INITIAL OUTCOMES ANALYSIS

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INTRODUCTION

This report gives an overview of Heading Home's ABQ StreetConnect (ABQSC) program, created in 2017 to address the needs of the highest utilizers of emergency services and medical care in downtown Albuquerque. Using best practices, ABQSC recruits, houses, and supports this population of people experiencing homelessness who are high-utilizers of public services for whom traditional outreach methods have not succeeded.

A literature review on homelessness, best practices, service utilization, hospital readmissions, and discharge planning is provided, as well as several ABQSC participant case studies. We examine the effectiveness of ABQSC through pre- and post-engagement utilization of Emergency, Inpatient, and Outpatient medical services and Emergency Medical Service (EMS) dispatches.

EMS dispatches have decreased 46.76%, and Emergency Department (ED) visits have decreased 47.44% since working with ABQSC. Inpatient and outpatient hospital visits increased 100% and 53.85%, respectively. Given the higher health risks and lower life expectancy that accompany chronic homelessness, a rise in utilization for these categories should not be misinterpreted as counterintuitive or counterproductive to long(er) term cost savings.

On the contrary, a rise of inpatient and outpatient services follows logic: If an underserved population finally receives long-awaited assistance that they were previously unable to access on their own, like government entitlements like Social Security and Medicaid (or Medicare in some cases) and access primary care physicians, then long-ignored and sporadically-treated physical and behavioral health conditions previously addressed for the most part via emergency services are instead appropriately treated with coordinated care using inpatient and outpatient settings.

ABQ STREETCONNECT (ABQSC) PROGRAM DESCRIPTION

About ABQSC

ABQSC is a program within Heading Home (HH) developed in August 2017 to provide intensive, individualized, housing-focused service navigation to individuals with mental illness experiencing chronic homelessness. ABQSC specifically recruits those with the highest records of utilization of emergency services and medical care in downtown Albuquerque. The mission of ABQSC is to house and support this population for whom traditional outreach methods have not succeeded.

Although there are many services available for mentally ill adults experiencing homelessness in Albuquerque, some of these individuals, specifically those who are high utilizers of first responder, jail and hospital services, are unable to access these without assistance navigating the system. For example, the Vulnerability Index and the Service Prioritization Decision Assistance Tool (VISPDAT) is a common assessment tool used by organizations providing support to the homeless, 29.63% of ABQSC clients had not completed a VISPDAT prior to ABQSC engagement. This means that these individuals did not seek support from or were not recruited for assessment by another organization prior to ABQSC.

Furthermore, those with preexisting VISPDAT scores may not be appropriately assessed for social and medical risk factors. As the VISPDAT is a self-report tool, it requires the client to have a certain level of functioning to answer the questions correctly. When the client does not have the capacity to fully understand the questions, and respond with accurate answers, the result can be a very low score which would indicate low medical and/or social risk when this is not, in fact, the case. Under normal circumstances, having a low score could lead to an individual not qualifying for housing placement.

ABQSC is dedicated in the effort to identify and prioritize individuals who have medical acuity, psychiatric acuity, and high utilization of first responder services. 100% of ABQSC clients have mental illness, are experiencing homelessness or income less than 30% of area median income, and one of the following: high utilizer of first response services or someone with high medical or psychiatric acuity who has not accessed services. Criminal history, substance dependence and or traumatic brain injury do not automatically disqualify an individual from services.

ABQSC uses the OrgCode approach to establish a coordinated entry system for housing. Clients are determined and ranked in order of descending acuity based on frequency of service utilization. ABQSC then functions as a universal case management organization, coordinating services and resources for clients into a continuum of care. According to Backer et al., “fully integrated services are the ideal, so that people using them can do “one-stop shopping” without having to deal with multiple agencies” (Backer, Howard, & Moran, 2007).

The ABQSC team is composed of a Licensed Mental Health Clinician, 2 Program Navigators, the Program Director, Albuquerque Police Department (APD) Community Resource Officers, and Outreach Specialists from Hopeworks and Albuquerque Health Care for the Homeless. Supportive services are provided by ABQSC Navigators, and clinical services and assessments are provided by the ABQSC Clinical Outreach Director. Final triage decisions are made by the

ABQSC Program Director. Navigators serve as intensive case managers for clients; due to the extensive complexities of this patient population, ABQSC maintains a 15:1 client to navigator ratio.

In order to provide wrap-around services, ABQSC partners with a number of local organizations. ABQSC collaborates with hospitals, law enforcement, the judicial system, EMS, and substance abuse and mental health treatment facilities. Others directly connected with ABQSC include an SSI/SSDI Outreach, Access, and Recovery (SOAR) representative, and the Albuquerque Crisis Intervention Team.

Recruitment and Engagement

ABQSC determines priority of client service through empirical methods to ensure that clients most in need of services will be first to receive them. Prioritization methods include direct clinical mental health evaluation and assessment of empirical emergency service utilization records. Final determination of transfer from the ABQSC Interest List to the ABQSC Active Client List will be determined by the ABQSC outreach committee during outreach briefing.

ABQSC clients are located in downtown Albuquerque. For the purposes of ABQSC client recruitment, downtown Albuquerque is defined as the area between 1st Street and 12th Street (East to West) and Silver to Copper (North to South). The program's focus on the downtown area was agreed upon collaboratively by local community stakeholders. The original five clients for the ABQSC pilot program were identified in 2017 through the point-in-time count and our recruitment and prioritization procedures.

The 2017-2018 pilot assessment demonstrated the need for further ABQSC involvement in the downtown area. For the 2018-2019 fiscal year, ABQSC is contracted to serve 30 individuals. These clients are also located in downtown Albuquerque based on the boundaries above, however this population tends to shift locations and a few exceptions to these boundaries were accepted based on referrals from local hospitals, APD, or Albuquerque Fire and Rescue.

Client selection procedure:

1. Once a potential client is placed on the ABQSC Interest List, the clinical director and outreach director work to determine priority through empirical service utilization data and clinical evaluation.
    - A. Empirical Service Utilization Determination
        - i. Outreach director accesses records of hospital, jail, and ABQ Fire and Rescue
    - B. Clinical Mental Health Evaluation
        - i. Client referred to contracted clinical mental health professional.
        - ii. Bio-psychosocial and other assessments will be determined and completed on an individual basis.
        - iii. Clinician reports back to the outreach director to determine prioritization.
2. When service utilization and mental health evaluations are completed, client cases are staffed and prioritized based on acuity.

3. Clients determined most vulnerable, through evaluations and service utilization, will be moved from the ABQSC Interest List to the ABQSC Active Client List and intensive navigation services begin.

Placements

A program priority is to provide permanent supportive housing (PSH) to vulnerable individuals experiencing homelessness downtown. ABQSC leveraged existing relationships with our nonprofit partners and downtown businesses to connect with housing and services in sites across the city. Housing subsidies are provided by partner agencies and entities including:

- New Mexico Coalition to End Homelessness (NMCEH)
- Supportive Housing Coalition of New Mexico (SHCNM)
- Therapeutic Living Services (TLS)
- Albuquerque Housing Authority (AHA)

Supportive housing placements may also include:

- Assisted Living: facilities designed for people who need help with complex Active Daily Living Skills.
- Group Homes: usually single-family dwellings which have been converted into group residences, for example elderly or disabled residents.
- Skilled Nursing Facilities: licensed medical treatment facilities.

Best Practices

The ABQSC approach is evidence-based. The program practices housing first, trauma informed care, and harm reduction. Strategies are adjusted to meet clients' individual needs and services offered are individually identified. The successes of the organization is two-fold; successful outcomes for the client are also best for the system. The UNM Institute for Social Research found that providing housing for a person experiencing chronic homelessness, as well as medically vulnerable, is 31.6% cheaper than allowing them to remain homeless (Guerin & Minssen, 2016).

Housing First

The Housing First model is based on the belief that basic needs such as housing, food, and clothing are the primary platform from which an individual can improve their quality of life (National Alliance to End Homelessness, 2016). The provision of access to permanent housing is without conditions, therefore, individuals are not excluded from housing due do mental health diagnoses or substance abuse. Supportive services are offered but are not a prerequisite for housing. Client choice is exercised in housing and supportive service participation because involvement is likely to contribute to client success in remaining housed and improving outcomes (National Alliance to End Homelessness, 2016).

Research on permanent supportive housing shows that Housing First clients report increased levels of autonomy, choice and control (Watson et al, 2013). Furthermore, clients in both permanent supportive housing (PSH) and rapid re-housing programs access housing faster and are more likely to remain housed (National Alliance to End Homelessness, 2016). Cost savings are another positive outcome of the Housing First model. In a study performed by the Colorado

Coalition for the Homeless, an average of $31,545 per person was saved on emergency services in individuals housed over the course of 2 years (Perlman & Parvensky, 2016).

