Transcript for Creating Pathways to Stability

We're really excited to have such a collaborative team to present today, and we're hoping that other communities can listen in to get some great ideas.

So, it's my pleasure to introduce the Partnership to Reduce The Emergency Department

Our first speaker is Melissa Danielle Perez and she'll be speaking first. Then, Suzanne Jarvis will [speak when Melissa is done] presenting. So, Melissa…

Melissa Perez-Halley: Hi, my name is Melissa Perez-Halley and I am a social worker and the population health supervisor that directly oversees the frontline staff for community health workers that consist of our multi-visit patient program. I will be co-presenting with Suzanne Jarvis, who is the director of data management and program analytics for Houston Recovery Center.

I'm really looking forward to speaking to you all today.

So, first off, our objectives. We'd love to provide a high-level overview of the multi-visit patient method, describe the importance of a definitive timely linkage and transforming care for our multi-visit patients and how we have co- created that process with the Houston Recovery Center.

And, then, I'll touch on some articles that have highlighted our shared success, and then Suzanne will go into some of the more specific patient stories.

First off, a little bit about Harris Health System. It is the third largest safety net system in the nation. It's located in one of the largest and most diverse metropolitan areas: Harris County, which includes Houston.

It consists of 16 ambulatory care clinics, three same day clinics, seven specialty clinics and then, of course our two hospitals, Lyndon B. Johnson (LBJ) and Ben Taub, which is where our program is based -- out of those two hospitals.

First, an overview of the multi -visit patient method. It's a method that is centrally focused on the multi-visit patient and other organizations or systems. They're often referred to as frequent fliers or super utilizers.

We go with the term multi-visit patients. It is a term of ours that was created by Dr. Amy Boutwell, which I'll speak of in a minute, but it is patients with a combination of medical, behavioral, social and systemic factors that have contributed to perpetuating their cycle of recurring utilization in, and it can occur in the emergency room or the inpatient setting.

As you can see, they're defined by high utilization, high costs and they are high risk, again, in the inpatient or ED setting, and they have that confluence of the medical, social, behavioral and systemic barriers.

The core of the MVP program, or method, is that it views high utilization as a symptom. And what we set out to do our -- community health workers -- is to find out root cause and effectively address it by engaging the patient where they come, which is the acute care setting in the ED, and collaborate across the continuum of care with internal and external agencies, little by little, overtime, to achieve that stability.

It consists of six steps in the care pathway to identify in real time, which is done by our [electronic record system] EMR. We work to assess, again, that driver of utilization and effectively engage the patients, building that relationship.

Then this key part is “definitively link.” We use that term “definitively link” as opposed to “refer” because we try, as you'll see with youth recovery centers, to build out that warm handoff as much as possible or it's like an integrated sort of transfer of relationship from the emergency department to the appropriate partner.

Of course, we hope to achieve stability or assist our patients and achieving stability over time, but much like the recovery model, we plan for the return in the way that relapse Is something that is part of the recovery model. Planning for the return is a key part of the care pathway because our patients are super vulnerable and they're constantly at this precipice of being stable versus unstable.

The multi-visit patient program method was developed, by Dr. Amy Boutwell, and she has implemented this in over 250 systems across the nation

All right. What does the MVP program look like at Harris Health System, specifically regarding our substance-use patients? So, in Quarter 1of 2023, we had 37 MVPs with substance use as their driver utilization. Again, the core root cause of why they're coming in. They may come in with altered mental status or trauma from a car wreck, but we know they're fundamentally coming in because they have substance use disorder. In the Quarter 1, they generated 182 visits across Harris Health System.

There are 61 MVP ED visits, monthly, directly tied to substance abuse, and obviously it decreases throughput. They use emergency center (EC) psych resources and take away from patients who have quote, unquote, “true medical emergencies.”

And then you see that kind of breakdown there. The majority are coming to Ben Taub, but we also have a fair amount that are coming to LBJ, as well.

How are we working together?

