Hospital and Housing Partnerships:

National Health Care for the Homeless Conference

Presenters

Myra Nagy, NCAB, Consumer Advisory Board, Colorado Coalition for the Homeless

Jenny Dearing, LCSW, LAC Director of Housing First and ACT Services, Colorado Coalition for the Homeless

Sarah Stella, MD, Associate Professor of Medicine, Denver Health Department of Medicine, University of Colorado School of Medicine

Ainslie (A.K.) Kopperud, LCSW
Project Manager—Housing Transitions Team, University of Colorado Hospital

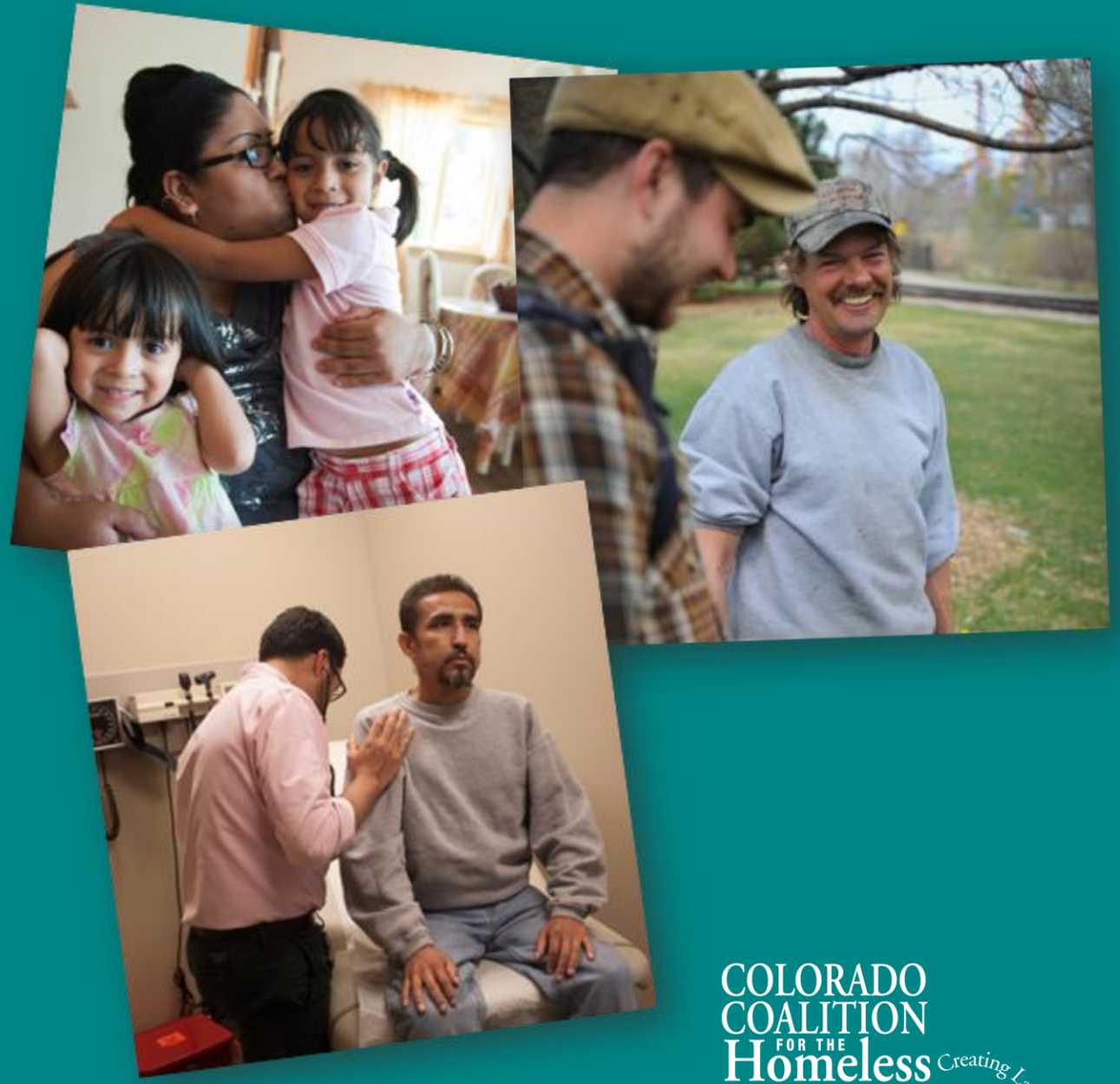
Agenda

- The why
- Spotlight CCH’s hospital-housing programs
- Denver Health and CCH partnerships
- UC Health partnerships with CCH
- Panel Q&A

The Why

Why is collaboration between hospitals and supportive housing programs important?

Who is the Colorado Coalition for the Homeless?



COLORADO COALITION FOR THE Homeless Creating Lasting Solutions

Housing. Healthcare. Support Services. Advocacy

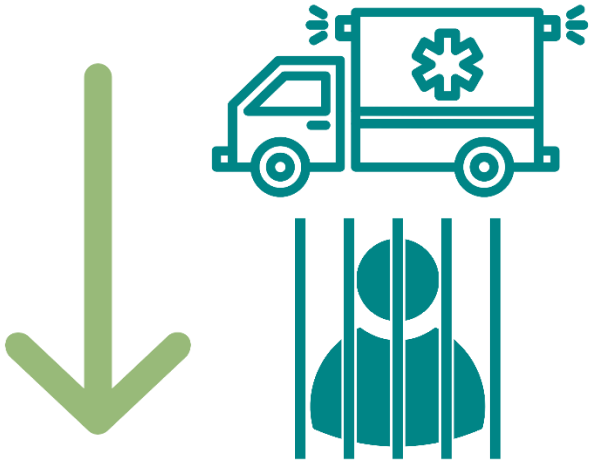
Colorado Coalition for the Homeless

Housing First is a belief that

Housing is Healthcare

And is a basic human right!

