Improving Community Health and Wellbeing Through a Multi-Sector Partnership

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September 19, 2019

Vita Health and Wellness

CHARTER OAK COMMUNITIES

STAMFORD HOSPITAL | The Regional Center for Health

Vita
CARE. GROW. ASPIRE.

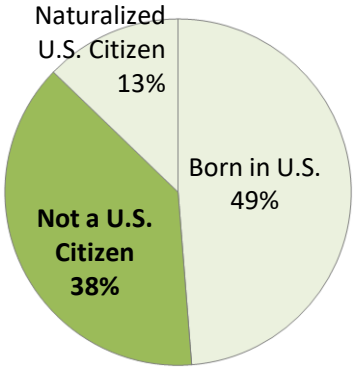
Vita Core Components

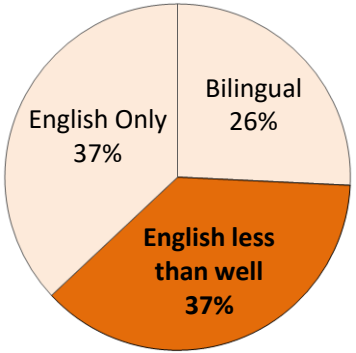
Vita* means *Life

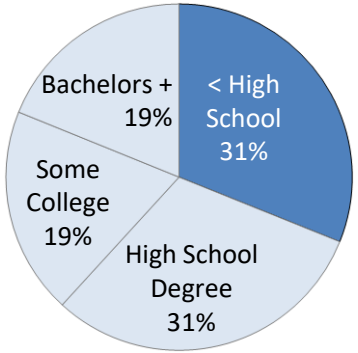
- Health & Wellness in the Community
- Healthy Eating: Urban Agriculture and Nutrition
- Housing Opportunities: Quality, Affordable Housing
- Active Living: Safe Places to Walk and Play
- Promoting Good Jobs and Local Businesses
- Hospital and Community Connections

Social-Economic Factors

WEST SIDE NEIGHBORHOOD, STAMFORD







38% Undocumented

37% Poor English Skills

31% < High School Degree

Median household income $36,000 - $45,000

20% living in poverty

American Community Survey 2007-2011

Health Disparities in the Vita District

- Higher rates of Chronic Disease and Associated Risk Factors:
  - Asthma
  - Diabetes
  - Overweight / Obesity
  - Hypertension / High Blood Pressure
  - High Cholesterol
- High rates of residents reporting No Physical Activity
- Higher percentage of population reporting fair / poor physical and mental health.

SOCIAL CAUSES OF HEALTH

- *When it comes to population health status, “Your Zip Code is more important than your Genetic Code!”*

Social Causes of Health

Socio-Economic Factors

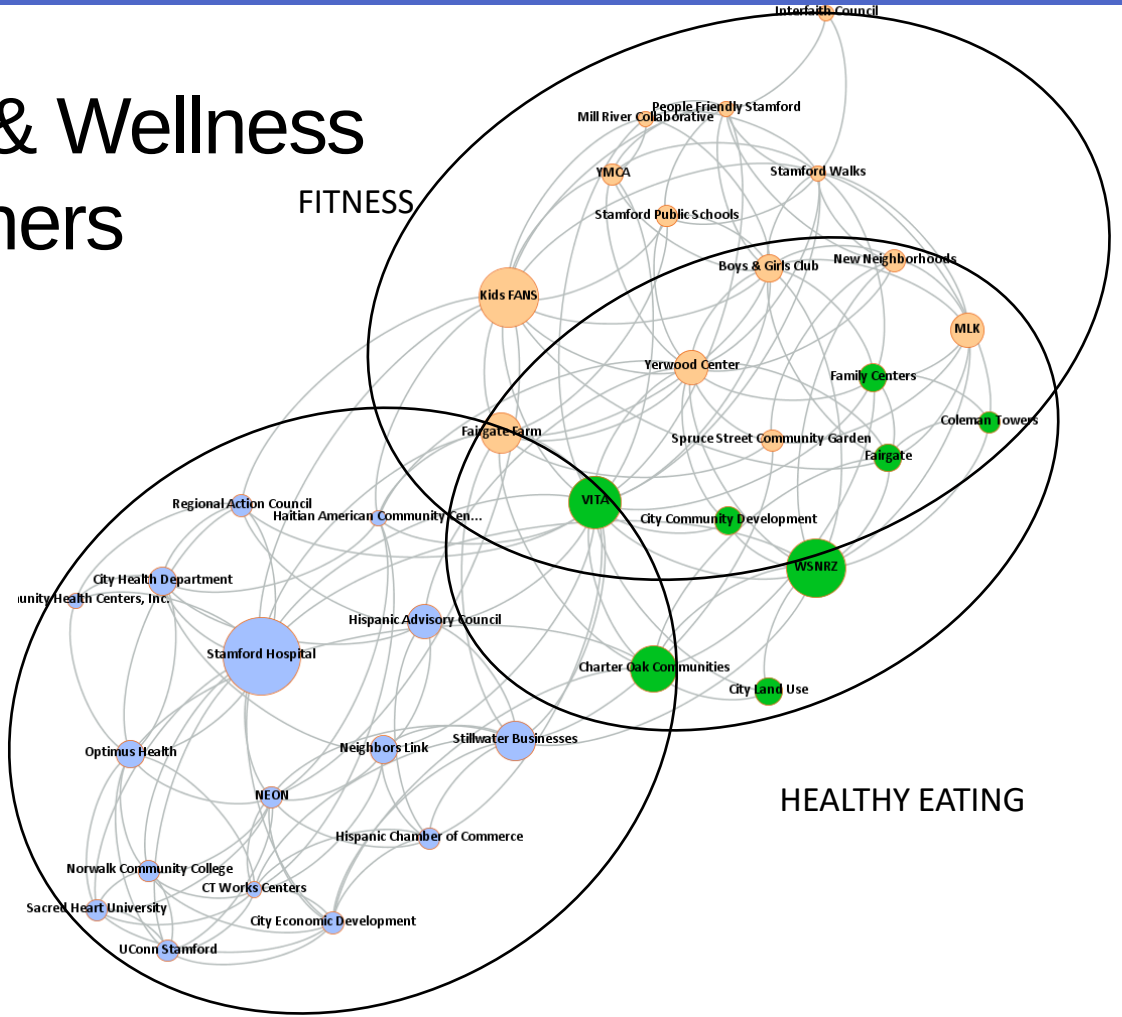
Access to Health Services

Physical Conditions

Individual Behaviors

www.healthypeople.gov/2020/about/DisparitiesAbout

Vita Health & Wellness Partners



Outcomes: Improved Livability & New Hospital Facility

- **Quality of Life:** Public-private investment in walk-able neighborhood, aligned with improvement in parks and public facilities; Reduction in crime and nuisance conditions

- **Hospital Replacement:** New $500M *state of the art* hospital with improved physical connections to the community

New Housing & Economic Development

- **Housing:** Created 550 units of attractive, mixed-income, healthy housing with on-site support services

- **Business Development:** Attracted new businesses and activated WSNRZ Merchants Association

Healthy Nutrition & Community Building

- **Access to Healthy Food:** Established Fairgate Farm, volunteer-powered working farm and nutrition education center, supported by programs, volunteerism, market and cooking classes

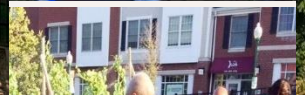
- **Obesity Prevention:** Kids' Fitness & Nutrition Services (KidsFANS), a community-wide taskforce for the prevention of childhood obesity has served thousands of children

Questions and Contact Information

- Website: http://vitastamford.com/
- Contact Us:

