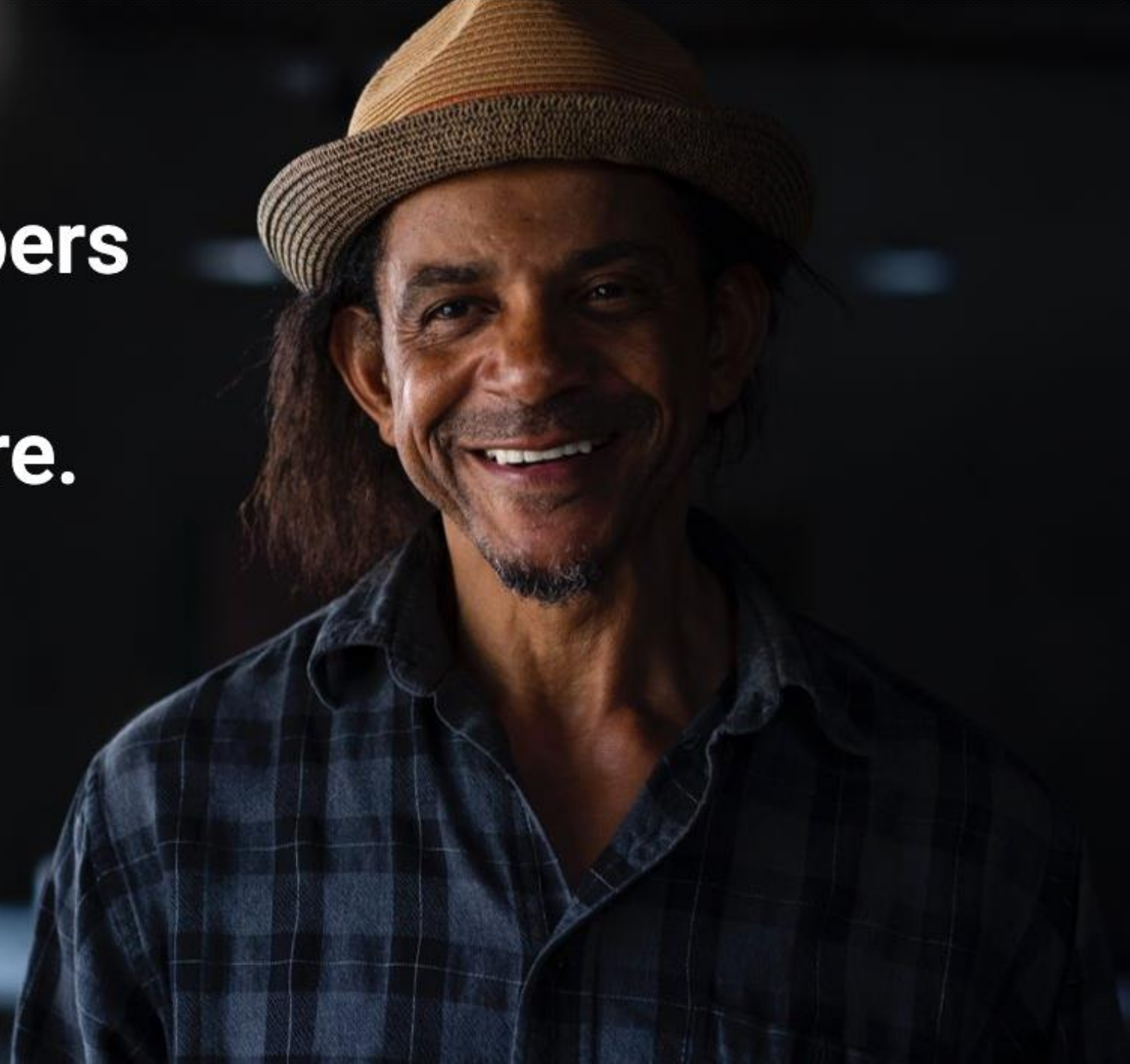
WellSky

Community members deserve greater control of their care.

Provide it, with the **WellSky® Community Services mobile app.**

Community member self-sufficiency through historical record retrieval, community resource access, and real-time visibility into shelter bed capacity.



CareForum 2022

The WellSky® Conference

Why Healthcare Systems Should Partner With AAAs and CoCs to Address Social Determinants of Health

Gabriel Cate

Vice President of Community Solutions

09/14/22

Agenda

- Introduction

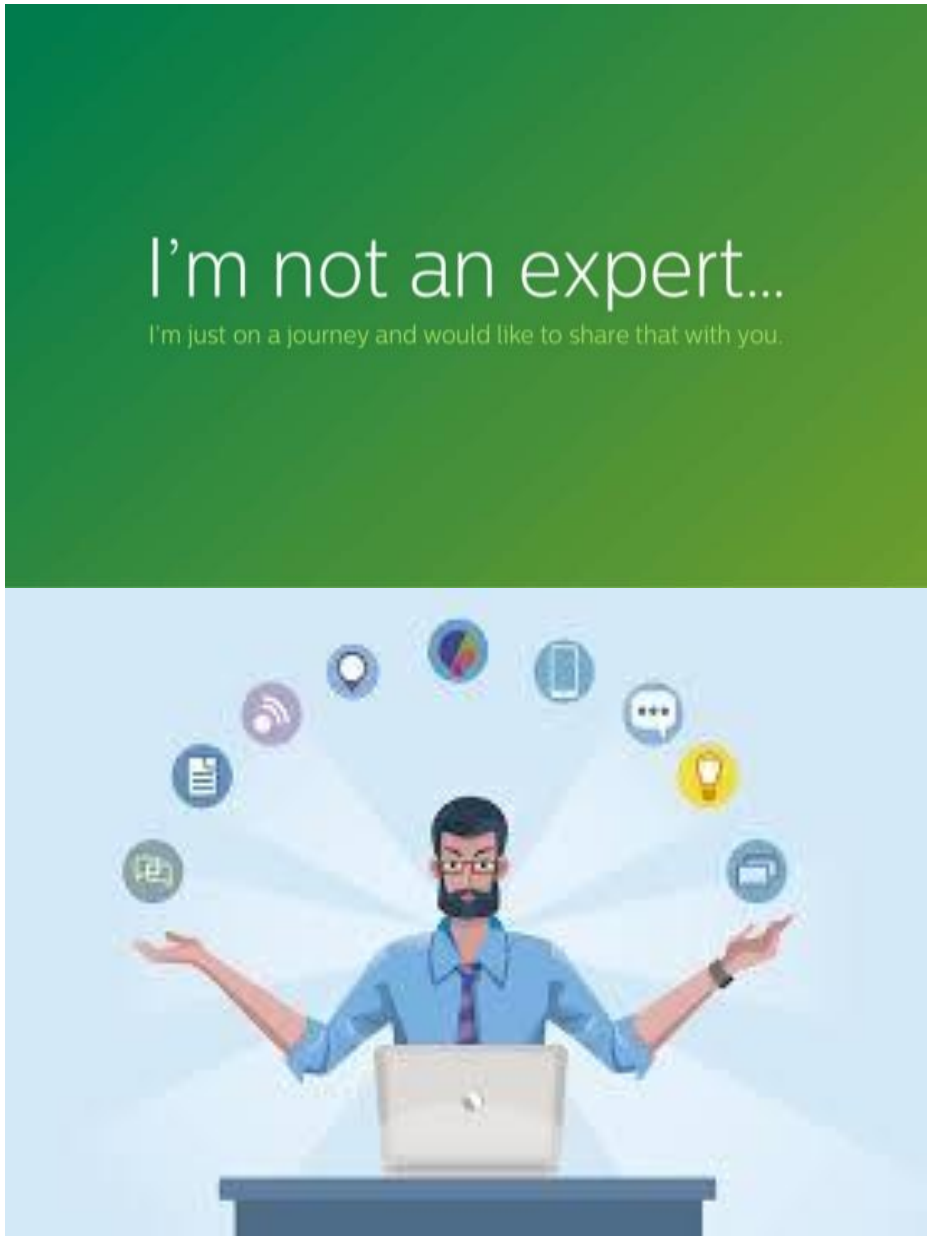
- Definition of the Problem
  - National Context: Healthcare Spending vs. Health Outcomes
    - Key Concepts: Value-Based Care; Income/Health Equity and Health Disparity; Social Determinants of Health
  - Drawing parallels between the healthcare continuum and the housing continuum

- Possible Solutions
  - Hospital-Community Partnerships
  - Payer-Sponsored Initiatives: Private and Public Insurance
  - Continuum of Care Corollary
  - Housing is Healthcare

Introduction

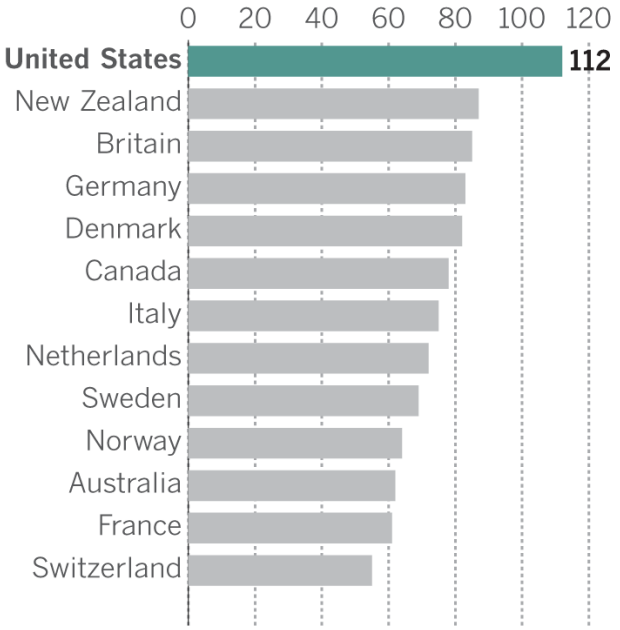
Who am I and what am I doing here?

- Vice President of Community Solutions for WellSky
- Constantly on a search for “what’s next”
- Interested in the intersection of healthcare and human services
- I am not an expert on …
  - Housing
  - Healthcare
  - Insurance
- I am in a position to help raise awareness of 2-1-1 and CoC/HMIS within the healthcare arena

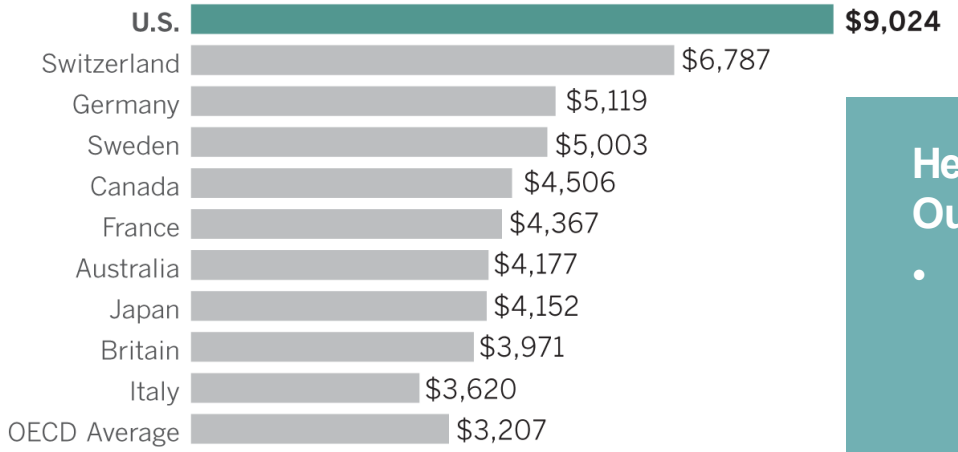


Definition of the problem: The Big Picture

What's this all about?



Number of deaths per 100,000 from preventable diseases or complications had adequate healthcare been available, in 2013



Countries with largest per capita healthcare expenditures, 2015

Healthcare Spending ≠ Health Outcomes

- Average annual spend on medical care is $9,024/person
  - Highest number of preventable deaths
  - Lowest life expectancy: 79.3 years

Healthcare is more than medical care

- 89% of health occurs outside of the clinical space
  - 36% Individual Behavior
  - ***24% Social Circumstance***
  - 22% Genetics and Biology
  - 7% Environment

http://www.latimes.com/nation/la-na-healthcare-comparison-20170715-htmlstory.html
https://www.goinvo.com/vision/determinants-of-health/

What's this all about?

