



Communities Working in Collaboration to Address Health Disparities

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Learning Objectives



- Learn how Health Plans & Public Housing Authorities partner to address chronic homelessness
- Identify partnerships between Health Plans & Criminal Justice system entities to reduce recidivism by supporting people re-entering their communities
- Describe Whole Person Care utilizing Medical Respite in partnership with hospitals



What is a Health Disparity?



- Differences in health outcomes that are closely linked with social, economic, and environmental disadvantage
- Differences in the incidence, prevalence, mortality, and burden of disease that exist among specific populations in the US



How do Health Disparities Arise?

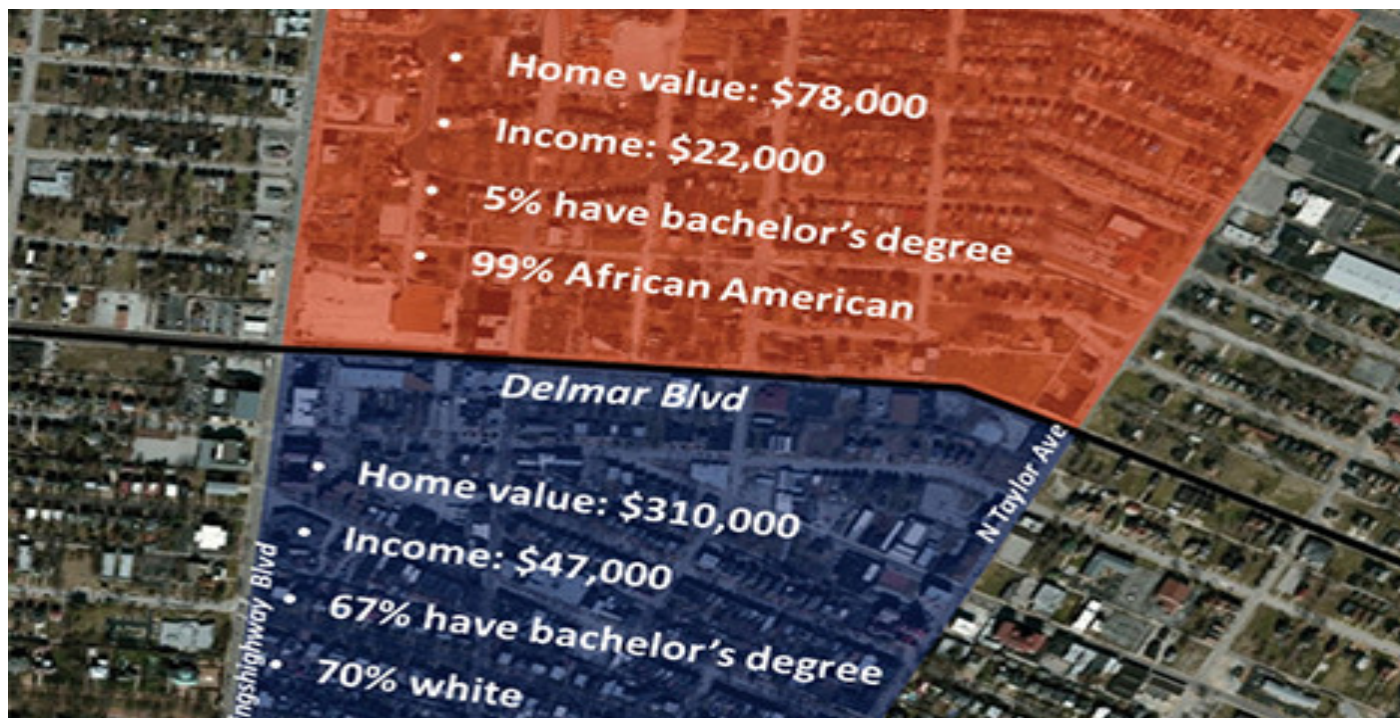


- Differences in the quality of care received
- Differences in access to health care, including preventive and curative services
- Differences in life opportunities, exposures, and stresses that result in differences in underlying health status

Why is our zip code more important than our genetic code?



