Wilder
Research

Hospital to Home One-Year Outcomes

February 2015

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.

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 17 Hospital to Home participants with approximately 12 months of outcome data through April 2014.

Changes in healthcare use

The total number of emergency department visits by participants decreased by 68% after enrollment.

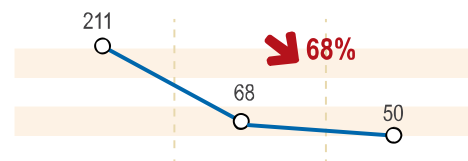
Aggregated clinic use dropped after six months of enrollment, though individual participants had varying patterns of use over time.

Pharmacy use peaked in the first six months of enrollment before decreasing to lower than pre-enrollment use.

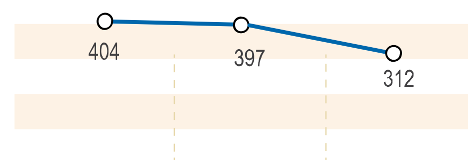
Over half of participants (65%) had an inpatient hospital stay in the year prior to enrollment, but fewer than half (41%) had a hospital stay in the year after enrollment, including only 12 percent with a stay between six and twelve months after enrollment.

0-6 months before enrollment | 0-6 months after enrollment | 7-12 months after enrollment

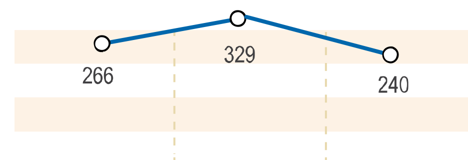
Emergency department visits



Clinic visits



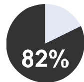
Pharmacy claims



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 88 percent were living in apartments as of April 2014.

Participants tended to have higher ratings of self-sufficiency in most domains after Hospital to Home enrollment.



While 76 percent of participants have a criminal history, most participants (82%) had no criminal charges after enrolling in Hospital to Home.

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.

Meet Lisa: Grandma. Animal Lover. Seamstress.

"I'm happy going at the speed I'm going. I've come so far."

After surgery for a degenerative back condition, Lisa found herself unemployed. Plagued by chronic pain due to vascular disease, she turned to prescription pain killers.

When unemployment benefits ran out, Lisa was unable to pay her rent. Disconnected from family and with nowhere else to go, she packed up her two small dogs and moved into her truck. "It was really cold in the winter," she says. "Sometimes I didn't have enough money for gas to keep my truck running."

During the three years living in her truck, Lisa never felt safe, and her health conditions grew worse. While parked at a friend's one day, Lisa lost track of how many pain pills she had taken. By the time her friend came to check on her, she was unresponsive. Paramedics rushed Lisa to Regions Hospital.

While receiving treatment at Regions, Lisa met Susan, a Case Manager for Guild Incorporated, who helped enroll Lisa in Hospital to Home (H2H). After completing treatment for substance use, she moved directly into an apartment that Susan helped her find. "It's quiet, I know this area well, and I feel comfortable," Lisa says of her apartment. She can often be found at her sewing machine or baking in her kitchen.

Lisa also received help managing her prescribed medications and getting to healthcare appointments to address health conditions including anxiety, vascular disease, schizoaffective disorder, post-traumatic stress disorder (PTSD), and asthma. **In the first six months in H2H, Lisa reduced her emergency department use to only two visits, down from seven visits in the previous six months.**

Today, with Guild's help, Lisa:

– Has maintained stable housing for over one year with support from a Hearth Connection HUD subsidy.
– Manages her conditions with medication and regular visits with primary care providers.
– Is actively working to maintain her sobriety.
– Has re-established relationships with her family, including providing childcare for three of her grandkids who she says, "are everything to me."

For more information

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