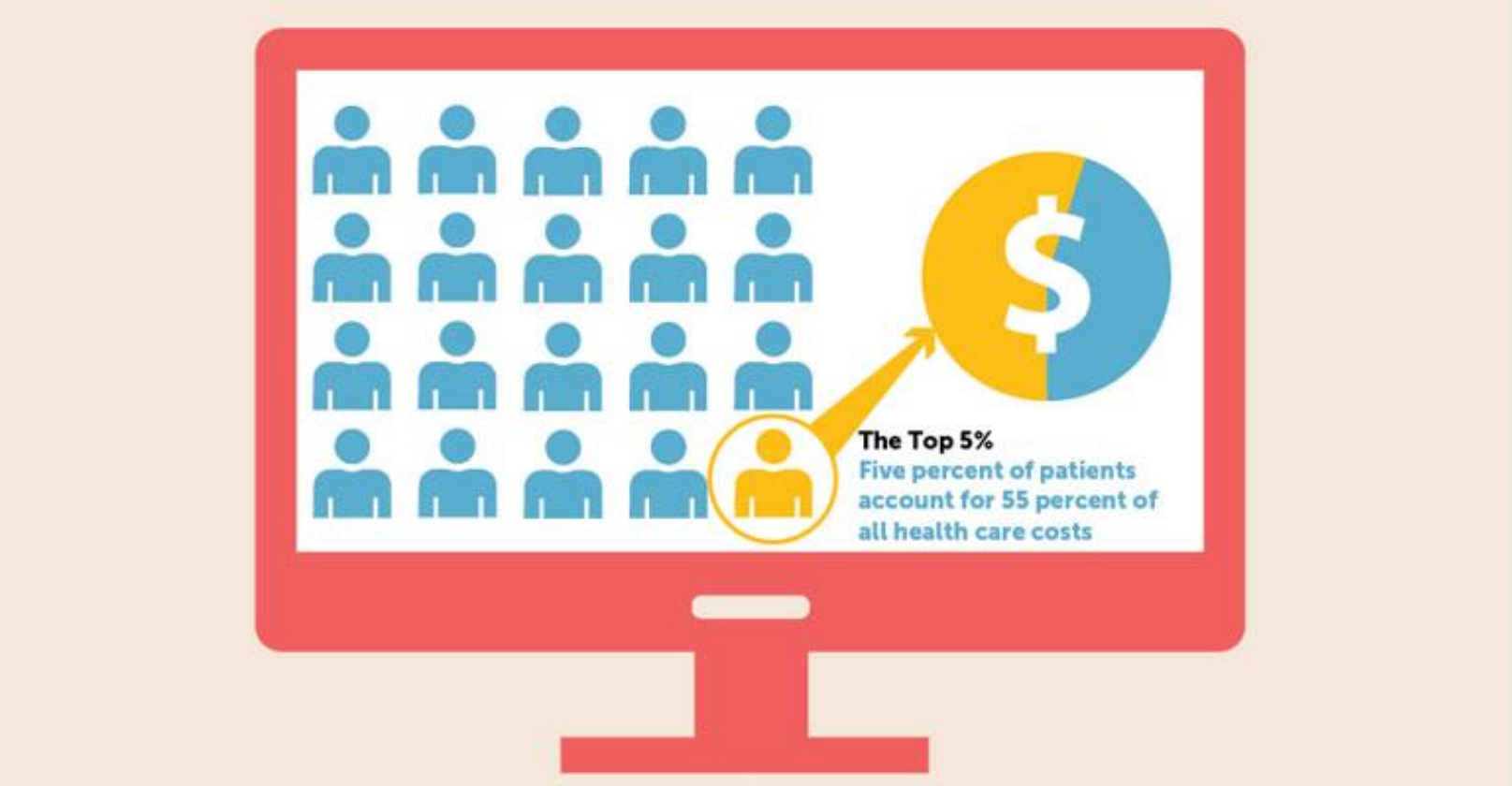
Health disparities are a driver for overall healthcare costs.

- **Super utilizers**
  - System transformation will begin by focusing on this population
  - 5 - 10% of Medicaid/Medicare patients account for over 50% of total spending

- **High-needs adults**
  - Average annual per-person spending on health care services and prescription medicines topped $21,000,
    - Nearly three times the average for adults with multiple chronic diseases only
    - More than four times the average for all U.S. adults
    - Out of Pocket Expenses: Twice as much as Average
    - Income: Half as much as Average

https://www.theatlantic.com/health/archive/2017/06/fixing-the-5-percent/532077/
https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2014.1186
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4291257/
https://www.commonwealthfund.org/publications/issue-briefs/2016/aug/high-need-high-cost-patients-who-are-they-and-how-do-they-use

Super-utilizers disproportionately responsible for healthcare costs



https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4291257/

http://www.ncsl.org/bookstore/state-legislatures-magazine/dollars-from-data.aspx

https://www.everydayhealth.com/healthy-living/0907/infogram-750-billion-a-year-wasted-on-healthcare.aspx

Key Concepts Driving the Conversations

Value-Based Care

Value-based healthcare is a healthcare delivery model in which providers, including hospitals and physicians, are **paid based on patient health outcomes**.

Under value-based care agreements, providers are rewarded for helping patients improve their health, reduce the effects and incidence of chronic disease, and live healthier lives in an evidence-based way.

Value-based care differs from a fee-for-service or capitated approach, in which providers are paid based on the amount of healthcare services they deliver.

The “value” in value-based healthcare is derived from **measuring health outcomes against the cost of delivering the outcomes**.

Value-Based Care

The US healthcare landscape is shifting from volume to value

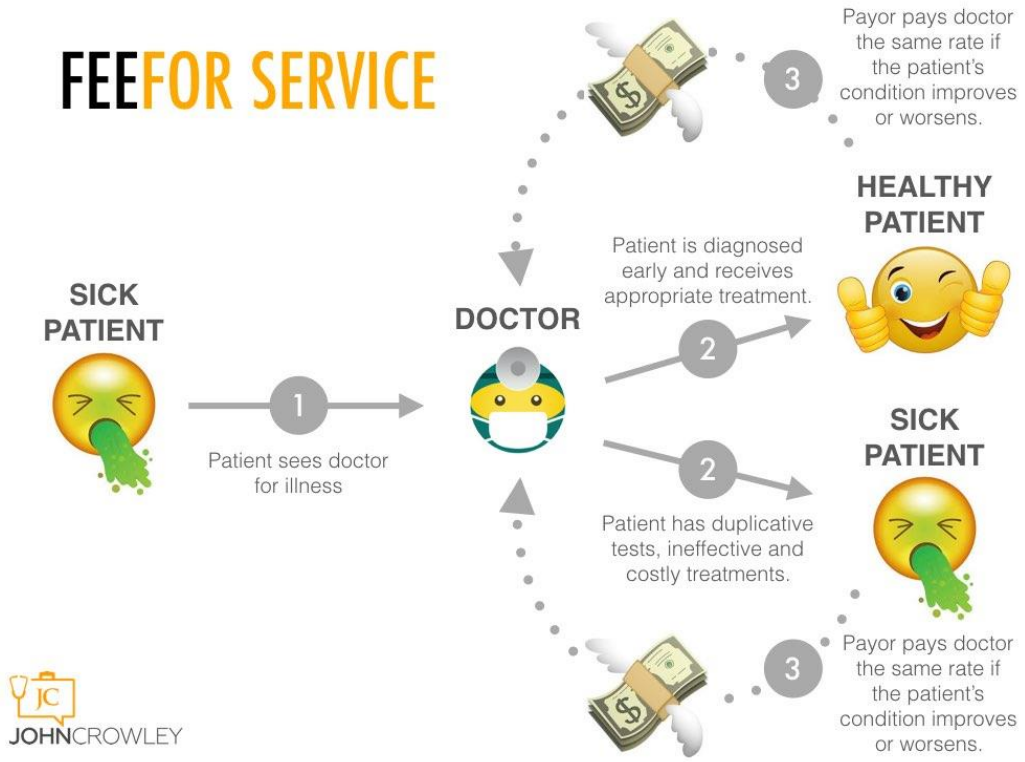
- Disconnected silos
- Variation in care, duplication and redundancy
- Provider centric

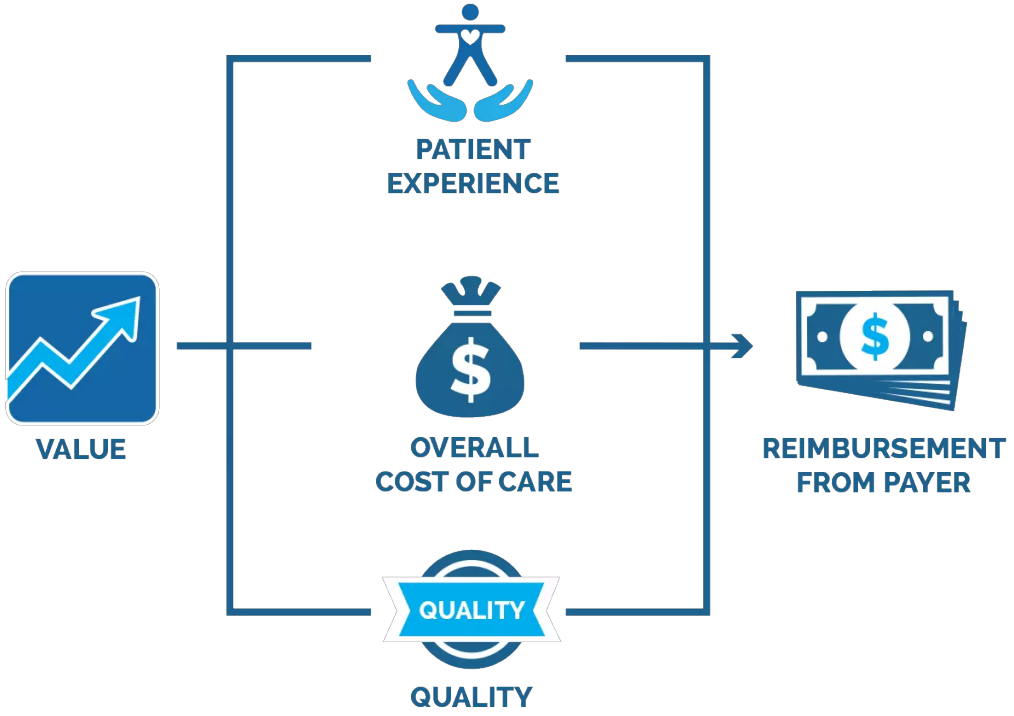
- Clinically integrated networks
- Evidence-based coordinated care
- Patient and population centric

https://catalyst.nejm.org/what-is-value-based-healthcare/

Fee for service ⇨ Value-Based Care

"Part of the problem is that, while each doctor gets paid for each procedure he or she performs, usually no one gets paid for taking a step back and using common sense to think about what would genuinely help the patient."





https://www.theatlantic.com/health/archive/2017/06/fixing-the-5-percent/532077/

Benefits of value-based healthcare delivery

- ✓ Patients spend less money to achieve better health
- ✓ Providers achieve efficiencies and greater patient satisfaction.
- ✓ Payers control costs and reduce risk.
- ✓ Suppliers align prices with patient outcomes.
- ✓ Society becomes healthier while reducing overall spending.

https://catalyst.nejm.org/what-is-value-based-healthcare/

What Is The Future Of Value-Based Healthcare?

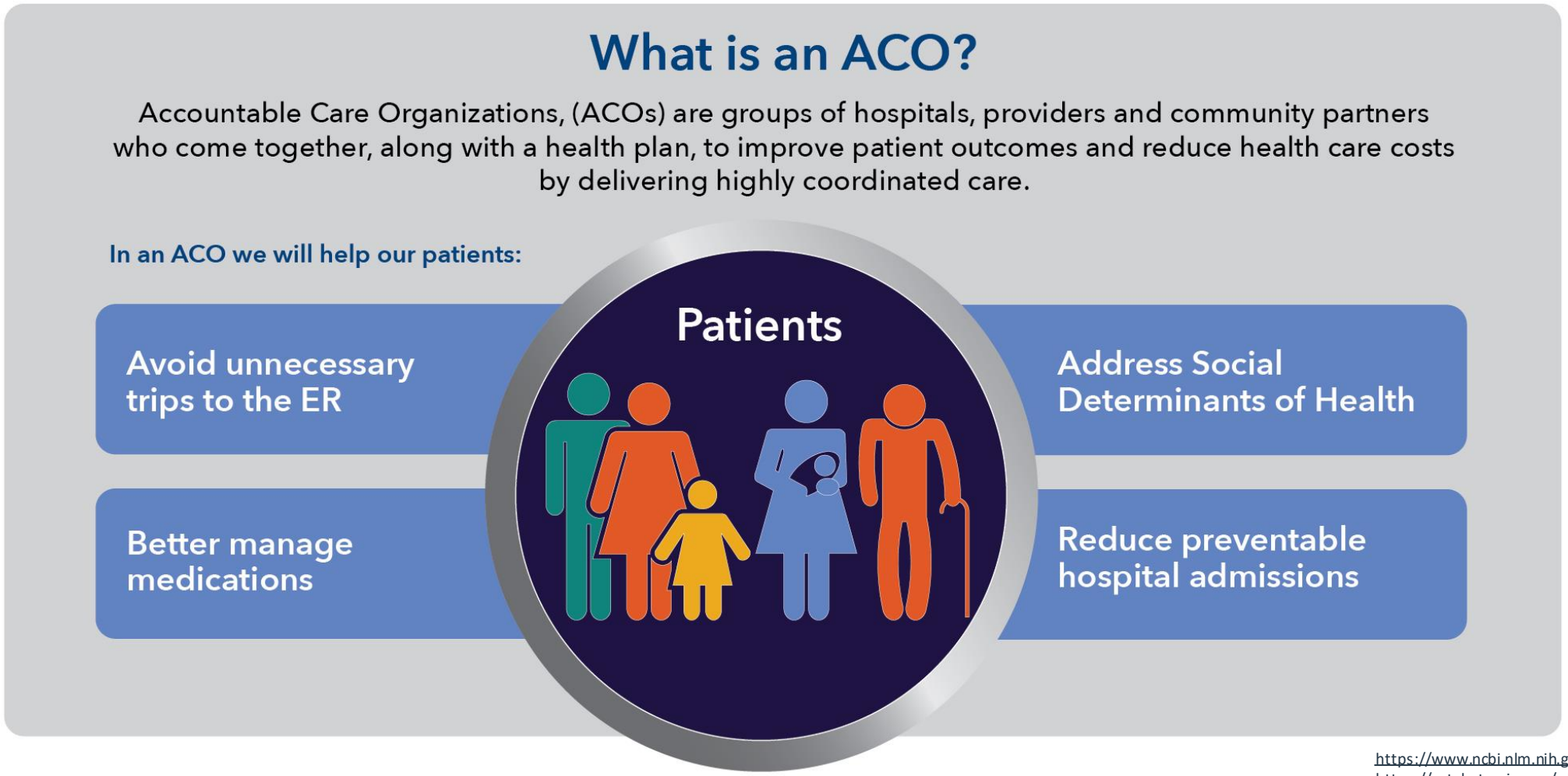
"Moving from a fee-for-service to a fee-for-value system will take time, and the transition has proved more difficult than expected. As the healthcare landscape continues to evolve and providers increase their adoption of value-based care models, they may see short-term financial hits before longer-term costs decline. However, the transition from fee-for-service to fee-for-value has been embraced as the best method for lowering healthcare costs while increasing quality care and helping people lead healthier lives."

