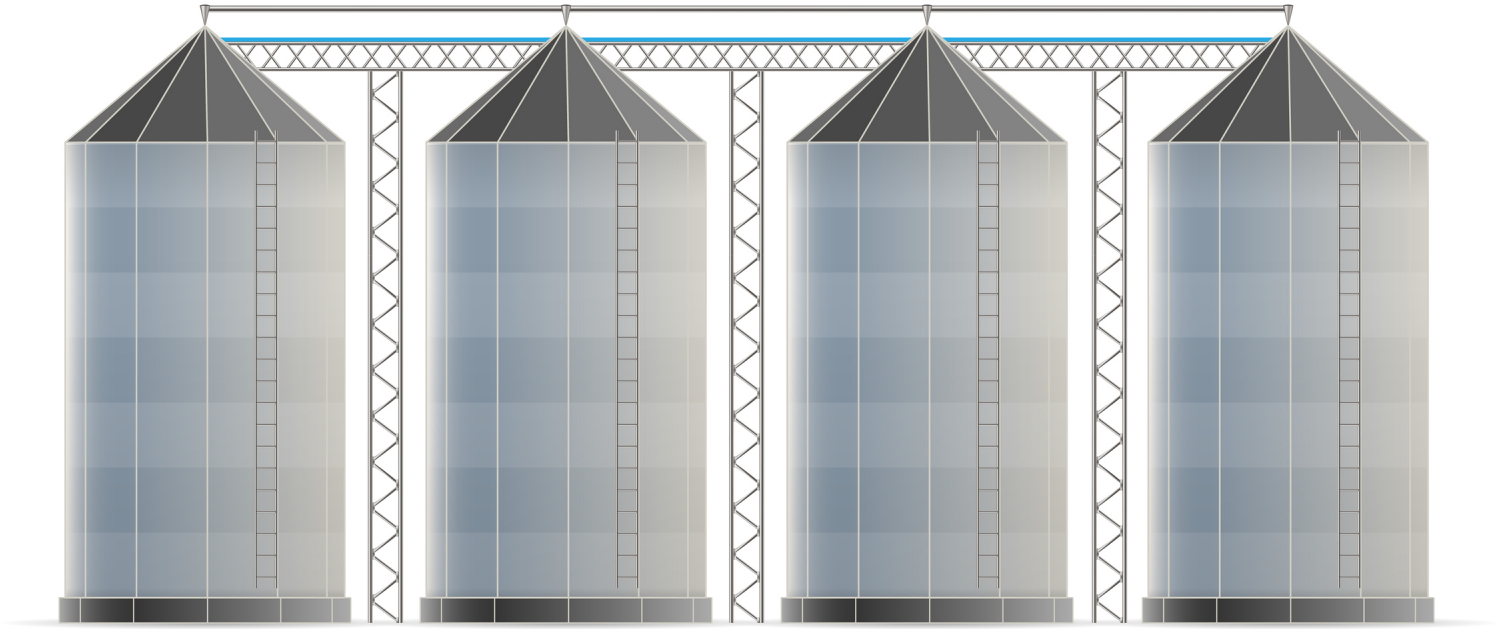
FY2018 UI Health Homeless Costs

Rankings by decile
40% have elevated costs

Decile	# of Homeless	Avg. UIH Patient Cost	Total Costs	Average Cost	Average Factor	High Cost	High Factor
10th	123	$5,835	$11,195,902	$90,290	15.47	938,133	160
9th	123	$5,835	$3,143,801	$25,535	4.35	36,141	6.19
8th	123	$5,835	$1,807,524	$14,577	2.50	18,770	3.22
7th	123	$5,835	$1,109,073	$8,944	1.53	11,138	1.91
6th	123	$5,835	$699,902	$5,644	.97	7,055	1.21
5th	123	$5,835	$433,458	$3,496	.60	4,388	.75
4th	123	$5,835	$231,159	$1,864	.32	2,530	.43
3rd	123	$5,835	$120,533	$972	.17	1,306	.22
2nd	123	$5,835	$58,523	$472	.08	672	.12
1st	123	$5,835	$26,845	$216	.04	321	.06

FY2018 cost analysis comparing patients believed to be homeless to all other UIH patients who had charges > $100. n= 162,178


Ambulance Ride: $800
ER Visit: $1,250
Hospital Admission: $2,633
Magnificent Mile Hotel:
$625/ evening

