A HEALTH SYSTEM'S ROLE IN ADVANCING RECUPERATIVE CARE

KATY BAZYLEWICZ
VP for Marketing and Population Health

MONICA RAY
Population Health Strategic Development Manager

BECKY SANTANA
Community Health Navigator

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Overview

- Engaging Leadership
- Assessing Needs
- Partnership and Program Design
- Cottage Recuperative Care Program at PATH
- Lessons Learned
- Discussion: Experiences in the Field

ENGAGING LEADERSHIP

Cottage Health

Santa Barbara Cottage Hospital
including Cottage Children's Medical Center, Cottage Rehabilitation Hospital and Cottage Residential Center

Goleta Valley Cottage Hospital
and Goleta Valley Medical Building, including Grotenhuis Pediatric Clinics

Santa Ynez Valley Cottage Hospital

Cottage Residential Center
for chemical dependency treatment

Villa Riviera Assisted Living

Pacific Diagnostic Laboratories

Level 1 Trauma Center at Santa Barbara Cottage Hospital

Level 2 Pediatric Trauma Center at Cottage Children's Medical Center

Santa Barbara County

Population: 448,299

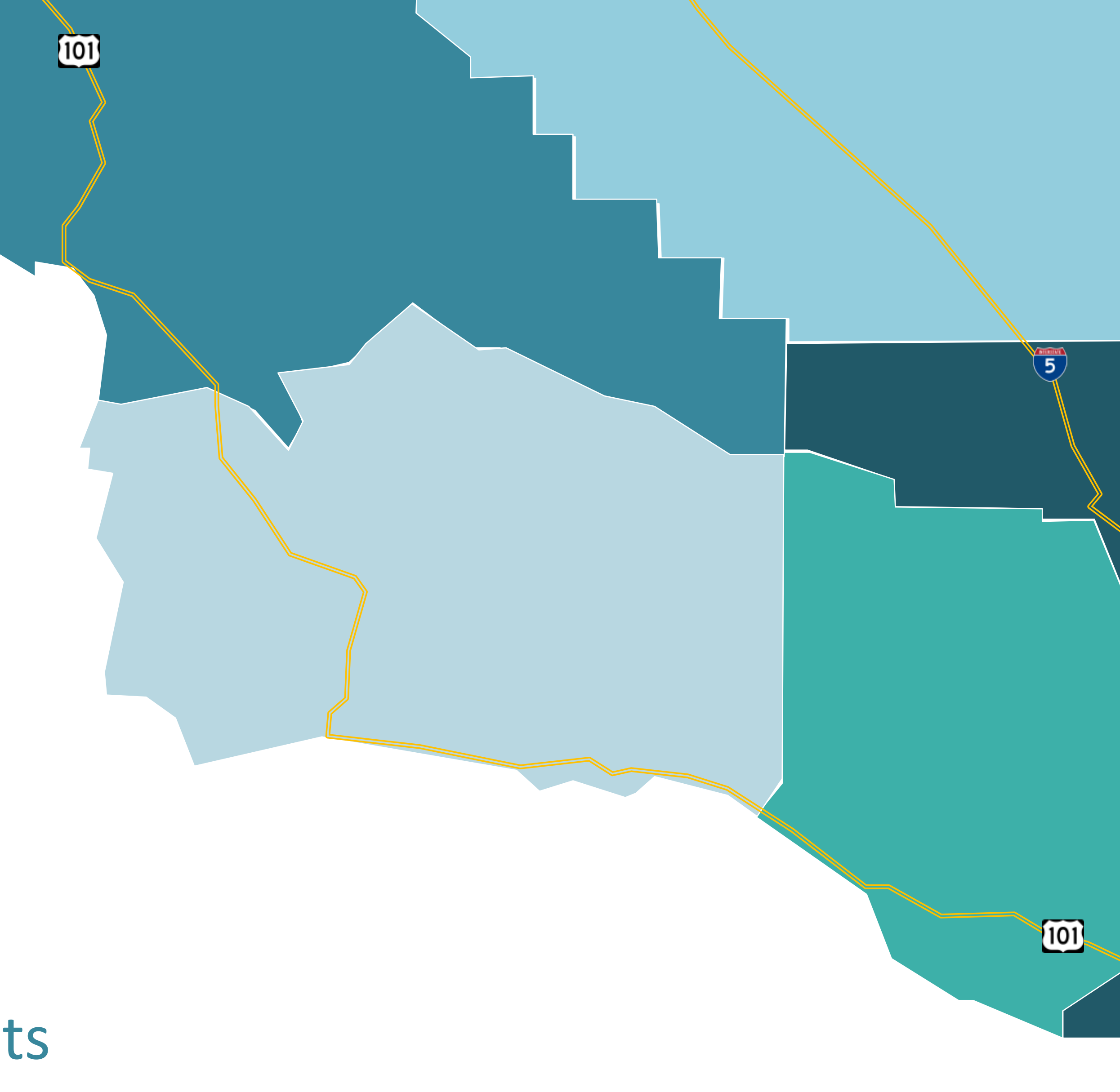
White: 43.8%   Hispanic: 46.0%

Living below the poverty level: 13.5%

1st highest % of homeless students

3rd highest % of families in poverty

4th highest % of English learner students



Source: U.S. Census Bureau and KidsData.org

MISSION

To provide superior health care for and improve the health of our communities through a commitment to our core values of excellence, integrity, and compassion.