Models of Care: Housing First + Assertive Community Treatment



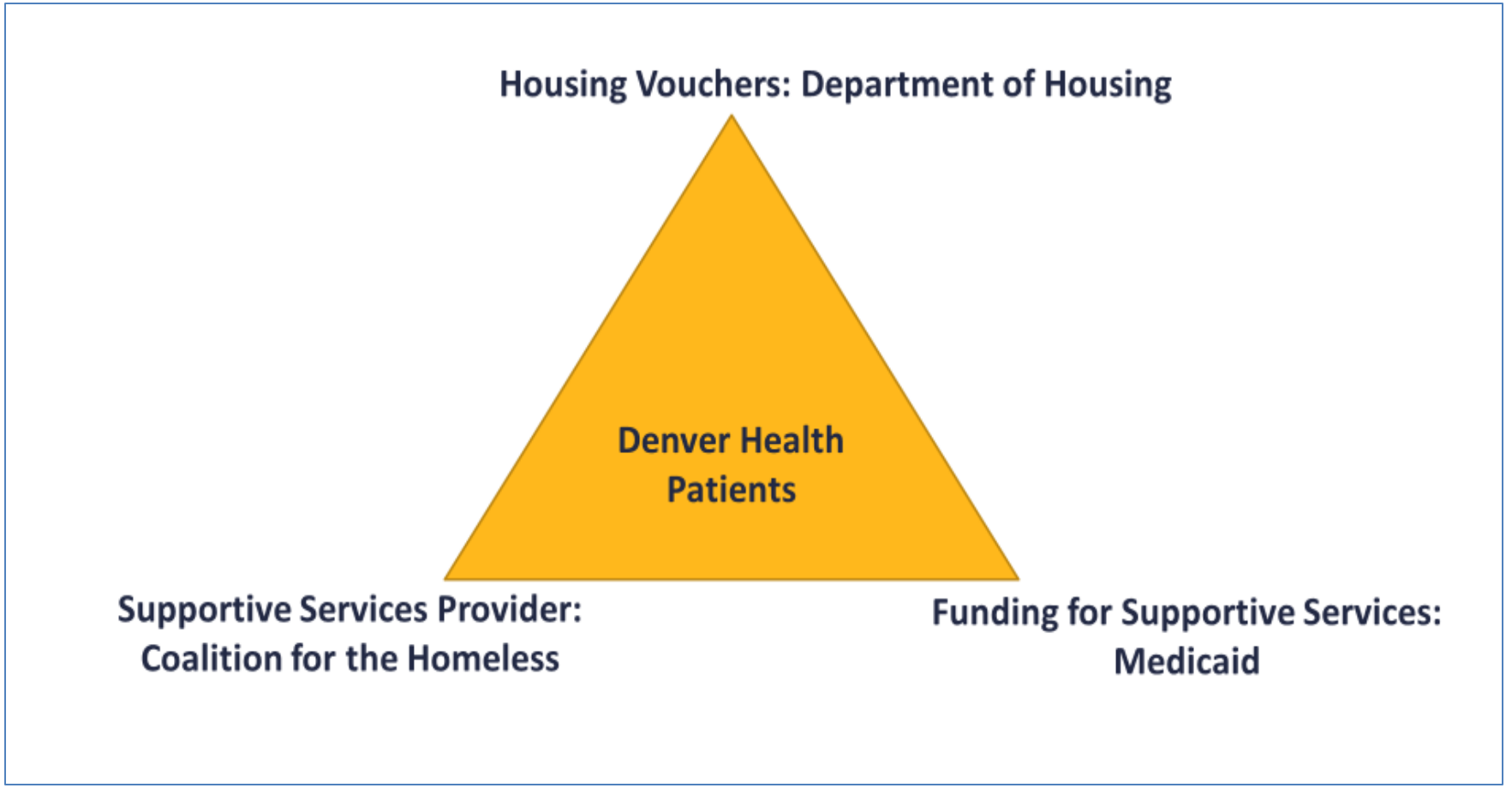
Housing First is proven to be **exceptionally successful in ending homelessness** for chronically homeless individuals and in saving communities significant financial resources through reduced ER & hospital visits, detox and jail stays.

Multiple cost benefit analyses show average **savings** of $15K-$18K per person, per year.

Colorado Coalition for the Homeless: Hospital and Housing Collaborations

- **H2H Home to Health** launched January 2020 and continues through June 2023
- **DRH Expansion** expanded an existing project with the City of Denver and launched April 2021 and continues through December 2023
- **SIPPRA** (Social Impact Partnership to Pay for Results Act) launched July 2022 and will continue through 2029
- **Stout Street Recuperative Care Center** Opened October 2023

Home to Health Pilot



Home to Health Pilot

- Better understand health and social needs of unhoused managed care Medicaid members identified as being at 'Rising Risk' for downstream adverse health outcomes and costs

- Assess feasibility and scalability, and contribute to broader policy discussions

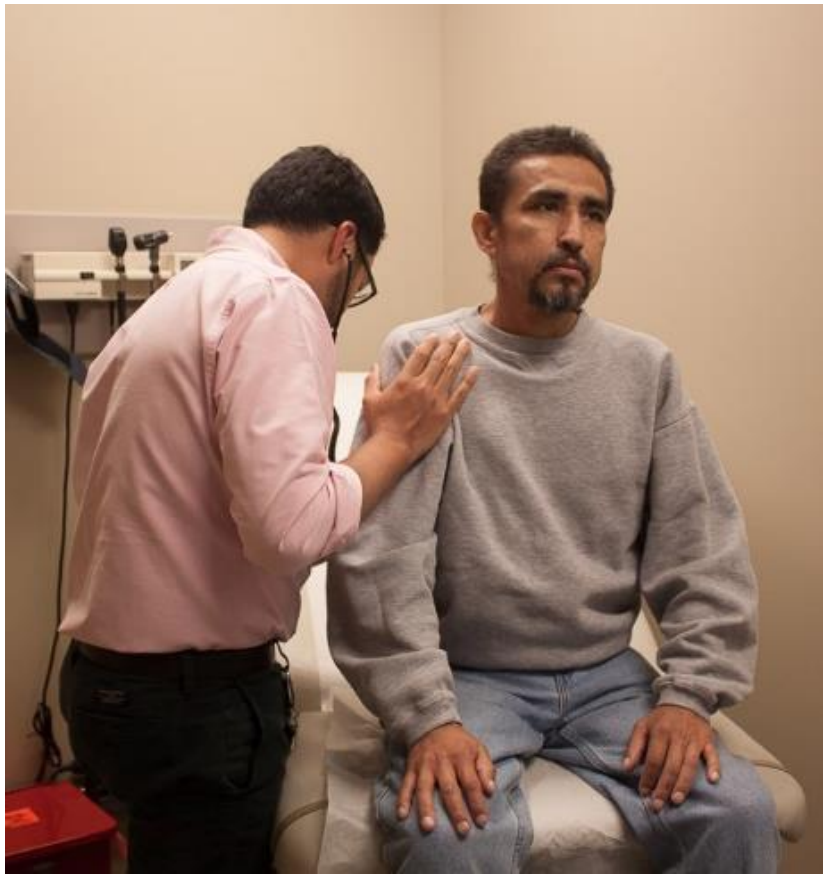


Photo courtesy of Cathy Alderman, Colorado Coalition for the Homeless

Fusion Studios

- Supportive Housing – 139 units
- Dedicated to Housing First Programs
- Onsite Resident Services Coordinator
- Clinical groups and support onsite
- Activities and community engagement for residents
- Resident Council governing body
- Housing Retention Committee

More Fusion Facts:

- Converted Hotel; Renovated and reopened in 2020
- 114 permanent support housing studios and 25 bridge housing studios.

