BUILDING BRIDGES

Care Transitions for People Experiencing Homelessness

May 7, 2015
National Health Care for the Homeless
Conference & Policy Symposium

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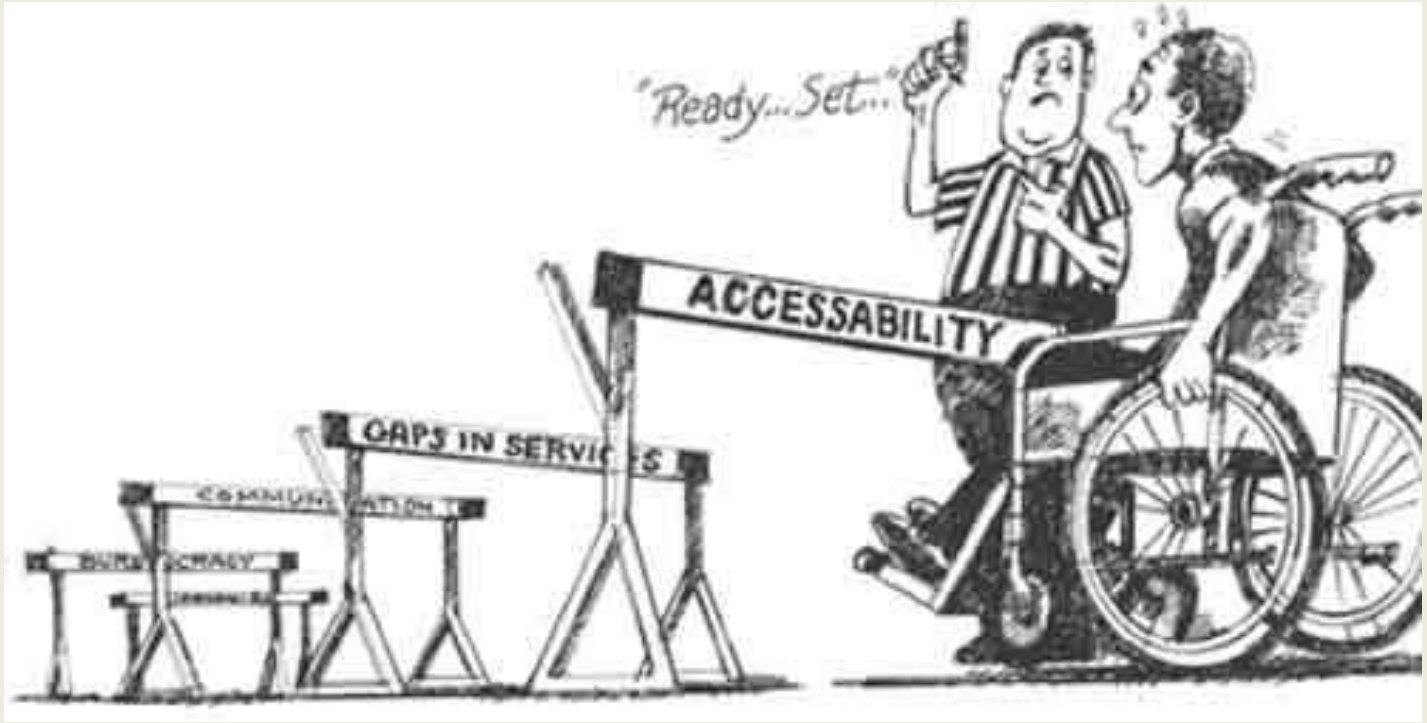

