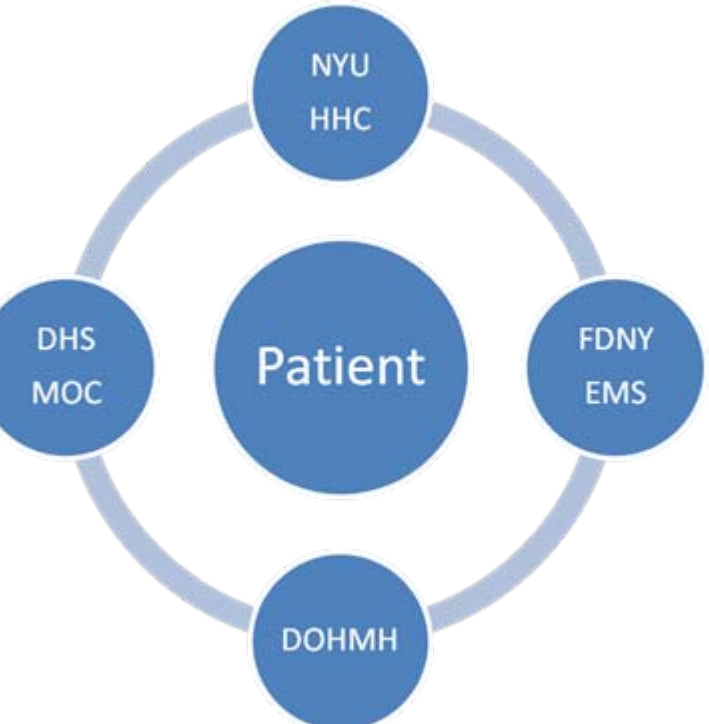
Intervention to Integrate Health and Social Services for Frequent ED Users with Alcohol Use Disorders



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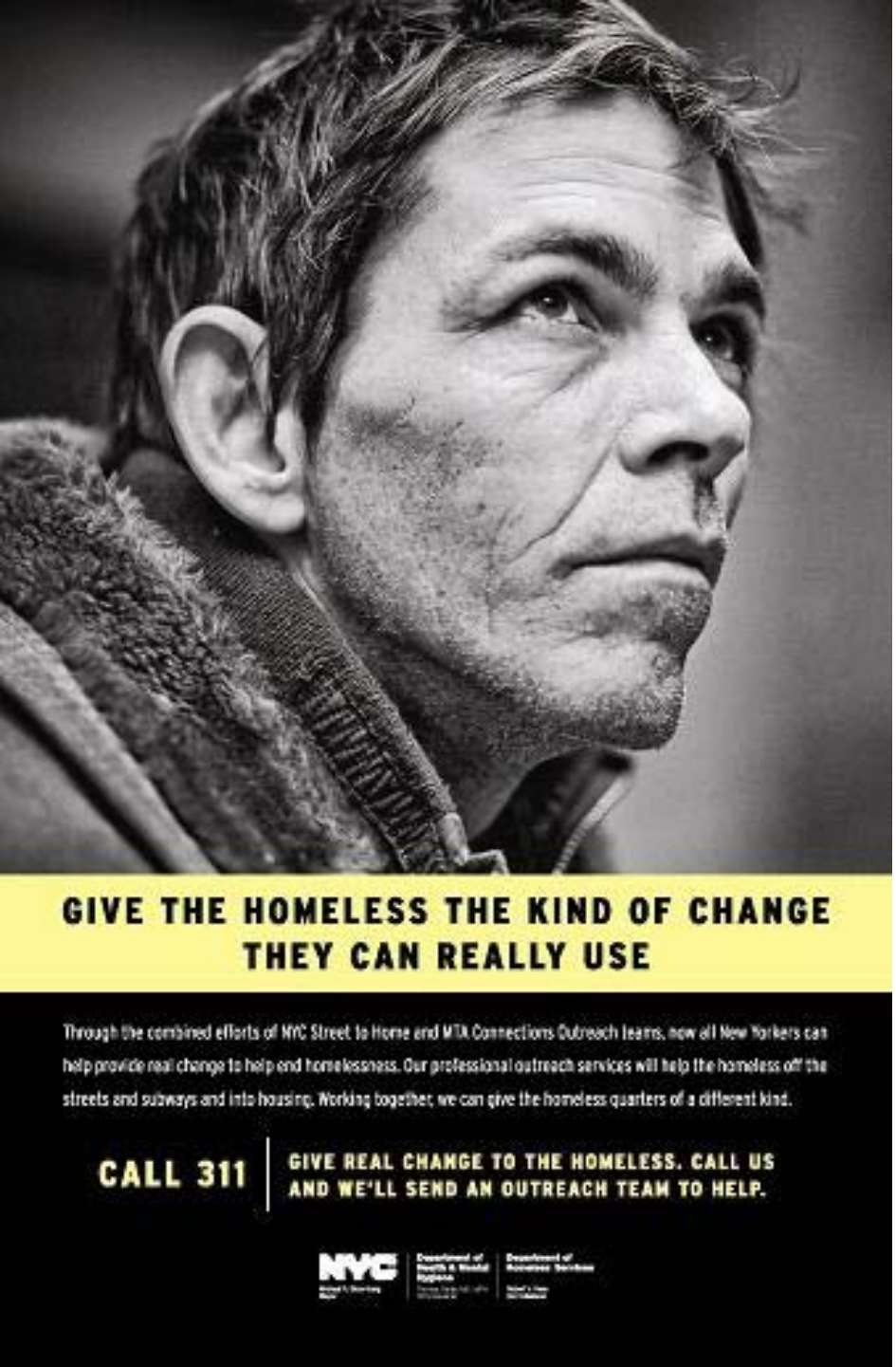


How DHS came to this project

- Street to Home model
- New performance based contract
- Homeless Death Prevention

Street to Home

Street to Home targets individuals sleeping in public places with housing placement services

- Target only individuals sleeping in public places with services
  - Not those who appear homeless, i.e. panhandlers, substance abusers
- Prioritize the most vulnerable long term street homeless
  - Average clients: 7 year street homeless
- Help them secure permanent housing
  - all aspects of the process: income, documents
- Arrange for support services in their new homes
  - Counseling, job training, financial management

