Returning Citizens:

An RHD Housing Smart Program

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The presenters have no real or perceived relevant financial relationships to the content of this presentation.

RESOURCES FOR HUMAN DEVELOPMENT

City of Philadelphia
DBHIDS
DEPARTMENT of BEHAVIORAL HEALTH and INTELLECTUAL disABILITY SERVICES

Housing Smart History

Pilot collaboration aimed at reducing avoidable ER utilization and hospital readmissions among individuals experiencing homelessness through peer outreach, supportive services, and subsidized housing resources

*"People who are **homeless** can often end up in an emergency department (ED) for problems that can often **be managed outside of the ED.**"*
– "The Health & Social Costs of Homelessness," Medical Care blog, R. Miguel, November 2018.

Partnership between Resources for Human Development (RHD), Temple University Hospital, Keystone Managed Care Organization (MCO), and Health Partners Plans MCO.

- Housing is paid for by Temple University Hospital
- Services are paid for through MCO Community-Based Care Management (CBCM) program
- Services are provided by RHD

Housing Smart Model

Who: Temple generated a list of eligible people using target population criteria and shared with MCOs; MCOs agreed to criteria for eligibility and generated a list of member referrals for RHD.

What: Using a multi-disciplinary team of three MCO-funded FTEs **(Peer Support Specialist, Care Coordinator, and Tenant Services Coordinator)**, RHD works to engage eligible members into services.

How: RHD located individuals using alerts from Temple's Electronic Health Record (EHR), Homeless Management Information System (HMIS), Healthcare Exchange (HSx) notifications of ED and inpatient admissions (from MCOs), and guidance from PH/BH MCOs, to find and engage members.

Why: Determine if providing housing and support services to vulnerable members improves their health outcomes and quality of life; Reduce unnecessary ED visits and hospital admissions; Identify role of services and stabilized living conditions on target population.

Returning Citizens History

- During 2020 COVID-19 lockdown, mass releases occurred from the Philadelphia Department of Prisons (PDP)
- People were released from PDP with no housing plan-- some entered the shelter, were hospitalized, or reincarcerated
- Philadelphia **Managing Directors Office** (MDO), **Office of Homeless Services** (OHS), **Department of Behavioral Health and Intellectual disAbility Services** (DBHIDS), and **RHD** came together to target a cohort of these individuals

Returning Citizens Model

- The program provides an individual with a housing opportunity and wraparound support services to help achieve housing stability, recovery, and long-term independence.
- Housing is paid for by OHS
- Services are paid for by the Behavioral Health MCO and OHS/MDO
- 25 individuals who were currently or recently incarcerated and had behavioral health challenges
- Services are provided by RHD
  - Tenant Services Coordinator
  - Care Coordinator
  - Peer Support Specialist

Ideal Process

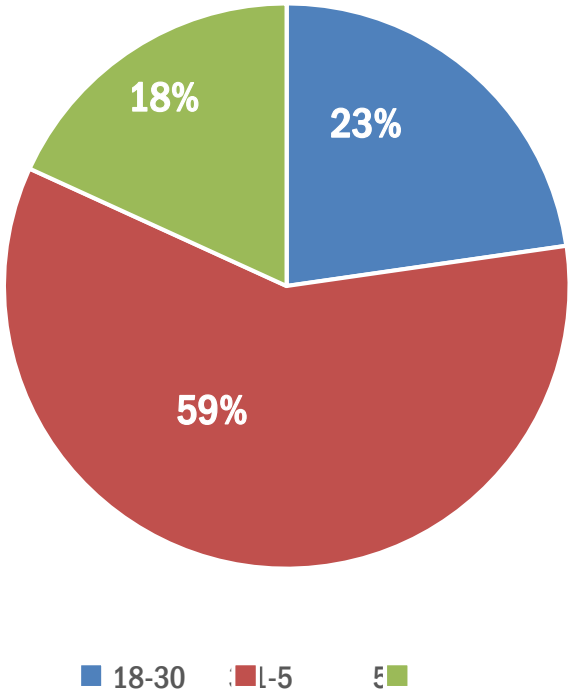
- Step 1: Intake Process
- Step 2: Obtain Identification
- Step 3: Connect with community-based services (Primary Care Physician (PCP), psychiatry, Social Determinants of Health (SDOH))
- Step 3: Identify Income (Supplemental Security Income (SSI), employment)
- Step 4: Acquire housing voucher
- Step 5: Referral to alternative services
- Step 6: Move into permanent housing
- Step 7: Discharge

