Slowing the Revolving Door
Hospitals and Homeless Services Collaboration to Disrupt the Hospital-Homeless Cycle

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Noel Concepción, LMSW (BronxWorks)
Juan Rivera, LMSW (BronxWorks)
Lizica Troneci, MD (SBH Health System)
Sarah Zammiello, LMSW (BronxWorks)
“Now I see the light.”

Pedro

“Take a look at your high-utilizer list...What story is it telling?”

Pat Belair, RN
Senior Vice President—Ambulatory Services and Strategy
SBH Health System
BronxWorks helps individuals and families improve their economic and social well-being. From toddlers to seniors, we feed, shelter, teach, and support our neighbors to build a stronger community.

As a result of the efforts of the BronxWorks Adult Homeless Services Department, there has been a more than 50% decline in the number of chronic street homeless people on Bronx streets over the past decade.

SBH Health System is committed to improving the health and wellness of our community and is dedicated to providing the highest quality care in a compassionate, comprehensive and safe environment where the patient always comes first, regardless of their ability to pay.

SBH Health System includes St. Barnabas Hospital, SBH Ambulatory Care Center, SBH Hemodialysis Center, SBH Behavioral Health, and Southern Medical Group.
Agenda

- Health and Homelessness Landscape in the Bronx
- Beginning a Collaboration
- Building a Toolkit
  - Tools for Data Collection
  - Tools for Individual and Systemic Interventions
- Toolkit in Motion
  - Case Presentation
- Best Practices and Scalability
- Future Directions
- Q&A
Health and Homelessness Landscape in the Bronx
Opioid Overdoses

- More New Yorkers die from overdose than from homicides, suicides, and motor vehicle crashes combined.¹

- There were 308 overdose deaths among Bronx residents during 2016, accounting for one-quarter (26%) of all deaths among New York City (NYC) residents.¹
  - Fentanyl was involved in nearly half during second half of 2016 (less than 5% before 2015)²

- Drug-related deaths accounted for 33% of deaths among people experiencing homelessness in FY 17.³
  - Nearly twice the number of deaths due to heart disease²
  - 161% increase since FY 07²

## Scope of the Issue

**Homeless Outreach Population Estimate (HOPE)**

- 3,892 “unsheltered” individuals on February 6, 2017 (estimate)

### Overnight Shelter Census on 3/19/18

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>11,122</td>
</tr>
<tr>
<td>Women</td>
<td>4,153</td>
</tr>
<tr>
<td>Single Adults</td>
<td>15,275</td>
</tr>
</tbody>
</table>

**Total Shelter Census**

| Including Adult Families and Families with Children | 60,355 |


### Hospital Use in the Bronx
#### Hospital HOPE Count Results

<table>
<thead>
<tr>
<th>Hospital</th>
<th># Homeless</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lincoln</td>
<td>13</td>
</tr>
<tr>
<td>St. Barnabas</td>
<td>13</td>
</tr>
<tr>
<td>Bronx Lebanon</td>
<td>10</td>
</tr>
<tr>
<td>Jacobi</td>
<td>8</td>
</tr>
<tr>
<td>Montefiore (3 locations)</td>
<td>6</td>
</tr>
<tr>
<td>North Central Bronx</td>
<td>4</td>
</tr>
<tr>
<td>Bronx VA</td>
<td>0</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>54</strong></td>
</tr>
</tbody>
</table>

154 participants citywide

55% (n=108) had no medical care outside ED

Top 5% of Enrollees Accounted for More than Half of Medicaid Spending, FY 2011

- Total Enrollees: 68.0 million
  - Top 5% of Spenders: 5%
  - Bottom 95% of Spenders: 95%

- Total Expenditures: $397.6 billion
  - Total Expenditures: 53%
  - Bottom 95% of Expenditures: 47%

SOURCE: KCMU/Urban Institute estimates based on data from FY 2011 MSIS and CMS-64. MSIS FY 2010 data were used for FL, KS, ME, MD, MT, NM, NJ, OK, TX, and UT, but adjusted to 2011 CMS-64.
Right to Shelter

- **Callahan v. Carey (1981)**
  
  “The City defendants shall provide shelter and board to each homeless man who applies for it provided that (a) the man meets the need standard to qualify for the home relief program established in New York State; or (b) the man by reason to physical, mental or social dysfunction is in need of temporary shelter.”