DRH Expansion: Program Description

Project Goals/Outcomes:

- Provide housing and wrap around services to 120 clients referred through Protective Action or DSOC

Collaborations:

- UC Health

SIPPRA: Program Description

Goals of SIPPRA evaluation:

Renaissance Legacy Lofts

- Supportive Housing – 98 units
- Dedicated to Housing First Programs
- Resident Services Coordinator
- Clinical groups and support onsite
- Activities and community engagement for residents
- Resident Council governing body
- Housing Retention Committee

More Legacy Lofts Facts:

- 81 one-bedroom units, 17 studio units
- Full bathrooms and kitchens, business center, bike storage, fourth-floor terrace, laundry, etc.

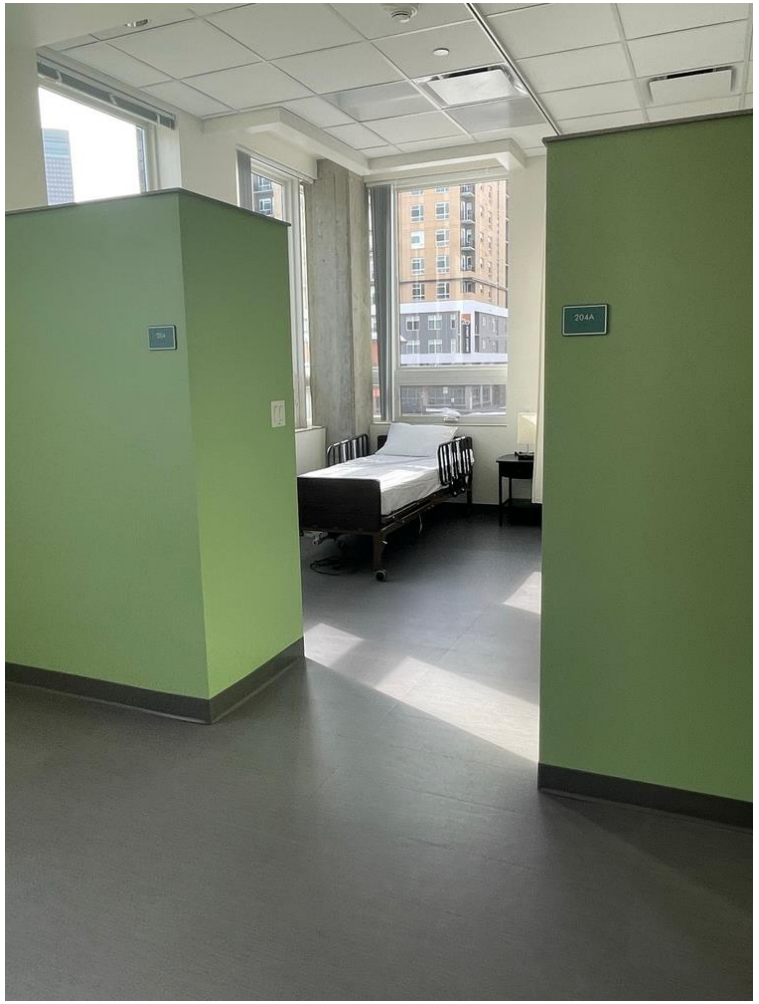
COLORADO COALITION FOR THE Homeless Creating Lasting Solutions

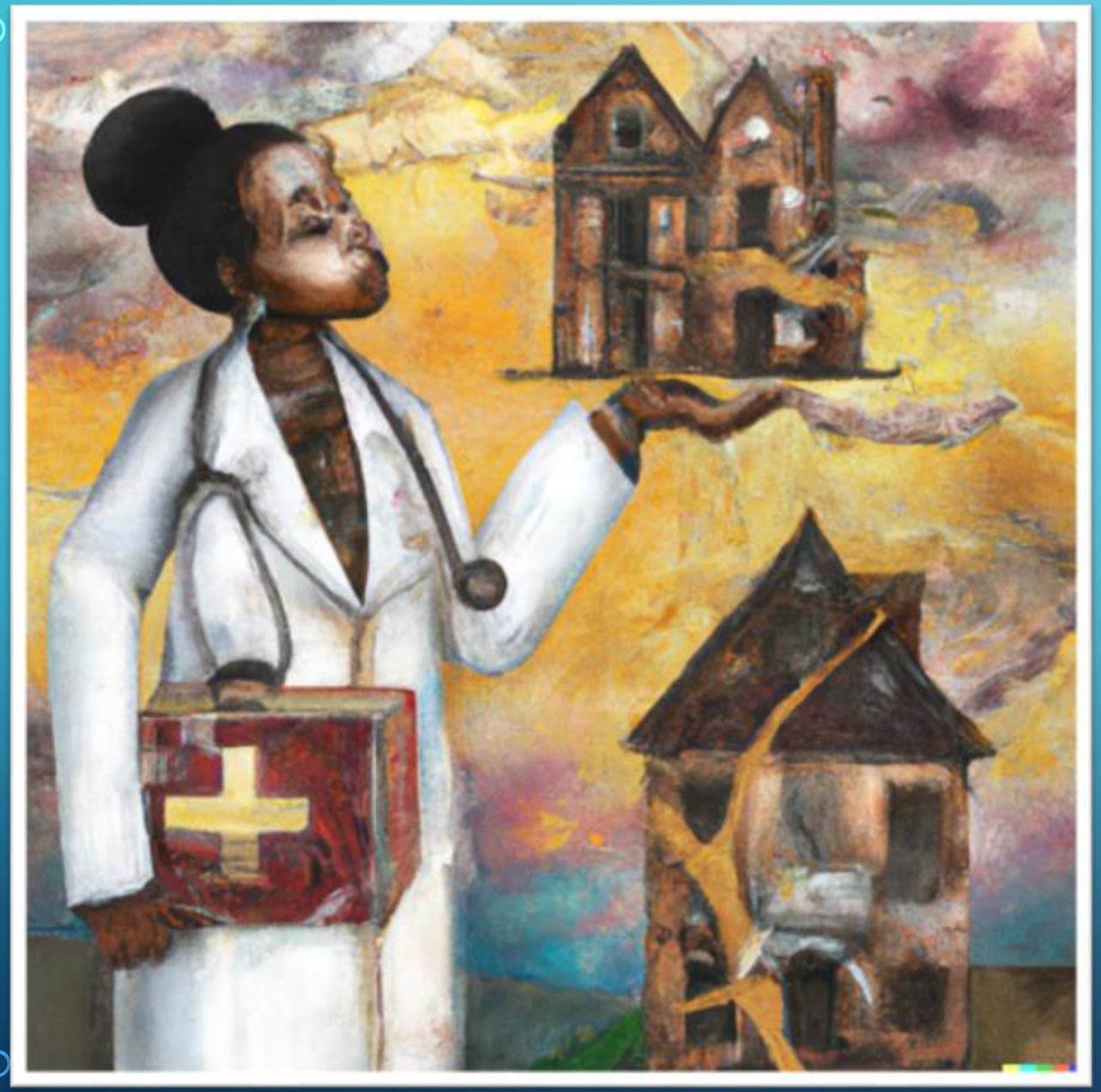
A SAFE PLACE TO GET WELL

JOHN PARVENSKY STOUT STREET RECUPERATIVE CARE CENTER

- The Stout Street Recuperative Care Center (SSRCC) provides safe, dignified, and quality spaces for people experiencing homelessness to heal and stabilize from medical issues.