Harvard Study Delmar Divide

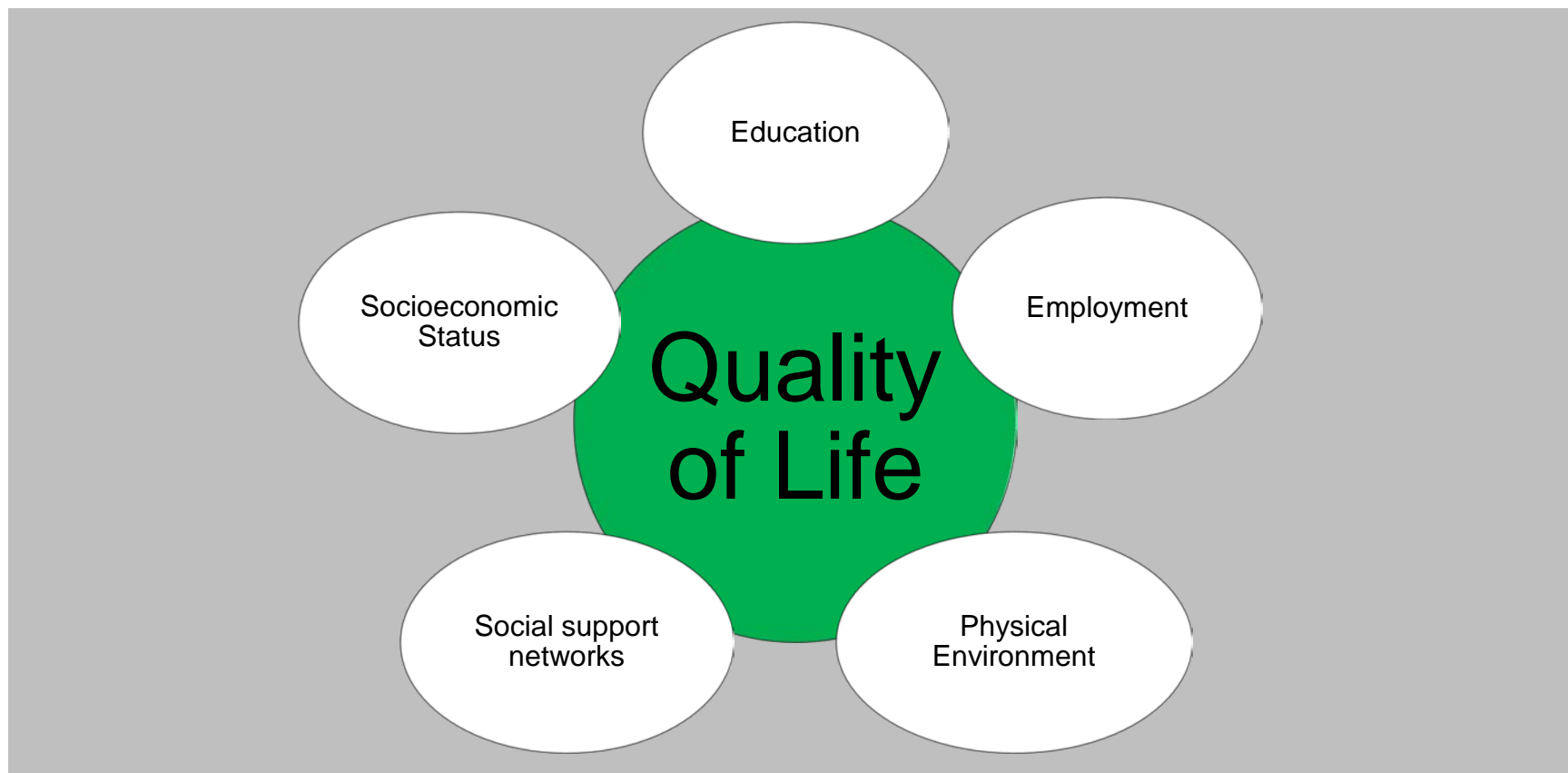




Social Determinants of Health (SDOH) are conditions in the places where people live, learn, and/or work that affect a wide range of health risks and outcomes. We know that poverty limits access to healthy foods and safe neighborhoods and that more education is a predictor of better health. We also know that differences in health are striking in communities with poor SDOH such as unstable housing, low incomes, unsafe neighborhoods, or substandard education.

