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White paper

Partnerships between CoCs & health care entities

How they enhance coordinated care, leading to sustainable, successful outcomes for the homeless population

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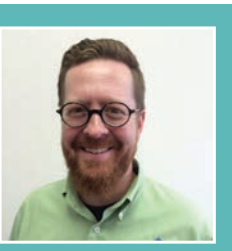


About the author

Gabriel (Gabe) Cate is responsible for strategic growth initiatives and partnerships across WellSky's Human and Social Services group focused on County and Local Government, coordinating care coalitions, and community-based organizations. Previously, Gabe served as the Chief Operating Officer at Bowman Systems, LLC, which had developed the first commercially available HMIS system in the industry and was acquired by WellSky in 2016. Gabe has presented to conferences on topics ranging from social determinants of health to technical solutions for data integration challenges.

For every human being, from cradle to grave, life is better lived within a support system. That support system starts with family and friends, and extends to educators, health care professionals, clergy, community leaders and many, many more. No group of people is more vulnerable and in need of a comprehensive support system, which includes both health and community-based care, than people experiencing homelessness.

Those who work in HUD's Continuum of Care (CoC) networks know this more keenly than almost anyone. A large aspect of their mission is to build and lead that support system for the homeless population. CoCs work with multiple community-based organizations to transcend silos and provide coordinated care for those living without a home. The ultimate objective is to help them not only find short-term shelter, nutrition, and health care, but also to provide them the systematic support needed to find permanent housing, a job, and the confidence and ability to improve their overall well-being.

CoC organizations have been capturing and aggregating data throughout the nation to help gain a broad perspective on the challenges facing those experiencing homelessness, with the objective of producing improved, sustainable outcomes. Foundational to this effort has been overcoming privacy concerns in order to share meaningful information throughout the network of community

services organizations. The infrastructure CoCs have established to support this activity includes robust participation agreements, data sharing policies, and governance structures that support care coordination among many disparate organizations.

The next step in this evolution of coordinated care is to develop formal partnerships with health care systems and professionals so health outcomes will be improved at a faster pace. CoC organizations and health system providers must have a cooperative and communicative relationship to truly convert homelessness from a short-term challenge into a solution that not only provides housing, but ultimately helps people resume healthier, more independent lives.

Why would health systems want to partner?

Health systems, as well as insurers, have an enormous stake in healthier outcomes and are highly motivated to keep people from unnecessary emergency room use, hospitalization, prescriptions, and chronic treatment while lowering the cost of care and improving outcomes. In 2015, per capita health care spending was $9,024 in the United States, leading all countries. But spending doesn't equal outcomes. The U.S. had more deaths per 100,000 people from preventable diseases and complications than any other country.[1]

Just as CoC professionals understand that the root issues causing homelessness are broader than the lack of housing, health care professionals know that health care is more than just medical care. A staggering 89 percent of health care challenges are outside the clinical context, including 36 percent

CMS Creates Model for Communities

The Center for Medicaid Services announced $157 million in funding for Accountable Health Communities (ACHs) in January, 2016.

ACHs address a critical gap between clinical care and community services 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, according to CMS.

triggered by individual behavior, 22 percent from genetics and biology, seven percent from environment, and 24 percent from social circumstance.[2]

Health care costs are driven higher by super utilizers, one segment of which is the homeless population. Five to 10 percent of Medicare/Medicaid patients account for more than 50 percent of overall health care spending.[3]

An evolving model: Better health care outcomes at lower costs

The health care model is evolving – albeit not at the pace everyone would like – to curtail that spending. The traditional health care model has been "fee-for-service," which is designed to treat a a patient's acute need. The doctor prescribes medication or completes a procedure, but can't account for the underlying determinants of the problem because she has little context to identify those determinants. The payer – private or public insurance – pays for the treatment, regardless of whether the condition gets better or worsens, or whether the patient returns with the same problem, continuing to increase costs.

