Impact of a Data-Driven Centralized Care Coordination Program in a Large Urban Shelter System

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Topics

- Background: New York City Shelter System
- Using Data to Identify High-risk Clients
- Centralized Care Coordination Program Overview
- Harm Reduction Principles for Care Coordination
- Program Outcomes & Next Steps
- ▶ Case Discussions

Background: New York City Shelter System

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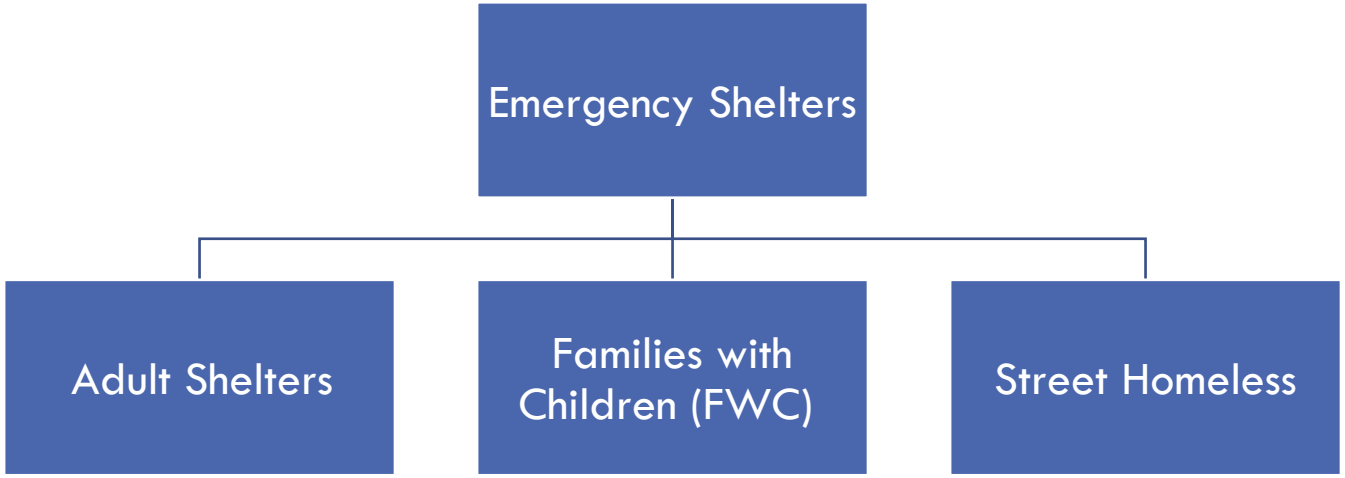
Medical Director, NYC Department of Homeless Services

New York City Department of Homeless (DHS) Services Shelter System



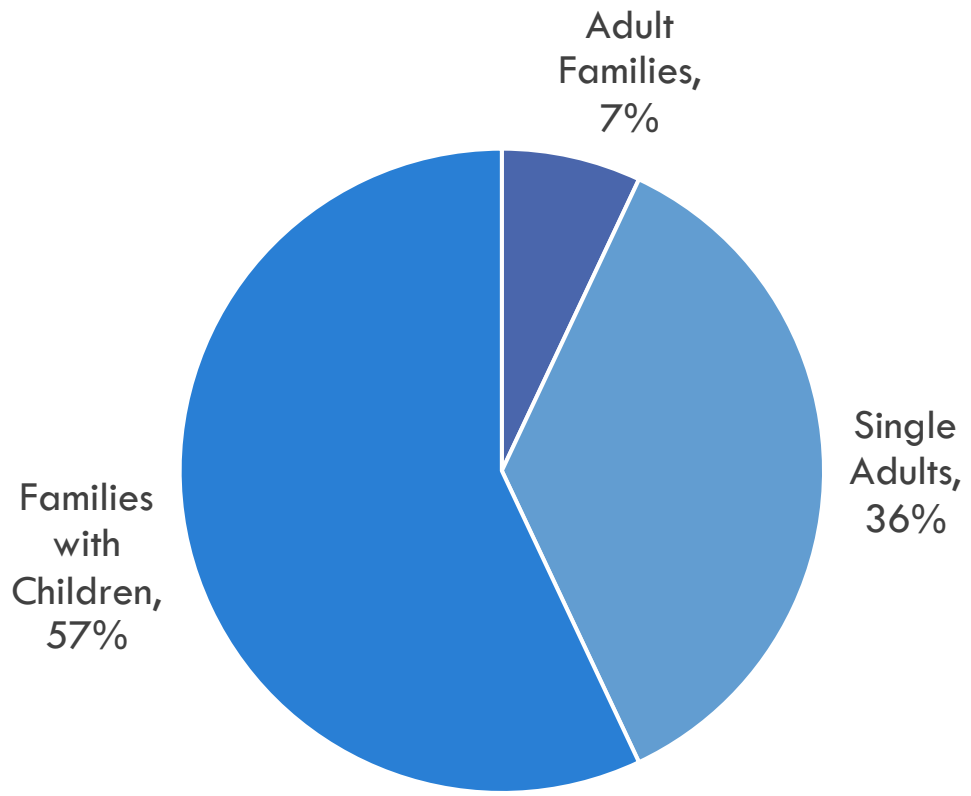
Single Adult Shelter Services

- Healthy meals
- Access to benefits and social services
- Access to job training and other supportive services
- Applications for housing
- Referrals and linkages
- No medical shelter – must be ADL independent