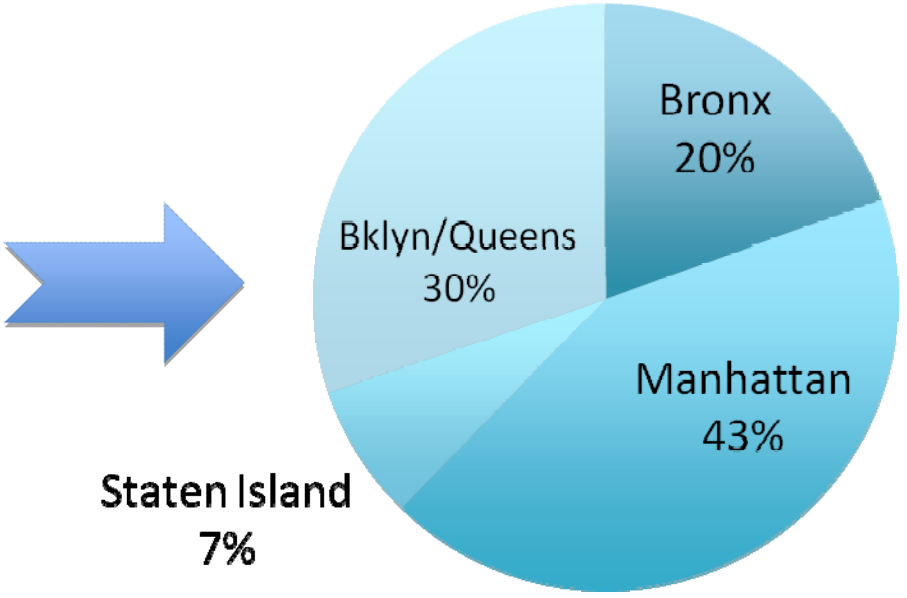
Source: Common Ground

Street to Home

NYC Street to Home began in September 2007

- Dept of Health and Homeless Service combine contracts
- MTA sets goals, but keeps contract separate
- Budgets determined by the size of the homeless population

	Baseline	HOPE 2010 Target
Manhattan	1413	601
Bronx	569	195
Brooklyn/Queens	886	309
Staten Island	221	77
Street Totals	*3089*	*1182*
Subway	1031	281
Total	**4120**	**1463**



Source: DHS

Street to Home has 90% housing retention

- The metric: Housing placements

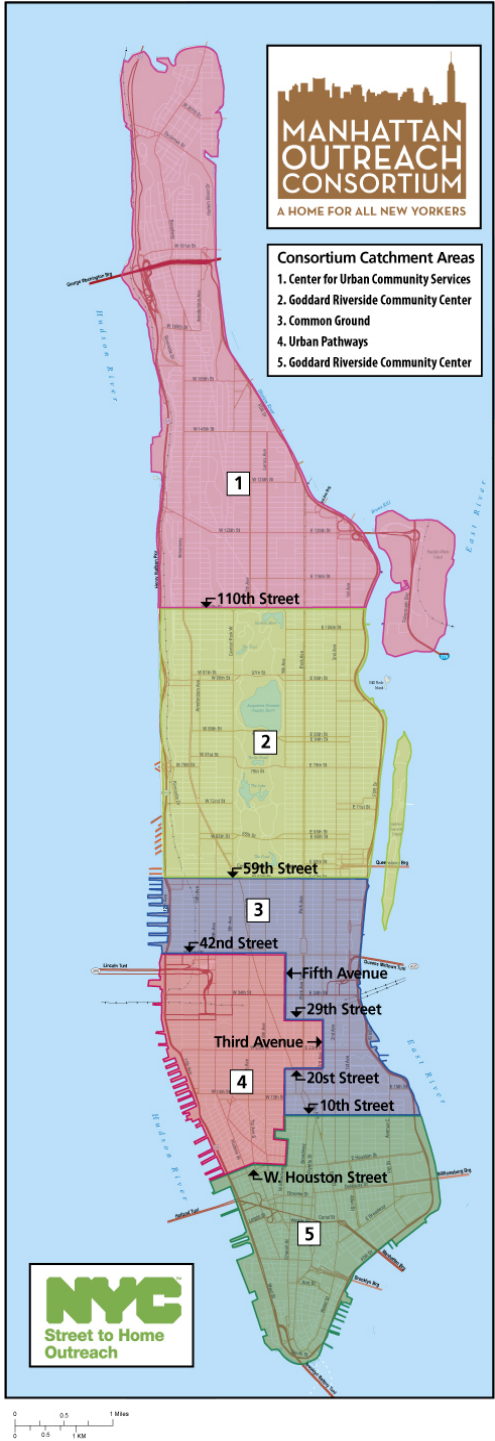
  Meaningful: housing is soul of these programs

  Measureable: well-defined and easily identified

  Manageable: easy to track and target

- Housing is the focus
  - monitoring, supervision, and work tasks

Source: CUCS



Performanc
e

25% of the contract earned through successful housing placements

- Pooled resources from Fed, State, City agencies
  - From 16 outreach contracts down to 4
  - Combine funds, objectives, and monitoring