So, here's a short history of our collaboration. We knew we were going to need the Houston Recovery Center in our pocket from the beginning. So, in 2019, as we were implementing our

own method, we had already started collaborating with the Houston Recovery Center. Then, in 2020 to 2021, we focused on the ED and building out that care pathway where Suzanne has her “pit” team. And they actually bring a van, they come pick up the patients and they take them directly to the Houston Recovery Center.

Then in 2021 to 2022, we continue to improve our operational process and develop more of like a back and forth that we knew a little bit more regarding what happened to our patients after they went to the Houston Recovery Center.

And then 2022 to now, we continue to deepen our collaboration and iterate to improve your pathways for our patients. One of the more recent things we're doing is focusing on the reduced use pathway, as opposed to abstinence only, in order to make sure that all of our patients that have substance use as a barrier have a variety of options for recovery.

So, the MVP and the Houston Recovery Center collaboration again focuses on this patient population and using creative solutions to problem solve.

Key concepts are, again, identifying the population in the root cause, linking them to the Houston Recovery Center, building that relationship and then co-managing the patients over time. And, then, in return, obviously it, it hopefully reduces the use and stabilizes the patient to improve their quality of life.

The keys to success have been clear eligibility requirements, accurate screening for patient readiness and eligibility, again, that pit team, that warm handoff to the provider, coordinated communication between agency teams, redirecting patients to providers to establish relationships and have consistency and then, again, of course, ongoing quality improvements.

Highlighting some of our successes, we have articles [you see] the health affairs article, “ A New Way to Support Frequent Emergency Department Visitors,” and the Houston Chronicle, “Harris Health MVP Program Helps Curb Over Reliance On Hospital Emergency Departments.”

In summary, the MVP initiatives goal is to address the underlying needs of the patients to improve their quality of life outcomes, decrease utilization and improve throughput.

Houston Recovery Center’s collaboration goal is to build a relationship with the patient and determine what the best next steps are collaboratively.

And, again, it's patient led, so what their goals are, or what we work toward, we assess engage over time. And then, the collaboration has proved, uh – and I believe Suzanne again is going to touch with the numbers a little bit more specifically -- but over a 180 linkages over these past few years.

All right, Suzanne, I'll hand it off to you. Thank you so much for your time.

Suzanne Jarvis: It’s awesome Melissa, thank you. It's great to be with everybody today. Thank you for inviting us to speak.

So, when you go through this presentation with me, I want you to kind of keep in mind how important the training of the staff is and making these successful linkages, matching the eligibility of the client to the service that they're being linked to. And that we really can shift the relationship from the emergency department to communities providers for drivers of utilization.

I'm going to give you a quick overview of what we do, why we were founded, the two different recovery pathways – abstinence and reduced use -- the MVP partnership and then we want to show you some of the impact on client stories and on the system itself.

We were originally started by the city of Houston to address public intoxication as a jail diversion program. So we were set up to divert individuals from jail to reduce the jail population to preserve law enforcement resources. And now we're talking about preserving medical resources. This is where the conversation comes in, and to stop the cycling of folks going through these systems with substance use disorders.

We started in 2013, and so our mission is to provide compassionate care to underserved individuals affected by substance use through early intervention and community care coordination to help them achieve lifelong recovery.

So, the early intervention part is identifying the problematic used in the community. And that's why it's so critical to have partnerships like MVP with Harris health system, they're identifying this in your system and sending over to us and then we coordinate the care of individuals in our recovery program. We've served more than 42,000 people to date.

So, we've created a comprehensive service system very quickly. We started with our sobering center to a 24/7 facility for public intoxication. The main driver of that was law enforcement diversions. Nine percent of the population was cycling through the center on a regular basis. Nobody was managing them in the community. They are a highly complex population, so we started a long-term recovery program for them and it’s free of charge. All of our services are free of charge.