DHS Client Overview

- More than 90% of homeless persons in NYC are in shelter
- Daily census as of 5/8/2023 was 78,573 individuals
- Street Homeless estimate, HOPE Count, 3,439 (1/23/2022)
- New arrival of thousands of asylum seekers beginning spring-summer 2022

DHS Clients, percent by program type, fiscal year 2022



Source: New York City Department of Homeless Services data dashboards, available at https://www.nyc.gov/site/dhs/about/stats-and-reports.page

NYC Homeless Services and Health Care

Right to Shelter Law in NYC

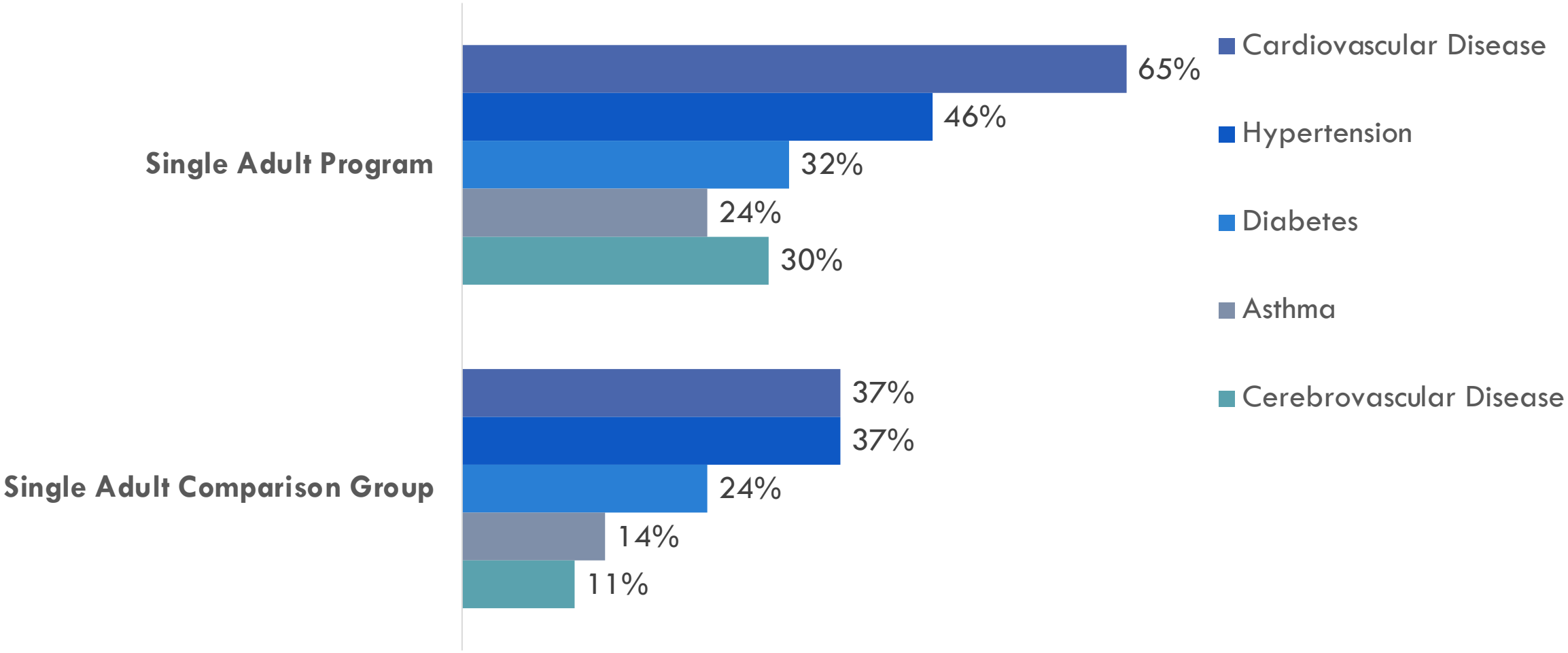
Mission is to provide temporary shelter & access to permanent housing

