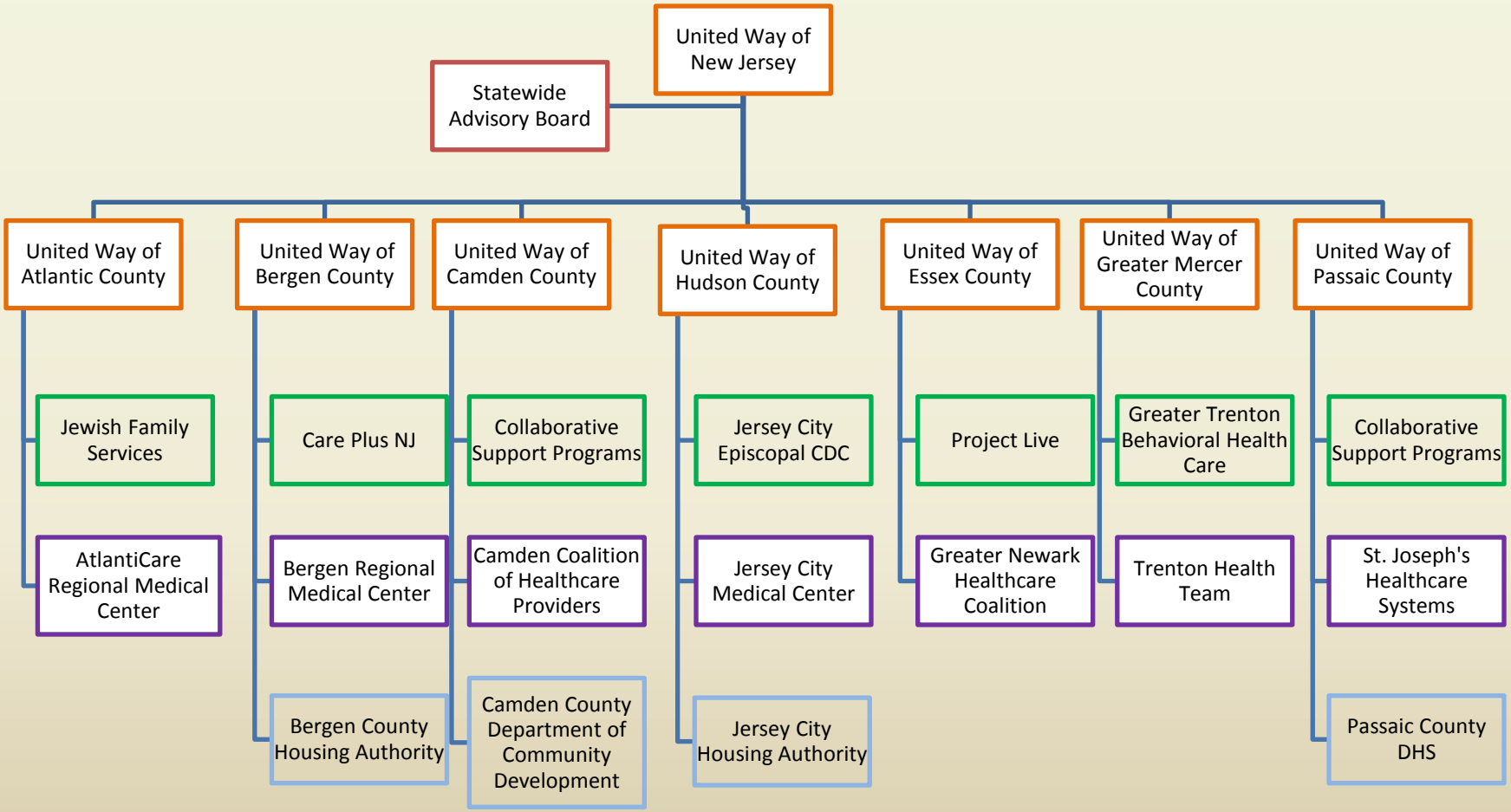
Urban Health and Home Initiative

Incorporating Wellness and Recovery into Integrated Primary and Behavioral Healthcare Programs

UHHI Program Purpose

- Issue – Group of homeless individuals costly to hospitals and other systems/institutions within the community
- Strategy – Provide permanent supportive housing using a housing first approach coupled with integrated primary and behavioral health care services that include wellness component

UHHI Organizational Chart



UHHI Target Population

140 High frequency users of emergency hospital services who are homeless

Population Characteristics:

- 4 -74 visits to the Emergency Department or Acute Care Admissions within a 6 month period
- 30% - 40% of the high frequency user population is uninsured
- Racial demographics matched that of the larger urban community
- Primarily Male between ages of 40 – 60
- Presenting issues: alcohol intoxification, sickle cell disease, respiratory infections, substance abuse & behavioral health issues

UHHI – Underlying Issues

- Causes of high frequency use of emergency services
  - Lack of stable housing
  - Appropriate health care access issues
  - Unhealthy lifestyle choice and risky behaviors

UHHI Service Structure

- Integrated Primary and Behavioral Healthcare
- Health Team includes: Care Manager, Nurse, Peer Wellness Navigator
- Housing with vouchers using Housing First approach within Harm Reduction Framework
- Core Services: Care Management, Care Coordination, Health Promotion, Comprehensive Transitional Care, Individual and Family Support Services, Referral to Community and Social Support Services

UHHI Program Goals

- 85% housed within 2 months of engagement
- 85% remain stably housed for 6 months
- 75% report improvement in quality of life
- 75% reduce harmful behaviors/improve health behaviors
- 20% reduction in emergency hospital services 6 months after housing as compared to 6 months prior to enrollment
- 85% connected to mainstream benefits
- 70% of those expressing interest connected to social activities (i.e. employment, volunteer, community activities)

UHHI Data Collection

- Comprehensive Assessment – program entry, every six months (for 2 years), program exit
- Quality of life Assessment – program entry, every six months (for 2 years), program exit
- Wellness plan – program entry, periodic updates
- Participant activities
- Service log
- Crisis service contact
- Benefits Enrollment
- Client Satisfaction Surveys

UHHI Data Storage & Analysis

- Hospital Partner – provide contact data (date, length, type, cost) in electronic format
- Health Team – provide all client data using HMIS
- United Way – responsible for data mapping & manage data warehouse
- Monarch & United Way – provide data analysis for service delivery feedback & program outcomes

UHHI Data Usage

- Program Quality Assurance:
  - Identification of inadequate/inappropriate service delivery
  - Identification of barriers to success for participants
- Inform Policy
  - Demonstrate effectiveness of model through meeting/exceeding identified outcomes
  - Ability to correlate service components to improved health outcomes
  - Identify/Address statewide barriers to successful implementation/outcomes

UHHI – Program Intent

- Build case for integrated care in a behavioral healthcare setting
- Re-orient services providers to include wellness services in programs
- Influence state policy makers/funders to include wellness and integrated care services in grant opportunities
- Improve coordination & communication between health providers, community providers & State
- Establish accepted service model for addressing needs of homeless high frequency users of emergency hospital services

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