And, we stabilize them. If they want abstinence to treatment pathway, and we reintegrate them into the community. And then we have a third service, which is a street outreach van -- Melissa referred to -- and we actually place staff in the criminal justice system and we actually go into emergency departments and work with individuals who have been admitted for overdoses, and [we have as a community] walk ins for services. And you can see 50,000 admissions, 4,400 enrollments and 16,000 encounters on the street. So, this is a proactive intervention in terms of identifying the problem in the community, and then this is the stabilization pathways that we have.

This is what our service model looks like. Most people end up in substance use recovery because they self-select to go in, but what we're doing is we're finding problematic use in the community, engaging those folks,- building a relationship, like what the emergency department

is doing with MVPs, and then assessing engaging and matching them and actually doing direct warm handoffs and linkages into the community. And, when they enroll in our program, we try to have them stay with us for 18 months or more, and I'll explain why. They're managed by a case manager and peer support.

So, our sobering center is a short-term stay for public intoxication. Very quickly: they have to be 18 years or older. We accept alcohol and other drugs. Bath salts, flakka and PCP are a flag for us because they can create instability in the client population, so we may turn someone away if they're on those substances.

[Our clients] have to be non-combative and mentally stable. If they have a mental health issue, and they have their meds, that's fine. [Our clients have to be] ambulatory -- they have to be able to get in and out of our class, you'll see pictures of our environment, and they have to pass a basic medical screening. We are not a medical facility. We have basic EMTs and peer recovery support specialists or recovery coaches that actually operate our sobering center. Our no admission rate is 4%, triage rates is 3%, so we're doing a pretty good job at managing complex folks coming through our system.

This is where we do the screening to see if they can come in and be admitted into our center. The brief medical exam is done there. These are the dorms; men have 68 cots, women have 16 cots. They have private bathrooms, as well as outdoor place to stay and this is the control area for the staff. If someone is in our sobering center, staff stay in there while they are sobering up with us.

I just explained this whole process. The average length of stay is four-to-six hours. The peers are discussing recovery options to identify if they have an issue. We offer our recovery program or telephone support. We will directly connect them to resources that are needed. I'll talk about the holdovers on another slide.

So in Partners in Recovery: there are two pathways that the clients can go through. The abstinence pathway involves detoxification treatment, transitional housing and then placing them into some type of permanent housing. And this is how substance use is stabilized in the community; these are all provided by individual service providers. Normally, someone enters, they complete the service, and then they go to the street. They have to go into treatment; they complete. They go to the street. They go into housing; they complete. They go to the street. So there are a lot of gaps in care to stabilize someone. And with the population that we're serving, they are very, very complex. They cannot navigate this pathway by themselves so we do that. We manage them in the community. They need identification medications, they need to have transportation and be ambulatory to get into these environments.

So not only are there eligibility requirements for Harris Health to send them into our sobering center -- not only do they need to meet that eligibility -- but we have to make sure that the clients meet the eligibility of the other places that we are sending them. And there's also wait periods between all of these services.

If we can't continuously get someone into state-funded beds, because most of them are uninsured, then we have to bring them back into the sobering center to wait until we can place them again. So this is a system of management and holdovers to get the population through this abstinence pathway. And we like to work with the population for 18 months, or longer, for folks who want us to abstain from using substances, because the longer they stay in that abstinence state, the return to use rates decreased dramatically to 20%.

If you look at three months of treatment, if someone were to go in that long (our population doesn't go in that long), but if they go into treatment for three months, 90% of those folks are going to return to use.

Return to use isn't a bad thing. They are re-learning how to live life without using a substance, but to get the rate at a lower level, it ensures more success in community integration. When they get to a five-year mark, they're considered entering the “long-term phase” of recovery, much like cancer. If someone remains cancer free for five years, they're considered in remission. The same thing happens with substance use disorders. So that's why we like an 18-month benchmark. We have been working with clients for up to seven years.