Vincent Tufo: VTufo@CharterOakCommunities.org

Pamela Koprowski: pamcardinaleassociates@gmail.com




FAIRGATE
FARM

Investing in Housing and Community Health

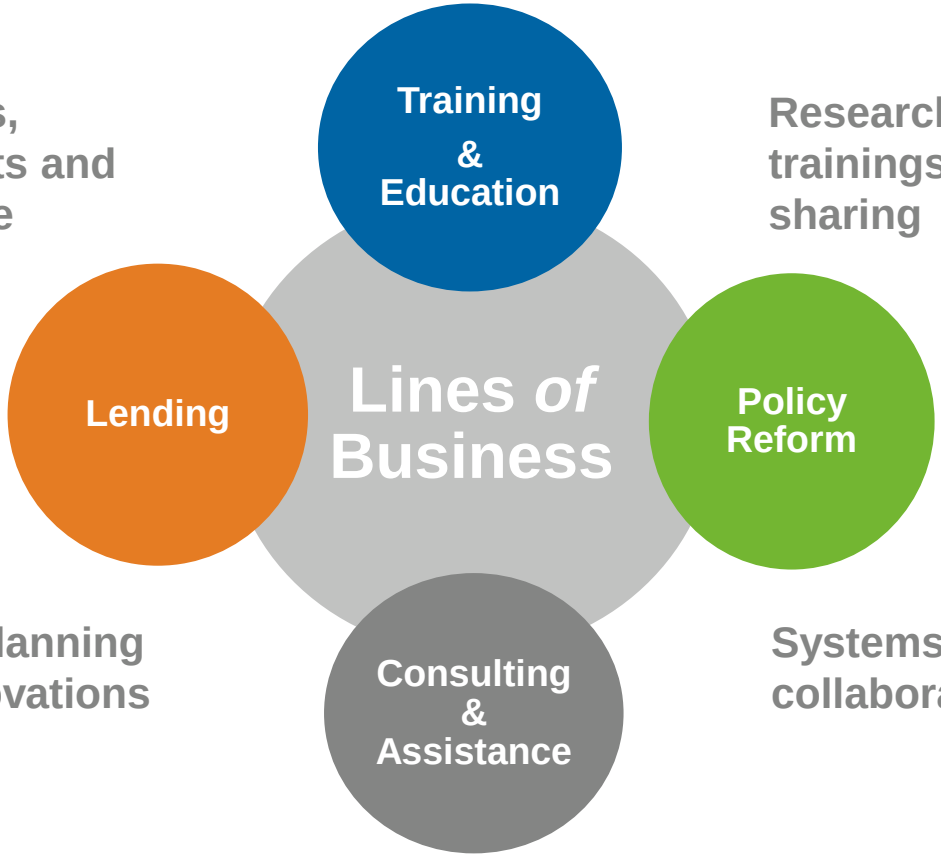
CSH

What We Do

CSH is a touchstone for new ideas and best practices, a collaborative and pragmatic community partner, and an influential advocate for supportive housing.

Powerful capital funds, specialty loan products and development expertise

Research-backed tools, trainings and knowledge sharing



Custom community planning and cutting-edge innovations

Systems reform, policy collaboration and advocacy

Shift in Focus: From Patient Outcomes to Community Outcomes

- Focus on Population Health is Driving a Realignment of the Traditional Hospital Business Model
  - *The Triple Aim*
  - *Hospital Community Benefit Requirements*

- New Value-based/ Value-oriented Payment Models Incentivize for Improved Health
  - *ACOs, DSRIP, PCMH, Medicaid Health Homes*

Housing As a Powerful Social Determinant of Health

Social determinants of health are the…

"…circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics."

- World Health Organization

Homelessness/ Housing Instability

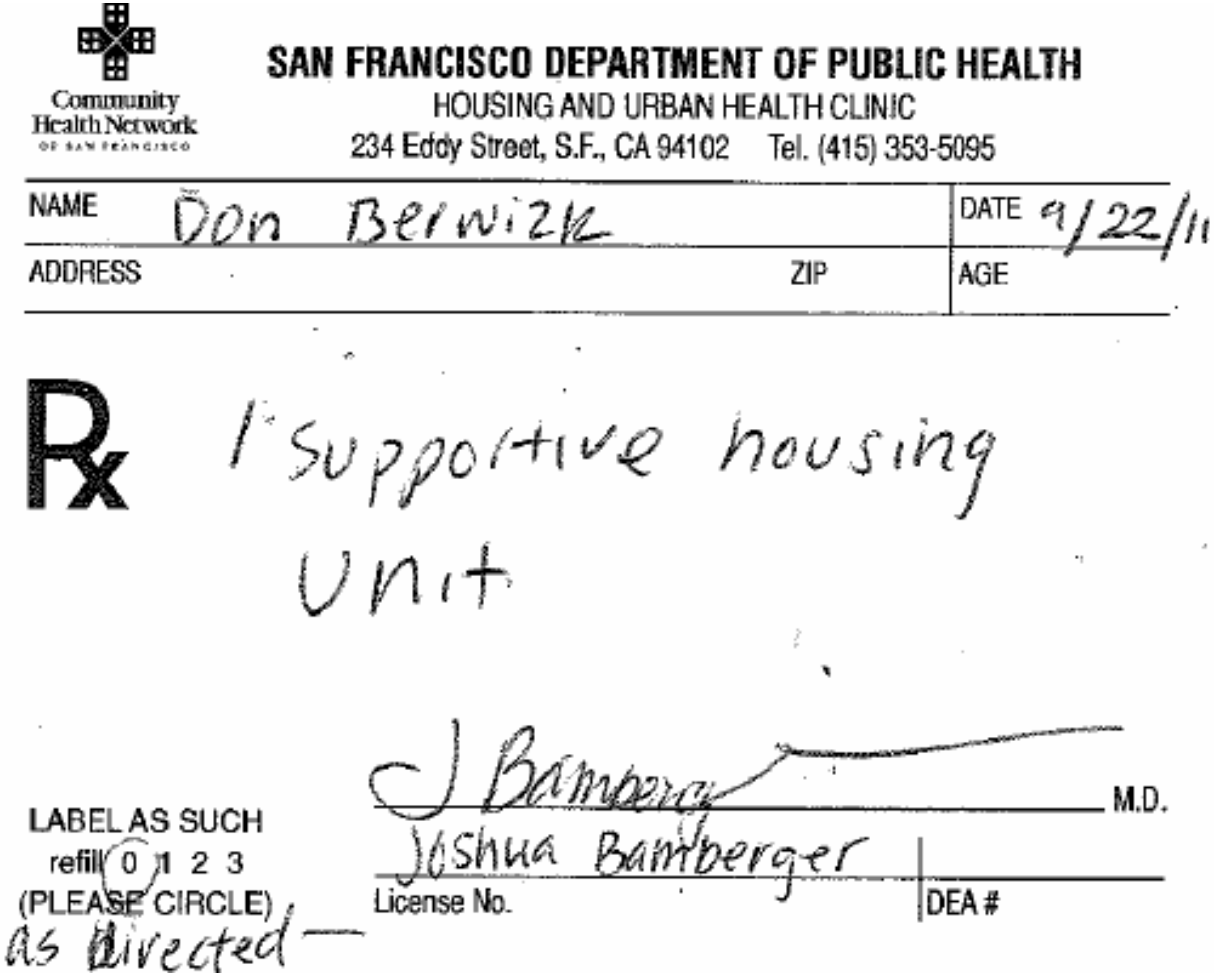
Poor Health

CSH

Benefits of Stable Housing

- Meets Basic Needs
- Platform for Service Delivery
- Improves Access to Health Care
- Locus of Integrated Health Efforts
- Beyond Crisis Management

The strongest healthcare intervention for high utilizers is **supportive housing**



Community Health Network OF SAN FRANCISCO

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH
HOUSING AND URBAN HEALTH CLINIC
234 Eddy Street, S.F., CA 94102 Tel. (415) 353-5095

NAME Don Berwick DATE 9/22/11
ADDRESS ZIP AGE

Rx 1 Supportive housing Unit

LABEL AS SUCH
refill 0 1 2 3
(PLEASE CIRCLE)
As Directed

J Bamberger M.D.
Joshua Bamberger
License No. DEA #

Supportive Housing: A Powerful Social Determinant

Supportive housing combines affordable housing with services that help people who face the most complex challenges to live with stability, autonomy and dignity.

Housing:
Affordable
Permanent
Independent

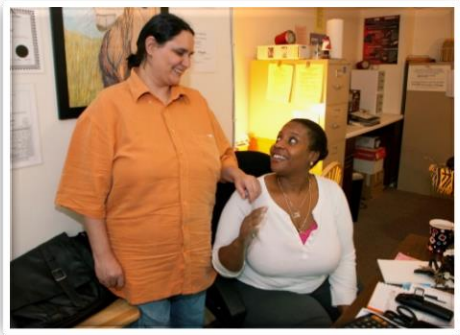
Support:
Flexible
Voluntary
Tenant-centered
Coordinated Services

High Quality Supportive Housing

A variety of housing models exist with common factors including:

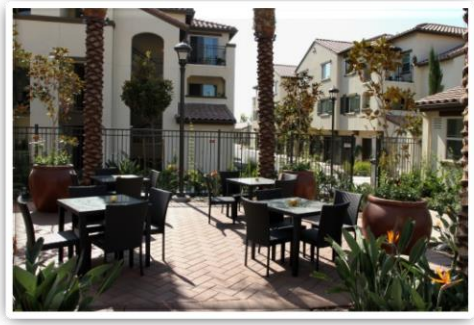
Located in within safe neighborhoods **with close proximity to:**

- **Transportation**
- **Employment opportunities**
- **Services**
- **shopping, recreation and socialization.**



Tenants *have a lease identical to those of tenants who are not in supportive housing*.

