UTHealth Houston | McGovern Medical School

Hospital to Home Evaluation Structure, Process and Preliminary Outcomes

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Achieving Health Equity among the Serious Mental Illness (SMI) Population Experiencing Homelessness

- **Health Equity:** attainment of the highest level of health for all people.
- **Underlying Principle:** a commitment to reduce—and, ultimately, eliminate health disparities and its determinants.
- **Effects of Health Inequities** compounded for population groups historically excluded or underrepresented such as the SMI population experiencing homelessness.
- Compared to the general population, people experiencing homelessness (PEH) suffer from **higher rates** of SMI and co-occurring disorders (COD).
- **Homelessness** is a key driver of poor health outcomes including a shorter life expectancy, increased morbidity, and higher acute care, psychiatric inpatient and emergency department utilization.

The Harris Center
Hospital to Home (H2H) Program

- Aims to improve community transitions and linkage to permanent housing and supports following psychiatric hospitalization for people experiencing homelessness (PEH).
- 34-bed, 90 to 180-day integrated, trauma-informed rehabilitative treatment program in a residential setting for adults (ages 18+ years) to address myriad mental/physical health and social needs of PEH with SMI/COD.
- H2H is administered by Evelyn Urdiales Locklin, MA, LPC, Harris Center Director, Emergency Services and Residential Programs.

Hospital to Home (H2H) Services/Activities

- Linkage to psychiatric medication management
- Harris Center nurse support line
- Care Coordination (linkages to all needed benefits and supports)
- Daily Psychosocial/Life Skills Groups
- Ask a Nurse (weekly group with a dedicated registered nurse)
- Substance Use Groups (Facilitated by a LCDC)
- Psychosocial Rehabilitation (e.g., gardening, bike riding, hygiene activities, and yoga/dancing)
- Coordinated Access housing assessments/housing navigation
- Supported Employment Services
- Cognitive Behavioral Therapy (through UTHealth HOMES)
- Linkage to primary care services

Mixed-Methods Research Evaluation Specific Aims

Aim 1) Conduct descriptive and inferential statistics to examine preliminary H2H and outcome data.

Aim 2) Administer two web-based surveys to (1) H2H providers and (2) UTHealth Harris County Psychiatric Center (HCPC) providers.

Aim 3) Conduct key informant interviews with a sample of H2H residents, H2H providers and HCPC providers to qualitatively understand and provide context for quantitative findings in Aims 1 and 2.

