AT Home

Austin/Travis County Home Initiative

PRESENTERS:

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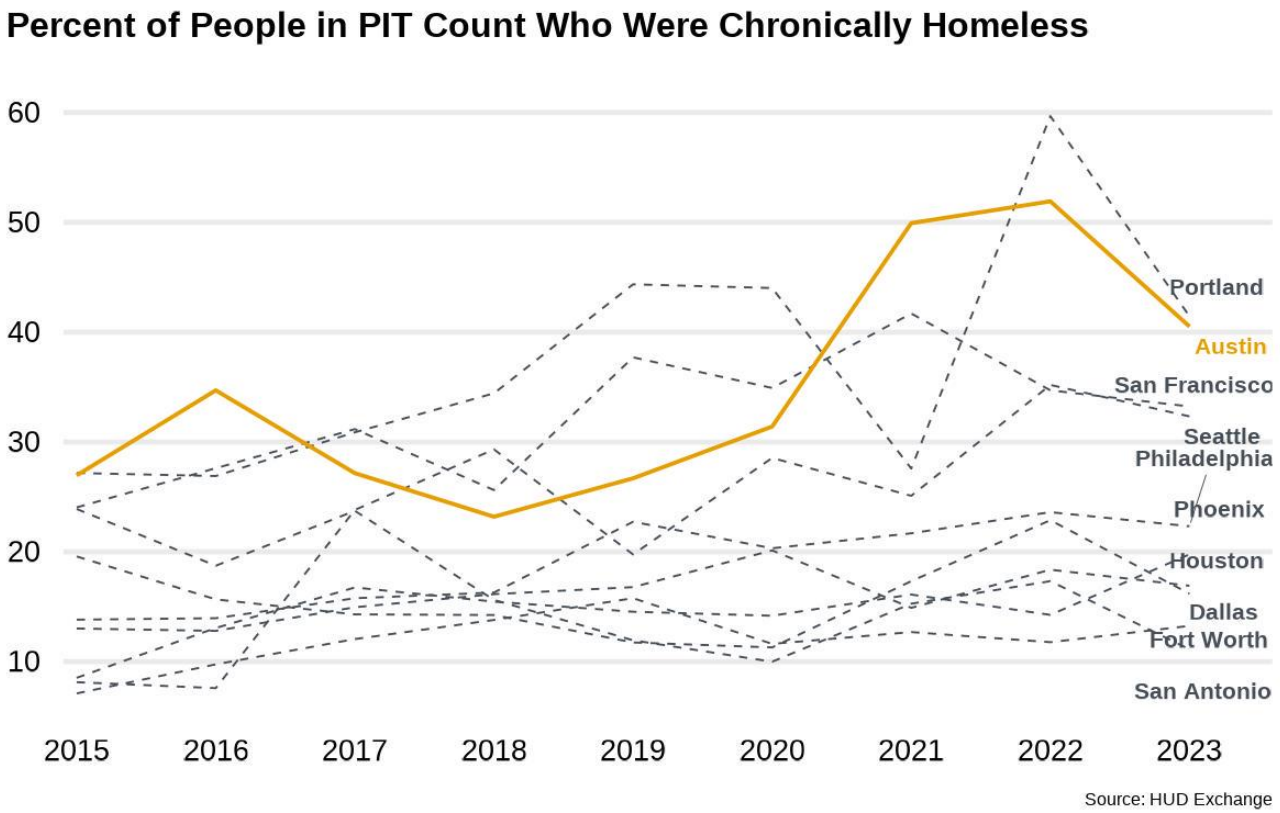
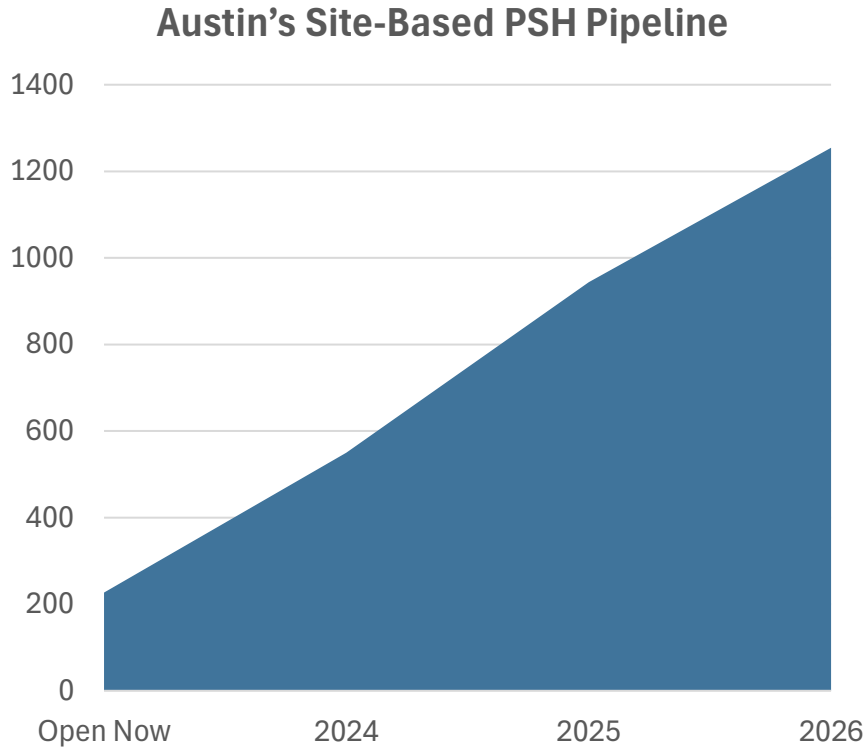
AGENDA