Cottage Center for Population Health

Convening & Leadership

- Pediatric Resiliency Collaborative (PeRC) & Santa Barbara County Network of Care
- Behavioral Health
- COVID-19 Collaboration

Partnerships & Programs

Programs & Initiatives

- Recuperative Care Program
- SB Connect Home
- Supportive Housing
- Transitional Care Program
- Employee Resource Connect
- Patient Resource Connect
- Parish Nursing
- Community Health Ambassadors
- Spanish Virtual Care

Grant Making

- Behavioral Health Initiative
- Care Transition
- Network of Care Buffering Services

Capacity Building & Data

Data & Evaluation

- Community Health Needs Assessment
- Data2Go
- Evaluation Toolkit
- Technical Assistance

Training & Education

- Community Health Workers
- PeRC Training Portal
- Graduate Medical Education

Applied Research

- Literature Reviews
- Community-based Research Studies
- Presentations
- Publications

ASSESSING NEEDS

2016 Community Health Needs Assessment

- Broad-based health needs and opportunities
- Internal and external
- Weighted data to match the demographics of SBC

2,459 respondents

randomly selected

20

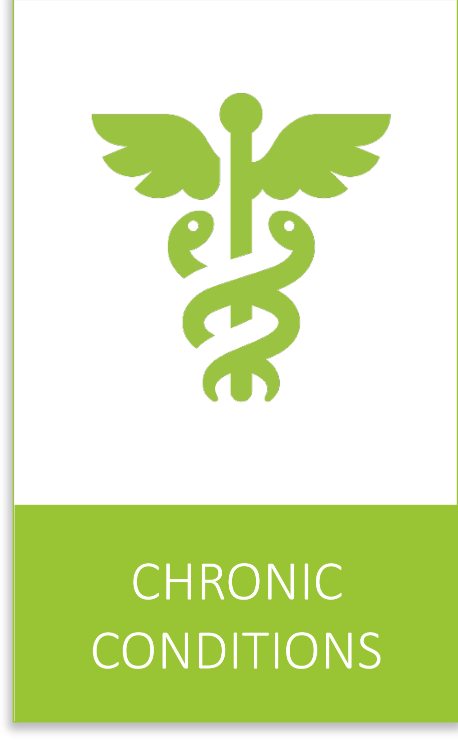
focus groups and interviews

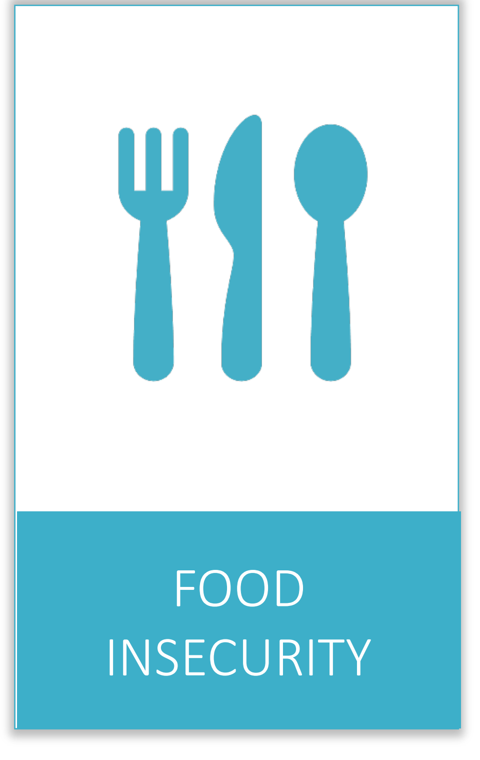
230

community members and leaders

adults age 18+

2016-2019 Priority Areas





Key Findings

2016 Community Health Needs Assessment and Listening Tour Findings

- Social needs (housing and food) identified as priorities
- Affordable and healthy living starts with housing

