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Replacing a Revolving Door

Care transition programs that address homelessness are one way to reduce emergency visits.

For people with complex health and social needs, the ED can be the most expensive and least effective place to get treatment. A number of innovative outreach programs designed to curb ED visits from "super-users"—those with chronic conditions who use EDs frequently for their care needs—have found success in addressing one of the most common needs of these patients: access to a stable living environment.

The Coordinating Center, a nonprofit, community-based care coordination organization in Millersville, Md., provides services to people who have very low incomes, are often unstably housed and face multiple challenges, including mental illness, substance use disorders, disabilities and chronic medical conditions. Through implementation of a Community Care Transition Program, the center has developed a relationship with three hospitals in west Baltimore (University of Maryland Medical Center Main Campus, the University of Maryland Midtown Campus, and Bon Secours Hospital) and the Baltimore City Aging and Disability Resource Center to reduce hospital readmissions.

The combined west Baltimore ZIP codes represent the highest disease burden in Maryland, with hospital readmission rates reaching more than 30 percent. Moreover, life expectancy in these neighborhoods is five to 12 years shorter than in other Maryland communities. One of the organizations—Bon Secours Hospital, an 88-bed acute care hospital—acts as a safety net for the community, a subset of which is chronically homeless. Bon Secours also is part of one of Maryland's designated Health Enterprise Zones, which focus on addressing the social determinants of health for a given population.

Designing interventions at multiple entry points is critical. Addressing all of a patient's needs, including those associated with social determinants of health and housing, is inexplicably tied to better outcomes and reduced readmission.

Beyond Hospital Doors: A Cross-Sector Problem

Analyses of hospital data have shown the relatively small subset of super-users of west Baltimore hospitals and other hospitals across Maryland—many of whom are chronically homeless—are most costly to the system. According to federal definition, a person is considered chronically homeless if he or she has been homeless for at least one year and has a serious physical health or behavioral health issue. Many such individuals also are engaged in high-cost use of other public services, such as jails, homeless shelters and detox—virtually caught in a costly, institutional cycle, largely due to the lack of housing and coordinated services. Intensive and comprehensive care coordination and supportive housing have been proven to decrease public service use and costs among this group while also stabilizing their health and housing.

In an era of elevated accountability for outcomes and cost of care, hospitals and health systems serving these individuals are expressing increasing concern and frustration and seeking real solutions to the revolving-door problem. These solutions involve stabilizing individuals' access to housing prior to addressing other complex issues such as mental health, substance abuse and multiple chronic health conditions—an approach called "Housing First."

The Coordinating Center reviewed statewide data for individuals with more than 25 hospital encounters for 2013, including ED services, inpatient admissions and observation stays.