1. Background on Austin
2. The AT Home Initiative
3. The Launch!
4. Next Steps
5. Breakout Groups
6. Discussion

Artist: Rory Skagen

Background on Austin





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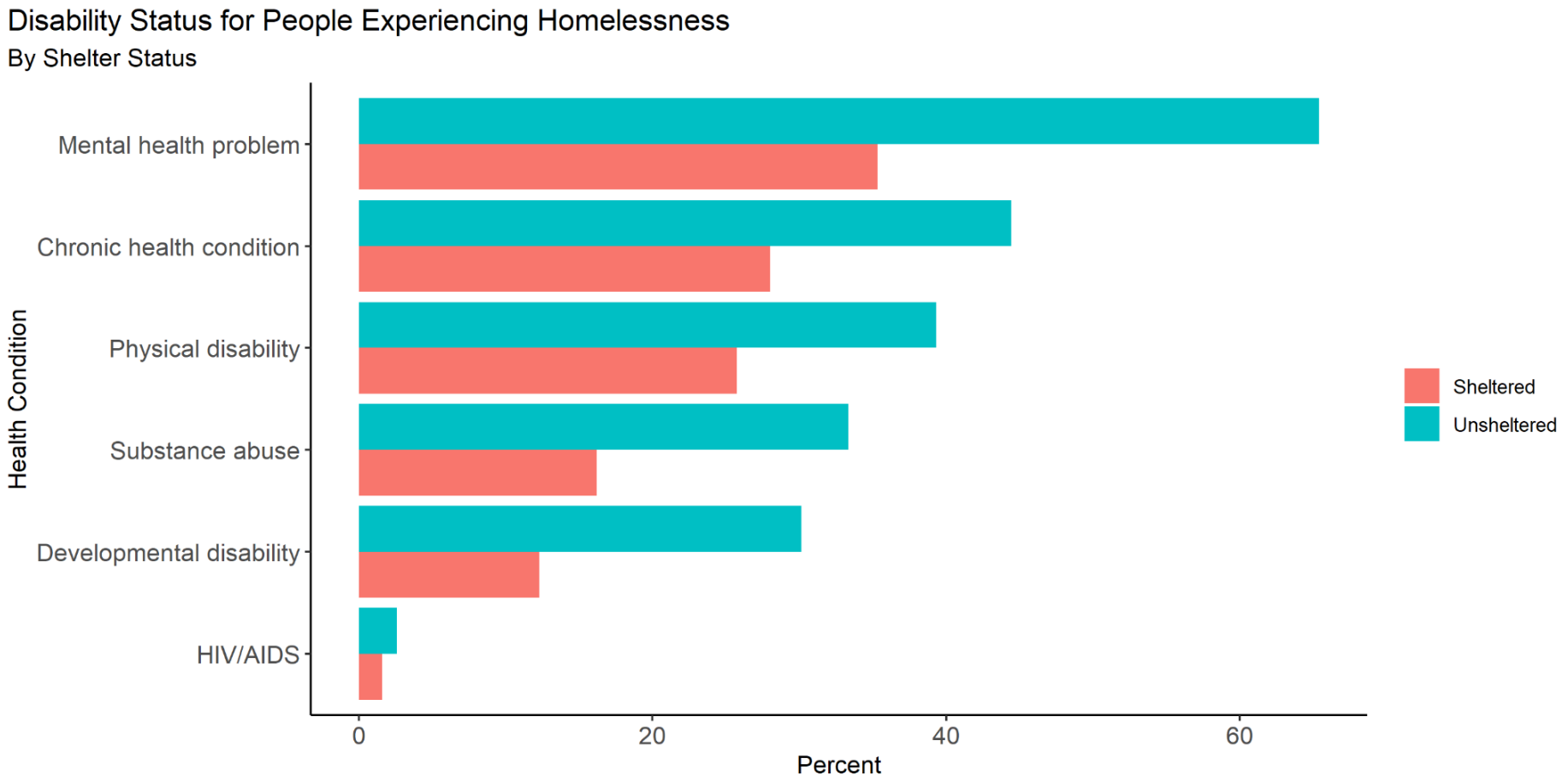