Services are voluntary and consumer-driven. **They focus on ensuring that tenants can obtain and thrive in stable housing, regardless of barriers they may face.**



The housing and its tenants are *good neighbors, contributing to meeting community needs* **and goals whenever possible.**

Supportive Housing is the Solution

- 80% of supportive housing tenants are able to maintain housing for at least a year
- Use of the most costly (and restrictive) services in homeless, health care and criminal justice systems declines when living in supportive housing
- Supportive housing tenants choose to participate in services even when they are not a requirement for tenancy

Current Housing Paradigm

- Shortage of affordable housing supply
  - Only 1 in 4 eligible households obtain rental assistance
- Housing is not an entitlement
- What the market is currently building: less than 1% affordable
- Needs of the very low-income and highly vulnerable population are not being met

Emerging Trends in Health System Investments Types

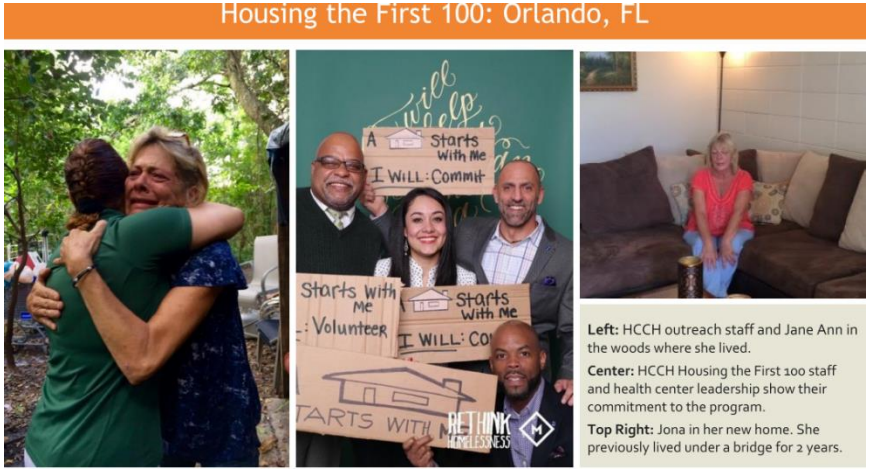
CSH

Not A One-Size-Fits-All Approach

Health Systems are exploring the myriad of ways they can address social determinants like housing:

- Hospital Community Benefit
- Donating Underutilized Hospital Land
- Financial Investment/ Donation
- Leveraging LIHTC/ Federal, State & Local Resources
- Respite

Financial Investment Ex: Florida's Housing the 1st 100



- ***What?*** – Collaborative that connects high cost, high need, homeless frequent users of multiple systems (homeless, hospital and jail) to housing and services.
- ***Who?*** – Partnership between Orange Blossom Family Health; Florida Hospital, CoC, law enforcement, and local government
- ***How?*** – Public outcry over street homelessness; Hospital system spending 3X the cost of housing on preventable services. FL hospital invested $6M for 3 yrs of services, City of Orlando provided $4M to fund Barrier Busting Fund and HF pilot. County and HUD funds used for rental assistance.
- ***Outcome*** –168 people housed. ↓ in incarcerations and hospitalizations, ↑ in individual income and housing retention.
- ***Moral of Story –*** Hospital looked at its own data to see cost of serving homeless; cross-sector collaboration and multiple funding sources

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HOUSING IS HEALTH COLLABORATIVE

Portland health care organizations are investing $21,500,000 allowing CCC to build 382 new housing units across three locations and a new health center in Southeast Portland. The health organizations supporting the initiative are: **Adventist Health Portland, CareOregon, Kaiser Permanente Northwest, Legacy Health, OHSU, Providence Health & Services – Oregon**

Housing + Health Care for the Whole Person

CENTRAL CITY CONCERN

HOMES | HEALTH | JOBS

Housing is Health Initiative Sites

Charlotte B Rutherford Apts

- 6905 N Interstate Ave
- 51 units of housing affordable for families earning 30% to 60% MFI
- Preference for displaced households who wish to return to the community

Hazel Heights Apts

- SE 126th and Stark St
- 153 units of permanent housing for people exiting transitional programs

The Blackburn Health & Recovery Ctr

- 175 affordable apartments for people with special needs:
- 51 beds providing medical & MH respite care
- 10 units of palliative care
- 114 units providing recovery housing
- 40,000 square foot health clinic

Information originally presented by Rachel Solotaroff, MD, Medical Director, Central City Concern at the ACHI Conference March 2018

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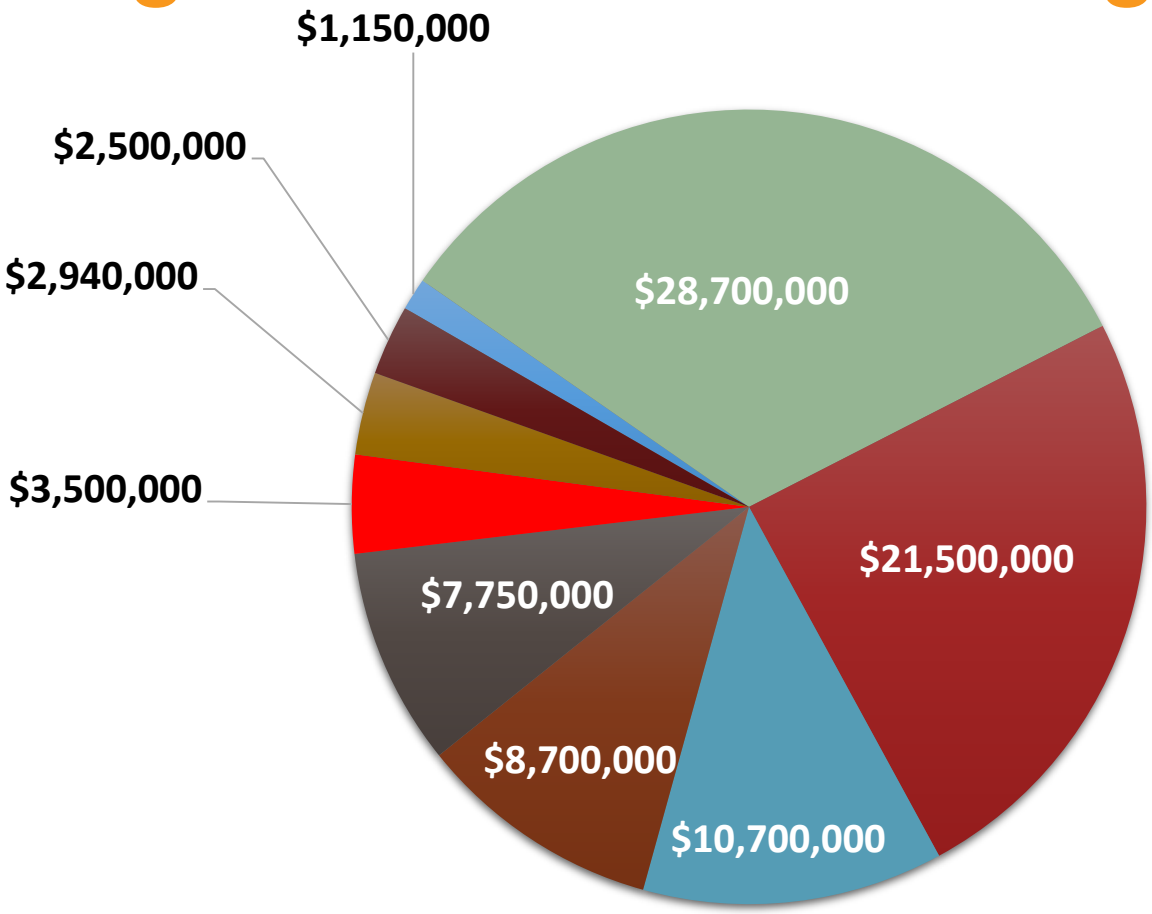
Funding Sources for Housing Is Health



Information originally presented by Rachel Solotaroff, MD, Medical Director, Central City Concern at the ACHI Conference March 2018

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CAMBA Gardens I & II

- A 2005 CSH White Paper influenced the decision on how to re-use surplus hospital land
- Model partnership between a public hospital, non-profit developer service provide and community stakeholders
- Phase I and II opened in 2013 and 2016 respectively on the campus of NYC Health + Hospitals' Kings County Hospital
- Provides a combined 502 affordable and supportive homes in the heart of Brooklyn, NY.
- Represents over $166 million in public/private investment.