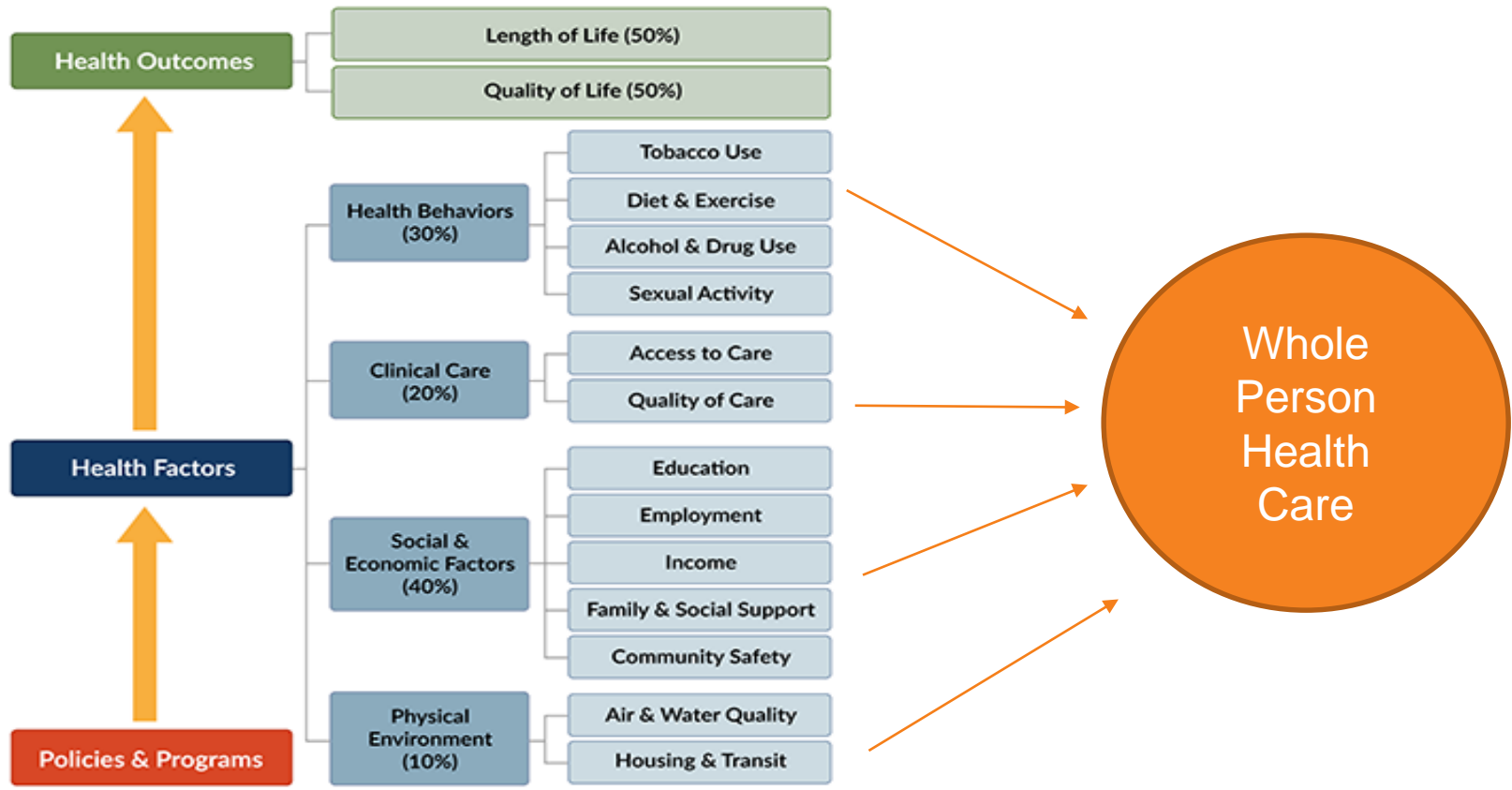


Social Determinants of Health






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County Health Rankings model © 2014 UWPHI



Housing Best Practice



Coordinate Entry using the Homelessness Management Information System (HMIS)



Tucson/Pima Collaboration to End Homelessness-HUD Continuum of Care



Health Care Providers	Government Agencies	Faith-Based Partners	Community Organizations
Cenpatico Integrated Care	City of Tucson	Gospel Rescue Mission	American Red Cross
Community Bridges, Inc.	Pima County	GAP Ministries	Emerge! Center Against Domestic Violence
COPE Community Services	State of AZ DES	Interfaith Community Services	Primavera Foundation
Old Pueblo Community Services	Southern Arizona VA Healthcare System	Trinity Resource Center	Salvation Army

*Above is a small sample of the 37 organizations who are TPCH voting members

Health Plan & Public Housing Partnerships



Twice per/month Case Conference committee meeting

- Case Conferencing is a community meeting where all homeless service providers discuss the provision of housing to those experiencing homelessness. Case Conferencing participants discuss identified barriers to securing housing for matched households and provide assistance to housing providers by improving collaboration and sharing resources within the community. This is done with the intention of decreasing the rate of homelessness in our communities and minimizing barriers to securing housing

Health Plan & Public Housing Partnerships



- Pima County is the HMIS lead chosen by the HUD Continuum of Care (CoC)
- CoC includes partnerships with faith-based and non faith-based emergency shelters
- Annual Point in Time Count of homeless persons is a joint venture
- Shared learning & professional development opportunities through Tucson Pima Collaboration to End Homelessness

HMIS at Work



Referrals for HUD programs are entered into HMIS (Homeless Management Information System) a Continuum of Care community-based, centralized housing referral data base

Why HMIS?



The primary goal of the centralized housing referral process is to ensure members with SMI, GMH, SA who are the most vulnerable according to the VI-SPDAT (HUD vulnerability assessment tool) and C-IC data are connected to housing supports. This process ensures vacancies across the network are fully utilized.

