

Hospital to Home Outcome Summary

December 2011

Background

The Hospital to Home initiative is a community-based intervention for low-resource homeless individuals with complex healthcare needs who turn to hospital emergency departments for ongoing health concerns. Their frequent use of emergency services for otherwise manageable conditions results in poorly coordinated care and higher healthcare costs.

Hospital to Home engages these individuals in a plan to improve their health, stability, and quality of life. Hospital to Home's mobile community health services team ensures access to permanent supportive housing and allows services to follow participants, wherever they are, keeping them engaged and providing continuity in their care. More information about the initiative can be found in the initial report from this Hospital to Home series, published in June 2011.

Guild Incorporated, Hearth Connection, Regions Hospital Departments of Emergency Medicine and Behavioral Health, and the Office of Performance Measurement and Quality Improvement within the Minnesota Department of Human Services have partnered to develop and implement Hospital to Home.

The information in this report includes participant outcomes through October 2010, approximately one year after most participants enrolled in Hospital to Home.

Hospital to Home Outcomes

Based on data from the Minnesota Department of Human Services, Regions Hospital, Hearth Connection, and Guild Incorporated, Hospital to Home has had notable outcomes for the seven participants.

Emergency department visits decreased for all participants after enrolling in Hospital to Home.

All participants decreased their use of emergency departments. The total number of visits decreased from 68 visits to eight locations in the three months prior to enrollment to 38 visits to four locations three months after enrollment.

Use of primary care clinics decreased after enrollment.

Five participants used clinics less often after enrollment, and the overall usage decreased between the three months prior to enrollment (70 visits to 25 clinics) and the three months after enrollment (37 visits to 14 clinics). However, average use of primary care clinics ultimately surpassed average use of the emergency department.

Inpatient hospital stays were less frequent and shorter after enrolling in Hospital to Home.

Four participants experienced at least one inpatient hospital stay prior to enrollment, but only two participants had hospital stays after enrollment.

Pharmacy claims immediately decreased and then leveled off after Hospital to Home enrollment.

Participants had one-third of the total pharmacy claims in the first three months after enrollment (33 claims) that they had in the three months prior to enrollment (99 claims). The number of claims then stabilized (42-47 claims per quarter).

All participants moved into stable housing within three months of enrollment in Hospital to Home.

Although all participants were homeless for between 14 months and 22 years (median of 4 years; average of 6.5 years) at enrollment, all moved into apartments within three months of enrollment and, as of October 2010, have lived in their apartments for between 3 and 13 months (median and average of 9 months).

Participants had generally higher ratings of self-sufficiency after Hospital to Home enrollment.

According to the Arizona Self-Sufficiency Matrix, participants had very low levels of self-sufficiency in most areas at enrollment, but higher ratings in nearly all of the 15 domains at follow-up, showing improvement in self-care and individual functioning.

Six out of seven participants had no further criminal charges after enrolling in Hospital to Home.

According to Minnesota court records, six of the seven Hospital to Home participants have a criminal history, but only one participant has had criminal misdemeanor charges since enrollment.

continued

Conclusions

Broader impacts on costs and resources

- Estimates from the Minnesota Department of Human Services and the Minnesota HealthScores Cost of Care website indicate that an average clinic visit costs 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 their medical services are public costs.
- Hospital to Home helps people receive the right care and services in the right place and time, improving the quality of care, decreasing public costs, and freeing up emergency department resources.

Core elements of Hospital to Home effectiveness

Hospital to Home staff have identified the following three core elements of the model that should continue to be evaluated and supported through resource allocations and policy initiatives:

- Coordination across all elements of the healthcare and social services systems
- Mobile services that “follow” and remain available to participants regardless of living arrangement
- Upfront and continued housing support services and subsidies

Future directions

- The findings from this report support the need for replication and expansion of the Hospital to Home model. In addition, there is need for the continued measurement and evaluation of costs, benefits, and participant outcomes.
- Additional outcomes will be reported in the fall of 2012, when data are available to examine longer-term outcomes.



Meet Bill: Individual Served, Son, Friend, Neighbor

“It feels good to have some independence back and contribute to the needs of my daily life!”

When Bill was introduced to Guild Incorporated’s services in November of 2009, he had been homeless for nearly two years. Due to struggles with chemical dependency, he was kicked out of his apartment and found himself sleeping either on a trash bag filled with his clothes or at Union Gospel Mission.

Bill suffers from multiple chronic health conditions, including Chronic Obstructive Pulmonary Disorder (COPD), borderline diabetes, and high blood pressure. With no health insurance, no primary care physician, and no access to medications, he relied on the Emergency Department. 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.

Just weeks after enrolling in Hospital to Home, Bill secured a “place to call home.” With stable housing in place, the team has 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.

Now, Bill:

- Has lived in stable housing for over two years
- Visits a primary care physician monthly
- Manages his health conditions with support
- Has reduced his Emergency Department use from 18 visits in 2009 to 8 visits in 2010
- Has goals for his future including maintaining his sobriety and getting his driver’s license
- Is working again in a part-time job

For more information

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

For more information about this report, contact Kristin Dillon at Wilder Research, 651-280-2656 or Julie Grothe at Guild Incorporated, 651-925-8481

Author: Kristin Dillon, Ph.D.
December 2011

**Wilder
Research**

Information. Insight. Impact.

451 Lexington Parkway North
Saint Paul, Minnesota 55104
651-280-2700; FAX 651-280-3700

