Cultivating Health for Success Program

*Integrating Housing and Healthcare: Ending Homelessness Among the Top Utilizers*
Speaking Today

Moderator
Jeremy Carter
Chief Housing Officer
Community Human Services

Panelists
Whitney Amoroso, RN, BSN, CCM
Clinical Care Manager, Insurance Division, UPMC

Laura Fiore, LCSW
Supervisor, Health Manager, UPMC
Health Plan-CCBH

Who Is Here?

Acronyms!

• DHS: Department of Human Services (HUD Funds flow through here)
• UPMC: University of Pittsburgh Medical Center
• PSH: Permanent Supportive Housing
• CoC: Continuum of Care (for housing)
• CHSP/CHFS: Cultivating Health for Success Program
Overview of **chs**

- Multi-service organization, serving over 6,000/year
  - Homeless Assistance Programs (ES, PSH, RRH, Outreach)
  - In-Home Care
  - Early Childhood Head Start
  - Clinical Team
  - Drop-in Center/Testing
  - Community Programs/Pantry
  - Mental Health Housing (SH, ESH, DOM/CRR)

Overview of **UPMC**

- Nonprofit World-Renown health care provider and insurer
- Largest non-governmental employer in PA – 65,000 employees
- 25 academic, community, and specialty hospitals, 600 doctors' offices and outpatient sites, employs 3,600 physicians
- 3 Million members under insurance
- $12.8 Billion Revenue
- Community Giving $892M or 15% of net patient revenue
How We Got Started...

• In 2009, CHS, DHS and UPMC partnered together to create an innovative program to solve a unique problem.

• Although S+C have been supported by HUD and DHS in the past, at the time of inception, there had not been a documented program that places an emphasis on providing S+C focused on coordinating care for individuals with physical disabilities with a hospital system.

• Mission was to create a residential environment that fosters greater autonomy, coordinated care and ability of participant to bridge the gap from homelessness to permanent housing with better physical health.

• 64% Dual, 16% SMI, 16% PWOD, 4% PWA

• Program Benchmarks over a 5 year period:
  • Maintain stable housing for at least 6 months
  • Decrease unplanned care costs
  • Limit inpatient admissions and number/frequency of ER
  • Increase PCP and specialty doctor visits
We’re A Little Different

**Housing First** – CHS was the first social service provider in the region to implement housing first, starting back in 1970s with our community housing programs. We continue to strongly uphold Housing First in our programs by not requiring clients to meet other criteria to enter a housing program, other than the basic contract eligibility of homelessness.

**Harm Reduction** – CHS is a strong advocate of providing programs centered around Harm Reduction. We structure all of our program policies and procedures (including termination and violation procedures) around Harm Reduction. The concept is quite literally reducing the harm of a behavior (could be anything) without requiring abstinence (more on this in a second)

**Progressive Engagement** – All of our Crisis Response and Rapid Re-Housing Programs practice Progressive Engagement. RRH programs start with 3 months followed by a comprehensive assessment that incorporates several different dimensions to guide a conversation between the clients, CSS and supervisor around further assistance. It is a mutual discussion.
Harm Reduction

We do not deny that there is a problem! We simply take a different approach to meet the client where they are at.

• Accepts, for better and or worse, that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them.

• Understands drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviors from severe abuse to total abstinence, and acknowledges that some ways of using drugs are clearly safer than others.

• Establishes quality of individual and community life and well-being—not necessarily cessation of all drug use—as the criteria for successful interventions and policies.

• Calls for the non-judgmental, non-coercive provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harm.

• Affirms drugs users themselves as the primary agents of reducing the harms of their drug use, and seeks to empower users to share information and support each other in strategies which meet their actual conditions of use.

• Recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities affect both people’s vulnerability to and capacity for effectively dealing with drug-related harm.

• Does not attempt to minimize or ignore the real and tragic harm and danger associated with licit and illicit drug use.
The Structure

• Currently serves 47 individuals
• 25 are connected with UPMC Community Team (Clinical Care Manager and Community Health Worker)
• Participants are in scattered-site permanent housing
• CoC PSH Grant from HUD (administered by DHS) for rental assistance and administration costs
• UPMC contract supports CHS housing social worker and service dollars
• To offset the cost of the program, 25 members had to be successfully housed annually

• Criteria
  • Must be HUD homeless (not Chronically Homeless)
  • Have UPMC For You Medicaid
  • Have at least 1 year of high health care expenditures
  • Willing to work with care managers to develop a health plan
  • Able to live independently
Physical and Mental Health Occurrences With Program Participants

