THE ROLE OF HOSPITALS IN ADDRESSING BARRIERS TO CARE

Thursday, February 22nd, 2018
3:00PM Eastern/12:00PM Pacific
PRESENTERS

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LEARNING OBJECTIVES

Participants will be able to:

• Discuss the effects and importance of hospital discharge planning.
• Describe differing definitions of homelessness among various entities.
• Identify ways to collaborate with community agencies to address barriers to care and create shared protocols.
• Explain why Population Health education is important and how it can break down silos within a hospital system.
• Summarize hospital involvement with the community.
Hospital Discharge & Community Expectations

- It always happens
- It shouldn’t happen
- It never happens

• Historic experience
• Recent examples
• Lessons learned
• Public policy framework

NATIONAL HEALTH CARE for the HOMELESS COUNCIL
HOSPITAL DISCHARGE IN CONTEXT

- Growing understanding that health is “more than…”
- Dis-investment in housing support and social safety nets...
- Overwhelmed systems referring to overwhelmed systems
Understanding “Homelessness”

• Competing federal definitions
  → HUD, HHS, Dept. of Education...

• Integration of multiple funding sources

• Developing a community understanding

• Developing an organizational understanding
WHAT HAPPENS ON THE OTHER SIDE

- Discharges to Health Care for the Homeless
- Discharges to shelter & service system
- Referrals to housing authorities
- Discharges to “home”
- Use of community resource guides
WHO ARE YOUR PATIENTS?

WholePerson Care

- In the Hospital
- In the ER
- Everything Else
- Life Skills/Health Ed
- Case Management

Whole-Person in the Hospital

- Hospital
- Emergency Department
- Everything Else
ADDRESSING COMMUNITY-LEVEL BARRIERS TO CARE

- Residential status
- Insurance status
- Accessibility and location of care
- Capacity for care plan – the 3 Fs
- Transportation
  → Difference between “coverage” and “access”
  → Appropriateness of modality
IDENTIFYING COMMUNITY PARTNERS

- Community-based clinics
- Behavioral health clinics/programs
- Continuums (Continua?) of Care
- Local Health Department and Housing Authorities
- United Way organizations
SEEKING SYSTEM CHANGE

- Understandably overwhelming pressure
- Strengthening systems
- Training & scalability
- Policy advocacy
  → Associations
  → Local, state, federal
POPULATION HEALTH EDUCATION IN HOSPITALS

- Discharge planners, care management, physician education, etc., is critical
- Pop Health macro overview and micro with specific examples on local resources that address the social determinants of health (ex: RN orientation at Mission Health)
• Each department speaks a different language, training needs to accommodate but at the same time use this opportunity to break down silos.
• If departments work more together, this team effort lifts burdens especially for complex patients.
• Coding and physician involvement to document disability.
• Ex: documenting on referrals, allowing access to care plans, use of HMIS (homeless management information system).
SHARED PROTOCOLS

- Important to have a point person in hospital that can develop protocols and have access to EMR/HIE
- Many agencies have different protocols, find a common ground
- Ex: if patient needs an ID to enter, see if discharge paperwork will work
SHARED PROTOCOL EXAMPLES

• When code purple is called (for inclement weather) make sure updated contact numbers in system

• Have point person that can advocate or address issues with shelters and develop relationships...this will help with discharge and avoid readmissions
Example: Wet Bed model/non medical detox beds
Collaborative model with largest emergency shelter, police department, hospital, and county gov
Came together to develop protocol from ER, escort with officer, to shelter bed
This was ground breaking...proof of how a dry facility accommodated to substance issues, took on a harm reduction approach
HOSPITAL INVOLVEMENT IN COMMUNITY

- Involvement with city and county government, local COCs, and housing authority will open doors for patients to have housing
- Collaborative effort to show how housing can be a cost saver and reduce readmissions is a win-win for both
INVolvEMENT EXAMPLES

• Point in Time involvement and use data for advocacy
• Permanent Supportive Housing projects: support data on how readmissions and cost will decrease
• Advocate for patients to have priority if they are highly vulnerable, EMR may have details that housing agency needs
• FUSE: frequent user system engagement model
• Have community groups meet at hospital, make sure ROI covers these entities
Q&A

- Please enter your questions for the presenters into the chat box below the presentation slides.