DEMONSTRATING VALUE

MEASURING THE VALUE AND IMPACT OF THE HEALTH CARE FOR THE HOMELESS GRANTEES

Speakers

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Agenda

I. Background
II. Value Analysis: “In the Absence of HCH”
III. Our Voices: Stories from the HCH community
IV. Tracking Value: Best Practices for HCH providers
V. Questions

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Alaina Boyer, PhD | NHCHC

Background

Background

- Value Statement
  - Strengthen clinicians and programs that serve people experiencing homelessness: best practices based on lived experiences, research, and policy analysis
  - Provide training, technical assistance and essential information required to adapt clinical and operating practices in a changing health environment

Background

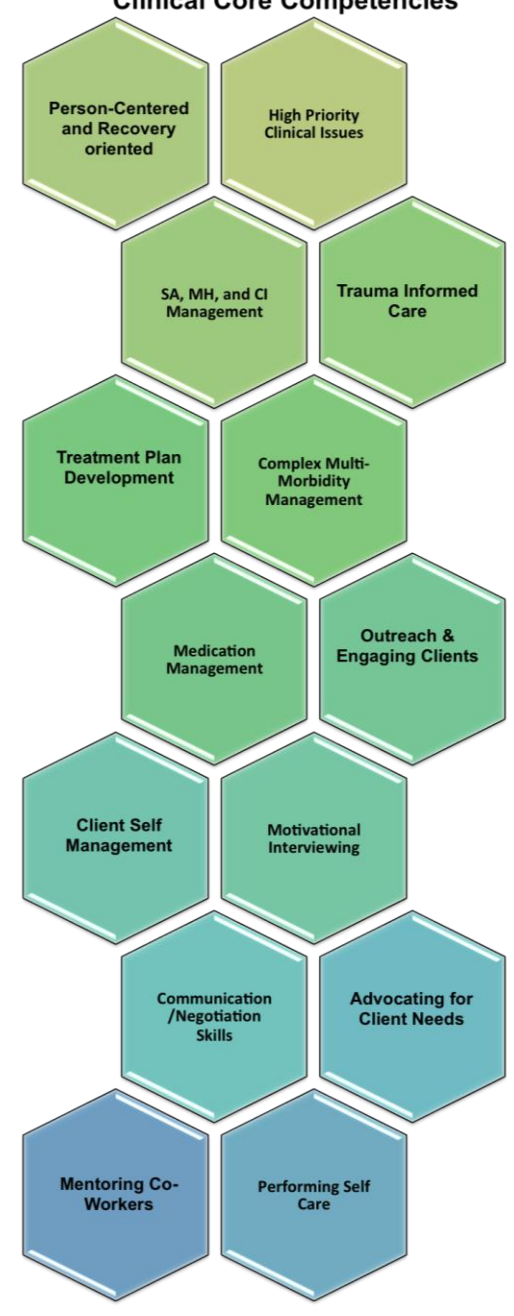
- Purpose
  - Demonstrate value of HCH grantees to sustainably measure health delivery to underserved populations
- Variation in measuring “value”
  - Cost effectiveness
  - Performance measures
  - Access to care
  - Quality care
  - Equitable care

Who We Serve

- Increased mortality, comorbidity and chronic conditions rates
- More complex health issues
- Greater trauma
- Exacerbated conditions
- Difficulty in linkage to health outcomes (Z-code)
- 1.2 Million served by FQHC; 94% by HCH grantees

Patient Characteristics	All Grantees	HCH Grantees
Total Patients	24,295,946	890,283
Total Homeless	1,191,772 (4.9%)	840,130 (94.4%)
Age		
Children (<18 years old)	31.2%	12.3%
Adult (18-64)	60.9%	82.9%
Older Adults (65 and over)	7.9%	4.8%
Income Status		
Patients at or below 200% of poverty	92.2%	97.7%
Patients at or below 100% of poverty	70.9%	87.8%
Insurance Status		
Uninsured	24.4%	37.6%
Medicaid	48.9%	49.1%

Housing Type	
Shelter	258,100 (30.7%)
Doubling Up	242,562 (28.9%)
Transitional	101,639 (12.1%)
Street	72,744 (8.7%)
Other	100,700 (12%)
Unknown	64,385 (7.7%)



Who We Are

- Distinct from general community health center population
- Trauma-informed and harm reduction approach
- Greater comprehensive care
- Reduced stigmatization and welcoming to patients
- Integrated care in otherwise fragmented delivery system
- Often collocated to reduce barriers
- Sensitive, innovative, passionate

What does HRSA look for?