Um, the reduced use pathway, you're going to see some cases that I'm going to show you. Most of those cases are starting at the age of 10, 11, and 12. And, these people are in their 40s 50s and 60s, so they've had a lifetime of use and abstaining from use. Their bodies are so dependent and adapted to the drug, alcohol being the primary drug, that it's very difficult for them to quit all together, so we build a relationship with them. We [follow our clients’] goals and we get them into some consistent, stable housing. We wrap services around them; we offer them recovery, coaching and peer support. Most of them are homeless, so they have the ability to adapt to a housing environment. It takes about six months [or more] for this for this to happen. So, what happens is, they're use naturally reduces and then their system utilization naturally goes down.

So, let's see who we get from the hospital system into the sobering center. This age graph is inverted. Most of the clients we get are 37 and younger, and then it adverts down, but in the hospitals, the age is distributed across all of these different age groups.

Alcohol and cocaine are the primary drugs coming in; we do get marijuana. Methamphetamines is a big threat in Texas and we've seen a rapid increase in meth. This is where we find our opioid population. Synthetic cannabinoids has has gone down, but the polysubstance use rate is 37%. In the community setting, through law enforcement diversions, polysubstance use is 9%, and in the criminal justice system, it's almost 70%. This is an indication of high dependence and full addiction.

The medical conditions that they come with are hypertension, asthma, seizures and diabetes. So, it’s chronic conditions they are self reporting. The social profile is very complex. Very high rates of being arrested, low income, homelessness, mental health and trauma, and they normally do not have a PCP and they normally are uninsured.

This is a very complex population. This is the profile actually of the frequent clients -- we can't call them MVPs because we will get mixed up with the MVP program, but the folks that are coming through on a regular basis and it's what our recovery program was designed to manage.

So, the MVP partnership, why are we doing this? Because the major bulk of the cost of a client cycling through emergency services happens in in the EMS and the hospital. So, this graph shows, we sent over eight years of our population to a third party to cross analyze their activity across sector analysis, and we found out that close to 11,000 of our clients had close to 56,000 transports to 65 different hospitals.

This graph shows, the breakdown of 3000 clients, not this full breakdown, but you can see that we can actually see the hospitals that they're going into and the rates that they're using them. We can also see the very high utilizers of EMS transports. This person had 381 transports, up to 80 transports and so forth. So there's a very, very high utilization.

Houston's a big area. This is a geographical map of the law enforcement diversions of our homeless population. You can see almost 10,000 clients have been diverted by 57 law enforcement agencies for 22,000 admissions. So, from the Woodlands down to League City, from Katie over to Baytown -- for people not familiar with Houston, this is about a 30 to 35 mile radius. It's a big geographical area. I think the greater Houston area has close to 80 hospitals, so it's a costly population to the system.

So, let's look at the pathway built out with the MVP team. The MVP population health team is identifying these clients with high utilization driver of utilization and substance use disorder.

When we first started linking up, they would say, "Oh, substance use disorder. Let's send them to Houston Recovery Center," because we were a primary partner for them. So, what we have to do was help educate the staff. And this is where education comes in, and now they're great at identifying the eligibility criteria and the people who are really ready for our services. If they have a serious mental health or a serious physical health issue, they need to be stabilized first before they can even address their substances treatment. They've got to go through these respite services and then be stabilized to come to us.

They are not coming to us for public intoxication because by the time they get through, they're already at a four-to-six hour mark. We are only taking folks that are ready to go into some kind of service surrounding recovery.

And what we decided to do was to give the MVP program a dedicated phone line. We did not want these calls going through our main switchboard. We did not want the communication to get lost.

So, we have four clinicians that man this phone. Each one takes a week; it's a cell phone and they sit on, but what happens is when we get the phone call, they can do another screening with the staff on the other end that is referring the patient over to us. So we can make sure that not only they right for our environment, but they're right for the services where we're going to

place them. During COVID-19, we had to make sure they had a negative COVID-19 test and we have to make sure that they have a supply of medications because once they're in treatment, they cannot leave treatment for appointments, there's a blackout period, so there's the criteria that we need in order to place them.