Data Sources

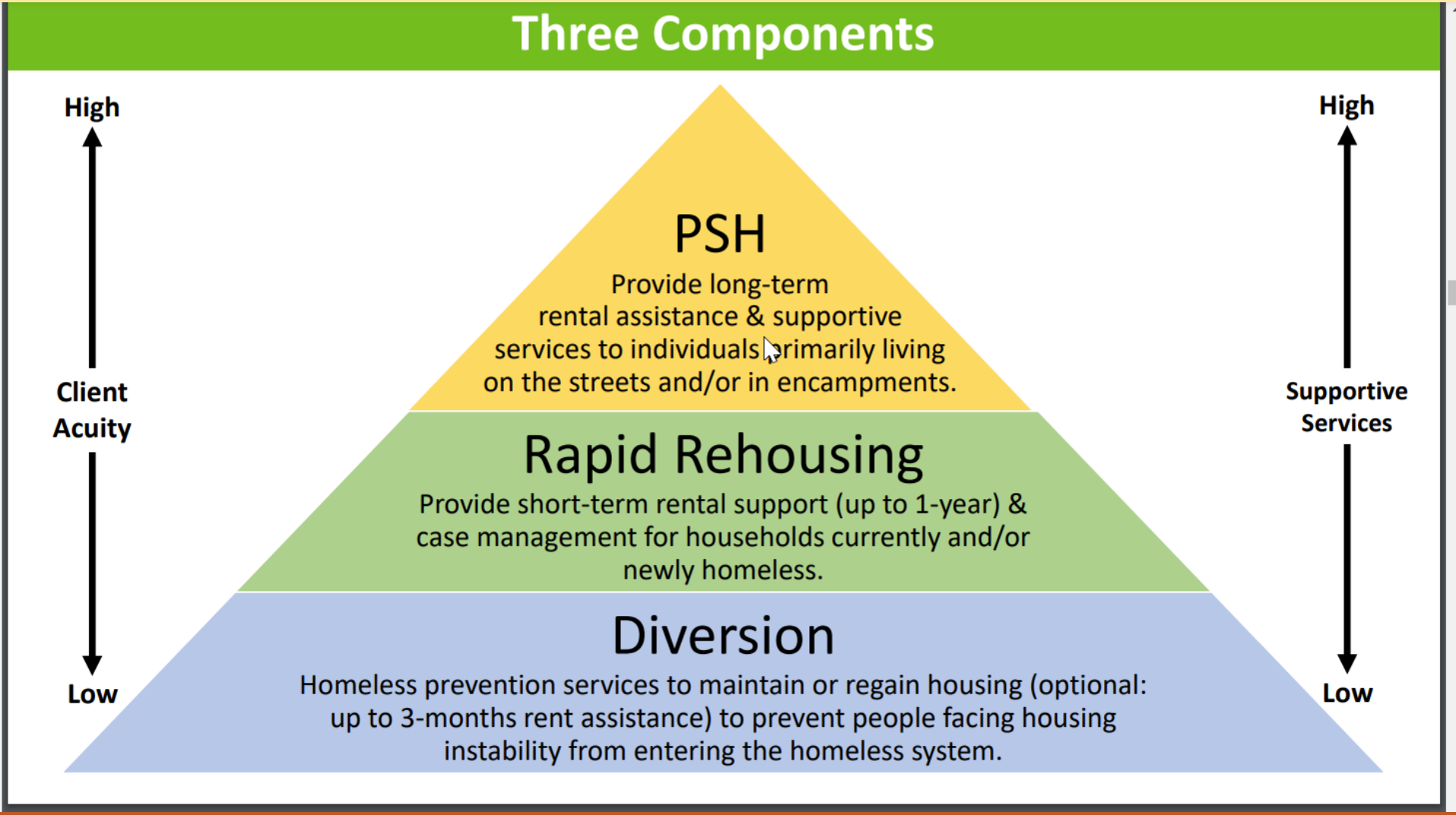
- Hospital to Home (H2H) housing outcomes data
- Electronic health record data from Harris County Psychiatric Center (HCPC) inpatient
- Harris Center electronic health record data
- Homeless Management Information System (HMIS)
- Clinical assessment data collected for UTHealth HOMES program for H2H patients enrolled in CBT
- Qualtrics survey data
- Key-informant interview data

Aim 1: H2H Resident Characteristics (n=370 Served)

- From 2020-2024, a total of **115 H2H residents** were documented as being placed in housing through the HUD CoC that included either PSH (n=29) or RRH (n=85).

Patient Characteristics	Number (Percentage)
Male	286 (77%)
Mean Age	45 Years
Black/African American	188 (51%)
Major Depression	106 (29%)
Bipolar Disorder	122 (33%)
Schizophrenia Spectrum	67 (18%)
Number Receiving CBT through UTHealth HOMES	145 (39%)
Mean Prior Psychiatric Hospitalizations	1.5*

Houston/Harris County Regional Housing Strategy



Housing Access following H2H Participation (*n*=370 Included in Analysis)	
Persons linked with Housing through Coordinated Access	115 (31%)
Persons linked with Housing through Coordinated Access staying at H2H for at least 7 days	111 (97%)
Persons linked with Housing through Coordinated Access staying at H2H for at least 30 days	102 (89%)
Persons linked with Housing through Coordinated Access staying at H2H for at least 90 days	68 (59%)
Housing Placement: Permanent Supportive Housing	29 (25%)
Housing Placement: Rapid Rehousing	85 (74%)
Housed at 30-Day Follow-up*	85 (74%)
Housed at 90-Day Follow-up*	54 (47%)
Linked with Outpatient Services*	37 (32%)