- Funding provided to grantees that *“demonstrate training and technical assistance to health centers to increase access to care, achieve operational excellence and quality improvement strategies, and enhance health outcomes and health equity within state and regional contexts”*

Value Provided

Access

- Availability of Resources
- Connecting to services
- Responsiveness to Learning Health Systems

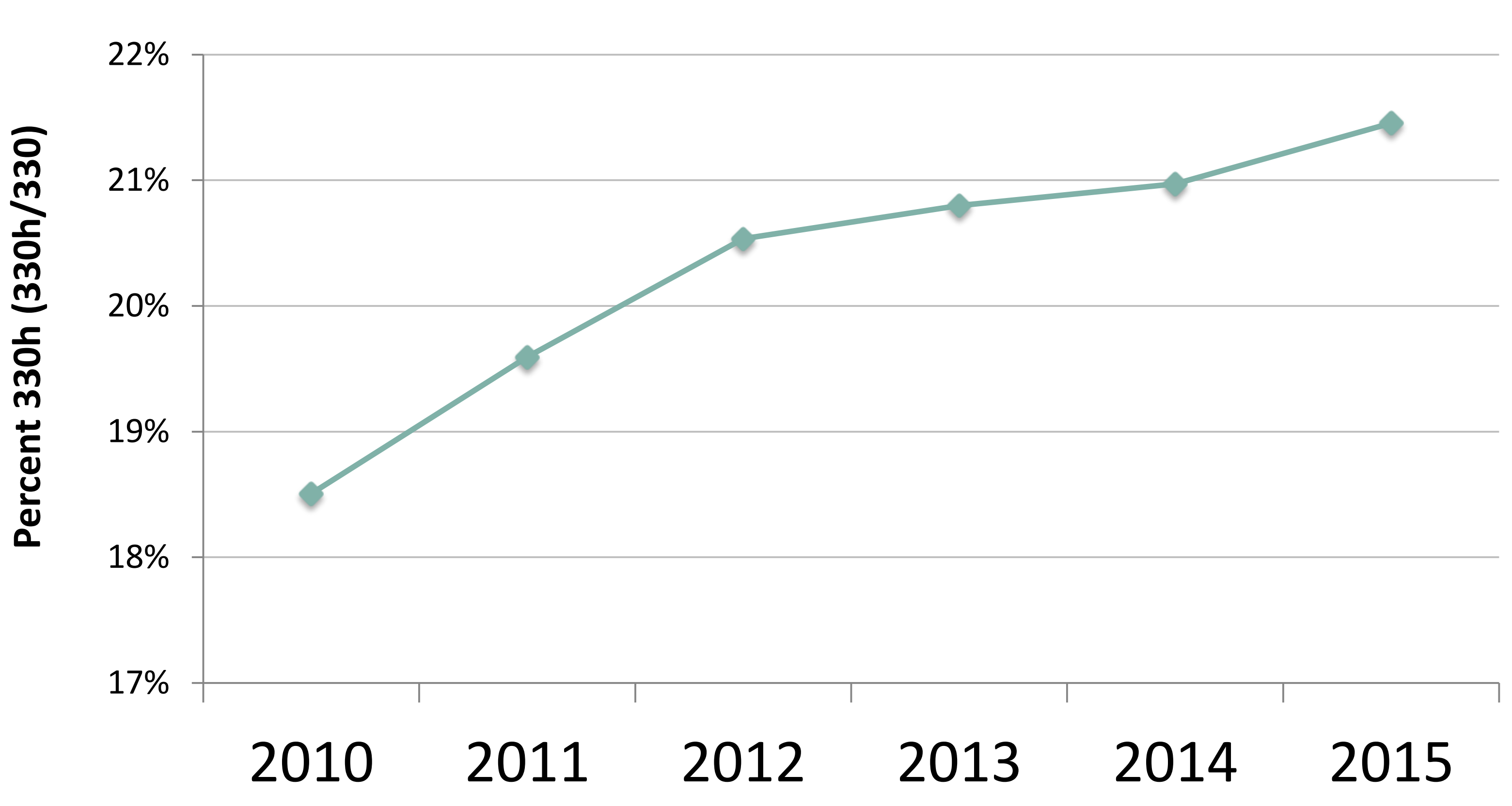
Quality

- Meaningful and deliberate care
- State of the Art Comprehensive Care
- Preventive Care