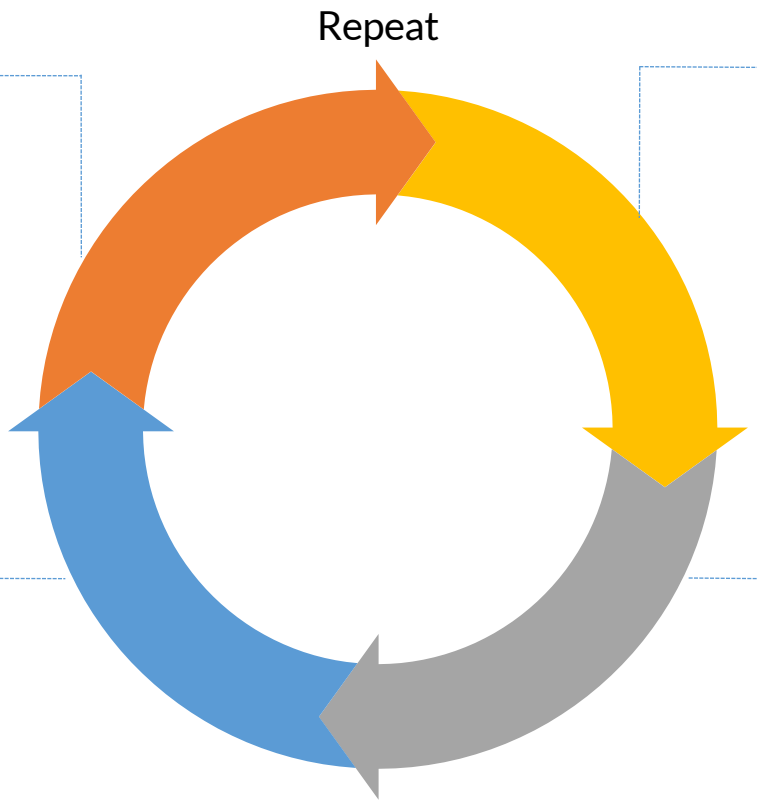


Lesson #4: Chronic homelessness is a complex social issue that requires alignment among public sector systems

Treating one condition at a time has contributed to ER being revolving doors

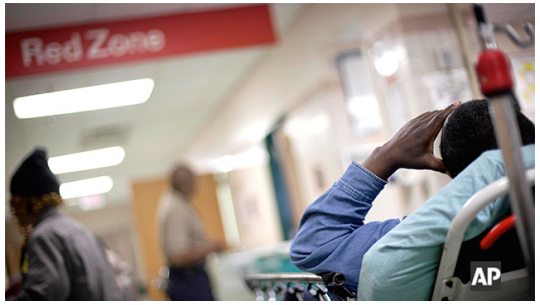
Fragmentation of Care: Healthcare's Role

Treat & Release



Injury, Public Nuisance, Intoxication, Psychiatric Crisis

ED Workup or Psych Admission



Transport To ED by police & fire

Alignment with housing:
A tiered approach

INSTITUTIONALIZATION
For patients with refractory, severe mental illness
LOCUS: 28 +

CLUSTERED OR PROJECT-BASED WITH ONSITE SUPPORT
For patients with severe mental illness or substance abuse
May include patients with Assisted Outpatient Treatment (AOT)
LOCUS: 25-27

SCATTERED SITE - WITH ASSERTIVE COMMUNITY TREATMENT (ACT)
For patients with moderate or well-controlled mental illness or substance abuse
LOCUS: 23-24

LOCUS:23-30

LOCUS:0-22

SCATTERED SITE - HOUSING CASE MANAGEMENT
For patients with controlled or mild mental illness and/or substance abuse
LOCUS: up to 22

RAPID RE-HOUSING
For patients identified as needing assistance locating affordable or supportive housing

Addressing system failures

Assisted Outpatient Treatment

For patients with untreated severe mental illness who cycle through EDs, jails, EMS and police. Patients placed on long-acting injectables, given Assertive Community Treatment ACT) and monitored by the courts

Medication Assisted Therapy

Suboxone, Methadone or Vivitrol for Opioid Use Disorders, coupled with trauma-informed psychotherapy. The critical phase is the first 5 days

Diversion Strategies

Psychiatric Stabilization Centers, Sobering Centers, Re-entry healthcare for patients exiting jail & prison

Assertive Community Treatment

A shortage of evidence-based ACT has led to high rates of untreated mental illness, readmissions, ER visits, and over-use of first responder and criminal justice systems

Towards Collective Impact:
The Flexible Housing Pool

- Based off a model in Los Angeles (city & county partnership)
- Led by the Center for Housing & Health, Chicago Department of Public Health (CDPH), the Department of Family and Support Services (DFSS) UI Health and the Corporation for Supportive Housing (CSH)
- Mitigates the “Wrong Pocket Problem” by braiding together subsidies, grants and investments into a common funding pool.
- Over $9m / $12 commitment from CDPH, DFSS, DPD & Cook County Health, Blue Cross, Advocate Aurora, UI Health
- Attracts investment from non-traditional funders (hospitals, insurance companies)
- Facilitates capacity-building: more apartments to come online

750 MORE APARTMENT UNITS

So why should healthcare pay for housing?

- Homelessness consumes exorbitant amounts of public sector cost & utilization
- It's a dangerous & deadly health condition that requires a sustained effort and a multi-sectoral approach
- Integrated health systems are the most motivated hospital/payors (Geisinger, Kaiser-Permanente)
- If hospitals focus on detection, they will find it (just like HIV)
- Hospitals with a strong sense of mission will embrace the responsibility
- Affordable Care Act (ACA) has incentives for hospitals to embrace population health
- Hospitals can demonstrate community benefit
- The Anchor Mission: Hospitals replacing industry as largest employer and economic engine of communities

Questions?

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The Process: From a Hospital to a Home

An Interdisciplinary, Interagency process that uses the **Housing First** model

1,500
Identification

Homeless Patient

60
Intake

Chronically Homeless Referral Panel (CHRP)

27

Outreach Worker

HEARTLAND ALLIANCE
ENDING POVERTY

26
Outreach & Placement

Bridge Unit 3 single room occupancy (SRO) hotels

26

Permanent Supportive Housing and case worker

26
Care Coordination

Systems Integration Team (SIT)

CHICAGO HOUSE
housing FORWARD
ending homelessness
THRESHOLDS
HOME | HEALTH | HOPE

+24 agencies

HH Center for Housing & Health

UI Health
Emergency Medicine
UIC


Red Zone