<table>
<thead>
<tr>
<th>Condition</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Illness</td>
<td>53</td>
</tr>
<tr>
<td>Chronic Health</td>
<td>42</td>
</tr>
<tr>
<td>Physical Disability</td>
<td>34</td>
</tr>
<tr>
<td>Drug Abuse</td>
<td>26</td>
</tr>
<tr>
<td>Alcohol Abuse</td>
<td>11</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>2</td>
</tr>
</tbody>
</table>
The Structure

Number of Known Conditions

- 1 Condition: 10%
- 2 Conditions: 26%
- 3+ Conditions: 64%

Total Known Conditions: 9
<table>
<thead>
<tr>
<th></th>
<th>HUD Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>60</td>
</tr>
<tr>
<td>Mean Age</td>
<td>45.6</td>
</tr>
<tr>
<td>%Female</td>
<td>53.3%</td>
</tr>
<tr>
<td>%Dual eligible</td>
<td>16.7%</td>
</tr>
<tr>
<td>Charlson Comorbidity Index</td>
<td>4.4</td>
</tr>
<tr>
<td>%Asthma</td>
<td>48.3%</td>
</tr>
<tr>
<td>%COPD</td>
<td>43.3%</td>
</tr>
<tr>
<td>%CHF</td>
<td>16.7%</td>
</tr>
<tr>
<td>%CAD</td>
<td>31.7%</td>
</tr>
<tr>
<td>%Diabetes</td>
<td>36.7%</td>
</tr>
<tr>
<td>%Renal/ESRD</td>
<td>16.7%</td>
</tr>
<tr>
<td>%Liver/Hepatitis</td>
<td>50.0%</td>
</tr>
<tr>
<td>%Epilepsy</td>
<td>26.6%</td>
</tr>
<tr>
<td>%High Risk Beh Health</td>
<td>53.3%</td>
</tr>
<tr>
<td>%Mood disorder</td>
<td>48.3%</td>
</tr>
<tr>
<td>%Other Beh Health</td>
<td>71.7%</td>
</tr>
<tr>
<td>%Drug or Alcohol</td>
<td>35.0%</td>
</tr>
</tbody>
</table>
WELLNESS

EMOTIONAL
Coping effectively with life and creating satisfying relationships.

ENVIRONMENTAL
Good health by occupying pleasant, stimulating environments that support well-being.

INTELLECTUAL
Recognizing creative abilities and finding ways to expand knowledge and skills.

PHYSICAL
Recognizing the need for physical activity, diet, sleep, and nutrition.

FINANCIAL
Satisfaction with current and future financial situations.

SOCIAL
Developing a sense of connection, belonging, and a well-developed support system.

SPIRITUAL
Expanding our sense of purpose and meaning in life.

OCCUPATIONAL
Personal satisfaction and enrichment derived from one’s work.

Goals

Food

Housing

Transportation
### A Truly Integrated Approach

<table>
<thead>
<tr>
<th>Community Human Services – HUD Staff</th>
<th>UPMC – Mobile Clinical Care Manager (Nurse)</th>
<th>UPMC – Community Health Worker</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing Search and Move-In Assistance</td>
<td>Care Management</td>
<td>Connection to appointments</td>
</tr>
<tr>
<td>Ongoing Rental Support</td>
<td>Medication Management</td>
<td>Linkages to community resources</td>
</tr>
<tr>
<td>Landlord Mediation</td>
<td>Referral to specialty care</td>
<td></td>
</tr>
<tr>
<td>Housing Supports</td>
<td>Some testing</td>
<td></td>
</tr>
</tbody>
</table>

- CHS and UPMC frontline staff meet bi-weekly for case coordination and daily huddle calls
- CHS and UPMC frontline and Administrative staff meet monthly for deep case conferencing
- CHS gets alerted if member goes to into ER or gets admitted
Services and Supports

Types of Support that CHS May Provide To Participants:
• Linkages to community resources
• Assistance with Daily Living Skills
• Assistance with preparing and buying food
• Help with paying bills
• Making and keeping appointments
• Making and obtaining individual goals
• Coordination with other providers of care
• Landlord mediation, housing search
• Help with furniture, household furnishings, appliances, clothing, transportation, food, hygiene supplies

Supports to Help Transition Off Program Successfully:
• Landlord meetings
• Linkage to Representative Payee
• Assistance with bill organization, financial literacy, automatic bill payments
• Follow Up check-ins
• Assistance with Homeless Preference Section 8, HVCP, or Public Housing
Services and Supports