In contrast, value-based health care focuses on a "fee-for-value" model and long-term outcomes for not only the patient, but for the population for which the health system is accountable. Rather than working in silos, health care providers work in a clinically integrated system using data and electronic medical records as one of several vehicles to communicate and provide more whole-person care. They provide evidenced-based coordinated care and treat not only the acute problem, but the overall health of the individual to prevent future sickness and the advent of chronic diseases.

Value-based care will ultimately lead to bundled payments, costs savings that are shared by the health system and the payers, and partial and global capitation of runaway costs. Patients spend less money out of pocket; health systems are more efficient and generate better outcomes; insurance companies reduce risk and control costs; suppliers align prices with patient outcomes; and society is healthier with lower overall costs.

This model is often supported by an accountable care organization (ACO), a group of doctors, hospitals, and other health care providers, who come together to coordinate high-quality care for the patients they serve. Coordinated care helps ensure that patients, especially the chronically ill, get the right care at the right time, with the goal of avoiding unnecessary duplication of services and preventing medical errors. All providers participating in an ACO share data and context to achieve these objectives. When high-quality care and cost reductions are coupled, the ACO providers share in the cost savings that result from this coordination. ACOs were originally designed by the Centers for Medicare & Medicaid Services (CMS) to provide high-quality medical care to Medicare patients. Today, more and more states are developing ACOs for the Medicaid population, which is one of the primary payers for the homeless population.

Social Determinants of Health (SDoH)

While health care systems are navigating the complexities of transitioning to value-based health care, other factors must be considered. The goals of greater efficiency, lower costs and better outcomes can only be achieved with a broad and deep perspective of all the factors that determine a person's health.

Inequalities in health care especially surface in living conditions, whether they are the physical environment including basic housing or shelter; economic and work environment including employment and income; social environment including race, gender, immigration, and violence; and the service environment including access to health care, social services, and the quality of health care itself.

The variables can largely be categorized as the social determinants of health (SDoH). They 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.[4]

CMS is driving the effort to reduce health inequalities that are caused by these social, non-medical determinants of health by shifting focus to "whole-person care." We must first efficiently identify people who have one or more social needs during the point of clinical care. Then, we need effective care coordination strategies that involve community-based organizations whose missions are to assist people with these social needs, such as housing, transportation, access to healthy food, and more.

Achieving health equity will require sustainable investments into social interventions, including Hospital-Community Partnerships that involve building a "provider network" of social service organizations, similar to what HUD has done through the creation of the CoC provider networks. These strategies will be measured by their effectiveness in improving health outcomes and reducing health care costs.

Homelessness is most prolific SDoH

Lack of housing is the highest negative-impact social determinant of health:

- People experiencing homelessness are three times more likely to use the emergency department than the general public.[5]

- Individuals experiencing homelessness or housing instability account for a significant portion of the five percent of individuals that contribute to 50 percent of all healthcare spending.[6]
- The American Hospital Association reported that 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. In 2015, children under four living with housing instability cost the industry $238 million, the organization added.[7]

Those experiencing homelessness are more vulnerable to infectious diseases, mental illness, and substance-use disorders as a result of their living conditions. Additionally, because the homeless population is aging, they are most susceptible to chronic diseases such as diabetes and heart disease, as well as depression, anxiety, and stress. Ultimately, supporting housing and other 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.

Private Insurance Looks to SDoH to Reduce Costs to Patients

A Health Plan called WellCare HealthConnections, was able to reduce patient costs by factoring in social determinants of health. HealthConnections focuses on addressing the socioeconomic needs of vulnerable patients by referring beneficiaries to community services, such as transportation to appointments or help paying for basic utility services.

To examine the relationship between social determinants of health and healthcare costs, the team compared the change in average healthcare expenses for patients enrolled in the HealthConnections program who had all their social needs met versus a group who didn't have any social needs met. The group that had all their social needs met experienced an 11 percent reduction, or $2,601, in total healthcare costs in the year after social service referrals.

