Partnership Opportunities at the Intersection of Healthcare and Homelessness

Hospital Discharge: Connecting Patients to Homeless Systems of Care

Homebase / The Center for Common Concerns

July 21, 2021

Introduction

- Who's in the room? Drop your name, organization, and something you're grateful for in the chat.
- Jamboard activity: https://jamboard.google.com/d/16CXi-xEdPfsgxpqkv1yFae5REA1aiMw_I8aVuxtpvBk/viewer?f=0

Today's Agenda

- The connection between housing and health care
- Planning to prevent discharges into homelessness
- SB 1152 requirements and components
- Application of equity and peer models to hospital discharge planning and protocols
- Community presentations
- Q&A

The Connection Between Housing and Health Care

The Connection Between Housing and Health Outcomes

- ***Housing is a social determinant of health.***
- Physical and behavioral health conditions are risk factors for homelessness.
- Experiences of homelessness increase the risk of poor physical and behavioral health outcomes.
- Homelessness can cause or exacerbate physical and behavioral health conditions and make access to consistent treatment more difficult.
- ***Safe and stable housing improves health outcomes.***

Homelessness, Health and Hospital Discharges

When people are discharged from medical institutions to the street or otherwise into homelessness, it disrupts the continuity of care started by the health care provider:

- Inconsistency with respect to food, rest, and ability for self-care
- Unsanitary conditions for medical recovery
- Compromise of medication compliance (e.g., lack of refrigeration)
- Difficulty maintaining contact with medical professionals to receive follow-up care
- Inability to prioritize medical condition over other essential needs

Discharge Planning: Homeless Response and Prevention

"Good discharge planning is the lynchpin of a comprehensive homelessness prevention strategy"

-HUD's Homeless Assistance Programs, *Customized Bibliography: Discharge Planning from Publicly Funded Institutions*

Photo by Julián Gentilezza on Unsplash

Photo by Online Marketing on Unsplash

Discharge Planning and COVID-19 Response

Effective hospital discharge planning is crucial for preventing and mitigating the spread of COVID-19 for people experiencing homelessness:

- Connections to respite, quarantine/isolation sites, and safe shelter or housing as appropriate
- Education regarding COVID-19 risks, symptoms, protective measures, and community resources (ex: testing sites)
- Ongoing care for COVID-19 recovery
- ***Access to the COVID-19 vaccine***

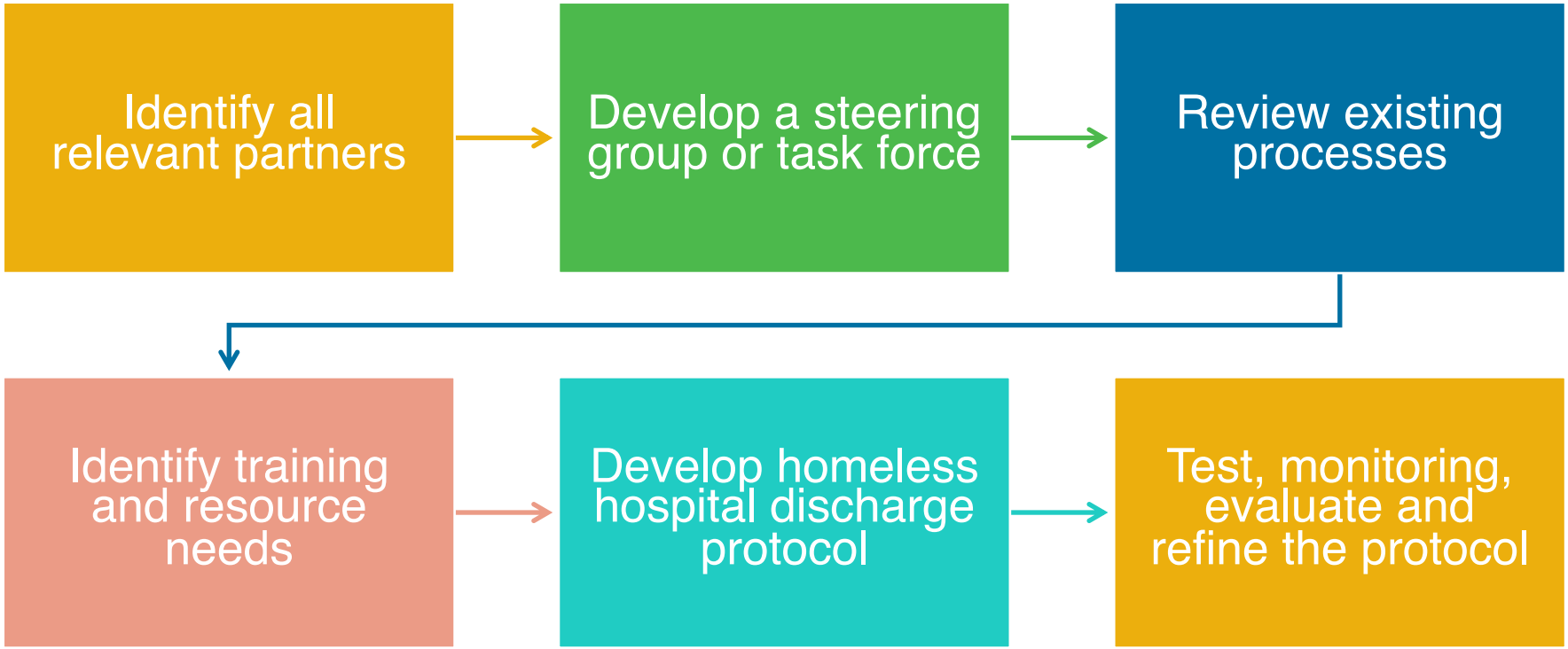
Preventing Hospital Discharges into Homelessness

