Growth	Resilience	Integrity	Tenacity

DEVELOPING A SAFETY NET FOR MANCHESTER WITH G.R.I.T.

January 30, 2020

BEWELL HEALTH

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CITY OF MANCHESTER INCORPORATED JUNE 1846

Growth	Resilience	Integrity	Tenacity
Create a systemic response to homelessness by strategically allocating and using resources.	Manchester has 8% of NH's population but 30% of the state's homeless. 46% of the homeless population in Manchester have either a severe mental illness or substance use disorder (MHSUD), which is higher than the national average.	Using an evidence-based approach, prioritize programs that use data and model practices, including cost-effectiveness and impact on positive outcomes.	Housing is an important social determinant of health. Housing stability is an essential foundation for achieving better health outcomes for people who have disabilities and chronic health conditions.

THE GOAL

This is an effort to end homelessness by ensuring effective diversion of the community's highest social service utilizers away from unnecessary, high-cost settings like emergency departments and criminal justice settings, and into a better system of treatment and care.

Whether in jails, or hospitals, shelters or police encounters, the uncoordinated ways in which systems interact with the mentally ill result in fragmented, high-cost care that often makes vulnerable individuals worse off and does not improve the safety nor the health of the community.

WHO IS BEHEALTHLE?

About Us Nationally & Internationally recognized for developing best practices to drive down the costs of healthcare; reduce unnecessary jail and hospital utilization; create community collaboration; blend, braid & integrate funding; and collect outcome data.

Our Mission Optimize the allocation and coordination of limited resources in order to connect high utilizer populations with the least restrictive and most cost-effective options for care.

What Do We Do We help create solutions for emergency department overcrowding, tackling the opioid epidemic, jail diversion, homelessness, healthcare rising costs, regulatory challenges, and hospital readmission rates.

Meet the Team Our team has over 100 years' experience in executive leadership and public and private healthcare sectors, non-for-profit community organizational leadership and government agency leadership.

BEXAR COUNTY MODEL

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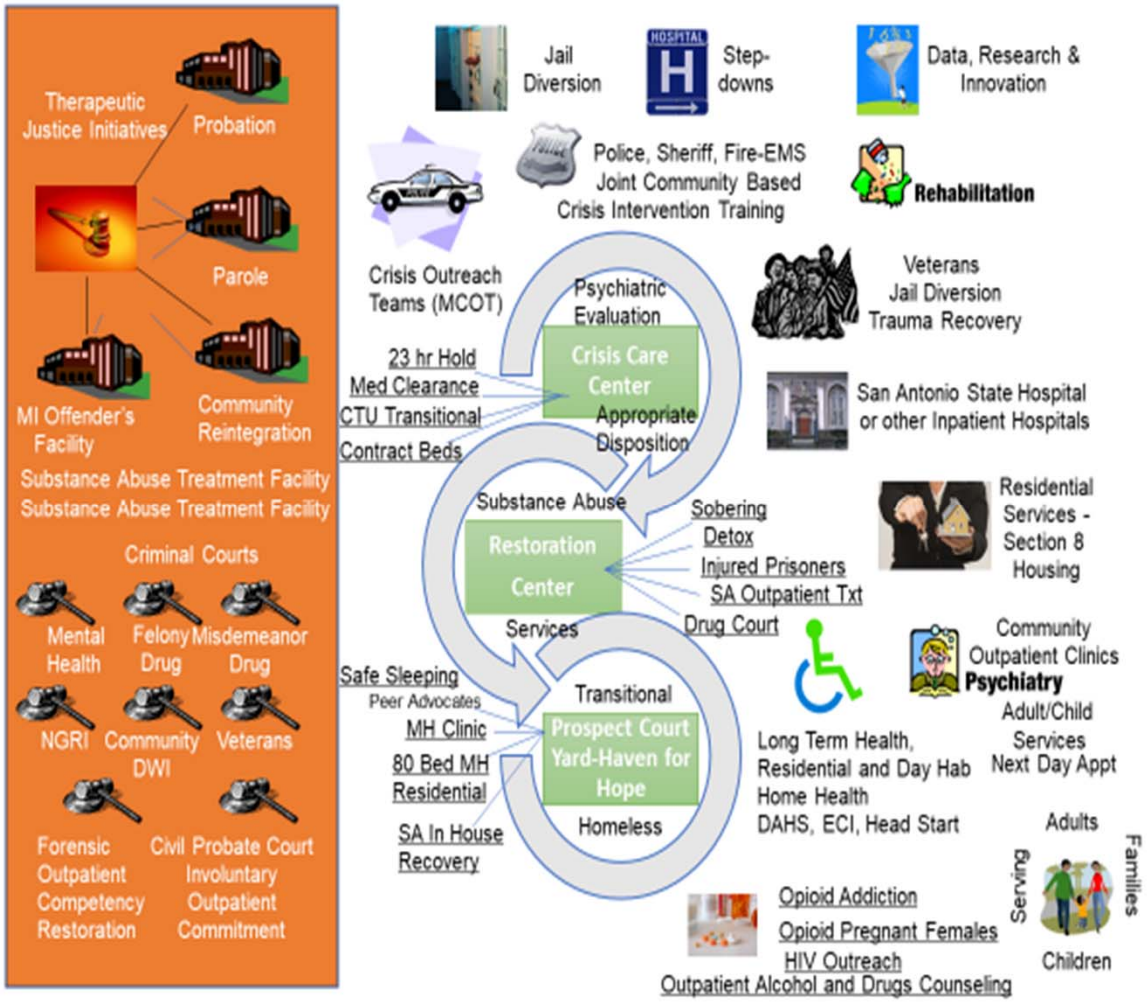