The impact of permanent supportive housing

One of the key solutions is connecting those experiencing homelessness to permanent supportive housing. A chronically homeless person costs the tax payer an average of $35,578 per year for publicly funded services such as the use of crisis services, including jails, hospitalizations, and emergency departments. Costs on average are reduced by 49.5 percent when they are placed in supportive housing. Supportive housing costs on average $12,800, making the net savings roughly $4,800 per year.[8]

According to a 2017 RAND Corporation research report called "Evaluation of Housing for Health Permanent Supportive Housing Program,"[9] Housing for Health in Los Angeles County revealed that every $1 invested in housing saved $1.20 in health care and social service costs. RAND Health, which is the nation's largest independent health policy research program, also concluded the following positive outcomes in the study:

> "Use of both medical and mental health services dropped substantially among the study 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."

The RAND study concluded that "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."

Another successful case was the Frequent Users of Health Services Initiative, a five-year, $10 million project jointly funded by the California Endowment and California Health Care Foundation. The objective was to develop integrated, innovative approaches to address the comprehensive health and social service needs of frequent users of emergency departments.

The initiative concluded that clients connected to permanent housing showed greater reductions in both emergency department use and charges compared to those who remained homeless or in less stable housing arrangements (a 34 percent reduction in emergency department visits for those connected to permanent housing compared to a 12 percent for those not connected; and a 32 percent reduction in emergency department charges for those connected compared to a 2 percent reduction for those who weren't).[10]

Discharge plans make tremendous difference

For people experiencing homelessness who are admitted to a hospital, having a discharge plan connected to permanent supportive housing results in much better outcomes than those not connected. Patients connected to housing saw a decrease of 27percent in costs associated with inpatient stays, while those not connected to housing saw an increase of 49 percent.

Circle the City case

Discharge planning is a key component of the Circle the City community-based homeless outreach program called Frequent User Engagement (FUSE). The program provides homeless primary and preventative care; homeless medical respite care; and permanent housing partnerships. The results speak for themselves:

- 93% housing retention rate
- 73% reduction in ER visits
- 77% reduction in ER costs
- 47% reduction in in-patient stays
- 36% reduction in in-patient costs
- 100% reduction in jail days


60 percent of the overall health of an individual is determined by SDoH

Case Study:

St. John's County CoC and Flagler Hospital foster healthier community outcomes

Value-based coordinated care takes incredible commitment and teamwork from the health system and a range of community partners, particularly for vulnerable populations, such as those experiencing homelessness. They may be unaware that social determinants of health (SDoH) are impacting their physical health, as well as their emotional and mental heath.

According to the New England Journal of Medicine, 60 percent of the overall health of an individual is determined by SDoH, including 40 percent from individual behavior and 20 percent from social and environmental factors.

Flagler Hospital and St. John's County in St. Augustine, FL provide a vivid example of teamwork between a health system and community partners that account for SDoH. Flagler is the sole community hospital, and in 2017 was awarded the lead agency role in the St. John's County Continuum of Care – "Go Live." Flagler fostered partnerships with St. John's County community agencies, Epic Behavioral Healthcare, Azalea Health, and Wildflower Clinic to earn the label of the "healthiest county" in Florida.

The foundation of the partnership started with Flagler Hospital's Community Needs Health Assessment (CHNA), which helped identify opportunities for collaboration on identified community needs.

The physicians at Flagler Hospital not only treat an acute need, but when appropriate, follow up using the St. John's Care Connect Program – the 'hub" of all community resources for St. John's County residents. Patients are put in touch with community-based agencies that address which SDoH are impacting the patient. These agencies include Housing Partnership, Dining with Dignity, St. John's County Social Services for disability and Social Security; Community Action Agency for Financial Assistance; Epic and First Coast Technical College (FCTC).

St. John's Care Connect is the community resource navigation program. It measures resource availability against community needs, recruits necessary community resources, and facilitates communication among and between resources to provide the most comprehensive and effective care for each patient.

The Care Connect Program conducts the universal intake application and integrates community resources into the health care continuum of care. It also coordinates centralized scheduling for community services.

Patients are provided a broad range of services including a medical home for primary care services, dental services, prescription assistance programs; rental assistance, utility payment and transportation assistance; homeless prevention services; access to food banks; and community resource navigation and case management services.