Over 400 shelters & 86 non-profit and for-profit shelter providers

62 hospitals, over 450 health centers, 288 substance use treatment programs

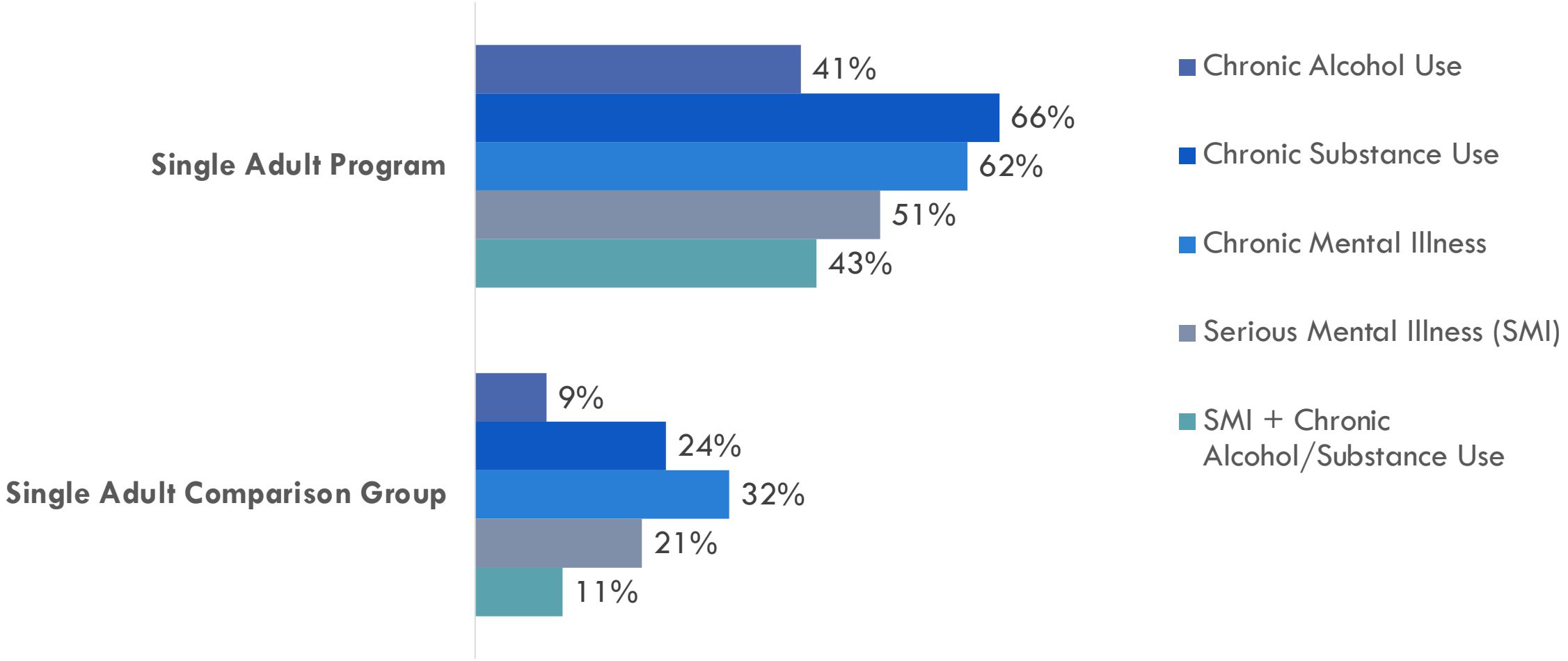
Second largest jail system in U.S.