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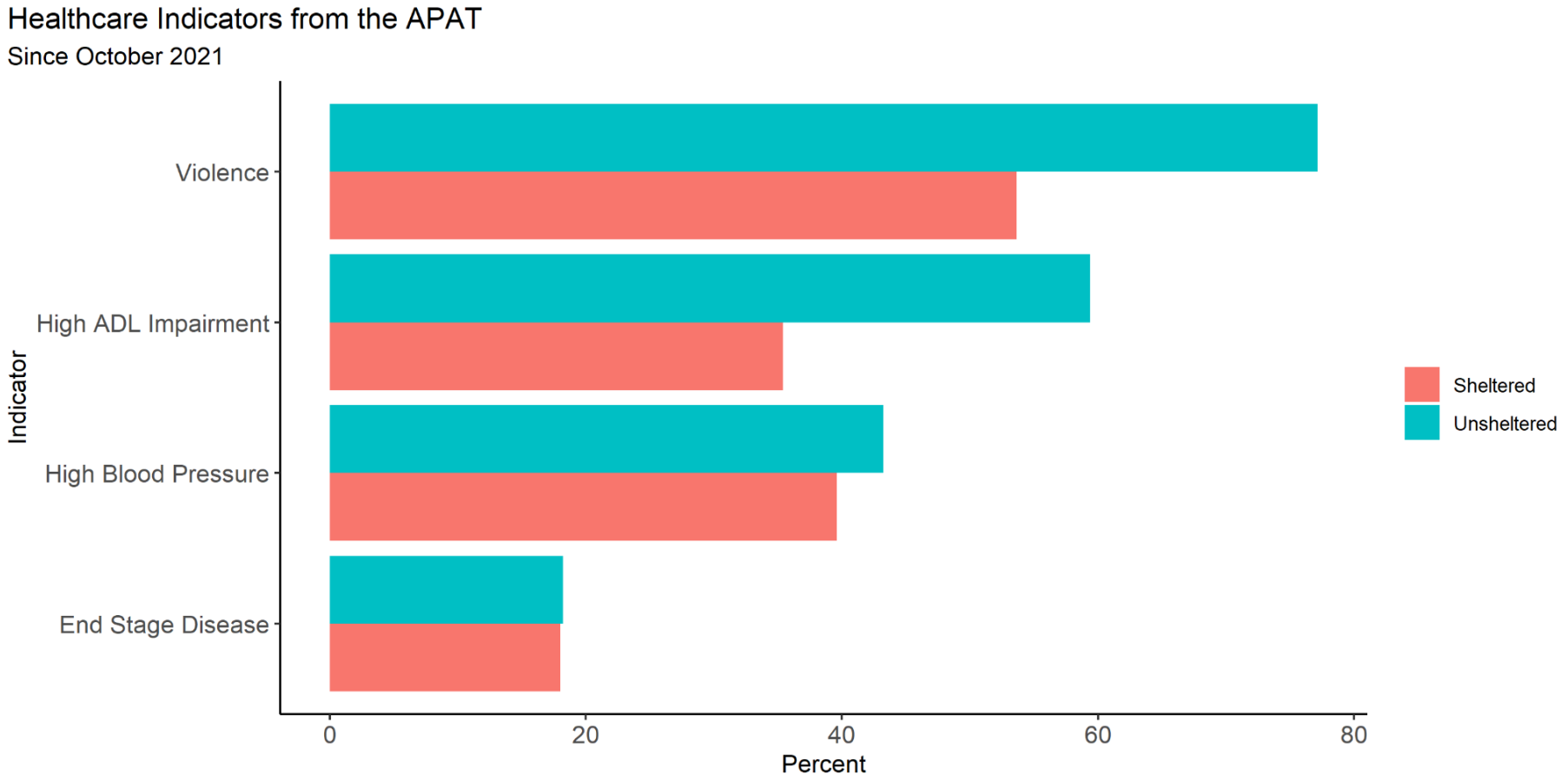