Equity

- Community First Care
- Fair and Tailored care
- Respectful and Informed Care

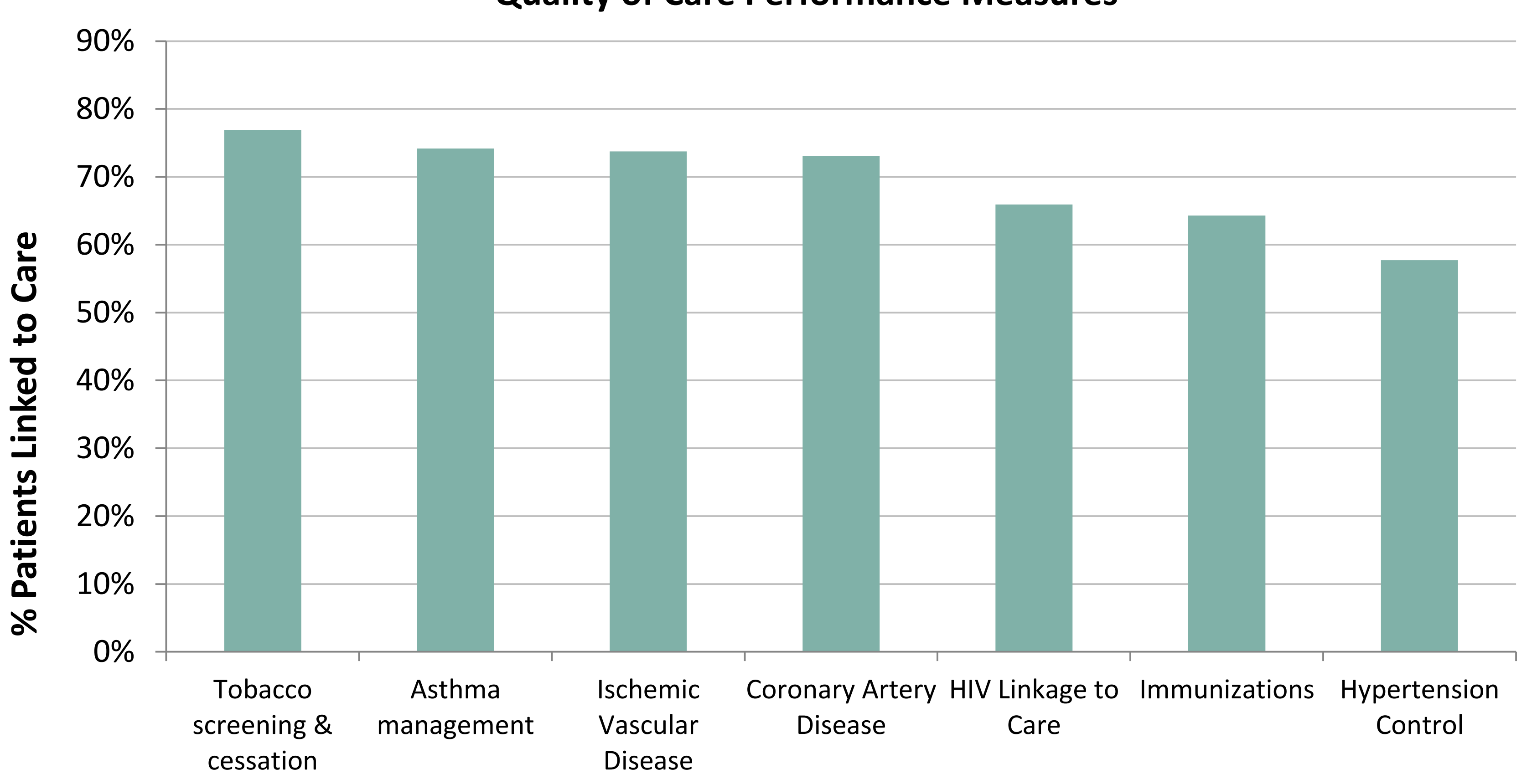
Access: Increase in HCH Grantees



Access to Services

Services Provided by HCH Grantees	
Type of Service	Percent of Clinics
Care/Case Management	91%
HIV Screening/Education	71%
Substance Abuse Services	68%
Street Outreach	66%
Support/Education Services	65%
Dental Services	64%
Pediatrics	61%
Pharmacy/Dispensary Services	41%
Geriatrics	41%
Perinatal Care	35%
Services in Supportive Housing	31%
Mobile Clinical Services	30%
Vision Services	26%
Medical Respite	18%

Quality of Care



Equity of Tailored Services

- Services not always captured by traditional health care surveillance
- HCH grantees wrote in tailored services provided on daily basis to meet patients where they are