Flagler Hospital was awarded $2.8 million in grant funding over a three-year period toward ending homelessness in St. John's County.

In 2016, after the third quarter 2015 intervention period, skilled nursing and homecare utilization decreased from 40% to 24%, and the average skilled nursing length of stay was reduced from 22 days to 15.3 days. During the same intervention period, outpatient therapy utilization decreased from 23% to 14% and readmission rates decreased from 9.6% to 4.8%.

In the first two quarters of 2018, 700 patients used St. John's Care Connect services and 132 universal intake applications were completed. Among this group, 159 unique needs were identified and 64% of these needs were fully met. More than $400,000 of free medication was dispensed through the Prescription Assistance Program. The Flagler Emergency Department has completed 345 follow-up appointments.

Outcomes like these happen as a result of a deep commitment to forge partnerships between health care and community services providers to treat not only acute needs, but to solve the broader challenge of making a community healthier.

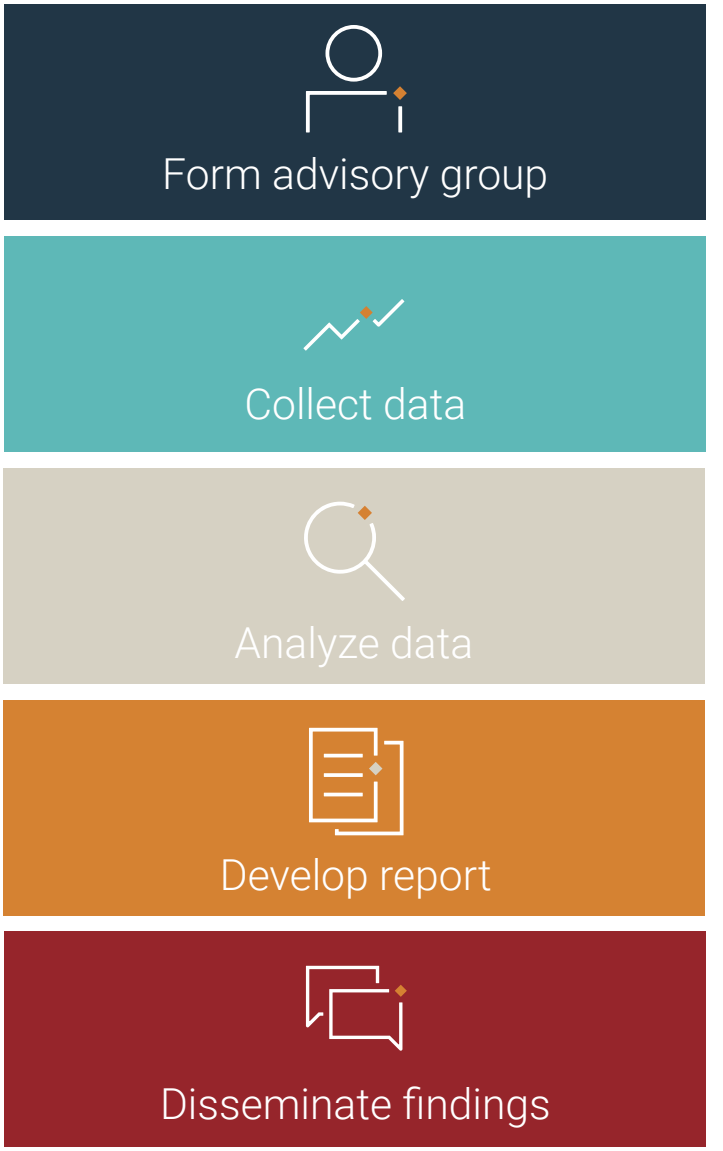
Data: the foundation of strong CoC and health system partnerships

Because housing and living conditions are such critical factors in the equation, the HUD Continuum of Care network is an integral part of any community partnership designed to improve the health care system. There are many data points and measurement criteria that are central to helping any partnership achieve the intended positive impact on the community. An accurate assessment of metrics germane to the population is essential to have as a baseline from which to track progress. The data needs to be manageable and shareable so all partners are on the same page. CoCs are well-positioned to leverage their existing infrastructure to support this effort.