Predictors of H2H Completion and Housing Linkage

Predictor	Significance	Odds Ratio	Confidence Interval
Age	.384	1.00	.986 - 1.037
Gender	.437	1.38	.616 - 3.068
Race	.907	.96	.504 - 1.838
H2H Length of Stay	<.001	1.03	1.020 - 1.034
UTHealth HOMES CBT Participation	.001	3.17	1.580 - 6.340
MDD	.058	.40	.159 - 1.030
Bipolar Disorder	.012	.31	.122 - .775
Schizophrenia	.145	.46	.160 - 1.310
Constant	.001	.05	

Nagelkerke R Square: .579

Predictors of Permanent Supportive Housing Placement

Predictor	Significance	Odds Ratio	Confidence Interval
Age	.101	1.03	.994 - 1.065
Gender	.857	.91	.309 - 2.656
Race	.360	1.52	.619 - 3.751
H2H Length of Stay	<.001	1.01	1.004 - 1.014
UTHealth HOMES CBT Participation	.003	5.38	1.801 - 16.050
MDD	.022	.21	.056 - .799
Bipolar Disorder	.536	.69	.211 - 2.244
Schizophrenia	.630	.73	.200 - 2.649
Constant	<.001	.01	

Nagelkerke R Square: .260

Predictors of Rapid Rehousing Placement

Predictor	Significance	Odds Ratio	Confidence Interval
Age	.619	1.01	.983 - 1.030
Gender	.978	1.01	.477 - 2.141
Race	.471	.80	.440 - 1.462
H2H Length of Stay	<.001	1.01	1.010 - 1.019
UTHealth HOMES CBT Participation	.014	2.24	1.179 - 4.272
MDD	.659	.83	.365 - 1.891
Bipolar Disorder	.086	.48	.204 - 1.112
Schizophrenia	.127	.46	.168 - 1.250
Constant	.007	.11	

Nagelkerke R Square: .355

Aim 2: UTHealth HCPC Provider Survey (*n*=40 Participants)

HCPC Provider Role	Number of responses	Percentage (%)
Social Service Clinician	19	48%
Social Service Administrator	4	10%
Psychiatrist	5	13%
Psychiatry Resident Physician	10	25%
Nurse Practitioner	2	5%

UTHealth HCPC Provider Survey Findings

- 81% of the participants perceived more difficulty in providing follow-up psychiatric care for HCPC patients who are homeless.
- 97% reported that HCPC patients who are homeless are likely to benefit from a referral to the Harris Center following hospitalization.
- 95% had concerns about the safety of these patients after they are discharged from HCPC.
- 83% were familiar with the H2H program.
- 58% did not consider H2H as a primary discharge placement option for HCPC patients experiencing homelessness because there are less beds available for women and the wait time is too long.
- 42% considered H2H as a primary discharge option because it is a well known program, has longer term support and connection to resources, and perceived as the best available option.

UTHealth HCPC Provider Survey Quotes

"I often want to refer patients to H2H because I think it is a fantastic resource; however, often times our social workers tell us that the wait time is too long/at capacity. I have only successfully discharged 1 patient to H2H."

