Community Health Improvement

Health to Home: A Pathway to Healing Collaborative

Achievements | 2023

Program Objective

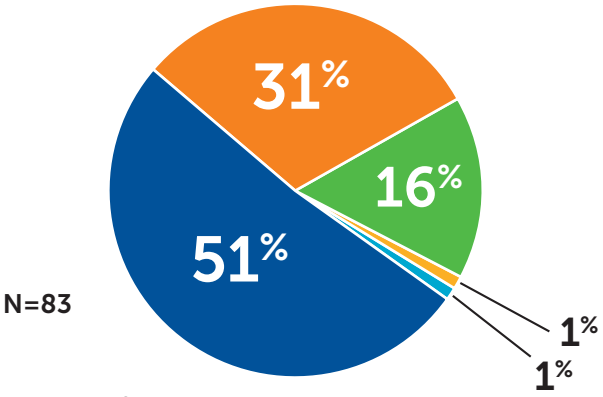
The Health to Home program aims to provide medical recuperation services to adults experiencing homelessness in a safe environment using an individualized approach by strategic partners to provide medical, behavioral health, and wraparound social services that address the underlying causes of homelessness.

Statement of Need*

- Homelessness is increasing across the nation. According to Doran et al. 70.3% of all hospitalizations of homeless people result in either readmission on an emergency department (ED) visit within 30-days after discharge.
- There is evidence that medical respite care reduces future hospital admissions, and length of in-hospital stay among unhoused people discharged from an acute hospitalization. It also enables the linkage with other social and housing services that benefits the whole person.

Demographic of People Served

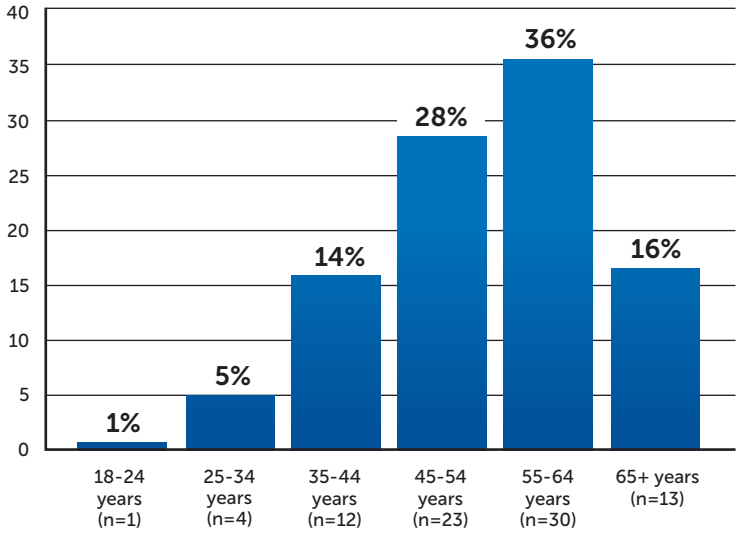
RACE OF ENROLLED PARTICIPANTS



- White n=42
- Black/African American n=26
- Hispanic n=13
- Middle Eastern or North African n=1
- American Indian/Alaska Native n=1

AGE GROUP BREAKDOWN

N=83



* Statement of Need sources:

Bring C., Kruse M., Ankarfeldt, M.Z., Brunes, N., Pedersen, M., Petersen., & Andersen, O. Post-hospital medical respite care for homeless people in Denmark: a randomized controlled trial and cost-utility analysis. BMC Health Services Research, 508. https://doi.org/10.1186/s12913-020-05358-4

Doran K.M., Ragins, K.T., Iacomacci, A.L., Cunningham, A., Jubanyik, K.J., & Jeng, G.Y. (2013). *The revolving hospital door: hospital readmissions among patients who are homeless.* Med Care. 2013, 51(9), 767 – 773.

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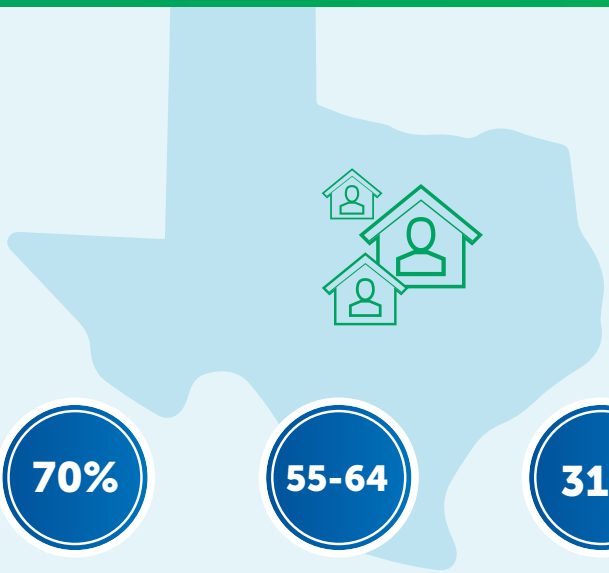

70%
Percentage of male individuals enrolled

55-64
Age range of most individuals enrolled

31%
Identified as Black/ African American

Health to Home is a collaborative program between Texas Health Presbyterian Hospital Dallas (THD) and Austin Street Center (ASC). Since its inception in late 2020, the program enrolled and served 280 unhoused individuals.

In 2023, 83 individuals enrolled in the medical respite unit at Austin Street Center, where they received medical care, case management, navigation, and housing support.

The current referral pipeline is open to community based organizations and other health systems including: Baylor Scott & White, Parkland and UT Southwestern.

Activities/Output

Out of 83 individuals enrolled in Health to Home:*

72
Engaged in case management services

5
Connected to a primary care provider or a patient-centered medical home

22
Received behavioral health services with community partner, Integrated Psychotherapeutic Services (IPS)

2
Received job training

Outcomes

33%
Participants were connected to an appropriate housing solution

Observations among 20 participants from THD were:

437.2%
Return on Investment (ROI) for every dollar spent on each participant that graduated from the program

86.3%
Decrease in total charges 6-months pre-intervention vs. 6 months post-intervention

43.3%
Decrease in total hospital visits 6-months pre-intervention vs. 6 months post-intervention

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*Of the total population, 11 were not represented in the number of unique participants as they are still enrolled in the program (10) or are deceased (1).

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