Beginning a Collaboration
Medicaid Accelerated eXchange (MAX Series)

Lower Costs

DSRIP
Delivery System Reform Incentive Payment Program

Better Health

Better Care

MAX Series
BronxWorks
SBH Health System
Other Partners

See https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_workshops/docs/2017-jan-jul_imp_care_for_high_utilizers.pdf
DOH MAX Series- Managing Care of Super Utilizers

“Our mission is to create a sustainable and collaborative system that reduces unnecessary ED visits by identifying people with substance abuse and homelessness and connecting them to alternative resources that meet their basic needs.”
MAX Methodology

- Structured program of interdisciplinary teams aimed to accelerate redesign and improvement
- Define the “target population”
- Form “Action Teams” to include administrative staff who can directly enact change and can be directly accountable for implementation
- “Identify today’s SUs(super utilizers)” - define the “super utilizer” by analyzing last year’s data
- “Assess SU needs” - view recurrent utilization as a symptom of unmet needs and identify the “driver of utilization” - not the primary diagnosis, not the chief complaint but the HUMAN
- “Do something different” - engage the patient, on site, now
- Follow up to ensure stability - use care plans
- Measure to drive implementation and results
Building a Toolkit
Tools for Data Collection
Business Associate Agreement

- An agreement between BronxWorks and SBH allowing SBH to share PHI to help coordinate care and reduce unnecessary healthcare utilization by shared, or potentially shared, clients/patients
- “Business Associate” is a term defined by HIPAA Privacy Rule
- “A ‘business associate’ is a person or entity, other than a member of the workforce of a covered entity, who performs functions or activities on behalf of, or provides certain services to, a covered entity that involve access by the business associate to protected health information.”

ED Utilization Data

► The top 50 super-utilizers (SUs) of St. Barnabas ED made up:

  0.6% of ED patient population

  2.74% of ED visits

  3195 ED visits

(11/2014-10/2015)

► Before MAX series (5/2015-10/2015):

  Average of 267 ED visits/month

► After MAX series (11/2015-6/2016):

  Average of 166 ED visits/month
Defining a Cohort

- Homeless?
- Familiarity with neighborhood?
- Substance use?
- Methadone patients?
- Use patterns?
  - Time of day
Refining the Cohort

- Top 50 Treat and Release Super-utilizers
  - Analyze use pattern and diagnoses for chronic disease and/or housing issue
- For housing issues, clarify:
  - Street homeless
  - Shelter
  - Unstably housed
- Identify subset of SUs known to BronxWorks Adult Homeless Services to focus intervention
Hospital Needs Assessment/Screening Tool

Emergency Department Psychosocial Needs Screening

1. [ ] Do you have access to food, water, shelter and medication (if needed) everyday?  [ ] Yes  [ ] No.
   If No, please specify.
   When was your last meal?
   Do you know when and where you will eat next?  [ ] Yes  [ ] No.
   Where did you spend the last five nights?

2. [ ] Have you ever had any symptoms such as feeling sad or nervous, hearing voices, having thoughts of killing yourself?  [ ] No  [ ] Yes. If Yes, please specify.
   Have you ever been hospitalized in a psychiatric hospital or received psychiatric treatment in a clinic?
   [ ] No  [ ] Yes.
   Do you receive treatment in a psychiatric clinic now?  [ ] No  [ ] Yes  [ ] If Yes, where?