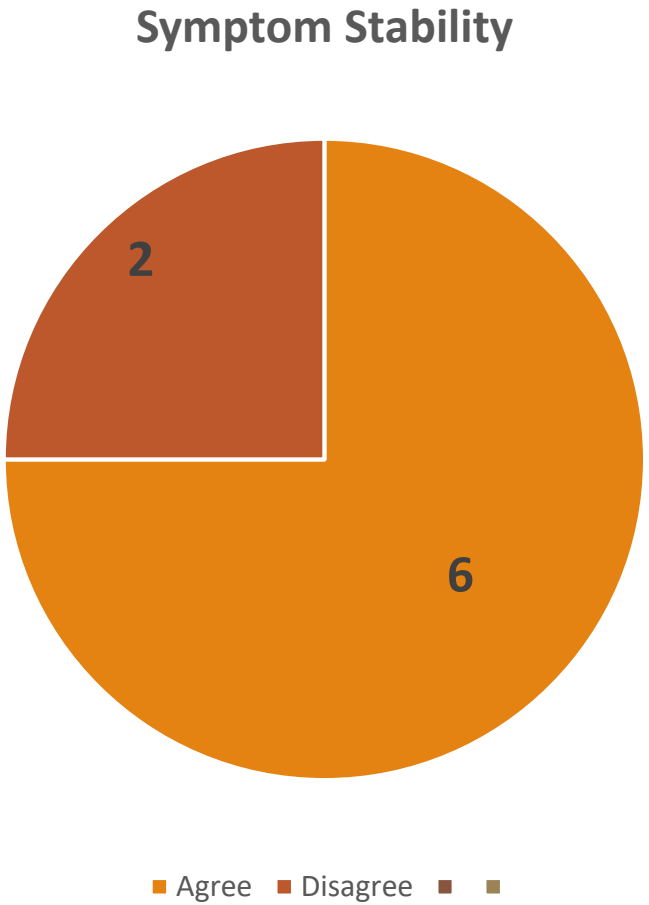
"It was a big win for our patient because he had multiple psychiatric hospitalizations due to not having access to follow up care and medications due to lack of resources and unstable housing. However, we did keep him in the hospital for 1 week extra to wait for a spot to open up at H2H".

"The resources provided, fast responses, normally available for men. women are a different story. I don't consider H2H when looking for placement for women."

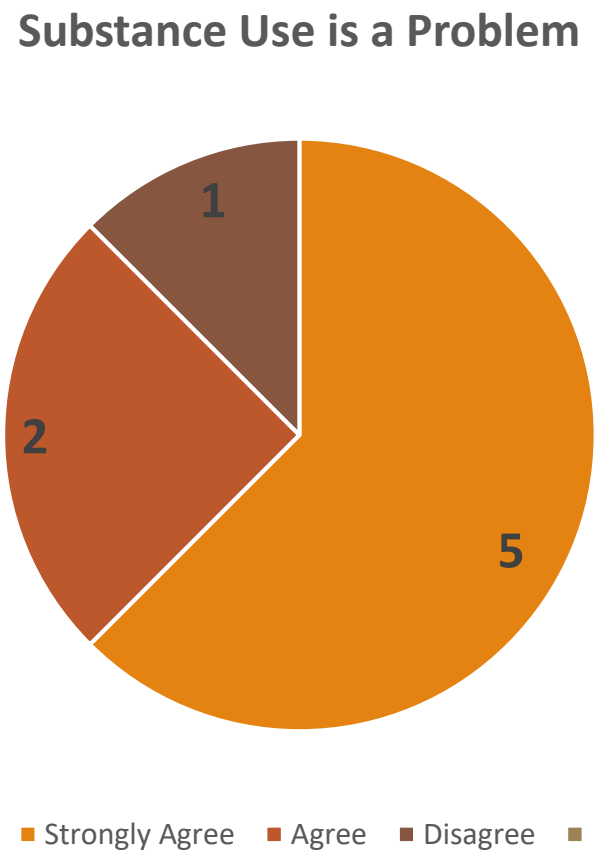
Aim 2: Hospital to Home (H2H) Provider Survey (*n*=9 Participants)

H2H Provider Characteristics	Number of responses	Percentage (%)
Care Coordinator	3	38%
Psychiatric Technician	5	63%
Employed 1-3 Years at H2H	6	67%
Employed 3+ Years at H2H	1	11%