https://catalyst.nejm.org/what-is-value-based-healthcare/

Value-based delivery models: Medical homes

https://www.cmics.org/chn/Home/PCMH
https://catalyst.nejm.org/what-is-value-based-healthcare/

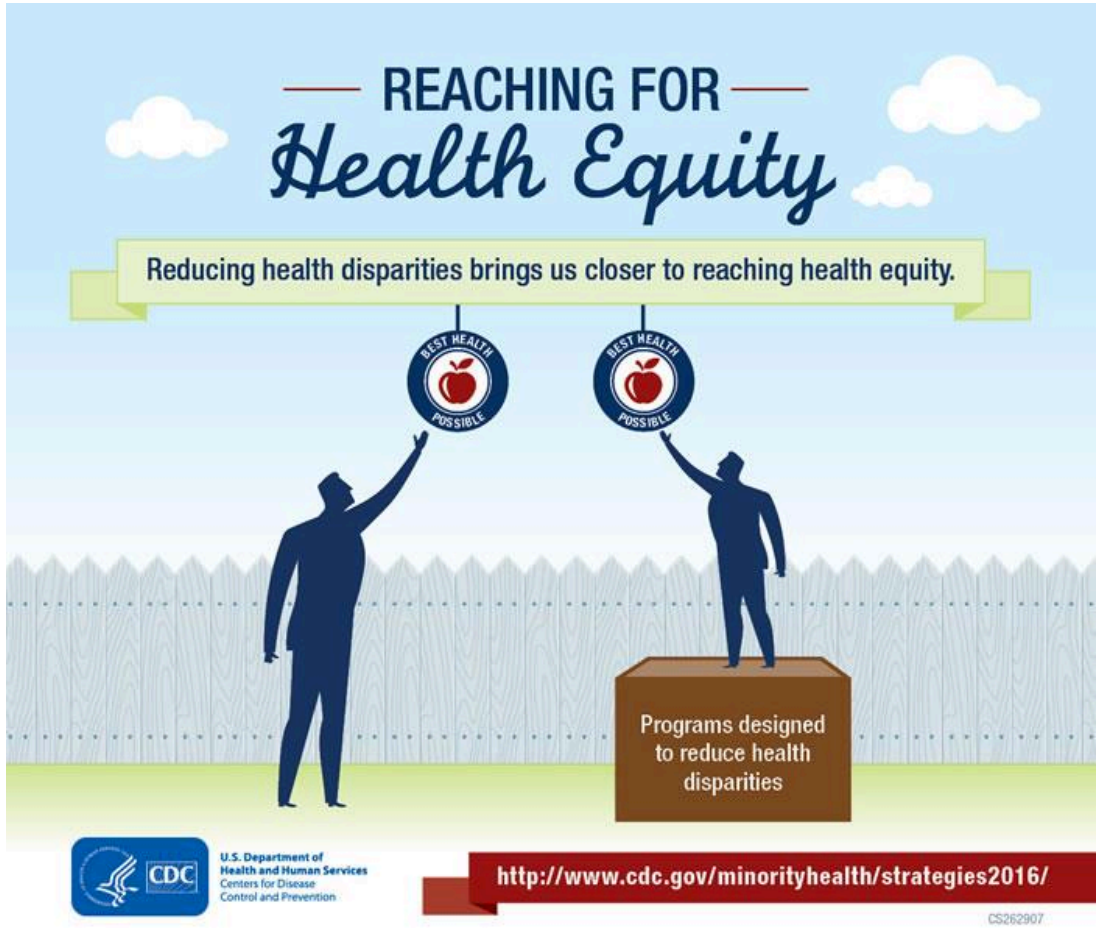
Value-based care models: accountable care organizations

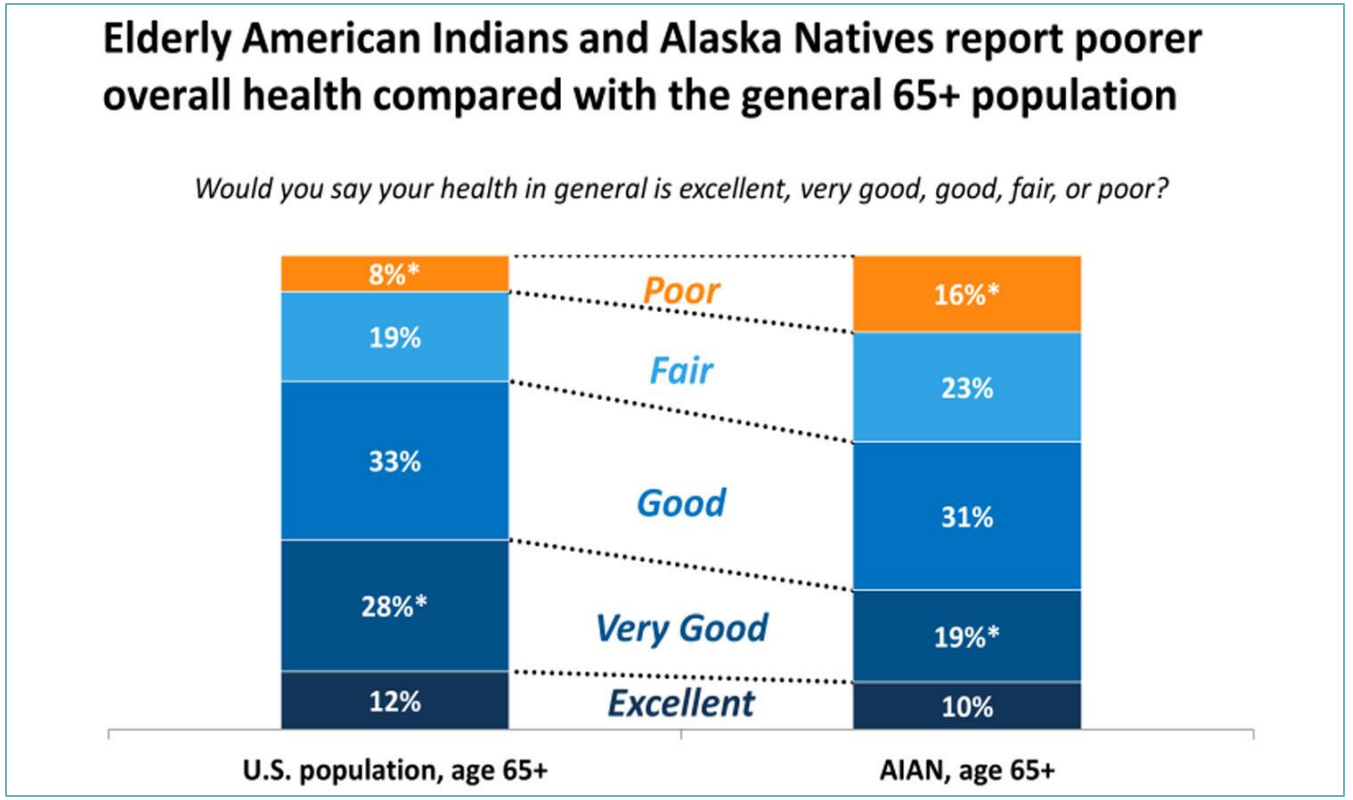


https://www.ncbi.nlm.nih.gov/pmc/articles/PMC537744
https://catalyst.nejm.org/what-is-value-based-healthca
https://development.bmc.org/our-impact/stories/bmc-a

Health equity and health disparity

Health equity and health disparity



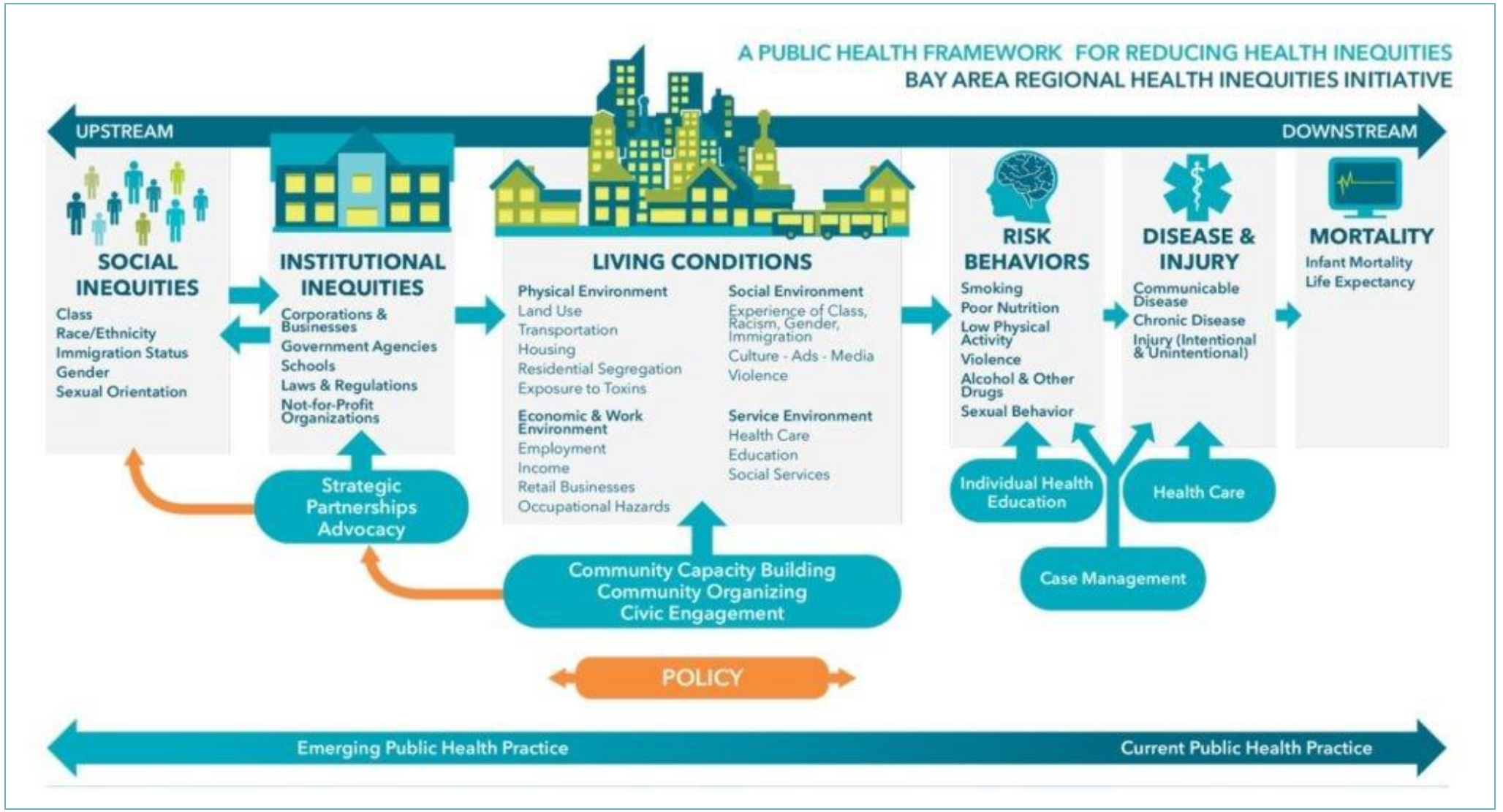


https://patientengagementhit.com/news/understanding-health-equity-in-value-based-patient-care

https://news.aamc.org/diversity/article/native-american-health-disparities/

https://www.cdc.gov/minorityhealth/strategies2016/index.html

How to reduce health inequalities



https://www.movinghealthcareupstream.org/#

How to reduce health inequalities

Moving Health Care Upstream

Innovating. Improving.
Inspiring a New Vision of Health.