Participant Responsibilities

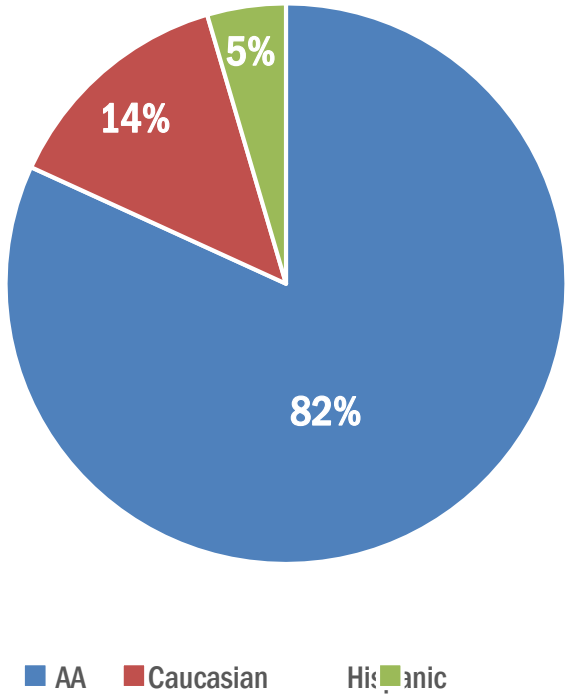
- Attending the program orientation
- Engaging with supporting services while in the program
- Abiding by lease requirements
- Paying for utilities
- Paying 30% of their income towards rent

Demographics

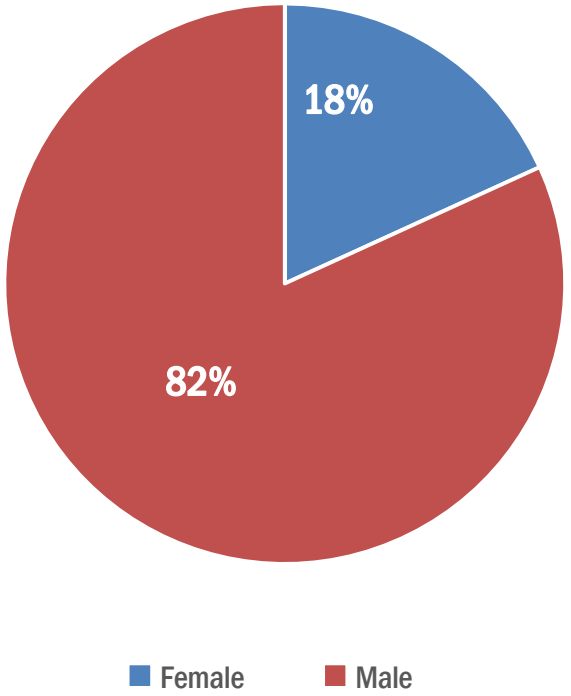
Ages Average Age: 40
Range: 19-57



Ethnicity/Race



Gender



Video Clip

Success Story #1

Joined program in September 2020:

- Incarcerated for aggravated assault
- Epilepsy & hypertension
- Substance Use

Returning Citizens Supports:

- Provided housing
- Case management & Mobile Psychiatric Rehabilitation (MPR)
- Obtained ID, birth certificate, & social security card
- Connected with PCP
- Connected with employment classes/supports

