Background

Homelessness and housing instability are associated with poor health outcomes, including high mortality and high rates of chronic illnesses. Often those experiencing homelessness or housing instability cycle in and out of hospital emergency departments (ED), costing the medical system millions of dollars each year.

Adults who are homeless represent 5% of the Medicaid population but are overrepresented in some types of care:

- 17% inpatient care
- 19% ED visits for adults with a primary behavioral health diagnosis
- 39% with 3+ inpatient medical detox episodes

Given these findings, hospitals have the potential to be a critical partner in interventions and care coordination for those experiencing homelessness. The Opening Doors-CT Hospital Initiative launched in 2014 as a collaboration between the Partnership for Strong Communities and the Connecticut Hospital Association. This project focuses on bridging the gap between hospitals and community providers, and better serving those who are homeless.

Target Population

Frequent visitors of hospital emergency departments (ED) and inpatient beds, also known as super-utilizers. Frequent visitors are those who have:

- Visited an ED 7+ times in the past 6 months

Strategies

- Implement homelessness screener in emergency department electronic health records
- Establish Community Care Teams (CCTs) to improve care coordination between hospital staff and community providers
- Develop peer sharing across participating hospitals

Goals

1. Better identify individuals experiencing homelessness or housing instability
2. Reduce emergency department visits and inpatient readmissions
3. Improve care coordination upon discharge from inpatient and outpatient settings
4. Reduce costs for the medical and health care system

In Partnership With:

Funded by:

Opening Doors in Connecticut...
...to a Future Where Everyone Has a Home
Preliminary Findings

35-40%
Percent of frequent visitors experiencing homelessness or housing instability

7-69
Number of ED visits per frequent visitor in the past six months

34%
Percent of frequent visitors who visited 3 or more EDs during the previous six months

62%
Percent of frequent visitors who are male

Outcomes Tracked
- Demographics (age, race, gender)
- Health insurance
- % ED visits accounted for by frequent visitors
- Readmission rates to ED and inpatient care (7- and 30-day follow up)
- Connection to care (7- and 30-day follow up)
- Housing/homelessness status
- Medicaid claims data
- SF-12 physical and mental health scales
- Substance use

Lessons Learned
- Importance of peer sharing across Community Care Teams (CCTs)
- Extensive time needed to develop release of information
- Need for flexible care plans
- Movement of frequent visitors between hospitals
- Prevalence of substance use by frequent visitors
- Value of having the Administrative Service Organization (ASO) at the table

Next Steps
- Evaluate the initiative - both process and outcome
- Expand the model to other institutions
- Develop a predictive model to better identify and serve frequent visitors
- Expand respite care options across the state
- Develop a more comprehensive continuum of care for substance users
- Explore Medicaid payments for supportive housing services
- Develop a model for sustainability

Homelessness is unacceptable. Homelessness is solvable and preventable.
Homelessness is expensive. Invest in solutions.