3. [ ] Have you ever had difficulties with alcohol or drugs?  [ ] No  [ ] Yes  [ ] If Yes, which one?
   If Yes, when was the last use?
   Do you receive treatment in an alcohol or drug program now?  [ ] No  [ ] Yes  [ ] If Yes, which one?

4. [ ] Are you experiencing any significant problems such as family, illness, legal?  [ ] No  [ ] Yes.
   If Yes, please specify.

5. [ ] Do you have a worker who calls or visits you?  [ ] No  [ ] Yes  [ ] If Yes, please provide contact information.

6. [ ] Are you currently connected to a homeless shelter or have you been to a shelter in the past?  [ ] No  [ ] Yes  [ ] If Yes, please specify.

7. Considering everything you told me about your situation, what can we help you with?

8. [ ] Referrals made:
   - Emergency Shelter
   - Transitional Housing
   - Mental Health
   - Substance Abuse Treatment
   - Food Assistance
   - Medication Assistance
   - Clothing Assistance
   - Childcare assistance
   - Case Management
   - Housing Placement Services
   - Outpatient Detox
   - Transportation Assistance
   - Other

   Name: ____________________  Signature: ____________________  Date: ____________________
Building a Toolkit
Tools for Intervention with Hospital and Client/Patient
Flagging/Developing a “Go Team”

- What happens when someone on the “list” walks through the door?
  - Security and Registrar have list of super-utilizers
- Change is made one person at a time.
Homeless Outreach in ED

- 24/7/365 outreach team goes into hospitals to engage individuals experiencing homelessness who are using the ED as shelter
- Offer transport to more appropriate shelter
- Repeated engagements
- Connection to services
Identifying Stakeholders

- Those who can say “No.”
  - Patients/Clients
  - Line staff (social workers, residents, RNs)
  - Supervisory staff (supervisors, attendings)
  - Administration (leadership, legal)
Generating Buy-in from All Stakeholders

Bottom up

- Involvement of Security staff
- Staff tours of BronxWorks facilities
- Presentation at ED Grand Rounds
- Staff interagency communication

Top down

- Weekly meetings for senior staff
- Eliminating roadblocks
- Invitation to present at ED Grand Rounds
- Integration of process into SBH/BronxWorks culture

BronxWorks | SBH Health System
Interdisciplinary Patient Profile Extraction Tool

Template – Multidisciplinary Meeting/Plan of Care

MRN:
History:
Meds:
Clinic visits:
ED visits:
Med Admissions:
Psychosocial issues:

Care Plan:
ED:

Ambulatory Clinics:
  Medicine:
  Specialty:

Health Home/Patient Navigator:

Inpatient:
# Centralized Interdisciplinary Care Plan

<table>
<thead>
<tr>
<th>Service/Department</th>
<th>Representative</th>
<th>Plan</th>
<th>Outcome</th>
<th>Follow up</th>
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<tbody>
<tr>
<td>Emergency Department</td>
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</tr>
<tr>
<td>Inpatient Psychiatry</td>
<td></td>
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<tr>
<td>Outpatient Psychiatric Provider</td>
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<tr>
<td>Medicine</td>
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<tr>
<td>Care Coordinator</td>
<td></td>
<td></td>
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<tr>
<td>Shelter</td>
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## Address Obstacles/Drivers of Utilization

<table>
<thead>
<tr>
<th>Component/Need</th>
<th>Responsible Party</th>
<th>Plan</th>
<th>Outcome</th>
<th>Comments</th>
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Examples of “Outside the Box” Drivers

- Anxiety about unknown/undiagnosed health condition
  - Somatic symptoms of undertreated anxiety?
- Ties to the area (with no other shelter options)
- Close to “spot”
  - Using EMS/Non-emergency transport as “taxi”
- Fear of being alone
- Interpersonal conflict
  - Fight with significant other/relative
- “Not my night”
  - Doubled up
Pedro

- 51-year-old Hispanic male
- Limited social support
- Mental illness
- Substance abuse
- Street homeless
- Known to SBH since 2007
- Average ED visits (2008-2010) 35/year

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**Emergency Department Psychosocial Needs Screen**

1. Do you have access to food, water, shelter and medication (if needed) every day? □ Yes □ No.
   
   If No, please specify: **Currently living on the street, no place to eat or drink water.**
   
   When was your last meal? Earlier in the day.
   