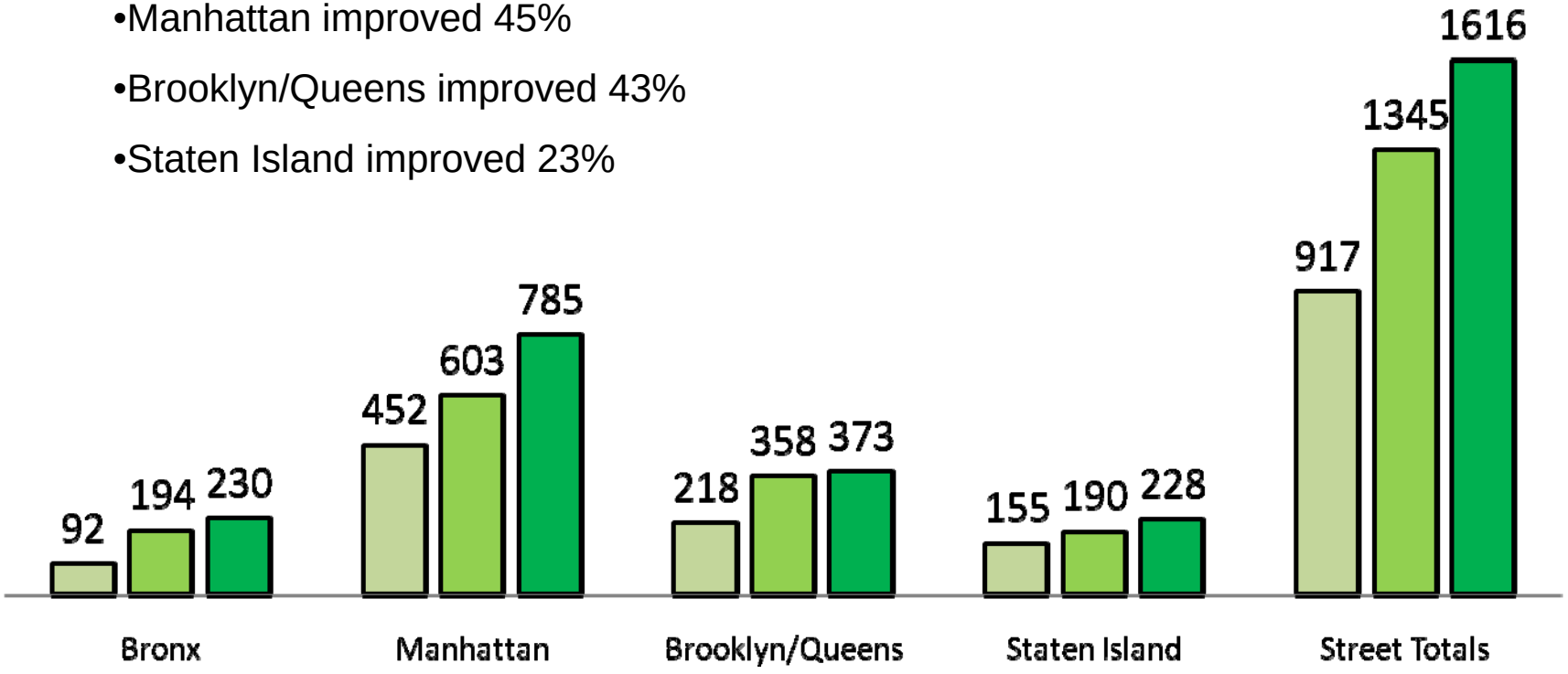
- 25% linked to performance milestones, 10% first year
  - Credit only for long term homeless individuals

Milestone	Year 1 Payments Per Milestone	Following Years Payments Per Milestone
Level I: *Long Term Transitional* 30 days +	$850	$2,000
Level II: *Permanent Housing* 90 days+	$2,000	$5,000

(Adapted from the RFP To Provide Street Homeless Outreach and Housing Placement Services)

Placements increased each year, for each contract

- Overall Street to Home improved 47%:
  - Bronx improved 108%
  - Manhattan improved 45%
  - Brooklyn/Queens improved 43%
  - Staten Island improved 23%

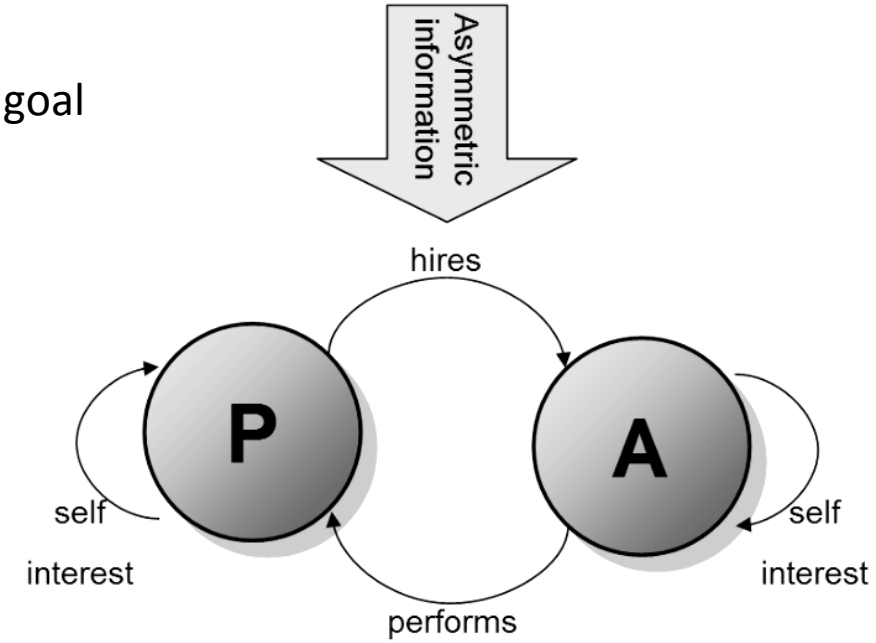


Source: DHS

Performanc
e

Pay for performance feature is enormously powerful

- Organized *Principals* and *Agents* to the same goal
  - Clarified the main objective/task
  - Reduced monitoring costs
  - Shared with frontline workers
  - Shifted risk to contractor



- Aligned *Extrinsic* and *Intrinsic* motivation
  - Risk of 'crowding out' tasks and motivation

- Matching with new contractors: risk and strategy
  - Separating Equilibrium

- Assisted in the price discovery process

	2005	2011	Change
Manhattan	1,805	786	-1,019 (-56%)
Bronx	587	115	-472 (-80%)
Brooklyn	592	242	-350 (-59%)
Queens	335	102	-233 (-70%)
Staten Island	231	128	-103 (-45%)
Subways	845	1,275	430 (51%)
Total Unsheltered	4,395	2,648	-1,747 (-40%)

Local Law 63 of 2005

- Requires the NYC Office of Chief Medical Examiner, Dept. of Homeless Services, Dept. of Housing Preservation and Development, and Human Resources Administration to investigate and report all homeless deaths to Dept. of Health and Mental Hygiene

- 2005–2010, 841 deaths occurred among NYC's homeless population and more than half were street homeless. A 1.5- to 11.5-times greater risk of dying relative to the general population.

