Baseline Monitoring of Standard Health Indicators in a Formerly Homeless Population

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Background

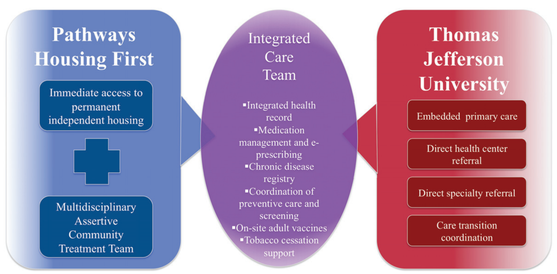
Pathways Housing First Model

Pathways to Housing ends chronic homelessness for individuals with serious mental illness (SMI) by providing housing *first*, and then combining that housing with supportive treatment services in the areas of mental and physical health, substance abuse, education, and employment. Housing is provided in apartments scattered throughout the community. This "scattered site" model fosters a sense of home and self-determination, and it helps speed a client's reintegration into the community. The Pathways model has been remarkable successful in addressing chronic homelessness.[1]

Photo Credit: Sarah Bones

The Pathways Program started in Philadelphia in 2008 serving 132 individuals. The program maintains a 92% retention rate even amongst those individuals not considered "housing ready" by other programs

Integrated care



Pathways to Housing Philadelphia has developed a novel integrated care program through a unique partnership with the Department of Family and Community Medicine at Thomas Jefferson University.

In keeping with the Housing First principle of consumer choice, individuals may choose to receive individual psychiatric and/or primary care from the Pathways physicians or in the community. However, the team supports all clients in medical and behavioral healthcare coordination. Integrated care team members include staff from social work, nursing, psychiatry, primary care, community integration, substance abuse support, and peer support. [2,3]

Research Question

What are the rates of baseline health status indicator recording at Pathways to Housing (PTH) using select recommended measures from the National Association of State Mental Health Program Directors (NASMHPD) and the Healthcare Effectiveness Data Information Set (HEDIS)?

How do health indicators compare between clients receiving direct clinical care in the integrated care program vs non-integrated care clients?

Methods

Charts from 123 patient-participants at the program were reviewed in order to abstract demographic and health condition information. All were PTH clients who meet the federal definition of chronic homelessness and have an SMI. All individuals in the PTH program receive ongoing nursing assessment and medical care coordination.
42 individuals who chose to access care from the PTH primary care physician and a PTH psychiatrist formed the integrated care (IC) subgroup. Measures of 7 NASMHPD indicators were abstracted for all individuals since entrance into the program. Measures of 5 HEDIS indicators were abstracted for all individuals over the past year.

Data analysis: Proportions of individuals with specific health characteristics and meeting specified quality assurance metrics were compared between the groups, in order to evaluate whether integrated care improves tracking of specific health indicators and possibly chronic disease management. The IC group was also compared to normative standards when available.

Results: Demographic & Health Characteristics

Average age of clients is 50 (range 22-77), 63% are male
71% are black, 27% are white

Average time in the program is 24 months (range is 2 – 42 months)
Axis 1 dx: Schizophrenia Spectrum Disorder (50%), Major Depressive Disorder (24%), Bipolar Disorder (11%), Other (21%)

Source of care:

- 72% of clients have an identified primary care provider
- 36% of clients receive primary care through PTH
- 85% of clients receive psychiatric care through PTH
- 35% of clients receive both psychiatric and primary care through PTH and form the Integrated Care (IC) subgroup

Results

PTH Clients: Health Characteristics

	PTH Non-IC (%) n=80	PTH IC (%) n= 43	Compare IC/ Non-IC	Phila. (%)	Compare IC/ Phil.
Any chronic physical disease	68.8	90.7	**	27.1[a]	***
≥2 chronic diseases	48.8	76.7	**	--	
Hypertension	20.7	50.0	*	35.9[b]	n.s.
Diabetes	7.5	16.3	n.s.	13.4[b]	p = .09
Asthma	20.0	7.0	p = .057	16.5[b]	n.s.
COPD	12.5	11.6	n.s.	--	
HIV	8.8	2.3	n.s.		
Overweight/Obese	70.2 (n=47)	62.5 (n=32)	n.s.	61.0[c]	n.s.
Tobacco use	82.8 (n=58)	83.8 (n=37)	n.s.	25.2	***
Substance use (excluding alcohol)	55.9 (n=68)	48.7 (n=39)	n.s.	--	

[a]Data from PHMC Community Health Database, 2008
[b]Data from PHMC Community Health Database, 2010
[c]Data from BRFSS Philadelphia, 2009
*p<.05, **p<.01. ***p<.001, n.s. = non-significant.

PTH Clients: Quality Assurance Measures

NASMHPD Assessments (baseline)	PTH Non-IC (%) (n=80)	PTH IC (%) (n=43)	Compare IC/ Non-IC	HEDIS Medicaid, 2009 (%)[d]
BMI	57.5	72.1	p = .08	35
BP	60.0	97.7	***	
Fasting Glucose/HgA1C	27.5	41.9	p = .079	
Fasting Lipid Panel	18.8	41.9	**	
Personal Hx DM,HTN, CVD	63.2 (n = 57)	73.0 (n = 37)	*	
Tobacco Use Hx	72.5	86.0	p = .08	
Substance Use Hx	85.0	90.7	n.s.	
HEDIS metrics (past year)				
HTN- BP <140/90	46.2 (n=13)	66.7 (n=20)	n.s.	55
DM- HgA1C screening	33.3 (n=6)	85.7 (n=7)	***	81
DM-LDL measured	0.0 (n=6)	71.4 (n=7)	**	74
DM-BP <140/90	66.7 (n=3)	100.0 (n=6)	n.s.	
DM-BP <130/80	0.0 (n=3)	100.0 (n=6)	**	

[d]Data from NCQA State of Health Care Quality 2010
*p<.05, **p<.01. ***p<.001, n.s. = non-significant.

Public Health Impact

Our results indicate:

a) integrated care serves a more vulnerable sub-population, with more chronic illnesses, and

b) monitoring of health indicators is possible in this Housing First setting.

This suggests that supportive housing programs may serve as an effective health home for particularly vulnerable populations and that integration of care may improve quality measures.

Ongoing improvements in population health status and process indicators may be achieved through systematically integrating primary care and health quality assurance methods into current systems of housing and social service support.

Literature Cited

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