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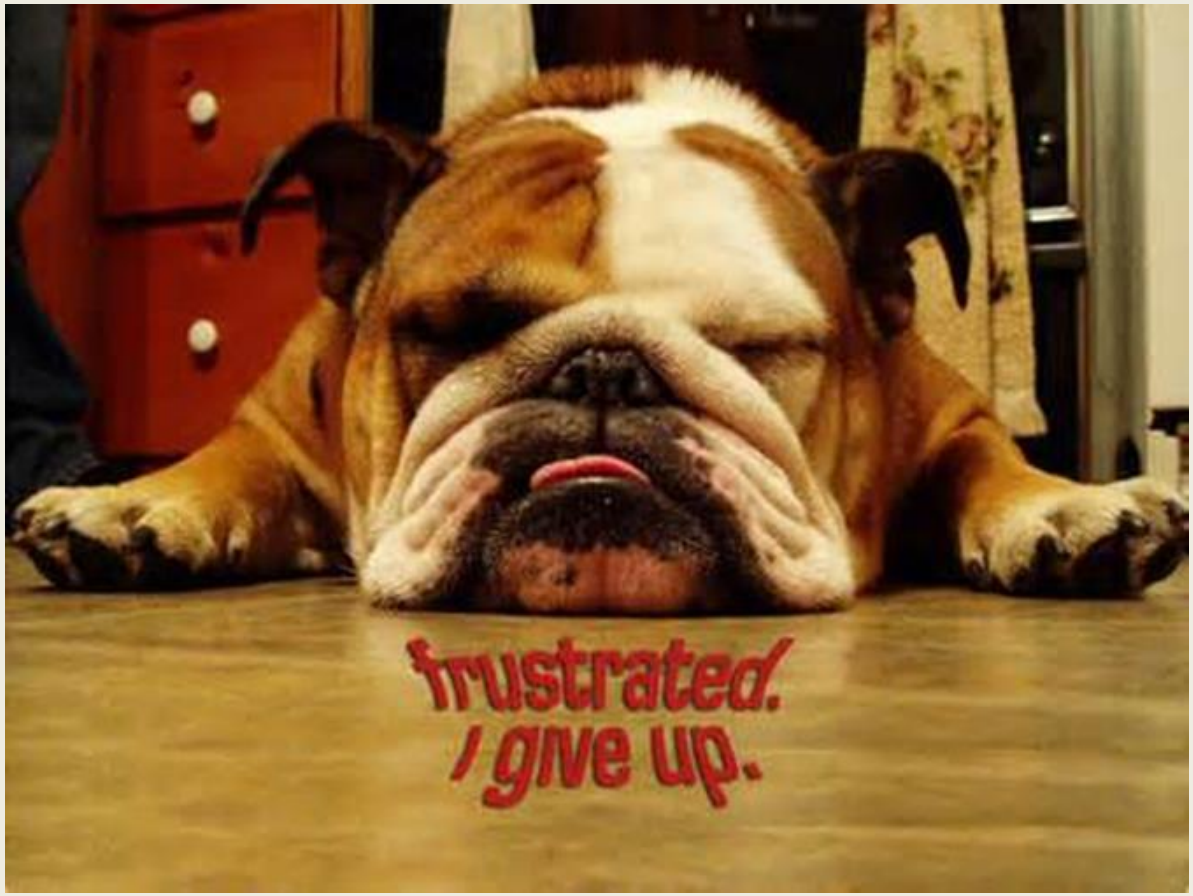
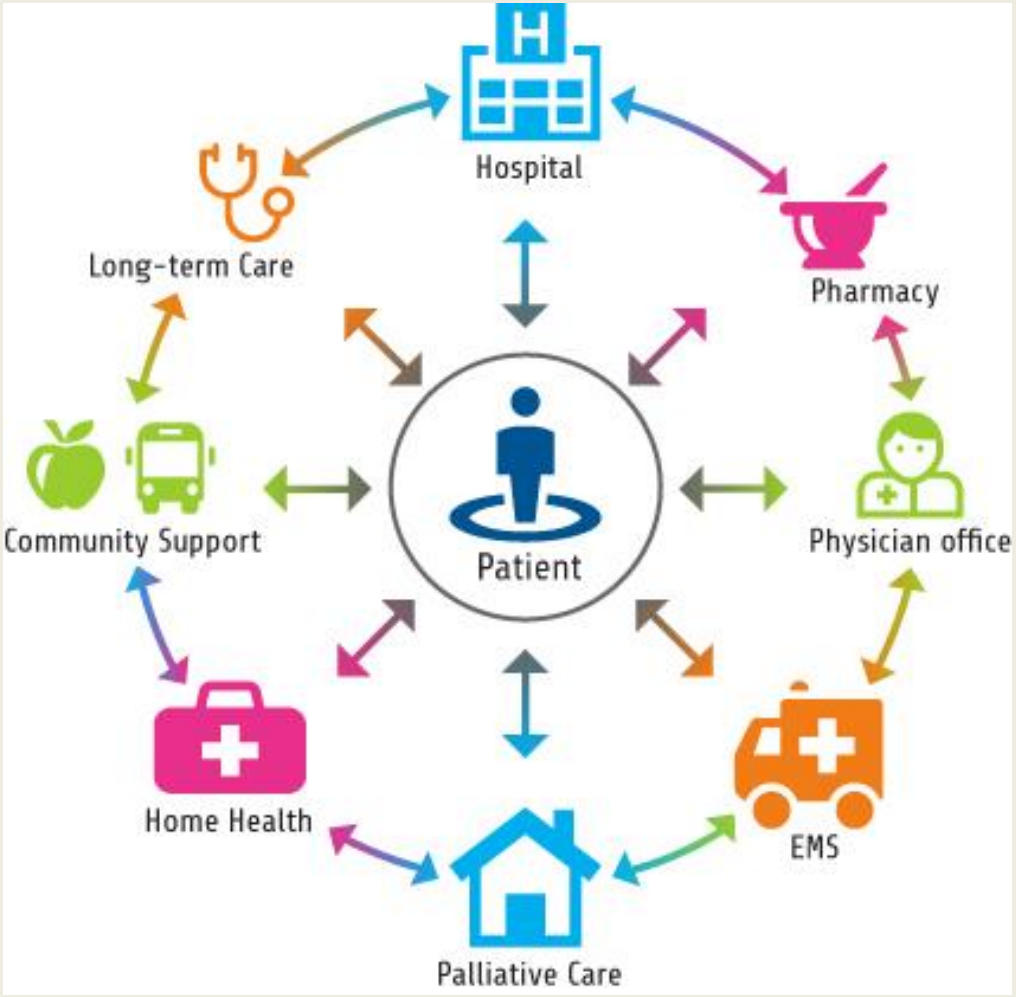
AMIDST THE CHAOS