Professional Services

Acupuncturists *Contract for Provider Services (M.D.)* Crisis Intervention *Audiologist* Dietician/Nutritionists Dietary Supplements *Naturopaths* Occupational therapist Dues & Licensing Physical Therapist Adult Residential Treatment Podiatry *Speech Pathologist*

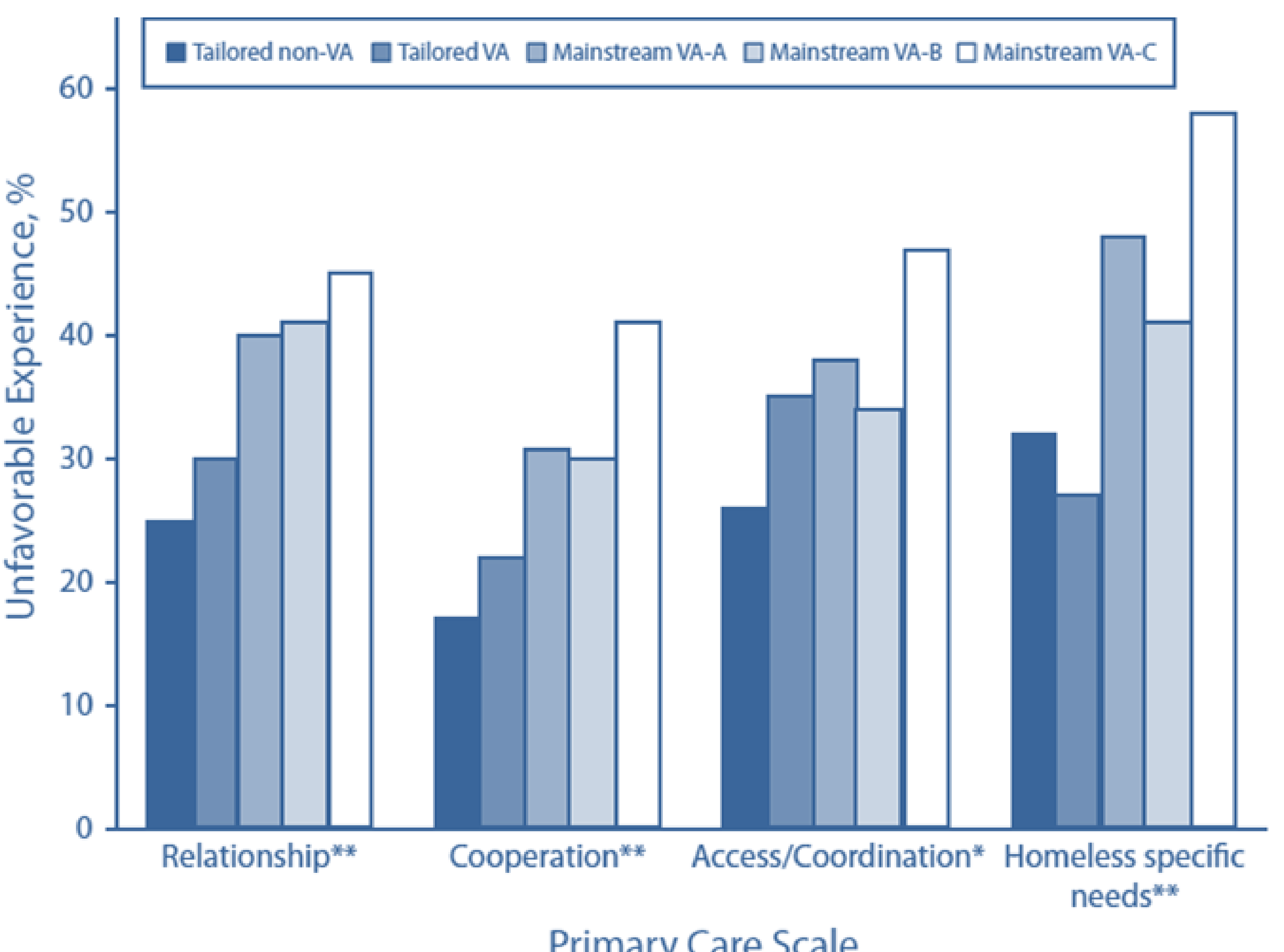
Enabling Services

Art Studio Staff Child Care Provider *Client Advocates* Community Health Worker Contracts for Services *Employment/Recruitment Specialist* Eyeglasses Homeless MIS data system: data collection and entry *Housing Specialist* Medical Home for Homeless Children Monetary Assistance *Navigator* Research Associate Respite Care Shelter & Lodging *Support Service* Stipends