PSH and rapid re-housing are two methods of implementing housing first. PSH includes low-cost housing, health care, and supportive services (National Health Care for the Homeless Council, 2019). PSH targets those experiencing chronic or recurrent homelessness, disabilities, substance abuse, and mental health barriers. The components of rapid re-housing are housing identification, rent and move-in assistance, and case management (National Health Care for the Homeless Council, 2019). Both PSH and rapid-re-housing are offered through ABQSC, and the choice between the two is dependent upon client needs.

Harm Reduction

Harm Reduction refers to interventions aimed at reducing risky behaviors and poor health consequences (National Health Care for the Homeless Council, 2010). Harm Reduction began in the early 1900s with narcotic maintenance clinics (Hawk, Coulter, Egan, Fisk, Friedman, Tula, & Kinsky, 2017). While traditional, the Harm Reduction approach has been applied in the context of substance abuse, these principles extend to a broader health context (Hawk, et al., 2017). Six principles of universal harm reduction have been identified for use in patients in any healthcare setting. These principles include: humanism, pragmatism, individualism, autonomy, incrementalism, and accountability without termination (National Health Care for the Homeless Council, 2010).

These principles guide specific approaches at ABQSC. We value and respect our clients as individuals; clients are able to make choices about their care and participate in shared decision making with providers. We understand that every client presents a unique set of needs. Therefore, interventions are tailored to each person. And, while individuals are responsible for their choices and behaviors, they are not punished or omitted from the program for not achieving goals.

Trauma Informed Care

Trauma-Informed Care (TIC) is a framework for responding to the impact of and individuals experienced trauma(s). Research shows that individuals experiencing homelessness are likely to have endured previous traumatic experiences (Hopper, Bassuk, & Olivet, 2010). Homelessness itself can be a traumatic experience. As an organization providing services to individuals experiencing homelessness, it is important to recognize the impact of traumatic stress on our clients and to contribute to healing.

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines six principles of TIC: safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice and choice; and cultural, historical, and gender issues (SAMHSA, 2018). ABQSC incorporates an understanding of trauma in the process of promoting recovery. Our goal is to increase healing and success through the empowerment, voice, and choice of our clients, as well as positive collaborative relationships with both clients and community partners. We prioritize client's physical and psychological safety and encourage peer support and mutual self-help. Lastly, we look past cultural stereotypes and biases (e.g., based on

race, ethnicity, sexual orientation, age, geography), offer gender-responsive services, leverage the healing value of traditional cultural connections, and recognize and address historical trauma.

SSI/SSDI Outreach, Access, and Recovery (SOAR)

The SSI/SSDI Outreach, Access, and Recovery (SOAR) process is used for expediting access to mainstream benefits for people who are homeless – and particularly for those who are chronically homeless and struggling with behavioral health issues. SOAR has been demonstrated to:

- Reduce the number of appeals from initial determination to approval
- Decrease the duration of time from initial application to approval

Heading Home contracts with a SOAR specialist, allowing ABQSC participants, including those previously denied, to benefit from the SOAR process. Table 1 illustrates participant results of Heading Home's contracted partnership with a SOAR specialist.

Table 1**:** SOAR-Assisted ABQSC Participant Results

HHID Number	**Decision**	**Date of Decision**
HHID Not Entered	Approved	04/02/18
9040	Approved	01/15/18
9045	Approved	03/28/18
9001	Approved	04/04/18
HHID Not Entered	Approved	01/16/19
9041	Approved	05/07/18
9009	Pending	Forthcoming
9032	Pending	Forthcoming
9042	Pending	Forthcoming
9010	Pending	Forthcoming
9043	Pending	Forthcoming
9007	Pending	Forthcoming
9044	App In Process	N/A
9033	App In Process	N/A
9002	App In Process	N/A
HHID Not Entered	App In Process	N/A

Through SOAR, our ABQSC participants currently have 6 approvals for SSI, 6 pending applications, and 4 applications in progress. ABQSC participants who are awarded benefits are able to fund (partially, if not fully) their own housing.

BACKGROUND

Chronic Homelessness in Albuquerque

On a given night in Albuquerque, 1,318 people report experiencing homelessness (2017 Point in Time Count Results, 2017). Every two years a PIT count is conducted in our city and led by NMCEH, working in partnership with local agencies. For the purposes of the count, a person is considered to be homeless based on the Department of Housing and Urban Development criteria: if he/she is staying in an emergency shelter, in a transitional housing program, or is sleeping outside or in a place not meant for human habitation (2017 Point in Time Count Results, 2017).

The 2017 count demonstrates an increase of 31 people over the 2015 PIT Count, but numbers of the chronically homeless have risen more dramatically (2017 Point in Time Count Results, 2017). In 2017, 379 people self-reported as chronically homeless, an increase of 119 people over the 2015 PIT Count (2017 Point in Time Count Results, 2017). Chronic homelessness describes those who have experienced homelessness and a concomitant disabling condition such as serious mental illness, substance use disorder, or physical disability for a year or more or has experienced at least four episodes of homelessness in the last three years (National Alliance to End Homelessness, 2019). Nationally, approximately 24% percent of the total homeless population is comprised of chronically homeless individuals (National Alliance to End Homelessness, 2019). Using the 2017 point in time data, the percentage of chronic homelessness in Albuquerque is almost 29%.

Homelessness and Mental Health

According to data from the Substance Abuse and Mental Health Services Administration (SAMHSA), about 30% of people who are chronically homeless have mental health conditions and about 50% have co-occurring substance use problems (2011). Serious mental illness is defined as "serious and persistent mental or emotional disorder (e.g., schizophrenia, mood disorders, schizoaffective disorder) that disrupts functional capacities for primary aspects of daily life such as self-care, interpersonal relationships, and employment or school" (Montgomery, Metraux, & Culhane, 2013). Major mental illness is often accompanied by decreased levels of functioning or the presence of psychiatric symptoms. These manifestations of mental illness on behavioral health serve as obstacles in the maintenance of an individuals' support network, their ability to access services, and their capacity to obtain or sustain stable housing or employment (Montgomery, Metraux, & Culhane, 2013).

Homelessness complicates the effective management of mental illness and its symptoms (Montgomery, Metraux, & Culhane, 2013). Those experiencing homelessness may have decreased functional capacity and decreased access to treatment. Stress resulting from difficulties in maintaining housing and other basic necessities can make behavioral health management and medication regimens difficult to maintain, while presenting the individual with a greater tendency to self-medicate with illicit drugs and alcohol (Montgomery, Metraux, & Culhane, 2013).

Research and support for individuals experiencing homelessness and mental illness has increased in recent years. In 2014, Rowe et al. conducted a study in order to help establish best practice standards for mental health outreach among persons who are also without homes. The authors

identified four main themes for optimal mental health outreach: constructive outreach team characteristics; availability of services and resources such as housing, behavioral and medical care, case management and vocational training; the capacity to navigate complex service systems; and appropriate work demands and staff training (Rowe, Styron & David, 2016). Of importance is the concept that outreach work should emphasize meeting people ‘‘where they are’’ in terms of physical location on the streets and in other sites as well as having respect for their experiences and needs (Rowe, Styron & David, 2016).

Housing had been cited as a critical component of providing effective mental health services and achieving some level of community integration for persons with serious mental health challenges (Wong & Solomon, 2002). Unstable housing and high illness rates in this population may contribute to frequent utilization of hospital services, paid for with public dollars (Sadowski, Kee & Vanderweele, 2009). In a 2006 study by Martinez and Burt, providing permanent supportive housing to homeless people with psychiatric and substance use disorders reduced their use of hospital emergency department and inpatient services (Martinez & Burt, 2006).

Furthermore, study results on access to mental health services show that a sample of people with severe behavioral health issues who were housed used five times as many mental health services as the people with severe mental illness who were homeless (Culhane, Gross, Parker, Poppe, & Sykes, 2008).

Homelessness, Illness, and Premature Death

Forty-one percent of the adults without housing and seen more than once in Health Care for the Homeless Clinics suffer from chronic illness(es), compared to twenty-five percent of housed patients. Treatment regimen compliance is notoriously difficult for patients without stable housing, and for these reasons many patients without homes are referred to inpatient care for treatments that housed people typically manage on an outpatient basis (Institute of Medicine [US] Committee on Health Care for Homeless People, 1988).