Preventing Hospital Discharges Into Homelessness

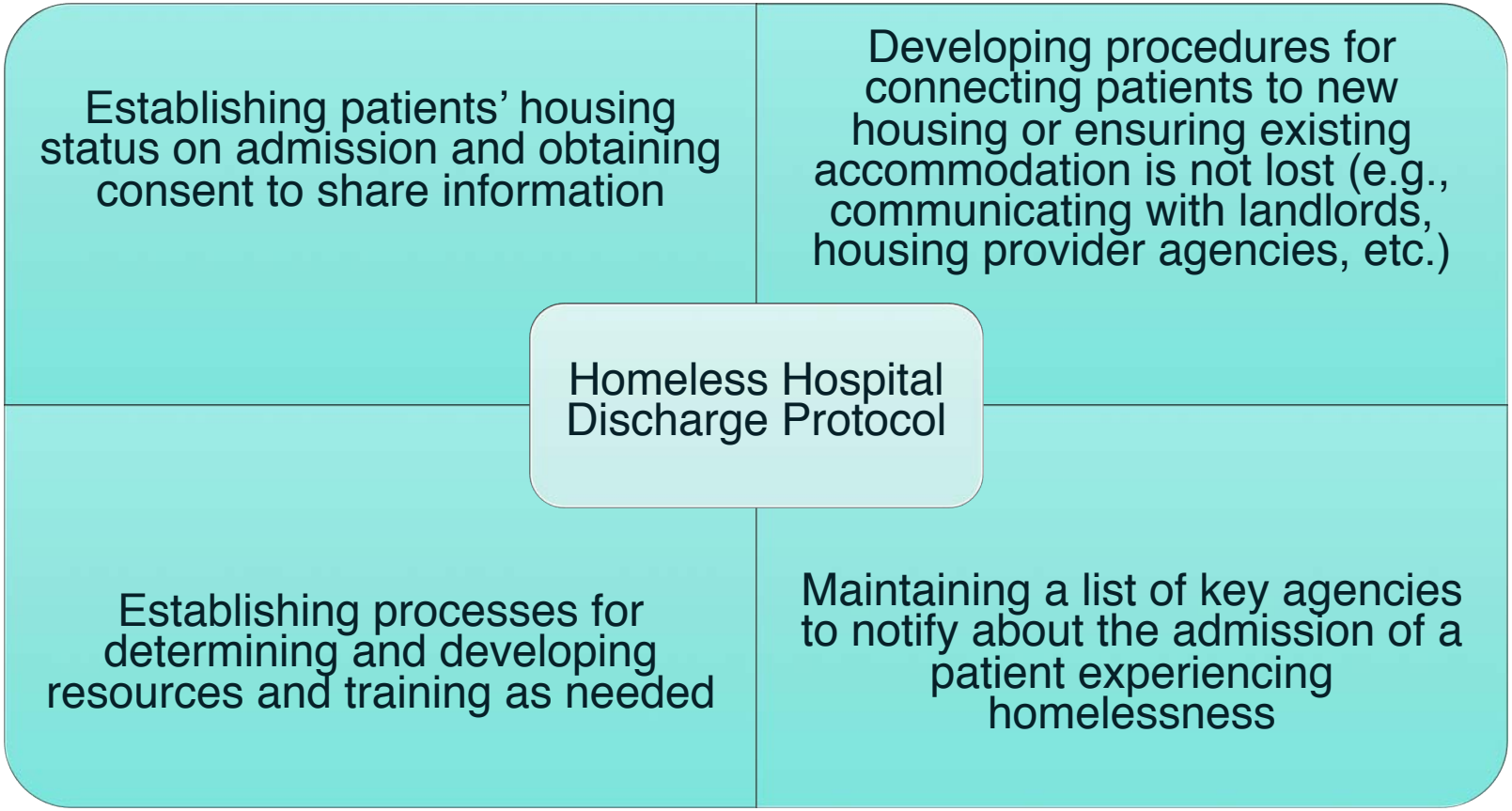
The National Health Care for the Homeless Council (NHCHC) recommends communities take the following steps to promote effective discharge planning and prevent exits into homelessness:

✓	Developing explicit discharge planning policies
✓	Prohibiting institutional discharge into homelessness from hospitals, treatment facilities, and other institutions of care
✓	Making effective discharge into stable housing an imperative outcome measure for hospitals and other institutions of care
✓	Requiring that hospitals and other institutions of care help residents secure all available entitlements (including housing) prior to discharge

Establishing a Hospital Discharge Planning Protocol for People Experiencing Homelessness



Components of an Effective Homeless Discharge Plan Protocol



Key Components of an Effective Discharge Plan

Housing Elements

May include (but are not limited to):

- Recuperative Care;
- Board and Care;
- Motel Vouchers;
- Halfway Houses;
- Bridge housing; and
- Permanent housing, including Permanent Supportive Housing (PSH) and Rapid Re-Housing (RRH).