Homelessness to Housing Outcomes

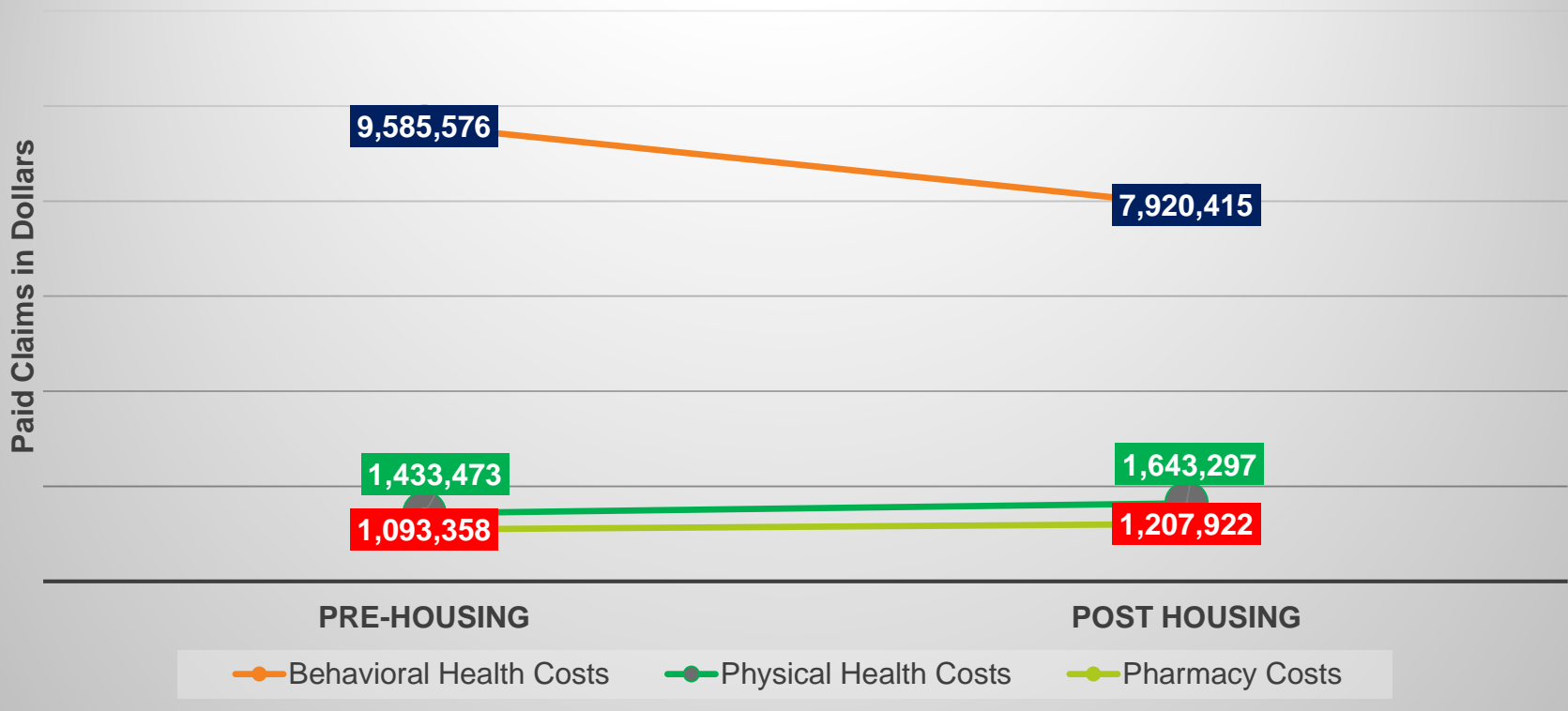


An analysis pre- and post-housing data for members entering housing between January 1, 2017 and June 30, 2017 reveals the following changes for the **six months prior- to versus six months after securing housing:**