Common Health Conditions among DHS Clients



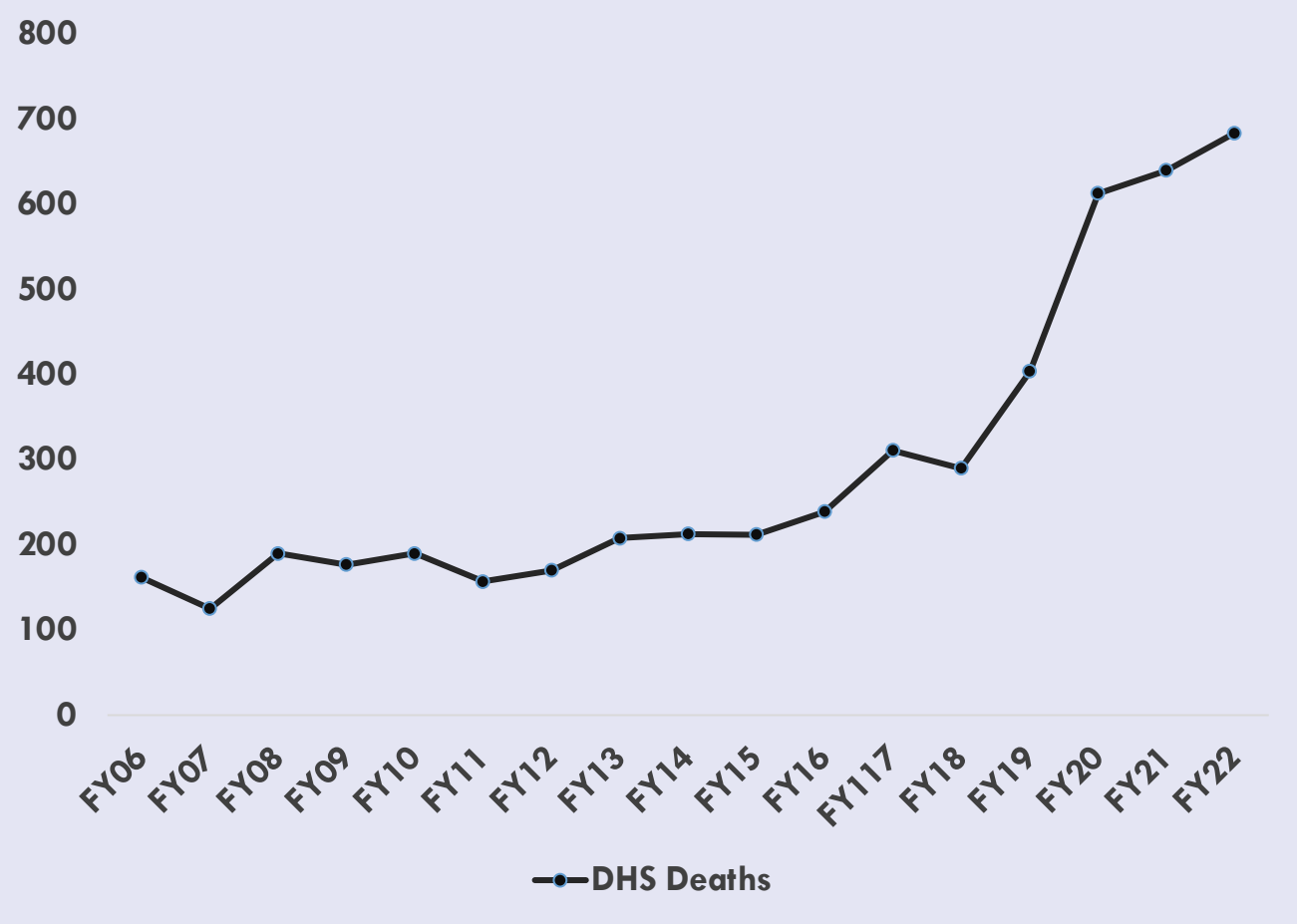
Source: Medicaid Claims Data, 2018

Behavioral Health Conditions among DHS Clients



Source: Medicaid Claims Data, 2018

NYC Homeless Mortality Data



Top causes of death FY 22

- Overdose
- Heart disease
- Accidents
- Alcohol-related
- Cancer

Median age at death for adult decedents was 51

Source: Local Law 7 (LL7) reports to NY City Council, FY06-FY2022

Using Data to Identify Complex Clients

Improving Outcomes for DHS Clients: Program Focus & Goals

- **Focus:** Clients associated with multiple negative incidents in shelter and community, who have cycled through multiple city systems
- **Goal:** Achieve best possible outcomes for clients, including suitable permanent placement & optimal engagement in services to reduce:
  - Aggressive and violent incidents
  - Self-harm
  - Criminal-justice involvement (arrest, etc.)
  - Emergency department visits and hospitalizations
  - Substance use incidents including altercations, accidents, and overdose

Data-Driven Versus Passive Referrals

Difficult for shelter providers to identify & refer highest-risk clients due to biases, lack of complete information, and frequent movement through systems

- *Availability bias*: tendency to give more weight to things that can be easily recalled (i.e., a client who always checks in and you see the most often)
- *Information bias*: information is collected or interpreted inaccurately (i.e., disruptive or non-adherent clients are incorrectly categorized as high risk)
- *Data gaps*: Shelters do not have access to diagnostic & treatment information; arrests, incidents, & hospitalizations outside of shelter

DHS Data Sources

- Client self-reported psychosocial, medical and substance use information
- Shelter incident reports and case notes
- *Institutional Referral* reports from hospital, nursing home and occasionally jail or prison
- Aggregate Medicaid data (through academic partnership)
- Limited PSYCKES/Medicaid data (billing data for ppl with mental health diagnoses)
- Mortality data

DHS Incident Reports

- **Incidents involving shelter clients are reported to DHS** electronically by shelter providers and classified by priority from least serious (Priority 3) to most serious (Priority 1)

- **Incidents include** accident, injury, hospitalization, fights, deaths, sexual assault, threats, arrests, arson, EMS calls for medical/psychiatric issues, overdose, intoxication, disorderly conduct, theft, domestic violence, attempted suicide, property damage, and more

- **All incident reports include** client name, unique client identifier, date of incident, shelter information, and outcome

Highest-risk clients

Definition and Parameters

Pilot:

50 single adult clients designated as complex or "high-risk" based on following preliminary criteria:

- 14 or more total incidents in past 6 months **and:**
  - At least one serious incident (Priority 1)
  - Client resided in DHS shelter system during Jan-Jun 2021

Prioritized clients with highest number of total or serious incidents, and highest number over past three months (escalation)

