Meet the Team

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School of Medicine
UNIVERSITY OF COLORADO
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uchealth

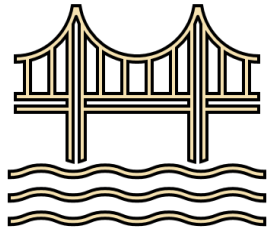
HTT Project Information

Transition of Care Focus: HTT serves along the care continuum from ED entry, inpatient stay, to discharge outpatient support. As a transition of care program, we work with patients to help them better connect to resources and ideally more stable housing situations.

Partner Development: Ongoing community partnership development to improve meaningful discharge destinations for patients to promote more choice.

Program Intention: HTT was devised to support unhoused individuals whose housing insecurity/deprivation has resulted in deferred medical care and hospital readmissions. Specifically, HTT will focus on those who face significant barriers to connecting with community housing programs and supportive services.

Community Bridge Support: HTT's mission is to provide increased access to intensive care management and community supports to address barriers to housing access, minimize impacts of social determinates of health (SDOH) and reduce overall ED visits.



HTT Care Management Bridge from Hospital to Community

Reducing Cost & Increasing Quality: HTT is supported by Medicaid Supplemental Funding through CU Medicine's Office of Value Based Performance, with an obligation to foster transitions of care programming and reduce total cost of care, ED utilization and hospital admissions. As a result, we are working to improve quality of care for patients by providing more tailored services to their needs.

Internal Collaboration: HTT collaborates with UCHealth's interdisciplinary teams to foster patient stability and ideally/eventually community reintegration. We routinely work with primary service social workers, RN care managers, care coordinators (DME), physicians, physician assistants, nurse practitioners, RNs, CNAs, etc.

General Info: HTT is physically located on Anschutz Campus (UCHealth)serving the Metro Denver area. Currently, Medicaid Supplemental Funding supports a full time SW, RN CM, Project Manager, equipment, mileage reimbursement and continuing education.
HTT project is in year 2.

Improving Linkage & Patient Participation: Meet and subsequently follow UCHealth-engaged individuals who are unhoused and experiencing frequent ED visits/hospital admissions & disrupted preventative health care. We work to develop patient-centered care plans aimed at helping individuals connect with meaningful resources.

HTT Project Goals & Initial Results

1. Reduced lengths of stay & organizational costs
    - HTT has helped patients reduce lengths of stays/readmissions by working with community partners to help patients successful connect with protective action respite motels, shelter to housing programs, transitional/respite facilities, and residential substance use treatment programs.

2. Improved linkage to community providers/SDOH data collection
    - HTT has partnered with several community agencies to provide transition of care support. We have also been consulted by other hospital systems to improve transition of care support for mutual patients. HTT has begun collecting social determinates of health data to better understand patients' needs/goals.

3. Development and partnership with housing voucher program
    - An initial pilot project has been created with the Colorado Coalition for the Homeless (CCH) nicknamed "PAR2Pad" that will link 10 UCHealth patients to protective action motels and then to permanent housing/apartments. HTT is currently working to see if a more formal housing partnership can be created between UCHealth, CCH, and other community partners to provide more permanent housing opportunities.

4. Attend community homeless service provider meetings to improve care coordination
    - HTT has met, outreached, and/or partnered with several community groups. We continue to attend ongoing meetings with city groups (e.g., Aurora's Built for Zero, Denver HOST's Complex Case Committee, etc.) to brainstorm solutions to help additional clients.

5. Partner with local cities/groups to improve patient access to housing instability initiatives
    - HTT participated in the annual Point in Time annual count with the City of Aurora's Homeless Program. We also have a partnership with the Salvation Army & City of Aurora to have dedicated spots for discharging patients to Safe Outdoor Space sites (Pallet Shelter). With the Denver Rescue Mission and Denver's Department of Housing Stability (HOST), HTT is working to improve oxygen coordination discharges to area shelter facilities.




(Double checking ADA accessibility with SOS Site to ensure appropriate discharge planning for patient with power wheelchair)

HTT Tier System (Service Priority)

Tier 3- Most in need of HTT as Primary

1. Pt cycling in and out of ED/UCH or has experienced recurrent hospitalizations (i.e., 2+ times in one month or 4+ times over six months)

2. Identified community services have been unable to meet an individual's care needs

3. Significant barriers to accessing identified resources and/or housing pathways

4. "Discharge to prior living situation" only identified discharge destination, and/or discharge plan is likely to result in a return to the ED/readmission to the hospital

Tier 2- In Need of HTT direction

1. PT is experiencing barriers to accessing resources (e.g., ongoing case management with Colorado Coalition for the Homeless) and one or both of the following applies:

--> Individual would benefit from HTT identifying and coordinating with contacts to facilitate more consistent follow up