Success:

- Attending Intensive Outpatient Program (IOP)
- Working at a staffing agency
- Enrolled in computer classes
- No longer on probation & all charges dismissed
- Received Emergency Housing Voucher through Philadelphia Housing Authority

Success Story #2

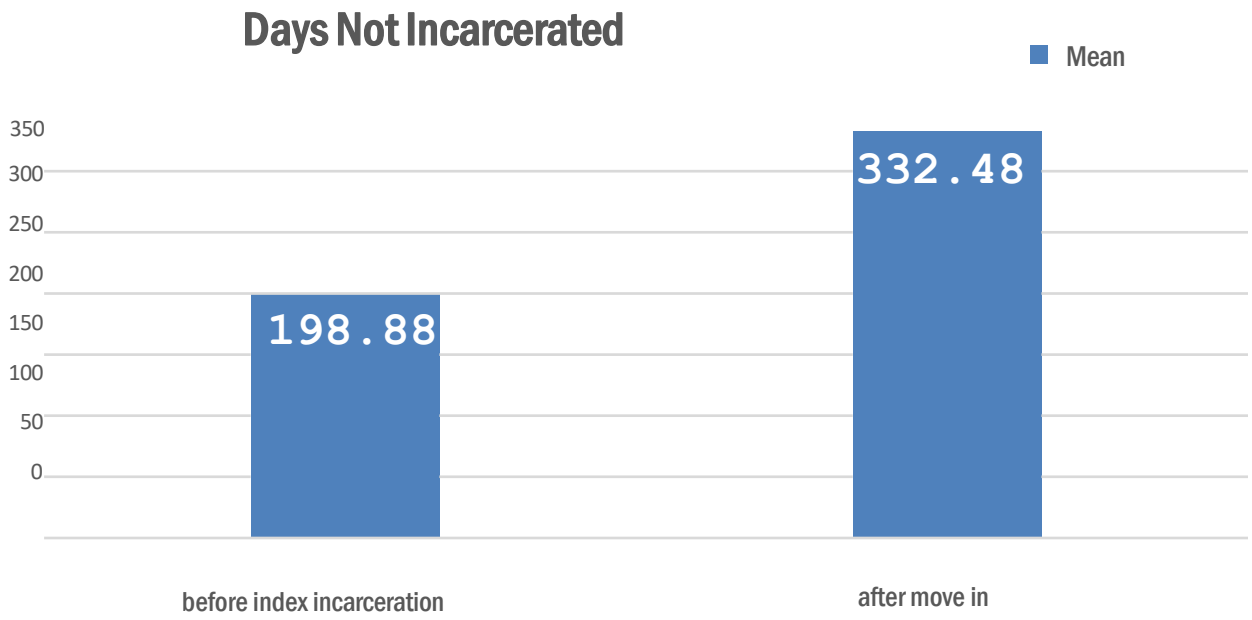
Joined program in October 2020:
- From Sierra Leone, survivor of civil war
- Incarcerated for burglary
- History of mental illness and substance use

Returning Citizens Supports:
- Housing & Furniture
- Houseware & Cleaning items
- Telephone
- Obtained ID
- Connected to PCP & psychiatrist

Challenges:
- Couldn't maintain a clean apartment or med management
- Had increase in Behavioral Health symptoms that led to involuntary hospitalization July 2021

Successes:
- In good standing with PO
- Taking anger management classes
- Working with Peer Supports
- Stable enough for permanent housing options