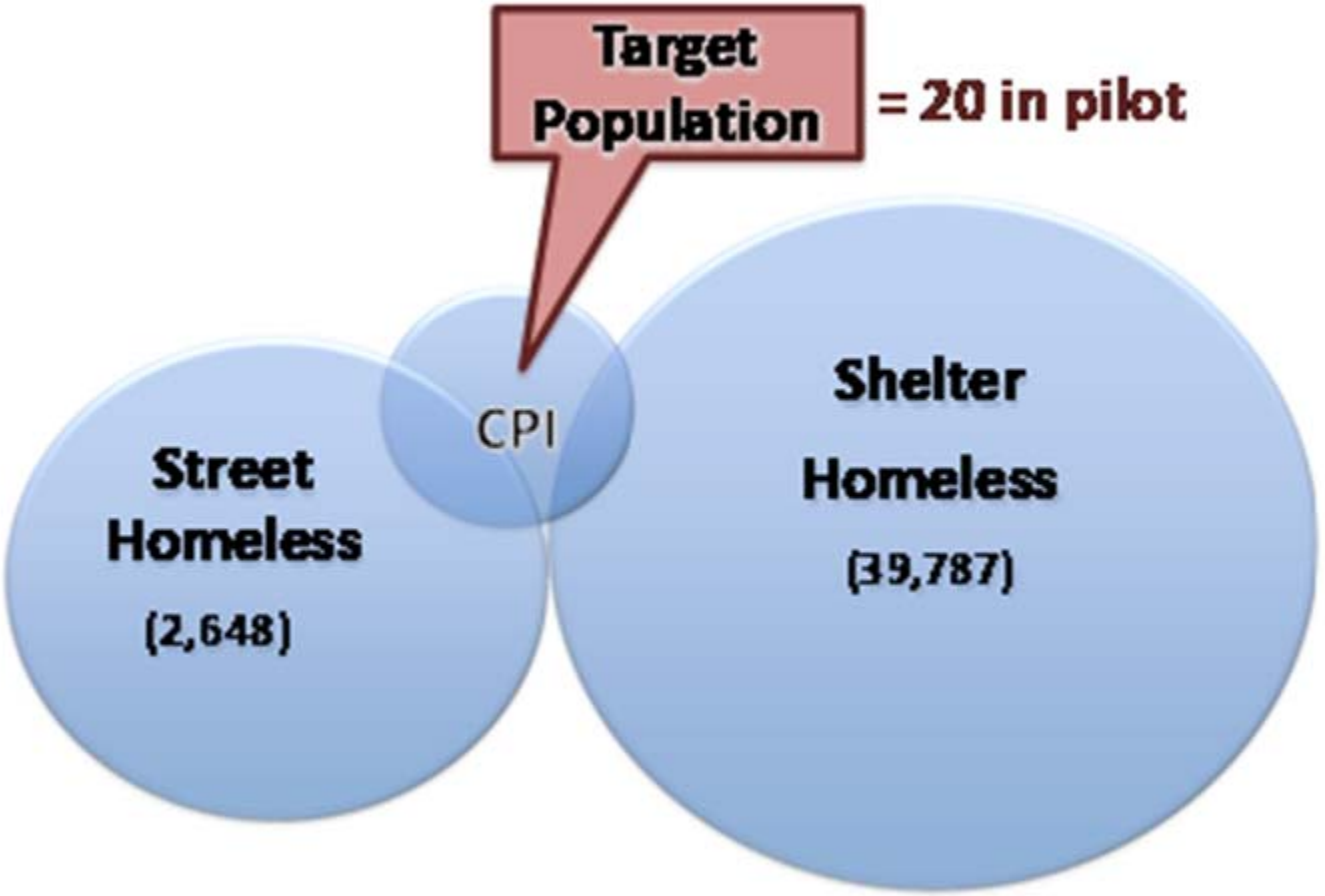
- 20% of street homeless deaths with medical bracelets or seen within the week by a hospital, yet largely unknown to outreach

Bellevue Hospital's own *Million Dollar Murray*

- In January 2009, pronounced dead of hypothermia on a New York City sidewalk, minimally responsive with presumed intoxication and urine soaked garments

- Age of 32 at death, had 429 ED visits, 9 ICU admissions (1 for hypothermia the prior year), and 12 inpatient stays at Bellevue alone.

New York City Homeless Population*



Chronic Public Inebriate (CPI)