- Important information is lost or never received by other providers (i.e., lab tests)
- Multiple care plans
- Discrepancies in medication
- Patient unable to follow through with myriad of instructions


frustrated.
I give up.

CARE TRANSITION

- The movement of patients between health care locations, providers, or different levels of care within the same location as their conditions and care needs change
- A subpart of the broader concept of care coordination


Hospital
Long-term Care
Pharmacy
Community Support
Patient
Physician office
Home Health
EMS
Palliative Care

ELEMENTS FOR SAFE, EFFECTIVE AND EFFICIENT CARE TRANSITIONS (HHS)

- Patient and caregiver training to increase self-care skills and activation
- Patient-centered care plans that are shared across care settings
- Standardized, and accurate communication and information exchange between transferring and receiving provider
- Medication reconciliation and safe medication practices
- Transportation for health care-related travel
- Procurement and timely delivery of durable medical equipment (if needed)
- Formal hand-off procedures that ensure full responsibility between sending/receiving provider

TRANSITIONAL CARE CHALLENGES FOR HOMELESS PATIENTS

- Hard to reach (lack of stable housing and telephone)
- Lack of transportation
- Poor health literacy and cognitive impairment
- Uninsured or underinsured
- Multiple practitioners to address complex health needs

Care Transitions for Homeless Persons in the Absence of a Formal Program or Process – Results from a Formative study

Donna J. Biederman, DrPH, MN, RN

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Point-in-Time Count Data

Homeless Totals			
Year	**Nationwide**	**North Carolina**	**Durham Area**
2009	643,067	12,746	535
2010	649,917	12,157	675
2011	636,017	12,908	652
2012	633,782	13,602	698
2013	610,042	12,147	759
2014	578,424	11,448	758
2015	Not yet available	Not yet available	813

2014 – Adults Discharged from a System within 30 days - n (%)			
	Criminal Justice	**Behavioral Health**	**Health Care**
North Carolina	503 (5.7)	465 (5.2)	274 (3.1)
Durham	65 (10.0)	41 (6.3)	22 (3.4)
2015	12 (1.7)	25 (3.5)	16 (2.3)

Research Questions

1. **What is the process for post-hospitalization care for homeless persons in the absence of a formal medical respite?**
2. **What options are used for post-hospitalization care of homeless persons in the absence of a medical respite?**
3. **How does absence of a homeless medical respite affect service providers?**
4. **How does absence of a homeless medical respite affect homeless persons?**