Costs in Comparison to Service Type



Paid Claims 1/1/2017-6/30/2017

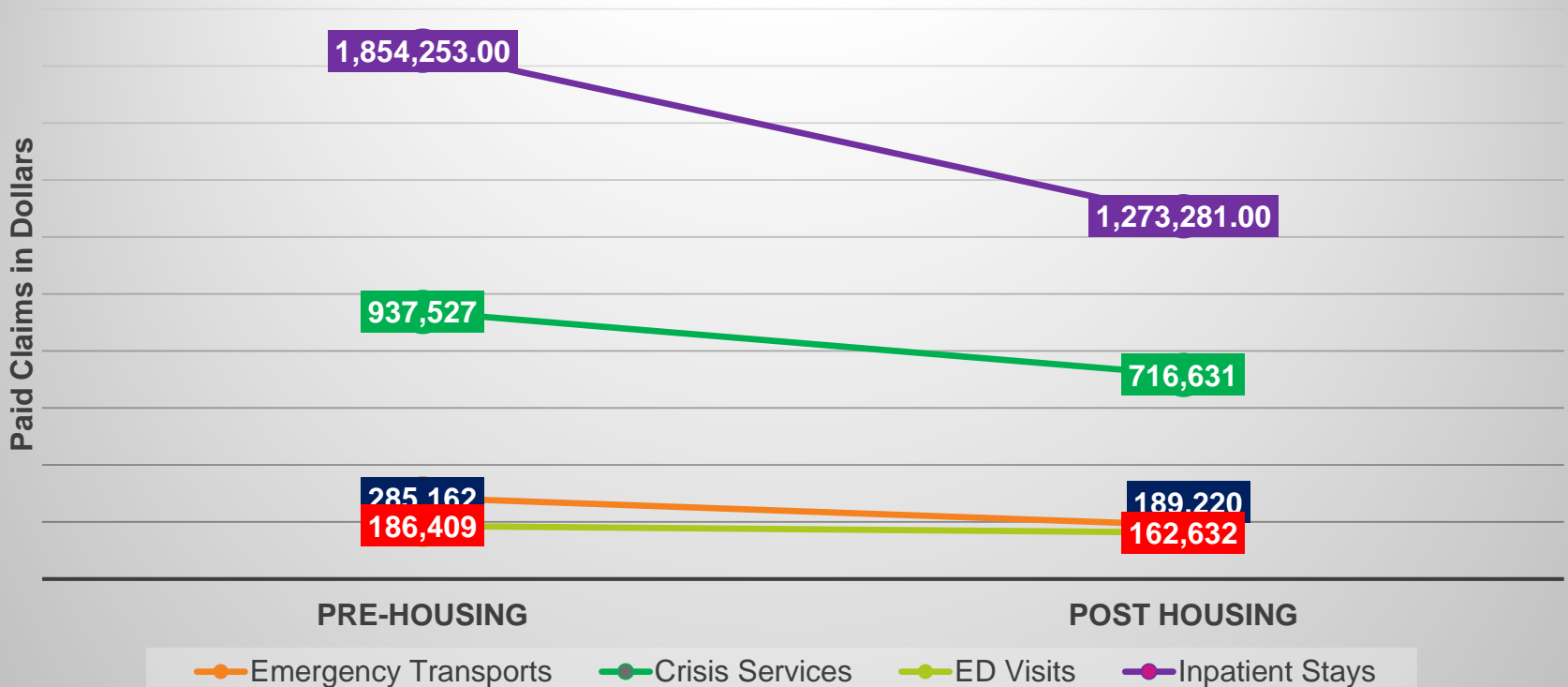


Cost Reductions per Service Type



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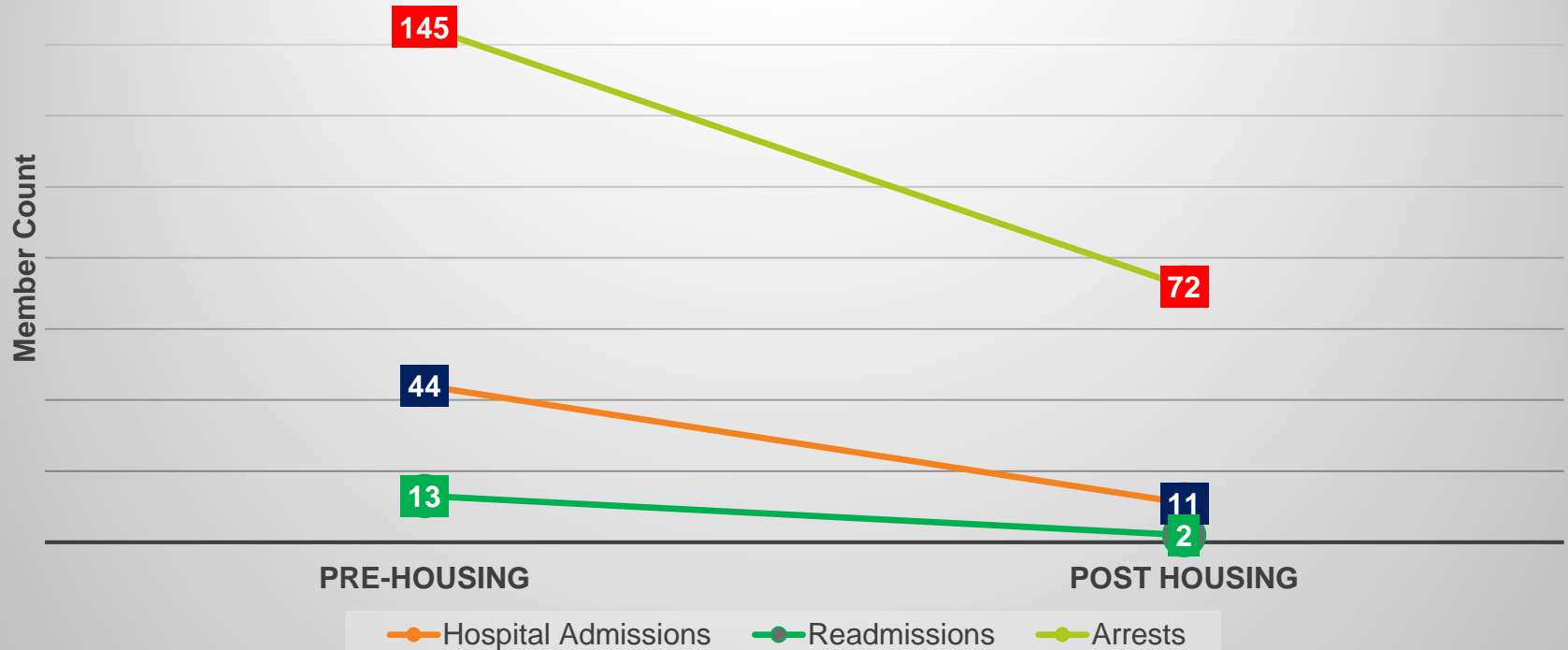
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Housing & Health Improving