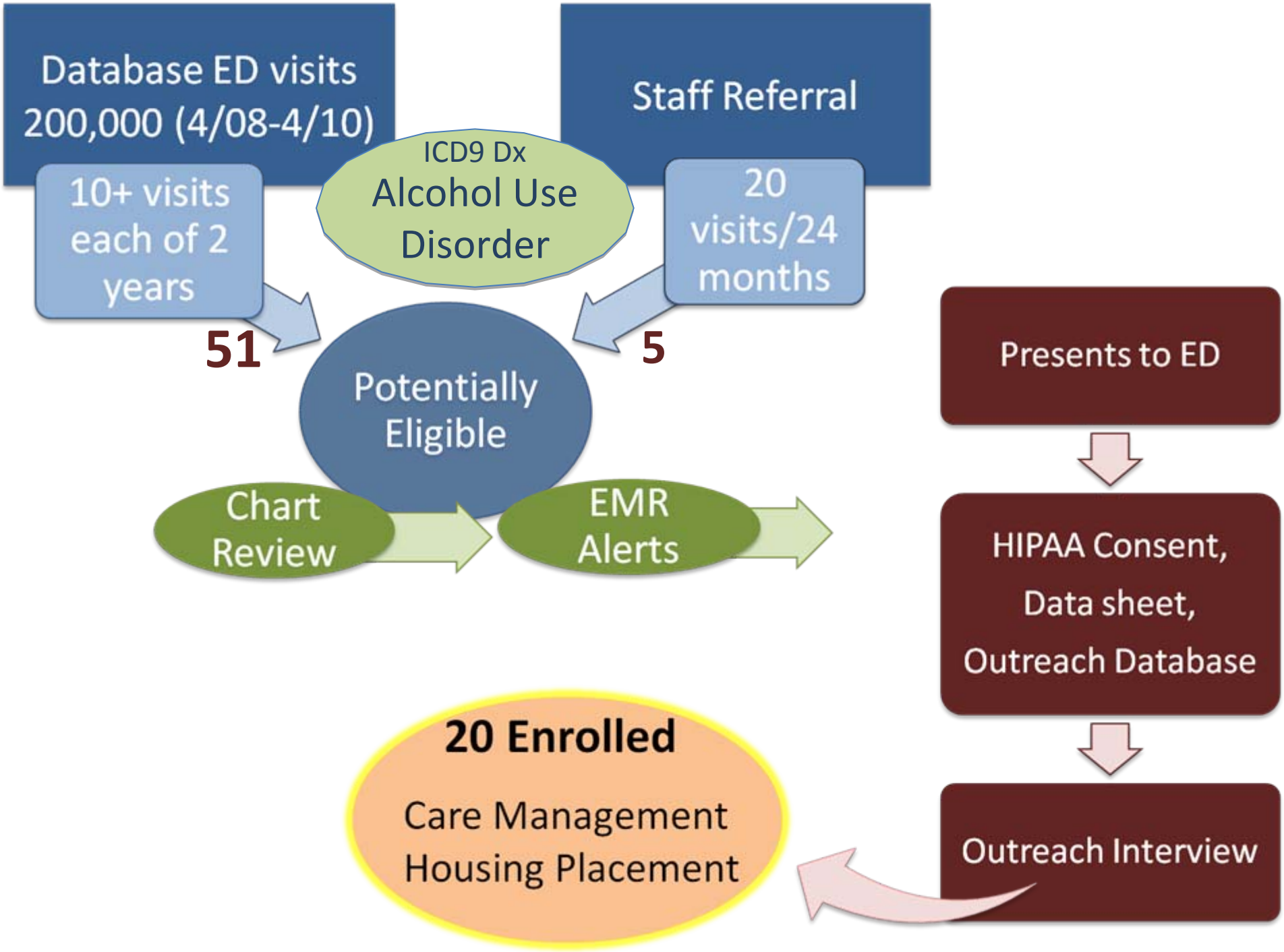
*image not to scale

GODDARD RIVERSIDE COMMUNITY CENTER

- Manhattan Outreach Consortium
- 4 Agencies covering the borough of Manhattan: Goddard being the lead agency
  - Contracted by DHS to provide services to homeless adults living on the streets of Manhattan, focusing on the chronic population
  - 24 hour housing and outreach program
  - Ultimate goal: placement into permanent housing and ending homelessness

CPI Pilot Design

- Identification of top users of ED presenting with alcohol use disorder
- Alert system
- Consent upon presenting at ED
- Linking patient with MOC
- Ongoing services


Database ED visits
200,000 (4/08-4/10)
Staff Referral
ICD9 Dx
Alcohol Use Disorder
10+ visits each of 2 years
20 visits/24 months
51
5
Potentially Eligible
Chart Review
EMR Alerts
Presents to ED
HIPAA Consent, Data sheet, Outreach Database
Outreach Interview
20 Enrolled
Care Management
Housing Placement

CPI Pilot Outcomes

As of April 30th, 2012

- Individuals served: 26
  - Individuals placed: 19
    - 41 transitional housing placements
    - 7 permanent housing placements
  - Individuals already in transitional when referred: 2
  - Individuals not placed: 5

CPI Pilot Outcomes, cont'

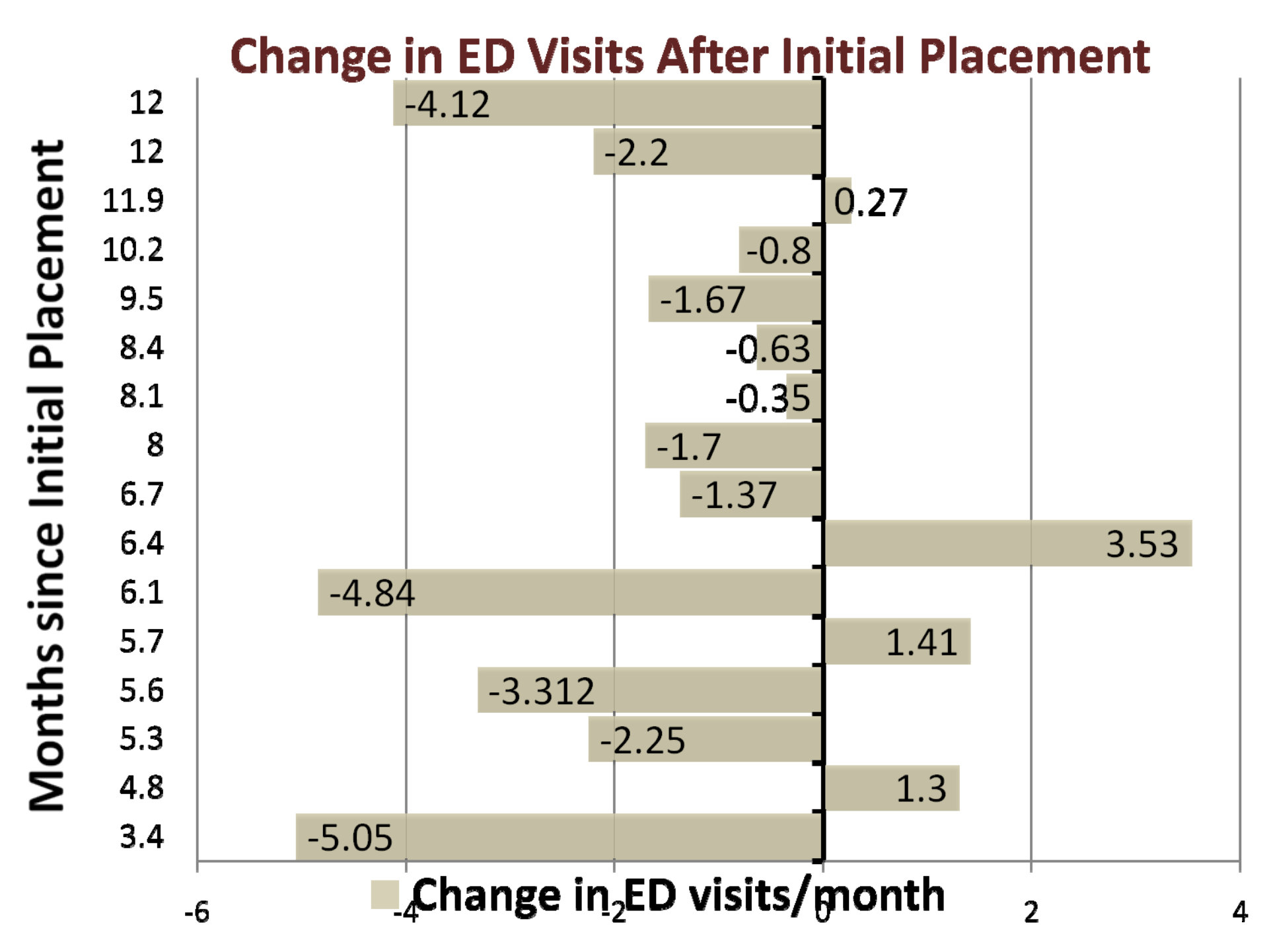
- Currently on caseload: 15
  - 6 are in the street
  - 5 are in transitional housing
  - 4 are in permanent housing
- Clients closed from Bellevue CPI list: 11
  - 3 lost to contact
  - 3 deceased
  - 5 transferred to other programs