Related Services

Clothing Food/Meals Haircuts Housing Related Services *Assistance, Eligibility* HUD Passthrough Rents Medical Respite Money Management Specialist Open Door –Supervisor *Peer Support* Specialists Personal Hygiene Items *Policy Team* Shelter Utilities Assistance *WIC*

Equity: Tailored Services



Barbara DiPietro, PhD | Senior Director of Policy, NHCHC

Value Analysis: In the Absence of HCH Grantees

In the Absence of HCH Grantees: Community Impact

- Compromised public health goals/initiatives
  - Chronic & communicable disease, behavioral health
  - Violence & injury
- Crowding & diversion at emergency departments & hospitals
- Greater reliance on police & other first responders
- More vulnerable people experiencing homelessness

Demonstrate:

Improved health outcomes & connections to care, trends in service utilization from a quality of care perspective, lower risk behaviors

In the Absence of HCH Grantees: Patient Impact

- Greater levels of homelessness
  - More likely to become homeless
  - Less likely to exit homelessness
- Higher morbidity and mortality
  - More difficult to engage in care

- Loss of productivity, family connection, employment, and human dignity

Demonstrate:

Patient satisfaction, greater preventive screenings, engagement in care, improved mental health status

In the Absence of HCH Grantees: Cost Impact

Key Question: Why should we pay you more?

- Greater costs accrued at EDs & hospitals & other care venues
  - (Re)admissions, lengths of stay, resources needed
- "Bending cost curve" harder to achieve
- Broader health & support services not as effective
- For consideration: acuity/risk-adjusted payments

Demonstrate:

Use of more appropriate care settings, trends in service use from cost perspective

Rick Brown, MA | Communications Manager, NHCHC

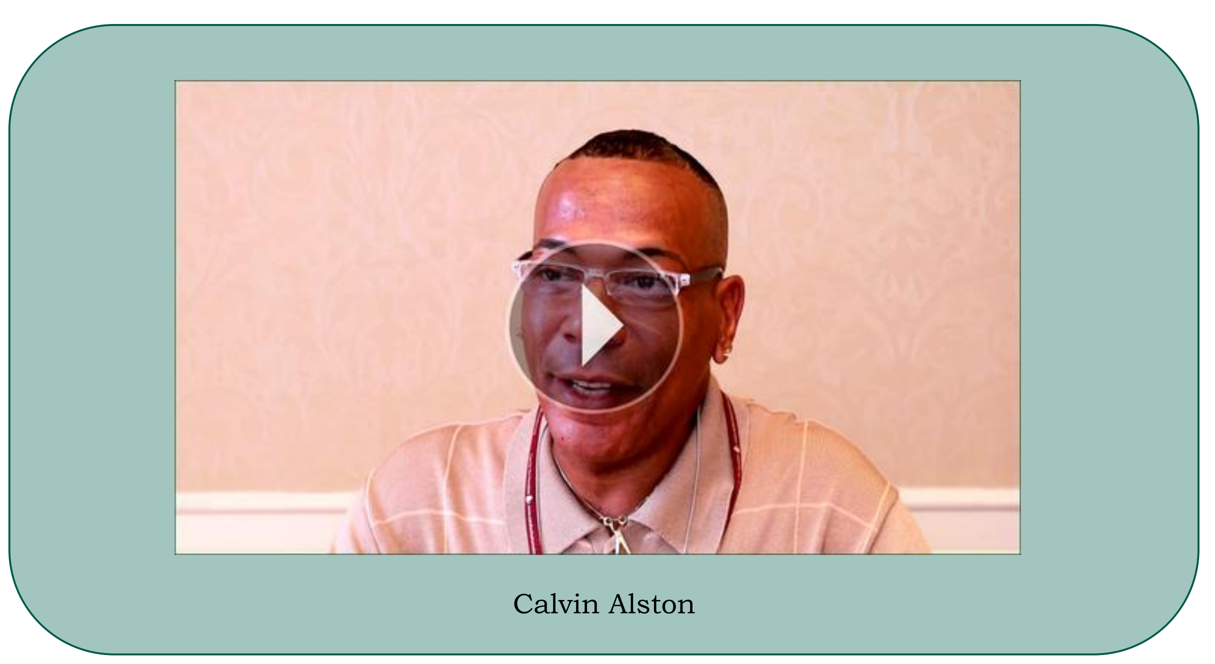
Our Voices: Stories from the HCH Community

The Importance of Storytelling

- Stories “put a face to” the value of Health Care for the Homeless
- Simple vignettes can highlight services, as well as health and housing outcomes, in a way that data sometimes cannot

An Example: *HCH Stories*

- Digital storytelling project of the National Health Care for the Homeless Council
  - Calvin Alston's Story
- Ideas for production and dissemination



Calvin Alston

Heidi Nelson | CEO, Duffy Health Center

Tracking Value: HCH and the Value Proposition - Intrinsic or Economic?