--> Confirmation of follow up would facilitate continuation of care and, if individual is admitted to UCH, expedition of eventual hospital discharge

2. Primary social worker has run into challenges coordinating with relevant community partners and verify discharge supports

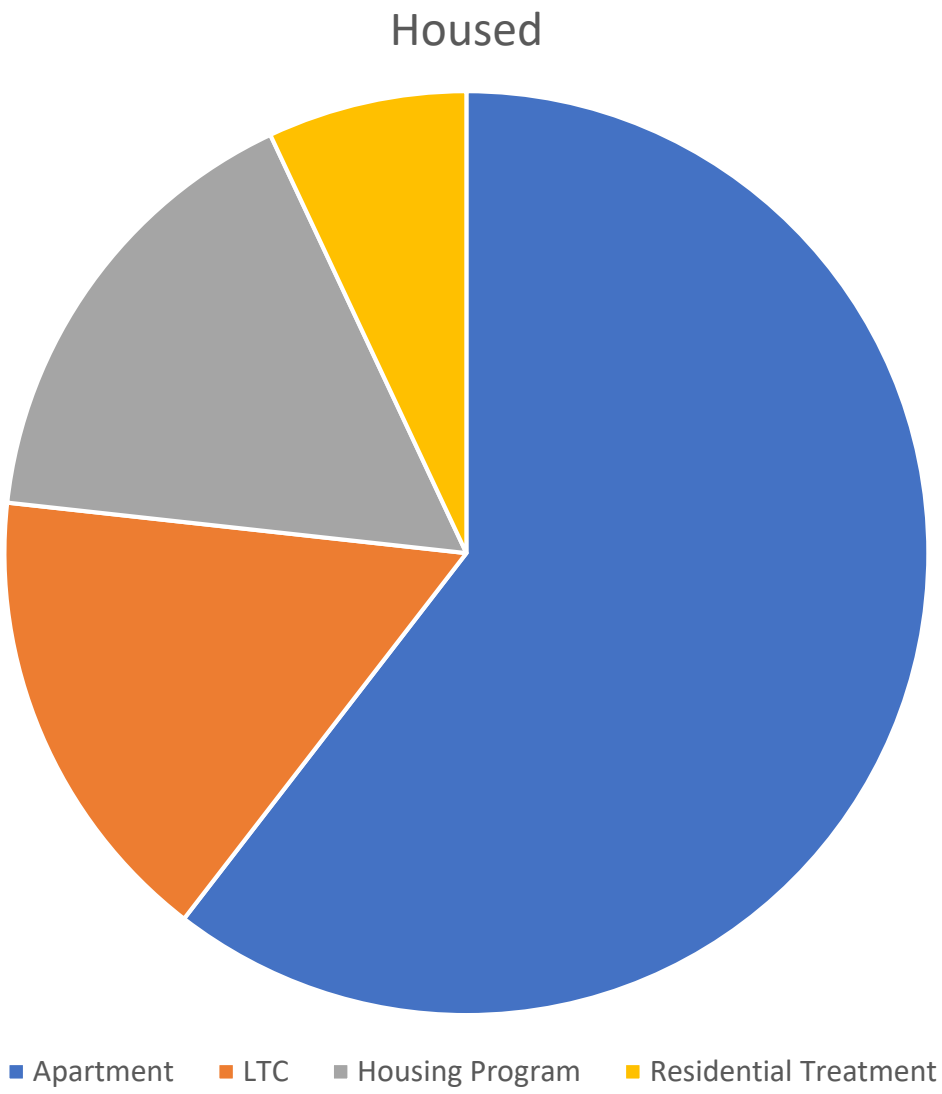
Tier 1- HTT direction to Primary SW

1. The individual is experiencing episodic housing insecurity, wherein the individual is perhaps not currently housed, but is likely capable of navigating community resources with assistance from primary team

2. The individual is engaged with community resources, and no immediate barriers identified that would prevent the individual from continued engagement and establishment of ongoing case management in community