Methods

- **Qualitative, Cross-sectional, Focus group methodology**
- **Purposive Sampling Strategy**
- **Inclusion Criteria – 18 years of age or older, English-speaking**
  - **Service Providers: work to secure ongoing medical resources for homeless persons post-hospitalization**
  - **Homeless Persons: had the need (current or previous) for post-hospitalization recovery resources**

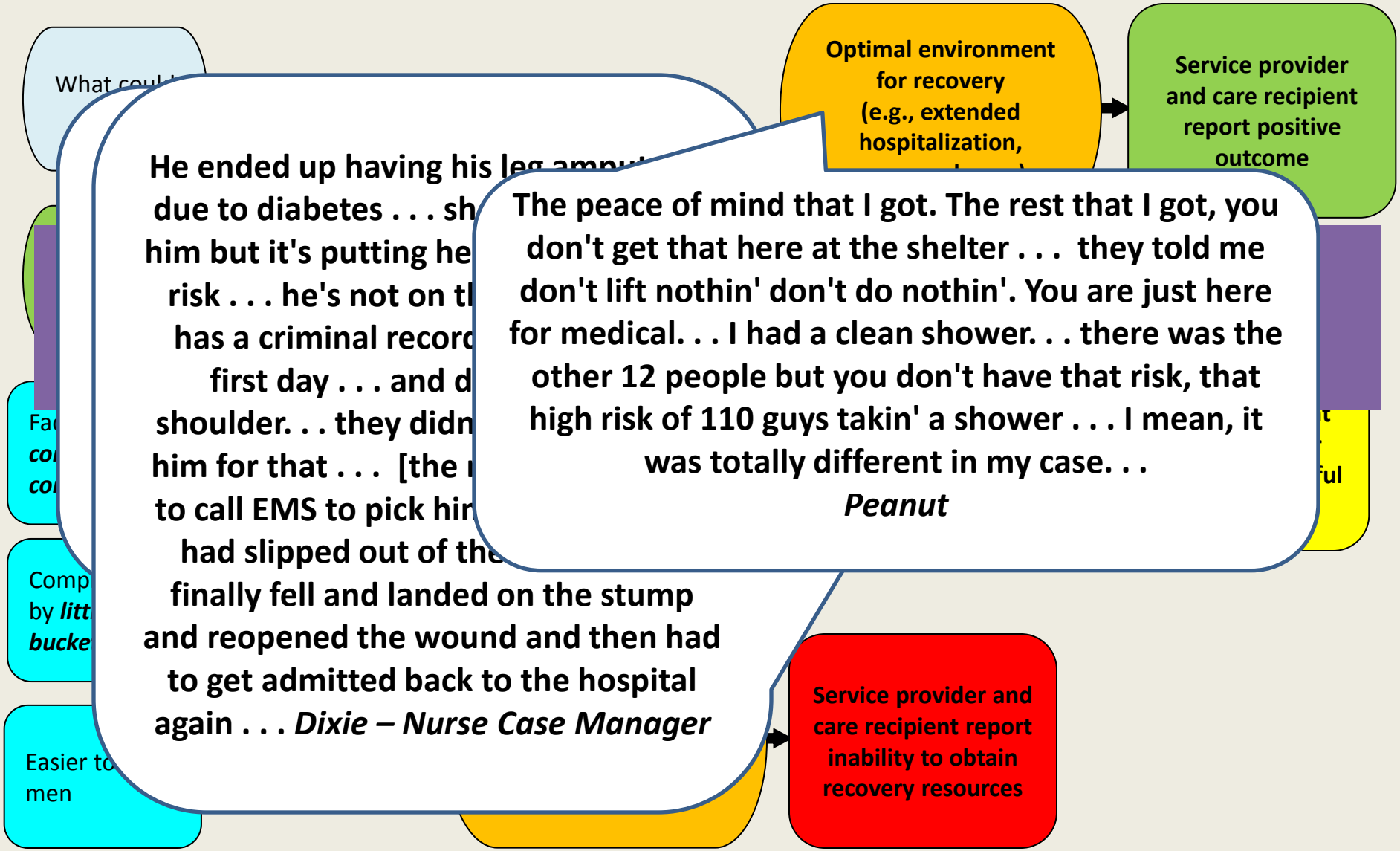
Participants

- **Service Providers (12)**
  - **Primary care providers, nurses, social workers, case managers, and / or program supervisors from three separate health systems, a shelter administrator, health professionals in leadership roles of community-based programs, and persons from the faith community**