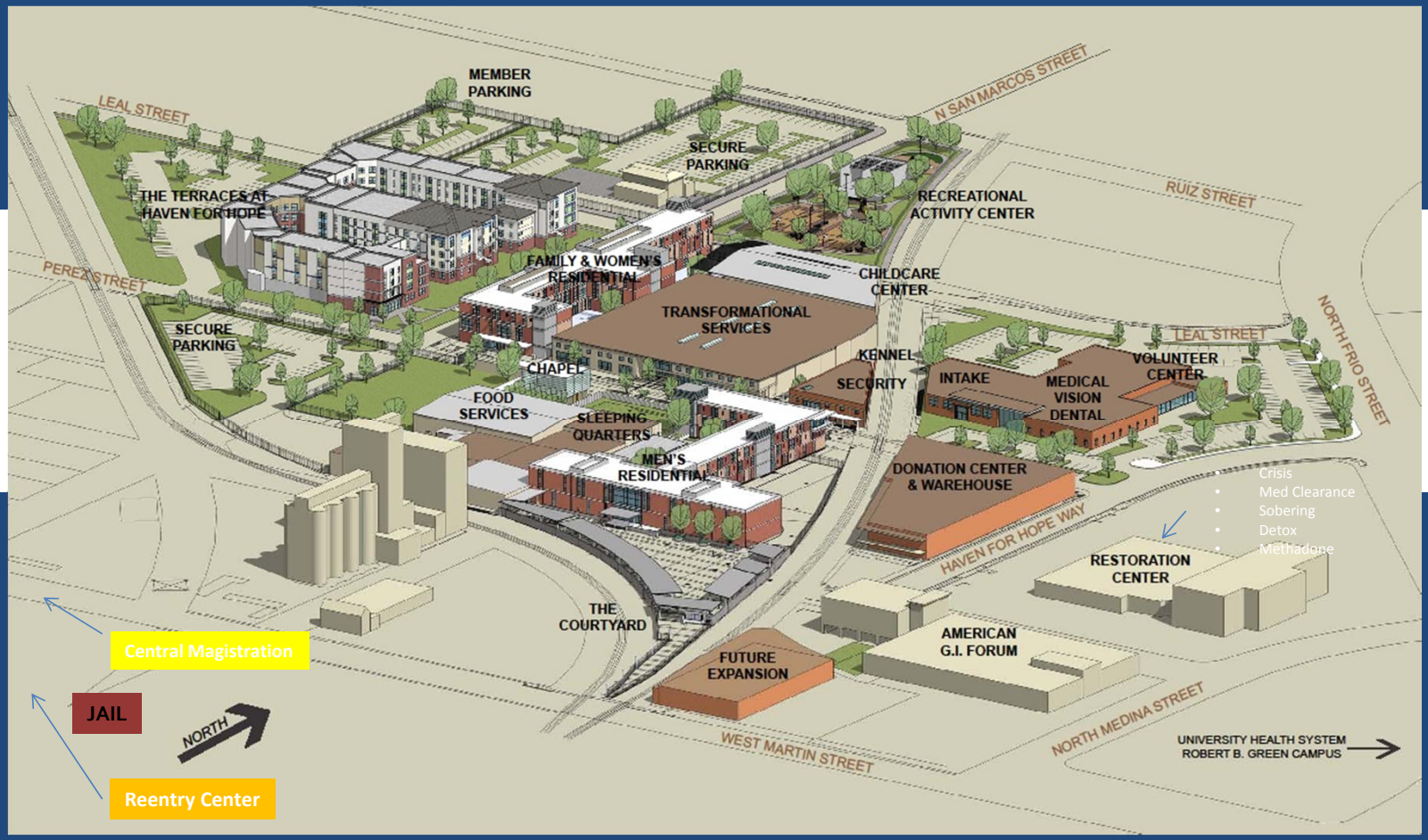
Haven for Hope Site Map

CHCS Restoration Center

- CIT
- Crisis (Psych/SA)
- Sobering
- Medical Clearance
- Detox
- In House Recovery access

Haven for Hope

- Safe Sleeping
- Integrated health care
- Transitional Homeless Campus +



Judicial Services/Mental Health

- 100% MH Screening
- Law Enforcement (Screening LE4)
- Public Defenders
- MH Clinical Assessments
- Pretrial, clinical, PD integration
- Direct Access to Treatment
- Criminal Justice Coordinating Council
- Criminal Justice Improvement Initiatives
- Mental Health Consortium

BEXAR COUNTY MODEL RESULTS

Cost Category	Year	City of San Antonio	Bexar County	Direct Cost Avoidance	Cost Category	Year	City of San Antonio	Bexar County	Direct Cost Avoidance
Public Inebriates Diverted from Detention Facility	Year 1-8	$7,018,376	$32,092,472	$54,453,566	Mentally Ill Diverted from UHS ER Cost	Year 1-8	$3,345,000	$8,028,000	$11,373,000
Injured Prisoner Diverted from UHS ER	Year 1-8	$3,715,000	$8,916,000	$12,631,000	Mentally Ill Diverted from UHS ER Cost	Year 1-8	$1,125,466	$7,431,464	$9,508,557
Reduction in Competency Restoration Wait Time in Jail for Hosp Admission	Year 1-5		$3,740,110	$8,924,110	Reduction in Wait Time in Jail for Outpatient Competence/Wait Time for Restoration compared to Inpatient	Year 1-5		$3,160,396	$6,616,396
Reduction in Jail Time for Competency Restoration on Bond and on Return	Year 1-5		$1,306,522	$1,519,522					
TOTALS Year 1-8		$18,453,462	$78,287,016	$96,740,478					

BEXAR COUNTY MODEL RESULTS

Reduced victimization and increased support for the homeless population.

Greater efficiency in the use of law enforcement, resulting in increased public safety and return of law enforcement officers back to community policing.