Care Management Interventions:
• Link to PCP and specialists
• Link to Behavioral Health
• Link to drug and alcohol services
• Coordinate Care
• Medication Management
• Referral for In-home Supports (AAA)
• Housing
• Transportation (MATP)
• Address end of life issues (Advanced Directives, Hospice, Palliative Care)
• Link to Community Resources (Utility, Food Banks, Meals on Wheels)
Second Chances:  
Barry, Age 60  
Barry, who joined CHFS 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 ED a few times during his enrollment, but has had no inpatient stays. Barry returned to his native Pittsburgh from Florida in 2011, but his aged parents asked him to leave their home due to his alcoholism. His drinking increased even more after his father was shot in the head during a convenience store robbery and remained on life support for more than a year before dying. Unable to pay his rent, Barry was evicted and became homeless. Barry has maintained sobriety since a stay in detox and rehab in July, 2015. His medical cost and unplanned visits drastically reduced after being housed in the program.
Connecting to Supports:
Geraldine, Age 48
A lifestyle of dealing and using drugs set the stage for Geraldine’s hemi-paralysis after a gunshot wound to her spine. Already three years sober, the African American grandmother joined CHFS in October, 2014, and was housed in a first-floor apartment. She sees an orthopedic specialist to help with her degenerative joint disease and knee pain after getting assistance with transportation to her medical appointments. She hasn’t visited the ED or been admitted to the hospital.

An Uphill Battle:
Roberta, Age 51
Roberta, a 51-year-old African American woman with a history of polysubstance abuse and several mental illnesses, went to the ED 30 times and was admitted to hospital twice while in CHFS, which found her housing in September, 2013. Attempts to improve her adherence to medication and bolster attendance at medical appointments were not successful, and she was arrested in December, 2015, for possession of drug paraphernalia and for retail theft. Her probation officer is offering her placement in ¾ house, either temporarily or long term. If she cannot comply with house rules or control her temper, she will be incarcerated.
Outcomes

Outcomes After a 5 Year Longitudinal Study:

• 85% of eligible members were successfully housed (some found other means for housing)
• Unplanned medical cost decreased after housing was established. There was an observable decrease in facility days after housing.
• Enrollment in the program was associated with an increase in PCP and specialist visits. Planned office visits doubled after housed.
• Additional increase in visits was observed once participant was stably housed
• Medical cost decreased after housing. Pharmacy cost continued to increase (due to planned medication management)

Basically....
✓ Unplanned Care Costs Decreased
✓ Rates of Primary/Specialty Visits Doubled
✓ Pharmacy Costs Increased
✓ It worked!
Outcomes

Unplanned medical PMPM decreases after housing

- Unplanned medical cost
- Other medical cost

Office visits increased and facility visits decreased after housing

- Facility rate
- Office rate

Medical PMPM

Pre Enrollment - 1 Year
Enrolled before housed
Enrolled after housed

Visits / 1,000

Pre Enrollment - 1 Year
Enrolled before housed
Enrolled after housed
Outcomes

Proportion of days at facility decreased after housing (n=51)

- Pre Housed - 1 Year: 15.5%
- Housed - Post 1 Year: 13.7%
- Housed - Post 2 Year: 11.4%
Comparison Study for CY 2015, 2016

An increase in Home, PCP and specialists visits indicate medical care is being performed outpatient rather than facility.

CHSP members had 70% fewer ER to Home discharges than comparison
Comparison Study for CY 2015, 2016

CHSP members had statistically higher pharmacy costs and lower unplanned care over the 2 years:

59% more routine office visits than comparison
57% more specialty office visits than comparison
72% more Rx spending, to manage their care
Outcome Benefits For UPMC

Key Findings of UPMC members enrolled in CHFS Program:

- Decline in medical costs and unplanned care
- Rates of primary care and specialists doubled after being housed
- **Average net savings for UPMC $6,384 per member**
  - Average medical costs savings $8,472
  - Pharmacy costs increased by an average of $2,088
Housing & Healthcare Increases Housing Stability, 
Even After Exiting The Program
Next Steps

• More comprehensive research, and updated evaluations (looking into cross-system utilization)

• HUD Definition of Homeless and Expansion (include unstably housed if non-federal funds are used)

• Explore alternative payment methods for possible expansion
Developing A Similar Program

Things to consider:

- Partner with a PSH Provider in your local CoC who is high-performing and has a Harm Reduction and Housing First view
- Identify your high utilizers
- Do you have housing capacity somewhere or does the PSH provider need to do the recruiting?
- Data Sharing: CHS and UPMC have mutual consent forms
- How to pay for the supportive services: UPMC uses Medicaid and Medicare administrative money as a care management expense
- Be open to learning from social workers, registered nurse, community health workers, HUD CoC and homeless individuals
Questions?

