2017 Fall Conference

San Diego, CA

October 11-12, 2017

Establishing Cross-Sector Data-Sharing Partnerships

Jon Olson & Kris Kuntz

What's Next:

In Data, Leadership, and Community

Today's Presenters

Jon Olson, CSH

Kris Kuntz, Lesar Development

About CSH

Improve lives of vulnerable people

Maximize public resources

Build strong, healthy communities

Learning Objectives

- Participants will understand the value of data-sharing partnerships through FUSE
- Participants will be able to explain how human service providers can establish and sustain data-sharing partnerships through collective efforts

IMPORTANCE OF IDENTIFYING FREQUENT USERS

Homelessness and Health

- Poor physical and behavioral health causes homelessness
- Homelessness causes new physical and behavioral health issues
- Recovery and healing are more difficult without housing
- Individuals experiencing homelessness have high rates of acute and chronic illness

Target Population

ER/Hospital Inpatient /Detox Population

Frequent Users

Chronically Homeless

Homeless Population

Defining Frequent Users

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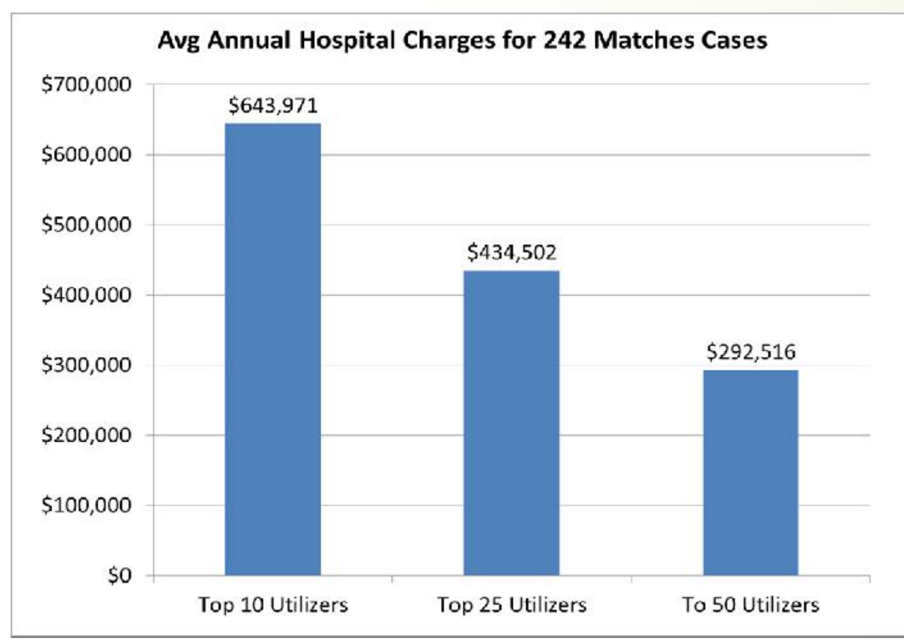
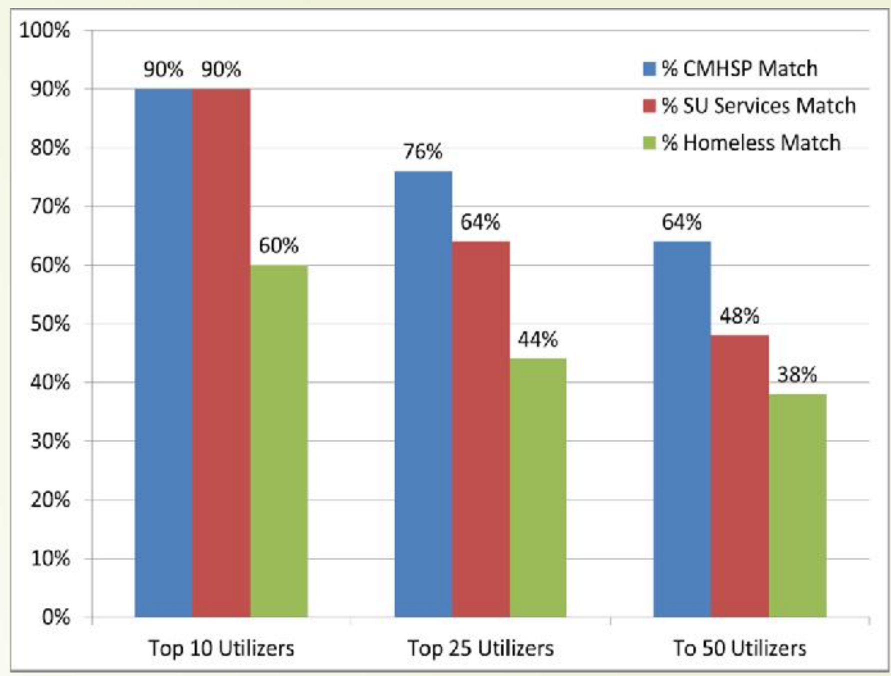
- Admin data match conducted between homeless system (HMIS, CMHSP) and health systems (St Joseph Mercy Hospital and U of M Hospital);
- 1634 matches