Programmatic Elements

May include (but are not limited to):

- Family reunification;
- Connection to the local Coordinated Entry System;
- Physical health care;
- Substance use treatment;
- Connection to a Federally Qualified Health Center (FQHC);
- Benefits assistance; and
- Mental health treatment.

The specific elements of an individual's plan will depend on their individualized needs and circumstances

California SB 1152

Hospital Patient Discharge Process: Homeless Patients

SB 1152 - Hospital Patient Discharge Process: Homeless Patients

- All patients, any acute care / psychiatric hospitals in California.
- Emergency Department, inpatient, or ambulatory surgery.
- Must be followed for all homeless discharges 24/7.
- Ensures minimum level of assistance for transition back into the community.
- Requires that ALL patients be assessed for homelessness.

SB 1152 - Who is Considered Homeless?

A "homeless patient":

- Lacks a fixed and regular nighttime residence; or
- Has a primary nighttime residence that is a supervised publicly or privately operated shelter designed to provide temporary living accommodations; or
- Is residing in a public or private place that was not designed to provide temporary living accommodations or to be used as a sleeping accommodation for human beings.

Examples:

- Living in a car or RV, even if parked in the same spot every night
- Living in a domestic violence shelter or sober living center
- Living in a tent on a sidewalk

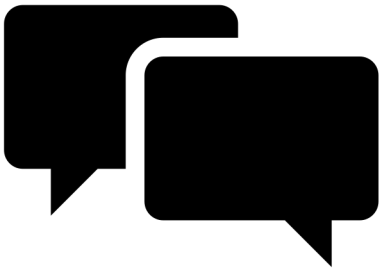
SB 1152 – Homeless Patient Identification

Drop in the chat:

How can you identify if a patient is experiencing homelessness?

What information or data may help to determine a patient's housing situation?

Homeless Patient Identification



- “Where have you been living during the past two months?”
- “Is this reliable housing that you own, rent, or stay in as part of a household?”
- “Are you able to return and stay there when you leave here?”

- Ensure this information is captured in the client’s medical record
  - Admissions - address
  - ICD-10-CM Code Z59.0 - Homelessness

SB 1152 - Required Components

Hospital discharge planning policy must include a homeless patient discharge planning component.

- **List of local shelters**
  - Hours of operation
  - Admission procedures, requirement
  - Population served
- **Procedures** for referral
- **Training** protocols for staff.
- **Maintained log** of homeless patients discharged and destination
- **Evidence** of completion in the log or in the patient's medical record.

Written plan for coordinating services and referrals for homeless patients with the county behavioral health agency, health care, and social services agencies in the region, other health care providers, and nonprofit social services providers to assist with ensuring appropriate homeless patient discharges.

SB 1152 - Required Components (continued)

Assessment	All patients must be assessed for homelessness.
Culture, Language	Information provided in a culturally competent manner, language the patient understands.
Individualized	Created in conjunction with and guided by best interests of the patient.
Destination	Identify a post discharge destination that the patient agrees to go to.
Examination	Physician examination, determination of stability for discharge.
Referral	Referral for follow up care, medical, and/or behavioral health care.

SB 1152 - Required Components (continued)

Food	A meal prior to discharge
Clothing	Weather appropriate clothing
Medications	Discharge medications or prescription.
Screening	Offer a screening for infectious diseases common to the region.
Vaccinations	Offer vaccinations appropriate to their presenting medical condition.
Transport	Offer transportation to his/her post discharge destination.
Healthcare	Help enroll in affordable health coverage.

Hospital Discharge Planning

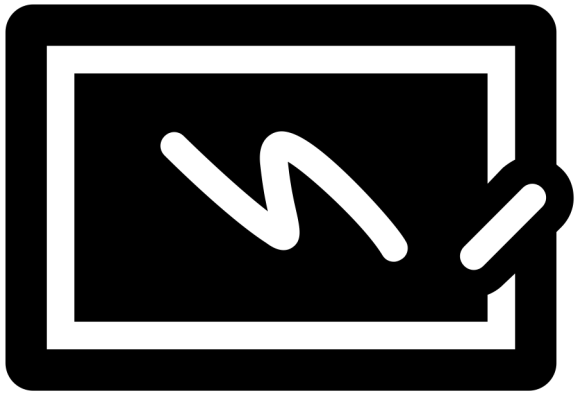
Challenges

Challenges of Discharge Planning

Stigma and discrimination	Time	Direct accountability
Financing	Consensus on standard practice	Adequate training
Tailoring plans to community	Readmission considerations	Eviction prevention