- The center features 75 medical respite beds targeted to people experiencing homelessness with acute medical conditions. The facility will serve approximately 500 people each year.





BUILDING CONNECTIVE TISSUE FOR HOUSING HEALTH PARTNERSHIPS

Sarah Stella, MD

DENVER HEALTH
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FOR LIFE'S JOURNEY

An innovative health care system that is a model for success in the nation.

TRUE NORTH

Change the world by transforming the health of our patients and community.

VALUES

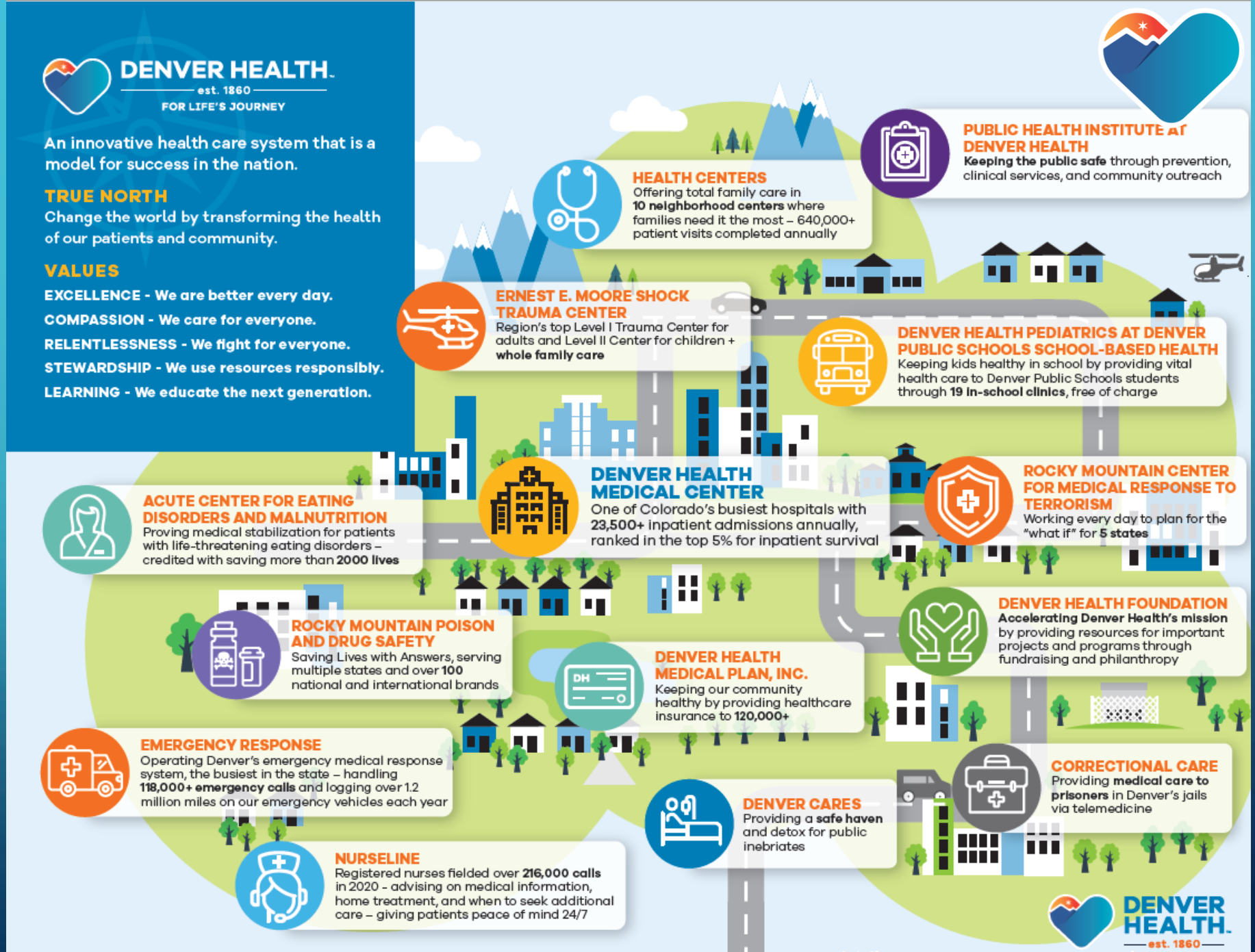
EXCELLENCE - We are better every day.

COMPASSION - We care for everyone.

RELENTLESSNESS - We fight for everyone.

STEWARDSHIP - We use resources responsibly.

LEARNING - We educate the next generation.



PUBLIC HEALTH INSTITUTE AT DENVER HEALTH
Keeping the public safe through prevention, clinical services, and community outreach

HEALTH CENTERS
Offering total family care in **10 neighborhood centers** where families need it the most – 640,000+ patient visits completed annually

ERNEST E. MOORE SHOCK TRAUMA CENTER
Region's top Level I Trauma Center for adults and Level II Center for children + **whole family care**

DENVER HEALTH PEDIATRICS AT DENVER PUBLIC SCHOOLS SCHOOL-BASED HEALTH
Keeping kids healthy in school by providing vital health care to Denver Public Schools students through **19 in-school clinics**, free of charge

DENVER HEALTH MEDICAL CENTER
One of Colorado's busiest hospitals with **23,500+** inpatient admissions annually, ranked in the top 5% for inpatient survival

ROCKY MOUNTAIN CENTER FOR MEDICAL RESPONSE TO TERRORISM
Working every day to plan for the "what if" for **5 states**

ACUTE CENTER FOR EATING DISORDERS AND MALNUTRITION
Proving medical stabilization for patients with life-threatening eating disorders – credited with saving more than **2000 lives**

DENVER HEALTH FOUNDATION
Accelerating Denver Health's mission by providing resources for important projects and programs through fundraising and philanthropy

ROCKY MOUNTAIN POISON AND DRUG SAFETY
Saving Lives with Answers, serving multiple states and over **100** national and international brands

DENVER HEALTH MEDICAL PLAN, INC.
Keeping our community healthy by providing healthcare insurance to **120,000+**

EMERGENCY RESPONSE
Operating Denver's emergency medical response system, the busiest in the state – handling **118,000+ emergency calls** and logging over 1.2 million miles on our emergency vehicles each year

CORRECTIONAL CARE
Providing **medical care to prisoners** in Denver's jails via telemedicine

DENVER CARES
Providing a **safe haven** and detox for public inebriates

NURSELINE
Registered nurses fielded over **216,000 calls** in 2020 - advising on medical information, home treatment, and when to seek additional care – giving patients peace of mind 24/7

PP2109-23 REV 2/22

DENVER HEALTH
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FOR LIFE'S JOURNEY

Where some patients live

DENVER HEALTH
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- In 2022, we cared for at least **7,259** patients experiencing homelessness who had **29,525** visits

Where some patients live

BUILDING CONNECTIVE TISSUE FOR HOUSING-HEALTH PARTNERSHIPS

To provide the best possible care for all our patients, Denver Health is working proactively to address identified gaps in care by facilitating connections to housing and other critical supports in collaboration with many other local organizations and partners, including:

Colorado Coalition for the Homeless

To improve care coordination and provide a safe place for patients to recover following hospitalization

Denver Housing Authority and Corporation for Supportive Housing

To design a 14-unit transitional housing program for older and disabled patients

Colorado Village Collaborative

To provide a safe outdoor space for 50 unsheltered individuals

The Denver Joint Task Force

To mitigate the impact of COVID-19 and emerging health threats on Denver's unhoused communities

Social Impact Partnership Pay for Performance Results Act (SIPPRA) Housing to Health program partners

To connect eligible patients with permanent supportive housing

DENVER HEALTH
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How it started...