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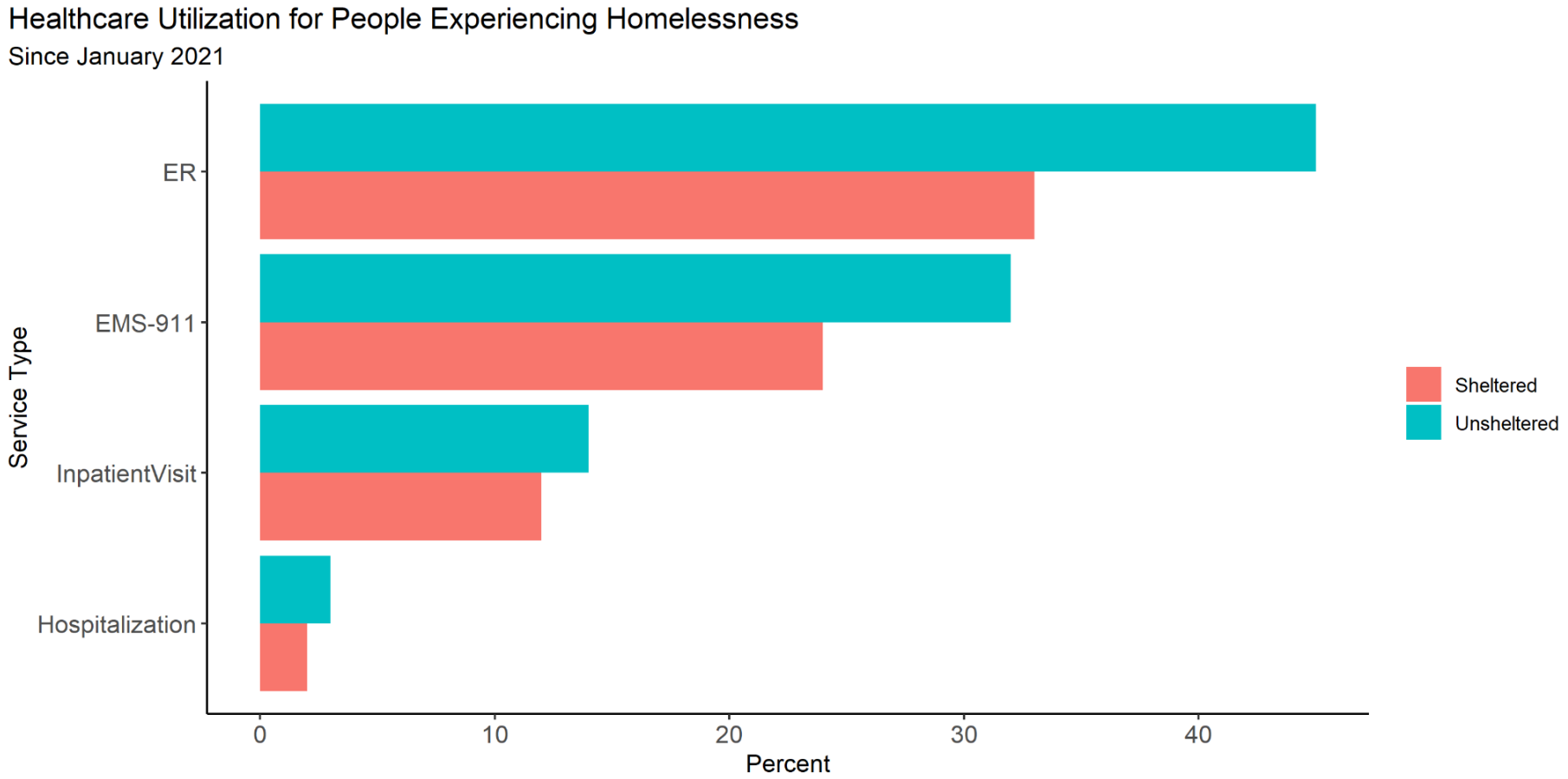
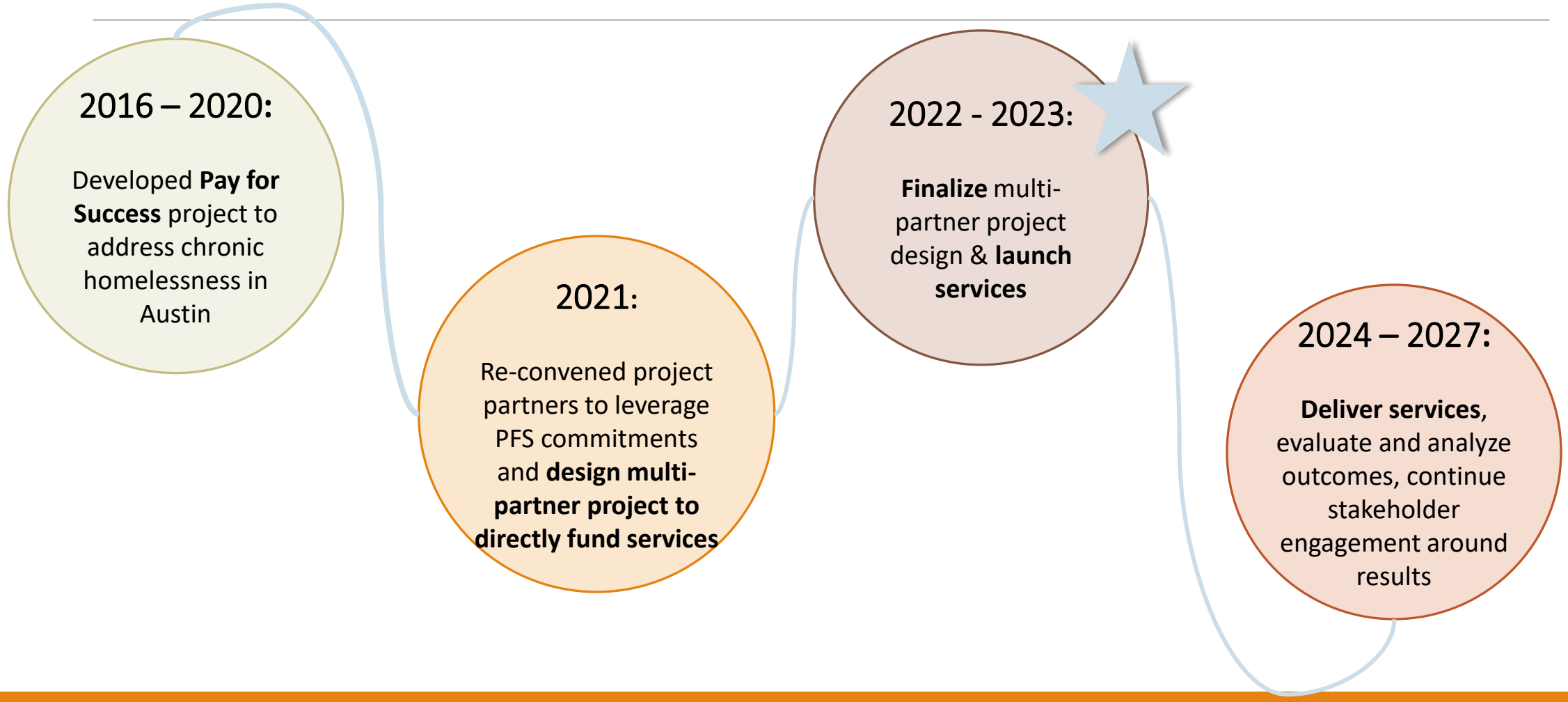