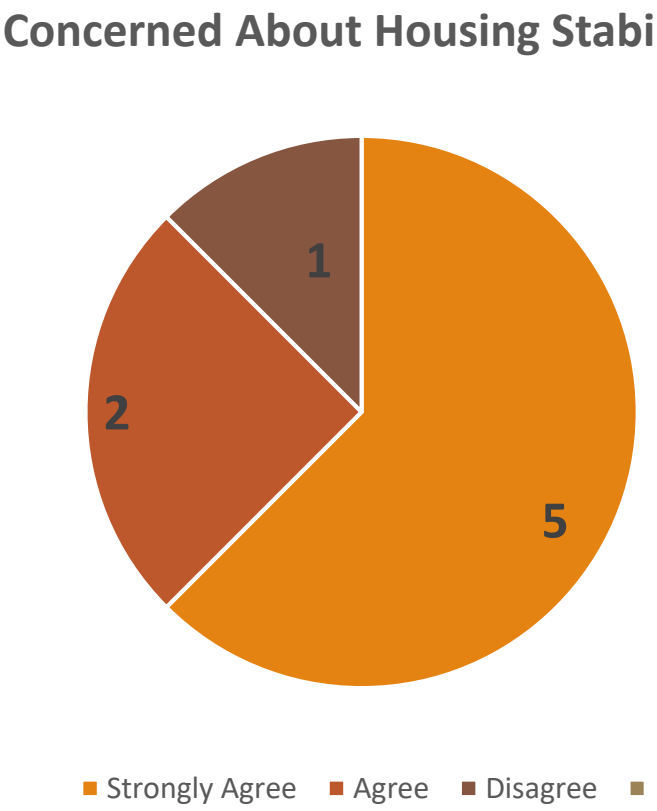
Q25.3: Psychiatric symptoms for most H2H clients are stable when they arrive at H2H.



25.4 Substance use is a problem faced by many H2H clients.



25.10 I am concerned about the housing stability of H2H clients after they are discharged from the H2H program.



Q30 - Do you believe that any of these subgroups have a more difficult time being retained in H2H program?

Subgroup	Percentage (%)	Number of Yes Responses
Younger adults (18-25 years)	75%	3/4
Persons with a substance use condition	50%	2/4
Persons who are experiencing psychosis	67%	2/3

Q39 - Do you believe that some H2H clients have challenges being adherent to psychiatric medications?

Answer	Percentage (%)	Number of responses
Yes	71%	5/7
No	29%	2/7

Comments: “Some clients are reluctant to taking certain medications.”

Q42 - How often do you discuss medication adherence with your patients?

Answer	Percentage (%)	Number of responses
Often	43%	3/7
Sometimes	29%	2/7
Not Often	14%	1/7
Never	14%	1/7

Factors Leading to High Program Engagement and Retention

All participants (100%) reported that most of the H2H clients are willing to participate in H2H program activities.

Participants reported that many of the most successful clients share the same denominator*: they were encouraged to assume personal responsibility for their progress through H2H.*

Participant comment: “Compassionate staff with great leads who understand everyone, staff or client, is human and prone to error. Leaders are willing to educate rather than punish every mistake. Many staff members are patient and feel proud in what they do every day”

Aim 3: Key-Informant Interviews

Interview Number	Location	Role	Date
1	H2H	Program Manager	8/9/2023
2	H2H	Care Coordinator	09/21/2023
3	H2H	UTHealth HOMES Therapist	08/16/2023
4	H2H	UTHealth HOMES Therapist	10/04/2023
5	H2H	Female Patient at H2H	07/17/2023
6	H2H	Male Patient at H2H	07/17/2023
7	H2H	Male Patient Discharged into Rapid Re-Housing	01/02/2024
8	HCPC	Social Services Director	09/28/2023
9	HCPC	Social Services Associate Director	09/20/2023
10	HCPC	Social Services Clinician	10/11/2023
11	HCPC	Social Services Clinician	10/11/2023
12	HCPC	Attending Physician	10/04/2023
13	HCPC	Resident Physician	09/28/2023

Aim 3: Key Informant Interviews with UTHealth HCPC Providers (Major Themes)