Reduced inappropriate incarceration of persons with mental illness and/or substance abuse issues.

Reduced inappropriate use of emergency rooms and hospitalizations

Increased efficiency and effectiveness in the use of public dollars

In Bexar County, it costs

$2,295 per jail booking

vs

$350 per diversion

ER utilization has dropped by 40% since the .This drop in utilization amounts to approximately **$4.7 million in savings**.

Between **25 and 30% of the expenses** incurred by the program are covered by Medicaid Administrative Claims provided from State and federal funds.

The Restoration Center sees about 2,200 people per month or 26,000 people per year who used to go to jails or emergency rooms, or return to the streets.

Prior to the Crisis Care Center and the Restoration Center, law enforcement officers spent an average of 12 to 14 hours in emergency rooms waiting on psychiatric evaluations. Officers now wait about **15 minutes**.

The County saves more than

$10 million per year

on averted jail costs

and emergency room costs.

BEXAR COUNTY MODEL RESULTS

HIGH UTILIZERS (HC/HN)

Individuals with complex behavioral, physical, and social needs who are frequent users of social services and have excessive and unnecessary utilization of high-cost emergency services and criminal justice system involvement. Despite the large amount of resources devoted to this population, they are often provided in fragmented ways that do not lead to stabilization or improved outcomes for individuals.

HIGH UTILIZERS

Health care expenditures are a significant driver of budgetary pressure on states and accelerate momentum to find sustainable health care solutions.