Centralized Care Coordination Program Overview

Eve Cleghorn, MPH

Complex Care Program Manager, NYC Department of Homeless Services

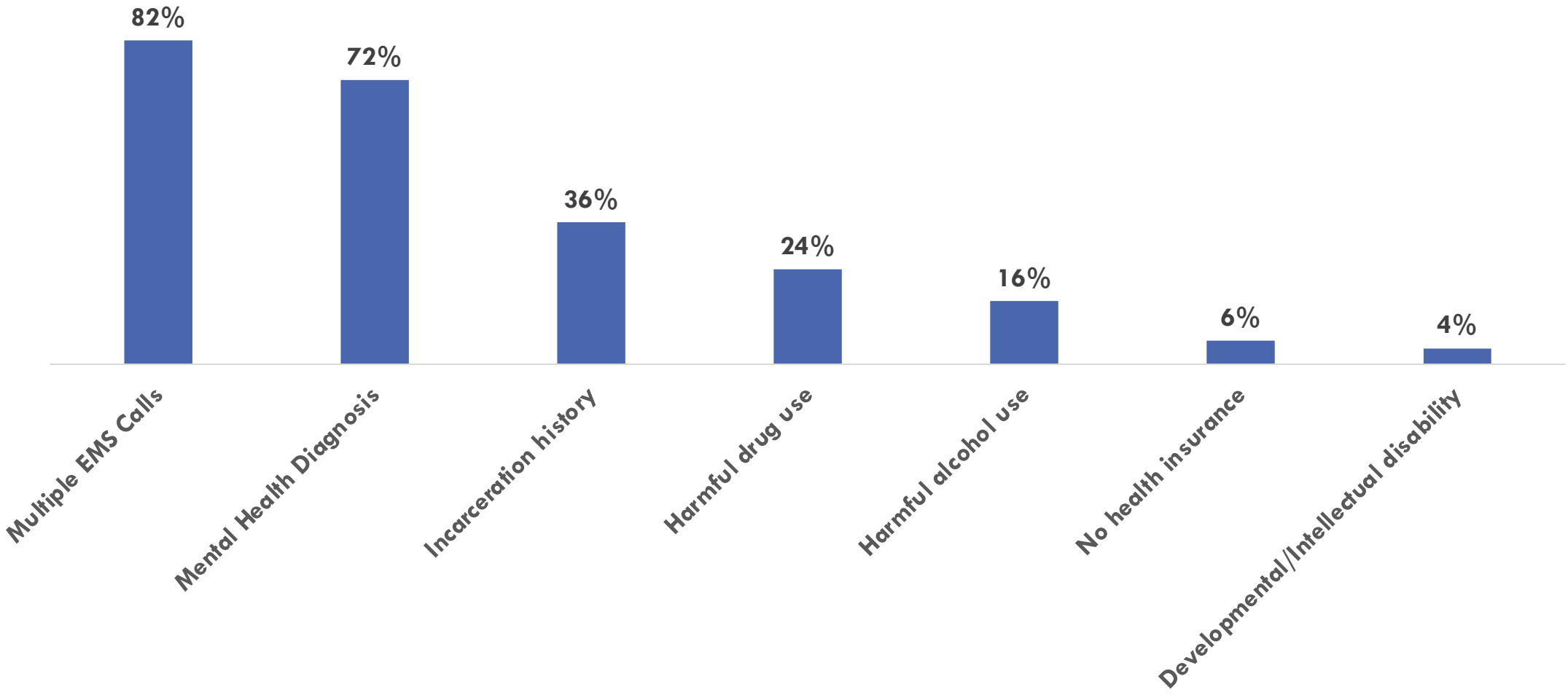
Care Coordination Program Fundamentals

- Use data for action
- Maximize existing resources and build on system strengths
- Coordinate and collaborate with partners
- Guided by principles of universal harm reduction
- Clearly defined responsibilities

Pilot Program: 50 High-risk Client Demographics and Incidents

- Average age: 41 years (range 23 – 64)
- 74% male, 22% female, 2% transwoman, 2% other
- Average of 24 of incidents (range 14-42), per client
- Average of 5 high priority incidents (range 1-14), per client
- Average of 10.93 years since first entered shelter system

Baseline Characteristics of High-risk Clients Selected for Centralized Care Coordination



Jan 1, 2021 – June 30, 2021; data source is self-reported data from DHS case management system

Centralized Care Coordination Model

Interventions include cross-agency coordination, frequent case conferences with clients' care team, and collaboration with hospitals & community-based providers

Development of "**care pathways**" for common conditions – multidisciplinary plans, unique to this population and setting

Long-term follow up is critical – many clients still require centralized care coordination after one year

Centralized documentation ensures complete data collection and supports sharing plan & information as clients move throughout various system

Collaborative Partners

- Contracted Shelter Providers
- Street Outreach Teams
- Local Health Department
- State Office of Mental Health
- Local Department of Social Services (benefits, supportive housing)
- Community-Based Providers
- Hospitals
- State Office for People with Developmental Disabilities (OPWDD)
- Local Disability Office
- And many others…

Key Program Resources

- Intensive Mobile Mental Health Teams
- Safety Net Primary Care Clinics
- Assisted Living Programs & Nursing Homes
- Local Disability Affairs Office
- Public Hospitals
- Crisis Service Providers

Care Pathways

Structured, interdisciplinary plans outlining critical steps to address specific conditions