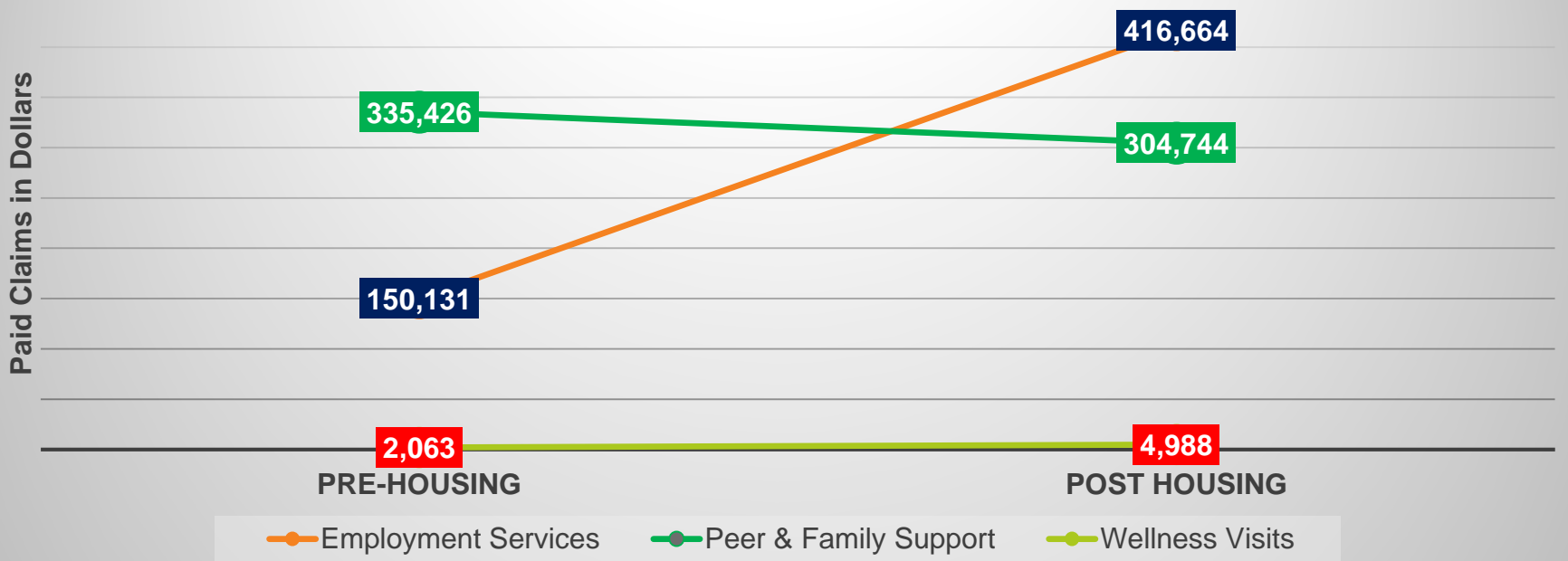
Member Count 1/1/2017-06/30/2017



Wraparound Approach Improving Members Health in Housing



Paid Claims 1/1/2017-6/30/2017



Housing & Health Outcome



The overall cost of Behavioral & Physical Healthcare decreased from \$11,019,050 (six months pre-housing) to \$9,563,439, a decrease of \$1,455,651 (13%).

Interdisciplinary Teams for Care Coordination



- Cenpatico Integrated Care Managers continue with care coordination to assist members in addressing their physical and behavioral/mental health needs
- Social Determinants of Health are addressed through referral and coordinated planning (ie: HMIS, Risk Rosters, etc.)

Incarcerated Pre-Release Planning & Care Coordination



Jail Liaisons assist the member with transition planning to the community

Social Determinants of Health assessed & Treatment Planning developed

IDT developed and work begins to connect the member to housing, employment, access to healthy food, etc.

Effective Strategies for IDT



- Health Plan funds positions known as Jail Liaisons within Health Homes to coordinate pre-release activities to meet the identified conditions of the Social Determinates of Health
- Data Sharing agreements with 5 of the 8 counties in Southern Arizona → Health Plan is alerted when a member has been arrested and/or incarcerated
- Collaborative training opportunities specific to the specialty population

Employment Matters Project



Members reentering our communities from incarceration need an opportunity to experience economic stability, experience success in the workplace and comply with their terms & conditions of probation, parole or both with the ultimate goal of ending justice system involvement

Employment Matters Project



- Health Home Jail Liaisons broker connections to Employment Specialty Provider Organizations that provide members with job development, job placement and job retention services
- Benefits Planning to ensure members maintain AHCCCS health insurance is key and DB101 is the tool utilized with members to address this
- Employment Specialty Provider Organizations educate the business community on the Federal Business Tax Credit programs related to hiring members with a disability.