- HCPC needs services/supports to address SDoH both during hospitalization and after discharge
- HCPC providers believe H2H is a great program
- HCPC providers believe H2H improves housing access
- H2H not first placement choice for HCPC providers due to limited beds keeping patients hospitalized longer/long wait
- Increase H2H beds recommended
- Provide more information about H2H waitlist status so HCPC patients stay informed while waiting and don't change mind about going
- HCPC patients have knowledge and positive perception of H2H
- Women patients at HCPC experiencing homelessness are hard to get into H2H

Aim 3: Key Informant Interviews with Harris Center H2H Providers (Major Themes)

- Residents not stable at H2H intake (elevated psychiatric symptoms)
- Most residents are medication adherent at H2H
- Misinformed given to patients about H2H program at HCPC (housing may be promised—but not guaranteed)
- Length of stay is too long due to housing wait (especially for PSH)
- Not having an ID prior to H2H admission is a barrier during placement/should be obtained during hospitalization (and other social services initiated prior to H2H admission)
- Substance use is a problem for many residents
- Many Residents have trauma in their backgrounds
- H2H residents primarily at H2H to obtain housing but are not always willing to work on their mental health
- H2H residents don't understand the housing process

Aim 3: Key Informant Interviews with H2H Residents (Major Themes)

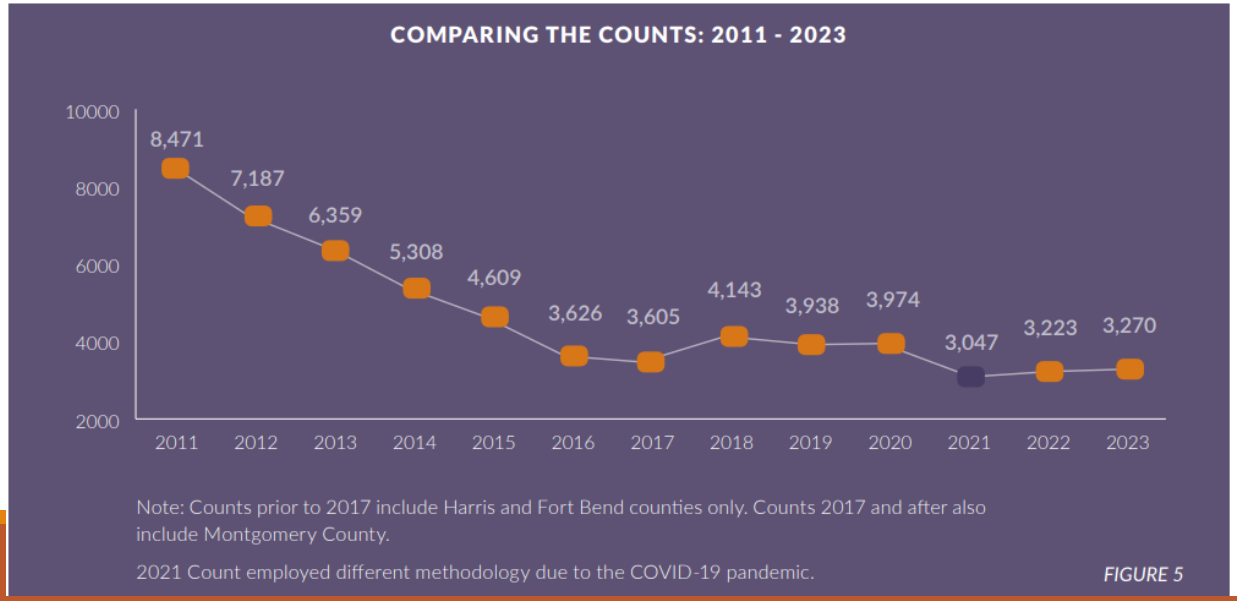
- Learning coping skills was important
- Housing process taking so long
- Supportive staff interactions
- Extended period of homelessness among residents prior to H2H admission
- Getting documents (ID, birth certificate) in order at H2H is helpful
- Reconnecting with family while at H2H
- H2H activities are helpful
- Therapy is helpful