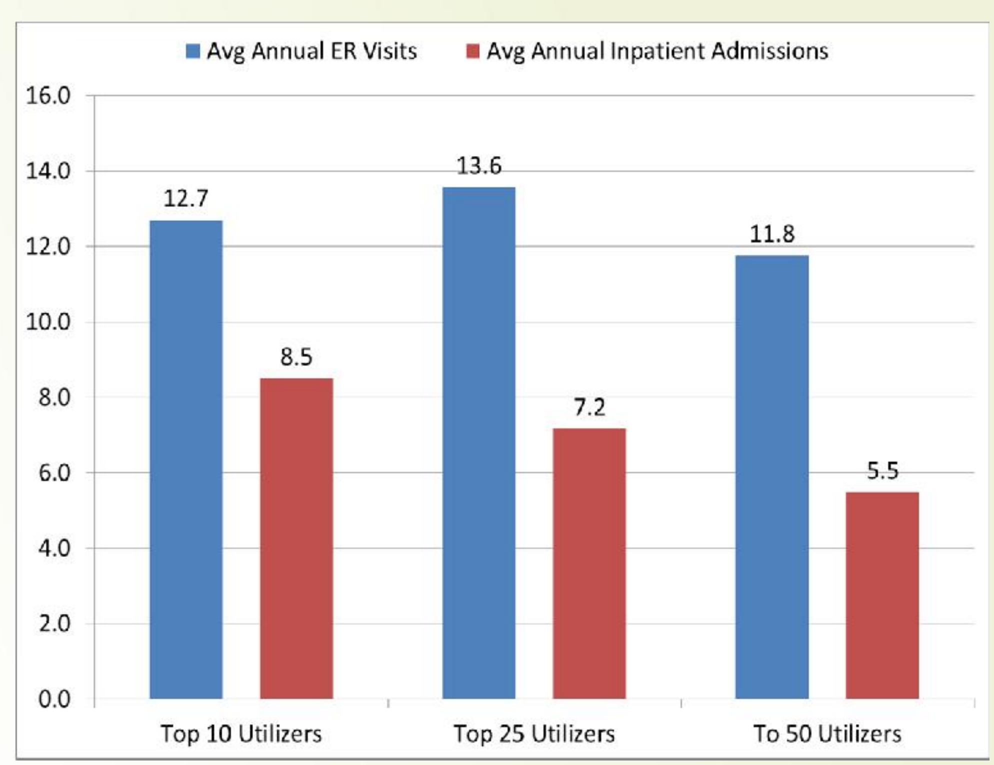




- Strong correlation between emergency health service utilization and homelessness, SMI and substance misuse
- Top Utilizer: $1.45 million in hospital charges

Hospital Use by Frequent Users

- Charges driven by inpatient hospitalizations
- Max ER visits: 53
- Max Inpatient Admissions: 17



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Housing = Healthcare

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

℞ 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 #

OVERVIEW OF FUSE AND CREATING DATA-SHARING PARTNERSHIPS

Overview of FUSE

Data-Driven Problem-Solving

- Cross-system data match to identify frequent users
- Track implementation progress
- Measure outcomes/impact and cost-effectiveness

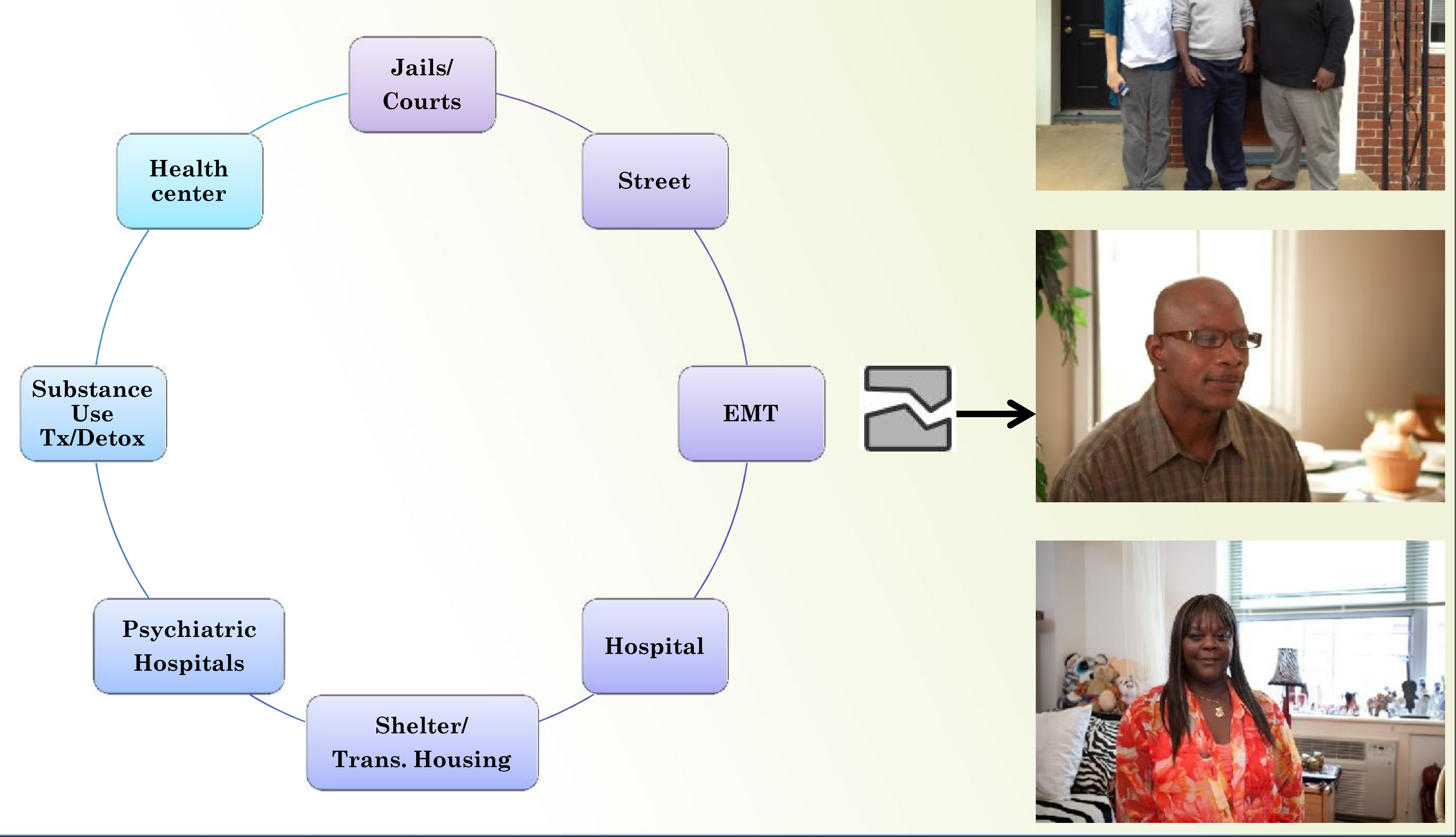
Policy and Systems Reform

- Convene interagency and multi-sector working group
- Troubleshoot barriers to housing placement and retention
- Enlist policymakers to bring FUSE to scale