Health Care for the Homeless
and the Value Proposition

In Health Care

"Since value depends on results, not inputs, value in health care is measured by the outcomes achieved, not the volume of services delivered, and shifting focus from volume to value is a central challenge."

-Perspective, New England Journal of Medicine, 12/23/2010

The Value Proposition
Where to Begin?

- Your health center’s data
- National health center data
- Statewide health center data
- Special studies
- Grant or program outcomes

Your Health Center Data

- Source:
  - UDS
  - Bureau of Primary Health Care Profile
  - Quality Reporting

BPHC Profile

- (Your Health Center Name) Google It!
- Derived from UDS data
- Benchmarked to your state's data and to national health center data

Pick your Favorite Scores!

	2013	2014	2015
Depression Screening		4%	74%
Blood Pressure Under Control	62%	58%	58%
Uncontrolled Diabetes	33%	24%	23%

National Association Data Source: NACHC Website

- Nationally,
  - 1,300 health centers
  - 23 million patients served
  - 9,000 service delivery sites
  - Serve one in three persons living in poverty

National Association Data Continued

- Health centers save $24 billion for the health system annually
- Health center are associated with lower costs of care for Medicare (11-34% less) and Medicaid (23% less) compared to other providers

National Association Data Continued

- Medicaid costs
  - Lower rates of multi-day hospitalizations (CA)
  - Less likely to use hospital-related services (CO)
  - Less total cost (TX)
  - Annual savings per patient (MI)
- Care for the uninsured
  - Less ED visits for uninsured patients (GA)
- Lower total health care spending (NC)

National Association Data
National HCH Council

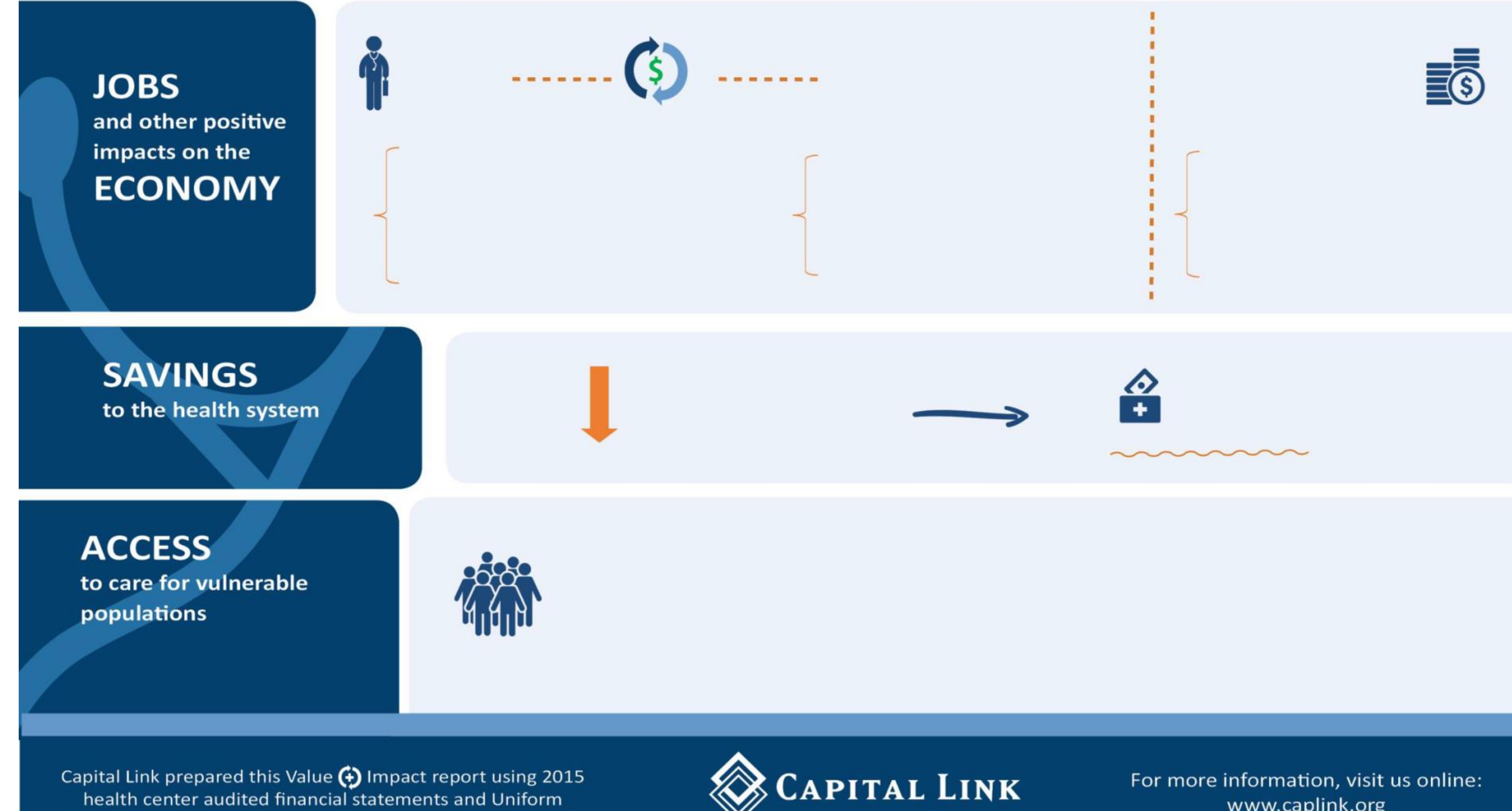
Nationally, in 2015, HCH programs served 1,191,772 patients

