Hospitals, Community Care Teams, and Recuperation:

Statewide Coordination to Identify, Monitor, and Care for the Homeless
Panelists

Elizabeth Grim
*Partnership for Strong Communities, elizabeth@pschousing.org*

Carl Schiessl
*Connecticut Hospital Association, schiessl@chime.org*

Terri DiPietro
*Middlesex Hospital, terri.dipietro@midhosp.org*

Michael Ferry
*Yale-New Haven Hospital, michael.ferry@ynhh.org*

Alison Cunningham
*Columbus House, acunningham@columbushouse.org*
Agenda

Overview of Homelessness in CT
Description of the Hospital Initiative
Role of Hospital Association & Policy Advocacy
Lessons from Middlesex County Community Care Team
Lessons from New Haven Community Care Team & Respite Program
Homelessness in CT

Based on 2014 Annual HMIS Data

12,918
People experienced homelessness in Connecticut during 2014.

2,569
People experienced chronic homelessness (homeless for a long time & have a disability).

1,250
Veterans experienced homelessness in Connecticut during 2014.
Homelessness & Health Care

35-40% Percent of frequent visitors to the emergency department experiencing homelessness or housing instability.
Opening Doors-CT Hospital Initiative

Goals:

1. Better identify individuals experiencing homelessness or housing instability
2. Reduce emergency department visits and inpatient readmissions
3. Improve care coordination upon discharge from inpatient and outpatient settings
4. Reduce costs for the medical and health care system
Opening Doors-CT Hospital Initiative

Led by:  

Funded by:  

Partners:  

MELVILLE CHARITABLE TRUST

Hartford Hospital

MIDDLESEX HOSPITAL

Connecticut Health Foundation

Norwalk Hospital

SAINT FRANCIS Hospital and Medical Center

YALE-NEW HAVEN HOSPITAL
Hospital Initiative Fact Sheet

Integrating Health Care & Housing: Opening Doors-CT Hospital Initiative

Background
Homelessness and housing instability are associated with poor health outcomes, including high mortality and high rates of chronic illness. Often those experiencing homelessness or housing instability cycle in and out of hospital emergency departments (ED), costing the medical system millions of dollars each year.

Adults who are homeless represent 5% of the Medicaid population, but are overrepresented in some types of care:

- 17% inpatient care
- 15% ED visits for adults with a primary behavioral health diagnosis
- 35% with 3+ inpatient medical detox episodes

Given these findings, hospitals have the potential to be a critical partner in interventions and care coordination for those experiencing homelessness. The Opening Doors-CT Hospital Initiative launched in 2014 as a collaboration between the Partnership for Strong Communities and the Connecticut Hospital Association. This project focuses on bridging the gap between hospitals and community providers, better serving those who are homeless.

Target Population
Frequent visitors of hospital emergency departments (ED) and inpatient beds, also known as super-utilizers. Frequent visitors are those who have:

- Visited an ED 7+ times in the past 6 months

Strategies
- Implement homelessness screen in emergency department electronic health records
- Establish Community Care Teams (CCTs) to improve care coordination between hospital staff and community providers
- Develop peer sharing across participating hospitals

Goals
1. Better identify individuals experiencing homelessness or housing instability
2. Reduce emergency department visits and inpatient readmissions
3. Improve care coordination upon discharge from inpatient and outpatient settings
4. Reduce costs for the medical and health care system

Preliminary Findings

<table>
<thead>
<tr>
<th>35-40%</th>
<th>Percent of frequent visitors experiencing homelessness or housing instability</th>
</tr>
</thead>
<tbody>
<tr>
<td>7-69%</td>
<td>Number of ED visits per frequent visitor in the past six months</td>
</tr>
<tr>
<td>34%</td>
<td>Percent of frequent visitors who visited 3 or more EDs during the previous six months</td>
</tr>
<tr>
<td>62%</td>
<td>Percent of frequent visitors who are male</td>
</tr>
</tbody>
</table>

Outcomes Tracked
- Demographics (age, race, gender)
- Health Insurance
- % ED visits accounted for by frequent visitors
- Readmission rates to ED and inpatient care (7- and 30-day follow up)
- Connection to care (7- and 30-day follow up)
- Housing/homelessness status
- Medicaid claims data
- SF-12 physical and mental health scales
- Substance use

Lessons Learned
- Importance of peer sharing across Community Care Teams (CCTs)
- Extensive time needed to develop release of information
- Need for flexible care plans
- Movement of frequent visitors between hospitals
- Prevalence of substance use by frequent visitors
- Value of having the Administrative Service Organization (ASO) at the table

Next Steps
- Evaluate the initiative - both process and outcome
- Expand the model to other institutions
- Develop a predictive model to better identify and serve frequent visitors
- Expand respite care options across the state
- Develop a more comprehensive continuum of care for substance users
- Explore Medicaid payments for supportive housing services
- Develop a model for sustainability

Opening Doors in Connecticut...
...to a Future Where Everyone Has a Home

Homelessness is unacceptable. Homelessness is solvable and preventable. Homelessness is expensive. Invest in solutions.
Middlesex County Community Care Team: Care Management for Emergency Department ED Frequent Visitors

NATIONAL HEALTH CARE FOR THE HOMELESS
May 8, 2015
Terri DiPietro, MBA, OTR/L
Director, Outpatient Behavioral Health
Middlesex Hospital
A Community Collaboration
A National Crisis: Emergency Department Perspective

Fraying of behavioral health systems

↓

Increasing numbers of behavioral health patients (BHPs) without adequate inpatient or outpatient care

↓

BHPs wind up in EDs (our medical system’s safety-net), often with long length of stay