Moreover, people experiencing homelessness are three times more likely to die prematurely than the housed population, with middle-aged men and young women at increased risk. The lives of those experiencing homelessness are roughly 30 years shorter than those who are housed (National Health Care for the Homeless Council, 2006).

Homelessness and Service Utilization

Untreated homelessness and health diagnoses are burdensome for the individual, as well as the community. The challenges of homelessness and the lack of coordinated services to address these issues contribute to a reliance on a safety-net of institutions. Without available housing, persons with serious behavioral health issues may resort to frequenting an “institutional circuit” comprised of hospital, jail, and homeless shelter stays (Hopper, Jost, Weber & Haugland, 1997). A study by the University of New Mexico’s Department of Social Research found the average annual cost of utilization of ambulance/ emergency rescue, emergency room, hospital inpatient, outpatient behavioral, jail and shelter services amongst homeless persons in Albuquerque to be $94,021 (Guerin & Minnisen, 2016).

Cycling through jails and hospitals is more common among people who experience chronic homelessness and severe behavioral health challenges. In a 2004 study, 82% of male and 52% of

female sheltered homeless adults had incarceration histories (US Dept. of Health and Human Services, 2007). A study by McNiel et al. (2005) found that people with histories of homelessness, mental illness, and substance use disorders experience an increased duration of incarceration (US Dept of Health and Human Services, 2007).

A greater proportion of homeless persons are hospitalized or visit the ED than the general population; however, it is a small number of homeless individuals that account for the majority of acute care use. These heavy utilizers tend to be chronically homeless and have co-morbid psychiatric diagnoses, substance abuse issues, and physical health problems (Kessell, Bhatia, & Bamberger, 2006). Folsom et al. (2005) found that homeless persons with severe psychiatric diagnoses were four times more likely than housed persons (with same and similar diagnoses) to use inpatient psychiatric hospitals and psychiatric emergency units, but were less likely to use outpatient mental health services (US Dept of Health and Human Services, 2007).

Reliance on emergency public systems is costly, and they do not provide effective long-term care necessary in treating patients with psychiatric conditions. Individuals experiencing homelessness are more likely to frequent emergency departments for health care needs, are hospitalized more often, and accumulate higher costs than those who are not homeless (Dirmyer, 2016). It is estimated that a population of "super-utilizers," patients with high medical costs from preventable, acute services, account for 50% of health care expenditures but only 5% of the population (Emeche, 2015).

Homelessness and Hospital Readmissions

A three-year retrospective study using hospital inpatient and discharge data (HIDD dataset) of non-federal hospitals for 2010-2012 of hospital readmissions among the Albuquerque area's homeless population revealed that 30.1 percent of homeless patients were readmitted within 30 days of their release. The readmission rate for Bernalillo County residents for the same time period was 12.3 percent (Dirmyer, 2015).

Two-thirds of readmissions for the population experiencing homelessness occurred within ten days of discharge; neuro-psychiatric conditions, followed by digestive diseases and then alcohol- and drug-related conditions were the predominant admitting primary diagnoses (Dirmyer, 2016). Of note in this analysis is that with each additional admission by a homeless patient, the odds of a 30-day readmission increased. In adjusted analyses, only a homeless person's age, number of admissions and primary neuro-psychotic condition diagnosis remained significantly associated with 30-day readmissions (Dirmyer, 2015).

The data from the Albuquerque study is consistent with other studies that show the increased rate and risk of readmission for patients experiencing homelessness. In 2013, Doran et al. found that the 30-day readmission Emergency Department rate for this population was 50.8%. They also found discharge location to be one of the strongest correlates to readmission; patients discharged to family or friends, or a skilled nursing facility or rehabilitation center had lower risks of readmissions compared to those released to the streets or a shelter (in Dirmyer, 2016).

From 2007-2010, the Centers for Medicare and Medicaid Services (CMS) estimated a 30-day readmission rate of roughly approximately 19 percent; CMS estimated the cost of these readmissions at nearly $17 billion (in Dirmyer, 2015). Hospitals need to take the necessary steps

to identify this population as they come through the door and create appropriate discharge plans to prevent costly readmission, most of which are being paid for out of state funds or charitable hospital funds (Dirmyer, 2015).

As the system stands, these patients are being released back to the streets or to shelters as routine discharges. Capturing these readmission rates shines a light on issues of quality of care of the entire episode of care, and will increasingly become an important means of measuring hospital quality (Dirmyer, 2015).

Discharge Planning

The Massachusetts Housing and Shelter Alliance defines discharge planning as "[T]he process—*beginning on admission*—to prepare a person in an institution for return into the community and the linkage of the individual to essential community services and supports" (HCH Clinicians' Network, 2008). Put another way, discharge planning can be understood as a *continuum of care* that begins with assessment and treatment, and ends with services and service coordination back into the community. This planning spans a client's initial institutional assessment and treatment with services and service coordination in the community. When initial assessment reveals housing instability or homelessness, housing interventions should be a focus of discharge planning (Backer et al, 2007).

The U.S. Department of Housing and Urban Development (HUD) states that "good discharge planning is the lynchpin of a comprehensive homelessness prevention strategy" (U.S. HUD, 2005). The McKinney-Vento Act requires that all state, county, and city governments applying for continuum of care funds certify that their communities have policies in place preventing the discharge of individuals into homelessness (McKinney-Vento, 2009).

Heading Home recognizes that the Centers for Medicare and Medicaid Services, citing the complexity of the rule and scope of public comments to the proposed discharge planning rule submitted in 2016, extended the timeline November 3, 2019 for publishing a final rule revising discharge planning requirements for hospitals, critical access hospitals, and home health agencies (in American Hospital Association, 2019). Also noted is that the American Hospital Association has requested that CMS, in their final rule, clarify that compliance with the updated standards will be evaluated within the context of hospitals' and critical access hospitals' community resources, acknowledging shortages of mental health care providers (American Hospital Association, 2019).

California recently rolled out new legislation on discharge planning. Phase 1 of Senate Bill 1152 went into effect on January 1, 2019. Hospitals (including acute care, psychiatric and special hospitals) are required to create a discharge planning policy specific to the issues of patients experiencing homelessness (CA Senate Bill No. 1152, 2018).

More specifically, effective January 1, 2019, California hospitals were required to:

- Determine each patient's housing status
- Connect patients experiencing homelessness with available community resources, treatment, shelter and other supportive services

- Inform patients about available housing options and identify a post-discharge destination for the homeless patient with priority given to identifying a sheltered destination with supportive services
- Document that the treating physician for a homeless patient has determined the patient to be clinically stable, alert, and oriented
- Document that the treating physician for has discussed medical needs with the patient and provided a prescription, if needed
- Offer a meal (unless contraindicated), weather-appropriate clothing if needed, and an appropriate supply of medication if needed
- Offer or referral to infectious disease screening
- Offer vaccinations appropriate to the homeless patient's presenting medical condition
- Document that the treating physician has provided a medical screening examination and evaluation
- Make good faith efforts to contact:
    - Patient's health plan, if applicable
    - Patient's primary care provider, if the patient has one
    - Another appropriate provider, including the coordinated entry system
- Assist with enrollment in affordable health insurance coverage
- Offer transportation to the identified housing option (Nielson Hardiman, 2018).

To facilitate improvement of the hospital's services for homeless patients, the hospital must develop a written plan for coordinating with county behavioral health, health care, and social services agencies. Plans should include certain information, such as homeless shelter information, including hours and admissions procedures (CA Senate Bill No. 1152, 2018).

Phase 2 (effective July 2019) places additional requirements on and emphasizes the necessary arrangements for post-discharge care, including identifying and connecting the patient experiencing homelessness with a family caregiver, as well as providing any needed counseling to the patient and caregiver. They must also provide contact information for at least one public or nonprofit organization that provides referrals for community-based long-term care for any patient that needs long-term care, and hospital must maintain a log of discharges that includes specific destinations. Finally, hospitals must document that discharge protocol was followed (Nelson Hardiman, 2018).

METHODS

Study Sample and Setting

The study sample is comprised of the 27 ABQSC program clients with whom ABQSC has had the most involvement, as determined by the housing director. The majority of individuals reside in Downtown Albuquerque, although exact participant location varies based on housing placement and participant self-relocation.

Six of the clients have exited the ABQSC program since engagement due to successful housing and a decrease in acuity. Their management has been transferred by ABQSC to Heading Home. Although these individuals are no longer actively engaged with ABQSC, their data was included in the study because the trends in their service utilization can be attributed to ABQSC intervention.