Then, we arrange the estimated arrival, confirm arrival. and then we follow up if the patient, for some reason, doesn't arrive. As Melissa said, we do have a van that will pick up some of these patients, but sometimes they come to us by cab if it's an off-hours linkage to us.

This is a very tightly managed communication between our two population health management teams, and this is very successful because, initially our staff did not want to participate, because when we first opened, we were taking referrals from hospitals, but we weren't getting the clients suitable for our system. But since this is a very tightly managed linkage process, this not only allowed us to successfully take MVPs, but now Harris Health System's other departments are successfully linking to us.

The MVP program is now starting to be adopted by Memorial Hermann, which is a big hospital system, as well, and we will be directly working with them.

We encourage the staff at Harris Health to send the person as many times as they will come to us. Because sometimes they get cold feet when they come to us, sometimes they have to build trust with us. You can see half the people that we have received come three or more times, which is a repeat client for us. This is miscoded in our system. They are MVPs, but they were miscoded, so they're showing up for a zero admission -- that was in the very beginning of the program.

What happens when they come to us? We have documented 123 MVPs in our system: 60% of them have enrolled in our recovery program, 68% have been referred to services, and they have a 67% successful referral rate. So that means they were placed into services, they stayed in services and they completed the services. For the complexity of this population, that's really, really good outcome.

And you can see where they're going. There have been over 187 of referrals to different services.

Let's get into the client stories. I'm not going to go into these in detail, but I'm showing you these different cases for different reasons. You will be getting the handout so you can look at them a little more closely. I've got very detailed profiles for them.

And, this whole profile is what we just went through. These are the details of this particular person. This is a PCP person who's got severe substance use disorder with PCP. He was the first linkage for us. He was the first point of contact through a hospital referral. We delivered 10 units of service. He self-selected to stay in three months extra in the program. When he went back into community, he returned to use and he's self-selected back into [treatment at the]. Salvation Army. He called us said, "I came in. I relapsed and I'm going back." And the coach

picked up with him again. So, he had 17 hospital visits prior to this linkage and he has not returned back. So, this is a case of showing that you can shift the relationship from the hospital to a community service provider.

This next client, we were already in touch with them in our street outreach. They walked in asking for help so we were starting to build trust with what we were doing. The hospital directed them to us through the MVP linkage. And at this point, he was ready to go into complete treatment. He went from 31 hospital visits to four hospital visits. Three of these are for medical reasons, not substance use disorder. This person probably needs to be linked to a medical home and this is over a year and a half period. So you're starting to see a more complex case, but very successful.

The next person, this is a very complex case. Schizophrenia is involved here. [Here is the] arrest history. You can see [he went from] 28 hospital visits down to none. This person is cycling through law enforcement, initially. We find him in jail; there are more law enforcement diversions. The hospitals sends them to us. He successfully completes treatment. He goes to a transitional housing facility that has a recovery program. He stays for two out of three months. He leaves and is actually talking to his pastor in the community. The pastor contacts the MVP staff. The MVP staff bring this person back to us, and we get them into the Salvation Army.

So this is where the population health management and the trusting relationships that we build with these patients and clients comes in, along with their willingness to try again.

This person I looked up has a very extensive arrest history. He has been in jail since 1987 with well over 30 admissions into jail. So this type of case needs a deeper intervention.

This next client was referred directly from Harris Health System, and this is what happened: Once we got the successful linkage going, a different department started referring to us and their referral [rate] is higher than the MVP for referrals.

Their basis is not high utilization. Their basis is substance use disorder and this is a person who's addicted to meth. Now you would not guess that he started using at age 46, and he has a master degree of education. So this is an educator with master's degree that started with meth and completely lost [his] life to the street because of the drug.

This particular case is interesting because this is more typical of the pathway for someone who's trying to recover. [There are] multiple attempts at treatment. And, every time they transition into new environments, you're seeing a return to use, which is really, really typical of a person in recovery. When they change environments, there's new rules, they get social anxiety, they haven't built the coping mechanisms to deal with new environments, and they returned to use. They're trying desperately to do this without returning to use, [but they have] no new coping mechanisms.