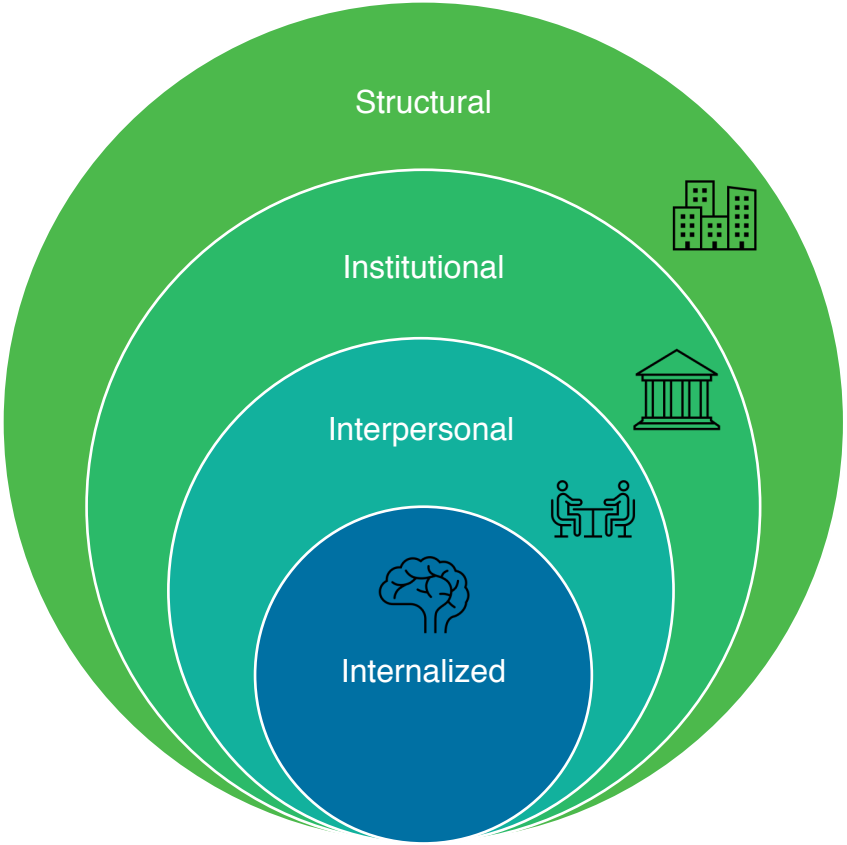
Challenges of Discharge Planning

Jamboard activity: https://jamboard.google.com/d/16CXi-xEdPfsgxpqkv1yFae5REA1aiMw_I8aVuxtpvBk/viewer?f=2



Racial Equity in Hospital Discharge Planning and Protocols

The Layers of Racism

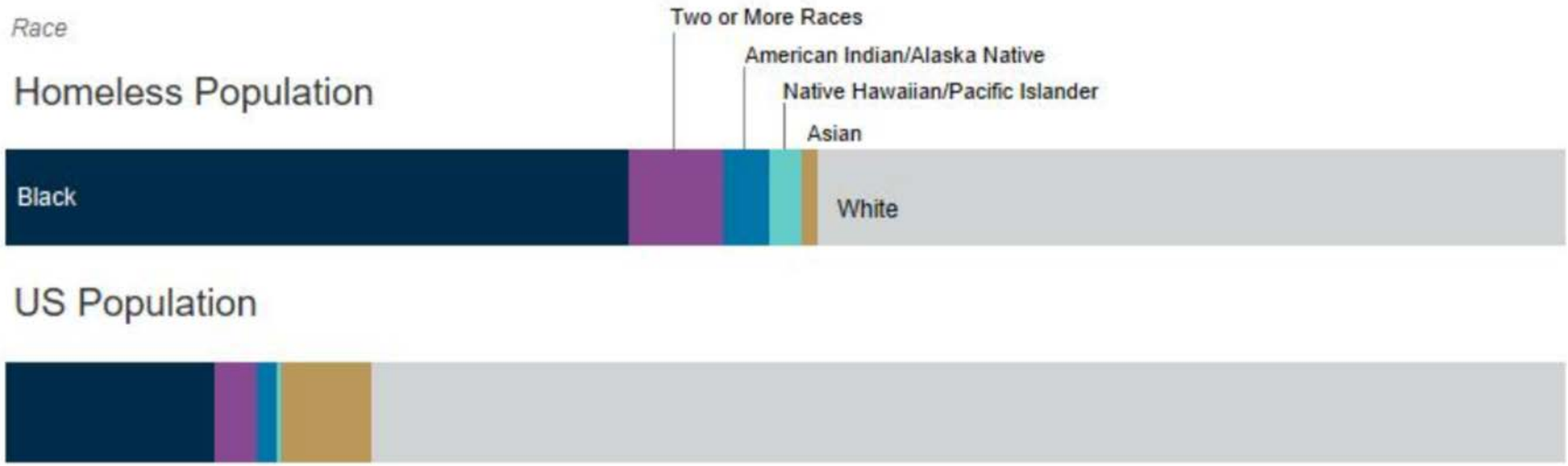


- Structural: The history and current compounded reality of racial bias *across institutions and society*
- Institutional: Policies, practices, and procedures that produce inequitable outcomes, based on race, *within institutions*
- Interpersonal: Public expressions about race that occurs *between individuals*
- Internalized: Private beliefs about race that reside *within individuals*