   Do you know where you will eat next? □ Yes □ No.
   
   Where did you spend the last five nights? In the street.

2. Have you ever had any symptoms such as feeling sad or nervous, hearing voices, having thoughts of killing yourself? □ No □ Yes. If yes, please specify: **I am very depressed.**
   
   Have you ever been hospitalized in a psychiatric hospital or received psychiatric treatment in a clinic? □ No □ Yes.
   
   Do you receive treatment in a psychiatric clinic now? □ No □ Yes. If Yes, where?

3. Have you ever had difficulties with alcohol or drugs? □ No □ Yes. If Yes, which one?
   
   If Yes, when was the last use? **Crack cocaine earlier in the day.**
   
   Do you receive treatment in an alcohol or drug program now? □ No □ Yes. If Yes, which one?

4. Are you experiencing any significant problems such as family, illness, legal? □ No □ Yes.
   
   If Yes, please specify: **Not getting along with sisters.**

5. Do you have a worker who calls or visits you? □ No □ Yes. If Yes, please provide contact information:

6. Are you currently connected to a homeless shelter or have you been to a shelter in the past? □ No □ Yes.
   
   If Yes, please specify:

7. Considering everything you told me about your situation, what can we help you with?

---

**Referrals made:**

- Emergency Shelter
- Mental Health
- Food Assistance
- Clothing Assistance
- Case Management
- Outpatient Detox
- Other

- Transitional Housing
- Substance Abuse Treatment
- Transport Assistance
- Housing Placement Services
- Life Skills Training

- Emergency Assistance (rent/utilities)
- Health/Income
- Transportation Assistance
- Parachute Program
Pedro at SBH 2016

Visits

<p>| | |</p>
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<tr>
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<td><strong>IP Psych</strong></td>
<td>0</td>
</tr>
<tr>
<td><strong>IP Detox</strong></td>
<td>2</td>
</tr>
</tbody>
</table>

*Sometimes 3x/day
** Few times patient absconded

Chief Complaint/Triage Note

- “stopped EMS and reported had drank and had seizures”
- “reported wanting to kill himself”
- “I caught 20 seizures”
- “my stomach hurts”
- “my feet hurt”
Pedro at SBH 2017

Visits

<table>
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<th>ED</th>
<th>23*</th>
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<tbody>
<tr>
<td>IP Psych</td>
<td>1</td>
</tr>
<tr>
<td>IP Detox</td>
<td>0</td>
</tr>
</tbody>
</table>

*21 from 1/1/17-7/1/17; 2 from 7/1/17-12/31/17

Chief Complaint/Triage Note

- “my legs are swollen and hurt”
- “he said he had a seizure today”
- “my kidney hurts”
- “per EMS found on the floor, intoxicated”
- “I had a seizure and fell down, I hit my head”

Inpatient Psychiatric Admission for 1 week in September 2017 for agitated, combative, bizarre behavior at the shelter
Pedro at SBH 2018
(up to 5/1/2018)

Visits

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>ED</td>
<td>1</td>
</tr>
<tr>
<td>IP Psych</td>
<td>0</td>
</tr>
<tr>
<td>IP Detox</td>
<td>0</td>
</tr>
</tbody>
</table>

Chief Complaint/Triage Note

- “talking to himself”
- Cooperative and calm
- Discharged after overnight observation and coordination of care with ACT and Bronx Works
Pedro’s Utilization (Inpatient and ED)

82% decrease (visits)  
(-9 months/+9 months)  
43% decrease (cost)  
(-9 months/+9 months)

$32,201.20 saved  
(9 months/+9 months)