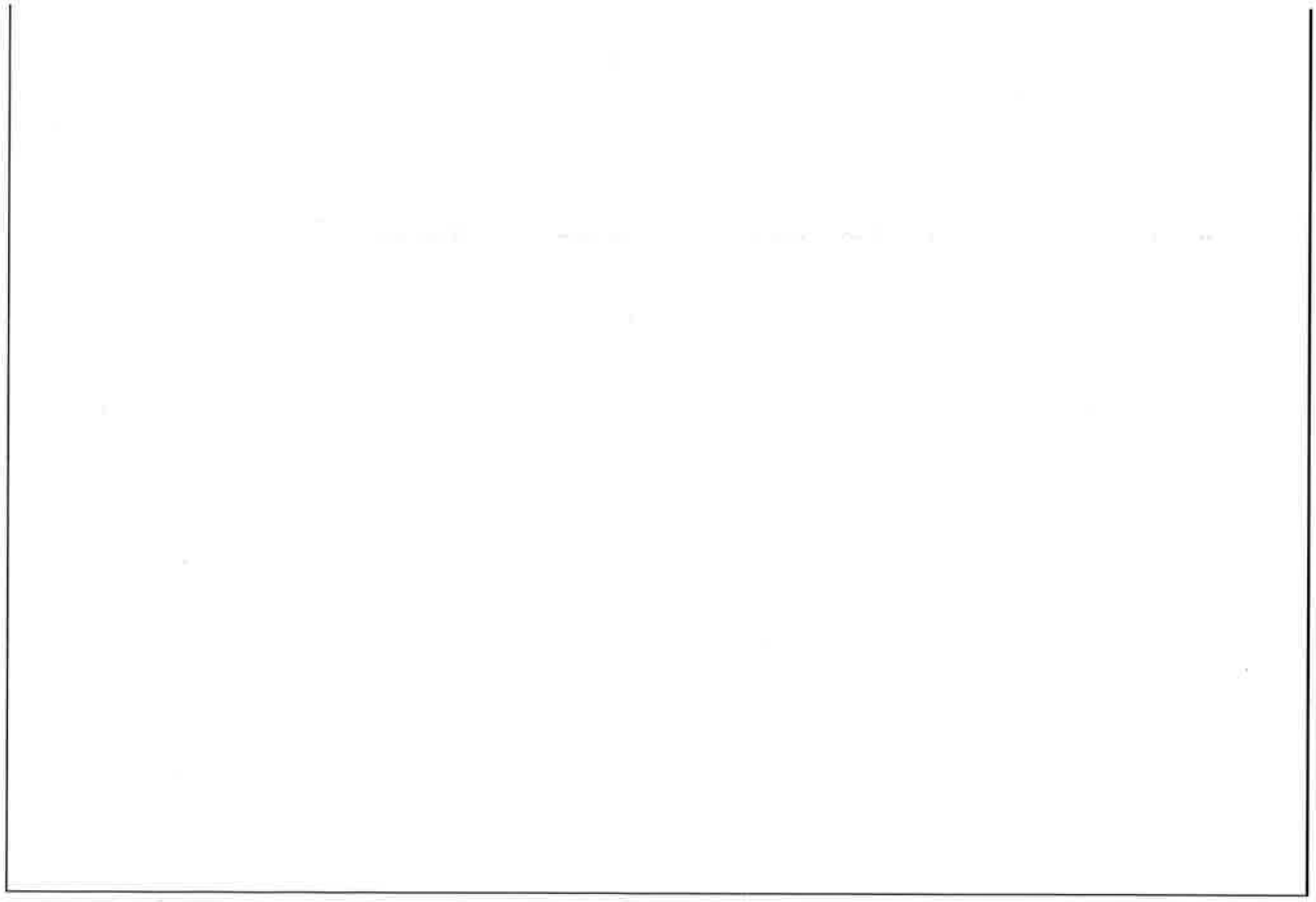
Statewide, there were more than 71,000 ED encounters per year, with 63 percent occurring in Baltimore City hospitals and recorded by just 1,562 people. Bon Secours Hospital accounts for more than 5.5 percent, or 4,036, ED encounters among these super-users. Top reasons for super-user hospital encounters include chest pain, abdominal pain, alcohol abuse, bipolar disorder, schizophrenia and sickle cell anemia. Although the data does not indicate what subset of this population is chronically homeless, hospital staff indicate this is a serious contributing factor.

Bon Secours Hospital is acutely aware of the ways in which limited access to housing and services affect patients' health. Lack of permanent housing, called one of the "social determinants of health," has been shown time and again to contribute greatly to poor health outcomes and high costs. Over time, it has become clear to hospital leaders that neither an ED visit nor hospital admission nor a 30-day care transition intervention would begin to meaningfully address the complexities of healthcare challenges for those who are chronically homeless. The Coordinating Center has been successful in securing permanent affordable housing and healthcare services for people with very complex needs and is exploring the feasibility of implementing a Housing First model to address the problem.

Closing the Door on Chronic Homelessness

Desiring a collective-impact approach to a complex cross-sector problem, The Coordinating Center engaged the Corporation for Supportive Housing (CSH) in the discussion. According to the Winter 2011 *Stanford Social Innovation Review*, the five core conditions of a collective-impact approach include a common agenda, shared measurement, mutually reinforcing activities, continuous communication and a backbone support entity. In west Baltimore, a collective-impact approach is gaining momentum as a disciplined, cross-sector process for solving social and environmental problems on a grand scale.

CSH is an established leader in the supportive housing movement. CSH's Frequent Users Systems Engagement model represents an integrated approach to addressing



frequent use of multiple systems by encouraging communities to combine data-driven targeting, cross-sector engagement and planning with quality supportive-housing initiatives to reduce costly, frequent use of multiple services, including healthcare. CSH works with sites across the country to implement the model and is demonstrating success in reducing avoidable costs to hospitals and public systems using a housing-first strategy. According to the January 2014 CSH report *The Business Case for Innovation: Linking Care Management and Supportive Housing*, pilot programs that are using the FUSE model have experienced an 81 percent decrease in hospital costs for 60 patients who have been placed in supportive housing in just one year, in part through decreased hospital use.

The FUSE model validates that strategic collective efforts that cross multiple sectors can effectively stabilize people who are high users of healthcare services. Using a collective impact model and a unique cross-sector, data-driven approach, The Coordinating Center acts as the backbone organization for planning and implementing a FUSE model to address the revolving-door cycle in west Baltimore hospitals.

To date, The Coordinating Center continues to work with west Baltimore hospitals to reduce inpatient readmissions while exploring and applying for funding to support full implementation of a FUSE program. The center continues to build and expand relationships in the community with entities such as Healthcare for the Homeless, local government, the public justice system, emergency medical services, behavioral health and others in stopping the cycle. ▲

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