"The idea behind Moving Health Care Upstream is that new approaches are needed to address persistent and costly health inequities, and that improving measures of health and well-being for patients and entire communities (population health) requires strategic layering of upstream, midstream, and downstream tactics."

https://www.movinghealthcareupstream.org

Social determinants of health

A rose by any other name …

Social determinants of health (sdoh)

Social drivers of health

Health-related social needs (hrsn)

Population health

https://. wwwrd.com/wp-content/uploads/2022/01/GettyImages-174655938.jpg

Social Determinants of Health

What are the social determinants of health (SDoH)?

The social determinants of health are the **conditions in which people are born, grow, live, work and age**. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are **mostly responsible for health inequities** - the unfair and avoidable differences in health status seen within and between countries.

http://www.who.int/social_determinants/sdh_definition/en/

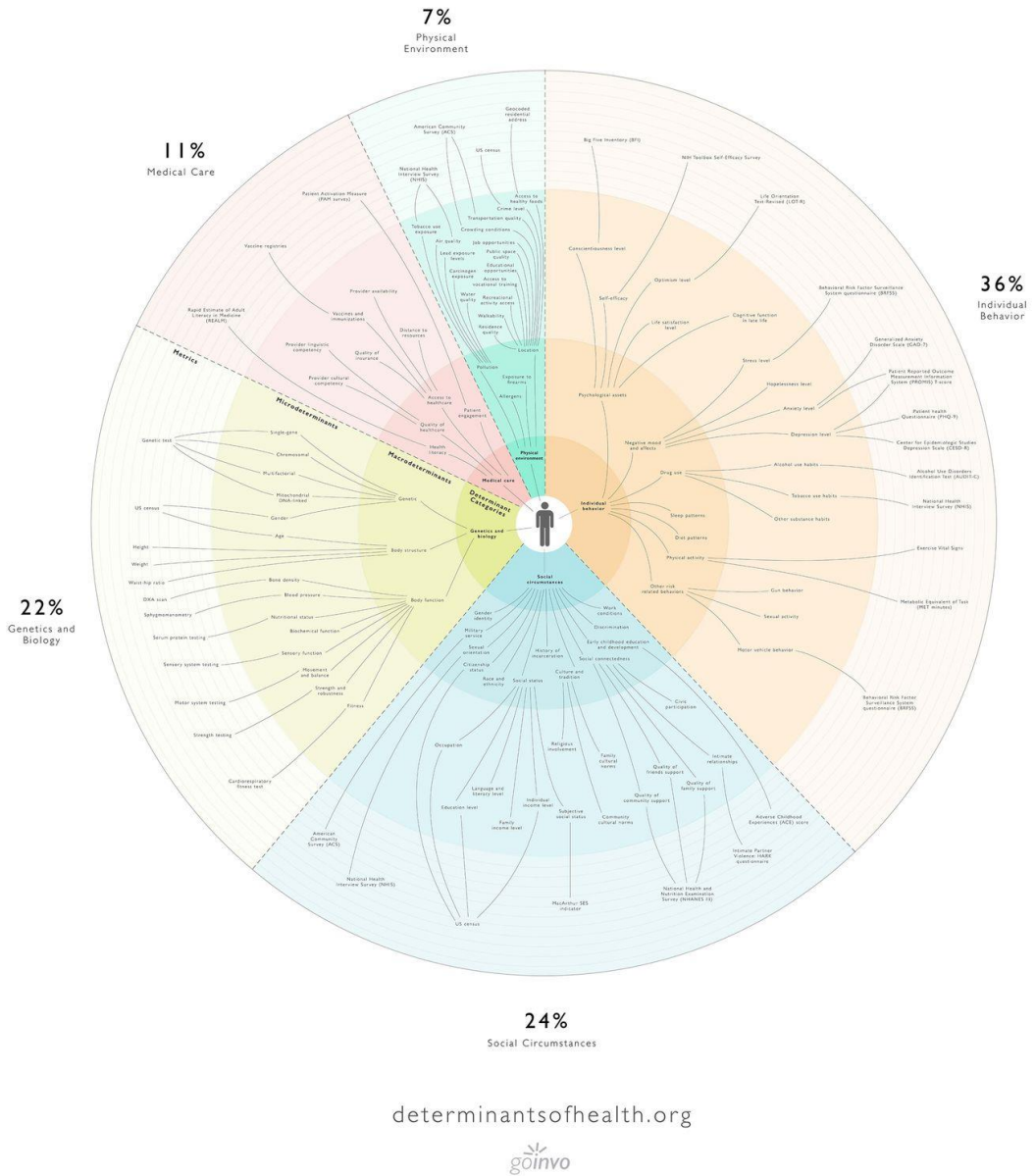
Social determinants of health

- **Housing and Personal Safety**
- **Utility Payment Assistance**
- **Access to Nutritious Food**
- **Transportation**
- **Education and Employment**
- **Family and Community Support**
- **Financial Services**
- **Substance Use Treatment**
- **Mental Health and Disability Supports**

What are the social determinants of health (SDoH)?

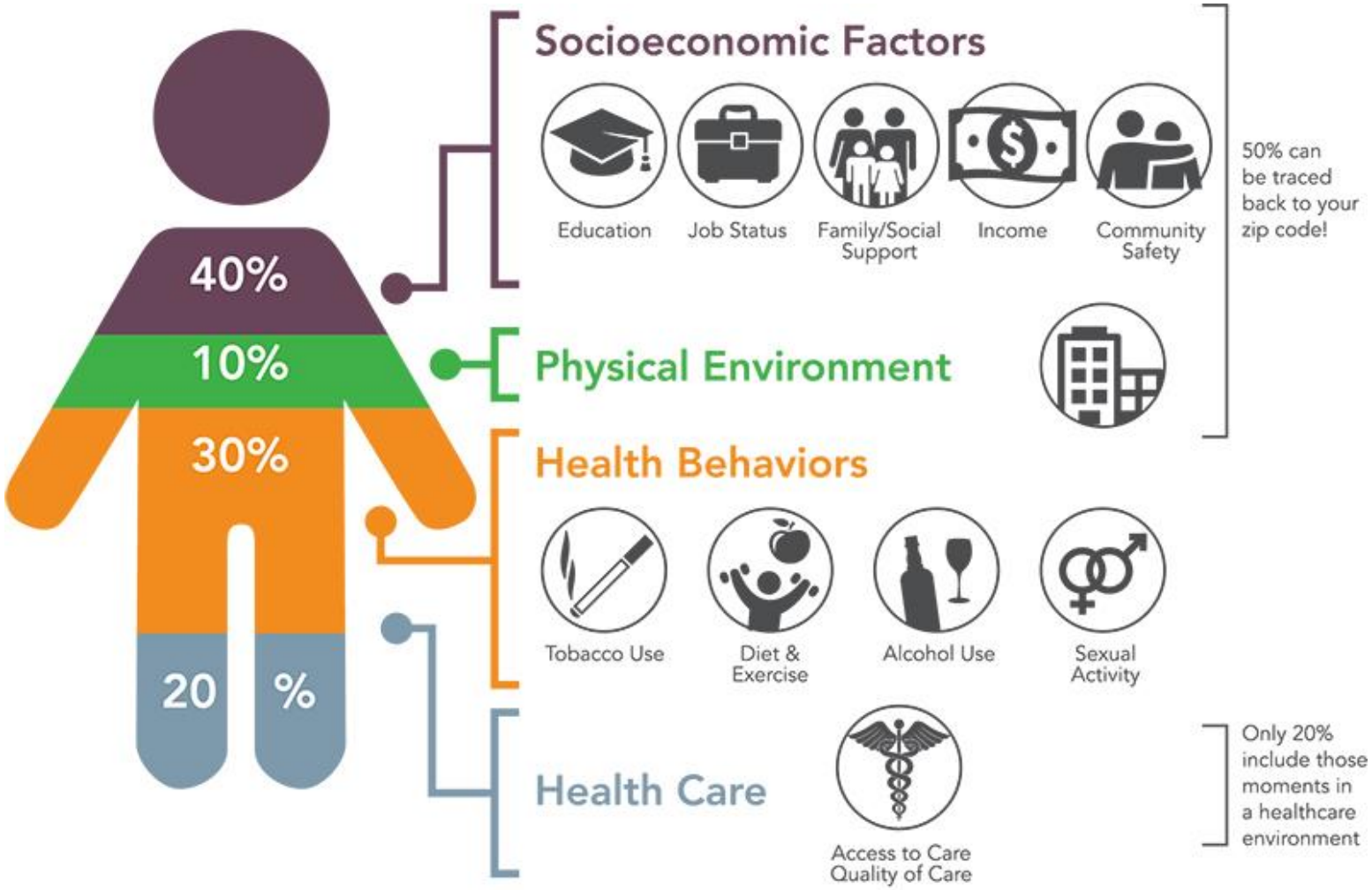
Social Determinants of Health

- **Social Connectedness**
  - Civic Participation
  - Intimate Relationships
  - Quality of Family Support
  - Quality of Friends Support
  - Quality of Community Support
- **Social Status**
  - Subjective Social Status
  - Individual Income Level
  - Language and Literacy Level
  - Education Level
  - Occupation
- **Culture and Tradition**
  - Religious Involvement
  - Community Cultural Norms
  - Family Cultural Norms
- **Race and Ethnicity**
- **Citizenship Status**
- **Sexual Orientation**
- **Military Service**
- **Gender Identity**
- **History of Incarceration**
- **Discrimination**
- **Work Conditions**



https://www.goinvo.com/vision/determinants-of-health/

Social Determinants of Health



Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

Possible solutions

“Next Generation” Strategies to Integrate SDOH

Medicaid programs are driving the next generation of efforts to address social service needs within an integrated platform—delivering on “whole person care.”

- ✓  Identifying beneficiaries with social needs (as a first step)
- ✓  Embedding SDOH into care management/care coordination platforms
-  Supporting sustainable investments in social interventions
-  Building a “provider network” of social service organizations
-  Evaluating the effectiveness of SDOH interventions on health outcomes and healthcare costs

Social determinants of health screening tools

Centers for Medicare and Medicaid Services (CMS) Accountable Health Communities (AHC) Categories Include:

- Housing Instability
- Food Insecurity
- Transportation Needs
- Utility Needs
- Interpersonal Safety

Box 1 | Accountable Health Communities Core Health-Related Social Needs Screening Questions

Underlined answer options indicate positive responses for the associated health-related social need. A value greater than 10 when the numerical values for answers to questions 7-10 are summed indicates a positive screen for interpersonal safety.

Housing Instability

1. What is your housing situation today?

- ☐ I do not have housing (I am staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
- ☐ I have housing today, but I am worried about losing housing in the future.
- ☐ I have housing

2. Think about the place you live. Do you have problems with any of the following? (check all that apply)

- ☐ Bug infestation
- ☐ Mold
- ☐ Lead paint or pipes
- ☐ Inadequate heat
- ☐ Oven or stove not working
- ☐ No or not working smoke detectors
- ☐ Water leaks
- ☐ None of the above

Food Insecurity

3. Within the past 12 months, you worried that your food would run out before you got money to buy more.

- ☐ Often true
- ☐ Sometimes true
- ☐ Never true

4. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.

- ☐ Often true
- ☐ Sometimes true
- ☐ Never true

Transportation Needs

5. In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living? (Check all that apply)

- ☐ Yes, it has kept me from medical appointments or getting medications
- ☐ Yes, it has kept me from non-medical meetings, appointments, work, or getting things that I need
- ☐ No

Utility Needs

6. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?

- ☐ Yes
- ☐ No
- ☐ Already shut off

Interpersonal Safety

7. How often does anyone, including family, physically hurt you?

- ☐ Never (1)
- ☐ Rarely (2)
- ☐ Sometimes (3)
- ☐ Fairly often (4)
- ☐ Frequently (5)

Social Determinants of Health Screening Tools

PRAPARE

The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) is a national effort to help health centers and other providers collect the data needed to better understand and act on their patients' social determinants of health. As providers are increasingly held accountable for reaching population health goals while reducing costs, it is important that they have tools and strategies to identify the upstream socioeconomic drivers of poor outcomes and higher costs. With data on the social determinants of health, health centers and other providers can define and document the increased complexity of their patients, transform care with integrated services and community partnerships to meet the needs of their patients, advocate for change in their communities, and demonstrate the value they bring to patients, communities, and payers.

http://www.nachc.org/wp-content/uploads/2018/05/PRAPARE_One_Pager_Sept_2016.pdf

Personal Characteristics

1. Are you Hispanic or Latino?

☐	Yes	☐	No	☐	I choose not to answer this question

2. Which race(s) are you? Check all that apply.

☐	Asian	☐	Native Hawaiian
☐	Pacific Islander	☐	Black/African American
☐	White	☐	American Indian/Alaskan Native
☐	Other (please write):		
☐	I choose not to answer this question		

3. At any point in the past 2 years, has season or migrant farm work been your or your family's main source of income?

☐	Yes	☐	No	☐	I choose not to answer this question

4. Have you been discharged from the armed forces of the United States?

☐	Yes	☐	No	☐	I choose not to answer this question

5. What language are you most comfortable speaking?

☐	English
☐	Language other than English (please write)
☐	I choose not to answer this question

Family & Home

6. How many family members, including yourself, do you currently live with? _____

☐	I choose not to answer this question

7. What is your housing situation today?

☐	I have housing
☐	I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)
☐	I choose not to answer this question

8. Are you worried about losing your housing?

☐	Yes	☐	No	☐	I choose not to answer this question

9. What address do you live at?

Street:_____
City, State, Zipcode: _____

Money & Resources

10. What is the highest level of school that you have finished?

☐	Less than high school degree	☐	High school diploma or GED
☐	More than high school	☐	I choose not to answer this question

11. What is your current work situation?

☐	Unemployed	☐	Part-time or temporary work	☐	Full-time work
☐	Otherwise unemployed but not seeking work (ex: student, retired, disabled, unpaid primary care giver) Please write:				
☐	I choose not to answer this question				

12. What is your main insurance?

☐	None/uninsured	☐	Medicaid
☐	CHIP Medicaid	☐	Medicare
☐	Other public insurance (not CHIP)	☐	Other Public Insurance (CHIP)
☐	Private Insurance		

“Next Generation” Strategies to Integrate SDOH

Medicaid programs are driving the next generation of efforts to address social service needs within an integrated platform—delivering on “whole person care.”

