Community Health Improvement

Health to Home: A Pathway to Healing Collaborative

Achievements | 2024

Program Objective

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

Statement of Need*

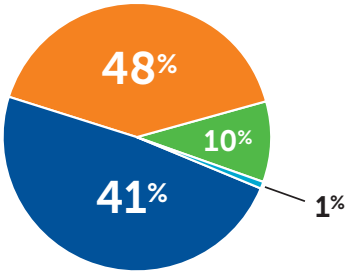
- Homelessness is increasing across the nation. According to Doran et al. 70.3% of all hospitalizations of homeless people result in either readmission on an emergency department (ED) visit within 30-days after discharge.
- There is evidence that medical respite care reduces future hospital admissions, and length of in-hospital stay among unhoused people discharged from an acute hospitalization. It also enables the linkage with other financial and housing services that benefit the whole person.
- According to the Texas Homeless Network, through the Texas Homeless Data Sharing Network (THDSN) and Homeless Management Information System (HMIS), only 18.3% of the general homeless population exited homelessness over the 2024 year.

Demographic of People Served

RACE OF ENROLLED PARTICIPANTS

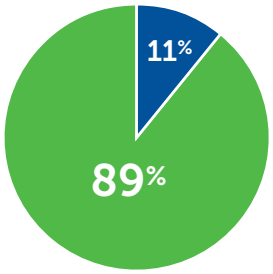
N=93

- Black/African American n=45
- White n=38
- Two or more races n=9
- American Indian/ Alaska Native n=1



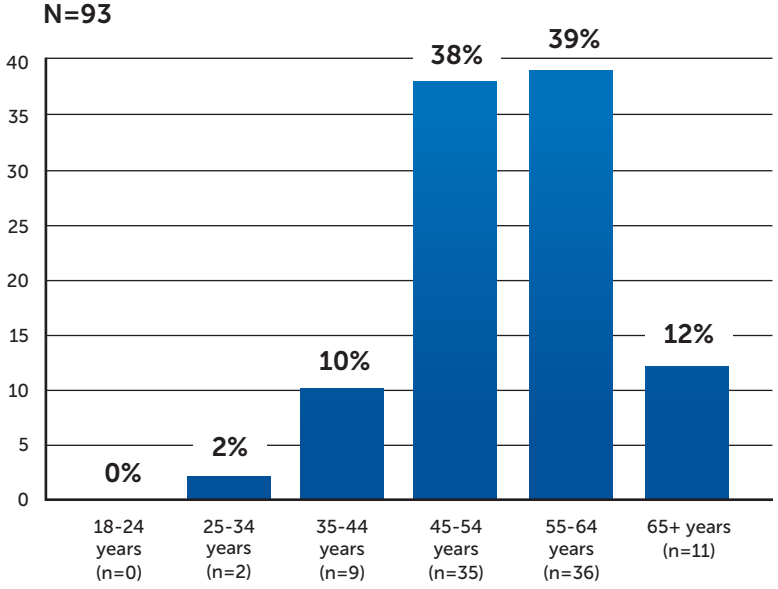
GENDER

- Female n=10
- Male n=83



AGE GROUP BREAKDOWN

N=93



* Statement of Need sources:

Texas Homeless Data Sharing Network Data Dashboard https://www.thn.org/thdsn/data/

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

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

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Texas Health Community Hope

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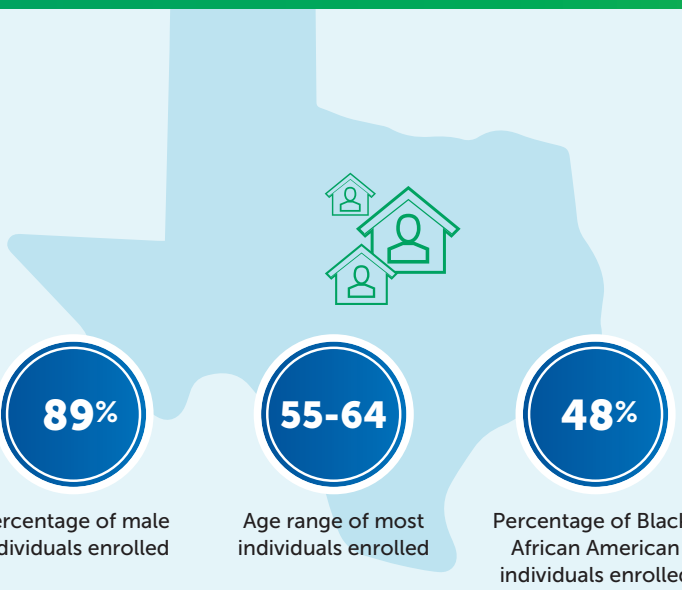

89%
Percentage of male individuals enrolled

55-64
Age range of most individuals enrolled

48%
Percentage of Black/ African American individuals enrolled

Health to Home is a collaborative program between Texas Health Presbyterian Hospital Dallas (THD) and Austin Street Center (ASC). Since its inception in late 2020, the program enrolled and served 373 unhoused individuals.

In 2024, 93 individuals enrolled in the medical respite unit at Austin Street Center, where they received medical care, case management, navigation, and housing support. Key indicators as shown on the left for 2024.

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

Activities/Output

Out of 93 individuals enrolled in Health to Home:

84	Engaged in case management services
7	Connected to a primary care provider or a patient-centered medical home
8	Received behavioral health services with community partner, Integrated Psychotherapeutic Services (IPS)
8	Received job training
1	Job placement

Outcomes

41% Participants were connected to an appropriate housing solution (24/59)

Observations among 8 participants from THD were:

564% Return on Investment (ROI) for every dollar spent on each participant that graduated from the program

97% Decrease in total charges 6-months pre intervention vs. 6 months post-intervention ($521,386.52 vs. $16,470.03)

86% Decrease in total hospital visits 6-months pre-intervention vs. 6 months post-intervention (22 vs. 3)

Housing Solution

0 Connected to transitional housing for homeless persons

4 Connected to long-term care facility or nursing home

1 Connected to residential project or halfway house with no homeless criteria

7 Connected to rental by client, with RRH or equivalent subsidy

1 Connected to rental by client, with other ongoing housing subsidy

1 Connected to rental by client, with no ongoing housing subsidy

10 Participants staying or living with family or friends

35 Participants who exited program to homelessness

MB 3412 5/25