University of Pittsburgh Medical Center Health Plan Tackles Homelessness

Scouting Health

Summary

In the United States nearly 85,000 individuals are chronically homeless.[1] To be considered chronically homeless an individual needs to have been continuously homeless for at least a year, or have had four periods of homelessness over the last three years.[2] Community-based efforts to reach this population have had limited success in part due to the coordinated resources needed to address the root causes of chronic homelessness. Further, an estimated 63% of this population also suffers from chronic or disabling health conditions, complicating their ability to work or find stable housing.[3] The lack of stable housing, transportation and access to telecommunication tools frequently prevents this population from obtaining regular preventative or maintenance care, which leads to health crises. Chronic homelessness among those with chronic or disabling health conditions costs the United States taxpayers, an estimated $30,000-$50,000 *per individual*, *per year*.[4]

Realizing that chronic homelessness is often a two-pronged issue, the UPMC Insurance Services Division sought to address the issues of shelter *and* access to reliable health care in one location. UPMC developed "Cultivating Health for Success," a program designed specifically for the chronically homeless who are also enrolled in UPMC's Medicaid or Medicare Advantage Special Needs programs.

Cultivating Health for Success (CHFS) provides individuals who are both chronically homeless and disabled with stable housing, and coordinated health care. Individuals enrolled in the program are connected with a team who coordinates their health care, helps them find stable housing, and arranges for their transportation to and from appointments. The program has seen medication adherence improve among enrollees, and significant reductions in emergency health care use.

[1] http://www.endhomelessness.org/page/-/files/State_of_Homelessness_2015_FINAL_online.pdf
[2] Ibid
[3] https://www.usich.gov/resources/uploads/asset_library/USICH_OpeningDoors_Amendment2015_FINAL.pdf#page=26
[4] https://www.usich.gov/goals/chronic

Context of the Innovation

Nearly half a million individuals in the United States are homeless and among this population, nearly 85,000 (approximately 15 percent) are considered chronically homeless; meaning they have been continuously homeless for at least a year or have experienced episodes of homelessness at least four times in the past three years).[5] Chronically homeless individuals are a highly vulnerable population as they typically have high rates of behavioral and physical health problems that may be exacerbated by injury or trauma. Consequently, they are frequent users of emergency services and hospitalizations, costing health systems approximately $40,000 per individual per year.[6] These physical and mental health issues often complicate their ability to find work and, thus, obtain affordable and stable housing.

UPMC Insurance Services Division is a 3,000,000-member entity with Medicaid, Medicare, behavioral and commercial plans. UPMC Insurance Services Division is a partner with the provider-based integrated health system delivery system, University of Pittsburgh Medical Center (UPMC) Health System. Together, the integrated systems are committed to community engagement and health care that accounts for "the whole person." This is particularly true for *UPMC for You,* the largest Medical Assistance program in western Pennsylvania, and affiliate of UPMC Insurance Health Services Division.

In addition to the humanitarian goals of addressing the health care and housing needs of the chronically homeless, research has shown that addressing these two issues actually reduces the costs of caring for this vulnerable population.[7] *UPMC for You* operates under a capitated full risk arrangement for its Medicaid and Medicare Advantage Special Needs populations, including the high-risk homeless population. CHFS was an initiative offered to chronically homeless and disabled members of *UPMC for You* that addressed the many needs of these individuals, while simultaneously aiming to reduce costs.

Description of the Innovative Activity

UPMC's Cultivating Health for Success (CHFS) is a pilot program whose goal is to encourage more appropriate health care usage among the chronically homeless and disabled who are enrolled in the *UPMC for You.* The program aims to reduce the amount of unplanned, crisis-oriented care that often involves the use of emergency services and hospitalization. Participants are provided with stable housing, creating access to regular medical and behavioral care within UPMC's medical home model, and offering access to needed social services (such as transportation and food).

The supportive housing aspect of CHFS is done in collaboration with Housing First, a program of the U.S. Department of Housing and Urban Development (HUD). Housing First aims to improve patient health outcomes and reduce health care and housing costs for this population.