- **Homeless Persons (6)**
  - **Persons who had undergone surgery or were awaiting surgery but unable to proceed due to lack of post-surgery recovery resources**

Methods – Data Analysis

- **Focus groups were transcribed verbatim**
- **Comparative analysis within and between transcripts for identification of consistent themes and construction of a process map**
- **Member checking was done for findings verification**
- **Research experts were consulted on process and findings**



Biederman, D.J., Gamble, J., Manson, M., & Taylor, D. (2014). Assessing the need for a medical respite: Perceptions of service providers and homeless persons. *Journal of Community Health Nursing, 31*, 145-156.

Results – How sit

- Service
  - Anger
  - Frustration
- Homel
  - Feel
  - Unce

"…so much of it's so unnecessary and um, it ends up costing the system a lot …people end up coming back in worse condition than when they left. …we're asking for such relatively small amounts of money in the big scheme of thin
er

"I gotta rest cause my stomach's wide open,
ired
y

"…we see huge amounts of resources being invested in people who often have a, you know, a different situation … their ongoing care is futile … they're in the ICU …they're gonna die anyway. And we're spending 10 - 12 thousand dollars a day …and then these tiny amounts of resources that we could deploy maybe in a more flexible way, could have such a big impact but yet the money's not there. …it can feel pretty frustrating."

Gerald – Internal Medicine Physician

Monetary Costs from lack of Medical Respite

- Inefficiency
- Cost of post-hospitalization resources (e.g., boarding house, motel)
- Extended hospital stay
- ED use
- Readmission

Human Costs from lack of Medical Respite

- Service providers
  - Anger
  - Frustration
  - Sense of remorse at the inability to fulfill professional and ethical role obligations
- Homeless persons
  - Stress / Uncertainty
  - Poor outcomes
  - Poor self-esteem / feeling like a burden

Limitations

- Small sample size may limit transferability
- All homeless participants were surgical patients
- Non-English speakers and youth excluded

Future Research

- Retrospective chart review to understand scope of issue and level of services needed
- Pilot program evaluation
- Ongoing program evaluation once program is initiated
- Comparative analysis with other specialty population and / or high risk groups