CAMBA Gardens Amenities

On site social services provided by CAMBA, including:

- Job training, Resume workshops, Healthy living workshops, - Assistance with accessing benefits, - Referrals to community based resources, including preventative healthcare at Kings County Hospital

24/7 front desk security

Computer rooms available for resume workshops, job searching, and computer skills trainings

Community rooms and multi-purpose rooms available for community and tenant meetings and workshops

Outdoor landscaped areas with seating and play areas for families

Community planting beds for tenant community garden programs

Teaching kitchen for healthy living and cooking classes integrated

CAMBA Gardens Unit

Teaching Kitchen

CSH

Funding Sources for CAMBA Gardens

CAMBA Gardens Project Financing

-Total Development Costs: $66,892,558

-Capitalized Lease Payment to HHC/KCHC: $2,300,000
  -Payment made at construction closing on June 30, 2011

-Construction Financing Sources:
  -New York State HFA Tax Exempt Bonds
    -Credit Enhancement provided by TD Bank
  -Federal Low Income Housing Tax Credit Financing
    -Syndicated by Enterprise Community Investment
  -NYC HPD Supportive Housing Loan Program
  -NYS Homeless Housing Assistance Corporation
  -Brooklyn Borough President Marty Markowitz
  -NYC Councilmember Mathieu Eugene
  -Federal Home Loan Bank of New York with HSBC
  -NYSERDA
-Social Service Funding Sources:
  -NYC Department of Health and Mental Hygiene
  -NYC York City Department of Homeless Services
-Operating Funding Sources:
  -125 Federal HUD Section 8 Vouchers Provide by HPD
-Predevelopment Financing Provided by Corporation for Supportive Housing and Enterprise Community Investment

Completed building at 738 Albany Avenue (Winter, 2014)

738 Albany rear yard with play equipment and passive seating areas (Winter, 2014)

CAMBA
Housing Ventures

CSH

NYC's St. Barnabas' Community Wellness Project

Project Summary

Medical Facility

- 8,000 SF Urgent Care
- 22,000 SF Mind Body Center

Population Health Space

- 13,000 SF Women and Children's Centers
- 6,000 SF Nutrition/WIC Programs

Affordable Housing

- 50 MRT Units
- 45 Working Homeless Units
- 219 Affordable Units

Commercial Space

- Extended Hour Daycare
- Local Pharmacy
- Healthy Food Cafe

Emerging Work:

Leveraging State Resources Ex: NJ Hospital Partnership Subsidy Pilot Program

- ***What?*** – NJHMFA to provide up to $12M in matching funds from 3-4 hospitals to develop AH and SH for special needs residents and/or frequent users of hospital ED. The project financing includes 4% LIHTC.
- ***Who?*** – NJHMFA, NJHA and up to 4 acute care hospital systems
- ***How?*** –NJHA President and HMFA ED were spurred by the Camden Coalition of Healthcare Providers “hot-spotting” efforts
- ***Outcome*** – TBD. LOI due 12/17/18
- ***Moral of Story –*** Emerging trends in health bring about unique partnerships to incentivize hospital investments

CSH

Medical Respite Care:

A Caring Place to Recover from Illness and Injury for People Experiencing Homelessness

Yale NewHaven Health

the way home
COLUMBUS HOUSE INC

Who Needs Medical Respite?

Patients who:

- Are discharged from the acute care provided by the hospital, but
- Lack housing in which to continue their recuperation, and
- Will benefit from professional nursing care to continue healing

Common Medical Conditions in Respite Referrals

- Post-surgery **wound care**
- Treatment of **Infections**
- **Respiratory** ailments
  - Pneumonia, COPD or asthma
- Bone **fractures**
- Temporary **med management** (antibiotics)

What are the Goals of Respite?

- Provide the location, supplies, and medical care that homeless patients require to recover
- Reduced length of stay, re-visits to the ED, and readmissions
- Reduced costs to the hospital and payers
- End the cycle between homelessness and hospitalization

Pre-2013: Culture of Medical Care

- Customize the treatments to the diagnosis, but otherwise consider every patient the same: “Why don’t homeless patients just take their medications and keep their appointments?”
- If lack of housing is disclosed, consult the social worker to assess and refer to services.
- No standardized method of patient interview, documentation of housing status, or collaboration among care- or community-providers

Pre-2013: Waking up to Homelessness

Some of us recognized that many homeless individuals were coming to YNHH with complex medical and social needs

We *suspected* they were receiving a disproportionate amount of Medicaid and hospital resources:

- A higher level of care for more days, with
- More readmissions, and
- Many more Emergency Department revisits

But without data, how bad was it?

Homelessness and Hospital Care…

Kelly Doran, MD – RWJ Scholar – 2012

Studied 113 homeless individuals during the 30 day period following hospitalizations

70.3% returned to the ED during that time

50.8% were readmitted to inpatient care

3.0% were readmitted for Observation

75% of these readmissions occurred **within 2 weeks**

Only 18.7% of Adult Medicaid patients were readmitted during this time

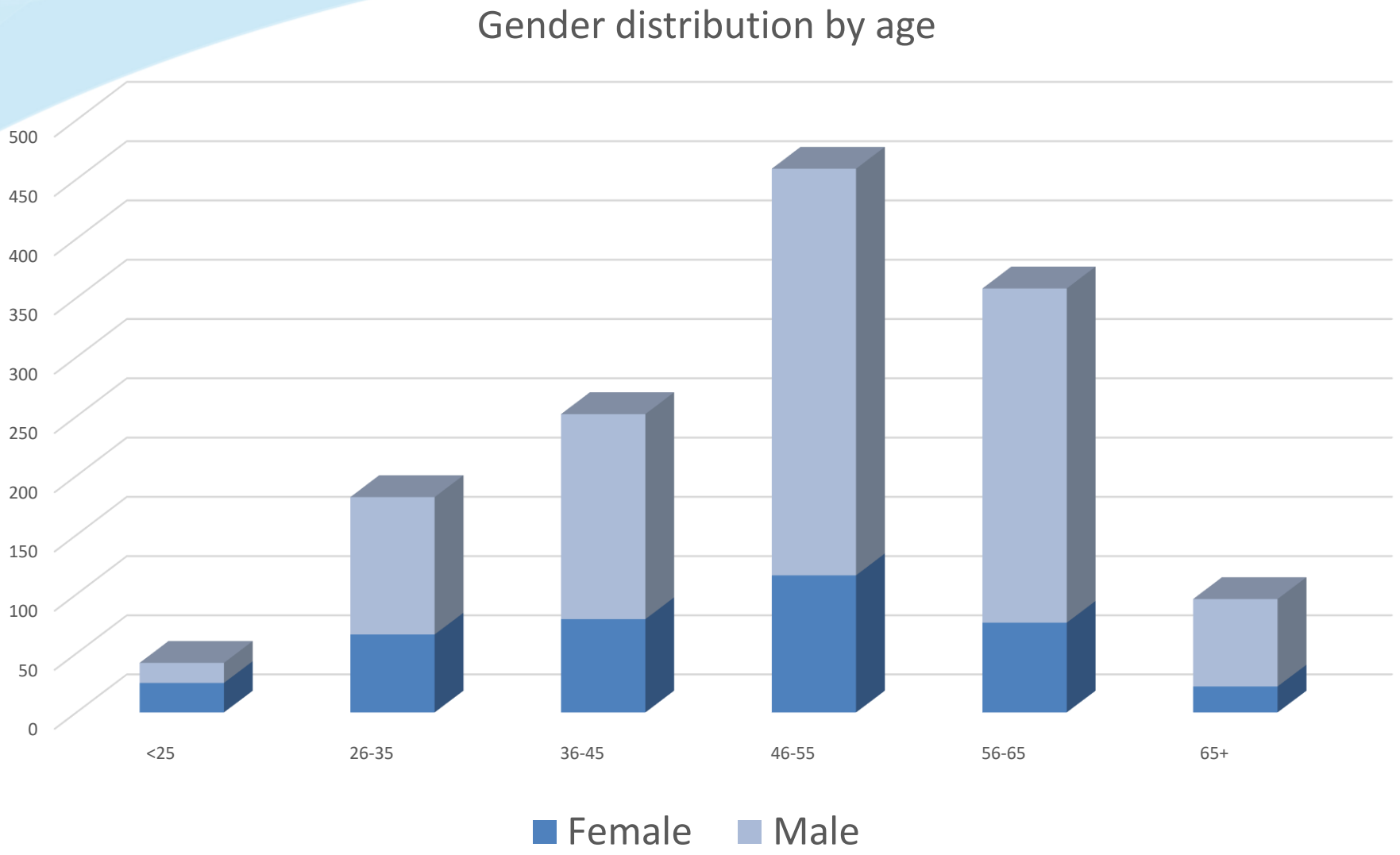
From Academics to Advocacy…

- A Task Force was formed with YNHH and Columbus House participants advocating to the Connecticut legislature for a Medical Respite program
- Former shelter director, then Senator Toni Harp of New Haven championed the bill
- With the assistance of our New Haven delegation to the CT Legislature, funds for Medical Respite have been included in each budget signed by Governors since July of 2013

Respite Design Issues

- Hospital referral required? ED? Clinic?
- What staffing is needed? Training? Accountability?
- Who will screen/approve patients, using what criteria?
- Will patients have visitors or leaves during their stay?
- Is substance use permitted? Before/During?
- What services will be provided during their stay?
  - Housing case management? Transportation? Supervision?
- When is a patient discharged? Medically/Behaviorally?
- How will success be measured?