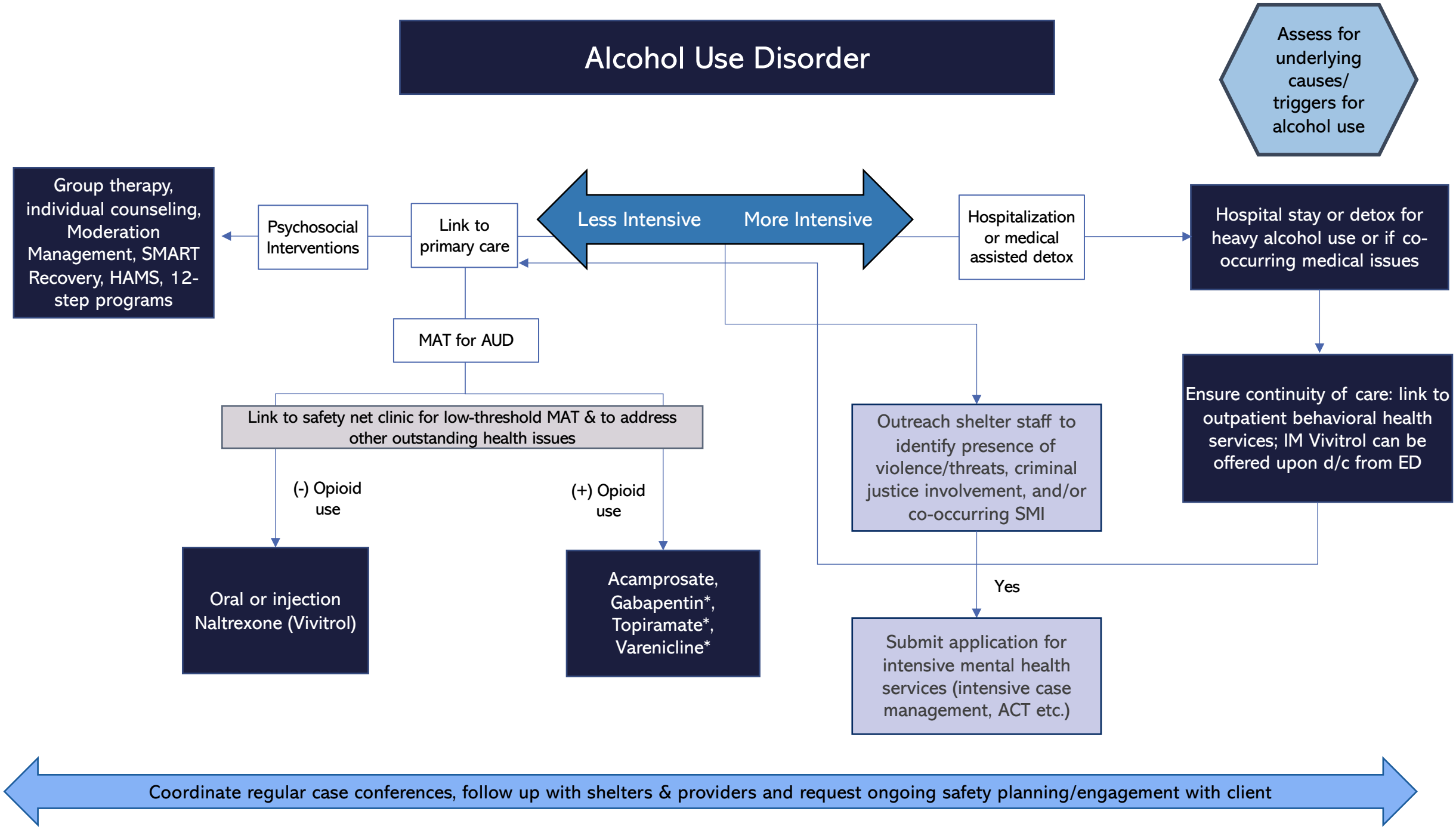
Facilitate introduction & implementation of evidence-based guidelines into practice

Improve multidisciplinary communication, collaboration, and planning

Reduce unwanted variation in practice

Source: Røsstad T., et al. (2015). Implementing a care pathway for elderly patients, a comparative qualitative process evaluation in primary care. *BMC Health Services Research;* Campbell, H., et al. (1998). Integrated care pathways. *BMJ*.

Alcohol Use Disorder



Conditions Affecting Cognition

Assess for vulnerability to victimization and/or harm to others

If SMI dual dx, consult w/ MH team & specialty consult for support

Known/suspected cognitive or neurologic impairment (ID/DD, FASD, TBI, unknown etiology)

OPWDD eligibility established

No established OPWDD eligibility

Refer for Intensive Mobile Treatment

Family support services

Coordinate with CCO for services, benefits and care plan

Day and employment services

Residential services (CRO)

Health care mental health rehabilitation

Crisis prevention and response

Consider ID/DD "lookalikes" (i.e., Traumatic Brain Injury, Seizure Disorder, Dementias)

Link to specialty clinic

Medicaid TBI Waiver (housing subsidy/support), nursing home, assisted living

Connect to Article 16/28 clinic for evaluations & CCO for application

Client > 22 y.o.

Process requires extensive documentation, guidance, and advocacy

Consult w/Disability Affairs throughout process/prior to submission

Frequent case conferences, coordination with jail and hospitals, high level of social support; attempt to create behavioral plan to follow individual across settings; engage family when possible to provide respite from shelter