The American Hospital Association (AHA) has developed a "playbook" detailing how health care organizations should work with community partnerships to engage patients more and improve the health of communities. According to the AHA, "Hospitals are best aligned to drive a culture of health that permeates the entire community."[11]

To that end, the Affordable Care Act (ACA) created Community Health Needs Assessments (CHNA) to help health care organizations uncover the health and social needs of a specific community, giving the organizations the tools to address the problems. In 2010, ACA revised the criteria for tax-exempt, non-profit hospitals, calling on all non-profit entities to complete a CHNA and submit it to the IRS.[12] The organizations are also required to publicly post their CHNA results.

Community Health Needs Assessments (CHNA)



Partnership "Hub" Includes Use of 2-1-1

In the Cincinnati, OH area, partners across multiple sectors, including health systems, insurance, government, community partners, and Federally Qualified Health Centers (FQHCs), work together to improve health outcomes.

The Health Collaborative, a non-profit organization, in partnership with United Way of Greater Cincinnati, was awarded $4.51 million in 2017 by the Center for Medicare and Medicaid Innovation's (CMMI) Accountable Health Communities (AHC) Model to serve as a community "hub" to address health-related social needs of the Greater Cincinnati community. The objective is to positively impact health status, experience, outcomes, and affordability, by fostering a connected system of healthcare and community health through innovation, integration, and informatics.

A key component of this partnership is leveraging United Way of Greater Cincinnati's 2-1-1 directory, which includes approximately 2,000 community resources. 2-1-1 offers yet another opportunity to mine data to help find the most optimal solutions and generate better outcomes.

Mary Ann Cooney, the Chief of Medical Systems Transformation at the Association of State and Territorial Health Officials (ASTHO) said CHNAs must link back to specific hospital services and programs that organization leaders can develop to meet community needs. Hospitals can also use these assessments to inform future community partnerships, such as ones with housing departments to chip away at a high homelessness rate.

Cooney cited the following quote from Pam Schwartz, senior director of community impact and learning at Kaiser Permanente, in an interview with PatientEngagementHIT.com.

"For us at Kaiser Permanente, it (CHNA) was more than just a compliance exercise," Schwartz said. "It helps us understand the health of our communities and it helps us prioritize how we can allocate resources to addressing the health needs. So ultimately it directs us toward the root causes of health and incorporates the wisdom of communities into the process."

Conclusion

Myriad opportunities exist for CoCs to partner with health systems, insurance companies, public insurance entities, and other government and community organizations to generate better long-term outcomes that decrease homelessness and the health care costs related to it. Ideal partnerships are those that include

Additional active health & housing partnerships

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 National 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

multiple organizations with an array of resources and tools and the common mission of increasing efficiencies, improving outcomes, and saving costs.

That mission is the guiding star that focuses everyone on providing highly integrated and coordinated care to address not only the acute problem for the short-term, but to treat the whole person. This is especially critical to help those experiencing homelessness, so their overall physical, mental, and emotional health are addressed and improved. It mandates a deep and broad look into the peripheral issues that may have contributed to a person's overall health.

Getting multiple organizations to coalesce around a common mission lays a strong foundation for success. But even those with the best intentions need additional support because they may have different tools to record, measure, and track their client/patient care and the documentation that is needed on a micro or macro level. The ability to integrate the data and share it in an easy-to-use and easy-to-digest manner is a critical dynamic to achieve the mission in an efficient, effective manner.

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WellSky delivers software and services to transform an ever-growing range of care services worldwide. We anticipate the needs of care providers and communities, empowering them with insights and solutions that support high quality, scalable, and personalized care. With our platforms and partnership, care providers can deliver their best while managing costs and resources, so both businesses and communities flourish.

Building on a history of excellence and a reputation for quality, WellSky leverages its broad experience in health care and human services to empower payers and non-profit community-based organizations to play an even greater role in protecting the wellness, safety, and stability of the most frail and at-risk members of our community.

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