Targeted Housing and Services

- Create supportive housing and develop assertive recruitment process
- Recruit and place clients into housing, and stabilize with services
- Expand model and house additional clients

Breaking the Institutional Circuit



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Data-Driven Problem-Solving: Finding the Target Population

ER/Hospital Inpatient /Detox Population

Frequent Users

Chronically Homeless

Homeless Population

Cross-Systems Data Matching

County Data

- Most FUSE communities are counties and have matched jail and HMIS records to look at frequency of use. Clark County, Nevada has built this matching into their homeless data so they can identify FUSE-eligible people in real-time. Orlando's HCH uses the regional HMIS system.
- More recently we see jail and HMIS data flowing to sources that can match data in a HIPAA protected environment, like hospitals system, county analysts, and Managed Care orgs.

Statewide Data Sources

- Connecticut: State Medicaid and homeless data to identify top 10% of users
- Connecticut: Statewide jail and homeless data

Predictive Algorithms

- Los Angeles: De-identified matched data analyzed to find conditions and systems usage patterns that predict likelihood of a person in top 10%

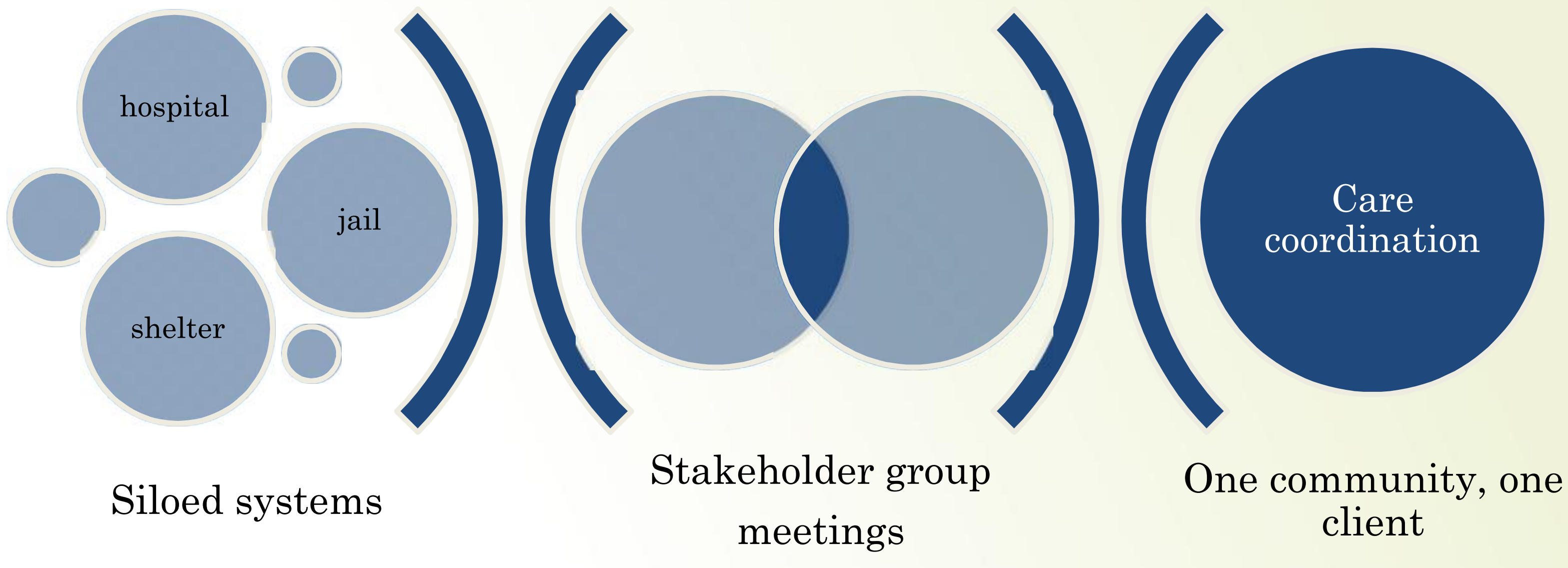
Finding the Target Population

When using a matched list of Frequent Users

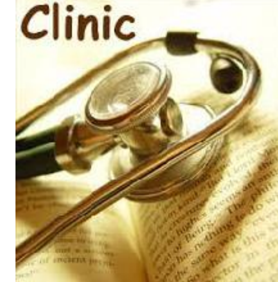
1. List of frequent users shared with jail/shelter/ hospital
2. Eligibility flag created in data system
3. Jail/shelter /hospital update provider weekly
4. Provider outreach to jail/shelter/ hospital for engagement

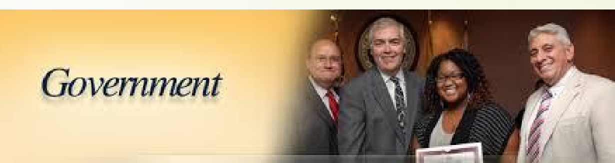
Creating Lasting Partnerships

Partnerships between systems emerge as most effective means of serving frequent users



