Wilder Research

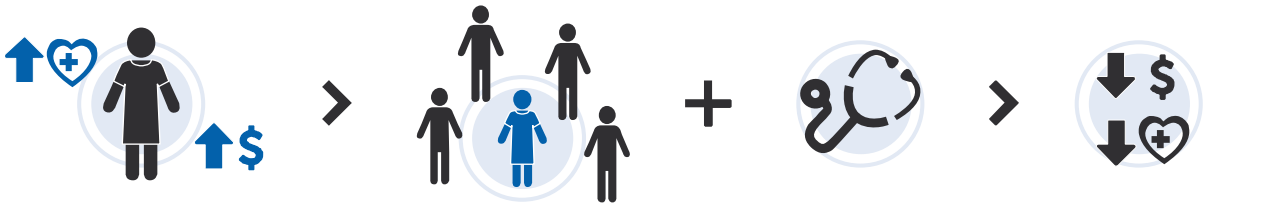
Hospital to Home One-Year Outcomes

June 2016

What is Hospital to Home?

There is an urgent need to reduce costs and better serve patients by targeting the highest need and highest cost patients with alternative interventions that also target the complex issues affecting their health.

Hospital to Home addresses this need by engaging these high need participants with a person-centered, multi-disciplinary Mobile Community Health Services Team that provides individually tailored care based on participant needs and preferences. Serving as the central hub of comprehensive care coordination, the Team is accountable to either provide directly, or arrange for and coordinate, all needed services including physical health, behavioral health, housing, social, and employment services. Mobile outreach and engagement strategies help to build and sustain trusting relationships with participants and remove barriers to success.



Highest need participants are the highest cost patients

Person-centered Mobile Community Health Services Team

Individually tailored care

Reduce costs and better serve patients

What impact has Hospital to Home made?

Based on data from the Minnesota Department of Human Services, Regions Hospital, Hearth Connection, and Guild Incorporated, the following outcomes emerged for the 31 Hospital to Home participants with approximately 12 months of outcome data through July 2015.

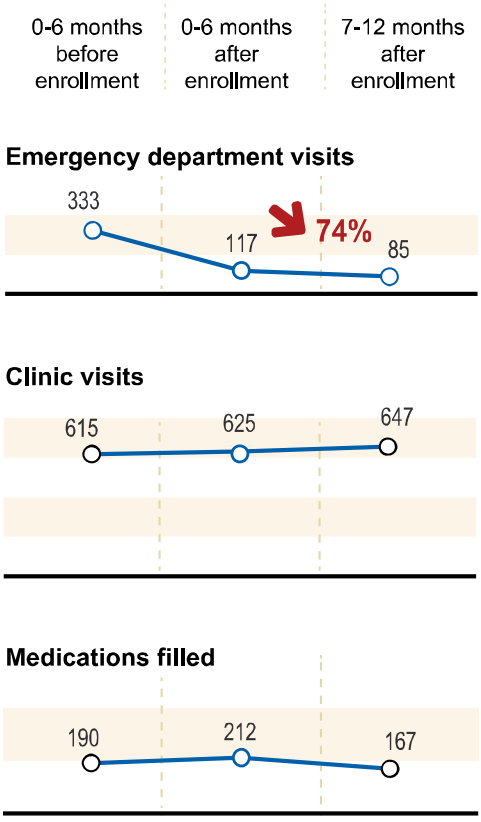
Changes in healthcare use

The total number of emergency department visits by participants decreased by 74% after enrollment.

Aggregated clinic use increased after enrollment, though individual participants had varying patterns of use over time.

Medications filled peaked in the first six months of enrollment before decreasing to lower than pre-enrollment numbers.

Nearly two-thirds of participants (65%) had an inpatient hospital stay in the six months prior to enrollment. However, this dropped to one third (32%) with an inpatient stay in the six months after enrollment, and further fell to 13 percent between six and twelve months after enrollment.



Participant outcomes: Changes in participant stability

Despite long histories of homelessness, all participants moved into stable housing within four months of enrollment in Hospital to Home and 87 percent were living in apartments as of July 2015.

Participants' average scores were higher at follow-up than at baseline in every domain. This difference was statistically significant ($p<.05$) for the following domains: housing, food, health care coverage, life skills, family relations, mobility, and safety.

Broader impacts on costs and resources

- Estimates from the Minnesota Department of Human Services and the Minnesota HealthScores Cost of Care website indicate that a clinic visit costs, on average, about one-quarter of the cost of an emergency department visit.
- Because these participants do not have access to private insurance, the costs associated with these medical services are public costs.
- Patients receiving the right care in the right place, including primary care clinics, will free up other resources within emergency departments to allow them to better serve the patients in need of emergency care.

For more information

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Meet Taylor: Grandpa. Student. Optimist.

"From 13 until Guild, it was my way or no way. I was going to live in the streets forever. But, I was proven wrong."

"I went from 13 to grown up," Taylor says of leaving his childhood home for the Chicago streets where he spent years living in a car, abandoned buildings, and friends' houses, drinking and using drugs to cope.

Taylor worked, but keeping jobs proved difficult. "I'd get paid for a job, get some money, stay in a hotel awhile, and then the drinking would take over," he says.

Frustrated and eager to connect with his granddaughter, Taylor came to Minnesota. He lived in his car and at the Union Gospel Mission, eventually pitching a tent behind the building. "Living in a tent is scary," he says. "You have to be intoxicated just to go to sleep. And if something happens to you, it will be better because you won't feel it as much."

Along with alcoholism and major depression, Taylor struggled with several health conditions including hypertension, arthritis, chronic back pain, and hyper-sensitivity to light. (Dark glasses help him manage a chronic, exaggerated facial tic.) He visited the emergency room often.

Referred by the hospital emergency room, he met Peggy, a Guild RN. "I was hurting so bad," he says. "I was suicidal; I felt like I didn't belong." Peggy helped Taylor get into a crisis program and locate housing options. Less than one month later, he had an apartment. Staff helped Taylor find a primary care physician at Open Cities Health Center and get to appointments. Three months later, with support from Senior Recovery, he stopped drinking.

In the first eleven months in H2H, Taylor reduced his emergency department use to none, down from nine visits the year prior to enrollment. He also had three inpatient hospital stays before enrollment and none after.

Today, with Guild's help, Taylor:

- Has maintained stable housing for over one and a half years
- Celebrates over one and a half years of sobriety
- Is studying to take the GED test, and hopes to pursue social work
- Sees a doctor regularly to address health concerns
- Maintains his goal of getting to know his granddaughter better