A disproportionately large portion of states' Medicaid budgets are used for a small segment of the Medicaid population's care: **5% of Medicaid enrollees nationwide account for more than 50 percent of all Medicaid spending.**

Those **high-need, high-cost** enrollees have complex health and social needs. **80% have three or more chronic health conditions,** and 60% have more than five. A majority MHSUD **challenges but** have limited access to outpatient behavioral health (BH) services (and virtually no access to evidence-based practices [EBP] in those domains).

HIGH UTILIZERS

This population also has a range of challenges in social determinants of health, such as safe and affordable housing, food security, employment, social connectedness and transportation. When these basic human needs go un- or under-addressed, illness self-management and routinely accessing primary care is secondary.

The result is often an overreliance on more costly sites of care, such as emergency department (EDs) and inpatient hospital services, for non-emergent issues.

Redirecting state funds to effectively address the social service needs of this population can improve health and functional outcomes of high-risk Medicaid enrollees, break down the barriers that segment the continuum of services required by this complex population and rein in escalating health care costs.

Evidence shows that programs that have been successful in breaking the cycle of avoidable acute care utilization and time in other public institutions (e.g., corrections) invest in well-coordinated transitions to and among outpatient primary and BH care, evidence-based pharmacotherapy and social services interventions.

HIGH UTILIZERS

On average, Medicaid super-utilizers had **more hospital stays, longer stays, higher hospital costs** per stay, and **higher hospital readmission rates** compared with other Medicaid patients.

Super-utilizers had an average all-cause **30-day readmission rate that was four to eight times higher** than the readmission rate for other patients.

Compared with other patients, Medicaid and privately insured super-utilizers had **longer hospital stays and higher average hospital costs.**

An average super-utilizer had approximately **four times as many hospital stays per year as did other patients.**

HIGH UTILIZERS

Patients with multiple chronic conditions accounted for a greater share of all hospital stays among super-utilizers than among other patients.

The top 10 conditions for super-utilizers in different payer groups included common acute conditions such as septicemia, pneumonia, and urinary tract infections.

Mental health and substance use disorders were among the top 10 principal diagnoses for super-utilizers aged 1 to 64 years regardless of payer.

THE 2017 INTERDEPARTMENTAL SERIOUS MENTAL ILLNESS COORDINATING COMMITTEE (ISMICC) REPORT TO CONGRESS

- In December 2016, the **21st Century Cures Act** was signed into law. Through this Act, the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC) was established to address the needs of adults with SMI and children and youth with SED and their families. The 2017 Report to Congress identified 5 areas of focus:
- Focus 1: Strengthen Federal Coordination to Improve Care
- Focus 2: Access and Engagement: Make It Easier to Get Good Care
- Focus 3: Treatment and Recovery: Close the Gap Between What Works and What is Offered
- Focus 4: Increase Opportunities for Diversion and Improve Care for People With SMI and SED Involved in the Criminal and Juvenile Justice Systems
- Focus 5: Develop Finance Strategies to Increase Availability and Affordability of Care
- **This report is intended to set the stage for work by HHS and other federal government departments in the years ahead**