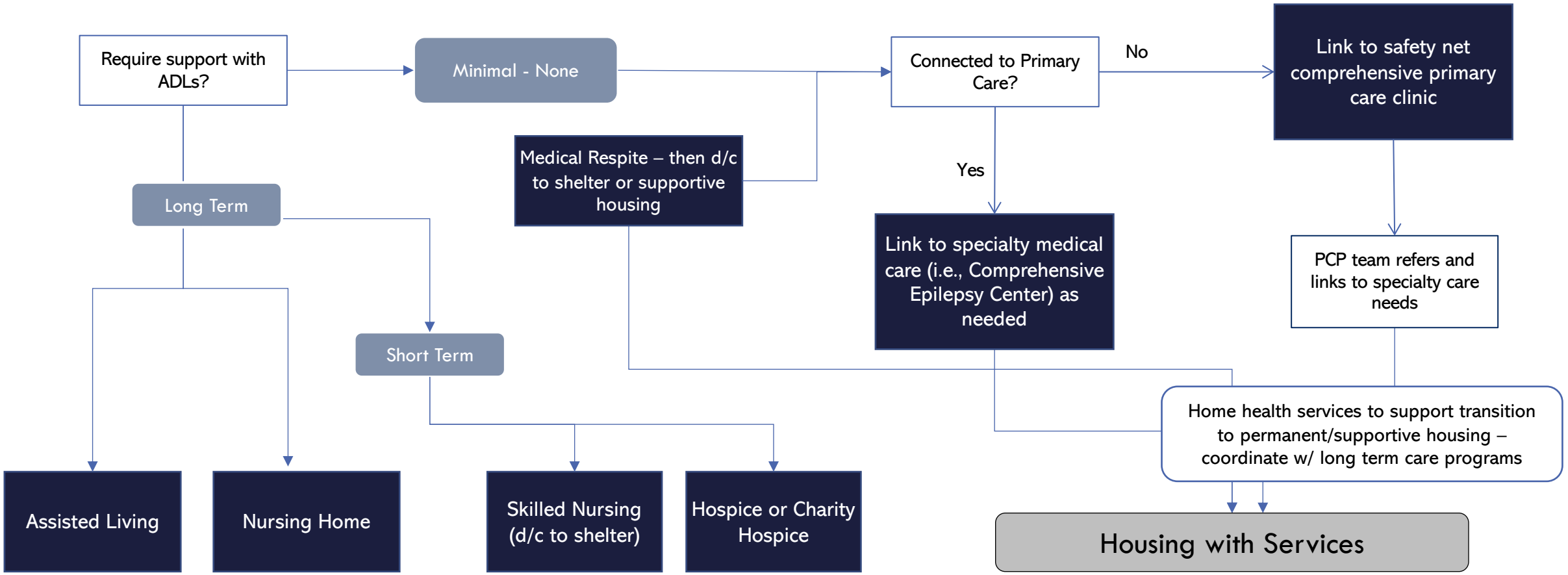
ID/DD: Intellectual or Developmental Disabilities **FASD**: Fetal Alcohol Spectrum Disorders; **TBI**: Traumatic Brain Injury; **OPWDD**: NYS Office for People with Developmental Disabilities; **CRO**: Certified Residential Opportunities

Complex Medical Conditions

Offer to link to palliative care services in community or hospital

Medical needs that are undermanaged, undiagnosed, and/or contributing to poor wellbeing, client may also be struggling with pain, breathlessness, fatigue, nausea and difficulty attending to their ADLs

Coordinate shelter, outpatient providers, & with hospital for admissions or ED visits



Harm Reduction Principles for Care Coordination

Jessie Schwartz, RN, MPH

Clinical Coordinator, NYC Department of Homeless Services

Challenges to Applying Harm Reduction Principles in Safety Net Settings

- *System-level*: Long wait times, fragmentation, poor documentation systems, staffing issues, general lack of resources, strict eligibility criteria for benefits and services
- *Provider-level*: Burn-out, long hours, stigma, internal biases, poor communication skills, lack of empathy/skills/training/support
- *Client-level*: Medical and psychosocial history, adverse childhood events, personality/feelings, expectations, poor quality of life, untreated, untreatable, or unknown diagnoses, language barriers, multiple stressors, competing needs

Principles of Harm Reduction for Health Services

- Humanism
- Pragmatism
- Individualism
- Autonomy
- Incrementalism
- Accountability Without Termination

Source: Hawk, M., et al. Harm reduction principles for healthcare settings. Harm Reduct J 14, 70 (2017)

Humanism

- In simple terms humanism represents the **care** in **health care**
- Each client is an individual with unique needs & experiences
- Concern for the whole person drives the process, does not focus on a specific desired outcome
- Providers are not "fixing" people
- Assess underlying organizational/personal views on moral worth

Source: Hawk, M., et al. Harm reduction principles for healthcare settings. *Harm Reduct J*. (2017); Pauly B., Shifting moral values to enhance access to health care: Harm reduction as a context for ethical nursing practice, *International Journal of Drug Policy*. (2008).

Individualism & Autonomy

- Assess strengths & needs; do not make assumptions based on harmful health behaviors
- Care should be an ongoing negotiation, not only a set of clinical recommendations
- It is a **critical role of providers** to enhance client decision-making capacity
- Explore personal and institutional practices around supporting choice

Source: Hawk, M., et al. Harm reduction principles for healthcare settings. *Harm Reduct J*. (2017); Pauly B., Shifting moral values to enhance access to health care: Harm reduction as a context for ethical nursing practice, *International Journal of Drug Policy*. (2008).