More resources are needed to address root causes of poor health of patients experiencing homelessness

Homelessness in Santa Barbara County

Santa Barbara County:
1,400 individuals experiencing homelessness in 2017

South Santa Barbara County:
900 in 2017

Cottage Health hospital averages for patients experiencing homelessness in 2018:

- 155 patient visits/month
- 2.57 inpatient visits/patient/year
- 3.90 ED visits/patient/year

PARTNERSHIP
AND PROGRAM DESIGN

Recuperative Care Program History

Prior to 2016:

Offered Transitional Care Program at PATH

2016:

Community Health Needs Assessment and priority areas defined

2017:

Initiated Recuperative Care planning and Steering Committee

2018:

Piloted Cottage Recuperative Care at PATH

2019:

Launched Recuperative Care with 10 beds

Transitional Care Program

- Patients with acute medical needs
- Short term place to recovery at shelter
- Average 5-7 day stay
- Part-time nurse

RECUPERATIVE CARE PARTNERS

Patient Care

Cottage Nurse

Cottage Navigator

Public Health

PATH Shelter Monitors

Funders

Cottage Health

CenCal Health

Private Foundation

Individual Philanthropists

Housing

Housing Authority of the City of SB

PATH

Steering Committee

Began meeting in September 2017

Members include:

- CenCal Health
- Cottage Health
- PATH Santa Barbara
- Santa Barbara County Public Health

Provides guidance and feedback for program

Contributes to program evaluation

Recuperative Care Models

Reviewed literature and 23 California programs

Conducted interviews and site visits to:

- Hope of the Valley in Mission Hills
- Illumination Foundation

Consulted on medical respite models with National Health Care for the Homeless Council

Recuperative Care Program: Discovery Findings

- Patients need both medical and basic needs support
- Longer lengths of stays facilitate more successful transitions to housing
- Hospital and shelter partnership opportunities

COTTAGE
RECUPERATIVE CARE PROGRAM
AT PATH

Cottage Recuperative Care Program at PATH Santa Barbara

10 patient beds

90 day maximum stay

1 medical director (part-time)
3 registered nurses (part-time)
1 social needs navigator
5 respite care monitors

- Hospital-led
- Onsite Public Health Care Center
- Referrals from hospital and community
- Continue to follow patients after exit

EMERGENCY EXIT ONLY
ALARM WILL SOUND

Recuperative Care Nurses

- Creates Medical Needs Care Plans
- Provides basic medical care and education
- Connects to a medical home
- Navigates to appointments and liaisons with physician
- Assists with medication management
- Liaisons with PATH Respite Care Monitors
- Continues to follow the patient after exiting program

Community Health Navigator

- Creates Social Needs Care Plans
- Connects with resources and support services for social or basic needs
- Helps become document-ready for housing
- Liaisons with PATH staff to coordinate case management
- Coordinates with Cottage case managers and social work
- Continues to follow the patient after exiting program

Patient Criteria

Patients must be:

- Experiencing homelessness
- Alert, oriented, and independent in ADLs or needing minimal assistance
- Agreeable to proposed treatment
- Able to self-administer medications
- Willing and able to adhere to PATH's rules
- Have appropriate acute medical need
- Low risk for severe, acute withdrawal syndrome from alcohol or illicit drugs

Exclusion Criteria

Inappropriate candidates:

- Sobering needs only
- Suicidal declaration without acute medical need
- Behavioral health diagnoses without acute medical need
- Eligible for a SNF

Recuperative Care Referral Process

- Referrals from:
  - Community organizations
  - Local agencies
  - Hospitals
- Referrals reviewed by:
  - Medical Director
  - Social Worker
- Patients must express a willingness to participate
- Transitional Care Program provides a landing spot for patients

Electronic Medical Record Documentation

- Launched in late 2020
- Custom Epic referral process and encounter
- Communicates status of patient to hospital providers
- Streamlined reporting