2018
- Community Advisory Panel identified opportunities to improve care

2019
- Joint Strategic Planning
- Data sharing to facilitate care transitions

2020
- Housing Pilot
- Coordinated COVID-19 activities

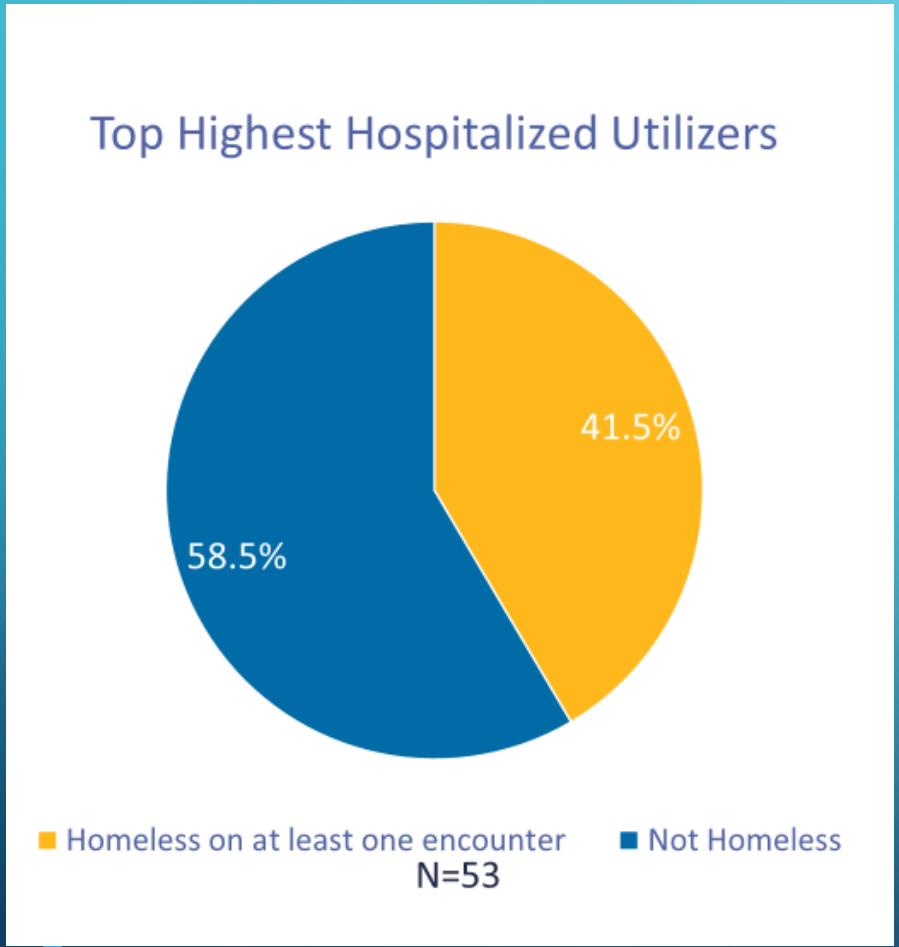
2021
- Joint funded research
- Data Integration & Care Coordination