EVOLUTION OF THIS MULTI-PARTNER PROJECT

Since 2016, Social Finance and ECHO have been working across local government, philanthropy, and providers to develop and launch a jointly funded initiative to support individuals experiencing chronic homelessness in Austin



AT HOME INITIATIVE: PROJECT OVERVIEW

The AT Home Initiative is a first of its kind, multi-partner, 5-year initiative that will **bring together resources** from numerous **local governments, philanthropies and non-profits** to deliver **permanent supportive housing** to **~200** of **our most vulnerable neighbors experiencing homelessness** in Austin-Travis County. The project will launch for the first cohort of clients in December 2023 at Espero at Rutland (a new PSH community) and will ramp up over the next 3 years.

Goals of the AT Home Initiative

Deliver **measurable impact** at scale for **individuals** experiencing **homelessness**

Leverage **community partnerships** to create a cost effective and efficient solution

Foster a **data-driven system** of learning and continual improvement

Drive **greater accountability** of taxpayer resources

PSH PROJECT MODEL

AT Home is a comprehensive project spanning from wraparound services to evaluation

Funders & Partners

Austin Public Health – PREVENT. PROMOTE. PROTECT.
CENTRAL HEALTH
County of Travis, State of Texas
ECHO
CommUnityCare
St. David's Foundation
SOCIAL FINANCE

Services:

Permanent Supportive Housing (PSH) with wraparound services including:

- Intensive **case management**
- Dedicated **mobile medical** services
- **Behavioral health** services, including substance use counseling & peer support
- Access to benefits & employment
- Move-in assistance

Clients

We used a data-driven approach to analyze Austin's by-name list and identify the most vulnerable clients

1. **Travis County Resident**
2. **Medically vulnerable**
3. **Chronically homeless**
4. **Below 200% FPL**
5. **High utilizers of public systems**

Outcomes & Evaluation

A rigorous evaluation will be conducted to better understand the effectiveness of the intervention, including:

- Long-term **housing stability**
- **Health outcomes**, including reducing inpatient hospitalizations and ER visits
- **Recidivism**

AT HOME FUNDING STRUCTURE & COMMITMENTS

2-phase project launch leverages units coming online at Espero, and will expand to service ~200 individuals

City - $6M

City will fund **PSH service provider(s)** via direct award (phase 1) and competitive solicitation (phase 2)