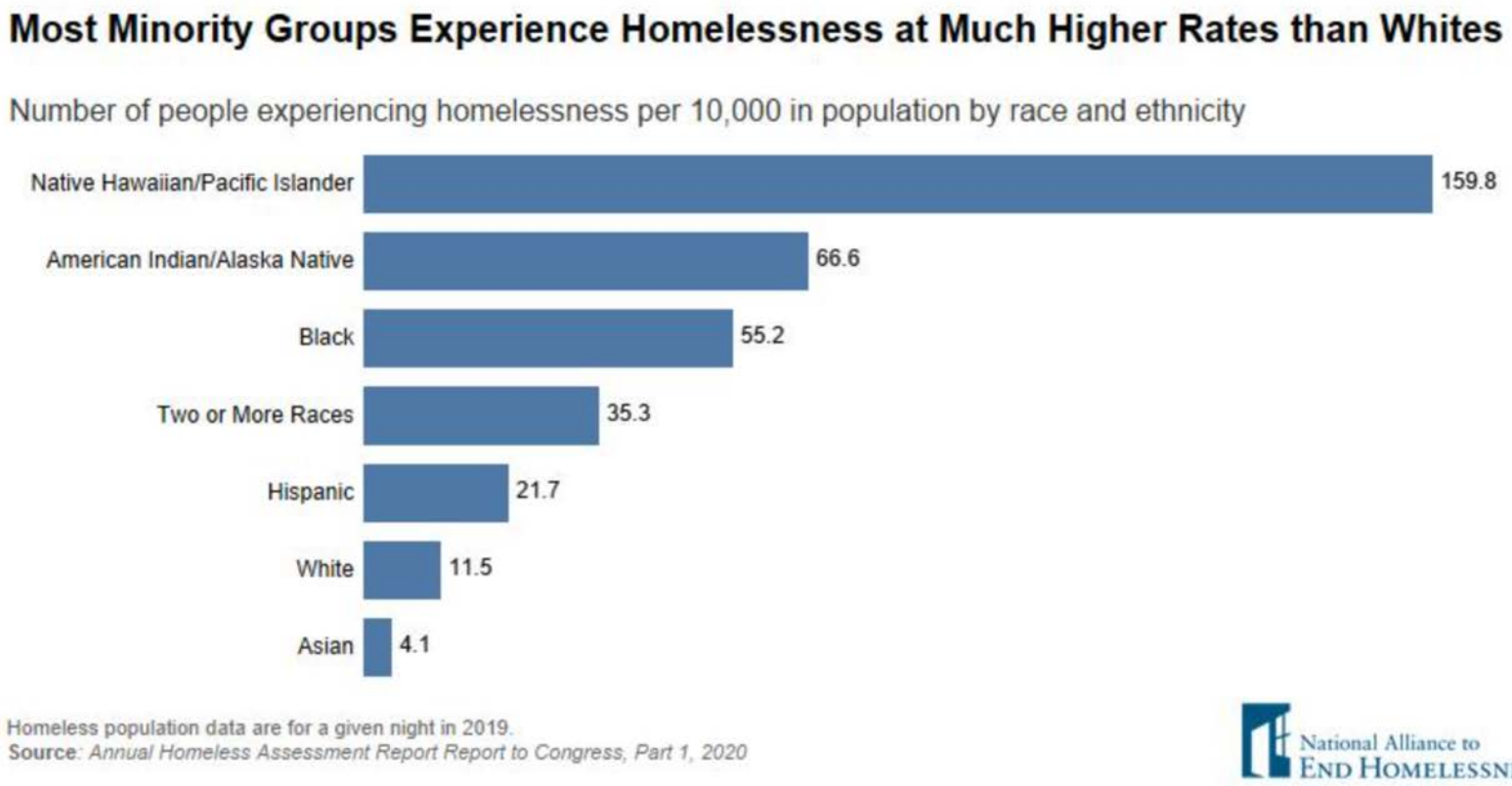
Racial Inequalities in Homelessness

Most Minority Groups Make up a Larger Share of the Homeless Population than They Do of the General Population

Race and ethnicity of those experiencing homelessness compared with the general population



Racial Inequalities in Homelessness



Distrust in the Medical System

- Systemic medical violence against Black, Indigenous, and People of Color (BIPOC)
- Histories of unnecessary, unsafe and non-consensual medical experimentation
- Health and homeless providers need empathy and tools to understand distrust in the medical system among BIPOC clients and patients

For more information, please see this Worksafe webinar on Black Centered Equity in Community Engagement (36:48 - 52:22)

Considerations for Instilling Equity in Hospital Discharge Processes

- Take specific health needs into consideration with discharge planning
- Acknowledge racialized trauma in comprehensive care plans
- Implement peer specialist program to ensure trust (details to come)
- Implement diversity, equity, inclusion and belonging (DEIB) practices in hospital staffing – hire staff representative of patients' backgrounds
- Train staff in cultural competency

Peer Models for Hospital Discharge

Peer Models

What are peer models?

- Peer models are frameworks for providing services and support that center around peer support.

Peers are those who share similar experiences or backgrounds.

- A **peer supporter** is a person who has knowledge from their own experiences with a condition, or of the circumstances of those they help, or has received training to be empathic and understanding in helping
- A **peer specialist** is a person with lived experience of a specific healthcare need (e.g., homelessness and recovery from substance use) who has been trained and certified to help his or her peers gain hope and achieve specific life and recovery goals.