↓

BHPs overwhelm EDs’ capacity to care for all ED patients

ED crowding

Decreased safety

Financial losses
A Closer Look…The Major Challenge of BH Super Users

This population does not get better with the traditional model of episodic care delivery

“Falling through the cracks”

Required: Care Coordination

Question Uncovered Along the Way:
How is the experience different for the homeless and those experiencing fragile housing?
Middlesex County CCT History

• 1990s: Mental Illness Substance Abuse project through Rushford (grant funded by state); continuing care team for dual diagnosis; strong relationships were developed

• 2007: Middlesex County initiated the 10 Year Plan to End Homelessness; a component was the formation of a community care team → without a designated champion, the team was never formed

• 2008: Middlesex Hospital conducted a health assessment

• 2010: Community Care Team (CCT) was developed
  • Middlesex Hospital agreed to be the organizer
  • 4 core agencies: Middlesex Hospital, Gilead, Rushford, RVS
  • met on a monthly basis
  • barrier addressed: common Release of Information (ROI)

• 2012: CCT expanded to 9 agencies

• 2015: CCT expanded to 13 agencies
CCT Agency Members

- Middlesex Hospital
- River Valley Services
- Connecticut Valley Hospital (Merritt Hall)
- Rushford Center, Inc.
- The Connection, Inc.
- St. Vincent de Paul Soup Kitchen
- Mercy Housing
- Columbus House
- Community Health Center
- Gilead Community Services, Inc.
- Advanced Behavioral Health
- Value Options, Connecticut
- Community Health Network

Case/care management agencies
CCT Guiding Principles

• **Objective**: To provide patient-centered care and improve outcomes by developing wrap-around services through multi-agency partnership and care planning

• **Core belief**: Community collaboration is necessary to improve health outcomes

• **Core understanding**: Psycho-social problems are community problems. No one entity alone can effectively improve outcomes for this population
CCT – Program Development

- Weekly meetings (1st meeting: March 27, 2012); for 1 hour
- Expansion of CCT Release of Information form (required for each patient)
- Developed process for patient selection
- DMHAS Grant Conversion extended/expanded Health Promotion Advocate (HPA) positions
  - only added labor resource (grant funded in 1st year by CHEFA; continued by DMHAS)
  - care coordination & case management
  - direct & indirect referrals to treatment
  - link between patient – ED – CCT – community services
  - does “check in” calls for those in community who are stabilized or still struggling
CCT Process

Patient Identification:

- ED visit threshold criteria (# of visits & behavioral diagnoses)
- Daily ED discharge reports (5+ visits in 6 months)
- Chair of Emergency Services dictates ED Care Plan for ROI to be signed
- Health Promotion Advocate referral
- CCT member referral

- Once ROI is signed, patient is added to CCT agenda

- Team meets on a weekly basis

- In year 1, utilization ranged from 12-80+ ED visits in past 12 months

- # of patients who have received CCT care planning to-date: 199
## CCT – Weekly Meeting Format

**Typical CCT meeting:** discuss 10-20 patients per meeting; weekly tracking minutes

<table>
<thead>
<tr>
<th>Research:</th>
<th>Team members research patient histories and psycho-social backgrounds (prior to meetings)</th>
</tr>
</thead>
</table>
| Review: | Team members share histories and review:  
1) Outpatient and inpatient utilization  
2) Access to care issues: what’s currently being provided, where there are gaps  
3) Housing status & options  
4) Insurance status; available resources based on insurance  
5) Arrests; arraignment reports |
| Brainstorm: | **Team brainstorms** re: best care management strategy |
| Care Plan: | Team members collaboratively develop customized care plans, with goals for:  
1) Treatment and/or stabilization (PECs and adjudication, if necessary)  
2) Stable housing  
3) State insurance redetermination  
4) Case management  
5) Linkage to primary care, psychiatrists, specialists, outpatient services  
6) Wrap-around services and supports for post-treatment  
7) After-care planning |
| Ongoing: | Long-term follow-up: team members follow-up, review progress and revise care plan as needed; *once on CCT agenda, always on CCT agenda* |
What We Track & Measure

**Impact Metrics:**
- # of visits (ED & inpatient) pre- and post- intervention (snapshot in time)
- Cost/losses

**Demographics:**
- # of patients who have received care planning
- Diagnosis category
- Gender and age distribution
- Insurance status
- Housing status
Community Care Team (CCT)

Complex high-risk and high-need ED “super user” patients with diagnoses of:

- **Dual Diagnosis**
  - Coexisting severe mental illness and substance abuse disorders (primarily alcohol)
  - 43%

- **Chronic Mental Illness**
  - Most frequent dxs: bipolar; schizophrenia; schizoaffective; borderline personality
  - 29%

- **Chronic Alcoholism**
  - Alcohol intoxication with/without suicidal ideation
  - 22%

- **Other Drug Dependence**
  - Opioids; cocaine with/without suicidal ideation
  - 6%

- Dual: alcohol only → 45%
- Dual: other drugs → 28%
- Dual: alcohol & other drugs → 27%
What We Track & Measure

Gender:
- Female – 37%
- Male – 63%

Payor Status:
- Medicaid – 54%
- Medicare – 40%
- Managed Care – 4%
- Self-pay no insurance – 2%
Housing is an Issue

- Homeless: 19%
- Marginal, non-stable housing: 11%
- Was homeless, has stable housing: 7%
- Was homeless, has marginal housing: 3%

Total = 40%
CCT Patients who are Chronically Homeless – Common Traits

- Behavioral Health problems
- Disjointed care/lack of care coordination
- Poor primary care connections
- Lack of social network
- Noncompliance (with meds, follow-up/discharge instructions)
- Loneliness/hopelessness
- Use of ED as “home” → multiple ED & IP visits
Building Communities of Care as Partners in Practice