Demographics

Study demographics are shown in Table 2 below and reflect a total of 27 male and female participants, 44% white, 26% Hispanic, 19% African American, and 7% Native American, and 4% of unknown or other origin. Participants' average age equals 41 years. 100% of ABQ StreetConnect participants have at least one mental health diagnosis, and just over 85% are dually diagnosed with substance abuse.

Table 2: ABQ StreetConnect Study Demographics	
# of Clients in Study Sample	27
Average age	40.53
% Female	29.63
% Hispanic	25.93
% NH African American	18.52
% NH White	44.44
% NH Native American	7.41
% Unknown/other	3.7
% With a mental health diagnosis	100
% With substance abuse	85.19

Data Sources

Data was analyzed to determine the average emergency room, inpatient, outpatient and Albuquerque Fire and Rescue (AFR) dispatch costs and utilization. All ABQSC clients fill out a Participant Authorization (See Appendix A) allowing sharing of personal information, including individually identifiable health information between ABQSC and our community partners. Caution was taken to protect personal information during data collection. Patients were given a unique identification number so that names and dates of birth were not unnecessarily attached to their data.

Medical Data

Medical service utilization data was obtained from New Mexico Health Information Collaborative's (NMHIC) Health Information Exchange (HIE). The HIE allows authorized professionals with patient consent access to the patient's health history from a variety of healthcare organizations. Patient information sources include hospitals, provider groups, pharmacies and other stakeholders using electronic health record (EHR) systems (see Appendix for a full list of HIE data sources). For the purposes of this data analysis, information accessed in HIE was limited to encounter history. Encounter history includes: admission date, discharge date, diagnosis, visit type, specialty and provider. Clients in the ABQSC study sample have signed Patient Consent Forms (see Appendixes B, C, and D) for release of HIE medical record access.

Emergency Medical Service (EMS) Data

Data about EMS dispatches was provided by our community partner, Albuquerque Fire Department. Data obtained includes dispatch date, status, location cleared to, and situation acuity.

Cost Analysis Design

Medical Costs

Outpatient and Emergency Medicine costs are based on costs from the 2016 City of Albuquerque Heading Home Initiative Cost Study Final Report produced by the UNM Institute for Social Research. Costs were based on actual medical costs of 95 homeless individuals in 2016 (using 2016 dollars). The data was obtained from Table 19: Services for Study Group Members 1-2 years (Guerin & Minssen, 2016). The 1-2 year time frame was used because it is most similar to our client engagement time. Post-service costs from the table were used to determine average costs because this time is nearest to present day. Based on this data, each emergency room visit and outpatient visit were assigned an average cost per encounter.

Inpatient costs were not obtained this way. The inpatient estimate from the Cost Study were not conservative estimates because there were many outliers in the data, falsely elevating the average nightly inpatient cost. Average daily inpatient cost used in this report were provided by UNMH. For our data analysis, average daily inpatient cost is used rather than an average by encounter because the range in the number of inpatient days is large.

EMS Costs

EMS costs are based on costs from the 2016 City of Albuquerque Heading Home Initiative Cost Study Final Report. The Cost Study Report EMS/Ambulance cost of service data is from Albuquerque Ambulance Service, Albuquerque Fire Department, and Bernalillo County Fire Department. We used the average cost of post-services from this report for our data analysis.

Each time emergency medical services are dispatched, a minimum of one private ambulance and one AFR vehicle is dispatched. Conducting our cost analysis, when two total vehicles were dispatched, the average EMS/ Ambulance cost was multiplied by 2. When three vehicles were dispatched, this cost was multiplied by 3, so on and so forth.

Data Analysis

Our data analysis was conducted with help from our community partner, UNM Institute for Social Research, lead by Dr. Paul Guerin. During data analysis patients were identified using a unique identification number so that personal identifiers were not disclosed.
All pre-engagement data is based upon client utilization before the time of ABQSC engagement. The clients' engagement date is the ABQSC first contact with the individual. The pre-engagement data only goes as far back as the post-engagement data can go forward from the engagement date. For example, if a client has been engaged for 200 days (# of post-days), the pre-engagement data only includes services from the 200 days immediately preceding the engagement date (#of pre-days). The mean number of post-days for our study sample is 340.

Study Limitations

This study has several limitations regarding data collection and analysis. Of significance, we do not have data from medical providers outside of the HIE database. While HIE contains information from many large health care provider systems in the state, a number of medical providers are not captured through HIE. Going forward, we would like to cast a wider net to include data from the Veterans Affairs Health Care System and other providers.

Costs used for the purposes of this data analysis are conservative estimates. We did not have exact dollar amounts for each of the services provided to our clients. Costs for outpatient and emergency room visits are likely to be underestimates of current costs because they are based upon 2015-2016 data and have not been altered to account for inflation. Daily inpatient costs were provided by UNMH and do not account for PHS or Lovelace inpatient costs. The daily inpatient cost used is an average and is not broken down into inpatient medical and inpatient behavioral health costs. We would like to include this breakdown in future studies.

EMS response costs are conservative estimates as well. The cost used was an average and only accounted for the number of vehicles dispatched, but not the type of vehicles on scene (ambulance, engine, ladder, rescue, or squad) as we were not able to obtain exact costs per vehicle dispatched.

RESULTS

Pre- and Post- Engagement Service Utilization Totals

Table 3 reports the service utilization for the study group members before and after ABQSC engagement. The EMS data is comprised of dispatch counts for the 21 (out of 27) study group members who were found in the AFR database. The medical visit data reflects the 23 of 27 study group participants who had signed HIE information release consents and were found in the HIE database.

After engagement, EMS dispatches and Emergency Department visits decreased by 46.76% and 47.44% respectively. Outpatient visits increased by 53.85% and inpatient stays increased by 100% post-engagement.

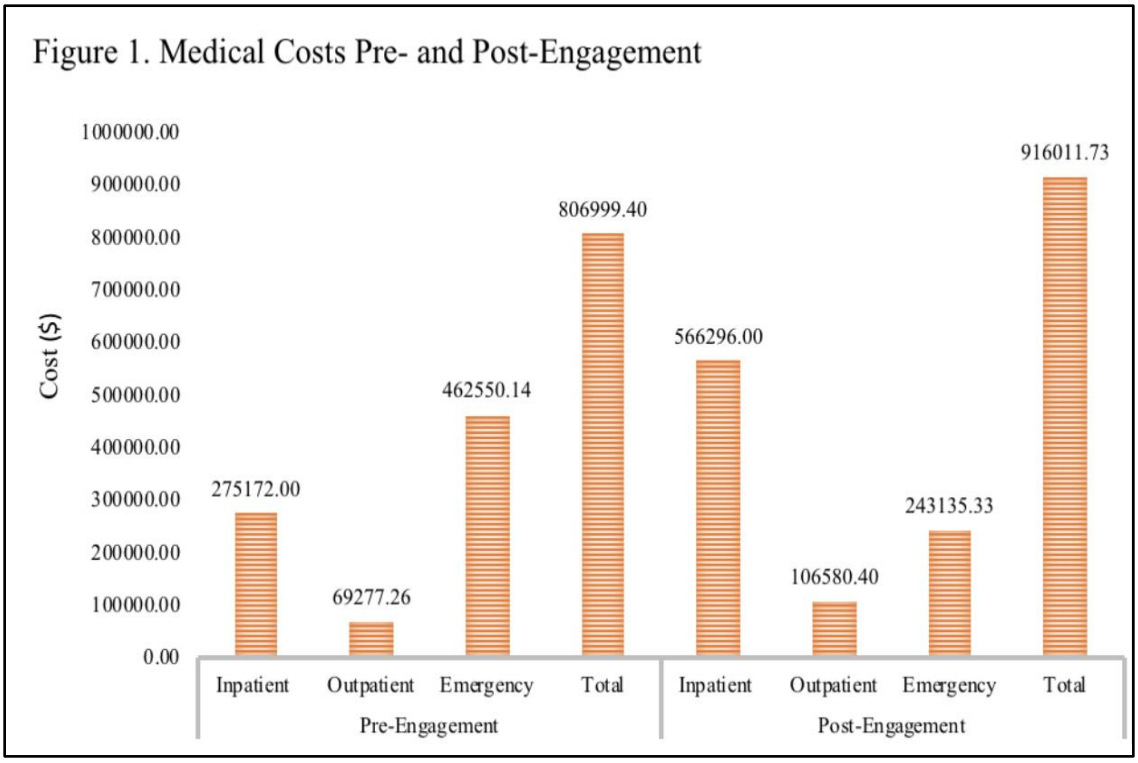
Table 3. Service Utilization Among ABQSC Clients

	Pre-Engagement	Post-Engagement	Difference	% Change
EMS Dispatches	139	74	-65	-46.76
ED Visits	234	123	-111	-47.44
Outpatient Visits	78	120	42	53.85
Inpatient Stays	14	28	14	100

Medical Costs

Figure 1 reports the pre- and post- engagement medical costs for the 23 ABQSC clients in the study sample who had a signed HIE consent and were accessible in the HIE database. One of the 27 study sample clients did not have a release for HIE access and therefore was not included in the HIE portion of the data collection or analysis. Three of the 27 clients did not show up in the HIE database.