Peers for progress http://peersforprogress.org/resource-guide/define-peer-support/
NHCHC, The Power of Peer Specialists, https://nhchc.org/wp-content/uploads/2019/08/healinghandsfall2013-1.pdf

Why Peer Models?

Challenges engaging people experiencing homelessness in healthcare:

1. Finding and engaging individuals in a way that builds trust, respect, mutual understanding
2. Keeping those experiencing homelessness or formerly homeless engaged in healthcare

Peer support:

- Non-hierarchical, reciprocal, flexible
- Complements, enhances other health care services
- Supports trust-building and engagement

Peer support staff:

- Discharge planning, discharge process, connections to local CoC and services

Lived experience of homelessness is essential to engaging people experiencing homelessness in healthcare (and other homelessness services) and building trust quickly. "As mentors and role models, peer specialists can provide familiarity and support."

Peers for progress http://peersforprogress.org/resource-guide/define-peer-support/
NHCHC, The Power of Peer Specialists, https://nhchc.org/wp-content/uploads/2019/08/healinghandsfall2013-1.pdf

How Peer Models Support Safe and Equitable Hospital Discharge Planning

- **Dedicated staff** who are peer specialists would help to solve the issues of time, accountability.
- Peer specialists who are dedicated discharge staff could also support **consensus process, training, and tailoring** of the process to the local community.
- Peer specialists could also help **counteract the discrimination and stigma** that individuals experiencing homelessness face, building trust with patients which can help to promote their cooperation, follow-through, coordination, etc.
- This would then help **counteract relapses**, and all of the above could incorporate **eviction prevention**.

Peers for progress http://peersforprogress.org/resource-guide/define-peer-support/
NHCHC, The Power of Peer Specialists, https://nhchc.org/wp-content/uploads/2019/08/healinghandsfall2013-1.pdf

Contributions and Benefits of Peer Support

Link people to share knowledge and experience	Provide **health education** to individuals and communities	Give **practical assistance** to achieve and sustain complex health behaviors	Offer **emotional and social support**
Help people **cope with the stressors** that accompany health problems	Help people **access and navigate clinical care** and **community resources**	Increase **individual and community capacity** for understanding health problems and promoting ways to address them	**Advocate** for patients and their communities
Build **relationships based on trust** rather than expertise	Build **cultural competence** of health care providers	Improve **two-way communication** between patients and healthcare teams	Help **address complex multi-morbidities**, serving as a bridge between primary care and behavioral health

Peers for progress http://peersforprogress.org/resource-guide/define-peer-support/

Equity in Peer Models

Training	Trainings for peer workers on equity.
Representation	Ensure that peer workers are representative of the populations they are supporting.
Compensation	Ensure peer workers are fairly compensated for their expertise, time, and labor.
Opportunities	Ensure that folx who would like to be peer specialists and do not have potentially required training have opportunities to acquire that training so that they are eligible.

Additional Best Practices

Medical Respite

Medical respite/recuperative care is acute and post-acute care for persons experiencing homelessness who are too ill or frail to recover from a physical illness or injury on the streets but are not ill enough to be in a hospital.

- Short-term residential care that allows individuals experiencing homelessness the opportunity to rest in a safe environment while accessing medical care and other supportive services.
- Is offered in a variety of settings including freestanding facilities, homeless shelters, nursing homes, and transitional housing.

NHCHC, https://nhchc.org/clinical-practice/medical-respite-care/

Medical Respite Program Standards

- Safe and quality accommodations
- Quality environmental services
- Timely and safe care transitions to medical respite from other settings
- High quality post-acute clinical care
- Assists in health care coordination
- Provides wrap-around support services
- Facilitates safe and appropriate care transitions from medical respite to other settings
- Driven by quality improvement

Care Coordination

Coordinate services and referrals:

- County behavioral health agency, health care, and social services agencies in the region
- Other health care providers
- Nonprofit social services providers
- COVID-19 resources (testing, vaccines, quarantine and isolation sites)

Collaborate with homeless advocacy groups:

- Create discharge planning policies
- Develop culturally competent training and/or materials
- Understand the unique needs of individuals experiencing homelessness
- Identify post-discharge destinations
- Coordinate with other service workers on follow-up and medical needs
- Develop guides and toolkits

One of the best options may be to ensure that the patient is directly connected to the local Continuum of Care (CoC) and/or Coordinated Entry System (CES), if there is one. See our toolkit. https://www.homebaseccc.org/post/institutional-discharge-planning-toolkit-july-2016

Dedicated Staff

Housing and/or discharge coordinators, outreach workers, and social care coordinators hired by hospitals to work with patients experiencing homelessness onsite.

- Ideally, representative of patients' backgrounds
- trained in culturally competent responses and take racial trauma into account when building holistic care plans

Staff responsibilities include:

- Coordinating care
- Completing intensive housing searches
- Networking with landlords
- Tracking discharges
- Creating and implementing safe hospital discharge protocol
- Training and educating hospital staff on the protocol

One of the best options may be to ensure that the patient is directly connected to the local Continuum of Care (CoC) and/or Coordinated Entry System (CES), if there is one. See our toolkit. https://www.homebaseccc.org/post/institutional-discharge-planning-toolkit-july-2016

Community Presentations & Examples

Community Presentations

Jennifer Koppel
Director

Lanc Co MyHome
Lancaster County Homelessness Coalition

Alberto Rodriguez
Sr. Director of Transformational Operations

Haven for Hope

We are a network of health and human service providers, business leaders and private sector individuals working to eradicate homelessness in Lancaster City and County through service coordination, advocacy, public education, and community organizing.