- Improved Health
- Reduced Costs

The Smarter Choice for Care

MIDDLESEX HOSPITAL
## Cost Reductions

<table>
<thead>
<tr>
<th>Hospital Cost Avoidance</th>
<th>Medicaid Claims Only</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All Claims</strong></td>
<td><strong>Savings Cost</strong></td>
</tr>
</tbody>
</table>

- 1142 reduction in visits x $1513.32 (average ED cost) = $1,728,205.99
- 640 reduction in visits x $915.66 (average ED cost) = $ 586,022.40
### Additional Benefits

**Patient:**
- Improved quality of life:
  - Sobriety
  - Mental health stabilization
  - Reduced homelessness
  - Re-entry to workforce
  - Re-connection with family
  - Achievement of feelings of self-worth and respect
- Linkages to:
  - Primary care physicians, psychiatrists, specialists, etc.
  - Supportive housing
  - Appropriate outpatient services

**Collaborative:**
- Improved patient care
- Improved agency-specific care plans
  - Improved inter-agency communication and relationships

**Society:**
- Increase in safety to all
- Reduction in Medicaid & Medicare expense
What Have We Learned?

1) This target population does not get better with the traditional model of care delivery

2) Chronically ill behavioral health patients consume a disproportionate amount of medical resources

3) Behavioral health chronic diseases require care coordination and customized treatment plans

4) Individualized care plans must have the ability to be flexible and evolve

5) Many agency providers were unaware of frequency of ED visits → communication allows for agency-specific care plans (a major part of CCT’s success)
Questions?

Thank You!

Terri DiPietro, MBA, OTR/L
Director, Outpatient Behavioral Health
Middlesex Hospital
28 Crescent Street
Middletown, CT 06457
office: 860-358-8802
cell: 860-918-0455
terri.dipietro@midhosp.org
Healing the Homeless:
A Community Collaboration

Alison Cunningham  
Executive Director  
Columbus House, Inc.

Michael Ferry  
Lead Social Worker  
Yale New-Haven Hospital
Creating the Impetus for Change

- **Ryan Greysen, MD – RWJ Scholar – 2010**
  - 67% of the homeless stay in shelters
  - 21% saying with family/friends – “couch-surfing”
  - 11% consistently staying on the street

- **Kelly Doran, MD – RWJ Scholar – 2012**
  
  Studied 113 homeless individuals over 30 days
  - 50.8% were readmitted to inpatient care
  - 3.0% were readmitted to Observation
  - 75% of these readmissions occurred within 2 weeks
  - Only 18.7% of Medicaid patients readmitted during this time
Advocacy

- Kelly Doran, MD and then Senator Toni Harp of New Haven advocated for a Medical Respite program.
- Respite was included first in a bill and later a budget signed by Governor Dannel Malloy in July of 2013.
- Medical Respite Care opened on October 7, 2013.
- Additional incentives for collaboration:
  - The need to reduce hospital readmissions.
  - Profound reduction in medical reimbursement at state level.
MEMORANDUM OF UNDERSTANDING

This MEMORANDUM OF UNDERSTANDING (this “MOU”) is made and entered into as of February 6, 2015 by and between Columbus House, Inc., a Connecticut non-stock corporation (“Columbus House”), and Yale-New Haven Hospital, Inc., a Connecticut non-stock corporation (“YNHH”). Columbus House and YNHH are referred to in this MOU individually as a “Party” and collectively as the “Parties”.

WHEREAS, the Parties mutually recognize the need for homeless individuals to receive recuperative care in a stable environment following hospitalization;

WHEREAS, Columbus House desires to establish and administer a medical respite program (the “Respite Program”) that allows homeless individuals located in and around the area of New Haven, Connecticut to seek and receive temporary shelter at Columbus House’s main shelter building at 586 Ella Grasso Boulevard, New Haven, Connecticut (the “Shelter”) so that such individuals may receive recuperative care at the Shelter;

WHEREAS, YNHH desires to identify and refer patients requiring recuperative care who may be experiencing homelessness for admission to the Respite Program;

WHEREAS, the Parties wish to set forth the terms on which Columbus House will administer the Respite Program and WHEREAS, YNHH plans to refer patients to the Respite Program;

NOW, THEREFORE, the parties hereby agree as follows:
Medical Respite Program
Columbus House

- Location: Third floor of Columbus House
- Number of Beds: 12
- Funding: Five-year pilot grant from the State of Connecticut
- Length of stay: Up to 30 days, with extensions permitted as needed
- Referrals: From Yale-New Haven and Veteran Administration Hospitals
- Staffing: 24-hour supervisory staff, Visiting nursing for medical care
Columbus House, New Haven
Respite Patient’s Room
Sensitizing Hospital Staff

- Training regarding homeless individuals and Medical Respite was provided to:
  - Social Workers
  - Care Managers
  - Physicians
  - Emergency Department staff
- Used to develop an appreciation of the unique needs and challenges faced by homeless individuals
Identifying Hospitalized Homeless Patients

- Patients disclose to staff:
  - Admissions
  - Physicians
  - Nursing
  - Social Work

- Documentation retrieved through software reports
  - Social Work
Eliciting Circumstances of Homelessness

“Where have you been living during the past two months?”

“Is this reliable housing that you own, rent, or stay in as part of a household?”

“Are you able to return and stay there following discharge?”

- If yes, “Are you able to receive a visiting nurse there?”