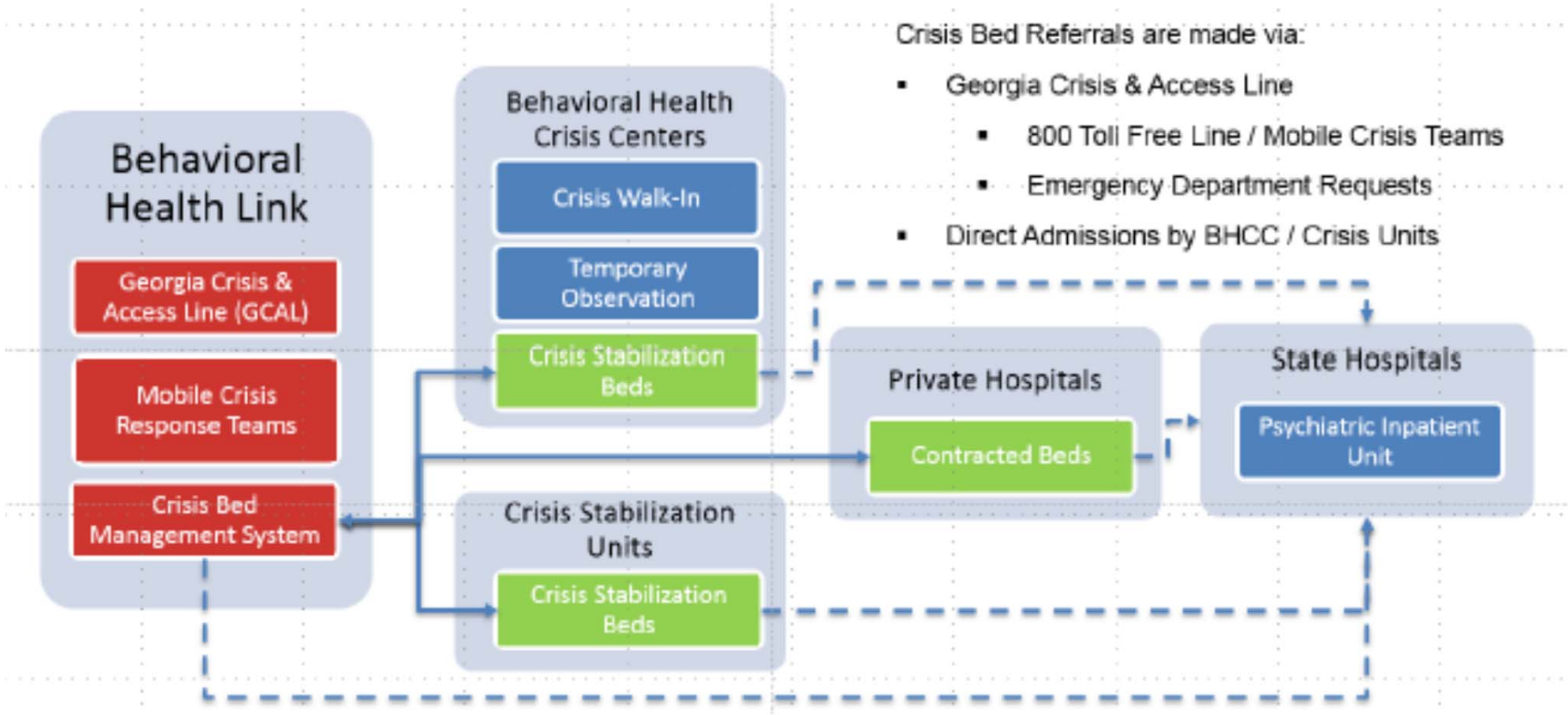
Develop a continuum of care that includes adequate psychiatric bed capacity and community-based alternatives to hospitalization.

Psychiatric crisis response using least-restrictive appropriate settings… eliminating "psychiatric boarding" in hospital emergency departments

INTERDEPARTMENTAL SERIOUS MENTAL ILLNESS COORDINATING COMMITTEE RECOMMENDATIONS

SAMHSA EXPERT PANEL ON BEST PRACTICES IN STATEWIDE REAL-TIME CRISIS BED DATABASES

- Inventory Existing Services and Systems
- Develop a Description of the Existing System
- Design a Database
- The database should be designed with two goals in mind: – To reflect the system that exists and – With an eye towards the system you want
- Engage Stakeholders
- Incentivize Participation in the Registry
- "Real Time" Must be Useful to Users
- Transparency and Quality Data-Sharing
- High-Level Decision-Maker Oversees Registry
- Engage the State Medicaid Office in the Process


Behavioral Health Link
Georgia Crisis & Access Line (GCAL)
Mobile Crisis Response Teams
Crisis Bed Management System
Behavioral Health Crisis Centers
Crisis Walk-In
Temporary Observation
Crisis Stabilization Beds
Crisis Stabilization Units
Crisis Stabilization Beds
Private Hospitals
Contracted Beds
State Hospitals
Psychiatric Inpatient Unit
Crisis Bed Referrals are made via:
Georgia Crisis & Access Line
800 Toll Free Line / Mobile Crisis Teams
Emergency Department Requests
Direct Admissions by BHCC / Crisis Units

OPIOID CRISIS

The opioid drug problem has reached crisis levels in the United States—in 2015, over **33,000 Americans died of a drug overdose** involving opioids.