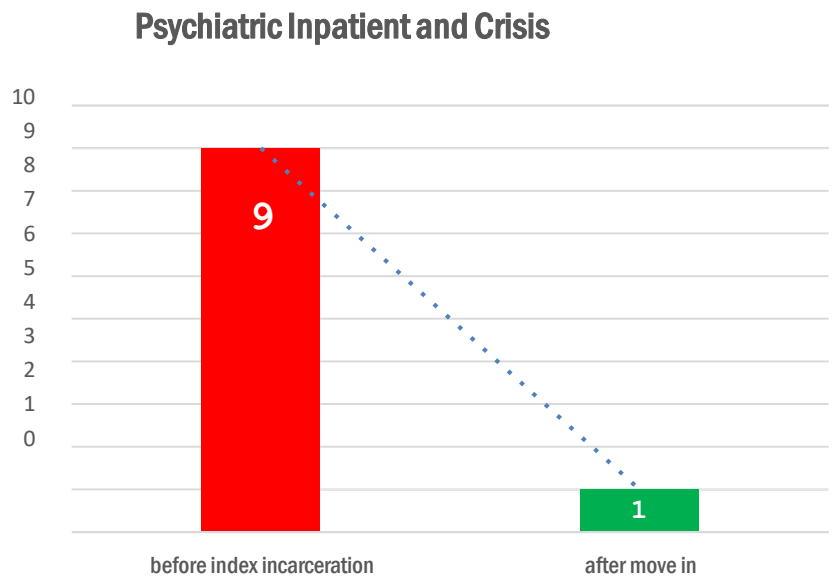
Preliminary Outcomes



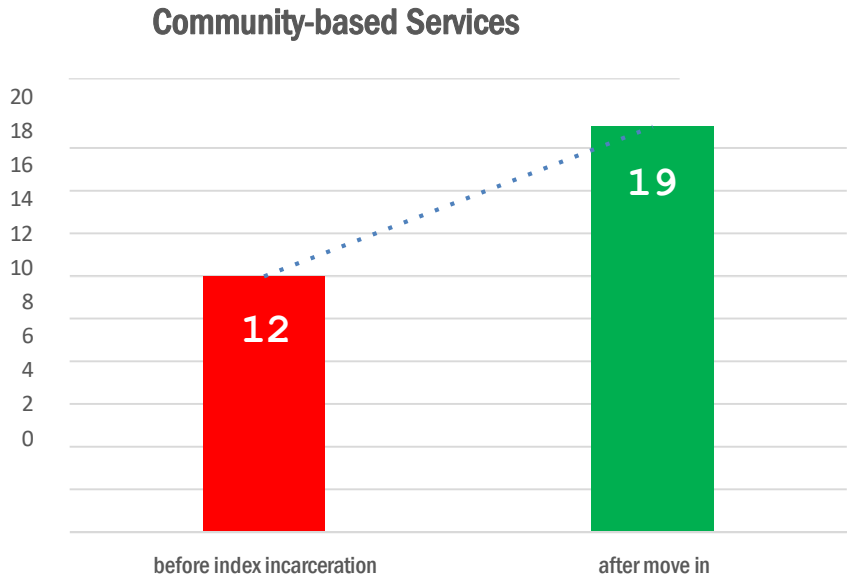
Mean increase: 67.2%
(Median increase: 66.67%)
68% of participants were not incarcerated again in the first year after move in

Index Incarceration: The individual's incarceration date closest to their move in date

Preliminary Outcomes



89% decrease in use of psychiatric inpatient and crisis services once housed and supported