Lanc Co MyHome

Lancaster County Homelessness Coalition

Hospital Discharge: Connecting Patients to Homeless Systems of Care

Wednesday, July 21, 2021

Coalition Supported by Partnership between County Govt. and LGH

County GOVT.

Contract with LGH for support of:

- Management of HUD grants by LGH Office of Coalition HUD-required services:
  - Coordinated Intake
  - Street Outreach
  - Permanent Supportive Housing
- Homeless Assistance grants
- Additional grants to support homeless provider services

Above grants provide required matching funds for HUD grants

COALITION of Homeless Providers and Community

Vision/Strategy

Approval of grant recommendations

Monitor and improve provider & community performance

Facilitates collaboration of homeless providers, community, and city/county govt.

Sustain grant funding for additional homeless services & support

Community Funding

Support for new projects/ services for those at risk of being/becoming homeless unrelated to HUD

LGH

Employs the Office of the Coalition (4 staff)

Provides:

- Staff salary and health/ pension benefits
- Legal & Contracting services
- Accounting and Financial services for all contracts/ grants
- Grant mgmt./compliance
- Office space including all necessary technology
- Secretarial support
- Web mgmt. and marketing support

Mobile Hygiene Unit

- Showers
- Mobile medical care
- Behavioral health
- Social service/housing support connections

HAVEN FOR HOPE
SAFE HOSPITAL DISCHARGES

Alberto Rodriguez

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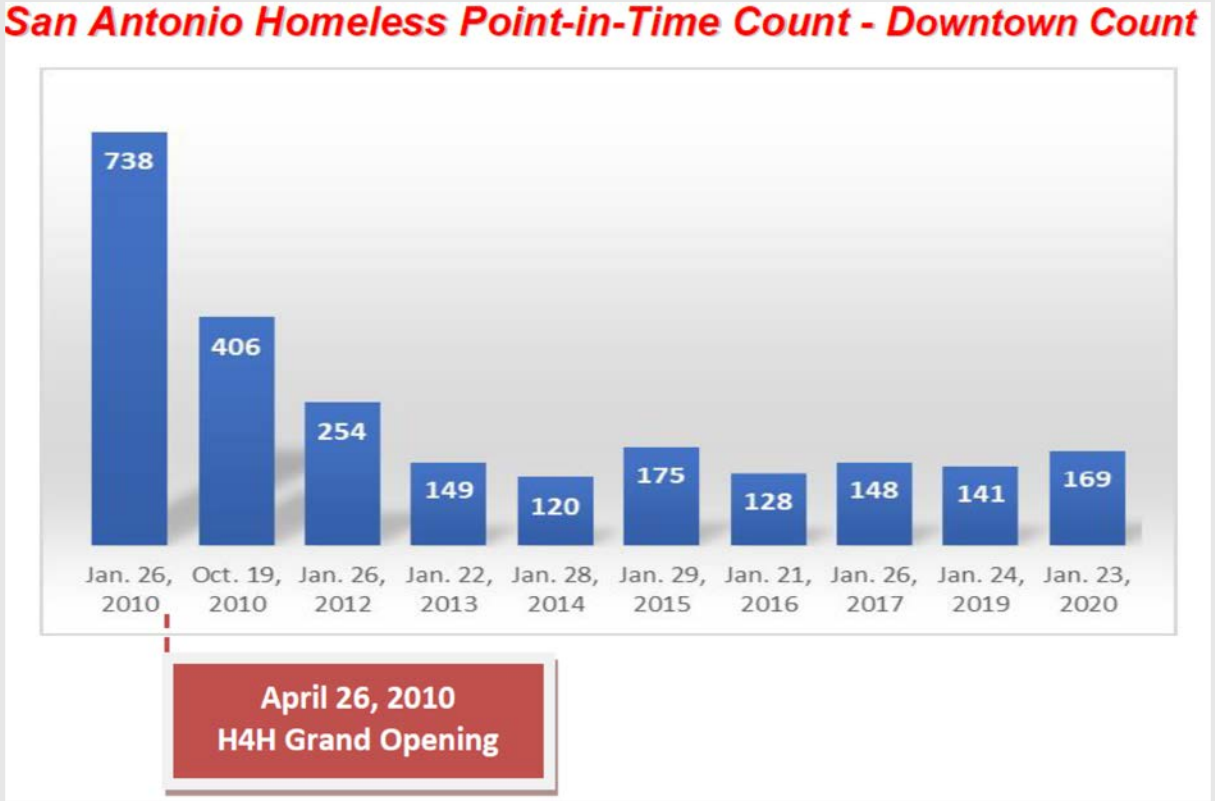
Haven for Hope

- Campus officially opened April 26, 2010; became fully operational June 30, 2010
- Offers housing, transformational and life-saving services for men, women and children experiencing homelessness in Bexar County
- **Since opening, over 5,901 people have exited the transformational campus and moved to permanent housing**
- After one year, 89% of people that exited with a housing placement did not return to homelessness
- The average length of stay for individuals staying at Haven for Hope for the last twelve months (July 2020-June 2021) was 141 days for single people and 113 days for families