- 88% of the patients are under 100% of the federal poverty level (FPL)
- 38% are uninsured
- 12% of patients were children and youth under the age of 18
- 5% were older adults age of 65 and over

State Association Data

Mass League Economic Engine Report

VALUE IMPACT of HEALTH CENTERS



Capital Link prepared this Value Impact report using 2015 health center audited financial statements and Uniform Data System information. Economic impact was measured using 2015 IMPLAN Online.

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Driving Successful Health Center Growth

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Duffy Health Center

Economic Impact Report
Capital Link

- 52 jobs, 21 skilled jobs, 11 entry level jobs
- $9.2 million total economic impact
  - $5.1 million direct health center spending
  - $4.1 million community spending
- Generates tax revenues
  - $264,000 in state and local taxes
  - $1.1 million in federal tax revenue
- 21% lower costs for Medicaid patients, saves the state $7 million annually

Duffy Health Center

Special Studies

Pay for Success! Social Innovation Financing

- Initiative of the Commonwealth and the Mass. Housing and Shelter Alliance

- Builds on the Success of
  - Home and Healthy for Good
  - Community Support Program for Ending Chronic Homelessness (CSPECH)

Duffy and Housing Assistance Corporation

Total # of Assessments Scored	Number of People Housed	Number of Exits	Current # of Tenants	# of Units Committed	# of Units Yet to Fill
104	21	4	17	30	17

Pay for Success:
Evaluation Outcomes Year One

Use of public services over 6 months

Nights in Emergency Shelter

11,848 11,848

8,000
6,000
4,000
2,000
-

47

In 6 months before housing In 6 months after ho

11,801 fewer days spent in emergency shelter

Use of public services over 6 months

Days Hospitalized

	6 months Before housing	6 months in housing
Days Hospitalized	1,272	492

1,400
1,200
1,000
800
600
400
200
-

1,272

1272

492

780 less days in hospital

6 months Before housing

6 months in housing

Use of public services over 6 months

Days in Detox

	In 6 months before housing	In 6 months after housing
Days in Detox	318	209

Chart labels: 318, 318, 209

Y-axis: 350, 300, 250, 200, 150, 100, 50, -

X-axis: In 6 months before housing; In 6 months after housing

109 less days in detox

Use of public services over 6 months

Days Incarcerated

	In 6 Months Before Housing		In 6 Months After Housing
Days Incarcerated	511	511	175

336 fewer days spent incarcerated

PFS Housing outcomes

30 Exits – Qualified Reason 9%

14 Exits – W/O Qualified Reason 4%

305 Continue to be housed in PFS 87%

Grant or Program Outcomes

For Example:

- HRSA Quality Award
- Addiction Treatment Data
- HRSA BHI Expansion Grant

HRSA Quality Awards
Just Google It!