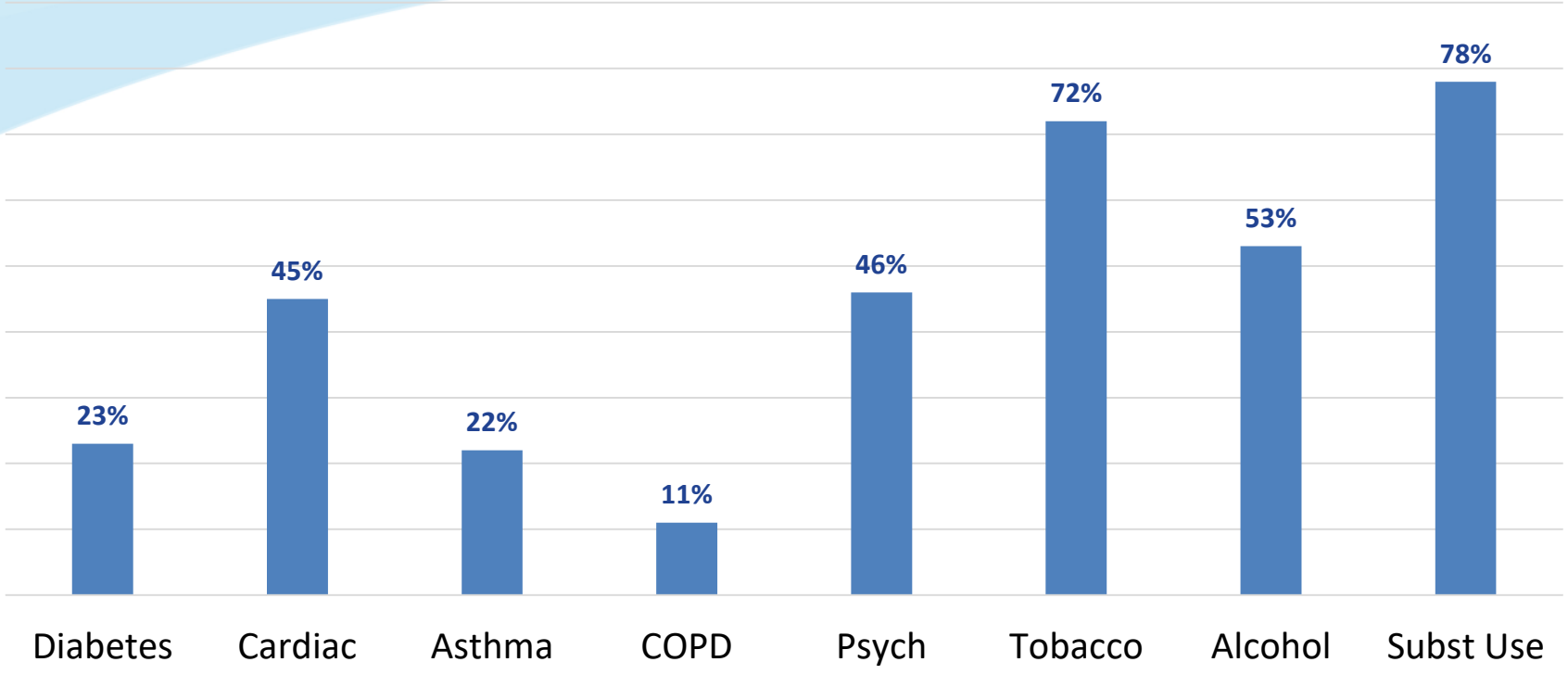
Age & Gender


Gender distribution by age
500
450
400
350
300
250
200
150
100
50
0
<25
26-35
36-45
46-55
56-65
65+
Female
Male

Mental Health & Substance Use

	No Psych	Psych	Total
Clean & Sober	16%	5%	21%
Alcohol and/or Drugs	36%	43%	79%
Total	52%	48%	100%

Above-Average Prevalence of Chronic Illness Among Homeless Inpatients



- Review of 1127 unique patients identified as homeless from 2014-2019
- These 1,127 individuals were associated with 2,335 inpatient visits.

Staffing

At the Hospital

- Admissions
- MDs and RNs
- Social workers
- Care managers
- Data collection & analysis

All covered by the hospital

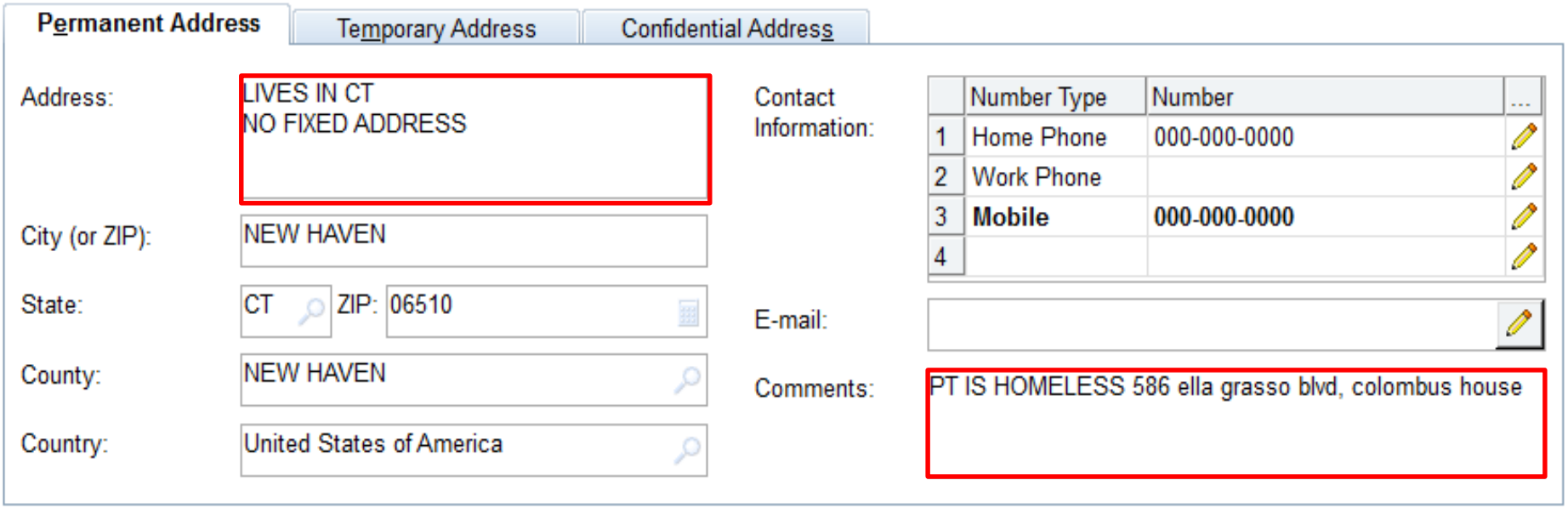
At Columbus House

- Shelter manager
- Respite case manager
- Transportation
- 24hr Residential staff
- On-site nurses*
- APRN 20hrs per week*

**Covered by the hospital*

Mining Medical Records: A Social Work responsibility

Data Entry for Patients Identified by **Admissions:**



Permanent Address | Temporary Address | Confidential Address

Address: LIVES IN CT
NO FIXED ADDRESS

City (or ZIP): NEW HAVEN

State: CT ZIP: 06510

County: NEW HAVEN

Country: United States of America

Contact Information:

	Number Type	Number	...
1	Home Phone	000-000-0000	
2	Work Phone		
3	**Mobile**	**000-000-0000**	
4			

E-mail:

Comments: PT IS HOMELESS 586 ella grasso blvd, colombus house

Mining Medical Records:

Physicians use **ICD codes** to indicate a patient is experiencing homelessness

Non-Hospital Problem List — Date Reviewed: **3/31/2014**

	ICD-9-CM	Priority	Class	Noted
Alcohol withdrawal	291.81			3/26/2014
Atrial fibrillation with rapid ventricular response	427.31			11/24/2013
Chronic pain syndrome	338.4			11/24/2013
Community acquired pneumonia	486			11/24/2013
Nicotine dependence	305.1			11/26/2013
Alcohol abuse	305.00			11/27/2013
Homelessness	V60.0			11/27/2013
Atrial fibrillation	427.31			2/4/2014
Atrial fibrillation with RVR	427.31			3/3/2014
Fibromyalgia	729.1			2/4/2014
Knee strain	844.8			3/3/2014
Hypertension	401.9			Unknown

ICD-9 code = **V60**

ICD-10 code = **Z59**

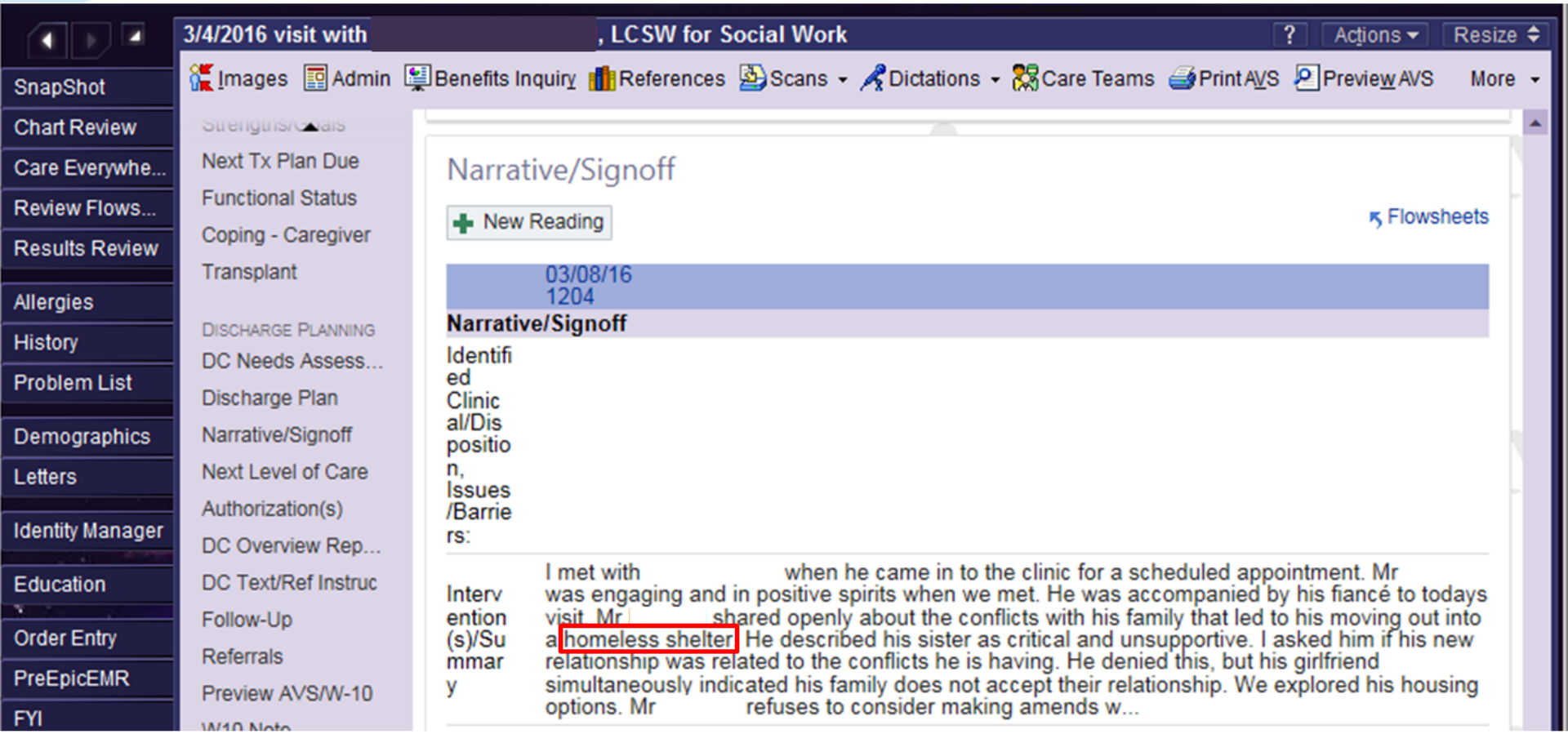
Mining Medical Records:

Data Entry for **Nursing** & **Social Work**

Housing / Transportation

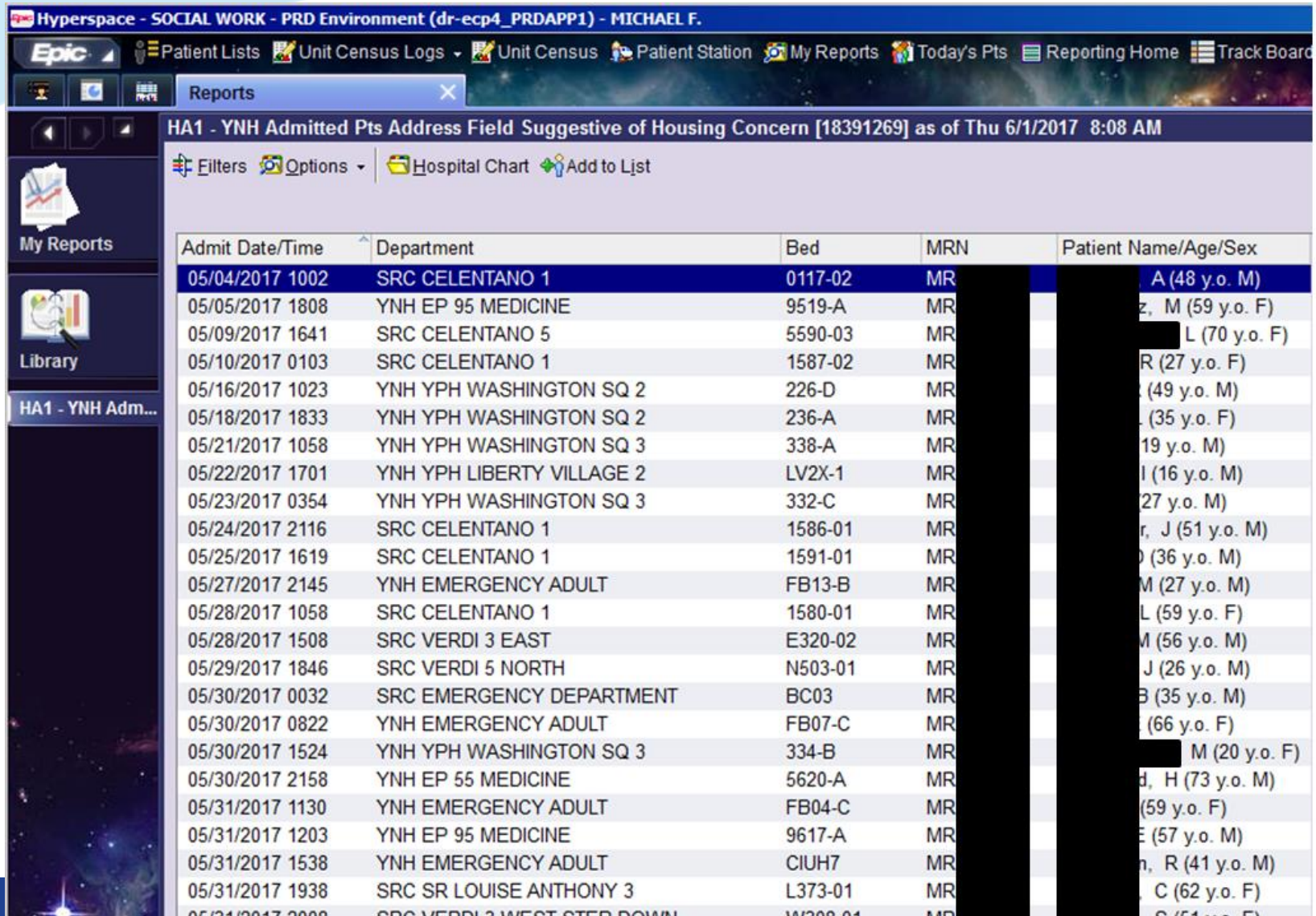
Living Arrangements for the past 2 months	apartment	assisted living facility	automobile	condominium
	correctional facility	emergently doubled-u...	extended care facility	foster care
	group home	hotel/motel	single-family house	multi-family house
	independent living faci...	mobile home	residential facility	rest home
	rooming house	**shelter**	other	**no permanent address**
Living Arrangements Comment				
Able to Return to Prior Living Arrangements following Visit/Discharge	yes	**no**	temporarily	other	unable to a...
Ability to Return to Prior Living Arrangement Comment				
Able to Receive Visiting Nurse at Prior Living Arrangement	yes	**no**	temporarily	other	unable to a...
Able to Receive Visiting Nurse Comment				
Environmental Concerns	no concerns	**no permanent re...**	insects/pests	air conditioning	electricity
	heat	natural gas	heating oil	indoor plumbing	lead
	lighting	mold	no back-up gene...	phone	running water
	smoke detector	refrigeration	chipping paint	unsafe stairwell	broken windows
	other	unable to assess			

