



CMO

MONTEFIORE CARE MANAGEMENT

Beyond Hospital Borders: Helping Homeless Patients

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Housing at Risk Program Goals

- Identify homeless/near homeless patients—Housing at Risk
- Integrate social and clinical needs along the patient pathway
- Support continuity through internal hand-offs
- Coordinate care beyond the hospital into the community (external hand-offs)
- Provide a *medical home to the homeless*

How Does It work?

- Define homeless or potentially homeless—
 - Street homeless
 - Living in shelter
 - Living in transitional housing
 - Doubling up
 - Potential eviction
 - Other precarious housing situations
- Triggers in registration system
 - BronxWorks hot list (living on street)
 - PCP in MMC Homeless Program
 - Address as MMC or FHC
 - Phone number FHC
 - Address-undomiciled, shelter, etc.
 - Discussed in case conference—high utilizers, complex

How Does it Work? (2)

- When there is a match...
 - Automatic page to ED social worker
 - E-mail to ED social work, Homeless Program SW, Clinical Director and others
 - ED physicians on-going orientation

“Alert” E-mail

FAC: MOSES
NAME: Hxxxxx, Hxxxxx
MRN: 123456 DOB: 01/1/1965
ACCOUNT: 123456789
ADDR1: X Shelter
ADDR2:
PHONE:
PCP: NO PCP
VISIT DT: 07/01/2015 8:07PM
BRONXWORKS:Y
BXWK CODE: Safe Hav
ED PRIORITY: Urgent

“Alert” E-mail

INSTRUCTIONS: CALL M M LMSW 646-123-4567, ask if she still lives with her sister, new psycho-social required

07/01/2015 MOSES O
06/04/2015 MOSES N WEAKNESS
05/25/2015 MOSES N MED ADMIN
05/01/2015 MOSES N
04/21/2015 MOSES N MEDS REFILL
01/25/2015 MOSES N MEDICAL ADMINISTRATION
11/26/2014 MOSES N MEDICATION REFILL
11/18/2014 MOSES N WHEEZING
11/15/2014 MOSES N MEDICAL PROBLEM MINOR
10/26/2014 MOSES N WHEEZING
10/12/2014 MOSES N MEDICATION ADMINISTRATION
10/11/2014 MOSES N WHEEZING
09/21/2014 MOSES N MEDICATION REFILL
08/03/2014 MOSES N RIGHT FOOT PAIN, SWELLING

BronxWorks and Other Links

- Use BronxWorks list for triggers (HOT, working to add shelters)
- Strengthened link to Living Room
- Targeted links to shelters, food pantries, others from ED Social Worker discussions
- Coordinate care
- Share learning, contacts and information

2014 Moses Data

- 757 people had ED alerts
- Average <2/day/site
- Admission rate trend overall 23% to 14% (a 39% reduction)
- Est. LOS 7.4 to 6.2 (19% reduction)

Housing at Risk Team Outcomes

- Of 58 active cases in 2014
 - Linked 20 people to housing
 - Prevented 8 evictions
 - Reduced utilization
 - New CBO partnerships-links to Assisted Living, Adult Homes

Creating and Maintaining CBO Networks

- Housing Partners
- Other Partners
- Secrets to Success (not so secret)
 - 2 way streets
 - Sharing the contacts
 - Sharing success

Comunilife Respite Program

- Hospital need for safe discharge
- Housing gap on the continuum needs filling
- Collaborate with Comunilife to build a pilot program based on real needs
- 3+ beds
- Housing, health care support, medications management, benefits support, housing support