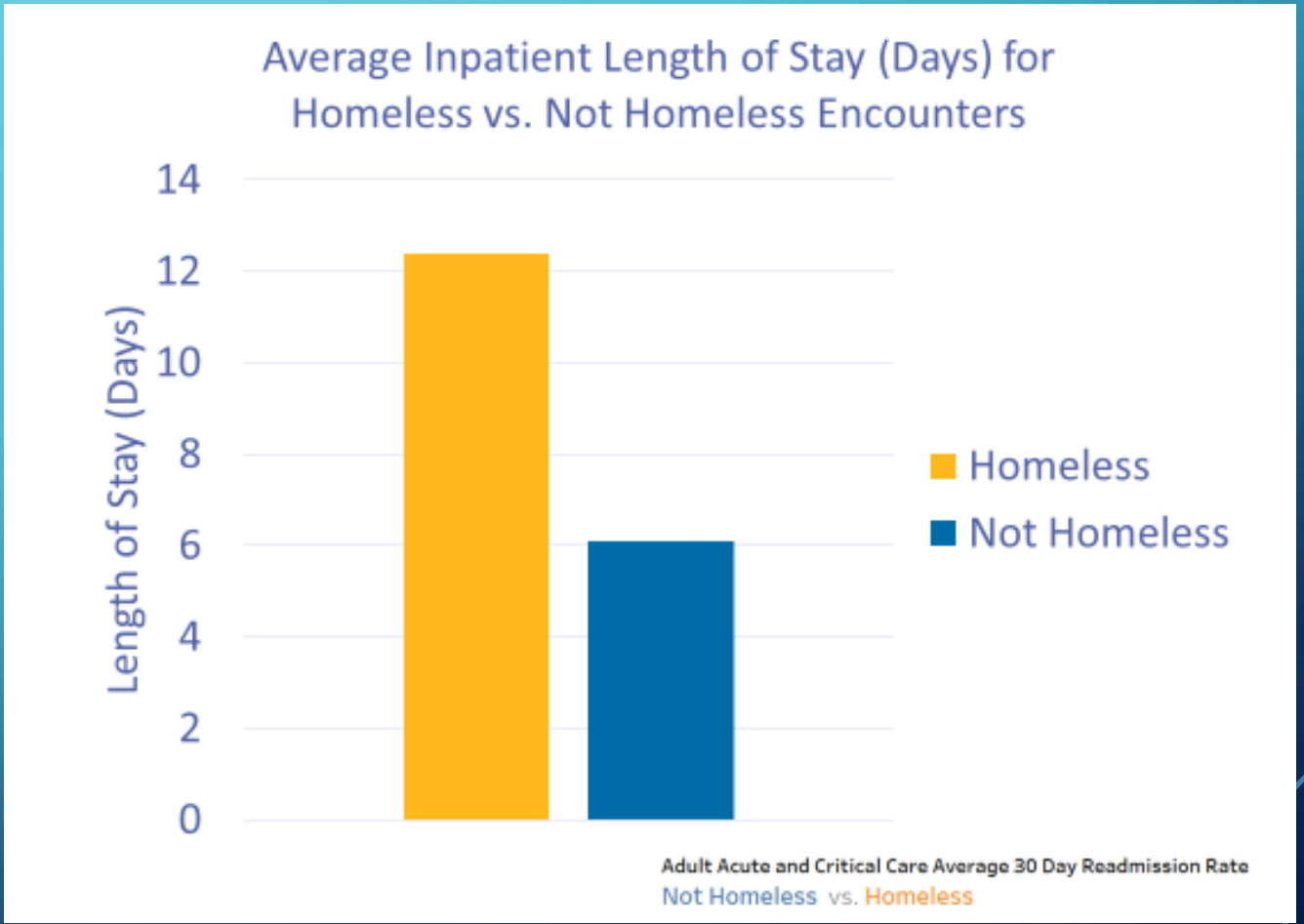
How its going

2022
- Recuperative Care
- SIPPRA Housing to Health Program

COLORADO COALITION FOR THE Homeless
Creating Lasting Solutions

Saving Money and Saving Lives: Building the Case for Recuperative Care





SIPPRA's Enhanced Health Focus and Denver Health's Role

1. Partnered on analyses to help understand healthcare utilization and develop eligibility criteria
2. Identification and referral of eligible patients
3. Ongoing partnership around care coordination

SIPPRA EARLY LESSONS LEARNED

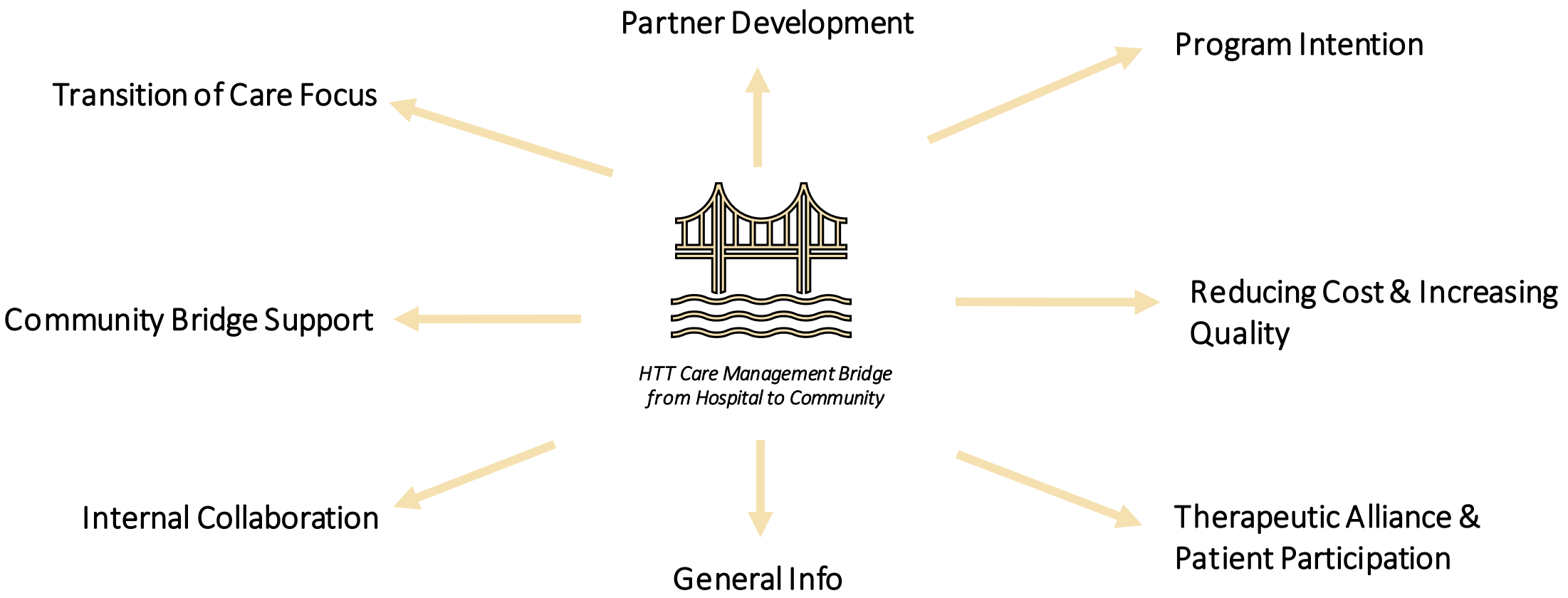
- High medical needs of patients referred
  - often lack relationships with community service providers or Coc
- Broader partnership work with CCH critical to operationalizing
- Project coordination, early and ongoing stakeholder engagement, flexibility critical to success
- Majority of connections from ED and hospital
- Few people have declined connection when offered

IMPACT ON PATIENTS AND CARE TEAMS

"It is hard to describe how grateful and ecstatic he was about his housing connection. And that joy was contagious. We regularly took a moment for a brief 'hooray' during rounds in the days leading up to discharge. Gave him a big high five on day of discharge!"

-Katie Raffel, MD

HTT Project Information



HTT Project Goals & Initial Results

Reduced lengths of stay & lower organizational costs

Improved linkage to community providers & data collection

Partnerships with housing providers

Attend community service provider meetings to improve care coordination

Partner with local cities/groups to improve patient access to housing stabilization initiatives

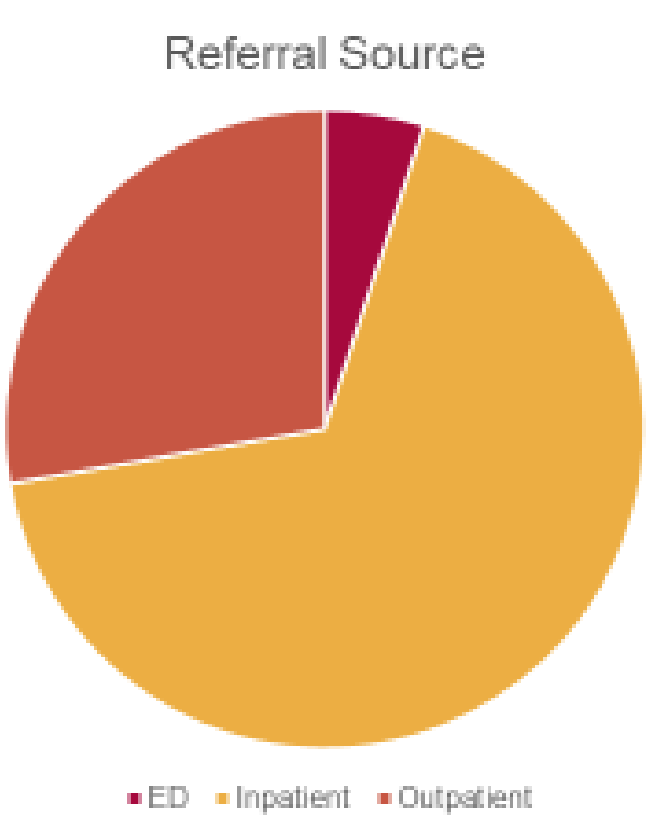
Image Sources: https://www.shutterstock.com/image-vector/open-door-simple-icon-613879370, https://free-printable-signs.com/dollar-sign/, https://www.vectorstock.com/royalty-free-vector/link-icon-linked-symbol-flat-vector-5430155, https://www.freeiconspng.com/images/community-icon, https://www.vecteezy.com/vector-art/2564235-medical-house-healthcare-hospital-pictogram-silhouette-style-icon