County - $3M

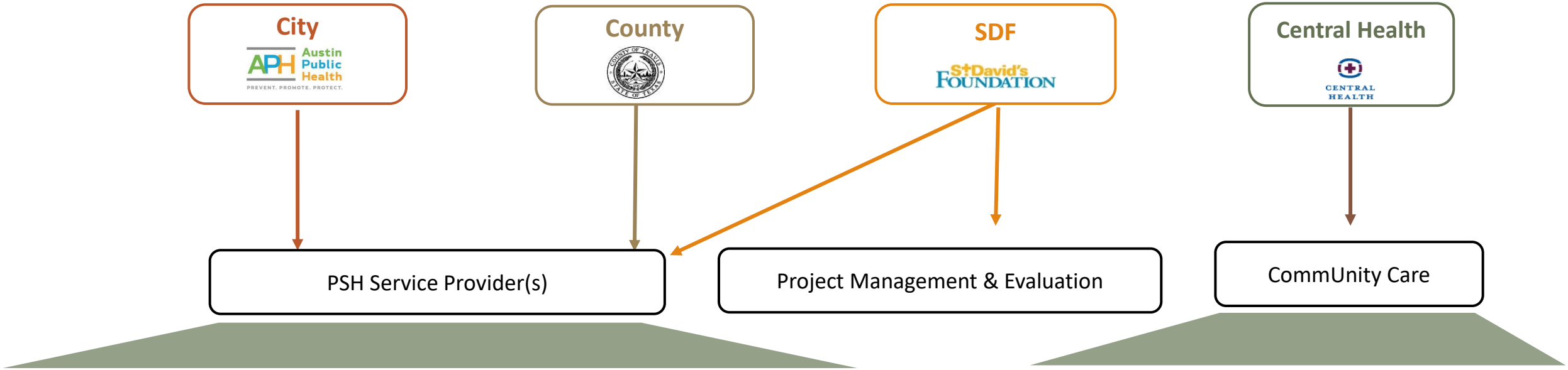
County will fund **PSH service provider(s)** via direct award (phase 1 and phase 2)

SDF - $4M

SDF will fund **client needs** and other gaps in the budget, as well as **project management and evaluation** costs

Central Health - $3M

Central Health will provide **dedicated capacity** for **mobile medical unit** (estimated costs ~$3M)



PSH Provider Contracting:

- **Phase 1:** City and County make a **direct award** to **Caritas Espero**.
- **Phase 2:** City to launch competitive **solicitation** to procure PSH provider(s) to serve the remaining **project clients to reach scale.** County to "piggyback" on City solicitation.

Medical services launch: CH and CuC have aligned on roles for initial medical services team and will be putting out JDs in coming weeks. Services will be delivered on both phase 1 and phase 2

Shift in Identifying Population to Serve:

Spotlight on Medical Severity and Hospital/ED utilization

	Race/Ethnicity	Diagnosis	ED visits/ 3 mo	CA
1	white	Anxiety	38	none
2	hispanic	CHF	14	none
3	white	SUD	13	11
4	hispanic	Chest pain, anxiety	13	none
5	black	CKD,HTN	12	12
6	hispanic	SUD, bipolar	11	12
7	hispanic	HTN, DM	11	6
8	hispanic	SUD	9	10
9	white	Chest pain, anemia	8	11
10	black	Schizophrenia, SI	8	9

Data from our local hospital "county equivalent" of top utilizers of ED and Hospital

1) 30-40% of patient did **not** have a coordinated assessment score or was outdated.
2) CA Scores did **not** correlate with severity of medical illness-
3) More than 50% patients never made it to their follow up appts (PCP, specialty, MAT, wound care)

Meet Mr. W

53 yo man with cirrhosis and ascites

2021- 12 ED visits, 1 hospitalization
2022- 10 ED visits, 6 hospitalizations

Ascites requires medications (diuretics) to help remove fluid from the abdomen. These medications are challenging to take when experiencing homelessness.

Admitted to medical respite for 137 days- able to maintain sobriety, start taking medications. No ED visits or hospitalizations after 2 months of stabilizing on his medications.

Childs Pugh Class B-->C
CA score=12

Points	Class	One year survival	Two year survival
5 – 6	**A**	100%	85%
7 – 9	**B**	81%	57%
10 – 15	**C**	45%	35%

1. R N Pugh, I M Murray-Lyon, J L Dawson, M C Pietroni, R Williams. Transection of the oesophagus for bleeding oesophageal varices. Br J Surg. 1973, 60(8);646-9 PubMed Link

PRIORITIES FOR ELIGIBILITY

While selecting project terms, partners aligned on priorities for the target population for AT Home – with minimum criteria and a focus on populations with complex health needs and contact with the criminal justice system