Health Center Grantee	EHR Reporters [1]	Clinical Quality Improvers [2]	Access Enhancers [5]	PCMH Recognition [7]
DUFFY HEALTH CENTER, INC.	$10,000	$4,641	$5,000	$30,000

Program Data:
Data Reports from your State

Duffy Health Center OBOT (Office-based Opioid Treatment) Program

Our Experience when Comparing Clients at Enrollment and Disenrollment

- Increased Employment (25% to 50%)
- Decreased Homelessness (18% to 9%)
- Decreased Dependence on Public Assistance (46% to 23%)

Program Data:
Grant Outcomes

Duffy Health Center

HRSA Behavioral Health Integration Grant

The Bridge Program

A team (CHW, Psych NP, led by a Therapist) visits the psychiatric unit and the day program at the local hospital twice weekly

Program Data
Grant Outcomes, Cont.

203 patients received consults (10/2015 – 2/2017)

- **31** not eligible/did not want
- Of the remaining **172** individuals,
  - **70** were seen by benefits (41%)
  - **131** kept medical appointments (76%)
  - **128** kept behavioral health appointments (75%)
  - **79** engaged in psychiatry (46%)

Start your Slide Deck Today!

Alaina Boyer, PhD | Director of Research, NHCHC

Closing: Best Practices

Opportunities to Demonstrate Value

- Collaboratively share metrics and trends with local level and publish findings
- Identify value benchmarks using this Capital Link toolkit (Performance Benchmarking Toolkit for Health Centers: Tracking Data to Improve Financial Performance)
- Maintain data dashboards with local safety net providers
- Increase capacity for linking health data and housing outcomes
- Celebrate Health Care for the Homeless (HCH) Day – Find ways to demonstrate value and celebrate the uniqueness of HCH
- Create Infographic with basic digestible information

What Makes Health Care for the Homeless (HCH) Health Centers Valuable to their Patients and Communities?

IMPROVE ACCESS TO CARE

Core Services Provided:

- Primary Care
- Addiction Treatment
- Case Management
- Outreach
- Mental Health
- Benefits Enrollment
- Trauma Informed Care

Culturally Appropriate Care Provided Where the Patients are:

- On the Street
- In Shelters
- In Tent Cities
- By Mobile Unit
- Care to All, No One Turned Away

PROVIDE QUALITY PATIENT TAILORED SERVICES

Literacy and Computer Skills Training

Vision Care

Job Training

Food Pantry

Childcare

Podiatry/ Foot Baths

Haircuts

Clothing

Showers & Personal Hygiene Kits

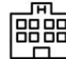
BENEFIT AND ADD VALUE TO COMMUNITIES

Housing is Health Care. Many HCH health centers provide housing to patients both health center owned and through community partnerships.

Focus on Community Safety. Several HCH health centers collaborate with Law Enforcement for safer communities and help with the decriminalization of homelessness.

Appropriate Discharge Planning. There are HCH health centers who provide Medical Respite Care for those too well to stay in the hospital or too sick to return to the street or shelter.

Addressing Food Security. Some HCH health centers sponsor Community Gardens to produce food for their patients and their community.



Critical Partners to Hospitals. HCH health centers partner with hospitals (and the broader health care system) to provide coordinated care, resulting in fewer ED visits, shorter patient stays, collaborations with community providers for follow-up care.

QUALITY HEALTH CARE

Tobacco: 77% of patients aged 18 and older screened and found to use tobacco, received cessation counseling**

Heart Disease: 73% of patients aged 18 and older diagnosed with Coronary Artery Disease (CAD) were prescribed a lipid lowering therapy**

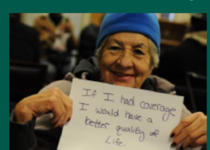
Asthma: 74% of patients aged 5 to 40 diagnosed with persistent asthma received acceptable pharmacological treatment plans**

HIV: 66% of patients first ever diagnosed with HIV received follow-up treatment within 90 days of diagnosis**

TWO IMPORTANT FACTS

People who are homeless have higher rates of chronic disease and live on average 12 years less than the general US population (66.5 vs. 78.8 years)*

Prevalence of Specific Health Conditions among the Homeless Population in Comparison to the General US Population*



Homeless	Condition	General US
18%	Diabetes	9.3%
50%	Hypertension	29%
35%	Heart attack	17%
20%	HIV	0.6%
36%	Hepatitis C	0.7%
49%	Depression	8%
58%	Substance use disorders	16%

SOURCES

*National Health Care for the Homeless Council. (June 2016) Advance Care Planning for Individuals Experiencing Homelessness: A Quarterly Research Review of the National HCH Council, 4:2. [Author: Claudia Davidson, Research Associate]. Nashville, TN: Available at: www.nhchc.org

**Uniform Data System. Data analysis related to 60 health centers receiving 330(h) funding only.

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Questions