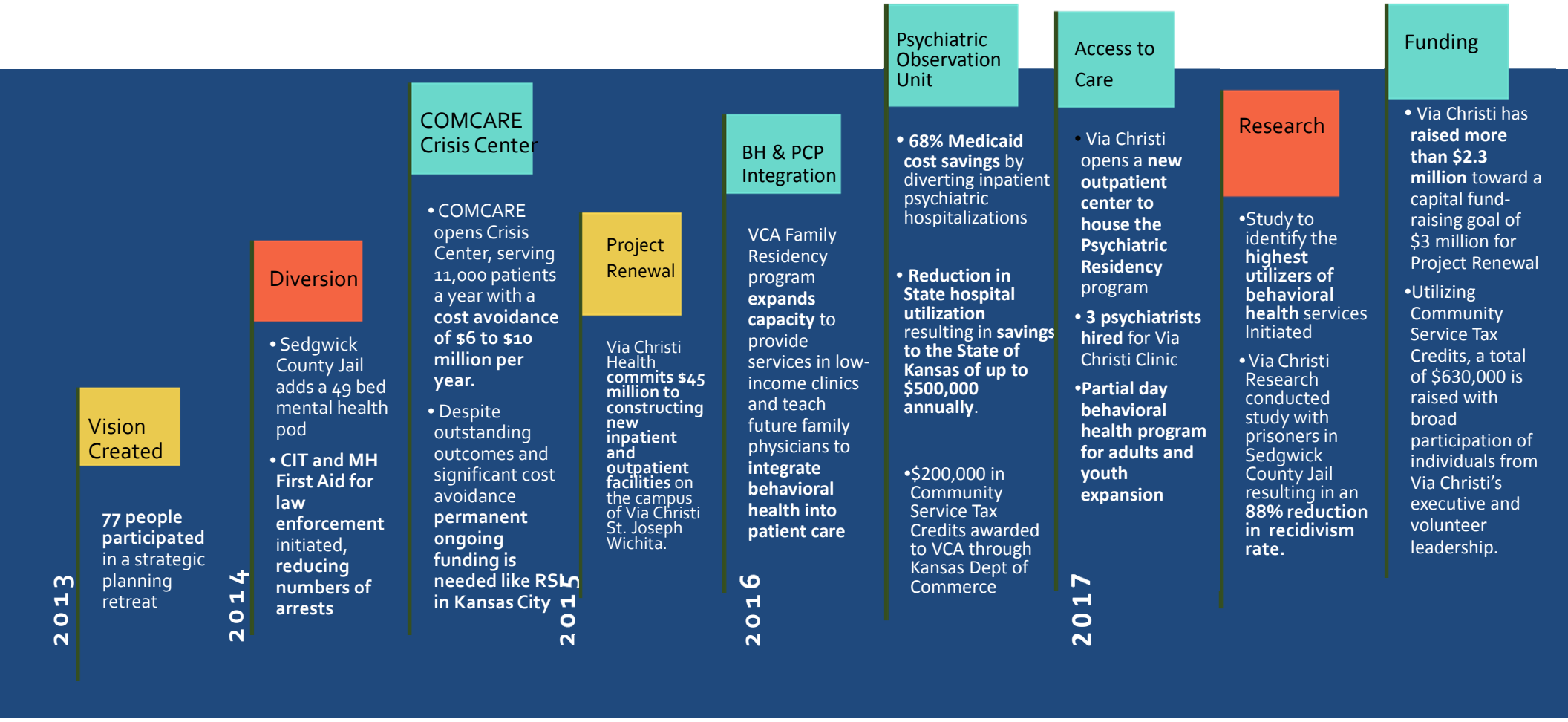
CEA finds that previous estimates of the economic cost of the opioid crisis greatly understate it by undervaluing the most important component of the loss—fatalities resulting from overdoses.

CEA estimates that in 2015, the **economic cost of the opioid crisis was $504.0 billion, or 2.8 percent of GDP that year**. This is **over six times larger** than the most recently estimated economic cost of the epidemic.

2.4 million Americans have an opioid-use disorder (Substance Use Disorder and Mental Health Services Administration 2016). This includes individuals who abuse prescription painkillers such as OxyContin and Vicodin and individuals who abuse heroin or other illicit opioids.

Prescription opioid misuse increases **healthcare and Substance Use Disorder treatment costs by $29.4 billion** and criminal justice costs by **$7.8 billion**

CASE STUDY: SEDGWICK COUNTY COMMUNITY COLLABORATIVE



HOMELESSNESS IN MANCHESTER

At least **$34.8M** is spent annually on homelessness in Manchester,
with **88%** concentrated in housing and healthcare.