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UPMC - CCBH  
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Health Care Integrated with Supportive Housing

Monica medina mccurdy, PA-C
VP, Healthcare services
• Mission: to **end and prevent homelessness in Philadelphia**

• Strategies aimed at the **SOCIAL DETERMINANTS** of homelessness and poverty: Street Outreach, **SUPPORTIVE HOUSING**, Education, Social Enterprises and Employment Support, **HEALTH CARE**, Neighborhood Development

• Co-Founders: Sister Mary Scullion & Joan McConnon in 1989

• [www.projecthome.org](http://www.projecthome.org)
WORKING TOWARD 1000 AFFORDABLE UNITS
Completed 714 Units
1515 Fairmount Avenue • Hope Haven I and II • Rowan Homes Diamond • Rowan Homes Jacob • Kairos House
1232 Fairmount Avenue • St. Columba • Women of Change • St. Elizabeth’s Recovery Residence • Kate’s Place
Corneley House • James Widener Ray Homes • JBI Soul Homes • Francis House of Peace

HOUSING

714 HOMES
335 IN DEVELOPMENT

EMPLOYMENT

508 JOBS SEARCHED
67 PEOPLE WORKED IN OUR HOME SPUN RESALE BOUTIQUE AND HOME MADE GIFTS BUSINESSES
10383 VISITS

MEDICAL

100% GRADUATED SENIORS ATTENDING COLLEGE
173 K TO 8 STUDENTS
107 TEEN
553 ADULT
78 COLLEGE ACCESS

EDUCATION

ADVOCACY

21333 MESSAGES TO 616 OFFICIALS
49 SPEAKERS BUREAU EVENTS
3074 ATTENDEES

DID YOU KNOW?
Our Hub of Hope is a winter walk-in engagement center under two Penn Center taxis. In 2016, over 9,668 visits from 1,712 people. Visitors are able to have their housing and medical needs addressed.

DID YOU KNOW?
Items from the Social Enterprises program include seasoned soups, candles, and Sister Mary’s Sinfully Delicious Cranberry Sauce. Buy online at projecthome.org/store.

DID YOU KNOW?
We operate our Stephen Klein Wellness Center in the 19121 ZIP code, one of Philadelphia’s poorest.

DID YOU KNOW?
Our Rendall Learning Center and Comcast Technology Labs offer programs tailored to boost the educational opportunities of both children and adults.

DID YOU KNOW?
To date, we have registered 17,860 voters.

NONE OF US ARE HOME UNTIL ALL OF US ARE HOME*
# Project HOME
## Strategic Plan 2011 - 2016

<table>
<thead>
<tr>
<th>Vision</th>
<th>None of us are home until all of us are home.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mission</td>
<td>To empower adults, children and families to break the cycle of homelessness and poverty, to alleviate the underlying causes of poverty, and to enable all of us to attain our fullest potential as individuals and as members of broader society.</td>
</tr>
<tr>
<td>Guiding Principles</td>
<td></td>
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<tr>
<td>○</td>
<td>Strong spiritual conviction of the dignity of each person</td>
</tr>
<tr>
<td>○</td>
<td>All persons are entitled to decent, affordable housing and access to quality education, employment, and health care</td>
</tr>
<tr>
<td>○</td>
<td>Transformational power of building relationships and community as the ultimate answer to the degradation of homelessness and poverty</td>
</tr>
<tr>
<td>○</td>
<td>Working to end homelessness and poverty enhances the economic vibrancy and quality of life for everyone in our local community, city and region</td>
</tr>
<tr>
<td>○</td>
<td>Critical resources entrusted to us to achieve our mission must be managed honorably and professionally</td>
</tr>
<tr>
<td>Strategic Goal 1</td>
<td>End chronic street homelessness in Philadelphia by:</td>
</tr>
<tr>
<td></td>
<td>• Partnering with the City of Philadelphia, civic leaders, and other community based organizations to end chronic street homelessness by a strategic use of our collective resources and experience; by engaging the participation and leadership of those that are experiencing homelessness; utilizing researched based best practices; by developing policies and practices to prevent street homelessness including but not limited to intake and coordinated access</td>
</tr>
<tr>
<td></td>
<td>• Increasing access to affordable rental housing for those who are experiencing or at-risk</td>
</tr>
</tbody>
</table>
### Project HOME