Aim 3: Key Informant Interviews with H2H Graduate in Rapid Rehousing (Major Themes)

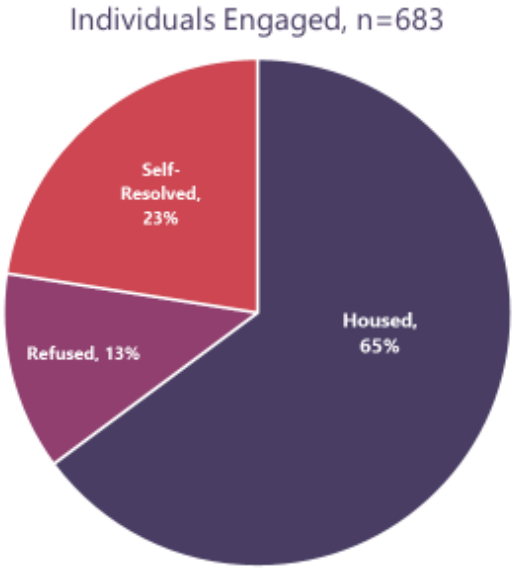
- Staff at H2H is like “having a friend”
- Long wait at H2H for rapid rehousing (RRH)
- Transportation barriers to psychiatric appointments in RRH
- Not able to fill medications on own (off psychiatric medications after discharge)
- Home support needed
- Three prior hospitalizations (one after placement in RRH)
- Unclear how RRH was determined through HUD coordinated access

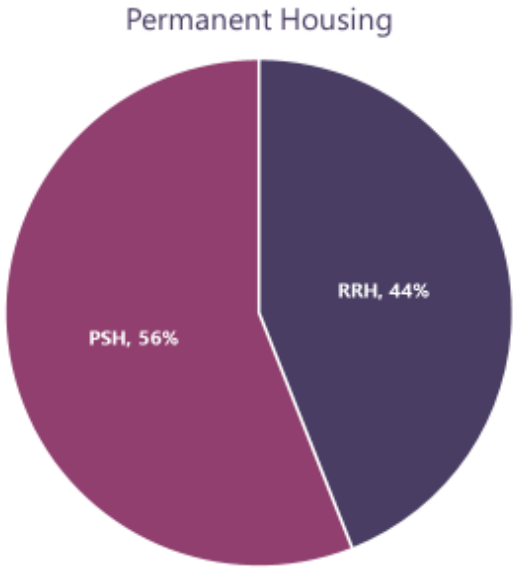
Key Policy Items and Housing Practices Unique to Houston

- **Housing First** is a major focus in Houston's homeless response system.
- **115 encampments** decommissioned in Houston since 2021.
- **62%** - Overall reduction in homelessness since 2011.
- In 2020 (during COVID) **$165 Million** ($65M + 100M) **investment** (City + County + HUD CoC collaboration) = **9,717 individuals housed**.
- Houston is a highly collaborative city with **100+ organizations led by the HUD CoC** working together to reduce homelessness (many public-private-university partnerships).



COALITION FOR THE HOMELESS





Encampments Decommissioned - 115

Summary of H2H Evaluation Findings

- H2H residents feel supported and valued by H2H staff
- Both H2H and HCPC providers reported a need for improved communication and coordination across organizations
- Permanent housing placements through coordinated access are not guaranteed and will be less available – especially for those with criminal records
- Majority of H2H housing placements were for **RRH** less for **PSH** – rental assistance is only provided in RRH for up to one year (many former H2H residents may not be prepared to pay their own rent after RRH rental assistance runs out)
- H2H providers see a need for addressing substance use and relapse prevention
- Evidence-based CBT is helping and associated with improved housing outcomes
- Disparities in access to H2H for women
- H2H wait list prohibits H2H for being a primary referral source for HCPC
- Provide social services at HCPC prior to H2H admission to get process started for IDs and other benefits (may shorten H2H length of stay and open up beds sooner)

Thank you!

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Questions