Potential Data-Sharing Partners





Identifying Stakeholders in Your Community

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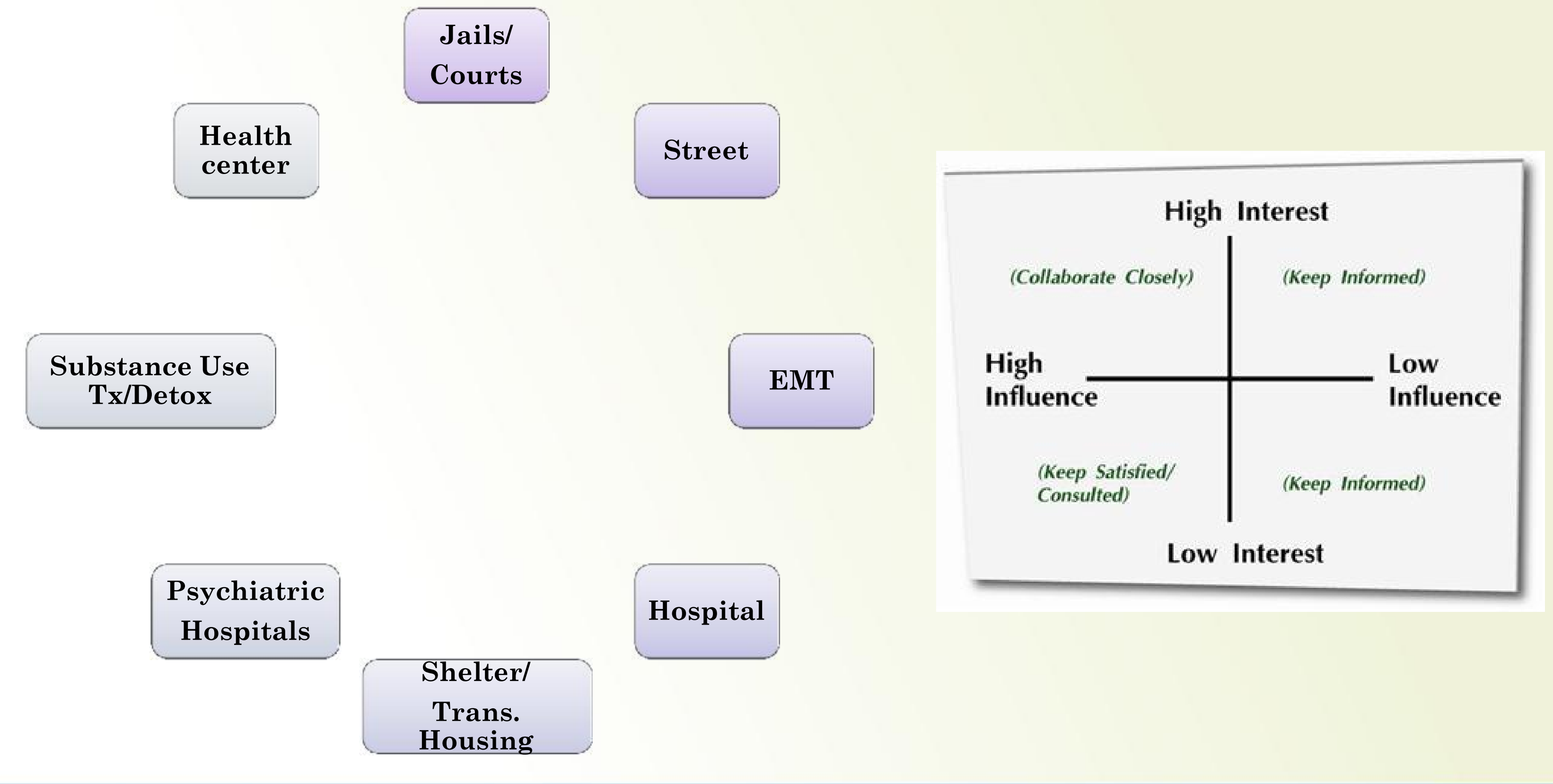
- What systems do frequent users touch?
- Who is interested in the population? Who is influential in the community politically and/or from a resource perspective?



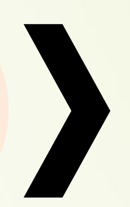
EXAMPLES OF DATA-SHARING PARTNERSHIPS

Los Angeles: 10th Decile Project

People experiencing homelessness who are the top 10% highest-cost, highest-need individuals in Los Angeles County.

Service Approach:

Highest-cost, highest-need
10% of homeless individuals



Collaboration
Hospitals, **FQHCs**, homeless services

Health Homes
Intensive case management/ care coordination

Permanent Supportive Housing
Housing navigation and retention

Partners:

- 5 Homeless Service Providers
- 7 Health Centers & Behavioral Health Providers
- 15 Hospitals

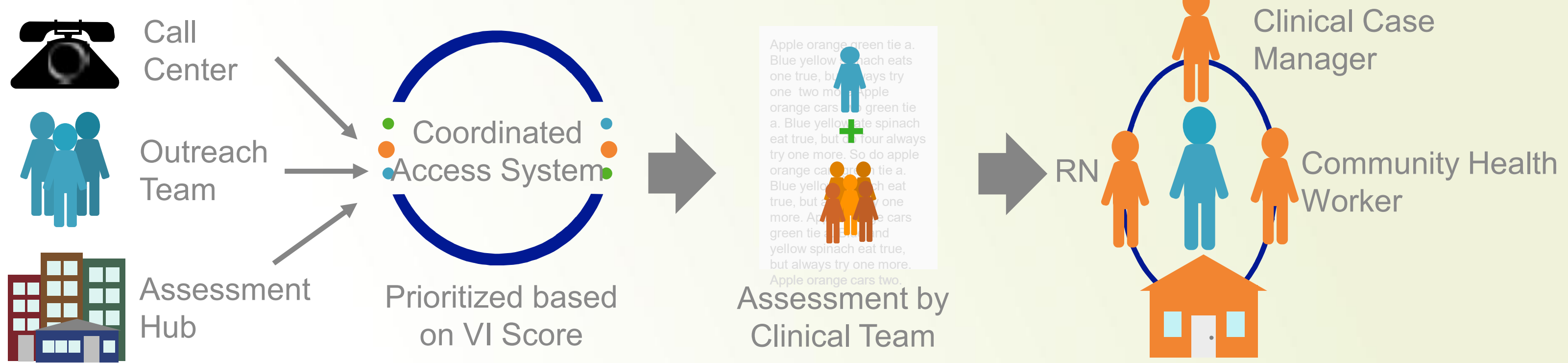
Outcomes:

- 51% Screened are Enrolled
- 47% in Housed in 6 months
- 98% in Housed two years
- Average Cost Reduction of $54,106 to the Public Sector
- Emergency Room Visits Reduced by 71%
- Hospital Admissions Reduced by 84%
- Inpatient Days Reduced by 80%

Houston: Integrated Care for the Chronically Homeless

People experiencing chronic homelessness with three or more emergency department visits, and are identified and prioritized through coordinated access.

Service Approach:



Partners:

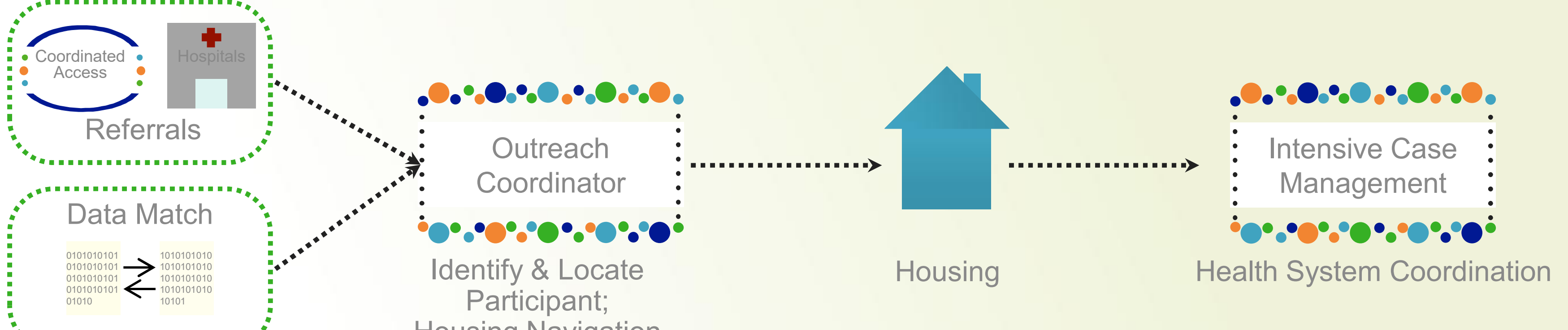
- Health Care for the Homeless – Houston
- SEARCH Homeless Services
- New Hope Housing, Inc.

Outcomes:

- Reduction in Inappropriate, Non-emergency, ED Use
- Meaningful Difference in Health Functional Status
- Clinically Significant Response in Overall Depression Scores

Washtenaw County: FUSE

Service Approach:



Partners:

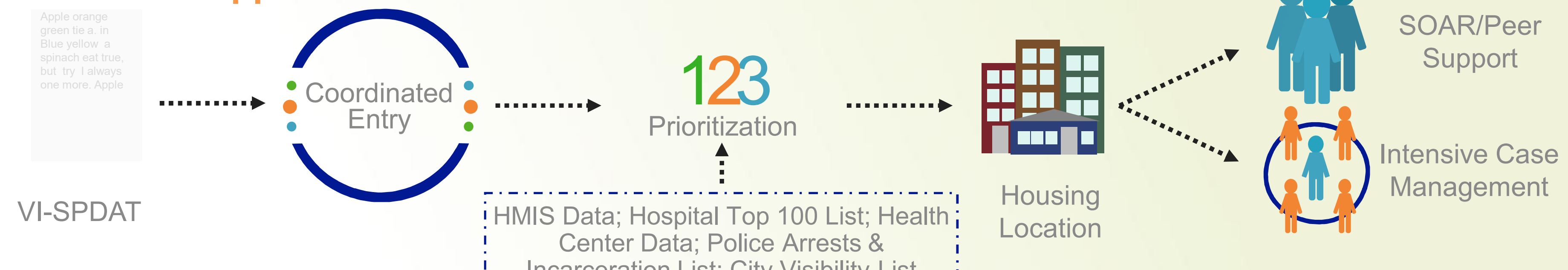
- Avalon Housing
- 2 Hospital Partners
- Washtenaw Community Mental Health Center
- Washtenaw Health Initiative
- Packard Health
- Washtenaw Public Health & Washtenaw Housing Alliance
- Ann Arbor Housing Commission
- Michigan Ability Partners and Shelter Association of Washtenaw County

Outcomes:

- 81% Housing Retention
- 87% Enrolled in Primary Care
- Reduction in Inappropriate ER and Hospital Usage
- Improved Quality of Life
- Improved Systems Level Coordination

Orlando: Housing the First 100

People experiencing chronic homelessness who are frequent users of the hospital system and have high hospital expenditures.