Total medical costs increased 13.51% after ABQSC engagement. While post-engagement inpatient costs increased 105.80% and outpatient costs increased 53.85%, emergency department visit costs decreased post-engagement by 47.44%.



Medical Facility Utilization

Table 4 shows the frequency of study sample utilization among major health care providers in Albuquerque: PHS (Presbyterian Health Services), UNMH (University of New Mexico Hospital), and Lovelace. PHS includes all Presbyterian medical groups, clinics, and hospitals. Likewise, UNMH and Lovelace include all affiliated provider organizations. Any health care organization outside of PHS, UNMH, and Lovelace is denoted "other."

ABQSC clients primarily utilize UNMH (37.1% of all utilizations) followed closely by Lovelace (31.9%) and PHS (30.5%). Total costs for each facility for ABQSC participants include study period pre- and post-engagement medical visits. UNMH accrued the greatest costs with a total of $780,346.36.

Table 4. Medical Facility Utilization

	Frequency	Percent	Cost ($)
PHS	182	30.5	460,467.83
UNMH	221	37.1	780,346.36
Lovelace	190	31.9	474,290.10
Other	3	0.5	5,930.13
Total	**596**	**100.0**	**$1,721,034.42**

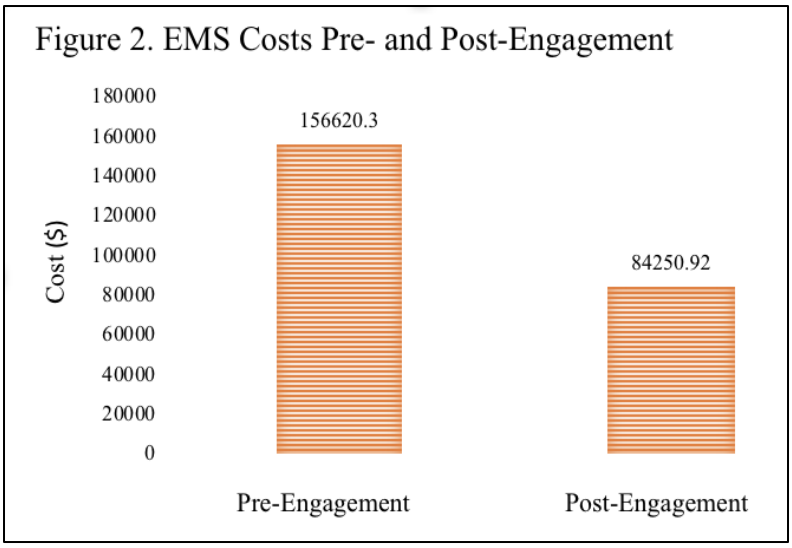
Table 5 reports the frequency of inpatient, outpatient and emergency room visits among the study sample by facility. UNMH had the greatest percentage of total inpatient and outpatient visits (69.0% and 87.9% respectively) while Lovelace had the greatest percentage of emergency room visits (51.4%).

Table 5. Visit Type by Facility

Facility		Inpatient	Outpatient	Emergency	Total
PHS	Count	7	23	152	182
	Percentage within Visit Type	16.7%	11.6%	42.7%	30.5%
UNMH	Count	29	174	18	221
	Percentage within Visit Type	69.0%	87.9%	5.1%	37.1%
Lovelace	Count	6	1	183	190
	Percentage within Visit Type	14.3%	0.5%	51.4%	31.9%
Other	Count	0	0	3	3
	Percentage within Visit Type	0.0%	0.0%	0.8%	0.5%
Total	Count	42	198	356	596
	Percentage within Visit Type	100.0%	100.0%	100.0%	100.0%

EMS Dispatch Costs

Figure 2 reports the pre- and post-engagement costs for the 21 ABQSC clients in the study sample with dispatch data in the AFR database. Post-engagement, EMS dispatch costs decreased 46.21%.



CASE STUDIES

We present a total of 3 ABQSC participant case studies in order to educate readers on specific challenges and barriers faced by both the case study individual, as well as by ABQSC as just one of the participant's continuum of care providers.

Case Study #1 (CS1) HHID 9044

MH Diagnoses: Schizophrenia
Date of ABQSC Engagement: 1/17/2018
SOAR Status: Pending

In December 2018, nearly one year post-engagement, ABQSC began receiving complaints regarding CS1's unwanted presence and undesirable behavior in the downtown area. ABQSC's clinical director determined that CS1 is a harm to self and others and a certificate of evaluation was written to facilitate CS1's involuntarily transport to UNMH Psychiatric Emergency Services (PES).

APD Community Resource Officers (CROs) located CS1 downtown and noted that CS1 was exhibiting extremely psychotic behavior and threatening the public. Upon arrival at PES, staff requested that the CROs stay until CS1 could be medicated, due to CS1's violent behavior. Before completing a psychiatric evaluation, PES transferred him to UNMH Emergency Department (ED) for treatment of an abscess. UNMH ED drained and treated the abscess. ABQSC requested that they be updated on CS1's status. PES said it was clearly noted that ABQSC is following CS1. PES stated that although they were transferring CS1 to ED, CS1 had a psych hold at PES.

CS1 was discharged from ED to the street. ABQSC received no updates. Within two weeks, CS1 was hit by a car. CS1 was re-admitted to UNMH for treatment of those injuries.

Because local skilled nursing facilities refuse to take CS1 due to mental health needs, CS1 was discharged to Respite Care at Heading Home's Albuquerque Opportunity Center.
ABQSC assisted in facilitating a SOAR application in order to award CS1 with social security income, which among other benefits, provides Medicaid coverage and a stable monthly income to help secure permanent housing.

Prior to CS1's engagement with ABQSC, HIE data reveals two inpatient stays at UNMH, as well as two outpatient visits for an estimated total of $39,662.34. CS1's post-engagement hospital costs, excluding costs related to injuries sustained after discharge to the streets without psychiatric evaluation, are estimated at $7,523.39.

Table 6 provides a hospital visit type and cost summary for CS1, and includes an entry to illustrate $115,650.00 in estimated readmission/ inpatient costs for injuries sustained within two weeks of being discharged to the streets.

Table 6. Case Study #1 Estimated Hospital Cost and Visit Type Summary				
Timeframe (pre- or post-engagement)	Amount	ED Visits	Inpatient Visits	Outpatient Visits
Pre-engagement	$39,662.34	0	2	2
Post-engagement	$7,523.39	1	1	4
Total Estimated Hospital Costs	$47,185.73*	1	3	6
*Study period hospital costs do not include CS1's eight-week, two-day inpatient stay for injuries sustained post-discharge to the street. That amount is captured in this entry.	$115,652.00.	N/A	1	N/A

Case Study #2 (CS2) HHID 9001

MH Diagnoses: Major Depressive Disorder; Suicidal Ideation; Alcohol abuse; Post Traumatic Stress Disorder; Borderline Personality Disorder
PH Diagnoses: Diabetes, Gout, High Blood Pressure
Date of Engagement: 9/6/2017
SOAR Status: Approved for SSI on 4/4/18

ABQSC engaged with CS2 after receiving a referral from ABQ's Fire Department Battalion Commander over concerns for the safety of CS2, as well as first responders. CS2 had been generating a high number of calls to Albuquerque Police and Fire Departments due to aggressive behavior and harm to self and others. CS2 was one of ABQSC's initial pilot program participants.

Barriers to housing and behavioral health services include the following:

- CS2 was one of health insurance company's highest utilizers, prompting the need for three different care coordinators
- CS2 has multiple legal issues and a notable history of arrests
- CS2 had been referred to Bernalillo County's Community Connections Supportive Housing Program for case management, but was denied entry because of past physical violence against law enforcement and healthcare workers
- CS2 has been banned from all substance abuse treatment and mental health facilities in New Mexico.