Recuperative Care Evaluation

October 2018 – March 2022

PATIENT OUTCOMES: 121 patients total, 33 repeating patients, 10 current patients

80% visited medical home during stay

55% document ready for housing at exit

47% currently in permanent housing

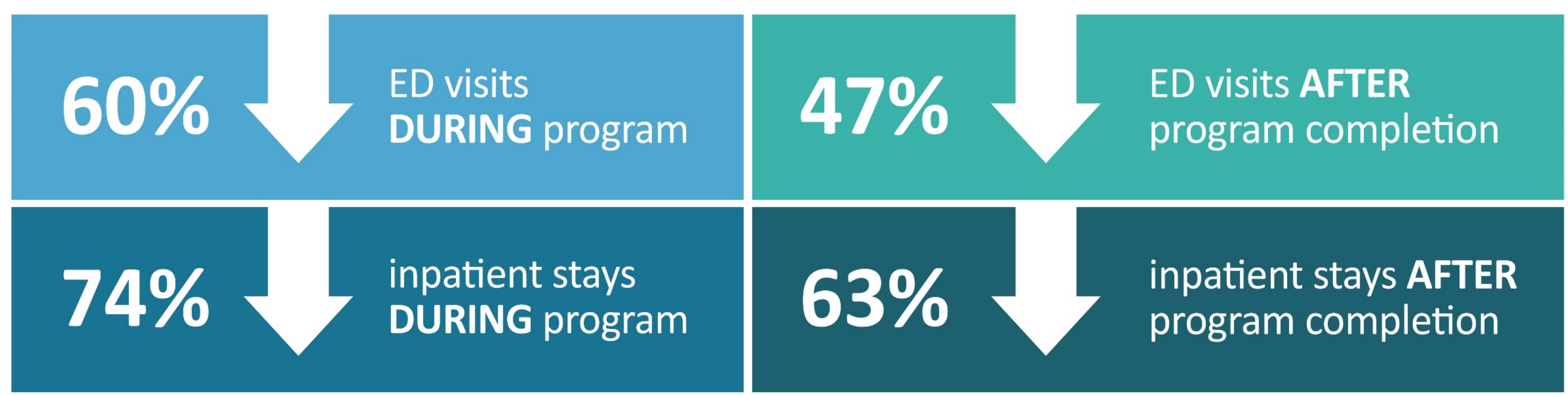
3.23 average # of PCP visits/patient stay

59% entered permanent housing

3.76 PCP to ED visits during program ratio

Hospital Utilization

October 2018 – March 2022



Document-ready for Housing

- Entered in VI-SPDAT
- Housing applications completed
- Personal documents secured

80% document-ready for housing at exit

89% personal documents secured

87% completed housing applications

88 unique patients from October 2018 – March 2022

Location if Ever Entered Permanent Housing

October 2018 – March 2022

n=48

	Count	Percent
Private Apartment	16	31%
City Housing Authority	15	29%
Family Reunification	5	10%
Other	5	10%
Skilled Nursing Facility	4	8%
County Housing Authority	3	6%
Community Housing Corporation	3	6%

LESSONS LEARNED

What We've Learned: Document-ready for Housing

- Support during the program helps patients enter housing in the future
  - 47% of graduates currently in permanent housing
- Transition to PATH shelter program provides continuation of key services
- More permanent, supportive housing options are needed

What We've Learned:
ED and Inpatient Use

- Connection to primary care provider is a top goal
  - 3.8 ratio of PCP to ED visits
- Hospital utilization changes over time
  - Research study to understand impact of COVID-19

What We've Learned:
Continuum of Care

- Staff employed by the health system allows for increased continuity of care
- Recuperative care team communicates with hospital care teams
- Recuperative team frequently supports transitional needs of hospital patients

What We've Learned: Documentation in the Medical Record

- Improves communication with clinical care team
- Flags on medical records connect to recuperative care team
- Continued education is needed to increase utilization among hospital care team

What We've Learned: Funding

- Hospitals can:
  - Leverage community benefit funding
  - Bring Medicaid expertise
  - Connect with broader philanthropic support

DISCUSSION:
EXPERIENCES IN THE FIELD

HOW WOULD YOU DESCRIBE

your experiences with hospital-shelter relations?

WHAT HAVE YOU LEARNED

in advocating to hospital leadership for those experiencing homelessness?

WHAT SHOULD BE THE ROLE of your hospital after the patient transitions to recuperative care?

WHAT OUTCOMES COULD
hospitals and shelters achieve together?

HOW CAN COLLABORATION among community partners support hospital-shelter roles and relations?

Questions?