Communicating Housing Status through Social Work Narratives



Workbench Reports in Epic to Identify Homeless Patients

Report Results



Admit Date/Time	Department	Bed	MRN	Patient Name/Age/Sex
05/04/2017 1002	SRC CELENTANO 1	0117-02	MR	A (48 y.o. M)
05/05/2017 1808	YNH EP 95 MEDICINE	9519-A	MR	z, M (59 y.o. F)
05/09/2017 1641	SRC CELENTANO 5	5590-03	MR	L (70 y.o. F)
05/10/2017 0103	SRC CELENTANO 1	1587-02	MR	R (27 y.o. F)
05/16/2017 1023	YNH YPH WASHINGTON SQ 2	226-D	MR	(49 y.o. M)
05/18/2017 1833	YNH YPH WASHINGTON SQ 2	236-A	MR	(35 y.o. F)
05/21/2017 1058	YNH YPH WASHINGTON SQ 3	338-A	MR	19 y.o. M)
05/22/2017 1701	YNH YPH LIBERTY VILLAGE 2	LV2X-1	MR	l (16 y.o. M)
05/23/2017 0354	YNH YPH WASHINGTON SQ 3	332-C	MR	27 y.o. M)
05/24/2017 2116	SRC CELENTANO 1	1586-01	MR	r, J (51 y.o. M)
05/25/2017 1619	SRC CELENTANO 1	1591-01	MR	(36 y.o. M)
05/27/2017 2145	YNH EMERGENCY ADULT	FB13-B	MR	M (27 y.o. M)
05/28/2017 1058	SRC CELENTANO 1	1580-01	MR	L (59 y.o. F)
05/28/2017 1508	SRC VERDI 3 EAST	E320-02	MR	M (56 y.o. M)
05/29/2017 1846	SRC VERDI 5 NORTH	N503-01	MR	J (26 y.o. M)
05/30/2017 0032	SRC EMERGENCY DEPARTMENT	BC03	MR	B (35 y.o. M)
05/30/2017 0822	YNH EMERGENCY ADULT	FB07-C	MR	(66 y.o. F)
05/30/2017 1524	YNH YPH WASHINGTON SQ 3	334-B	MR	M (20 y.o. F)
05/30/2017 2158	YNH EP 55 MEDICINE	5620-A	MR	d, H (73 y.o. M)
05/31/2017 1130	YNH EMERGENCY ADULT	FB04-C	MR	(59 y.o. F)
05/31/2017 1203	YNH EP 95 MEDICINE	9617-A	MR	E (57 y.o. M)
05/31/2017 1538	YNH EMERGENCY ADULT	CIUH7	MR	n, R (41 y.o. M)
05/31/2017 1938	SRC SR LOUISE ANTHONY 3	L373-01	MR	C (62 y.o. F)

Asking about Housing Status in a Manner that Preserves **Dignity**

"Where have you been **living during the past two months**?"

"Is this **reliable housing** that you own, rent, or stay in as part of a household?"

"Are you **able to return** and stay there following discharge?"

- If yes, "Are you able to **receive a visiting nurse** there?"
- If no, will this patient have a **post-discharge medical need** requiring respite?

Medications (Apothecary)

- **Deliver medications**
  - prescribed & over the counter
- **Efficiently resolve med issues**
  - single source
- **Comprehensive review** of meds
  - possible drug interactions
- Waive charges to the **uninsured** & **underinsured**
  - And resolve billing issues

Patient Navigation in Support of the Medical Plan

- Assist patients with connecting to, and keeping appointments with:
  - Primary care
  - Mental health treatment
  - Substance abuse treatment
- Provide oversight and encouragement to adhere to medical & dietary recommendations
- Share observations and concerns with medical staff

Case Management

- Create housing service plan
- Benefit applications
  - Social Security, Food Stamps, SAGA, etc
- Refer to employment specialist
- Housing applications and move-ins
- Support in addressing court/probation matters
- Transportation

Ongoing Review & Coordination of Care

- **Weekly Case Review** meetings
  - Yale New Haven Hospital
    - Social workers, care managers
  - Columbus House Medical Respite staff
  - APRN and nursing
  - Apothecary staff
  - Primary Care Clinics
    - including Cornell Scott-Hill Health Center

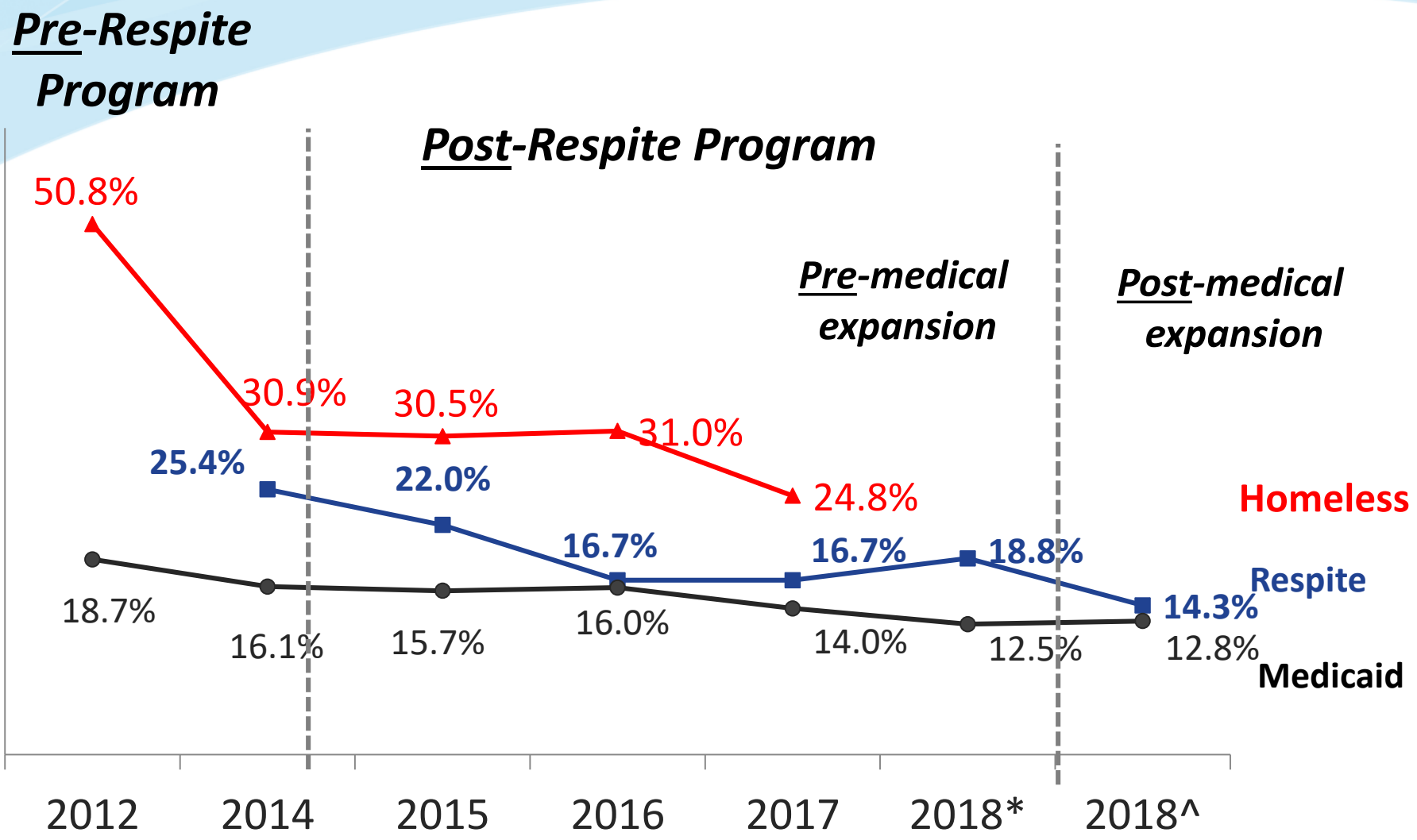
What Are the Results?