Identifying beneficiaries with social needs (as a first step)

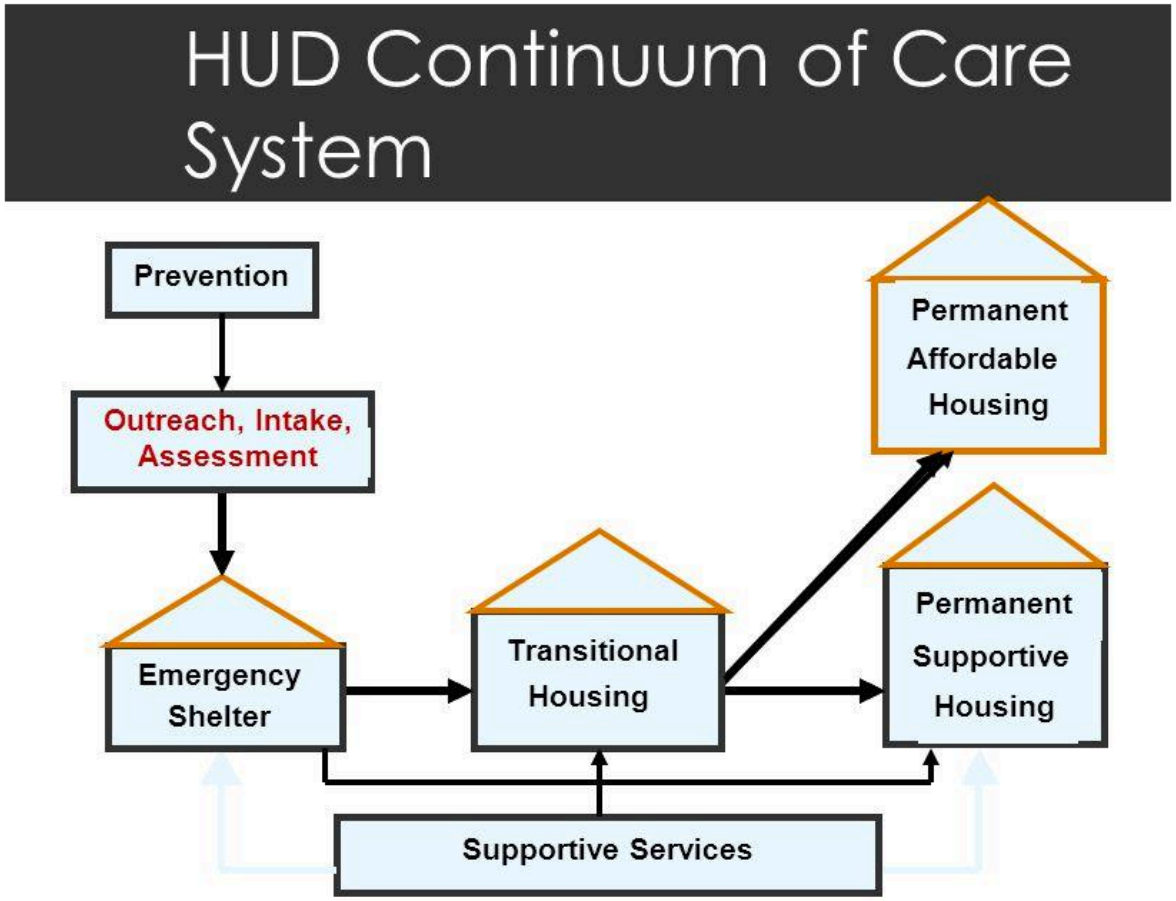
Embedding SDOH into care management/care coordination platforms

Supporting sustainable investments in social interventions

Building a “provider network” of social service organizations

Evaluating the effectiveness of SDOH interventions on health outcomes and healthcare costs

Building a provider network



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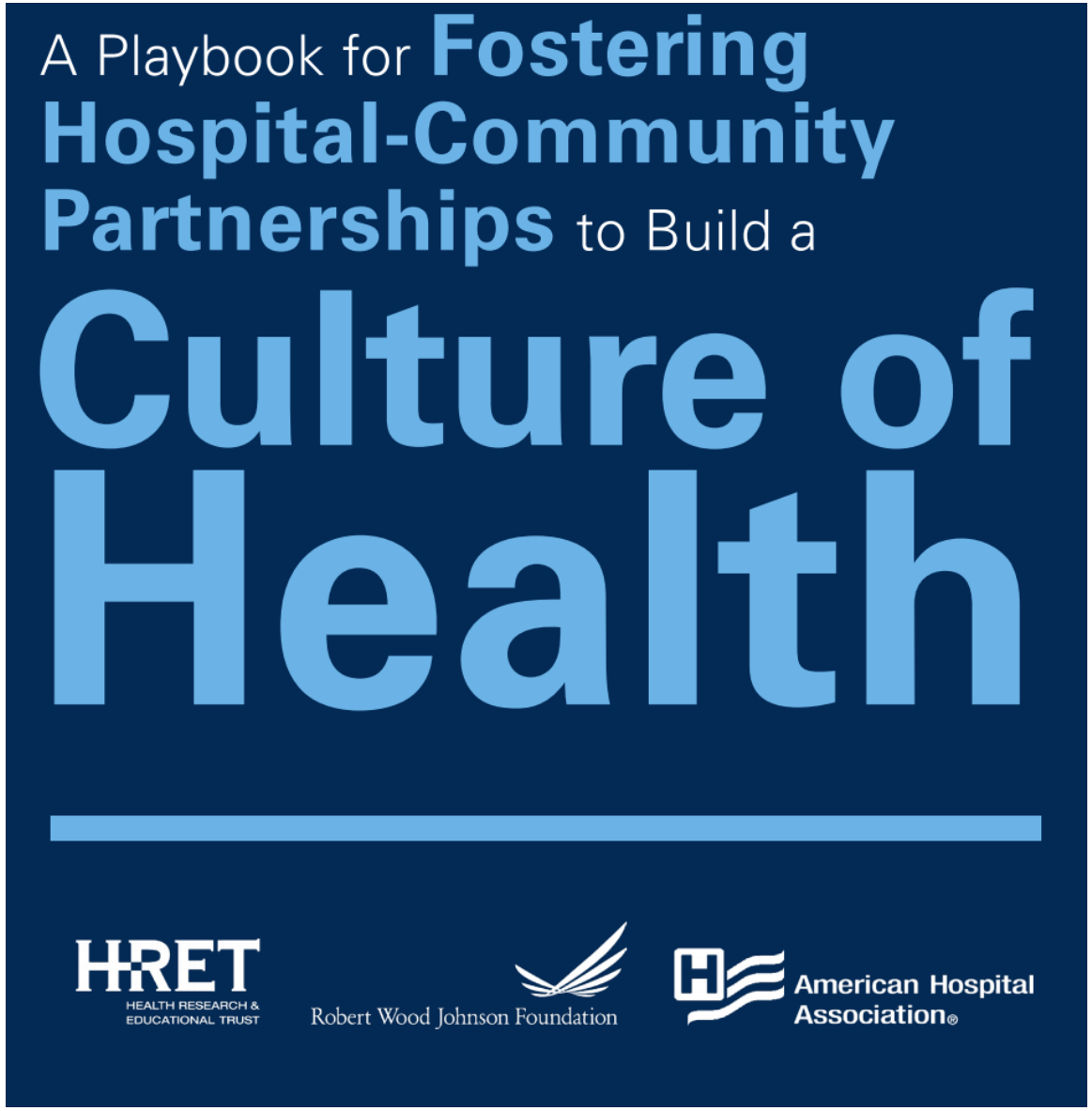
Hospital-community partnerships

Hospital-community partnerships

https://patientengagementhit.com/news/understanding-health-equity-in-value-based-patient-care

Hospital-community partnerships



"Community partners can also help account for the clinical care, socioeconomic, behavioral, and environmental **factors driving health**."

https://patientengagementhit.com/news/aha-playbook-details-community-healthcare-partnerships

https://www.aha.org/ahahret-guides/2017-07-27-playbook-fostering-hospital-community-partnerships-build-culture-health

Hospital-community partnerships

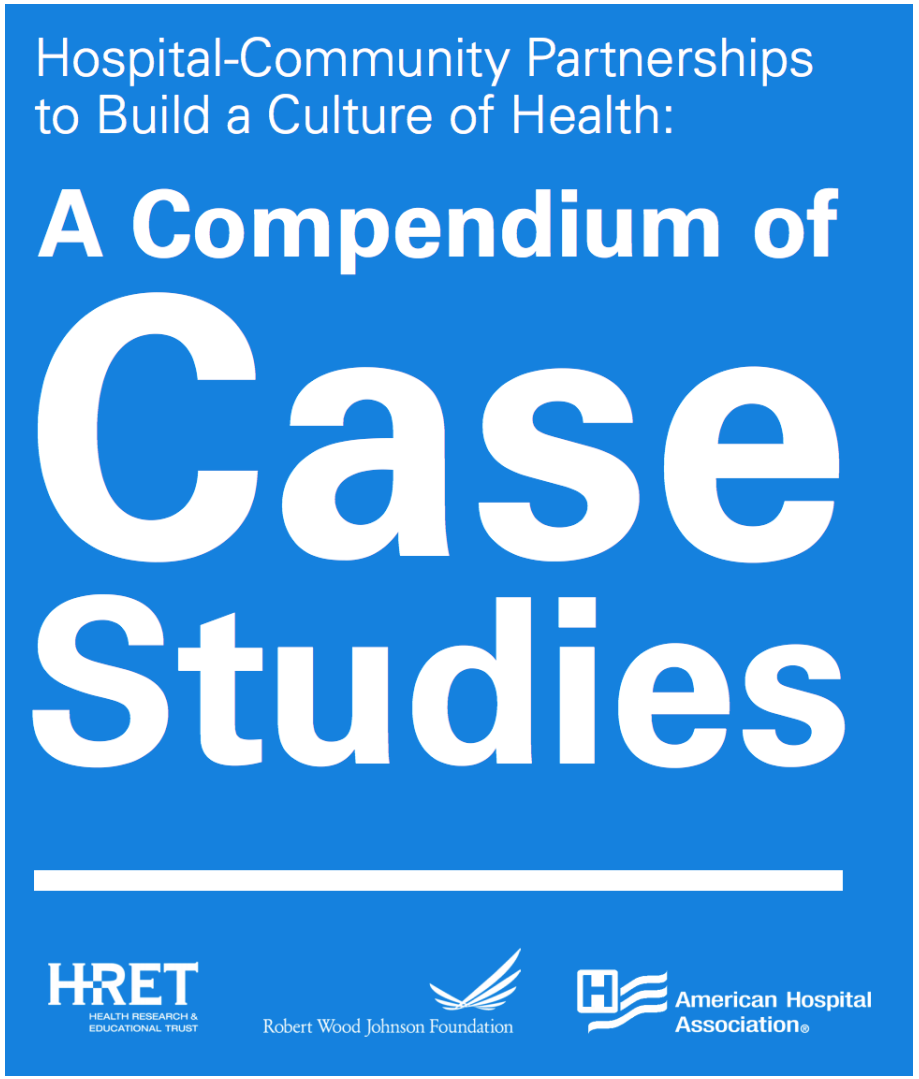
Community health needs assessment

"Community health needs assessments are not conducted solely for the purpose of meeting the IRS regulations. The true reason for conducting them is to demonstrate the needs within the community that a hospital then prepares some of its programs around.

For example, if a hospital uncovers a significant homeless population within the community, the organization should work on hospital and community partnerships that would meet that need. These programs might include clinic vans or collaborations with health departments to offer free clinic days. Solutions will largely depend on the specific needs of the community."

https://patientengagementhit.com/news/how-to-create-and-conduct-community-health-needs-assessments

Hospital-community partnerships



https://www.aha.org/system/files/hpoe/Reports-HPOE/2017/hospital-community-partnerships-case-study-compendium.pdf

Key takeaways from the playbook include:

- Partnerships share valuable assets such as resources, tools and expertise.
- Hospital-community partnerships are necessary to address community health issues nonclinically.
- The process of identifying partners and assets and developing an action plan can be simplified by incorporating structured activities and exercises.
- Aligned goals, transparent communication and strong leadership can drive a partnership to measurable success.
- Leveraging strengths and identifying weaknesses in a partnership help overcome challenges.
- Evaluating, reflecting on and celebrating progress strengthen a partnership and accelerate momentum.
- Sustainable partnerships are established by including more innovative strategies and practical tools in existing practices.