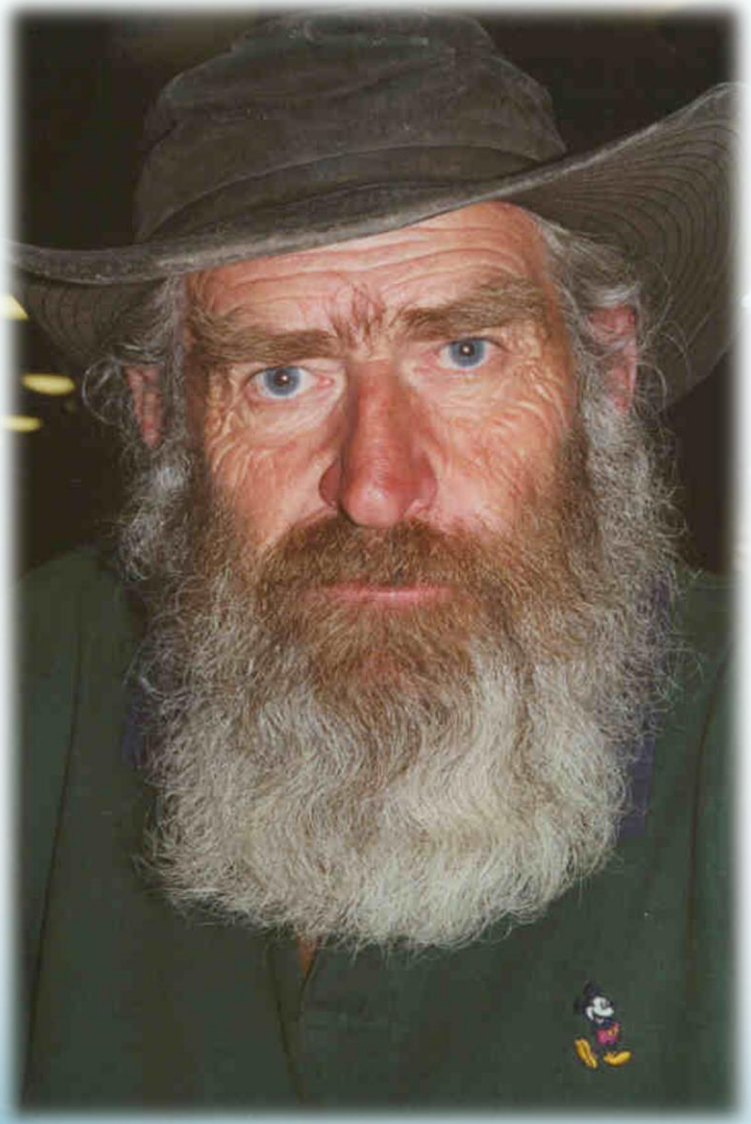
Doing this in your community

- Workshop Session 1 – Thursday - 10 – 11:30 – “Focus group leader training of community members: how to use cognitive interviewing to strengthen outcomes”
- Benefits and challenges of a multi-disciplinary team
- Developing academic partnerships

Questions / Discussion

Transitional Care in a Medical Respite Program

Rebecca Doughty, MN, RN, Phd Student
Founder/Director, Inland Northwest Transitional Respite Program
Director of Medical Services, Catholic Charities Spokane



Background

- Inland Northwest Transitional Respite Program
- Serves homeless men and women in Spokane, Washington
- Started with 1 male bed in 2012

House of Charity

Background

- Shelter-based
- Patients are too well to remain hospitalized, too sick to be discharged to street
- Able to receive home health services at the respite program
- Currently have 21 beds—19 male and 2 female

Hope House

Program processes

- Referral
- Screening
- Patient transport
- Patient assessment
- Adapted CTI

Pillar:	Medication Self-Management	Dynamic Patient-Centered Record	Follow-Up	Red Flags
Goal	Patient is knowledgeable about medications and has system	Patient understands and manages a Personal Health Record (PHR)	Patient schedules and completes follow-up visit with Primary Care Provider/Specialist	Patient is knowledgeable about indications that condition is worsening and how to respond
Hospital Visit	Discuss importance of knowing medications	Explain PHR	Recommend Primary Care Provider follow-up visit	Discuss symptoms and drug reactions
Home Visit	Reconcile pre- and post-hospitalization medication lists Identify and correct any discrepancies	Review and update PHR Review discharge summary Encourage patient to share PHR with Primary Care Provider and/or Specialist	Emphasize importance of the follow-up visit Practice and role-play questions for the Primary Care Provider	Discuss symptoms and side effects of medications
Follow-Up Calls	Answer any remaining medication questions	Discuss outcome of visit with Primary Care Provider or Specialist	Provide advocacy in getting appointment, if necessary	Reinforce when/if Primary Care Provider should be called

Program Processes

- Discharge instructions, follow-up appointments, medications
- Wrap-around services
- Care management coordination

Program Processes

- Patient receives a waterproof notebook
- Medications recorded by the patient as they are sorted into the provided mediset
- Health goals are identified

Program Processes

- Discussion around health diagnoses, both acute and chronic; management of red flags and symptoms
- Ongoing process over course of respite stay


NRA

Program Outcomes

- One day of hospital care in Spokane, Washington costs approximately $2,200
- Significant decrease in hospital length of stay
- One day of transitional respite care costs $60
- 2013 stats
- 2014 stats
- In 2014, 27 patients discharged from respite into permanent housing

Non-Respite Supportive Services

- Providence Consistent Care Spokane
  - Program funded by insurers
  - Case managers
  - Engagement of local ED providers
  - Creation of individualized care plans
  - Engagement of community resources

Non-Respite Supportive Services

- Insurance company case managers
- Hotspotters group
- Volunteers of America
- Catholic Charities

Questions?

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A special thank you to Providence Health & Services

for support of this program

Discussion

What process do you have in place to support care transitions for patients who do not need of medical respite care?

- Presenter response
- Audience response