Haven for Hope Point in Time

- Controlling for population increase, the downtown homeless count has decreased by 77% since 2010



The Need for Better Coordination

- In early 2016, we identified a growing concern of hospitals "dumping/unsafely discharging" patients to Haven for Hope.
- **Tracking:** Over a three-month period (June – August 2016) , 80 patients were dropped off inappropriately at our gates with no communication or coordination and in all these cases the individual was not medically stable to be able to care for themselves. This data represents only the number of individuals that EMS was called back onto site to assess the individuals and EMS made the determination to transport patient back to the hospital.
  - We had individuals being dropped off with only a hospital gown, no undergarments, individuals with pic lines and IV ports that had not been removed, individuals so sick that EMS staff were not even able to assist them in getting out of the vehicle., individuals with open and infected wounds that had gone untreated, and so many more serious concerns.

Difficult Conversations w/ Hospitals

- In June of 2016, Intake Leadership began having difficult conversations with discharging hospital on each unsafe discharge that was been transported to our gates.
  - These conversations included in some cases making reports to Adult Protective Services and as needed filing grievances on behalf of the patients who were in many cases released form the hospital without being treated and transported to Haven for Hope directly.
- During these conversations it was clear that relationships and expectations needed to be established.

Collaboration and Partnerships

- In July of 2016, Intake Management met with CentroMed Sarah Davidson clinic to begin conversations of jointly developing a “safe discharge protocol” to implement with hospitals and nursing homes to help reduce the number of unsafe discharges and improve on coordination and continuity of care once discharged.
- In September 2016, Haven initiated the first Pilot to partner and collaborate with the local referring hospitals choosing University Health Systems as the first pilot site as University Hospital had the largest discharging volume of patients to Haven for Hope, being as they serve as the County Hospital for unfunded individuals and a teaching hospital as well.
- Intake and CentroMed leadership visited with University Health staff to implement the initial pilot and helped answer questions about Haven services. We soon found out that hospital staff believed that Haven for Hope had medical staff that were able to provide care to patients.
- Within the first quarter of FY 2017, all major hospital systems within San Antonio had agreed to participate in the Safe Discharge Process. Our average of 27 unsafe discharges a month was drastically reduced to 2-3 a month.

Process

- Safe Discharge Referral Checklist
- Intake Reviews for completion
- CentroMed reviews file for medical clearance
- Intake coordinates with hospital discharging staff for a scheduled discharge
- Individual is escorted to CentroMed upon arrival to Haven for Hope for post-discharge appointment
  - CentroMed provides free medications and schedules follow up
- FY 2017 data tracked showed a reduction of 60% rehospitalizations within 30 days for individuals that met with CentroMed for post-discharge follow up.

Partners

- CentroMed Sarah Davidson Clinic
- University Health Systems
- Metropolitan Methodist
- Baptist Health System
- Laurel Ridge
- San Antonio State Hospital
- EMS Agencies and Private Transporters
- San Antonio Fire Department
- Yellow Cab
- Acute Care Station
- STRAC – South Texas Regional Advisory Council

Key to Success: Relationships

Quarterly Meetings

Haven for Hope Intake Leadership, and CentroMed leadership meet quarterly with each referring hospital to address changes, remind of process, ask for feed back, and meet new staff.

24/7 Call Availability

All hospital Social Work Directors or Directors in charge of discharging team have direct phone contact with Sr. Director of Transformational Operations.

Tours

All hospital staff responsible for coordinating discharges have toured the Haven for Hope facility, and refresher tours are offered as needed.

Questions?

Contact:

Alberto Rodriguez, M.Ed.

Sr. Director of Transformational Operations

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Arrowhead Regional Medical Center (Southern CA)

- Different assessments for homelessness built into each of the medical centers three emergency departments (regular, behavioral, and labor and delivery)
- Assessment begins with questions to determine if a patient is homeless
  - “Do you have a permanent place of residence?”
  - “Do you stay or sleep on the street?”
- When a client is identified as experiencing homelessness, case managers and social workers:
  - Identify a safe place to discharge the patient
  - Document where they are going and how they will be transported, and
  - Record discharge notes and prescriptions
- Use data track the volume and frequency of visits and any readmissions.
- Looked at common reasons for people experiencing homelessness to either avoid or overuse hospital services and tried to find solutions.

Homeless Health Care Los Angeles

Homeless Health Care Los Angeles (HHCLA) developed an innovative training model designed to assist clinicians with discharge planning for homeless patients.

- Training curriculum focuses on:
  - Clinicians' roles in discharge planning and legal and regulatory responsibilities;
  - Community resources, including social services;
  - Assessment as a continuous process on which planning criteria are based; and
  - Strategies to reduce avoidable inpatient days through better discharge planning.

Q&A

Closing

Jamboard activity: https://jamboard.google.com/d/16CXi-xEdPfsgxpqkv1yFae5REA1aiMw_I8aVuxtpvBk/viewer?f=3

Thank you for joining today!

Please join our next webinar in this series:

Street Medicine: Cross-Sector Partnerships that Center Equity and Peer Models

July 28, 1:00 - 2:30 p.m. PT