Hospital-community partnerships

Payer sponsored initiatives

Private health plan initiatives

Private health plan driven initiative

Costs Fell by 11% When Payer Addressed Social Determinants of Health

WellCare Health Plans | Healthy Connections

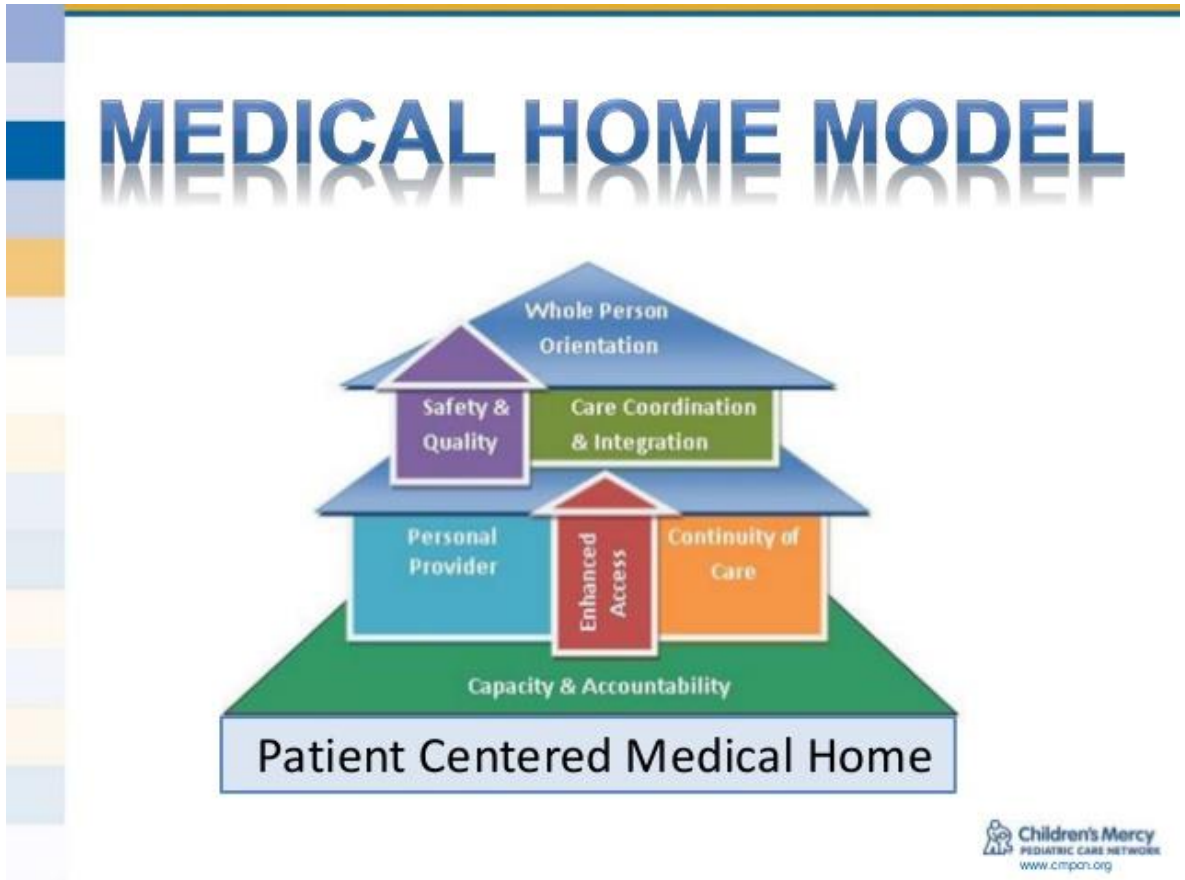
https://healthitanalytics.com/news/costs-fell-by-11-when-payer-addressed-social-determinants-of-health

Private health plan driven initiative

83 Intermountain Clinics Become Patient-Centered Medical Homes

Intermountain Healthcare

RECOGNIZED NCQA PATIENT-CENTERED MEDICAL HOME



https://healthitanalytics.com/news/83-intermountain-clinics-become-patient-centered-medical-homes

Public insurance (Medicare and Medicaid) plan initiative

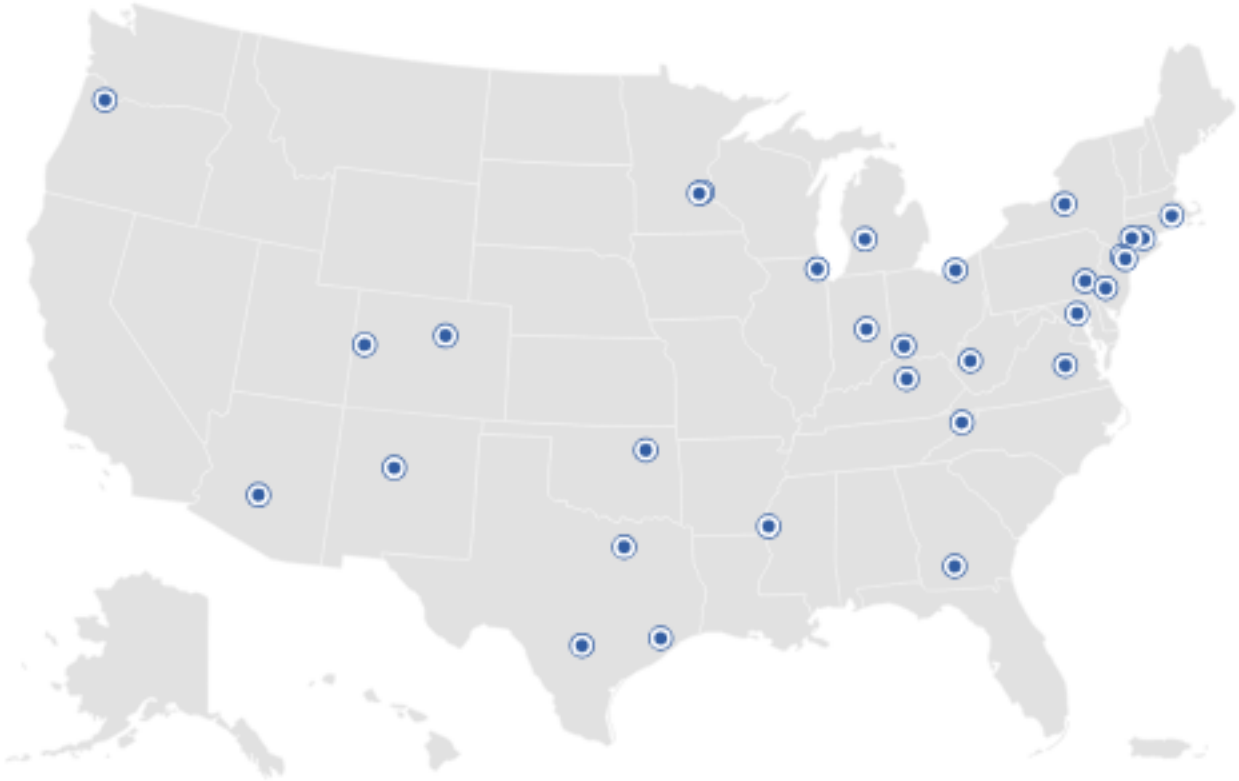
Accountable health communities

What is CMS' AHC Initiative?

January 2016 – CMS announced $157 million in funding for this initiative over 5 years

"The Accountable Health Communities Model addresses a critical **gap between clinical care and community services** in the current health care delivery system by testing whether systematically identifying and addressing the health-related social needs of Medicare and Medicaid beneficiaries' through **screening, referral, and community navigation services** will impact health care costs and reduce health care utilization.

Funds for this model support the **infrastructure and staffing needs of bridge organizations**, and do not pay directly or indirectly for any community services (e.g., housing, food, violence intervention programs, utilities, or transportation)."

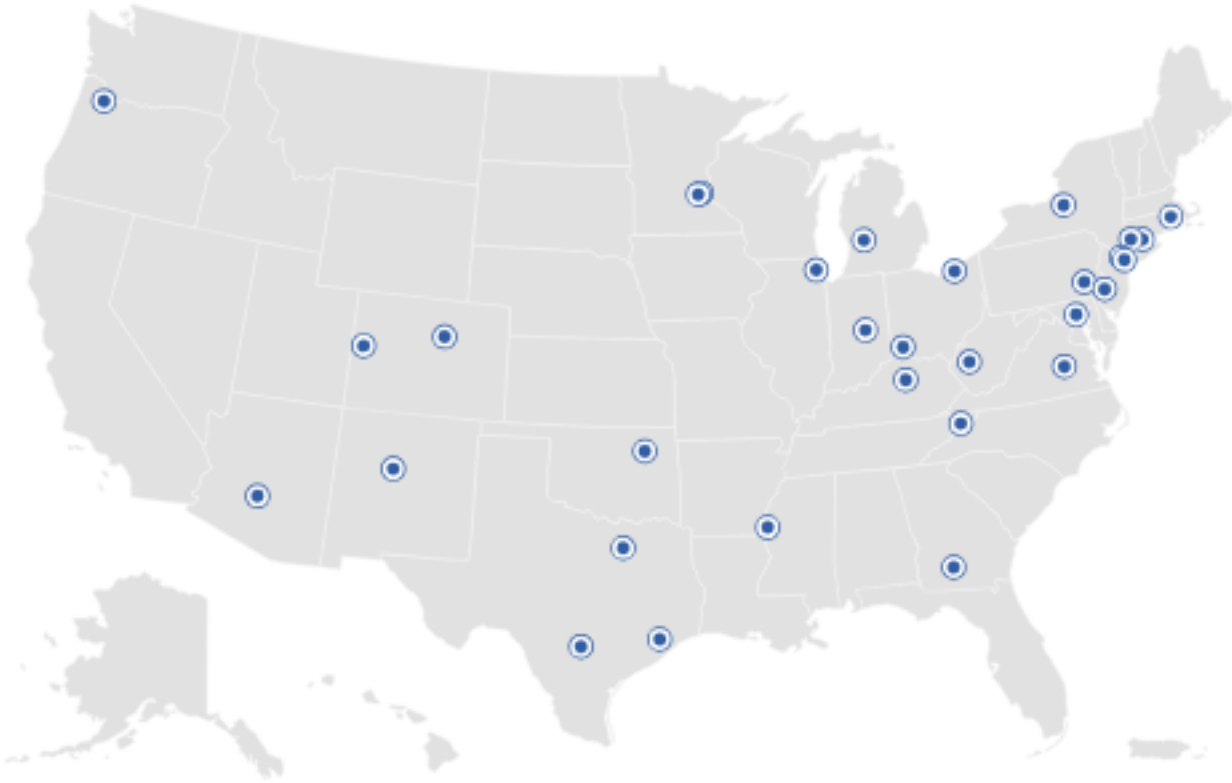


Source: Centers for Medicare & Medicaid Services

https://dhhr.wv.gov/News/Pages/West-Virginia-Selected-by-CMS-for-Accountable-Health-Communities-Model-.aspx
https://innovation.cms.gov/initiatives/ahcm/

Accountable Health Communities

Washington State Health Care Authority



Source: Centers for Medicare & Medicaid Services

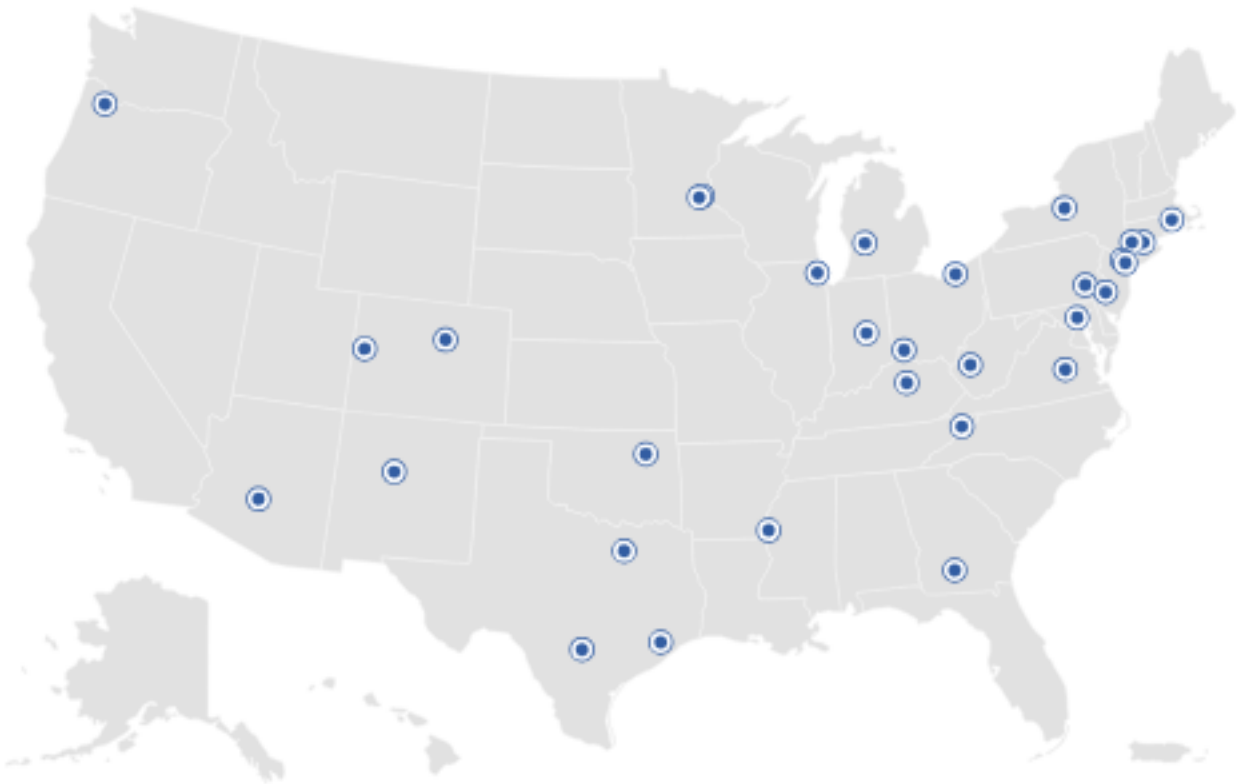
https://www.hca.wa.gov/about-hca/healthier-washington/accountable-communities-health-ach

Accountable Health Communities

THE HEALTH COLLABORATIVE

2-1-1™
Get Connected. Get Answers.
United Way of Greater Cincinnati

CMS Awards
$4.51m



Source: Centers for Medicare & Medicaid Services

http://healthcollab.org/cms-accountable-health-communities-model-selects-cincinnati-to-link-clinical-and-community-services/

Accountable communities of health

What is the ACH Initiative?