Baseline Criteria

Minimum Criteria

- Meets HUD chronicity criteria**
- Travis County resident
- 200% below FPL

Potential Additional Priorities

Complex Health Needs

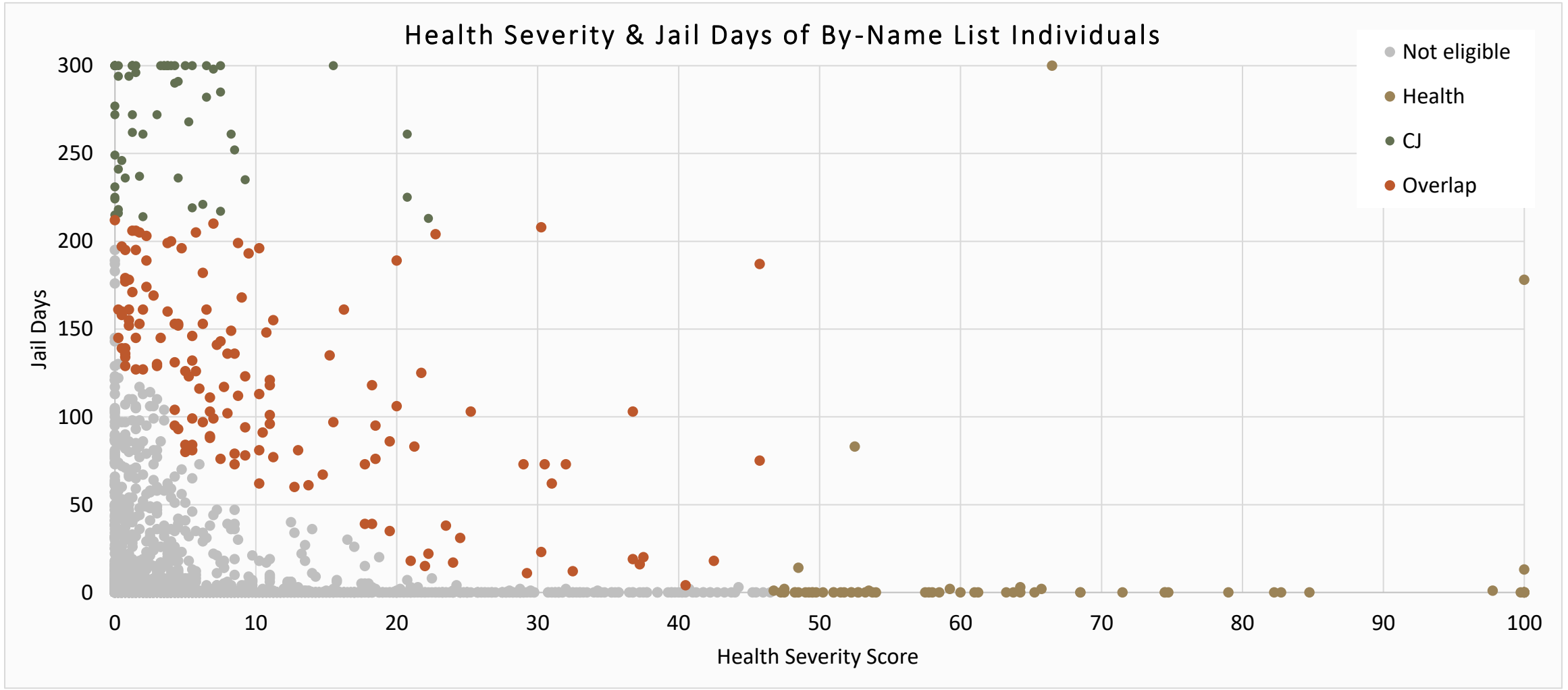
- High ER Utilization
- Frequent inpatient visits
- Complex health conditions
- Co-morbidities; Tri-morbidities

Contact with the CJ System

- Frequent jail bookings and/or citations
- High number of jail days
- Other specific needs (e.g., individuals that need housing to be released)

HUD Chronicity criteria: A homeless individual with a disability as defined in section 401(9) of the McKinney-Vento Assistance Act (42 U.S.C. 11360(9)), who:; Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter, and; Has been homeless and living as described for at least 12 months* or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described. (See Addendum for more detail)

AT HOME ELIGIBILITY VISUALIZATION



ELIGIBILITY: SUMMARY

The refreshed eligibility criteria consider broader funder and community goals, allow for additional flexibility in which utilizers we enroll into the program, and prioritize individuals who may not already have access to housing.