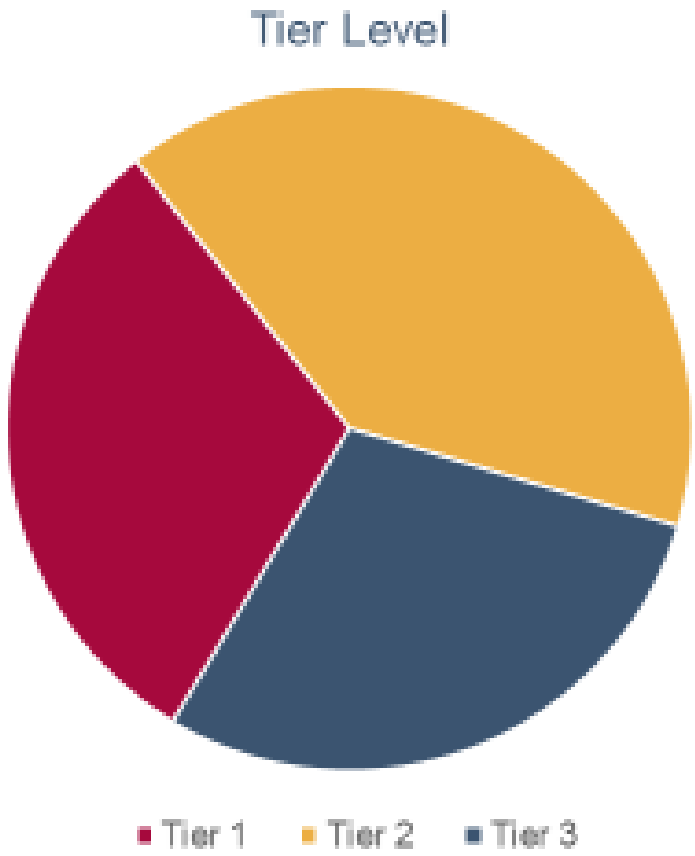
Tier Referral System

Level of Patient Engagement

 **Tier 3** **Patients with most needs. HTT to provide time-limited community support.**	 **Tier 2** **Patients in need of some housing resource support. HTT will collaborate with primary SW on specific needs.**	 **Tier 1** **For consult/resource questions only. HTT to sign off after help provided.**
Criteria 1. The patient has a documented history (e.g., encounters in Epic) of cycling in & out of ED/UCH or has experienced recurrent hospitalizations: 3 ED visits over 6 months 2. Community services have been unable to meet the patient's current and/or ongoing medical needs. 3. There are significant barriers to accessing identified resources and/or housing pathways. As a result, patient is experiencing chronic housing instability. 4. Primary service SW has assessed that discharge plan is likely to result in a return to the ED/readmission to the hospital.	**Criteria** 1. The individual is engaged with the community but still experiencing communication barriers. Individual would benefit from HTT identifying and coordinating with community providers to facilitate more consistent follow up and/or improve continuity of care. 2. Primary social worker has run into challenges coordinating with relevant community partners and verifying discharge supports (e.g., has called/emailed and not received any actionable response).	**Criteria** 1. The individual is experiencing episodic housing insecurity (e.g., housed but at risk of eviction, couch surfing, exploring rental assistance) but is capable of navigating community resources independently. 2. The individual is engaged with community resources, and there are no immediate barriers preventing the individual from continued work with community agencies. 3. Identified barriers can likely be addressed using community resources and tip sheets already available to primary SW (e.g., assisting individual in accessing a phone, applying for benefits, coordinating transportation, connecting with housing resources). *Primary SW is always welcome to re-consult HTT if new information is obtained, or an individual's situation deteriorates, and a new tier assessment is needed.

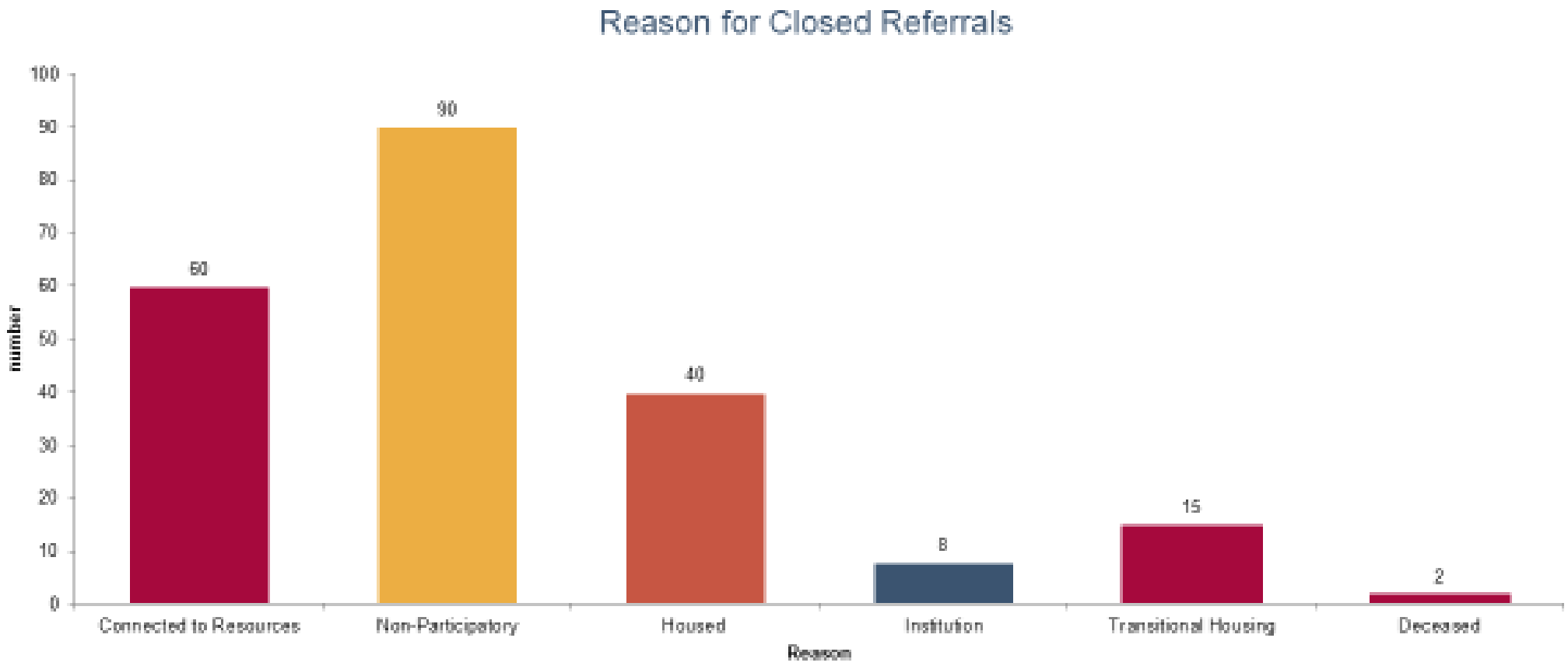
Image source: https://www.freeiconspng.com/img/206