**Strategic Plan 2011 - 2016**

- of homelessness through the development of permanent supportive housing and other appropriate permanent housing
  - Advancing public policy and support for the human and civil rights of persons who are experiencing homelessness, poverty and/or disability
  - Incorporating promising and evidence based practices to ensure the highest quality of services are offered to people living on the street and Project HOME residents and alumni that promote health, wellness, recovery, community inclusion, and successful transition from the street to housing including transitioning from entry level housing to more permanent supportive housing
  - Exploring the creation of a technical assistance arm of Project HOME to support staff and other organizations to more effectively deliver services that help end chronic homelessness

<table>
<thead>
<tr>
<th>Goal 2</th>
<th>Eliminate health disparities for people who are experiencing homelessness. Project HOME’s residents, alumni and the children, youth and adults who live, work or go to school in North Central Philadelphia by:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Increasing access to primary, behavioral and specialty healthcare services</td>
</tr>
<tr>
<td></td>
<td>• Establishing the Project HOME Wellness Center to serve as a central location for the provision of community health services</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Goal 3</th>
<th>Improve educational and employment opportunities for Project HOME’s residents, alumni and the children, youth and adults who live, work or go to school in North Central Philadelphia by:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Increasing access to education, counseling, internships, job training and employment; increasing access to post-secondary education for youth at the Honickman Learning Center and Comcast Technology Labs</td>
</tr>
</tbody>
</table>
Project HOME
Strategic Plan 2011 - 2016

- Increasing access to education, job training, skill building and career placement services for adults at the Honickman Learning Center and Comcast Technology Labs, local businesses, and Project HOME’s social enterprises and employment services
- Positioning the Honickman Learning Center and Comcast Technology Labs as a center for innovation in urban education and employment
- Partnering with higher education and the business community to develop a high-quality workforce for green, technology, healthcare, service, and other growing sectors of Philadelphia’s economy

Goal 4
Ensure that all developments reflect the shared values of economic, social and, to the greatest extent possible, environmental sustainability by:
- Ensuring all future development initiatives will be environmentally sustainable
- Reducing the carbon footprint of Project HOME’s existing facilities and infrastructure
- Becoming a model for sustainable neighborhood development
- Acting as a catalyst for economic development in North Central Philadelphia

Goal 5
Build Project HOME’s capacity to achieve our mission and strategic goals by:
- Enhancing our strong, unified brand identity by broadening recognition of the scope of our work
- Continuing to actively engage residents and alumni in conversations about our mission and strategy
- Cultivating a larger community of diverse and engaged staff, volunteers, donors, neighbors, allies and advocates
- Investing in leading edge information and technology solutions
- Developing a model program for our property management services to effectively operate and manage our existing and future buildings
Project HOME
Strategic Plan 2011 - 2016

- Enhancing the efficiency and effectiveness of financial management services
- Increasing leadership and professional development opportunities for staff
- Recruiting and retaining the best and brightest minds to help achieve our mission and vision
- Strengthening and diversifying sources of income
Stephen Klein Wellness Center, 2144 Cecil B. Moore, Philadelphia, PA 19121
Serving: People experiencing homelessness or living in 19121 and 19132 (North Philadelphia)

- Primary medical care
- Behavioral health care
- Dental care
- Pharmacy
- Wellness classes
- Mobile nurse
- Legal clinic
- Emergency food pantry
- Shower/laundry
- Patient navigation
- Assistance with applying for health insurance
- YMCA-operated fitness facility
- Physical therapy
What is supportive housing (SH)?

- Affordable Housing
- Intensive tenancy support services
- Intended for people with history of chronic homelessness complex challenges
- Results in housing stability
- Supports community integration
- Improves health outcomes
- Reduce public systems utilization
What is healthcare integrated with SH at Project HOME?

- Primary, behavioral and dental health care coordinated with specialty care
- Healthcare without walls – in housing, street-side, in engagement centers
- Person-centered health home
- Open access

- Persons with histories of chronic homelessness
- Serious persistent mental illness and/or substance use disorder and/or physical disability
Financing integrated healthcare and housing: Medicaid Billing

- Psychiatric Rehab Services
- Federally Qualified Health Center
contact info

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