- If no, will this patient have a post-discharge medical need requiring respite?
Communicating Housing Status through the Medical Record

From Admissions:

- **Address:** LIVES IN CT  NO FIXED ADDRESS
- **City (or ZIP):** NEW HAVEN
- **State:** CT  ZIP: 06510
- **County:** NEW HAVEN
- **Response:** PT IS HOMELESS 586 ella grasso blvd, colombus house
Communicating Housing Status through the Medical Record

From Physicians:

```
<table>
<thead>
<tr>
<th>Non-Hospital Problem List</th>
<th>ICD-9-CM</th>
<th>Priority</th>
<th>Class</th>
<th>Date Reviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol withdrawal</td>
<td>291.81</td>
<td></td>
<td></td>
<td>3/26/2014</td>
</tr>
<tr>
<td>Atrial fibrillation with rapid ventricular response</td>
<td>427.31</td>
<td></td>
<td></td>
<td>11/24/2013</td>
</tr>
<tr>
<td>Chronic pain syndrome</td>
<td>338.4</td>
<td></td>
<td></td>
<td>11/24/2013</td>
</tr>
<tr>
<td>Community acquired pneumonia</td>
<td>486</td>
<td></td>
<td></td>
<td>11/24/2013</td>
</tr>
<tr>
<td>Nicotine dependence</td>
<td>305.1</td>
<td></td>
<td></td>
<td>11/26/2013</td>
</tr>
<tr>
<td>Alcohol abuse</td>
<td>305.00</td>
<td></td>
<td></td>
<td>11/27/2013</td>
</tr>
<tr>
<td>Homelessness</td>
<td>V60.0</td>
<td></td>
<td></td>
<td>11/27/2013</td>
</tr>
<tr>
<td>Atrial fibrillation</td>
<td>427.31</td>
<td></td>
<td></td>
<td>2/4/2014</td>
</tr>
<tr>
<td>Atrial fibrillation with RVR</td>
<td>427.31</td>
<td></td>
<td></td>
<td>3/3/2014</td>
</tr>
<tr>
<td>Fibromyalgia</td>
<td>729.1</td>
<td></td>
<td></td>
<td>2/4/2014</td>
</tr>
<tr>
<td>Knee strain</td>
<td>844.8</td>
<td></td>
<td></td>
<td>3/3/2014</td>
</tr>
<tr>
<td>Hypertension</td>
<td>401.9</td>
<td></td>
<td></td>
<td>Unknown</td>
</tr>
</tbody>
</table>
```
Communicating Housing Status through the Medical Record

- From Nursing & Social Work
Establishing Communication

Release of Information

Yale-New Haven Hospital/Columbus House Medical Respite Care Program
Participation Agreement and Authorization for Access/Release of Information

PATIENT/CLIENT NAME: __________________________________________ DATE OF BIRTH: _____-_____-_____

YNHH Medical Record# ____________________ NAME OF FRIEND/NEXT-OF-KIN ETC. __________________________

ADDRESS/PHONE NUMBER (if applicable):________________________ May I leave a message at this #? □ Yes □ No

This document authorizes Yale-New Haven Hospital (YNHH) and Columbus House Medical Respite Care Program to use, share and disclose protected health information (PHI) of the person named above with one another, as well as with other entities participating in the Medical Respite Care Program. These entities include, but are not limited to, Columbus House, YNHH and its Primary Care Center, Cornell Scott-Hill Health Center, Visiting Nurse Association of South Central Connecticut, Continuum of Care and The Apothecary (collectively the “Participants”) for purposes of screening for participation in the program, as well as ongoing care and treatment.

I authorize YNHH, as well as the Participants named above, to release the information from my medical records as necessary and to obtain information from:

Columbus House Medical Respite Care Program, 586 Ella Grasso Boulevard, New Haven CT 06519 Phone: 203-401-4400

The person to be contacted at YNHH regarding medical questions or concerns is __________________________ Phone: _____________
(name of social worker or care manager)

INFORMATION TO BE RELEASED OR OBTAINED (IN EITHER VERBAL OR WRITTEN FORM) may include:

□ Relevant Social and Health History
□ Medication Required Following Discharge
□ Protected Health Information affecting home care needs
□ Information related to necessary contact precautions
Collaboration

• Throughout the admission process
• Weekly Case Review meetings:
  • Social workers, care managers, physician, and pharmacy from Yale-New Haven Hospital
  • Staff from the Medical Respite Care program
  • Staff from the Cornell Scott-Hill Health Center and Primary Care Center, and
  • Staff from Continuum of Care and VNA of South Central CT
• Ongoing steering committee meetings to address systemic issues impacting the program and patient care
Using Data to Describe the Problem and Effectiveness of the Solution

From October 1, 2013 to September 30, 2014:

- 804 patients were identified as homeless and screened (includes repeat patients)
- The above screenings resulted in 475 unique patients
Average Age = 48.44 Years
Sex

- Male: 75%
- Female: 25%
Race

- White: 51%
- Black: 32%
- Hispanic: 15%
- Other: 1%
Hospitalized Homeless Affected by Mental Health & Substance Abuse

- Patients assigned a mental health diagnosis, even if not currently experiencing symptoms= 58.2%
- Patients abusing alcohol: 52.5%
- Patients using illicit drugs: 50.9%
- Combining the alcohol & drug numbers, 84.7% of patients were actively abusing alcohol or using illicit drugs, while 15.3% were not misusing either.
Medical Factors Impacting the Hospitalized Homeless

(Includes repeat patients)

- Patients without a Primary Care Provider upon admission = 38.6%
- Average number of Emergency Department visits during the prior 365 days = 13.6
- Most common medical conditions upon admission:
  - Alcohol Intoxication/Withdrawal (18.2%)
  - Chest Pain (9.6%)
  - Diabetes (23.2%)
- Average inpatient length of stay = 7.0 Days
- Average number of medications prescribed at discharge = 6.7
Insurance Numbers...