Safe Haven placement 12/28/16
Super-utilizers Evaluation Process

- Stop the revolving door of ED visits with brief evaluation and rapid disposition
- Assess immediate aspects of care: medical or psychiatric
- Admit patient (medicine or psychiatry) for evaluation/management and an in-depth assessment of needs and challenges
- Organize multidisciplinary team meeting early in the admission
 Toolkit in Motion

Mr. W

Interdisciplinary Patient Profile

MRN

History: 21 y/o male h/o bipolar disorder, h/o suicidal attempts (last 7/15), asthma admission for hypoglycemia work up as prior work up incomplete. Patient also h/o feeling depressed. Recently admitted to ICU 12/28 but eloped. Multiple ED visits this year (84 visits) for depression/dizziness/hypoglycemia.

Patient presently admitted and being seen by endocrine for work up for recurrent hypoglycemia.

No h/o diabetes mellitus

**Patient has a diagnosis of Hyperammonemiac hyperinsulinemic hypoglycemia requiring diazoxide PO as treatment. He is non compliant because of the taste. Pharmacy reviewing to mix meds to lessen harshness of the flavor.

Meds: Zoloft 50mg daily, Seroquel 400mg bid, Albuterol MDI PRN
I/v +tobacco/+PCP/+heroin/+cocaine/THC – No IVDU

Labs: Utx on 12/30 +benzodiazepine

PCP: None

Clinic visits: 5/11 – Dr. M.

ED visits: 12/22, 12/17, 12/14, 10/27, 9/30, 9/15, 8/30, 8/28, 8/27, 8/25, 8/21, 8/19, 8/18, 8/16, 8/6, 7/23, 7/14, 7/10, 7/7, 7/3, 7/1, 6/25, 6/22, 6/20, 6/16, 6/12, 6/11, 6/10, 6/8, 6/6, 6/5, 6/4, 6/3, 5/1, 5/15, 5/13, 5/11, 5/7, 5/5, 5/4, 4/25, 3/13, 2/23

41 additional ED visits with second MRN – total 84 visits in 2015 to the ED

Med Admissions: 12/26 – still admitted
12/26-12/27 – AMA
5/7-5/8 – ANA

Psychosocial Issues: Patient homeless. Educated till 11th grade, unemployed. Estranged from family. Aunt died 3 years ago and has been homeless since. Pt was institutionalized at Queens Childrens and was also at Leaker Watts with h/o aggressive behavior.

Insurance: United Healthcare HMO, Medicaid (active)
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</tr>
</thead>
<tbody>
<tr>
<td>Emergency Department</td>
<td>A.B</td>
<td>Patient diagnosed with Hyperammonemic hyperinsulinemic hypoglycemia requiring diazoxide PO as treatment</td>
<td>He is non compliant because of the taste. Pharmacy reviewing to mix meds to lessen harshness of the flavor.</td>
<td>If patient returns to the ED with symptoms of hypoglycemia – endocrinology to be consulted</td>
</tr>
<tr>
<td>Case Management from insurance company</td>
<td>C.D.</td>
<td>C.D. will follow up on authorization with insurance company (United HealthCare)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient provider</td>
<td>E.F.</td>
<td>Early Medicine clinic appointment to be made</td>
<td>Consider endocrinology appt on the same day</td>
<td></td>
</tr>
<tr>
<td>Shelter/Bronx Works</td>
<td>G.H.</td>
<td>Seen by J.B. from Bronx Works</td>
<td>Patient to be assigned to a room at Safe Haven</td>
<td></td>
</tr>
<tr>
<td>Patient Navigator/Health Home Program</td>
<td>I.J.</td>
<td>Referral made and navigator assigned</td>
<td>Contact made</td>
<td></td>
</tr>
<tr>
<td>Component/need</td>
<td>Responsible party</td>
<td>Plan</td>
<td>Outcome</td>
<td>Comments</td>
</tr>
<tr>
<td>----------------------</td>
<td>-------------------</td>
<td>-------------------------------</td>
<td>--------------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Clothing</td>
<td>M.L.</td>
<td>Clean clothes closet</td>
<td>Secured pants/sweater</td>
<td>Need for shoes</td>
</tr>
<tr>
<td>Cell. Phone</td>
<td>M.L.</td>
<td>Verify property</td>
<td>Checked No SIM card</td>
<td>Purchased</td>
</tr>
<tr>
<td>Transportation</td>
<td>M.L.</td>
<td>Pick up by shelter staff</td>
<td>Confirmed</td>
<td>None</td>
</tr>
<tr>
<td>Medication delivery</td>
<td>L.T.</td>
<td>Eprescribe 1 day in advance</td>
<td>Available on the unit</td>
<td></td>
</tr>
<tr>
<td>Insurance</td>
<td>G.O.</td>
<td>Call and inquire if patient has Case Manager</td>
<td>Contacted and discussed plan</td>
<td></td>
</tr>
<tr>
<td>Medicine</td>
<td>M.K.</td>
<td>Obtain early medicine clinic appt. on the day of discharge</td>
<td></td>
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</tr>
</tbody>
</table>
Emergency Department Utilization (Ms. J)