Pragmatism & Incrementalism

- Target interventions to specific modifiable risks & harms
- Recognize behavior change is extremely hard, use creative thinking to make it easier to stay safe
- Focus on practical solutions that are short-term, concrete, and rooted in the client's unique experience
- Expect and plan for backward movements

Source: Hawk, M., et al. Harm reduction principles for healthcare settings. *Harm Reduct J*. (2017)

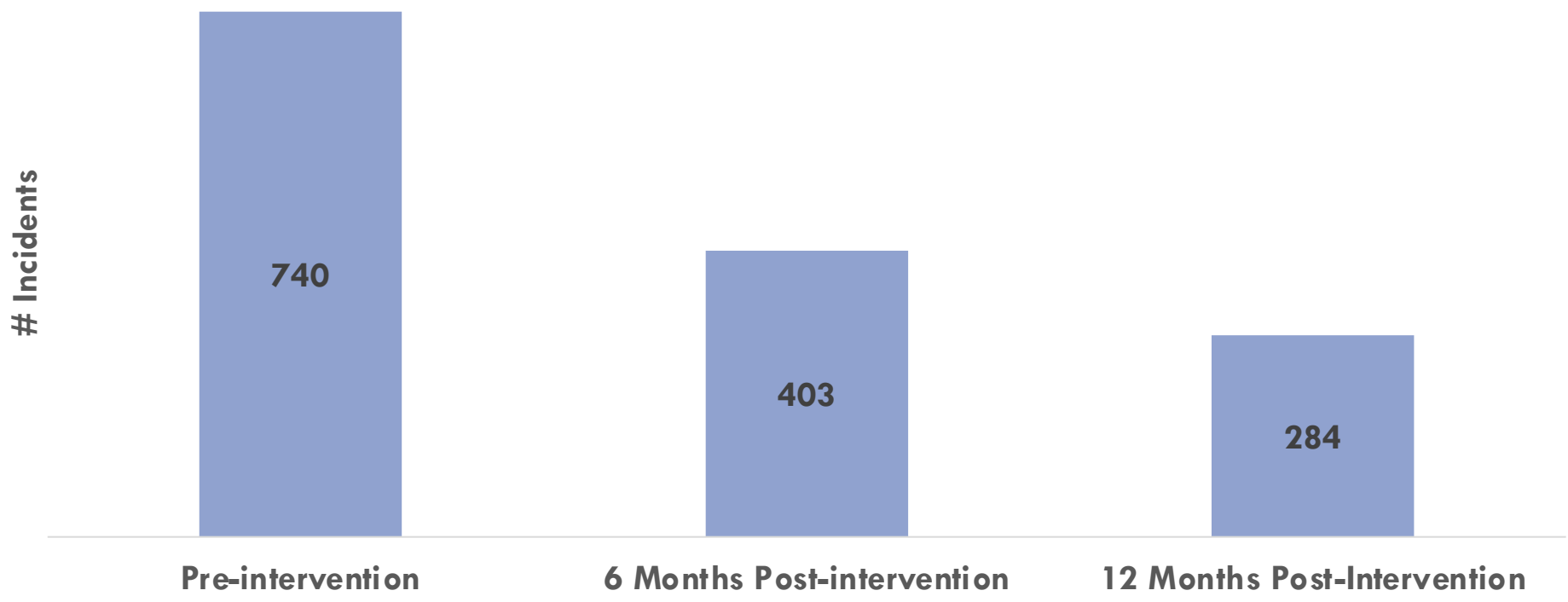
Accountability Without Termination

- Clients are responsible for their own choices and health behaviors
- Avoid judgements about non-adherence with treatment plans
- Develop specific guidance for when, why, and how services/relationships can be terminated (if at all); do not leave it up to individuals to decide this
- Break down barriers to make it easier for clients to attend appointments and adhere to care plans
- Use behavior support plans that are consistent across providers if possible

Source: Hawk, M., et al. Harm reduction principles for healthcare settings. *Harm Reduct J*. (2017)

Program Outcomes

Outcomes: Incidents Reported in Shelter before and after Centralized Care Coordination Intervention



Excludes those out of shelter >70%, died, or placed in alternate housing (N=20)

Pilot outcomes to date

High-risk Client Outcomes through March 2023 (not mutually exclusive)	N=50	%
Outcomes		
Died	4	8 %
Alternate placement (i.e., supportive housing, assisted living)	17	34 %
Incarcerated	6	12 %
Coordination		
SPOA[1] application submitted to Health Department	10	20 %
Referral to for comprehensive/specialty care (multiple conditions, need specialty care)	10	20 %
Referral to agency for application to OPWDD services/placement as adult	1	2 %
Barriers		
Shelter assessed client may have difficulty living independently	32	64 %
Frequently out of shelter/difficult to find	28	56 %
Alcohol use as barrier	8	16 %
Drug use as barrier	12	24 %
Developmental or intellectual disabilities as barrier	4	8 %
Uninsured/Uninsurable	3	6 %

*SPOA=single point of access application for intensive mental health treatment (Intensive Mobile Treatment or Assertive Community Treatment in NYC)

Case Study #1

Case Study #2

Program Sustainability

- Since the launch of the initial pilot, DHS has identified and attempted to serve a total of 245 clients through this program
- The local public hospital system has committed to provide staff to increase capacity to provide centralized coordination services and more intensive follow-up
- DHS was successfully funded by HUD through the special supportive services NOFO to implement similar program for clients experiencing street homelessness or in safe havens

Conclusion

People experiencing homelessness have serious health conditions and poor health outcomes

Centralized Care Coordination programs should be data-driven to avoid potential biases in referral systems

Care pathways provide staff with a guide for systematically managing complex cases while maintaining a client-centered, individualized, trauma-informed, and harm reduction approach

Centralized documentation, data collection, and evaluation allow for objective assessment of outcomes and efficacy that will help to build and improve the program

Sustained funding is needed for Centralized Care Coordination in homeless service systems; currently care coordination funding is directed towards traditional health providers

Questions?

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