(Includes repeat patients)

- Covered by Medicaid = 75.0%
- Covered by Medicare = 16.0%
- Covered by private insurance = 3.0%
- No insurance = 9.4%
- Patients with Medicare or Husky C and thus are either aged or disabled = 32.7%
## Readmission Rates

<table>
<thead>
<tr>
<th>Inpatient Readmission Type</th>
<th>All (age &gt; 17) Medicaid</th>
<th>Homeless Medicaid Patients</th>
<th>Respite Medicaid Patients</th>
<th>Percent Difference in Readmission Rate for those Homeless Provided with Respite Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 day</td>
<td>18.6%</td>
<td>35.0%</td>
<td>25.0%</td>
<td>28.6% ✨</td>
</tr>
<tr>
<td>14 day</td>
<td>12.0%</td>
<td>24.8%</td>
<td>12.5%</td>
<td>49.6% ✨</td>
</tr>
<tr>
<td>7 day</td>
<td>7.6%</td>
<td>15.4%</td>
<td>7.1%</td>
<td>53.9% ✨</td>
</tr>
</tbody>
</table>
### Hospital Length of Stay

<table>
<thead>
<tr>
<th>Discharge Disposition</th>
<th>No Nursing Care Recommended</th>
<th>Required Home Nursing or Respite Care</th>
<th>Required Nursing Home Placement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All Medicaid (Age &gt;17)</strong></td>
<td>5.3 Days</td>
<td>6.4 Days</td>
<td>11.5 Days</td>
</tr>
<tr>
<td><strong>Homeless (Age &gt;17)</strong></td>
<td>6.5 Days</td>
<td>10.2 Days</td>
<td>15.9 Days</td>
</tr>
<tr>
<td><strong>Difference</strong></td>
<td>1.2 Days</td>
<td>3.8 Days</td>
<td>4.4 Days</td>
</tr>
</tbody>
</table>
Possible Reasons for Higher Length of Stay for Homeless & Respite Patients:

• Sicker population
• Increased discharge preparation planning for the homeless implemented in April
• Evaluation by & communication with Columbus House for Respite patients
• Respite discharges are infrequent per staff, requiring re-learning each time
• Limited admission window for shelters
Disposition of the Hospitalized Homeless …

Out of 804 discharges (includes repeat patients):
• 85 patients were admitted to Medical Respite (10.5%)
• 54 patients went to a skilled nursing facility (because their needs were more than could be managed at Respite) (6.7%)
• 131 patients had family or friends willing to take them in (16.2%)
• 275 patients went to standard shelter services, due to not meeting criteria (typically due to lack of a medical need requiring recuperation) (34.2%)
• 92 patients declined respite or shelter services choosing the street instead (11.4%)
• 83 patients identified as homeless had a residence or acquired housing at discharge (10.3%)
• 72 patients went on to other forms of care, e.g. inpatient psychiatric or substance abuse treatment (8.9%)
• 12 patients could not be included, e.g. due to rapid discharge or demise (1.4%)
Applied for Respite, Not Admitted

Nine-Month Sample: 25 Patients

- Secured own housing: 6 pts, 24%
- Went to nursing home: 5 pts, 20%
- Non-compliance issues: 4 pts, 16%
- Chronic conditions only: 3 pts, 12%
- Left before Respite eval: 3 pts, 12%
- No home nursing needs: 2 pts, 8%
- Left against medical advice: 2 pts, 8%
Additional Community Collaborations
Project Night Time, 2014

- A seasonal program that guides homeless visitors to the Emergency Department (who are not injured or ill) to services more appropriate to their needs.
  - Organized through a collaboration between the hospital and local shelters, including Columbus House
  - Homeless individuals are asked for their name, date of birth, and prior location of residence
  - Provided with transportation when necessary
  - Dropped the number of people situated in the YNHH waiting room dramatically
100-Days Program

- Begun in April of 2014
- Brought many community agencies together on many levels
- Furthered the efforts to share information
- Coordinated efforts to survey the homeless and provide housing
Coordinated Access Network (CAN)

- Launched January 25, 2015
- Multi-agency collaboration by housing agencies - with hospital input
  - Homeless individuals are assisted in calling InfoLine (211) and are scheduled for an intake interview
  - If eligible, they are guided to the nearest shelter bed
  - Standardizes the emergency shelter process
Overnight Winter Warming Center, 2015

- A follow-up program to provide the homeless with an overnight walk-in location to stay out of the winter weather
  - Organized by a collaboration of many local agencies including YNHH and Columbus House
  - January 15 to March 15, chairs & tables only
  - 30 to 35 visitors per night, police and case manager presence, no concerning incidents
  - Greatly reduced visitors to our Emergency Departments
Brandeis Innovation Study

- Five Respite programs across the U.S.
- Evaluating each program for the purpose to determining whether Respite should be covered by federally-funded insurances
  - ED visits
  - Length of stay
  - Readmission rate
  - Diagnoses, treatments
  - Charges, costs, reimbursements
South Central Community Care Team

- Led by Value Options
- Established in August 2014
- Meets weekly on Thursday afternoons
- Address the needs of frequent visitors (7x in past 6 months) to the ED with behavioral health problems
- Additional meeting now established for those with primarily substance abuse difficulties
Hospitalized Homeless Patients

February 17, 2014 thru May 1, 2015
Hospitalized Homeless and Housing Placements

[Graph showing trends in hospitalizations and placements over months from July to April.]
Hospitalized Homeless and Housing Placements (w/ Guides)

