Wilder Research

Hospital to Home Factsheet

June 2011

What is Hospital to Home?

Guild Incorporated, Hearth Connection, Regions Hospital, and the Minnesota Department of Human Services partnered to implement the Hospital to Home pilot innovation. For the pilot, Regions Hospital identified patients who had used its emergency department five or more times in the previous year and had one or more chronic health conditions, serious and persistent mental illness, and long histories of homelessness.

From the patients identified by Regions Hospital, seven individuals were enrolled in the Hospital to Home pilot between August 2009 and May 2010. Guild Incorporated has been engaging these individuals in a plan to improve their health, stability, and quality of life. A multi-disciplinary community health services team provides individually tailored care, based on participant needs and preferences. The mobile nature of the community health services team allows services to follow participants, wherever they are, thus keeping participants engaged and essentially serving as their health care home. These mobile outreach and engagement strategies build and sustain trusting relationships with participants and remove barriers to success.

Why is Hospital to Home important?

Evidence is increasing from around the country that shows a disproportionate amount of hospital emergency department and inpatient resources are being used by a small group of people who have chronic medical conditions and who also have high risk factors such as homelessness, mental health disorders, and/or substance abuse problems.

For a variety of reasons, these individuals use hospital emergency departments at a high frequency for non-emergency health concerns, which results in avoidable health care expenses and ties-up emergency room resources unnecessarily. There is an urgent need to reduce costs by targeting the highest cost patients with alternative interventions.

What are the goals of Hospital to Home?

Hospital to Home aims to:

- Support participants in securing stable housing, which is a strong determinant of positive physical and mental health outcomes.
- Reduce participant emergency department visits, thus freeing up emergency department resources for acute medical crises and reducing unnecessary healthcare expenditures.
- Increase participant relationships with primary care clinics so they will seek medical care from clinics rather than emergency departments.
- Assist participants with accessing affordable medications from a limited number of pharmacies to allow for medication monitoring.
- Promote participant self-reliance and life functioning.

Who does Hospital to Home serve?

High need participants

Hospital to Home targets adults with multiple, complex needs. At intake, all seven of the participants currently enrolled in Hospital to Home were:

- Diagnosed with a serious mental illness and at least one chronic health condition.
- Homeless, and had been homeless for between 14 months and 22 years.
- Assessed with the Level of Care Utilization System (LOCUS) for Psychiatric and Addiction Services and had a recommended level of care ranging from high intensity community based services to medically managed residential services in a locked environment.

Participants with a high frequency of healthcare use

According to Department of Human Services medical claims data, in the year prior to enrolling in Hospital to Home, the seven participants:

- Had 110 emergency department visits total, including between 5 and 31 visits per person.
- Visited 41 different primary care clinics for a total of 355 separate visits.
- Purchased 456 medications at 24 different pharmacies.

What has been the immediate impact of Hospital to Home?

- At intake, all of the participants' suspected mental illnesses were confirmed through diagnostic screenings, which has allowed for appropriate treatments.
- Despite the complex and severe presenting issues, all of the participants are successfully served by community-based services, rather than residential or facility-based services.
- Every participant has been connected to a primary care physician who is able to provide consistent medical care.
- All participants were securely housed in private rental properties in the community within three months of enrollment in Hospital to Home.
- Additional outcomes data, including changes in housing, self-sufficiency, healthcare usage, will be reported in the fall of 2011, when more data are available and adequate claims data can be analyzed and accurately reported.

Bill's Story

When Bill was introduced to Guild Incorporated's services in November of 2009 he had been homeless for nearly two years. He was kicked out of his apartment because of his struggles with chemical dependency. He found himself moving from sleeping on a hefty bag filled with his clothes in a friend's basement, to a foreclosed home with no electricity, to the crowded Union Gospel Mission.

Bill visited the Emergency Department at Regions Hospital 19 times in the past twelve months due to the many chronic health conditions he suffered from, including Chronic Obstructive Pulmonary Disorder (COPD), asthma, and high blood pressure. He had no health insurance, no primary care physician, and no access to needed medications. Bill says, "I was crying out for help, but didn't know who to talk to or where to go." A Regions' Hospital social worker introduced Bill to Guild.

Bill secured a "cozy place to call home" just weeks after enrolling in Hospital to Home. With stable housing in place, the Hospital to Home team supported Bill in managing his health issues, including his Bipolar Disorder, and helped him navigate the application process for Social Security Disability Insurance (SSDI) and Medicaid.

Today, Bill:

- Has lived in stable housing for over one year
- Visits a primary care physician monthly
- Manages his health conditions with support
- Reduced his Emergency Department visits from 19 to 4 over the past year
- Enjoys a sense of community with friends and neighbors
- Has goals for his future including maintaining his sobriety and getting his driver's license

Wilder Research
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For more information

This summary presents highlights of the Initial Report - Hospital to Home: Reducing Avoidable Hospital Emergency Department Visits While Improving Stability and Health.

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