HOMELESSNESS IN MANCHESTER, NH

- Manchester has 8% of NH's population but 30% of the state's homeless.
- 46% of the homeless population in Manchester have either a severe mental illness or substance use disorder
- Existing services do not coordinate care effectively enough to address the complex behavioral health needs among the homeless population
- Most resources go to healthcare (47%) and housing (41%)
- Definitions for homelessness are inconsistent, leading to difficulties obtaining an accurate count, as well as with data collection. The homeless count ranges from 427 to 2600.

HOUSING AS HEALTHCARE

Evidence suggests that providing housing to certain high-need, high-cost patients can transform lives and have a very meaningful return on investment. Among the most important interventions for this group is addressing homelessness and housing instability. Some estimates show that as many as one-third to almost half of high-need, high-cost individuals are homeless. Both pioneering and emerging programs are prioritizing housing interventions as a means of cost-effectively intervening with this subset.

State health leaders are actively pursuing solutions for homelessness as part of health system transformation efforts, working with their housing counterparts to build linkages and use resources effectively.

Recognizing the value for these individuals and the Medicaid program, many are taking advantage of clarification from the Centers for Medicare & Medicaid Services (CMS) on coverage of housing-related activities and services for individuals with disabilities to maximize payment for services through Medicaid.

Source: F. Arabo, S. Wilkniss, S. Malone and F. Isasi, Housing as Health Care: A Road Map for States (Washington, D.C.: National Governors Association Center for Best Practices, September, 2016)

WHAT WORKS?

The framework

GENERATE COMMUNITY SUPPORT

- Rally support to address the issue and develop a shared vision by bringing together a diverse group
- Use data to tell the story and demonstrate the need
- Ascertain agreement that improving outcomes for the high utilizer population is a priority and cross-sector collaboration is needed.

IDENTIFY THE PEOPLE YOU HOPE TO SERVE

- Make agreements and document the specific uses of sharing data
- Identify the minimum types and amounts needed to achieve the goals
- Provide ongoing opportunities to inform individuals and the community how data is being used to build trust
- Use HIPPA as a tool https://www.hhs.gov/hipaa/for-professionals/faq/2073/may-covered-entity-collect-use-disclose-criminal-data-under-hipaa.html

DEVELOP A DIVERSION STRATEGY

- CIT Training
- Co-Responder Model
- Mobile Crisis Teams
- Field-Administered MHSUD Screenings
- Crisis Lines/Warm Lines

DIVERT TO WHO? AND WHERE?

- Crisis Stabilization
- Detoxification Centers
- Psychiatric Emergency Programs provide short-term (24-72 hours) psychiatric stabilization for individuals in crisis, and may include detoxification
- Community Respite Programs offer moderate-term (1-2 weeks) psychiatric stabilization as an alternative to psychiatric
- Peer Crisis Programs
- Service or "Solutions" Centers
- Service-Based Diversion and Referral (SBDR)

SUPPORTIVE HOUSING/HOUSING FIRST

- Supportive Housing combines affordable, subsidized housing and support services for people with serious mental illness, substance use disorders, or chronic physical health issues.
- Housing First approach provide immediate housing with no preconditions (other than complying with a leasing agreement) to individuals with behavioral health issues and unstable housing situations, allowing them to achieve enough stability to work on their recovery process. When coupled with a Supportive Housing model, this becomes an intervention into which a high-utilizer can be diverted. Housing First is a proven method of ending all types of homelessness. Housing First yields higher housing retention rates, lower returns to homelessness, and significant reductions in the use of crisis service and institutions. By coupling a Housing First model with treatment services such as ACT, the whole individual's needs can start to be addressed. ACT is described in further detail in Strategy 5: Initiate and Deliver Ongoing Services Effectively.

INITIATE AND DELIVER ONGOING SERVICES EFFECTIVELY

- Medication-Assisted Treatment
- Assertive Community Treatment
- Intensive Case Management
- Peer Support Services

LEVERAGE FUNDING TO OPTIMIZE CARE

I. **Medicaid**

- 1115 Waiver
- Home & Community-Based Services
- MCO
- HITECH funding (HIE)
- Innovation Accelerator Program
- SSI/SSDI Outreach, Access, and Recovery (SOAR)

I. **Medicare/Dual Eligibles**

II. **SSI**

III. **VA**

QUESTIONS?

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Thank You!

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