- Admitted
- Placed
- Poly. (Admitted)
- Poly. (Placed)

91% negative correlation
Statistically significant: p-value of .0006

(Calculations by Dan Shetler of Columbus House, Inc.)
Conclusions

- Advocacy makes a difference
- Training counts
- Collaborative relationships work!
- Data can make your case
- Multiple approaches may be needed
- Housing is its own form of health care!
Supporting Documents

Example Releases of Information
Agency Contact Information
Coordinated Access Network ROI

---

**Greater New Haven Case Conferencing**

**AUTHORIZATION FOR RELEASE OF INFORMATION**

This authorization is voluntary. The information you authorize us to disclose may be subject to re-disclosure by the recipient and if the person or organization authorized to receive the information is not a health plan or health care provider, the information may no longer be protected by Federal privacy regulations. We may not condition your receipt of treatment, payment, enrollment, or eligibility for benefits on completion of this authorization.

**NAME (LAST, FIRST):**

**DATE OF BIRTH:**

I hereby authorize the agencies listed below to exchange the indicated information for the purpose of ensuring effective coordination of services. (With one or more of the other agencies)

Initial each type of information to release:

- Medical
- Mental Health/Psychiatric
- Criminal Record
- HIV/AIDS
- Housing
- Alcohol and/or drug abuse
- Other:

Agencies covered by the terms and conditions of this authorization are:

1. [Organization Name 1]
2. [Organization Name 2]
3. [Organization Name 3]
4. [Organization Name 4]
5. [Organization Name 5]
6. [Organization Name 6]

I understand that some or all of my information may be protected under Federal regulations (42 C.F.R. Part 2) and/or Connecticut state law and cannot be further disclosed without my written consent. I further understand that this authorization will expire one year from the date I sign the authorization. I may revoke this authorization in writing at any time, however, any revocation will not be effective retroactively for information disclosures that have already occurred.

**Client Signature:**

**Date:**

**Print Name**

**Note:** If you are a legal guardian or representative, you must attach a copy of your legal authority to represent the member and complete the following:

**Signature of Guardian/Representative:**

**Print:**

**Legal Authority:**

---

**NOTICE TO RECIPIENT OF INFORMATION**

All or a portion of this information may have been disclosed to you from records protected by Federal and/or Connecticut state law which prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law(s). A general authorization for the release of medical or other information is NOT sufficient for this purpose. In addition, Federal Rules (42 C.F.R. Part 2) prohibit any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
100-Day Campaign ROI
Medical Respite ROI

Yale-New Haven Hospital/Columbus House Medical Respite Care Program
Participation Agreement and Authorization for Access/Release of Information

PATIENT/CAREGIVER NAME: ___________________________ DATE OF BIRTH: ___/___/___

YNHH Medical Record# ______________________ NAME OF FRIEND/NEXT-OF-KIN ETC. __________________________

ADDRESS/PHONE NUMBER (If applicable) ___________________________ May I leave a message at this #? ☐ Yes ☐ No

This document authorizes Yale-New Haven Hospital (YNHH) and Columbus House Medical Respite Care Program to use, share and discuss protected health information (PHI) of the person named above with one another, as well as with other entities participating in the Medical Respite Care Program. These entities include, but are not limited to, Columbus House, YNHH and its Primary Care Center, Cornell Scott Hill Health Center, Visiting Nurses Association of South Central Connecticut, Continuum of Care and The Apothecary (collectively the “Participants”) for purposes of counseling for participation in the program, as well as ongoing care and treatment.

I authorize YNHH, as well as the Participants named above, to release the information from my medical records as necessary and to obtain information from:

Columbus House Medical Respite Care Program, 585 Ella Grasso Boulevard, New Haven CT 06519  Phone: 203-401-4400

The person to be contacted at YNHH regarding medical questions or concerns is ____________________________  Phone: __________________________

INFORMATION TO BE RELEASED OR OBTAINED (IN EITHER VERBAL OR WRITTEN FORM) may include:

☐ Relevant Social and Health History  ☐ Protected Health information affecting home care needs
☐ Medication Required Following Discharge  ☐ Information related to necessary contact precautions

1. I understand that this authorization will expire one year after I have signed this form, or other date as specified: ___/___/___

2. If I change my mind about allowing YNHH and Columbus House Medical Respite Care Program to share my information, I will tell YNHH and Columbus House in writing. This change will be effective on the date the organization receives it but will not affect anything that has already happened.

3. I understand that information used or disclosed as part of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by privacy regulations.

4. I understand that I am not required to sign this form in order to receive treatment or payment for my care.

5. I understand that information to be released or obtained may include mental health information in accordance with GRS 52-146(d), substance abuse treatment information in accordance with 42 CFR 2.1.2-67, and/or HIV/AIDS-related information except as below:
   ☐ No Mental Health  ☐ No Substance Abuse Treatment Information  ☐ No HIV/AIDS Information

Patient Signature ____________________________ Date ___/___/___  Time ___:___

Print Name ____________________________

Parent/Legal Guardian/Authorized Person ____________________________ Date ___/___/___  Time ___:___

Relationship to Patient ____________________________

PATIENT MAY RECEIVE A COPY OF THIS FORM AFTER SIGNING
(White - YNHH Medical Record, Yellow - Columbus House MR Program, Pink - Patient)
Questions?
Keep In Touch!

Partnership for Strong Communities
www.pschousing.org
@pschousing

Connecticut Hospital Association
www.chime.org
@cthosp
Keep In Touch

Middlesex Hospital
www.middlesexhospital.org

Columbus House, Inc.
www.columbushouse.org
@columbushouseCT

Yale-New Haven Hospital
www.ynhh.org
@YNHH
Background

Homelessness and housing instability are associated with poor health outcomes, including high mortality and high rates of chronic illnesses. Often those experiencing homelessness or housing instability cycle in and out of hospital emergency departments (ED), costing the medical system millions of dollars each year.