[5] http://www.endhomelessness.org/page/-/files/State_of_Homelessness_2015_FINAL_online.pdf
[6] http://www.journals.uchicago.edu/doi/full/10.1086/676142
[7] http://www.commonwealthfund.org/publications/newsletters/quality-matters/2014/october-november/in-focus

Housing funds for Cultivating Health for Success are administered by the local area's own Allegheny County's Housing Authority, and case management is coordinated through its partner organization Community Health Services (CHS). The funding that *UPMC for You* provides to support these efforts serves as the match for HUD funding for the permanent supported housing. Since it started in 2010, the program has enrolled 60 members, of which 25 were active in 2015. The program is run by a multidisciplinary team that includes a mobile nurse, a community health worker, and a housing case manager. The nurse and community health workers are employees of *UPMC for You* and help each patient identify and establish a networked medical home in the community for their health care needs; the nurse coordinates the medical and behavioral care while the community health worker works to engage the member in both medical and social support services.

Impact

Broadly, CHFS successfully reduced overall health care costs and unplanned care (i.e. emergency department use and unscheduled hospital admissions and re-admissions) while providing stable housing and improved access to health care and social services. Overall, the program has proven successful in five key areas: providing housing, decreasing use of emergency services, increasing use of preventative health care, increasing medication adherence among patients, and improved care coordination among the observed participants.

- During the first five years of the program, 51 of 60 participants were successfully housed.
  - After housing was stabilized, unplanned care decreased by as much as 19.2%.
- Planned visits to primary care and specialist doctors rose. The observed decrease in total unplanned care suggests the project offers enhanced management of physical and behavioral symptoms among the participants.
- Medication adherence among the housed participants improved.
- An average cost savings of $6,384 *for each housed participant* was observed after stable housing was achieved through the project. These savings are broken down as: an average of $8,472 savings in medical costs (mostly through a decrease of hospitalization and emergency department visits), and an increase in $2,088 in pharmacy costs (pharmacy services and prescription drug costs) per year. The pharmacy costs were predominately driven by medications for treating chronic behavioral and physical conditions.

Participant Success Stories

- **Connecting to Support:**
  Geraldine, Age 48
  Geraldine, who has a history of substance use disorders, suffered hemi-paralysis after a gunshot wound to her spine. Now, with three years of sobriety, the grandmother joined CHFS in October, 2014, and was housed in a first-floor apartment. She now sees an orthopedic specialist to help with her degenerative joint disease and knee pain through CHFS, and receives assistance with transportation to her medical appointments. She has not visited the emergency department or been admitted to the hospital since enrollment in CHFS.
- **Second Chances**:
  Barry, Age 60
  Barry returned to his native Pittsburgh in 2011, but his aged parents asked him to leave their home due to problems stemming from his alcohol use disorder. His drinking then increased after his father was injured during a convenience store robbery and required life support

for more than a year. Unable to pay his rent during this time, Barry became homeless. Barry, who joined the program in April 2014, now lives in an apartment, interacts several times a week with peers, utilizes a gym, and participates in offered social activities. He has visited the emergency department a few times during his enrollment, but has not been hospitalized. Since enrollment, Barry's condition has significantly improved. His medical costs and unplanned medical visits drastically reduced after being housed in the program. Barry has also maintained sobriety since starting treatment in July 2015.

Lessons Learned

- **Partnering with HUD**. Due to the partnership with HUD, eligibility was limited to those who met the "chronically homeless" requirements set forth by the department. The eligibility restriction was challenging for UPMC, as by it's nature chronic homelessness is difficult to "prove." UPMC is exploring different avenues for funding the housing function of the program to expand the definition and scope of those served through CHFS. Management staff continue to explore options to expand the program through other HUD funding opportunities, including housing choice vouchers, public housing, and subsidized housing options.
- **Patient Complexity**. *UPMC for You* discovered unanticipated aspects rooted in the complexity of patients' lives and the use of community services. Patients entering the program had more behavioral challenges than originally anticipated through available claims-related information.
- **ROI Trajectory**. The pilot program costs $150,000 annually to run, and, as it is still in its infancy, has not yet been able to "break even." The program is investigating improvements to the identification and enrollment of participants, and other factors that would improve the efficiency of the program. For example, they added the community health worker to the project team to facilitate participants' housing searches. Finding patients to be considerably more socially and behaviorally complex than originally anticipated, UPMC has continued to refine its analysis and understanding of the necessary input needed to create change.
- **Treating the "Whole Person."** While the primary objective of the program is to ensure enrollees find sustainable housing to reduce unplanned, crisis-oriented care, there are other necessities that also need to be addressed, including general transportation and food. Having a community health worker engaged with the resources

throughout the community helps enrollees gain access to needed social services and provides a path to offering access to better overall care.