2022 Annual Data:

HTT closed referrals in 2022:



Community Connections & Resource Development

Image Source: https://us-canad.com/denver.html

- Mile High Behavioral Healthcare (Comitis Crisis Center & Aurora Day Resource Center)
- Colorado Coalition for the Homeless (Stout Street Recuperative Care Center, PAR hotels/motels, Housing First, Vocational Services, Family Support Services, Community Resources, & Outreach)
- Denver Rescue Mission (shelters & case management teams)
- Aurora Mental Health (PATH program/outreach team)
- U.S. Dept. of Veterans Affairs (Homeless Program, HUD VASH Program, inpatient/outpatient social work teams)
- Metro Denver Homeless Initiative (MDHI). *UCHealth participates in the Homeless Management Information System (Clarity/One Home) to collaborate with community partners.
- Colorado Department of Local Affairs, Division of Housing (Office of Homeless Initiatives)
- Aurora Outreach Collaborative (partnership of several agencies)
- *+ many more*

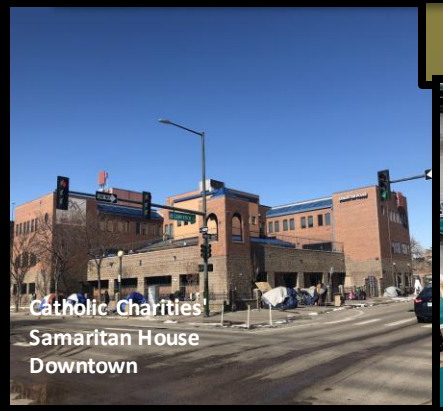
Community Sites

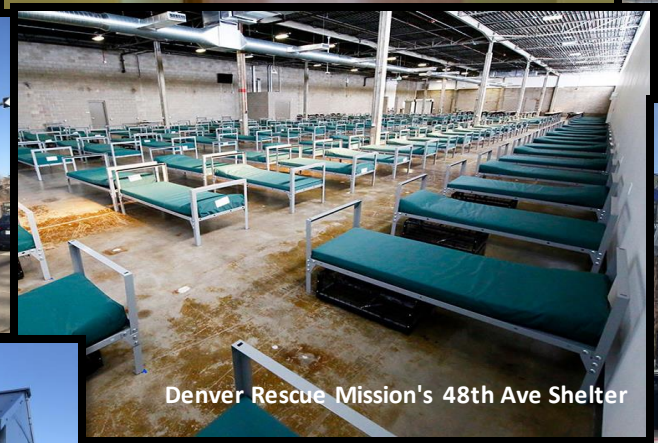
Denver Rescue Mission's Lawrence Street Shelter Downtown

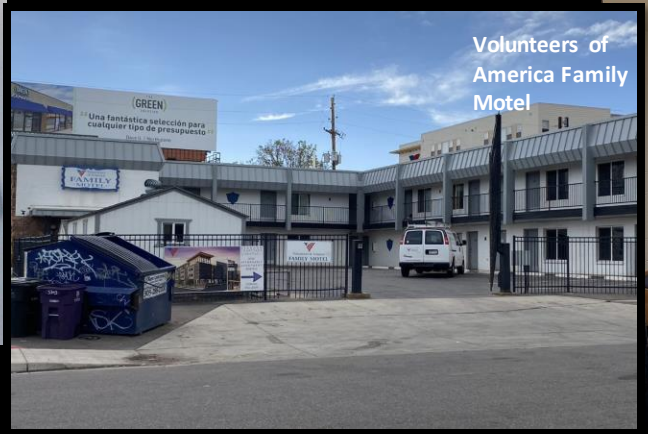

CCH's Stout Street Recuperative Care Center


Catholic Charities 48th Ave Shelter


RecoveryWorks Today


Catholic Charities' Samaritan House Downtown


Denver Rescue Mission's 48th Ave Shelter



Volunteers of America Family Motel


MHBHC's Comitis Crisis Center

Salvation Army's Aurora Safe Outdoor Space (SOS Peoria)


A Loft Hotel (Denver's HOST & Salvation Army) Protective Action Respite Site

School of Medicine
UNIVERSITY OF COLORADO
ANSCHUTZ MEDICAL CAMPUS

Photo Sources: Original onsite photos, Google Images, DRM, & Denverite.

HTT Timeline Service Highlights

8.23.2021 = HTT fully staffed & begins training/community partner engagement.

11.24.2021 = HTT supports patient's wish to explore independent housing. Then helps with eventual transfer to LTC with hospice by working with another hospital system.

3.7.2022 = First PAR to Pad patient officially housed in apartment through Colorado Coalition for the Homeless (CCH).

11.16.2022 = Denver Housing Authority & HTT begin pilot project. 22 Housing Choice Vouchers reserved for patients with connection to City/County of Denver.

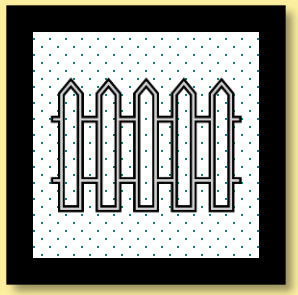
Program Successes

Improved discharge planning for patients

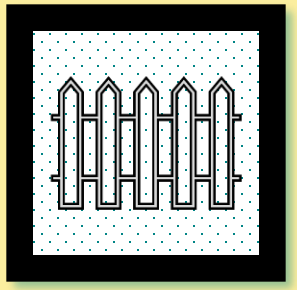
Increased community partnerships & new resource pathways

Increased community partnerships & new resource pathways

Program Barriers



Limited discharge options for patients with complex needs



Challenges with initial linkage, technology barriers, and staying connected

Image Source: https://www.google.com/search?q=free+house+outline+symbol&rlz=1C1GCEU_en&sxsrf=APwXEdcWA_14SUjRuLhp_IJFHr1YyQn1TQ:1683227383478&source=lnms&tbm=isch&sa=X&ved=2ahUKEwiRwpLSrtz-AhVWJzQIHQbpDHMQ0pQJegQIAxAC&biw=1920&bih=880&dpr=1

Thanks from HTT!

For additional questions or info, email us at: housingtransitionsteam@uchealth.org

Ongoing need for additional opportunities for Hospital and Housing collaboration


Questions?