Adults who are homeless represent 5% of the Medicaid population but are overrepresented in some types of care:

- 17% inpatient care
- 19% ED visits for adults with a primary behavioral health diagnosis
- 39% with 3+ inpatient medical detox episodes

Given these findings, hospitals have the potential to be a critical partner in interventions and care coordination for those experiencing homelessness. The Opening Doors-CT Hospital Initiative launched in 2014 as a collaboration between the Partnership for Strong Communities and the Connecticut Hospital Association. This project focuses on bridging the gap between hospitals and community providers, and better serving those who are homeless.

Target Population

Frequent visitors of hospital emergency departments (ED) and inpatient beds, also known as super-utilizers. Frequent visitors are those who have:

- Visited an ED 7+ times in the past 6 months

Strategies

- Implement homelessness screener in emergency department electronic health records
- Establish Community Care Teams (CCTs) to improve care coordination between hospital staff and community providers
- Develop peer sharing across participating hospitals

Goals

1. Better identify individuals experiencing homelessness or housing instability
2. Reduce emergency department visits and inpatient readmissions
3. Improve care coordination upon discharge from inpatient and outpatient settings
4. Reduce costs for the medical and health care system

In Partnership With:

Funded by:

Opening Doors in Connecticut...
...to a Future Where Everyone Has a Home
Integrating Health Care & Housing: Opening Doors-CT Hospital Initiative

**Preliminary Findings**

- **35-40%**
  - Percent of frequent visitors experiencing homelessness or housing instability

- **7-69**
  - Number of ED visits per frequent visitor in the past six months

- **34%**
  - Percent of frequent visitors who visited 3 or more EDs during the previous six months

- **62%**
  - Percent of frequent visitors who are male

**Outcomes Tracked**

- Demographics (age, race, gender)
- Health insurance
- % ED visits accounted for by frequent visitors
- Readmission rates to ED and inpatient care (7- and 30-day follow up)
- Connection to care (7- and 30-day follow up)
- Housing/homelessness status
- Medicaid claims data
- SF-12 physical and mental health scales
- Substance use

**Lessons Learned**

- Importance of peer sharing across Community Care Teams (CCTs)
- Extensive time needed to develop release of information
- Need for flexible care plans
- Movement of frequent visitors between hospitals
- Prevalence of substance use by frequent visitors
- Value of having the Administrative Service Organization (ASO) at the table

**Next Steps**

- Evaluate the initiative - both process and outcome
- Expand the model to other institutions
- Develop a predictive model to better identify and serve frequent visitors
- Expand respite care options across the state
- Develop a more comprehensive continuum of care for substance users
- Explore Medicaid payments for supportive housing services
- Develop a model for sustainability

**Homelessness is unacceptable. Homelessness is solvable and preventable.**
**Homelessness is expensive. Invest in solutions.**
Greater New Haven Case Conference

Authorization for Release of Information

This authorization is voluntary. The information you authorize us to disclose may be subject to re-disclosure by the recipient and if the person or organization authorized to receive the information is not a health plan or health care provider, the information may no longer be protected by Federal privacy regulations. We may not condition your receipt of treatment, payment, enrollment, or eligibility for benefits on completion of this authorization.

Name (Last, First): ________________________________ Date of Birth: ______________

I hereby authorize the agencies listed below to exchange the indicated information for the purpose of ensuring effective coordination of services. (With one or more of the other agencies)

Initial each type of information to release:

- Medical
- Mental Health/Psychiatric
- Criminal Record
- HIV/AIDS
- Housing
- Alcohol and/or drug abuse
- Other: ____________________________
- All of the above

Agencies covered by the terms and conditions of this authorization are:

- Fellowship Place, Inc.
- Connecticut Mental Health Center
- Liberty Community Services, Inc.
- Continuum Home Health
- Columbus House, Inc.
- Cornell Scott Hill Health Center
- The Connection, Inc.
- Easter Seals Goodwill Industries Rehabilitation Center, Inc.
- Leeway, Inc.
- New Haven Legal Assistance Association
- City of New Haven
- VNA South Central Consultant
- New Reach
- Yale-New Haven Hospital
- Youth Continuum, Inc.
- Christian Community Action
- Yale School of Medicine
- Continuum of Care, Inc.
- Connecticut Court Support Services Division
- Emergency Shelter Management Services
- Connecticut Department of Correction
- Connecticut State Dept. of Mental Health and Addiction Services
- AIDS Project New Haven
- Community Solutions
- Veterans Service Administration
- Marrakech, Inc.
- Beth-El Center, Inc.
- BHCare
- Connecticut Health Network
- Spooner, Inc.

I understand that some or all of my information may be protected under Federal regulations (42 C.F.R. Part 2) and/or Connecticut state law and cannot be further disclosed without my written consent. I further understand that this authorization will expire one year from the date I sign the authorization. I may revoke this authorization in writing at any time; however, any revocation will not be effective retroactively for information disclosures that have already occurred.