CPI Pilot Strengths: Outreach Perspective

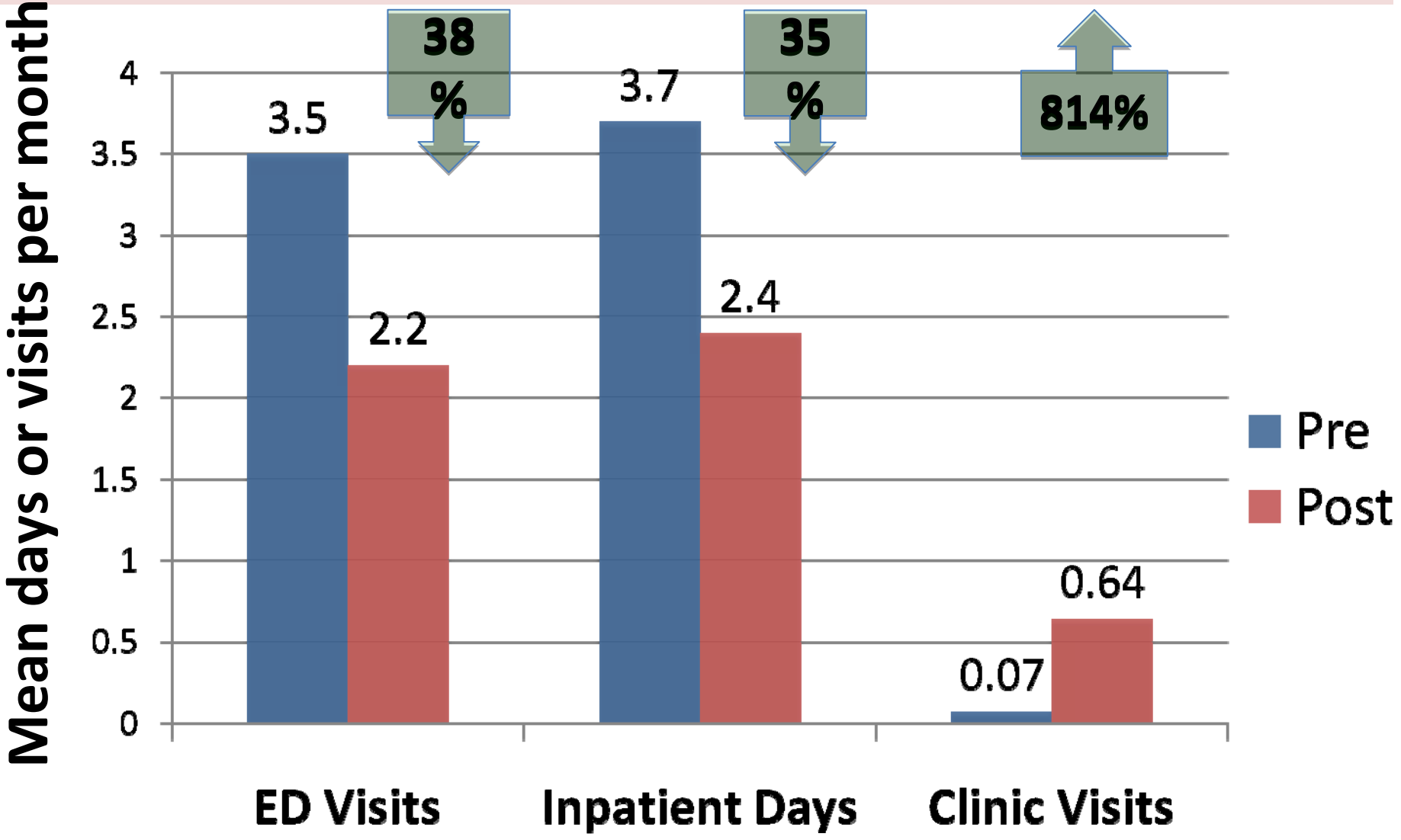
- Connecting with vulnerable street homeless not otherwise encountered
- Having access to more intensive services at Bellevue for pilot clients
- Care Managers
- Developing relationships with Bellevue that carry over to other work