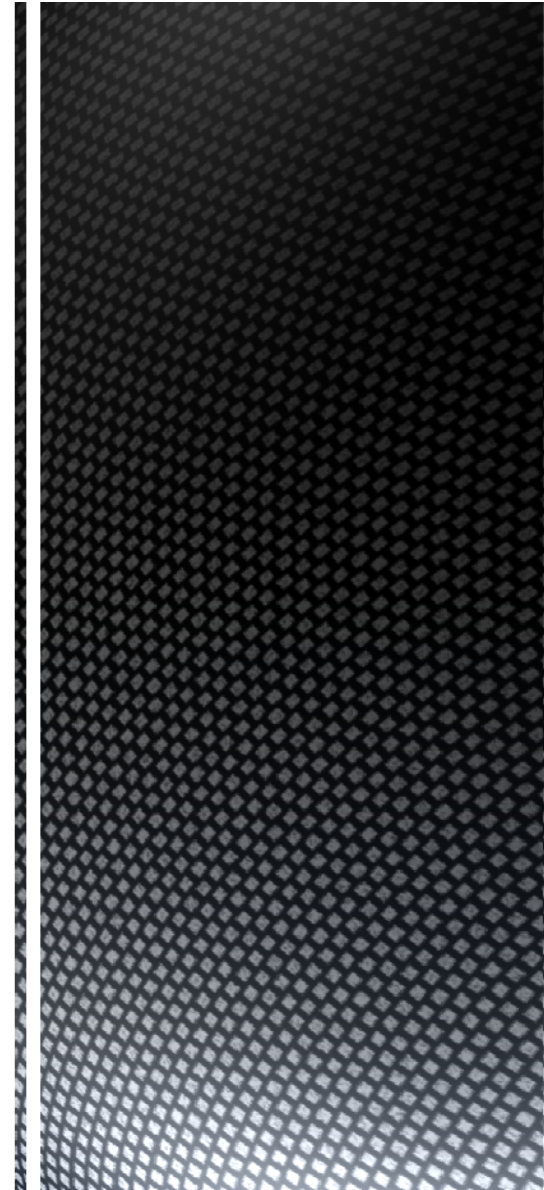
2014 Respite Data

- 16 people in 2014
- 56% had some days in the hospital while in respite care
- Median age is 45, 44% are over 60
- 75% male
- Average LOS in respite for those discharged in 2014=109 days
- Avg beds used=4.13
- Health issues--mental health disorders, various chronic conditions, paraplegic, renal disease, wounds, trauma, visual impairment, cancer, sickle cell.
- ROI=Great
- Link to more CBOs via Comunilife—via joint case review



Bonnie Mohan, Director Bronx Health & Housing Consortium

The Bronx Health & Housing Consortium is a collaborative network of representatives from health, housing, and social service providers, governmental agencies, and the four Health Homes in the Bronx with the shared goal of streamlining client access to health care and quality housing.



Who We Are

- **Health Organizations/Health Homes:**
 - Bronx Lebanon Hospital Center/Bronx Health Home
 - Montefiore Medical Center/Bronx Accountable Healthcare Network (BAHN)
 - NYC Health & Hospitals Corporation
 - Community Care Management Partners (CCMP)
- **Housing and Community-Based Organizations:**
 - BronxWorks
 - Concern for Independent Living
 - Geel Community Services
 - Urban Pathways
 - West Side Federation for Senior and Supportive Housing
- **Government:**
 - NYC Department of Health & Mental Hygiene, Transitional Health Care Coordination

What We Do

- Try to understand what's happening
 - Listen to our members
 - Hospital HOPE Count
 - Bronx Health Homes Housing Needs study
- Support the people on the ground
 - Housing Referral Manual
 - Health Home White Pages and Procedure for Dual Enrollment
 - Training Program
 - Cross-Organizational Case Conferences

What We Do

- **Spread the word and advocate**
 - Health Homes and Homelessness White Paper with CSH
 - Advocate to DHS to include hospitals in their annual homeless count
 - More housing, including respite
- **Bring People Together**
 - Housing Marketplace Series
 - Targeting MRT Housing beds
 - Annual Convening
 - Workgroups

What We Know

- Housing helps reduce readmissions and improves health
- Partnership with *meaningful* collaboration and coordination works and makes care transitions more successful
- True partnership, both within and across organizations, requires relationships on a person-to-person level

What does this mean for you?

- Talk with one another
- Involve housing, formally or informally, in your PPS
- Commit to strengthening your partnerships
- Start NOW!

Thank you!

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