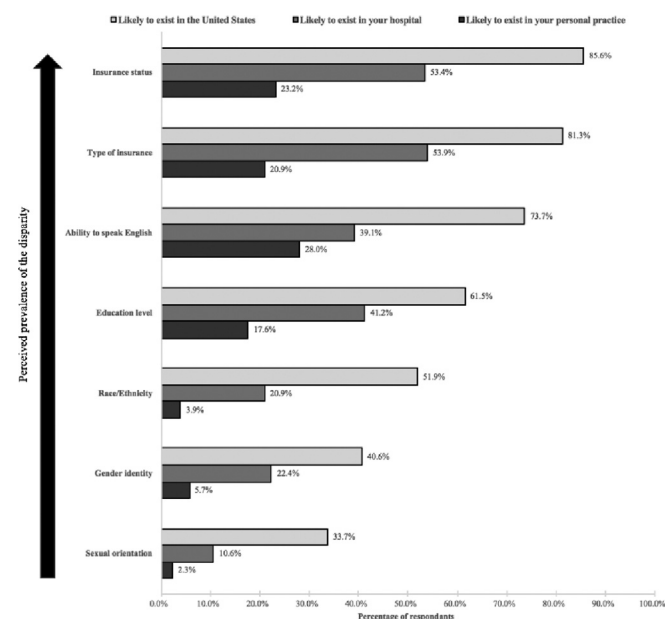


55.4% (race/ethnicity) to 26.5% (sexual orientation) for emergency medicine. Perceived strength of the evidence strongly associated with physicians' acknowledgment of specific disparities in the United States (p-values ranged from <0.001 to 0.018) but demonstrated comparatively poor associations with acknowledgment of the same disparities in one's personal practice (p-values ranged from 0.033 to 0.433).

Conclusions: As evidence documenting disparities continues to increase, action is needed to address disparities in EM care. Health professionals as leaders in the field play an essential role. Nevertheless, despite recognition of health care providers as a contributing factor to the existence of disparities, only one-fourth (down to as low as 1 in 50) acknowledge that disparities in their personal practice exist.



302 The Better Health Through Housing Program: Applying the Housing First Model in an Urban Emergency Department

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Study Objectives: The Better Health Through Housing (BHH) program is a partnership between the Center for Housing and Health (CHH) and the University of Illinois Hospital and Health Sciences System (UIH) in Chicago to improve health care utilization and costs of our homeless population. The 12-month pilot is the first to use ED patients as the source for referrals of homeless individuals and place them into community-based permanent supportive housing based on the Housing First model. The specific aims of BHH are:

1. Pilot a health care to Housing First program utilizing an interdisciplinary and interagency process for screening, referring, and housing chronically homeless individuals presenting to the ED.
2. Develop methods to identify chronically homeless individuals in the ED.
3. Assess health care cost and utilization of homeless patients before and after BHH.

Methods: UIH Homeless Patient Registry: EHR data at UIH was used to identify homeless individuals through chart audits, cross-referencing of home addresses with known crisis shelter locations, and source data mining from problem and diagnosis lists using SNOMED and ICD-10 coding. Health care costs and utilization data for BHH participants were obtained and monitored for 12 months before and after enrollment.

Chronically Homeless Referral Panel (CHRP): An interdisciplinary and interagency panel was created for equitable assessment of participants referred to the program. Housing and Urban Development (HUD) criteria of chronic homelessness, Vulnerability Index (VI) scores for mortality risk and housing needs, criminal histories, and overall readiness for participation were reviewed.

Placement and Care Coordination: Eligible participants were contacted in the ED or in their encampment communities by outreach workers, placed into bridge units, and assigned case managers who assisted with their transition into permanent supportive housing. Monthly Systems Integration Team (SIT) meetings were held to discuss and coordinate housing, social service and medical care needs of participants.

Results: 575 individuals were identified and entered into the UIH Homeless Patient Registry over 12 months. 60 individuals meeting the HUD definition of chronically homeless were reviewed by the CHRP. 45 cases were referred for intake to a community outreach worker and 26 individuals were placed into permanent supportive housing. Of the 26 individuals housed, 4 participants died and 11 were discharged from the program for several reasons including unstable psychiatric illness, substance abuse, or imprisonment. 11 participants continue to be housed in community-based permanent supportive housing. Overall UIH health care costs decreased by 21% and UIH ED utilization decreased by 57% for participants in the BHH program over 12 months.

Conclusions: With increased health care utilization and costs driven by unmet social needs, the burden of housing the homeless has been shifted to health care. The BHH pilot program demonstrates that EDs partnering with community agencies are well situated to facilitate permanent supportive housing placement for chronically homeless patients and reduce their overall health care utilization and cost. Our first cohort had a high rate of participant illness and mortality, suggesting that strategies for improved management of complex medical conditions are needed in conjunction with permanent supportive housing for this highly vulnerable population.

303 Emergency Department Homeless Patient Medicaid Status: Differences in Demographics, Morbidity, and Care

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Study Objectives: Homelessness continues to affect communities throughout the United States and is associated with multiple morbidities, such as chronic disease and substance abuse, that can manifest acutely in the emergency department (ED). Disease burden and costs of care may be affected by Medicaid or health care access. Our objective was to identify differences in psychiatric morbidity, substance abuse, and ED care between homeless patient visits with Medicaid and those without any insurance.

Methods: A retrospective, cross-sectional analysis using statistical software, SPSS 24.0.0.0, was performed on National Hospital Ambulatory Medical Care Survey (NHAMCS) data from 2011-2015. The database is a total weighted probability sample of approximately 675 million patient encounters (based on 130,219 actual visits), which included de-identified information on patient demographics, treatment, and disposition, and was collected from surveys filled out by ED providers nationwide. Visits with homeless patients ages ≥ 18 with either Medicaid or no insurance were included. For the primary outcome, differences in ED course were evaluated by comparing variables including past ED discharge within 72 hours, acuity (measured as emergent, urgent, semi-urgent, and non-urgent), and post-discharge outpatient follow-up planning. For the secondary analysis, presenting ED complaints related to psychiatric morbidity and substance abuse were evaluated. Descriptive statistics, bivariate analyses, and multivariate logistic regression evaluated statistical correlations between insurance status and variables related to ED care and presenting complaint while controlling for demographics, such as age and race.

Results: From 2011-2015, there were 4.3 million homeless patient ED visits constituting 0.6% of all visits. Within the visit population, 54% possessed Medicaid (95% CI 47.7% - 60.3%) and 46.0% indicated no insurance (95% CI 39.7% - 52.3%). Bivariate analyses were significant for positive correlations between insurance status and psychiatric complaints ($p < 0.000$), ED discharge within the past 72 hours ($p = 0.038$), and lower acuity status ($p = 0.022$). There were negative correlations between insurance status and ED substance abuse complaints ($p = 0.013$). The multivariate analysis was most significant for insured visits having a 2.41 times (95% CI 1.45 - 4.01) more likely chance of presenting with a psychiatric complaint compared to no insurance ($p = 0.001$). Females were 0.50 times (95% CI 0.32 to 0.80) as likely to be uninsured versus males ($p = 0.004$). With acuity level controlled, there were no statistical differences in post-discharge follow up planning and substance abuse complaints.