Partners:

- Health Care Center for the Homeless
- Homeless Services Network (CoC)
- Florida Hospital
- Local Law Enforcement
- City of Orlando/Orange County

Outcomes:

- 106 Housed, 100% Retention
- 127 Engaged
- 100% of landlords have 24 hour access to Housing Specialist
- 85.7% maintain or reduce hospitalizations
- 100% maintain or increase income
- 90% reduced incarcerations

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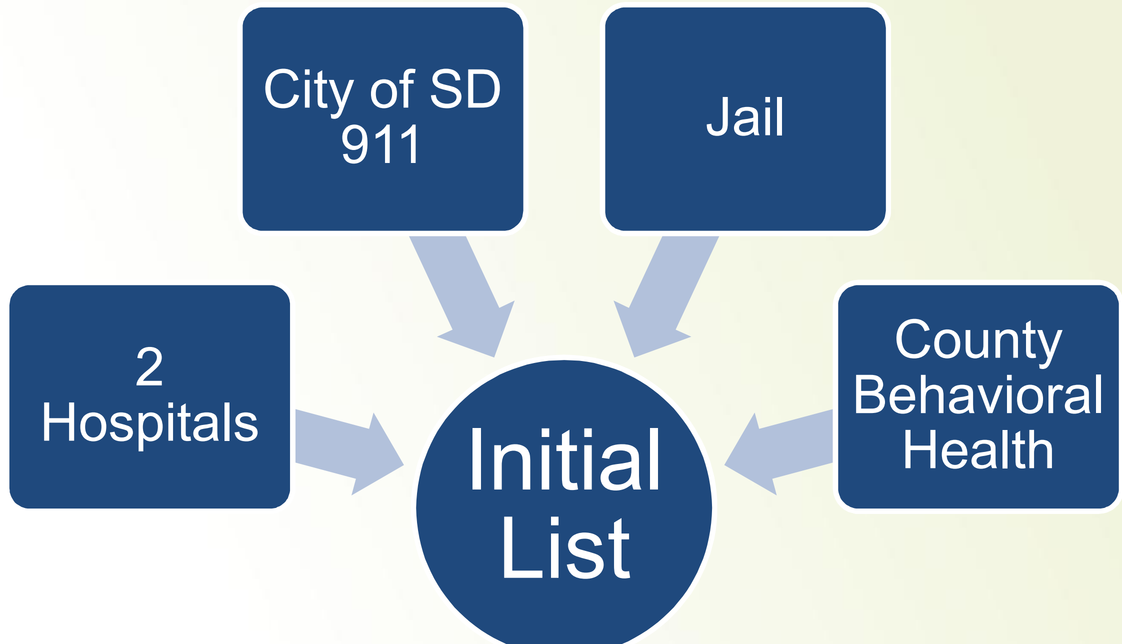
Project 25 Pilot

"It costs more to do nothing."

United Way
of San Diego County

Identifying High Utilizers for Enrollment



MOU's to share very limited information for matching.

Important for partners to understand the benefit of sharing data

Project 25 Model of Service Delivery

- Housing First – Street to home
- RELATIONSHIP critical
- Harm Reduction
- Medical Home
- High Contact – 1 to 6 caseload ratio
- SOAR
- Not possible to fail out, be non-compliant, etc…

Project 25 REAL Model of Service Delivery

"People are people, and they get into situations they don't necessarily plan on. My philosophy about primary care is that the only person who has changed anyone's life is their mother. The reason is that she cares about them, and she says the same simple thing over and over."

Dr. Jeff Brenner

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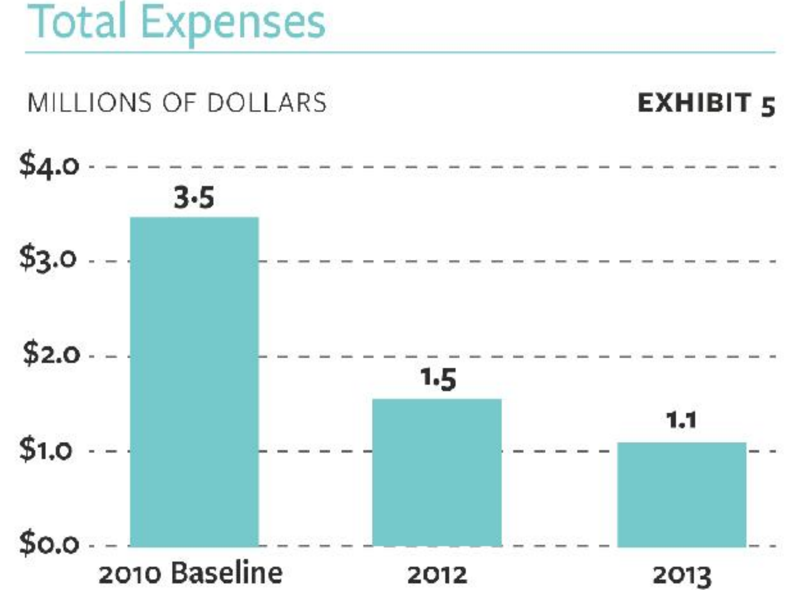
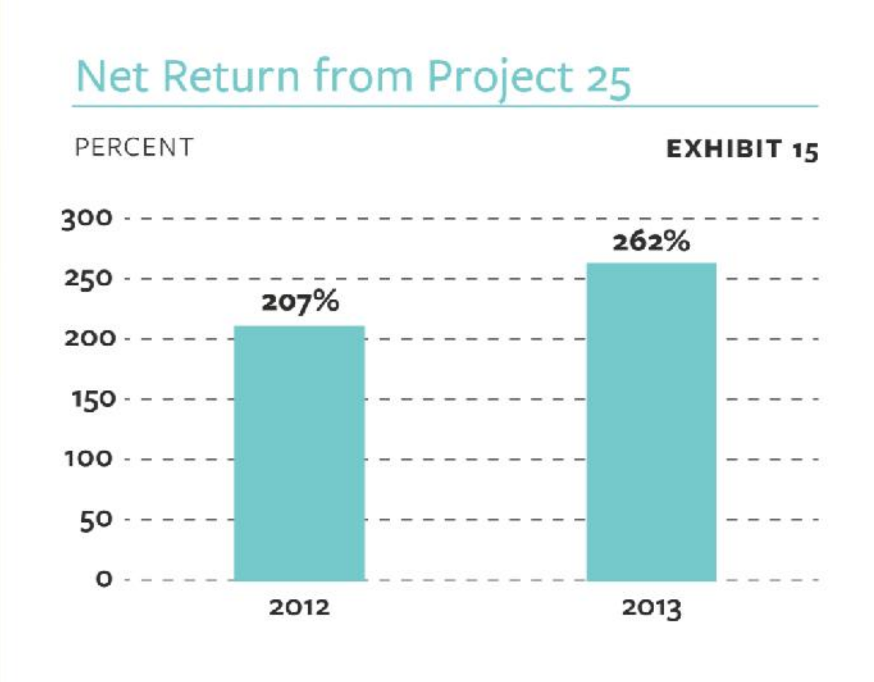
Project 25 Results