Employment Matters Project



98% of the members remained free of hospitalizations while in the project

93% of the members remained in the community while in the project

70% of the members expressed increased self-confidence and/or self awareness during their involvement

21% of the members reported improvement with managing symptomology related to substance use

17% obtained full-time employment within their first 30 days of the project



Medical Respite



- Acute and post-acute medical care for homeless persons who are too ill to recover on the streets but who are not ill enough to be hospitalized
- Housed in a variety of settings including shelters, nursing homes, and transitional housing

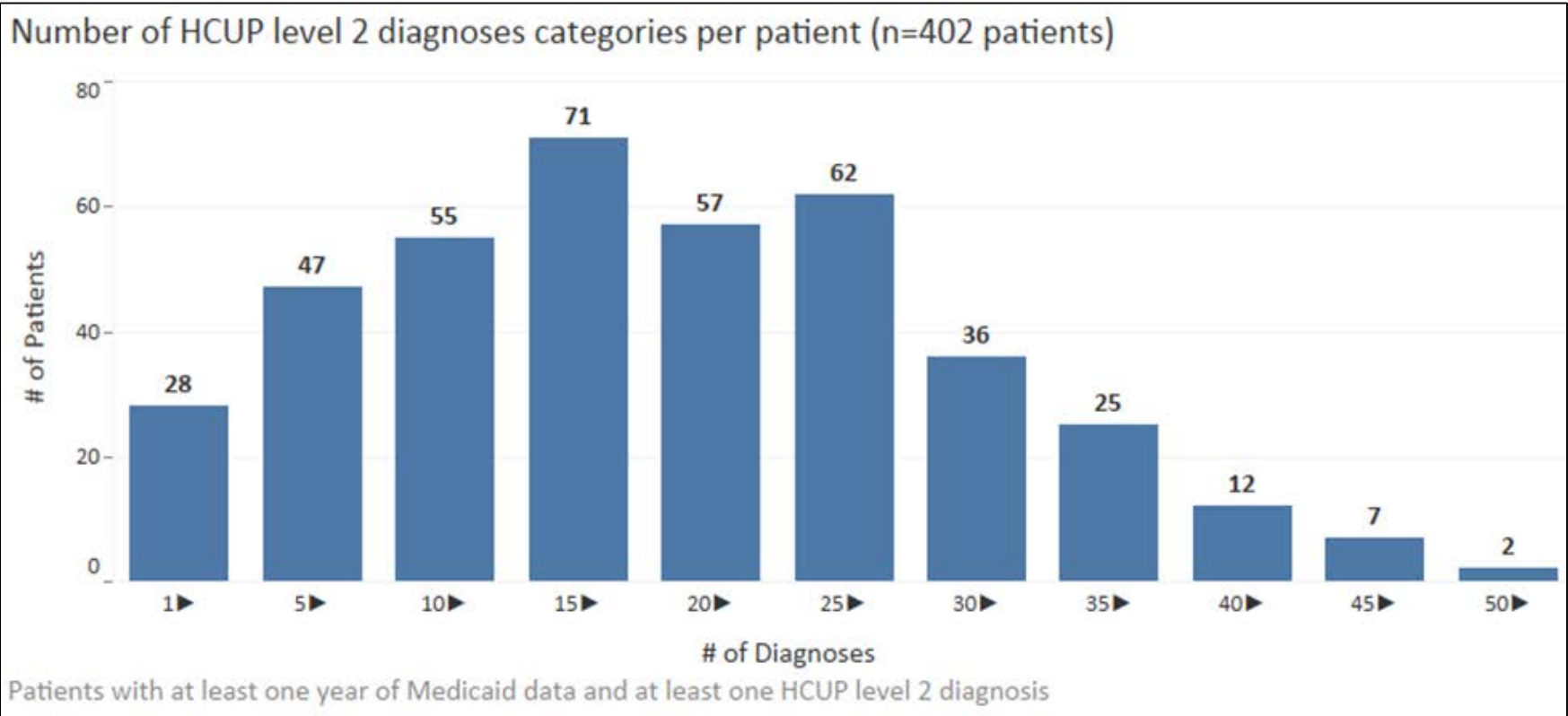
Why Medical Respite?



- Homeless individuals are 3-4 times more likely to die prematurely
- They are often discharged with care instructions that are difficult to follow while living on the streets
- The average hospital stay for most patients is 4.6 days, but those facing homelessness average stays nearly twice as long