Funder Goals

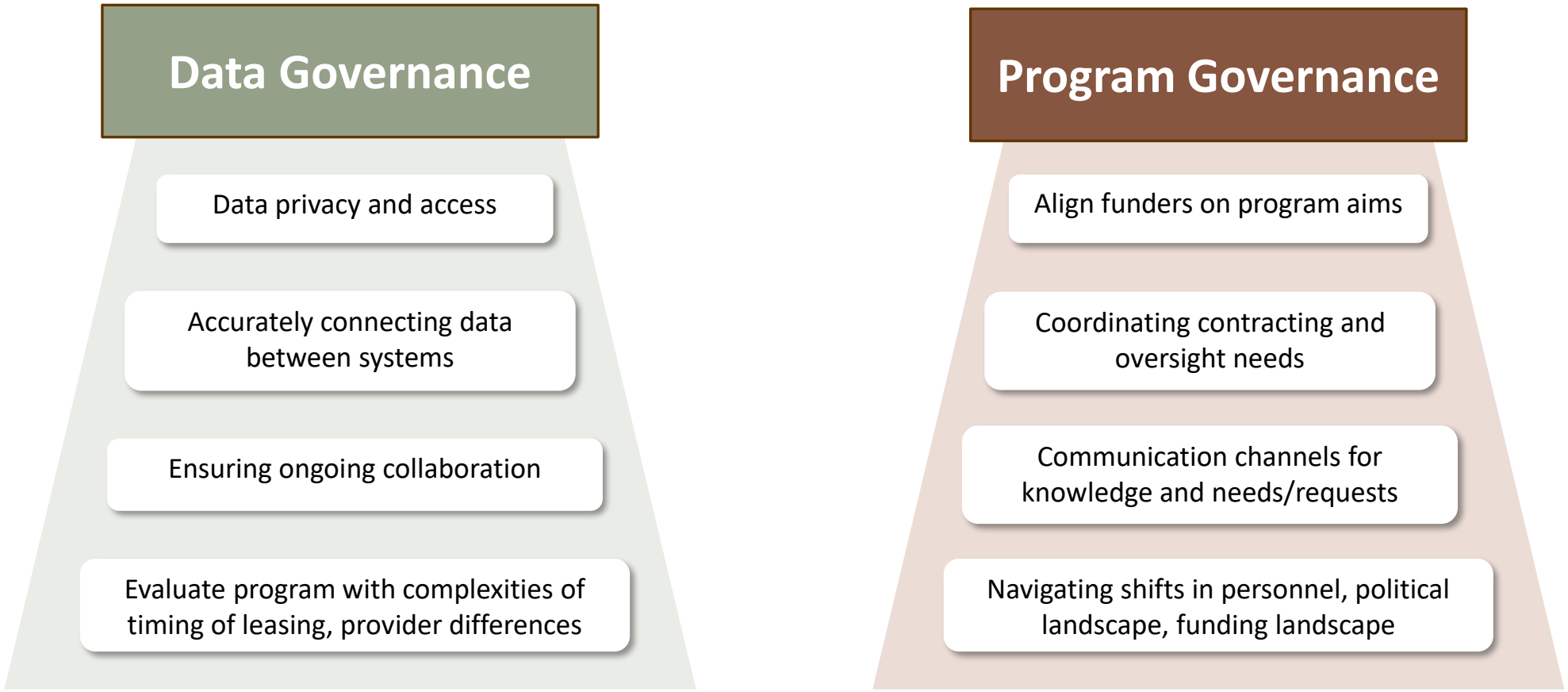
- Prioritize **highest need clients**, including those individuals utilizing public systems
- Allow for the flexibility to serve individuals who **are not currently prioritized** for housing
- Ensure a **sufficiently broad population** to meet the overall enrollment targets for the project

Proposal: a multi-pronged approach that includes **individuals experiencing chronic homelessness** across **three different subpopulations**

Health Need (25%)	Criminal Justice Need (25%)	Overlap Group (50%)
• Ranks each client based on a score that includes: ❑ ER/EMS visits; ❑ Inpatient stays; ❑ Health diagnoses • Selects the top 1% of clients (~75 Individuals)	• Ranks each client based on their jail days • Selects the top 1% of clients (~75 individuals)	• Ranks each client based on a combined health and criminal justice score • Selects the top 4% of clients (~150 individuals)

*In total, this translates to **266 individuals** total (based on March data). The group has an average of **141 jail days** and an **"health severity score" of 23.8** (see appendix for scoring), and an average APAT of 9.1.*

Planning & Governance Structure



AT Home Launched in 2023

Mobile Medical Team Planning

Home visits by street team

Mobile team- onsite clinic

RN liaison to HCH team/CUC

*No gold standard of core components of PSH:

Hybrid Street/Mobile

- Provider
- RN (with wound care experience)
- MA-MAC x 2
- CHW
- Psych NP

Provider
MA

Psych NP
MA

RN
CHA

Early Experiences with Program Startup

Operations and planning support

Program launch

Planning for an Evaluation

Research Questions

- ***RQ1:*** Did AT Home lead to the following outcomes among program participants?
  - Long-term housing stability
  - Better healthcare outcomes
  - Decreased recidivism
- ***RQ2:*** What components of the program contributed to housing stability, better healthcare outcomes, and decreased recidivism?
- ***RQ3:*** How did participants' experiences with the program affect the outcomes above? From the perspective of participants, was the program a success?

Planning for an Evaluation

Evaluation Highlights

- ***Process:***
  - Contracted with a third-party evaluator (at UT-Austin).
  - First contract just for the research design; subsequent contract for the 5-year evaluation.
  - Implemented data-sharing agreements; shared data from external non-HMIS sources.
- ***Timeline:***
  - Research design started in April 2023.
  - HUD/Urban Institute approval of research plan in March 2024.
  - Five-year evaluation starts in April 2024.

Next Steps in Implementation

Solicitation

Governance Structure

Data: Defining your priority population and navigating data sharing challenges

Performance: Using outcomes to monitor performance; building a business case for investing in Permanent Supportive Housing

Collaboration: Building structures to collaborate and engage in shared decision-making across multiple partners

Healthcare: Prioritizing and serving individuals with high health needs

Breakout Groups