Client Signature: ________________________________ Date: ______________

Print Name

Note: If you are a legal guardian or representative, you must attach a copy of your legal authorization to represent the member and complete the following:

Signature of Guardian/Representative: ________________________________ Date: ______________

Print: ________________________________ Date: ______________

Legal Authority: ________________________________

Notice to Recipient of Information

All or a portion of this information may have been disclosed to you from records protected by Federal and/or Connecticut state law which prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law(s). A general authorization for the release of medical or other information is NOT sufficient for this purpose. In addition, Federal rules (42 C.F.R. Part 2) restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
AUTHORIZATION FOR RELEASE OF INFORMATION

This authorization is voluntary. The information you authorize us to disclose may be subject to re-disclosure by the recipient and if the person or organization authorized to receive the information is not a health plan or health care provider, the information may no longer be protected by Federal privacy regulations. We may not condition your receipt of treatment, payment, enrollment, or eligibility for benefits on completion of this authorization.

NAME (LAST, FIRST): _________________ DATE OF BIRTH: _________________

I hereby authorize the agencies listed below to disclose information from one year ago to present and exchange the indicated information for the purpose of ensuring effective coordination of services related to 100,000 Homes Campaign.

Initial each type of information to release:

_____ Medical  _____ Mental Health/Psychiatric  _____ Criminal Record  _____ HIV/AIDS

 _____ Housing  _____ Alcohol and/or drug abuse  _____ Other: _______________________  _____ All of the above

Agencies covered by the terms and conditions of this authorization are:

AIDS Project New Haven  Emergency Shelter Management Services
APT Foundation  Fellowship
City of New Haven  Leeeway New Haven
Columbus House, Inc.  Liberty Community Services, Inc.
Community Services Network  Marrakech, Inc.
Community Solutions  New Haven Correctional Center
Connecticut Behavioral Health Partnership/Value Options  New Haven Home Recovery
Connecticut Court Support Services Division  New Haven Legal Assistance Association
Connecticut Dept. of Corrections  Ryan White Program
Connecticut Dept. of Mental Health and Addiction Services  The Connection, Inc.
Connecticut Mental Health Center  Veterans Service Administration
Continuum of Care  VNA of South Central Connecticut
Continuum Home Health  Yale-New Haven Hospital
Cornell Scott-Hill Health Center  Yale School of Medicine
Easter Seals Goodwill Industries  Youth Continuum

I understand that some or all of my information may be protected under Federal regulations (42 C.F.R. Part 2) and/or Connecticut state law and cannot be further disclosed without my written consent. I further understand that this authorization will expire one year from the date I sign the authorization. I may revoke this authorization in writing at any time; however, any revocation will not be effective retroactively for information disclosures that have already occurred.

Client Signature  Date  Time

Print Name

Note: If you are a legal guardian or representative, you must attach a copy of your legal authorization to represent the member and complete the following:

Signature of Guardian/Representative  Date  Time

Print Name:

Legal Relationship: _______________________

NOTICE TO RECIPIENT OF INFORMATION

All or a portion of this information may have been disclosed to you from records protected by Federal and/or Connecticut state law which prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law(s). A general authorization for the release of medical or other information is NOT sufficient for this purpose. In addition, Federal rules (42 C.F.R. Part 2) restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
Yale-New Haven Hospital/Columbus House Medical Respite Care Program
Participation Agreement and Authorization for Access/Release of Information

PATIENT/CLIENT NAME: __________________________________________ DATE OF BIRTH: ______-____-____
YNHH Medical Record# __________________ NAME OF FRIEND/NEXT-OF-KIN ETC. ________________________
ADDRESS/PHONE NUMBER (if applicable): ____________________________ May I leave a message at this #? □ Yes □ No

This document authorizes Yale-New Haven Hospital (YNHH) and Columbus House Medical Respite Care Program to use, share and disclose protected health information (PHI) of the person named above with one another, as well as with other entities participating in the Medical Respite Care Program. These entities include, but are not limited to, Columbus House, YNHH and its Primary Care Center, Cornell Scott-Hill Health Center, Visiting Nurse Association of South Central Connecticut, Continuum of Care and The Apothecary (collectively the “Participants”) for purposes of screening for participation in the program, as well as ongoing care and treatment.

I authorize YNHH, as well as the Participants named above, to release the information from my medical records as necessary and to obtain information from:

Columbus House Medical Respite Care Program, 586 Ella Grasso Boulevard, New Haven CT 06519 Phone: 203-401-4400

The person to be contacted at YNHH regarding medical questions or concerns is ___________________ Phone: __________
(name of social worker or care manager)

INFORMATION TO BE RELEASED OR OBTAINED (IN EITHER VERBAL OR WRITTEN FORM) may include:

□ Relevant Social and Health History □ Medication Required Following Discharge □ Protected Health Information affecting home care needs
□ Information related to necessary contact precautions

1. I understand that this authorization will expire one year after I have signed this form, or other date as specified: ___/___/____

2. If I change my mind about allowing YNHH and Columbus House Medical Respite Care Program to share my information, I will tell YNHH and Columbus House in writing. This change will be effective on the date the organization receives it but will not affect anything that has already happened.

3. I understand that information used or disclosed as part of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by privacy regulations.

4. I understand that I am not required to sign this form in order to receive treatment or payment for my care.

5. I understand that information to be released or obtained may include mental health information in accordance with CGS 52-146(d), substance abuse treatment information in accordance with 42 CFR 2.1-2.67, and/or HIV/AIDS-related information except as below:

□ No Mental Health □ No Substance Abuse treatment information □ No HIV/AIDS information

__________________________________________________________ Date __________ Time __________
Patient Signature

__________________________________________________________ Date __________ Time __________
Print Name

__________________________________________________________ Date __________ Time __________
Parent/Legal Guardian/Authorized Person

__________________________________________________________
Relationship to Patient

PATIENT MAY RECEIVE A COPY OF THIS FORM AFTER SIGNING
(White - YNHH Medical Record, Yellow - Columbus House MR Program, Pink - Patient)

F7589 (Rev. 02/14)