Medical Complexity of People Experiencing Homelessness

n= 43,537 claims analyzed



93% of eligible patients enrolled in study had 5+ co-occurring diagnoses

Source: Circle the City et al., 2015-2017

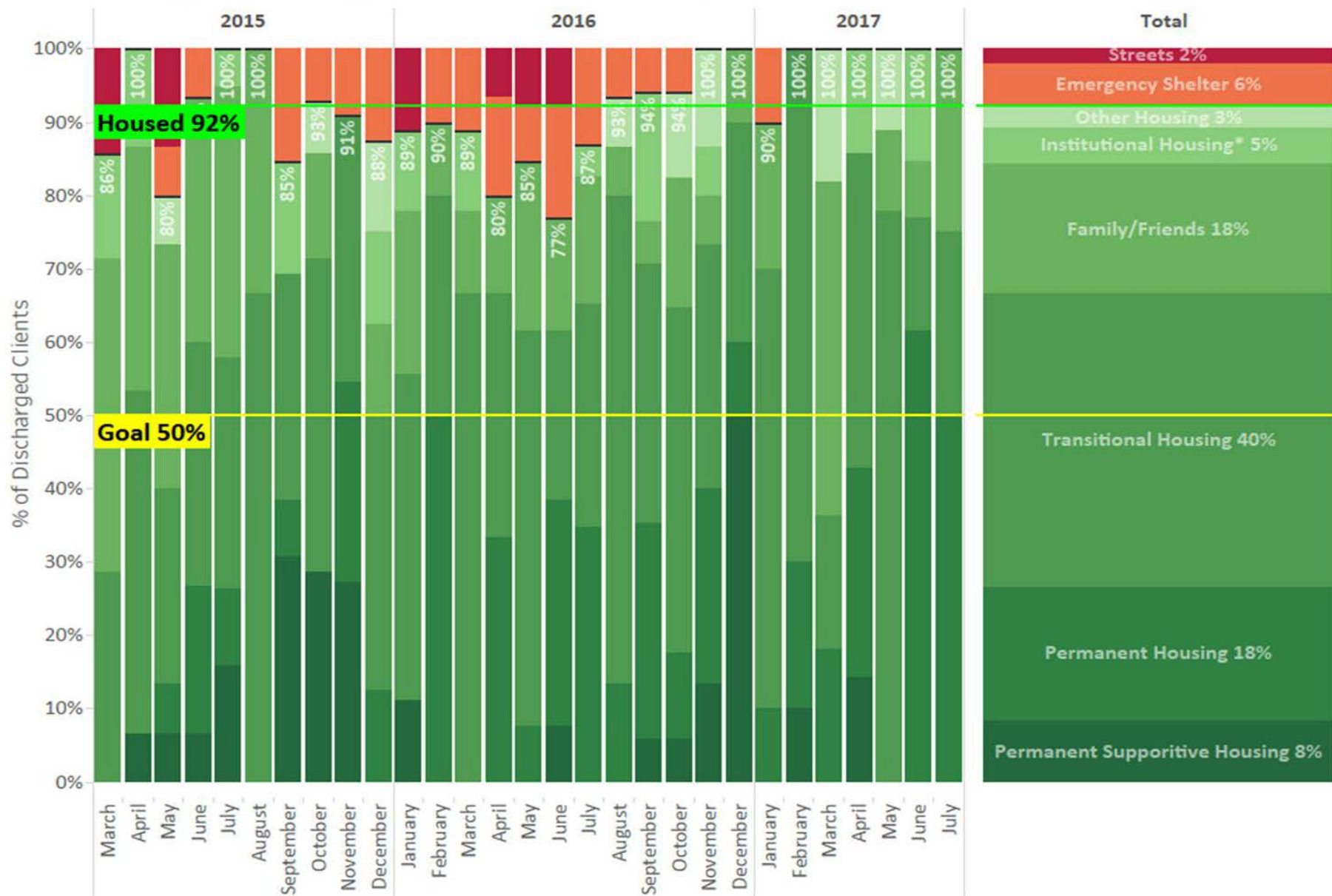
Circle the City



- Homeless Medical Respite Care
- Homeless Specialty Primary/Preventative Care
- Community-Based Homeless Health Outreach



Circle The City Medical Respite Housed 92% of Participants



*Institutional housing includes hospice, inpatient treatment facilities, and residential chemical treatment programs. Patients exiting to a hospital and those without a known exit destination have been excluded.

Circle the City's Impact on Population Health



- 2015 – HealthNet of AZ reported results of 12 month cohort-based study of 54 members admitted to CTC's respite program
 - 72% reduction in total cost of care in year following engagement
 - 77% reduction in inpatient costs
 - 36% reduction in emergency room costs

Source: Circle the City

Circle the City's Impact on Population Health



- 2017 – The National Healthcare for the Homeless Council publishes preliminary results from 3 year CMS Healthcare Innovation initiative
 - 58.1% reduction in total cost of care
 - More than \$4.7M in system savings attributed to 309 individuals enrolled in the study

Source: Circle the City et al., 2015-2017

Homeless Medical Respite Pilot Program



- Multi-agency collaboration in Pima County to provide health care to homeless individuals while they live in a safe setting and recuperate from a medical issue
 - Cenpatico Integrated Care
 - St. Mary's Hospital
 - El Rio Community Health Center
 - Salvation Army
 - Primavera Foundation
 - Pima County HMIS Program

Homeless Medical Respite Pilot Program



Utilizes whole person care by allowing for recovery from medical issues while providing targeted case management to connect members with resources and housing



Homeless Medical Respite Pilot Program



- FQHC embedded in ED and homeless shelters to ID members appropriate for the program
- Member is placed at appropriate shelter
- Assigned a Health Plan CM for follow up

Addressing Your Own SDOH



- Experiential Activity-*Making Choices*
- Group Discussion