In 2010, 28 people cost $3.5 million



Fermanian Business and Economic Institute
Point Loma Nazarene University



Total cost savings year 1 = $1.6 million

Total cost savings year 2 = $2.1 million

Total cost savings 2 years = $3.7 million

Project 25 REAL Results

On the streets

Year 3 in his apartment

Project 25 Expansion

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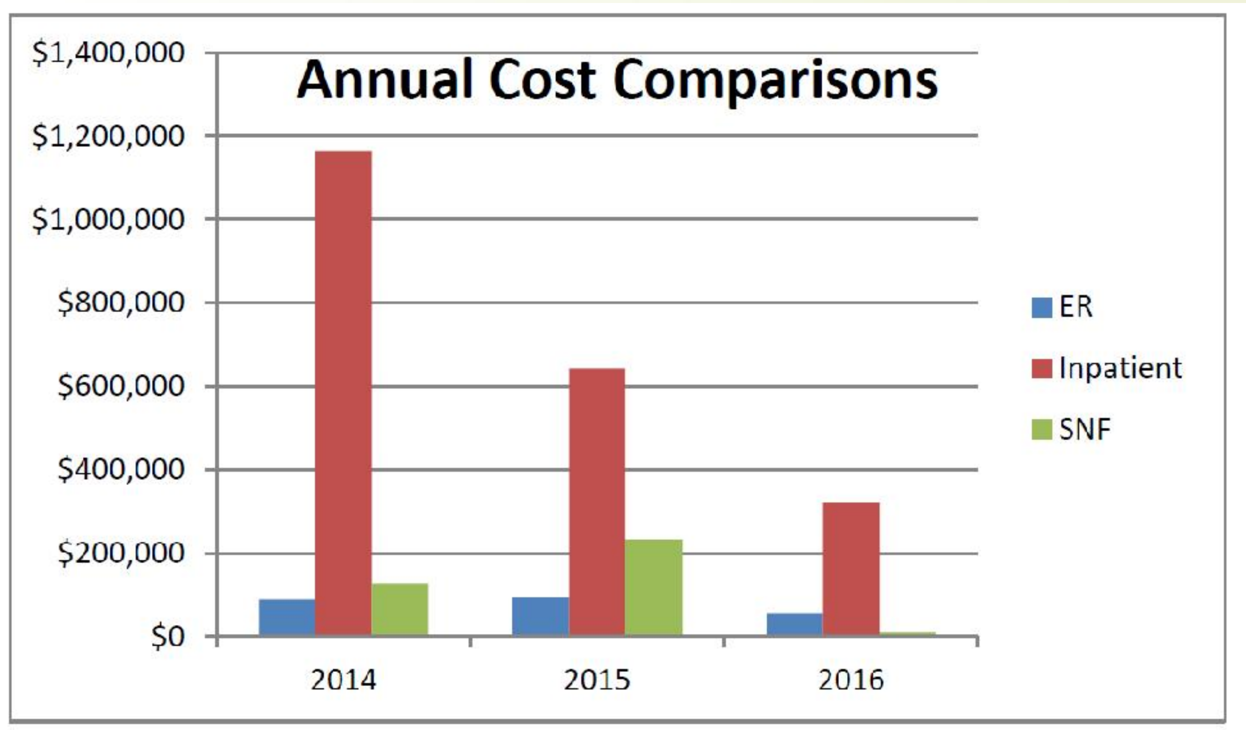
Funders