58% increase in use of community-based services once housed and supported

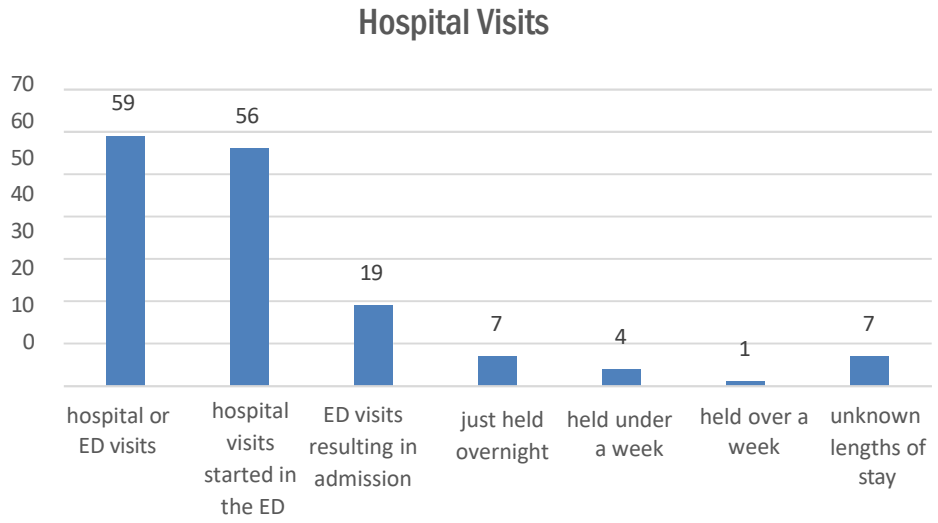
Preliminary Outcomes

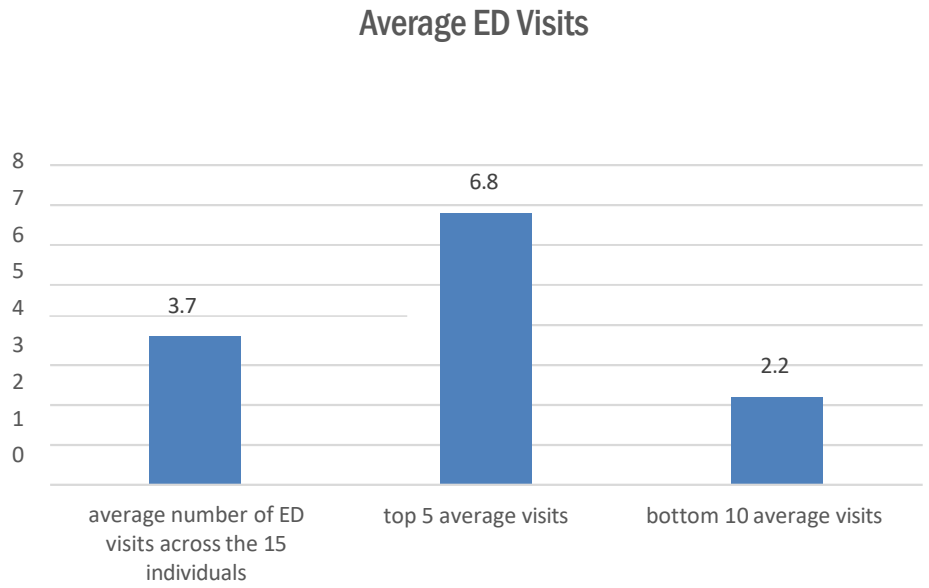
Community-based Services

- 76% of participants were connected to community-based cervices within 90 days of being housed
- Most common services:
  - Case management: 90%
  - Outpatient BH: 63%
  - Rehabilitation/habilitation: 37%

