THE ROLE OF HOSPITALS IN ADDRESSING BARRIERS TO CARE

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

NATIONAL
HEALTH CARE
for the
HOMELESS
COUNCIL

PRESENTERS

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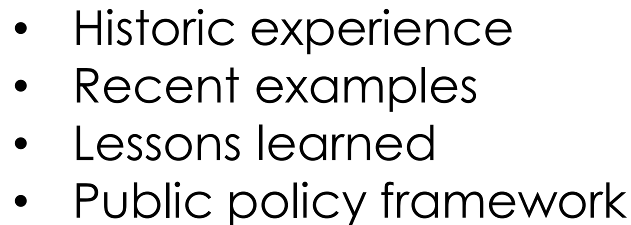
LEARNING OBJECTIVES

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



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

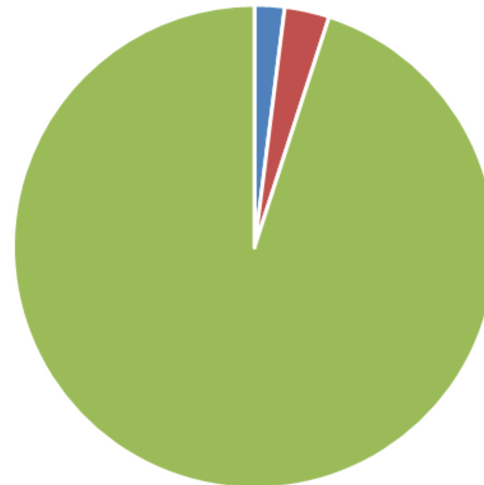
- Discharges to Health Care for the Homeless
- Discharges to shelter & service system
- Referrals to housing authorities
- Discharges to "home"
- Use of community resource guides

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

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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)

Cont'd

- 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

Cont'd

- 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.