So, this is a very typical pathway, but he got really stressed out working for Goodwill, returned to use, called us. We got him back into a center treatment, transitional housing – he's

successful there, is successfully employed at the Dollar Store and is working really hard to get themselves back off the street. Hopefully he gets stable enough to get back into his occupation with his Master's degree, and get back into the educational system.

So, let's look at the impact on systems. We were originally charged [dropping] the jail admissions by diverting people and preserving law enforcement resources. In 2010, we were working with the city to open a sobering center. It took three years to do that, which is very fast actually, if you look at this type of intervention. We had full support of the mayor and the chief of police and so forth.

The public intoxication admissions were at 20,000. [It was a] very overcrowded jail and they naturally started declining to 12,000 before we opened. Then, once we opened, it dropped to 6,300. It has declined now; it's around in the 200 hundreds mark -- it's a 98% decrease.

What we would like is to get this kind of dramatic decrease with the very, very high utilizers in the different emergency departments across the city.

So, the takeaway is that hospitals are a critical point of intervention for problematic use. You're on the front lines of this, you are sharing this population with law enforcement, with jail and with other community providers. Knowing the right eligibility and the right service to link them to is really, really important, and having a very clear system of linkage, where staff are trained on both sides, lends to the success of the linkage.

Individuals with chronic substance use disorders must be managed in emergency service systems and the community. You can see that they don't have the resource capacity, nor do they have the wherewithal to navigate bus systems or public transportation, to make appointments and get there on time; they just don't have it. So, they really are a population that needs to be managed and they do stabilize. They do want to change. They need to gain confidence in themselves again. They need to get that self-efficacy. They need to be understood because they've had a lot of trauma and they need support over time.

And it may not be abstinence. Okay. The society says, “Oh, did they quit?” And that isn't the only pathway to help people. There’s harm reduction with medication assistant treatment, along with peer support. People with lived experience -- I can't say enough about our staff. They have been in the shoes of many of our clients, they know how to talk to them. They know how to support them. They know when they're ready. They take them back when they returned to use, or if they fell out of contact, and we just pick up and keep going with them.

And we have quite a population that is still with us for five, six, even seven years since we've opened this program.

So, I’m going to turn this back over. We do have a publication out, in the American Journal of Public Health, about sobering centers, if you're interested. San Antonio has one, Austin has one, Dallas has one and Houston has one. So, if you're interested in learning about them, we do have a publication out there, and you can contact me or anybody else.

Kimberly Jungkind: Great, well, I want to thank both of our presenters. Great job today in presenting a lot of information. And, I guess I also wanted to say, thank you to your staff. This is a lot of work, a lot really good work that they're doing.

We have some time for some questions and this will be a great time to put that in chat. Identify yourself and just say, “Hey, I have a question.” And, while you’re thinking of questions, I have a couple.

I think this one was for Suzanne and it's about the reduced use halfway. Do you have any more details or can you explain that? If you think it pathways, you want to highly utilize it. But it's the opposite, I think.

Suzanne: Well, not really. So everything we do is client centered and that's where the industry's going. The person's going to tell you what's most important to them. When they start taking ownership of the next steps and what they're willing to do and address in their life, then then we go with that.

So if they're in our sobering center, and they really need a medical appointment, we'll do the medical appointment instead of saying, “You need to go to treatment.” If they have legal issues that are bothering them; they may really want to get housed, but they don't really want to reduce their substance use or they're not ready.

We had a woman we found on the street, the staff have been working with her for five months. She was addicted to methamphetamines and she had HIV and she must have weighed about 80 pounds, and she said, “Okay, I'm ready. She stayed in our sobering center for 43 days, waiting for all the ducks to line up to get housed. She didn't really want to address her use and so that was a reduced use pathway to get her off the street, to get her safe, to address all the medical issues, get her stable with HIV and then her use naturally declined, but she didn't quit.