Patients Served

Fiscal Year	Homeless Admissions	Unique Patients (by MR#)	Respite Applicants	Respite Patients
2014	803	**427**	104	**53**
2015	693	**406**	100	**64**
2016	731	**461**	98	**89**
2017	638	**415**	81	**72**
2018	757	**480**	96	**73**
Five-Year Total	**3,622**	**1,270***	**479**	**351**

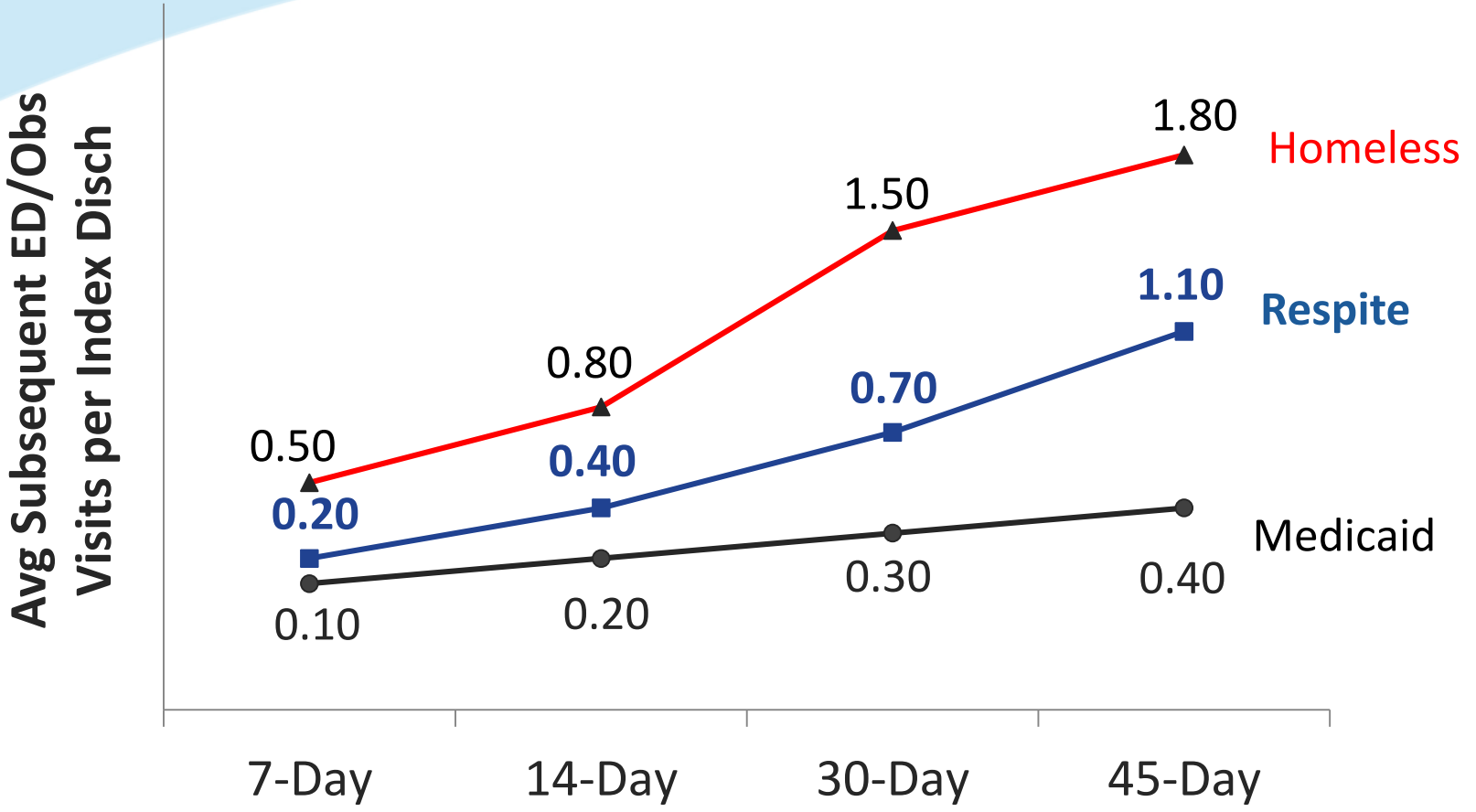
*unique patients over 5 year period

Inpatient 30-Day Readmission Rates



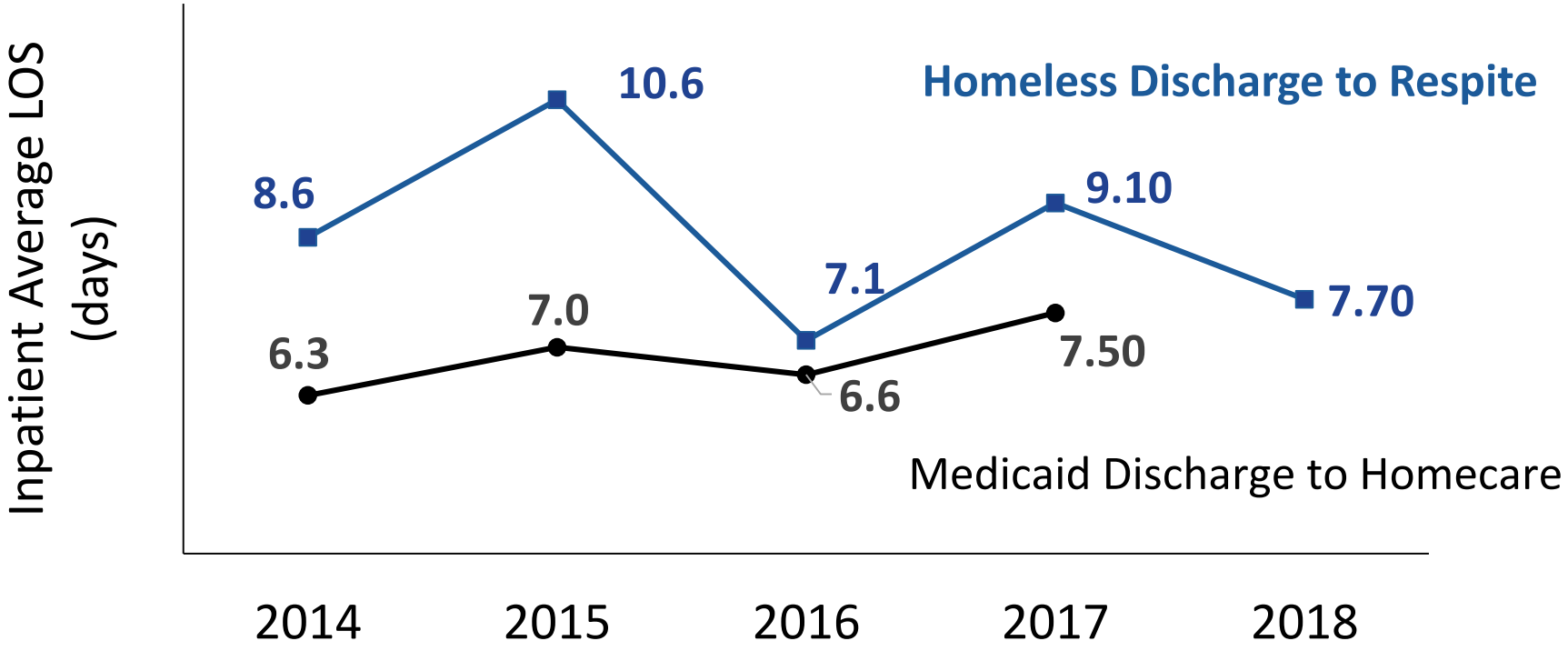
2012: Homeless Patient Analysis presented at YNHH by Kelly Doran MD, Sept., 2013

2017 Reduced ED/Observation Re-Visits



Data Source: YNHH 2017 inpatient, ED and Observation visits

Reduced Hospital Length of Stay



Average LOS reduction from 10.6 days in FY 2015 to 7.1 days in FY 2016 was associated with a $300,000 reduction in Direct Cost for the care of these patients.

When Patients Have Housing…

- **Medical Respite**: the Medicaid-covered, per-person cost of care is ***reduced*** by between $12,000 and $25,000 in the following 12 months
- **Permanent Housing**: On average, each time the CAN houses a person experiencing homelessness, their likelihood of hospital readmission drops by half.
- **Housing saves healthcare dollars**:
  - Prevents people from needing care in the first place
  - Avoids recurrence of illness & injury during recovery

Reasons for Success

- Housing *is* Health Care
- Advocacy & Innovation
- Increased commitment to staffing and resources
- Increased collaboration & training
- Improved care
- Faster, more efficient processes
- Intensive case management