Accountable health approaches (often called Accountable Communities for Health or Accountable Health Communities) offer, in varying degrees, an integrated approach to the health (prevention and public health), health care, and social needs of individuals and communities in order to **improve health outcomes, reduce costs, and resolve upstream factors that affect health**. In a value-based purchasing environment, accountable *care* holds providers responsible for better management of clinical conditions in a patient population; **accountable *health* holds multiple sectors** (including health and health care) **responsible for the health of a community.**

A common observation is that **building relationships and trust at the local level takes considerable effort and time**, much more than the three years often provided under grants. When forming partnerships between and among clinical health care services and community-based organizations to serve high-risk populations, different organizations **need time** to discover and **articulate their spheres of accountability and measures of success most relevant to their sector**, as well as **build collaborative skills** and leadership support.

Sound familiar?

Accountable Communities of Health

Principles for Accountable Health - Changing Organizations Evolving Over Time:

I. A **"backbone" organization** which serves as convener and integrator for a defined geographic area; that organization (or another) could also serve as the fiduciary agent.

II. A **governance structure** with respected community leaders builds on a history of collaboration in addressing the health of the community while engaging a diverse consumer perspective.

III. Effective **cross-sector alignment** is evident among health care providers, health plans, public health, community and social services, education, business and labor.

IV. Active engagement of community leaders and stakeholders in establishing **a shared vision, goals, and agenda**, with full community engagement in decision making regarding the use of resources and investment in building community capacity for this shared decision making.

V. An ACH is responsible for improving the health of the entire community, however certain conditions or **target populations may be the focus of interventions for joint action**.

VI. **Data systems** are aligned across sectors and participants for **planning, coordination of care and services across a continuum of health and social determinants**, and for quality improvement and evaluation. Essential data for decision making will be accessible to all participants. Each sector will establish measures of accountability for contributions to resolving community needs.

VII. A business case and **return on investment** is defined for all sectors engaged in the ACH. Investments may be long term or short term.

VIII. Participating organizations **use evidence to collaboratively identify and address issues** that require policy, regulatory, and systems change.

IX. **Multiple funding sources** are made available for sustainability of the ACH efforts.

X. Accountable Communities are **engaged in continuous learning** as efforts to improve the health of the community and health equity evolve over time.

http://accountablehealth.gwu.edu/funders-forum/principles-accountable-health

Parallels with continuum of care infrastructure

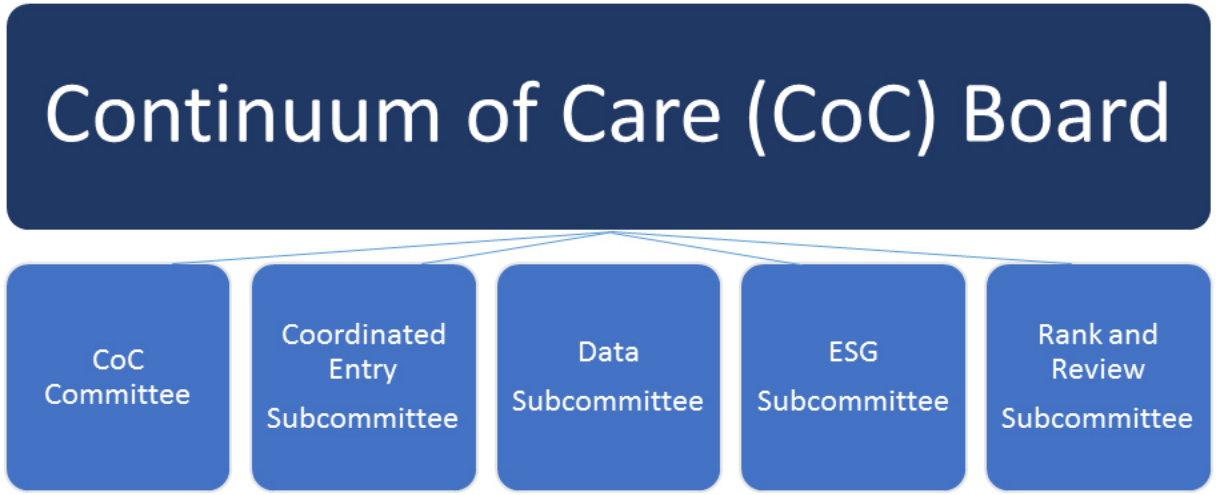
Accountable Health Community	Continuum of Care
Backbone organization	CoC lead
Governance structure	CoC board, governance committee
Cross-sector alignment	Housing services providers and wrap around services
Shared vision, goals, agenda	End homelessness
Target population to focus intervention for joint action	People experiencing, or at risk of experiencing, homelessness
Data system for coordination of services	HMIS – HMIS lead
Long and short-term investments	PSH, ESG, HMIS
Use evidence to collaboratively identify and address issues	AHAR, LSA, APR
Multiple funding sources	HUD, VA, SAMSHA, ACF, local
Continuous learning and optimization	Annual updates to data collection and reporting

Parallels with continuum of care infrastructure

Continuum of Care Plan

Comprehensive

- It is a long range strategic plan to address homelessness that is updated annually.
- It sets realistic short- and long-term goals and accomplishments.
- It should be tied to the local Consolidated Plan and other local planning efforts.
- All eligible resources are identified and utilized to address homelessness, not just HUD funds.



Target population: People experiencing homelessness

Housing: The most important social determinant of health?

People experiencing homelessness are 3 times more likely to use an Emergency Department than the general public

Nearly 75% of inpatient stays by people experiencing homelessness began in the ED compared with 50% of general public

Individuals experiencing homelessness or housing instability account for some, but not necessarily all, of the five percent of individuals contributing to 50 percent of all healthcare spending.

Patients with housing instability are more likely to be admitted to an acute care hospital for an average of **one to four days**, costing up to **$4,000 per stay**, AHA reported. In 2015, children under four living with housing instability cost the industry $238 million, the organization added.

https://www.hcup-us.ahrq.gov/reports/statbriefs/sb229-Homeless-ED-Visits-2014.jsp
https://www.csh.org/wp-content/uploads/2015/10/Frequent-User-Initiative-Profile-Booklet-10th-Decile-Project-Final.pdf
https://www.aha.org/ahahret-guides/2017-07-27-playbook-fostering-hospital-community-partnerships-build-culture-health

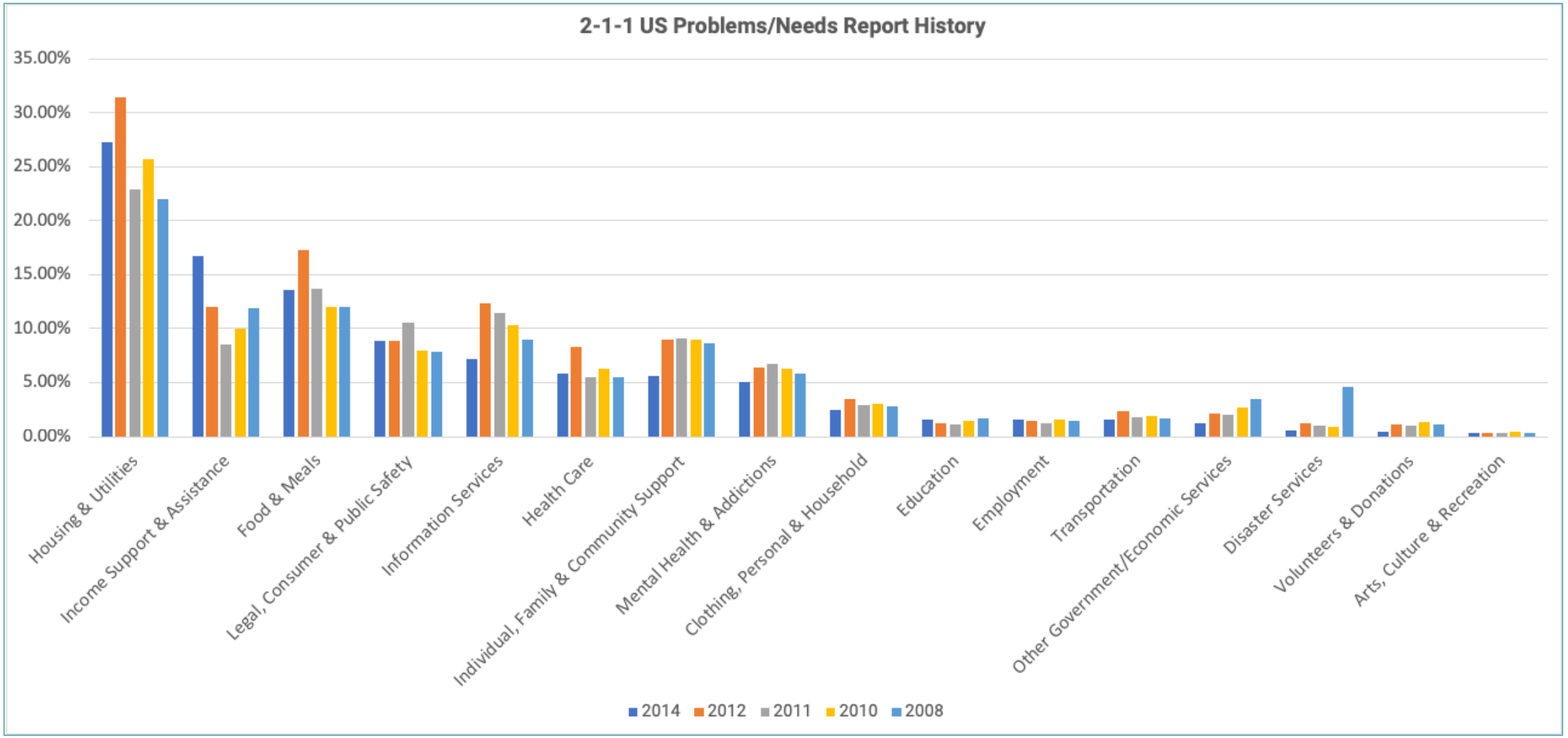
Housing: The most important social determinant of health?

How Housing Support Addresses the Social Determinants of Health

- Offering housing support and addressing other social determinants of health can create **thousands of dollars in cost savings**
- Homeless patients are more susceptible to infectious diseases such as HIV/AIDS, pneumonia, and tuberculosis because of their living conditions. They are also more liable for **mental illness and substance abuse disorder** because of their living conditions.
- The **homeless population is aging.** As individuals age, they naturally fall into a **series of chronic illness**, such as COPD, diabetes, cardiovascular disease, and some cognitive conditions such as Alzheimer's and dementia. Patients experiencing homelessness also suffer from **increased stress, depression, and anxiety levels**.
- Patients often can't do anything about these conditions, making matters worse. These patients usually can't afford primary and preventive care or chronic care management tools.
- Ultimately, **supporting housing and social needs** of patients can result in **cost savings ranging from $9,000 and $30,000 per person per year**, depending upon the level of outreach and severity of need.

https://patientengagementhit.com/news/how-housing-support-addresses-the-social-determinants-of-health

Housing: The most important social determinant of health?



Housing: The most important social determinant of health?

Permanent Supportive Housing Reduces Healthcare Spending

Numerous studies, many conducted recently, have sought to document the costs and benefits of supportive housing in the U.S. The majority have documented how PSH reduces the use of publicly funded crisis services, including **jails**, **hospitalizations, and emergency departments**.