CPI Pilot Weaknesses: Outreach Perspective

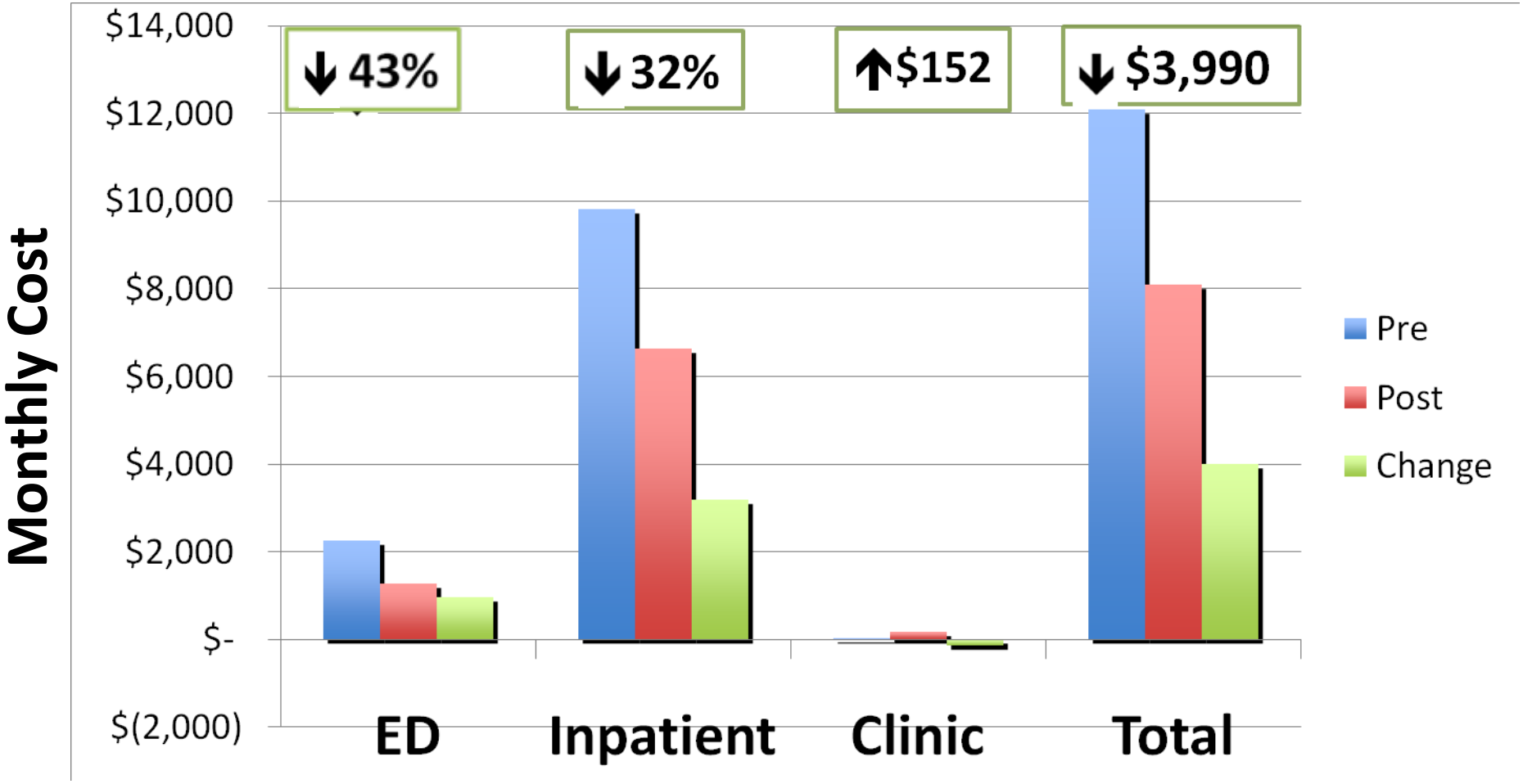
- Information sharing
- Buy-in from all departments at Bellevue
- Alert system
- Coordinated treatment and discharge plans
- Limited resources
- Developing list of potential participants managed solely by hospital


Change in ED Visits After Initial Placement
Months since Initial Placement
12
12
11.9
10.2
9.5
8.4
8.1
8
6.7
6.4
6.1
5.7
5.6
5.3
4.8
3.4
-4.12
-2.2
0.27
-0.8
-1.67
-0.63
-0.35
-1.7
-1.37
3.53
-4.84
1.41
-3.312
-2.25
1.3
-5.05
-6
-4
-2
0
2
4
Change in ED visits/month