Since engaging with CS2, ABQSC has:

- Assisted in CS2's application for the Housing First program
- Assisted client in securing a new Primary Care Physician
- Assisted with food stamps, Medicaid, and SOAR application
- Assisted client in obtaining a photo identification, social security card and birth certificate
- Assisted client in obtaining financial award letters
- Was assigned a case manager through Heading Home
- Received a housing voucher through Heading Home and the Supportive Housing Coalition of NM and has been housed since April 2018.

CS2 was approved for Social Security Insurance benefits through SOAR. CS2 has been independently housed since April 2018 and is keeping scheduled appointments with probation officer and fulfilling pre-trial service requirements.

CS2 has incurred estimated total hospital costs of $361,304.06. CS2's pre-engagement hospital costs equal $241,833.41 and post-engagement costs are $119,470.65, roughly a 50% reduction in hospital costs. CS2 had 85 emergency department visits pre-engagement with ABQSC and 37 emergency department encounters post-engagement, reflecting a 56% reduction. Table 7 shows the breakdown of pre- and post-engagement hospital costs, as well as the breakdown of visit type.

Table 7. Case Study #2 Estimated Hospital Cost and Visit Type Summary

Timeframe (pre- or post-engagement)	Amount	ED Visits	Inpatient Visits	Outpatient Visits
Pre-engagement	$241,833.41	85	5	18
Post-engagement	$119,470.65	37	4	10
Total Estimated Hospital Costs	$361,304.06	112	9	28

Case Study #3 (CS3) HHID 9040

MH Diagnoses: Schizophrenia, Substance Abuse
PH Diagnoses: (primary – severe, chronic) Traumatic Brain Injury
Date of Engagement: 10/31/17
SOAR Status: Approved for SSI 1/15/2018

Hopeworks' outreach team had been engaging with CS3 since 2015. ABQSC engaged with CS3 in October 2017, and was approved for SSI in January 2018 through SOAR. CS3 also received a voucher for permanent housing assistance through the Supportive Housing Coalition of New Mexico.

Although housed, high-utilizer CS3 continued to spend a great deal of time on the streets in the downtown area. On August 9, 2018, CS3 was assaulted while sleeping in the doorway of Deep Space Coffee at 5th and Central. Locally, this was a highly publicized incident. Local TV news ran the story, and the Albuquerque Journal published it as well.

CS3 sustained severe injuries, prompting surgery and an 18-day stay at UNMH. Without notification to ABQSC, on August 27th, UNMH transferred CS3 to AMG Specialty Hospital to heal. ABQSC outreach navigators observed CS3 highly agitated and attempted unsuccessfully to run away from AMG.

On September 4th, ABQSC received a call from CS3's AMG social worker stating that CS3 had been transferred to Presbyterian's Kaseman facility due to CS3's repeated escape attempts and staff concerns that CS3 would become gravely ill if not recovered from an open tracheotomy wound and a wired jaw. AMG social worker also stated CS3 had expressed suicidal and homicidal ideation.

ABQSC received a call from CS3's provider at Kaseman just a little later. The provider stated that CS3 struck her as honest, that CS3 denied suicidality and homicidality, and that CS3's behavior was calm and story clear. CS3 had passed basic competency screenings, which left no grounds to keep CS3 there. Remarkably, during the Kaseman provider's interview, CS3 reported that the "bright spot" in his life was working with Heading Home's ABQSC staff. He was transferred back to AMG to continue healing, but was discharged just two days after on September 7, trach hole open, jaw wired shut to AOC. With a Certificate for Evaluation written by ABQSC clinical director, paramedics transported CS3 from AOC to UNMH for stabilization.

On September 8, ABQSC outreach director learned via voicemail that UNMH was discharging CS3 back to AOC respite. CS3, however, then showed up at Heading Home (downtown) at around 10AM. A staff member was present to triage CS3, contact APD, but the staff member did not let CS3 inside. ABQSC Clinician wrote another Certificate for Evaluation and CS3 was taken to UNMH PES.

ABQSC outreach director and CS3 met with PES doctor the following morning. ABQSC learned CS3 had tested positive for methamphetamine, heroin, cocaine, and marijuana upon intake and that CS3 had attempted to remove the wires in his jaw. During that meeting, CS3 stated he didn't know where he was and became verbally aggressive. ABQSC requested CS3 stay at PES instead

of back to AOC respite, but PES reported CS3 did not meet psychiatric acuity to remain there on hold.

PES doctor stated CS3 has sustained chronic severe brain injuries, which caused ABQSC to change their focus on addressing those injuries. ABQSC then contacted a TBI specialist at Carrie Tingly Hospital, who referred ABQSC to another doctor at UNM PES doctor who practices Brain Injury Medicine, so that a neuropsychological evaluation could be ordered.

CS3 has incurred estimated total hospital costs of $117,263.51; $116,375.34 was post-engagement, the majority of which is explained by his post-assault hospital stay. CS3's pre-engagement estimated hospital costs are $1,976.71 for one Emergency Department visit. Table 7 presents a summary of CS3's estimated hospital costs and visit types.

Table 8. Case Study #3 Estimated Hospital Cost and Visit Type Summary

Timeframe (pre- or post-engagement)	Amount	ED Visits	Inpatient Visits	Outpatient Visits
Pre-engagement	$1,976.71	1	0	0
Post-engagement	$116,375.34	1	3	17
Total Estimated Hospital Costs	$117,263.51	2	3	17

CHALLENGES AND BARRIERS

Challenges and barriers to ABQSC participants, ABQSC, continuum of care community partners and fellow service providers, as well as the City, County, and State at large include:

- Hospitals do not code for homelessness
- Skilled nursing facilities refuse clients with severe behavioral health issues
- No respite specifically for behavioral health
- No solid assessment tool. The VISPDAT is a self-report questionnaire; the majority of ABQSC participants do not have the capacity to accurately complete it
- Poor discharge planning, which should begin at admission, including lacking communication between medical providers (across departments), and between providers' discharge planners and ABQSC
- Poor discharge planning often results in Inappropriate Discharges to streets (or shelters), which increases (often unnecessary) readmissions
- Currently there is only 1 licensed behavioral health group home option (TLS)
- Long wait times for medical and psychiatric care, which we recognize is partially due to a shortage of NM medical and psychiatric service providers

RECOMMENDATIONS

In response to the challenges posed by inappropriate discharges to patients experiencing homelessness and continuum of care providers, and ultimately the community, Heading Home recommends the following:

- Integrating housing solutions into health care reform as an integral part of the continuum of care process. This means recognizing a patients' lack of stable housing upon admission.
- Improving communication and documentation protocols within hospitals and other continuum of care organizations to decrease inappropriate discharges.
- Advocating for additional licensed group homes in New Mexico
- Increased collaboration between continuum of care providers to brainstorm solutions to increase service providers for the underserved
- Advocating for NM discharge and post-discharge planning regulations and laws similar to those of California SB-1152 (2018), including and especially placing navigators within medical institutions who complete real-time and in-person referrals.

This report's data highlights the overall cost effectiveness of reducing EMS and ER costs by securing permanent housing for this particularly challenging population of individuals experiencing homelessness. As such, ABQSC also recommends:

- Expanding the ABQSC program throughout the metro area. It is currently limited to the downtown area.
- Mirror the ABQSC-APD partnership in the County Sheriff's Department to increase footprint of service area.

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Appendix A: HIE Participating Organizations