A chronically homeless person costs the taxpayer an average of **$35,578 per year**. Costs on average are **reduced by 49.5%** when they are placed in supportive housing. Supportive housing costs on average $12,800, making the **net savings roughly $4,800 per year**.

https://endhomelessness.org/resource/ending-chronic-homelessness-saves-taxpayers-money/
http://www.flhousing.org/wp-content/uploads/2014/10/Components-of-an-Effective-Housing-Crisis-Response-System2-01-e1502285833741.jpg

Academic research abounds

Studies show …

- 2003-2006 Study in Chicago: Housing and Case Management reduced ED visits by 24% and hospitalizations by 29%
  - https://www.ncbi.nlm.nih.gov/pubmed/19417194

- 2007 Study from Australia: “Treating homelessness as a combined health and social issue is critical to improving the abysmal health outcomes of people experiencing homelessness. In addition, the enormous economic costs of hospital care for people who are homeless can be reduced when housing and other social determinants are taken into account.”
  - https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5750953/

Academic Research Abounds

Housing can help alleviate the cost burden on the system while improving health outcomes

- 2017: Housing for Health – LA County
  - $1 invested in housing = $1.20 saved in health care and other social service costs
  - Use of both medical and mental health services dropped substantially among the group. After moving into permanent supportive housing, participants made an average of 1.64 fewer emergency room visits in the ensuing year and inpatient hospital stays decreased by more than 4 days.
  - Across all the services examined by researchers, the costs for public services consumed in the year after receipt of permanent supportive housing declined by nearly 60 percent. In the year prior to housing, participants received public services that cost an average of $38,146. That total fell to $15,358 in the year after housing was received. Even after taking into account the costs of permanent supportive housing, savings to the county was about 20 percent.

“These findings suggest that a permanent supportive housing program that targets people who are both homeless and frequent users of county health services is feasible and may save local government money overall.”

https://www.rand.org/news/press/2017/12/05/index1.html

Frequent Users of Health Services Initiative – California 2003-2007

Housing can help alleviate the cost burden on the system while improving health outcomes

The Frequent Users of Health Services Initiative was a five-year, $10 million project jointly funded by The California Endowment and the California HealthCare Foundation. The goal of the *Initiative* was to promote the development and implementation of innovative, integrated approaches to addressing the comprehensive health and social service needs of frequent users of emergency departments. *Initiative* funding supported a program office for six years, and funded six one-year planning grants, six implementation grants, technical assistance to the planning and implementation grantees, and an external process and outcome evaluation of both the planning and implementation grants.

"Overall, clients connected to PH showed greater reductions in both ED use and charges compared to those who remained homeless or in less stable housing arrangements (a 34% reduction compared to a 12% reduction in ED visits, a 32% reduction compared to a 2% reduction in ED charges)."

https://www.chcf.org/wp-content/uploads/2017/12/PDF-FUHSIEvaluationReport.pdf

Frequent Users of Health Services Initiative – California 2003-2007

Housing can help alleviate the cost burden on the system while improving health outcomes

There is evidence of the success of the Frequent Users of Health Services Initiative, both in terms of the impact on individuals and the impact on grantee communities. In addition to the successes achieved and documented on the individual and organizational levels, the grantees' experiences and lessons learned through the course of implementation provide understanding about the ongoing challenges to serving frequent users, developing successful partnerships and demonstrating the value and impact of a frequent user program. Achieving success with frequent users requires significant financial investment, intensive health and behavioral health interventions, small caseload sizes, resources and capacity in the community, partnership across systems of care, and an understanding that the issues faced by the frequent user population are complex. Treatment solutions will require long-term vision and commitment.

Discharge Planning is Key

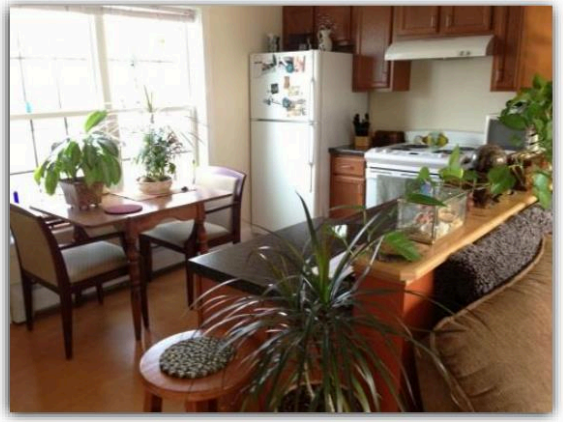
Patients connected to housing saw a DECREASE in costs associated with inpatient stays of 27%, while those not connected to housing saw an INCREASE of 49%.

In terms of inpatient outcomes among homeless clients, clients connected to housing and clients not connected to housing fared similarly in terms of reductions in the number of inpatient admissions (27% connected vs. 23% not connected). However, those connected to housing showed significantly greater reductions in the number of inpatient days (a 27% *decrease* for those connected vs. a 26% *increase* for those not connected) and inpatient charges (a 27% *decrease* for those connected vs. a 49% *increase* for those not connected). The difference between connected and not-connected homeless clients for inpatient days and charges is likely related to the discharge planning issues hospitals face with homeless patients.

Medical Respite Programs

Circle the City
healthcare for the homeless

- Community-Based Homeless Health Outreach
  - Homeless Primary and Preventative Care
  - Homeless Medical Respite Care
- Permanent Housing Partnerships

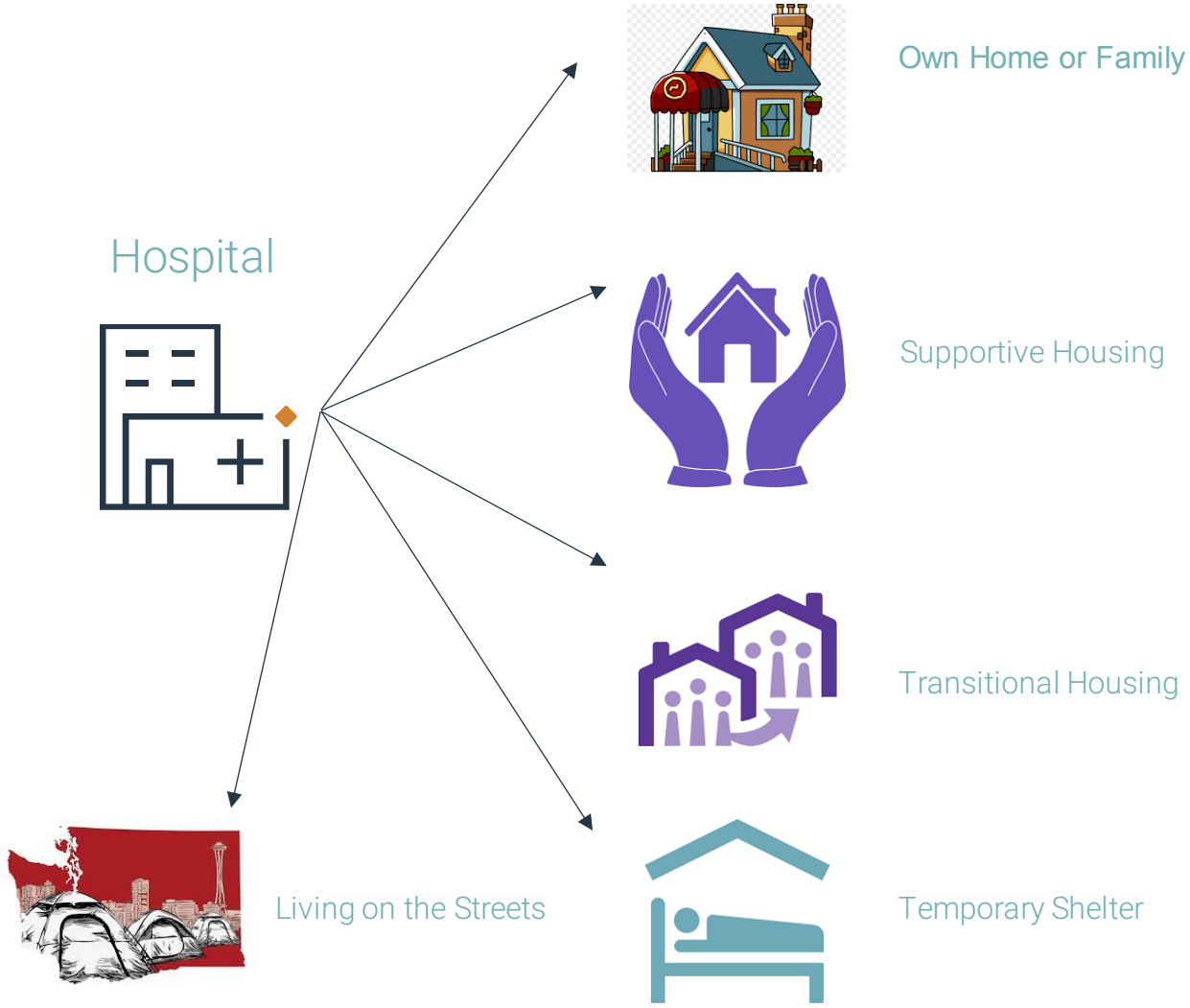


Frequent User Engagement (FUSE) Outcomes

- Housing Retention
  - 93%
- ER Utilization
  - 73.8% reduction in ER visits
  - 74.7% reduction in ER costs
- Hospital Inpatient
  - 47.2% reduction in-patient days
  - 36.6% reduction in-patient costs
- Jail
  - 100% reduction in jail days

https://static1.squarespace.com/static/56ec8d2562cd9413e14c0019/t/5bb7a8c68165f5a569939213/1538762954592/AZPHA+Workshop+Homelessness.pdf

Patient destinations post-hospital discharge



Post-discharge activities

- Attend follow up appointments
- Medication compliance
- Home health services
- Rehabilitation services
- Hospice care
- Adherence to dietary guidance

Health related social needs (CMS)

- Living situation
- Food
- Transportation
- Utilities
- Personal safety
- Financial
- Employment
- Family/community support
- Education
- Physical activity
- Substance use
- Mental health
- Disability

Don’t Take My Word For It

http://ngahousingroadmap.cwsit.org/housingroadmap.pdf

Inventory of Active Projects Connecting Health and Housing

This is a partial list of active projects/investments

- AmeriHealth Caritas Invests $250K in Housing and Support Services to Improve Health Outcomes in Washington, DC
  https://www.businesswire.com/news/home/20180329006201/en/AmeriHealth-Caritas-Invests-150K-Housing-Support-Services

- Kaiser Permanente To Invest $200 Million Into Community-Based Efforts to Tackle Natinoal Homeless Crisis
  https://www.openminds.com/market-intelligence/news/kaiser-permanente-to-invest-200-million-into-community-based-efforts-to-tackle-national-homeless-crisis/

- United Health Foundation Awards $1 Million Partnership Grant to Circle the City
  https://www.businesswire.com/news/home/20180510006122/en/United-Health-Foundation-Awards-1-Million-Partnership

- Medicaid Plan UPMC Partners with Community Human Services in Allegheny County
  http://www.post-gazette.com/news/health/2018/08/13/UPMC-for-You-Community-Human-Services-homeless-Medicaid/stories/201808130126

About WellSky

Trends defining the next decade

1. **A rapidly aging population**
   Care is shifting its focus from the hospital and other institutions towards less expensive settings.

2. **Value-based reimbursement**
   Providers are focused on patient outcomes, calling for investments in preventative care.

3. **Machine learning/applied insights**
   Care decisions can be informed by real-time predictive and prescriptive algorithms.

We partner with organizations across the care spectrum

Hospital:
Ensuring hospitals can focus on delivering superior patient care safely and efficiently

Practices & Facilities:
Enhancing providers' abilities to streamline operations and focus on the delivery of care

Home:
Empowering providers to deliver exceptional care while focusing on improving outcomes

Community:
Supporting dynamic communities of care with our diverse set of human services solutions

WellSky Client Networks

2-1-1 Contact Centers

2-1-1 connects people to community resource specialists who help people find local services in the following areas:

- Supplemental food and nutrition programs
- Shelter and housing options and utility assistance
- Employment and education opportunities
- Services for veterans
- Health care, vaccination and health epidemic information
- Addiction prevention and rehabilitation programs
- Reentry help for ex-offenders
- Support groups for individuals with mental illness or special needs
- A safe, confidential path our of physical and/or emotional domestic abuse

*www.211.org

HUD Continuum of Care Networks

"The Continuum of Care (CoC) Program is designed to promote communitywide commitment to the goal of ending homelessness; provide funding for efforts by nonprofit providers, and State and local governments to quickly rehouse homeless individuals and families while minimizing the trauma and dislocation caused to homeless individuals, families, and communities by homelessness; **promote access to and effect utilization of mainstream programs by homeless individuals and families;** and optimize self-sufficiency among individuals and families experiencing homelessness."*

CoC Member organizations are in large part the organizations to which 2-1-1 will refer its callers who are in need of the services listed to the left.

Stay connected to your clients with the **WellSky Community Services mobile app**

Request a consultation today!

WellSky

Thank you

Contact us:
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Vice President of Community Solutions
Gabe.Cate@wellsky.com