Project 25 Expansion Results



2014 = Pre-intervention 2015 and 2016 = Post

Costs are Medicaid dollars paid

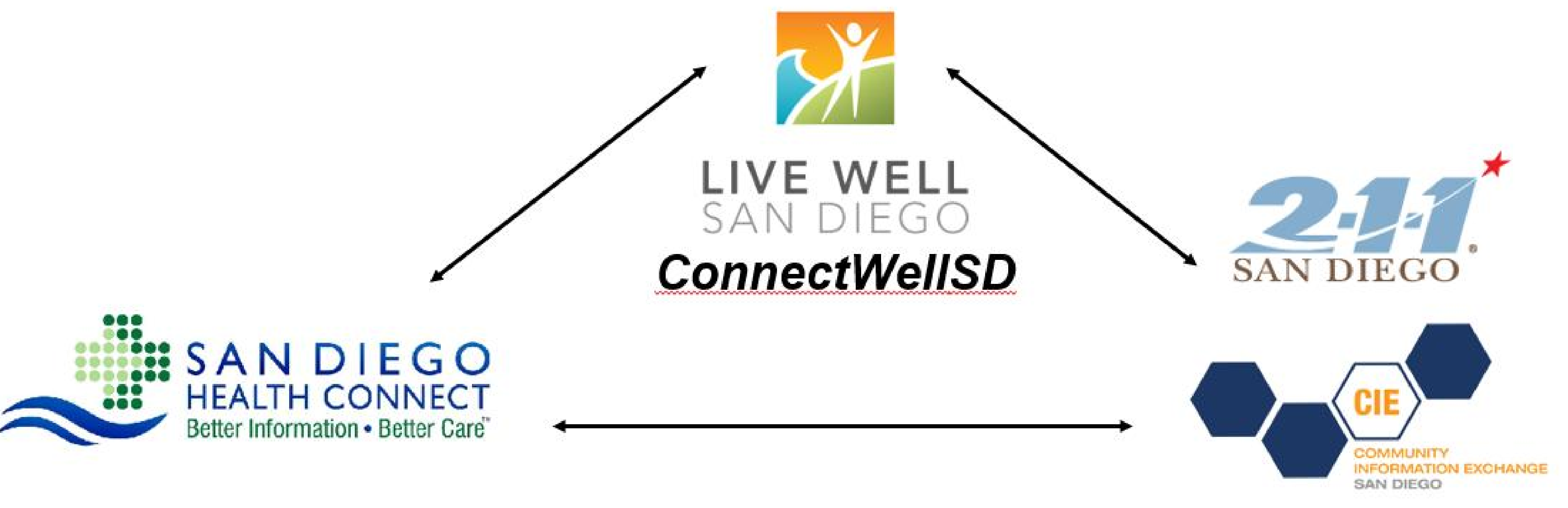
More than just a successful small pilot and program…

Brought array of sectors to the table to care about homelessness

Local example of Housing First

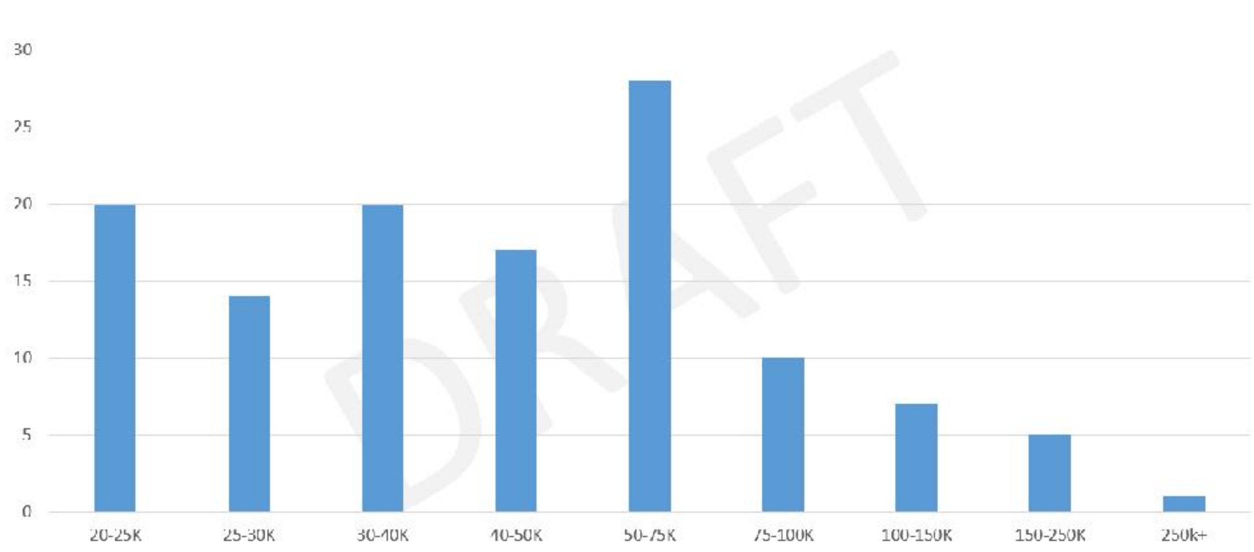
Proved that anyone can be housed and successful with the right configuration of housing and services

Informed thinking around data sharing



Informed our thinking on Whole Person Care pilot (Medicaid Demonstration Project)

Target Population = High cost user of Medicaid who are homeless/at risk and have severe mental illness, substance use disorder, or chronic health problem



Matching HMIS data and Health Plan data

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Informed our thinking on Coordinated Entry

Appendix C. CES Prioritization Guidelines

Documentation of Priority Status

	Priority	Homeless Category	Length of Stay in Homelessness	Where Experienced Homelessness	Documented Disability	Severity of Service Needs
Permanent Supportive Housing	1	Category 1 - Homeless Individual or Family	> 12 months continuous OR Total of at least 4 episodes totaling >12 months in 3 years	Unsheltered, Emergency Shelter, Safe Haven	Yes	High = VI-SPDAT 2 score of 8 or higher for singles and 9 or higher for families AND/OR Documented frequent user of health or criminal justice systems through data source
	2	Category 1 - Homeless Individual or Family	> 12 months continuous OR Total of at least 4 episodes totaling >12 months in 3 years	Unsheltered, Emergency Shelter, Safe Haven	Required	Low = VI-SPDAT Score of less than 8 for individuals and less than 9 for families
	3	Category 1 - Homeless Individual or Family	Total of at least 4 episodes total <12 months in 3 years	Unsheltered, Emergency Shelter, Safe Haven	Required	High = VI-SPDAT 2 score of 8 or higher for singles and 9 or higher for families AND/OR Documented frequent user of health or criminal justice systems through data source
	4	Category 1 - Homeless Individual or Family	Total of at least 4 episodes total <12 months in 3 years	Unsheltered, Emergency Shelter, Safe Haven	Required	Low = VI-SPDAT Score of less than 8 for individuals and less than 9 for families

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Pushed our thinking on Pay For Success models

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