NM Health Information Collaborative—Health Information Exchange

NMHIC HIE Participant Status Update- Q1 2019

Organization Name	Current Data Provider*	NMHIC HIE Portal Access	*Communicate*** Direct Secure Messaging
University of New Mexico Health Sciences Center			
UNMH – ABQ	✖	✖	
UNM Sandoval Regional Med Center – Rio Rancho	✖	✖	
UNM Medical Group		In Queue	
UNM College of Pharmacy/NM Poison & Drug Info Ctr		✖	
Presbyterian Healthcare Services			
Presbyterian Hospital – ABQ	✖		
Presbyterian Kaseman – ABQ	✖		
Presbyterian Plains Regional Medical Center – Clovis	✖		
Presbyterian Rust Medical Center – Rio Rancho	✖		
Presbyterian - Espanola	✖		
Presbyterian Santa Fe Medical Center – Santa Fe	✖		
Presbyterian Lincoln County MC – Ruidoso	✖		
Presbyterian Dan C. Trigg MC – Tucumcari	✖		
Presbyterian Socorro General – Socorro	✖		
Presbyterian Medical Group	✖		
Lovelace Hospitals			
Lovelace Health System	✖		✖
Lovelace Medical Center – ABQ	✖		
Lovelace Women's Hospital – ABQ	✖		
Lovelace Westside Hospital – ABQ	✖		
Lovelace Rehabilitation Hospital – ABQ	✖		
Lovelace Heart Hospital NM – ABQ	✖		
Lovelace Regional – Roswell	✖		
LifePoint Hospitals			
Memorial Medical Center – Las Cruces	✖	✖	✖
Los Alamos Medical Center – Los Alamos		In Queue	
Hospitals (*continued*)			
Artesia General Hospital – Artesia	✖	✖	
Carlsbad Medical Center (Community Health Services)- Carlsbad	✖		
Christus St. Vincent Regional MC – Santa Fe	✖	✖	
Cibola General Hospital - Grants	✖		
Gerald Champion Regional Medical Center – Alamogordo		In Queue	
Gila Regional Medical Center – Silver City			In Queue
Holy Cross Hospital – Taos	✖	In Queue	
Mountain View Regional Medical Center – Las Cruces	In Queue		
Nor Lea General Hospital – Lovington		✖	
San Juan Regional MC – Farmington	✖		
Rehoboth McKinley Christian Hospital – Gallup			✖
Sierra Vista Hospital – T or C		In Queue	
Union County Hospital – Clayton		In Queue	
Emergency Medical Services (EMS)			
Albuquerque Fire Department/ABQ Fire Rescue		✖	
Provider Groups			
Active Life Orthotics and Prosthetics - ABQ			✖
Active Solutions Therapy – ABQ		✖	✖
Armada Therapy (ABQ & RR)			✖
DaVita Medical Group (previously ABQ Health Partners)	✖	✖	
Distinctly Dermatology (aka NM Specialty Med. Svcs. LLC) - ABQ			In Queue
First Choice Community Healthcare (ABQ, Belen, LL, Edgewood)			✖
Go Private MD - ABQ		✖	
Heading Home - ABQ		In Queue	
Heather Brislen, MD – ABQ		✖	
InnovAge – ABQ		✖	
Jeffrey D. Miller, MD – ABQ		✖	
La Clinica de Familia– Las Cruces		In Queue	In Queue
Las Cruces Physician Practice, LLC – Las Cruces			✖
Lovelace Cancer Care (previously Hematology Oncology Assoc)		✖	
Memorial Plastic and Reconstruction (LCPP)			✖
Mountain View Therapy Services, LLC. - ABQ			✖
NM Cancer Center/NM Onc Hem Consultants – ABQ		✖	
New Mexico Primary Care Association - ABQ		✖	
Paradigm Physical Therapy and Wellness (ABQ, Belen, Bern., LL)			✖
PCI Pain & Vein Clinic- ABQ		✖	✖
Quality Sleep Solutions – Multiple Locations			✖

NM Health Information Collaborative—Health Information Exchange

Organization Name	Current Data Provider*	NMHIC HIE Portal Access	*Communicate*** Direct Secure Messaging
Rio Abajo Family Practice – Los Lunas		✖	
Sandia Neurology PC – ABQ		✖	
Taos Clinic for Children and Youth – Taos		✖	
Teddi Rivera (SOAR Rep) – ABQ		✖	
Women's Specialists of New Mexico – ABQ		✖	
Home Health and/or Hospice			
Armada Hospice (ABQ & RR)			✖
Armada Skilled Homecare (ABQ & RR)			✖
Kindred At Home – ABQ			✖
Legacy Home Health			In Queue
Tender Care Home Health – Las Cruces			✖
Diagnostic Services			
Assured Imaging			✖
Laboratory Corporation of America (LabCorp)	In Implementation Queue	✖	
Quest Diagnostics	✖	✖	
Radiology Associates of Albuquerque	✖	✖	✖
TriCore Reference Laboratories	✖	✖	
X Ray Associates of New Mexico	✖	✖	
Payers			
Anthem, Inc./Amerigroup (Medicare Advantage)	Demographic Info	✖	
BCBS NM (Centennial Care MCO)	Demographic Info		
Molina Healthcare (Centennial Care MCO)	Demographic Info	✖	
New Mexico Health Connections	Demographic Info	✖	
Presbyterian Health Plan (Centennial Care MCO)	Demographic Info		
True Health			
United Healthcare (Centennial Care MCO)	Demographic Info	✖	
Western Sky Community Healthcare	Pending	In Queue	
Public Health			
NM Department of Health		✖	
Pharmacies			
Vida Pharmacy		✖	

* *Please request a NMHIC HIE Data Providers & Data Elements Table if more detailed information is needed.*

** *Many organizations are using the DIRECT secure messaging feature of their Electronic Health Record. Communicate is a cloud-based service offered through NMHIC from our vendor, Orion Health.*

LCF Research, a New Mexico nonprofit organization with a community board, d/b/a NM Health Information Collaborative (NMHIC), provides a Statewide Health Information Exchange (HIE), powered by Orion Health, allowing healthcare professionals quick access to patient history, to improve the quality, safety and efficiency of healthcare delivery across the state.

NMHIC HIE receives data from a minimum of 73% of all emergency department admissions, and 80% overall inpatient admissions. Current participants include most NM hospitals, provider groups, NM Medicaid and commercial payer organizations, three laboratories, three diagnostic imaging organizations, a professional healthcare association representing Federally Qualified Health Clinics (FQHCs), home health and/or hospice agencies, EMS and public health. We welcome additional stakeholders, i.e., skilled nursing facilities, behavioral health, corrections, employers, school-based clinics, and ancillary service providers.

The use of HIE holds much potential for rural New Mexico. Rural health care providers and patients often face obstacles different from those experienced in urban areas—including geographical, cultural, and economic factors—that impacts how providers deliver care and how patients receive it. NMHIC will continue to assess the health IT needs in rural NM and work on gathering additional data from area hospitals.

NMHIC has been working on connection to the National HIE (eHealthExchange). We are recognized by the New Mexico Department of Health as its agent for hospital public health reporting.

HIEs have been shown to save lives, avoid complications, and deliver optimal quality care by:

- avoiding duplicative testing, imaging and treatment
- preventing unnecessary readmissions to the hospital
- reducing adverse drug events
- reducing length and complexity of hospitalization
- reduced costs associated with traditional medical records processes
- improvement in the patient experience
- providing emergency department and hospital admission notifications and other analytics for providers as well as managed care organizations.
- helping payers and care managers to interceded early using risk assessments obtained from data in the HIE.

This is a powerful clinical tool that is improving the quality and safety of care every day in New Mexico; however, ***in order to maximize benefit, all of the providers and hospitals in New Mexico should participate.*** For more information, please contact Michelle Bowdich, Director of Outreach & Communications, at 505-938-9909 or michelle@nmhic.org; or visit our website at www.nmhic.org

Appendix B: ABQSC Participant Authorization

ABQ StreetConnect

Connecting those most in need to critical services

Albuquerque StreetConnect
Participant Authorization

This release is for the purposes of case management and continuity of care.

As a participant of the Albuquerque Heading Home Initiative this voluntary authorization will benefit you by allowing the named organizations/entities of the Albuquerque Heading Home Project to share information in order for them to assist you by providing coordinated care. This information will be shared only when necessary and will include only the minimum amount of information necessary for the purpose of effectively coordinating your care. The types of information which will be shared includes your location, housing situation, medically related diagnoses (as applicable), case management history, entitlement benefit procurement, legal status, and any other condition you self-disclose that may help in service provision and referral.

I understand that this authorization is voluntary. I understand that my health information may be protected by the Federal Rules for Privacy and Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter 1, Part 2), and/or state laws. I understand that organizations that are not healthcare or behavioral health organizations may not be bound by HIPAA and CFR-42.II regulations.

I understand that I may revoke this authorization at any time by notifying Heading Home in writing. However, the revocation will not have an effect on any actions the organization took before it received the revocation and some information may have already been shared. I have been told that information released from my records may not be given to people or agencies other than those named on this form without my permission (Section 34-2A-18 NMSA 1953).

I authorize Heading Home, specifically the Albuquerque Heading Home Initiative and it agents, affiliated contractors, and community partners, including but not limited to: St. Martin's Hospitality Center; Albuquerque Health Care for the Homeless; Supportive Housing Coalition of New Mexico; University of New Mexico Institute for Social Research; First Nations Community Healthsource; New Mexico Solutions; Therapeutic Living Services, New Mexico Veterans Integration Center; and Catholic Charities; to share information necessary to help ensure my success in the Albuquerque Heading Home Initiative and to receive or disclose my individually identifiable health information as described above.

I understand that I have the right to examine and copy and printed information to be released. I also understand this authorization expires automatically one (1) year from the date of signature.