65% decrease (visits)
(-6 months/+6 months)
Best Practices and Scalability

Toolkit of Best Practices

BronxWorks | SBH Health System
Review of Toolkit

Data Gathering
- Business Associate Agreement
- Utilization Data
- Define Cohort
- Data Match
- Refine Cohort
- Hospital Screener

Intervention
- Systems/Process Mapping
- Flagging/Developing a “Go Team”
- Homeless Outreach in ED
- Identify Stakeholders
- Generate Buy-in
- Interdisciplinary Patient Profile
- Centralized Care Plan
- Address Obstacles/Drivers of Utilization
## Results

### During MAX series (11/2015-6/2016):

- 5 patients engaged in BronxWorks services
  - 3 placed in the Safe Haven
  - 2 placed on Drop-In Center caseload
- Connected patients had **10.33 fewer ED visits**/month since Safe Haven engagement (90.7% reduction)
- Connecting these 3 patients to services was **projected to prevent 124 ED visits annually**

### During MAX (5/2015-7/2016)

- **131** patients engaged by Homeless Outreach Team
- **59** patients transported to drop-in center or shelter
- **36% reduction in ED visits by SUs**

### To Date (as of 4/24/18)

- **609** patients engaged by Homeless Outreach Team
- **157** patients transported to drop-in center or shelter
- **17** clients placed in Safe Haven or stabilization bed
Looking to the Future

Broadening the Scope
Building on Past Successes

- Expanding best practices in care coordination to other hospitals
- Partnering with SBH Health System to build permanent supportive housing near hospital
- Embedding Housing Coordinators in Hospital EDs to supplement existing social work staff and focus on unique issues for people who are unstably housed or experiencing homelessness
- ED Navigators hired by hospitals for further care coordination
- Exploring options for medical respite in NYC
  - Possible site identified for respite program
- Testifying before NYC City Council on health care for individuals experiencing homelessness and opioid overdoses
Contact Information

- John Betts, LMSW (BronxWorks)—jbetts@bronxworks.org
- Noel Concepción, LMSW (BronxWorks)—nconcepcion@bronxworks.org
- Juan Rivera, LMSW (BronxWorks)—jrivera@bronxworks.org
- Lizica Troneci, MD (SBH Health System)—ltroneci@sbhny.org
- Sarah Zammiello, LMSW (BronxWorks)—szammiello@bronxworks.org
Special Thanks

- William Wilcox (BronxWorks)
- Jamila Martinez, LMSW (BronxWorks)
- Pat Belair, RN (SBH Health System)
- Megan Fogarty, LMSW
- Bronx Health and Housing Consortium
- KPMG Consulting (MAX series)
- Dr. Amy Boutwell