Preliminary Outcomes

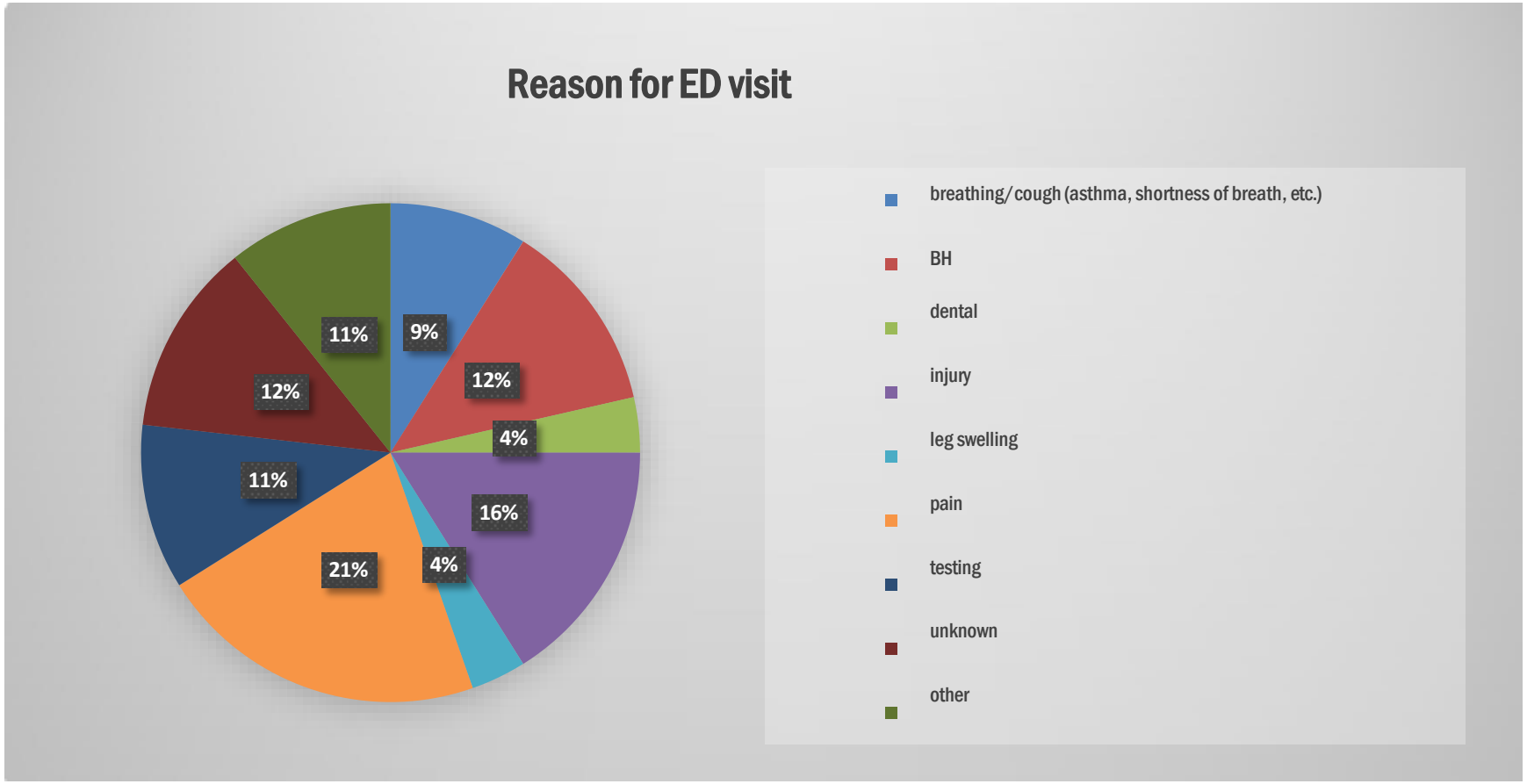
Top 5 utilizers of EDs made up 60% of visits





15 individuals have hospital data

Preliminary Outcomes



Challenges

- Permanent Supportive Housing - even after obtaining housing vouchers, finding landlords to accept participants creates a barrier
- Staffing - as with all programs, staffing Returning Citizens is a challenge
- Despite increased use of BH community-based services, participants continue to use the emergency department for non-emergency needs
- Getting identification is required for accessing many services/supports but is challenging to obtain

Recommendations for Replicating

- Having everything under one program entity or have well established, clearly defined partnerships
- Having an established relationship with a permanent housing organization/company to support graduation

Future Plans

- Opportunities to integrate medical connections, perhaps by incorporating a community health worker into the team
- RHD will start conducting follow-up calls
  - 3 months post Permanent Housing graduation
  - 1 year post Permanent Housing graduation
- RHD will develop a Participant Advisory Committee made up of graduates from original Housing Smart and Returning Citizens programs