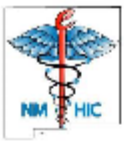
_____

Participant Name (Print)

_____ _____

Participant Signature (Date)

Appendix C: HIE Patient Consent Form



New Mexico Health Information Collaborative (NMHIC)

The Statewide Health Information Exchange (HIE) Network

Patient Consent Form

Hospitals, doctors, and clinics use different computer systems. Doctors need the most complete view of your health information to give you the best care. NMHIC HIE gets health information from many health care organizations using a Health Information Exchange (HIE). This allows your doctor to see the most information about what care you have gotten in the past. Your doctor and other health care workers must have your consent to view this information.

Only those authorized health care workers in organizations that are a part of NMHIC HIE can see your patient information with your permission.

By signing below, I give my consent to **Heading Home** to read any and all of my health information from other NMHIC participating organizations for my care. This information could include these conditions:

- **Human Immunodeficiency Virus (HIV)**
- **Sexually Transmitted Diseases**
- **Behavioral Health Treatment**
- **Genetic Information**
- **Alcohol & Drug Treatment**

I understand that this consent will be in effect until I withdraw it in writing or I opt-out of the NMHIC HIE. I also understand I can get a copy of this consent form and of my health information being shared.

_____ _____

Signature of Patient or Authorized Representative | Date

_____ _____

Patient Name or Authorized Representative (Print) | Relationship to Patient (if not Patient)

_____ _____

Patient Date of Birth (mm/dd/yyyy) | Patient Medical Record Number

Patient Address _____

City:_____ State:_____ Zip:_____

_____ _____

Patient E-mail (Optional) | Patient Primary Phone Number

V2016_07_13

Appendix D: Heading Home/ABQ StreetConnect Patient Consent Electronic Medical Record Access

HEADING HOME/ABQ STREETCONNECT
PATIENT CONSENT
ELECTRONIC MEDICAL RECORD ACCESS

What is this consent?

State and federal governments are encouraging all health care providers to use an electronic format for the exchange of health care information. It is believed that the use of an electronic exchange of health care information will lead to better health care for you and may lower health care costs.

The attached consent is your agreement that **Heading Home/ABQ StreetConnect** can access your medical records from other health care providers and other health care organizations in an electronic format. This is called "Health Information Exchange." The Health Information Exchange is a secure and privacy-protected computer network. The network and any health care provider or other health care organization that uses it must follow strict federal and state laws designed to protect the confidentiality of your health information. The Health Information Exchange is operated by the New Mexico Health Information Collaborative, an independent, nonprofit organization.

Using the Health Information Exchange **Heading Home/ABQ StreetConnect** can see your tests and other treatments from other providers and health care organizations. **Heading Home/ABQ StreetConnect** can also access details about your medical condition that you may not be aware of or have forgotten. Since it is all electronic **Heading Home/ABQ StreetConnect** can see this information quickly. This information may be important for your treatment or care.

State and federal laws allow your information to be transmitted electronically through a Health Information Exchange unless you opt-out, as described in more detail below. State and federal laws also require your consent to the disclosure of certain information as described in more detail below. In order to insure the privacy of your medical information and to comply with law, the Health Information Exchange does not let **Heading Home/ABQ StreetConnect** electronically access or view your information unless you give your consent.

If I give my consent, what will you be able to do?

When you sign this consent, **Heading Home/ABQ StreetConnect** will be allowed to have access to your electronic medical records from all of your health care providers and other health care organizations that participate in the Health Information Exchange.

Am I giving up my privacy rights if I give my consent?

Giving your approval for **Heading Home/ABQ StreetConnect** to access your medical records from the Health Information Exchange does not mean that you are giving up your right to privacy. It does not mean you are giving up any confidentiality of your health information. **The electronic records have the same protection as your paper medical records.**

What happens if I don't consent?

You are not required to give your approval/consent. Your health care benefits from your health insurance or government program will be the same. You will still get medical treatment based on the information available to **Heading Home/ABQ StreetConnect**, including any information you provide. But, if you do not consent, **Heading Home/ABQ StreetConnect** may not have access to important information related to your treatment and care.

What happens if I change my mind after giving consent?

If you change your mind about giving your approval for **Heading Home/ABQ StreetConnect** to get access to your information from other providers and organizations through the Health Information Exchange you can, at any time, stop the access. You can simply tell **Heading Home/ABQ StreetConnect** to withdraw your approval or you can "opt-out" of participation in the Health Information Exchange altogether. See the "Opt-Out" information below.

1

HEADING HOME/ABQ STREETCONNECT
PATIENT CONSENT
ELECTRONIC MEDICAL RECORD ACCESS

All medical records are confidential under federal regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). New Mexico and other federal laws also provide special protection for certain medical conditions and/or test results. These special protections are provided for the following medical conditions:

Viral Hepatitis	**Genetic Information**
Human Immunodeficiency Virus (HIV)	**Alcohol & Drug Treatment**
Sexually Transmitted Diseases	**Behavioral Health Treatment**

Because of these special protections **Heading Home/ABQ StreetConnect** must get your specific approval/consent to access any of your information using the Health Information Exchange **regardless** of whether you have any of these conditions. Giving your consent for **Heading Home/ABQ StreetConnect** to access your information **does not mean** that you are saying that you have any of these medical conditions.

By signing below I give my permission for **Heading Home/ABQ StreetConnect** to electronically access any and all of the medical information from other providers and organizations, including information for any of the conditions or treatments listed above and to disclose such information electronically, if another provider I have given my consent to requests it from **Heading Home/ABQ StreetConnect.** This information will be accessed through the New Mexico Health Information Exchange for the purposes of providing me health care services. Once accessed, this information will continue to be protected by the state and federal privacy laws.

I understand that this consent will be in effect until I revoke it or opt out of the Health Information Exchange or until my death. I understand I can revoke this consent at any time by contacting **Heading Home/ABQ StreetConnect at (505)344-2323**, and requesting a revocation form. The revocation will be effective from date of receipt by **Heading Home/ABQ StreetConnect** but will not affect information obtained prior to the revocation.

I understand that if I do not sign this consent, **Heading Home/ABQ StreetConnect** will not be able to access medical records from other providers or facilities through the Health Information Exchange.

I UNDERSTAND THAT THERE IS NO PENALTY TO ME IF I DO NOT PARTICIPATE OR GIVE MY PERMISSION OR IF I CHANGE MY MIND LATER.

I understand that I can opt-out of the Health Information Exchange altogether by sending an "Opt-Out" form (available upon request) to the Health Information Exchange.

I understand I can get a copy of this consent form and of my health information being shared.

_____ Date: _____

Signature of Patient or Authorized Representative

_____ _____

Name of Patient or Authorized Representative (Please Print)

Relationship to the Patient if not Patient (Please Print)

2

HEADING HOME/ABQ STREETCONNECT
PATIENT CONSENT
ELECTRONIC MEDICAL RECORD ACCESS

PATIENT
REVOCATION OR OPT-OUT

Under state and/or federal law you have the right to:

1. Not participate in the electronic New Mexico Health Information Exchange. You may OPT-OUT of the Health Information Exchange by contacting New Mexico Health Information Exchange, see information below;

OR

2. Revoke a consent you have previously given. You can take back your permission for **Heading Home/ABQ StreetConnect** to see your information. You will not have any penalties for doing this. Contact Heading Home/ABQ StreetConnect at (505)344-2323 to revoke your previously given consent.

YOU MAY OPT OUT OF THE HEALTH INFORMATION EXCHANGE BY ANY OF THE FOLLOWING METHODS:

- Request an opt-out form from your provider
- Get the form by going on to the following website: www.nmhic.org
- Contact NMHIC directly by calling or writing:

  By Phone: (505) 938-9900

  By Mail: New Mexico Health Information Collaborative
  2309 Renard Pl. SE, Suite 103
  Albuquerque, NM 87106

It may take up to 30 (thirty) days for NMHIC to process your request once your form is received.

ATTENTION HEALTHCARE PROVIDERS

If this patient's medical record contains information about viral hepatitis, human immunodeficiency virus or sexually transmitted disease testing, please be aware that the information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of such information without the specific written consent of the person to whom such information pertains or as otherwise permitted by state law. A person who makes an unauthorized disclosure of this information is guilty of a petty misdemeanor and shall be sentenced to imprisonment in the county jail for a definite term not to exceed (6) six months or the payment of a fine of not more than five hundred dollars ($500.00) or both.

If this patient's medical record contains information about Alcohol or Substance Abuse Treatment records please be aware that the information has been disclosed to you from records protected by Federal confidentially rules 42 CFR Part 2. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