So, why are we holding people to a standard? If you are involved with this, [will you tell her that abstinence is] the only thing that you will support her doing? Because there are so many different things in a person's life that may be triggers their use. We have some people coming through and say, “You know, I have severe pain. I am not going to stop drinking because this is how I medicate my pain. I'm living on my street on the street.” So, maybe if we get their pain addressed medically first, then when that problem is reduced, they'll be ready for treatment. So that's why we have a very broad bandwidth [for when we provide service]. We engage people wherever they are, and we roll with that.

But for the staff at the hospital, if they just ask, “Are you ready for treatment?” They will miss the opportunity to come to us -- a recovery center where people have been in their shoes,, know how to talk to them and see what action step they are actually ready to take and then move with them on that pathway.

So, that's why we're opening up the conversation with, “Well, if you're not ready for treatment, would you want to go over and talk to someone who's in recovery and see if there's something else that's really important for you in your life right now.”

Kimberly: Okay, great. Um, so wonderful explanation.

Kimberly: It seems like you've got teams on both sides, and your case management support, you said was continuous for 18 months. Is there a separate case managers on both sides to help out with this program?

Suzanne: What they would do is follow the plan that we have developed with the client. If, in fact, we are the primary care provider for the client and the community, but I'll let Melissa talk about case management in the hospital.

Melissa: Basically, I would say that there are two care teams. We build the relationship with the patient as they're frequenting the emergency department, but we try to foster the relationship through the Houston Recovery Center. So we have that relationship and we utilize it to create this bridge to the Houston Recovery Center. We consistently meet them every time they're in the emergency room. We have a care plan placed in the EMR for them. So much change happens, but it’s based specifically on the relationship itself and being patient centered.

Kimberly: I had another question. So, the length of stay for one of the patients was four-to-six hours for that process. There are gaps. Are you looking at, going into the future, how to decrease those gaps? I know that's a huge challenge.

Suzanne: Okay, so I'll clarify. The four-to-six hour normal stay in the sobering center is for people who are admitted for public intoxication, and are sobering up. That's a short term, voluntary stay.

If we're placing people in treatment, the average stay in the sobering center is three days. So, we're not really set up for it, but we make it work. It's not the ideal environment, but we will get them food -- we have to purchase food because we don't have a kitchen -- and they will remain with us until they can get placed into those different services.

The actual timeline of stabilizing someone in the community going through those gaps that you saw of detox treatment, transitional housing and so forth really depends on the length of the access to care, how long they stay there, if they complete the service and when the next service is ready. So, that's going to vary over time, but that's a long-term process of at least 12 months, at least, if they're going into transitional housing.

And then the community integration is another piece. People don't understand, particularly for homeless, folks living unsheltered on the street that are initially housed -- it can take five-to-six months for them to readapt to housing. They have to relearn how to manage their money, how to stay clean, how to manage food, how to pay their rent. They have to manage people not

wanting to invade their apartment and stay with them; how to follow the rules. So, they need a lot of support as they relearn those basic things.

Kimberly: One quick question. Melissa in the hospital situation, if you have a group dedicated to the MVP program, you probably have, and I'm just guessing, a case management group that is handling just the regular patients within the hospital and then you've got this case management group that's doing the MVP [work], correct? And they're probably contacting each other as well, I'm thinking.

Melissa: So the structure of the multi-visit patient team for Harris Health is for community health workers that engage again on a daily basis in the emergency departments. We do coordinate with clinical case management for some of our patients, but, obviously, for the purposes today we're focusing on substance use, but we have 10 drivers of utilization.

So, we work on everything from substance use to homelessness to inadequate supports and services and inadequate plans for chronic conditions, goals of care that aren't being properly addressed. So, shout out to my team -- I think some of them are on here today -- but they literally if they work on a variety of complex issues and again we iterate with internal and external community partners as appropriate for the patient's care needs.

Kimberly: Great, allright, well, thank you to both of you, Suzanne and Melissa, for such a great presentation.

Kimberly: I think that’s it for today. Thanks so much!