Visits Before and After Initial Placement

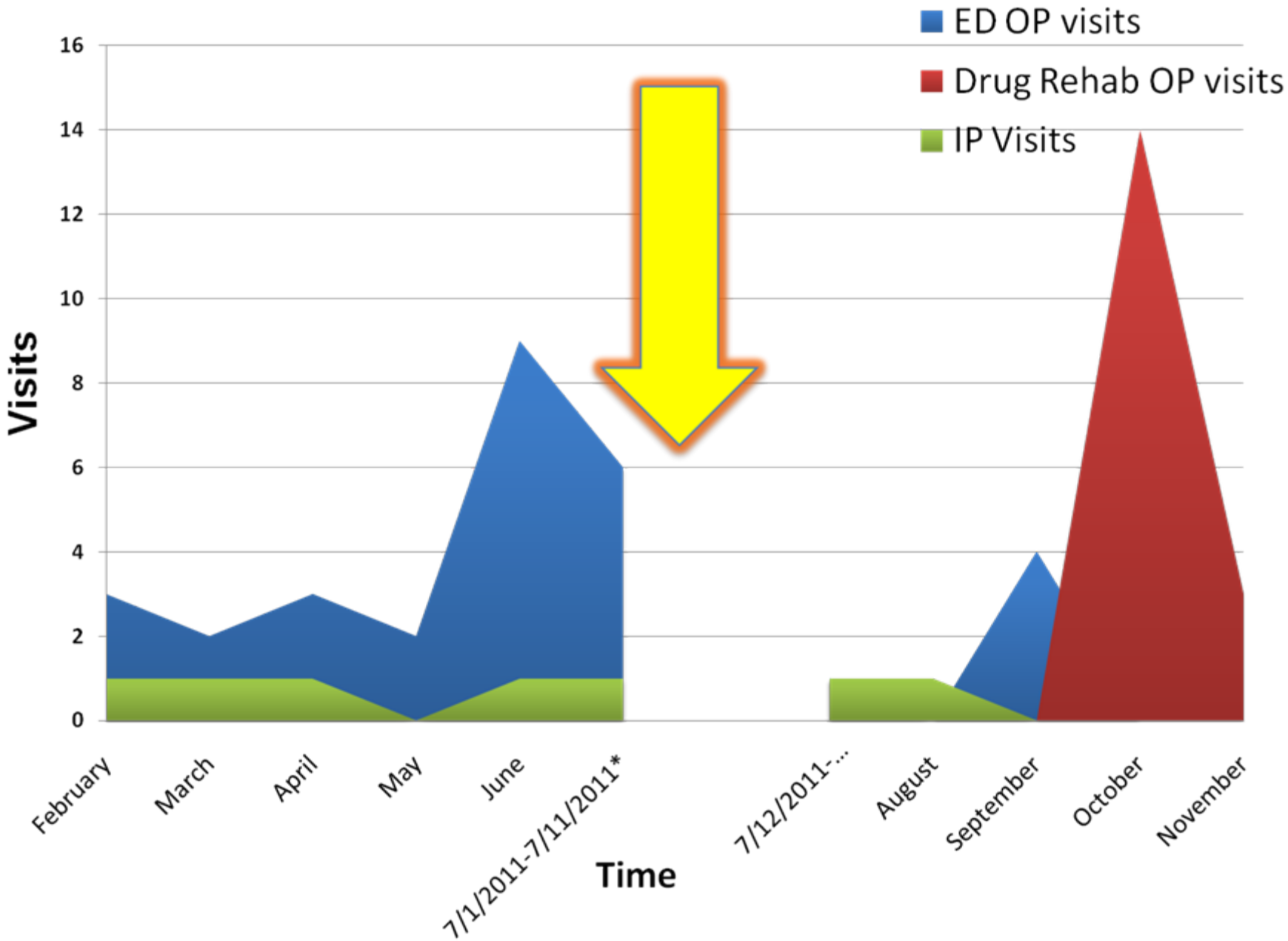


Change in Health Care Cost after Initial Placement



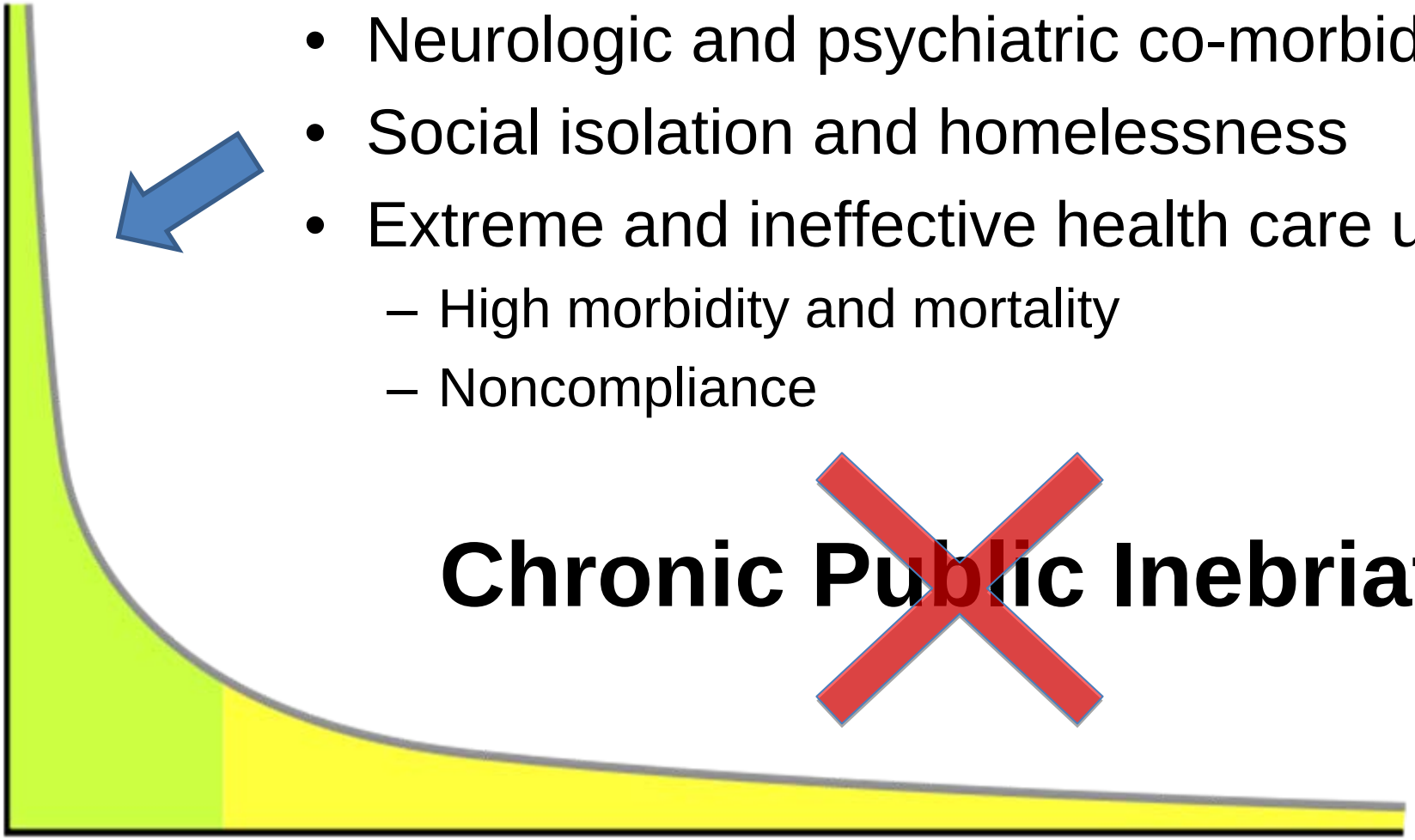
Pre- Placement : 6 months **Post-Placement**: 7.75 months (mean)

Bellevue's Top Visitor



Persistent Combined Neurological and/or Psychiatric Alcohol Use Disorder

- Alcohol use disorder sequelae
- Neurologic and psychiatric co-morbidity
- Social isolation and homelessness
- Extreme and ineffective health care use
  - High morbidity and mortality
  - Noncompliance



Chronic Public Inebriate

While the label of chronic public inebriate is frequently used in the literature to describe this population, our results suggest that the term fails to capture the complexity of the medical-psychological and social factors that characterize these homeless patients. Historically, CPI patients have been conceptualized as being “just drunk” and either incapable of rehabilitation or indifferent to it. This perception of CPIs and their behavior of poor compliance to care has likely allowed these patients to avoid the kind of close assessment and treatment that would otherwise be developed for other patients with similar risks of morbidity and mortality. The introduction of a care model that is more intensive and proportionate to the morbidity of this patient population challenges the current clinical practice paradigms. Consequently, interagency multi-stakeholder partnerships are essential to create accountability and to develop treatment plans and innovative approaches to addiction. If these goals can be realized, there are opportunities for potential improved individual health and economic benefits for society.