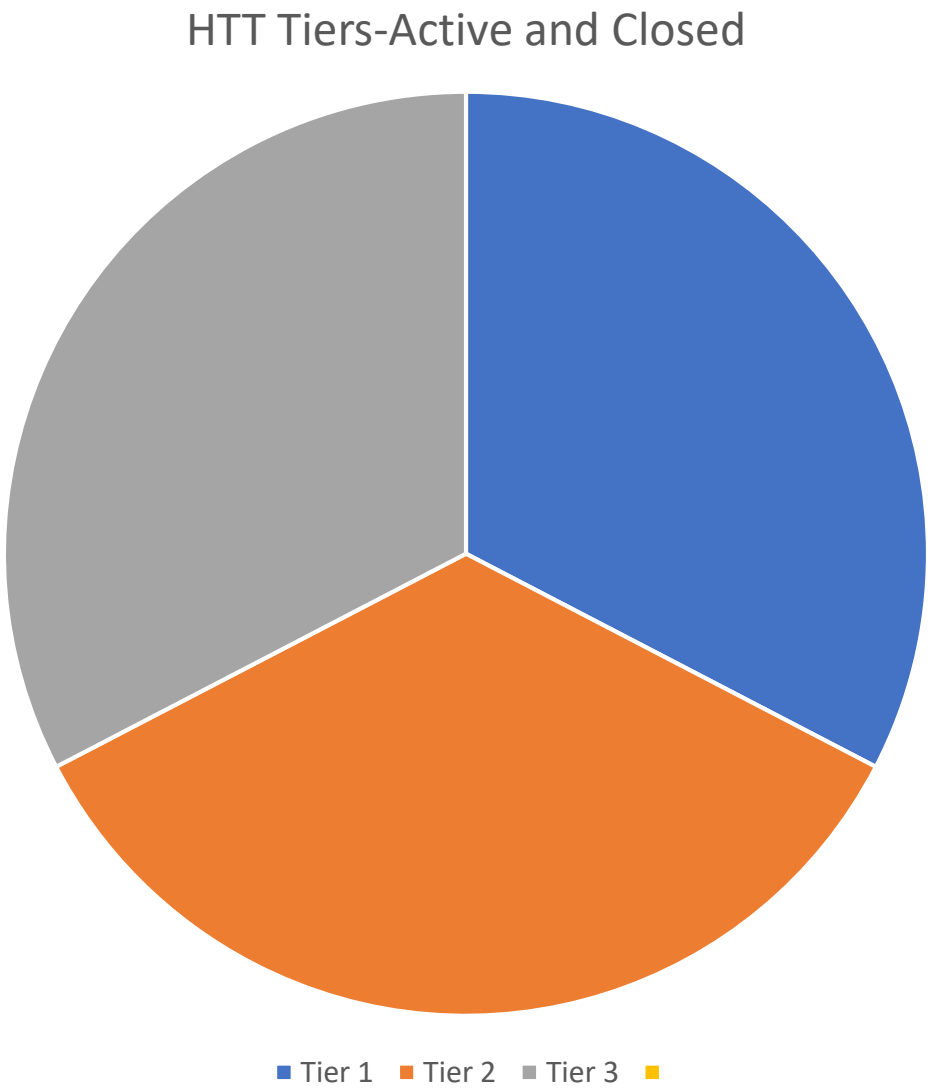
3. Identified barriers can likely be addressed using community resources and tip sheets already available to primary SW (e.g., assisting individual in accessing a phone, applying for benefits, coordinating transportation)

HTT Housing Statistics



HTT engagement from 10/2021 to 8/2022

HTT Tier/Acuity Statistics



HTT engagement from 10/2021 to 8/2022

Community Connections & Resource Development

1. Mile High Behavioral Healthcare (Comitis Crisis Center & Aurora Day Resource Center)
2. Colorado Coalition for the Homeless (Beacon Place respite, PAR hotels/motels, Housing First, Vocational Services, Family Support Services, Community Resources, & Outreach)
3. Denver Rescue Mission (shelters & case management teams)
4. Catholic Charities (shelters & case management teams)
5. Salvation Army (Crossroads Center shelter, Safe Outdoor Spaces Aurora, & Harbor Light)
6. The Gathering Place (High Street & Rodeway Inn PAR motel)
7. Aurora Mental Health (PATH program/outreach team)
8. U.S. Dept. of Veterans Affairs (Homeless Program, HUD VASH Program, inpatient/outpatient social work teams)
9. Metro Denver Homeless Initiative (MDHI). *UCHealth now has access to Homeless Management Information System (Clarity/One Home) to collaborate with community partners.
10. Colorado Department of Local Affairs, Division of Housing (Office of Homeless Initiatives)
11. Aurora Outreach Collaborative (partnership of several agencies)
12. Denver Street Outreach Collaborative (partnership of several agencies)

13. City & County of Denver's Department of Housing Stability (HOST)

14. City of Aurora's Division of Housing & Community Services (Homeless Program, Aurora Flex Fund, Built for Zero, & Aurora@Home)

15. Other hospital systems to support mutual patient discharge planning: Denver Health, Rose Medical Center (HealthONE), Swedish Medical Center (HealthONE), Porter Adventist Hospital (Centura), St. Joesph's Hospital (SCL), Lutheran Medical Center (SCL), etc.

16. Adams County Homeless Program

17. Commerce City Homeless Program

18. The Housing Authority of the City of Aurora

19. Denver Housing Authority

20. Boulder Shelter for the Homeless

21. Rocky Mountain Immigration Advocacy Network (RMIAN)

22. Delores Project

23. Colorado ID Project (Colorado Legal Services)

24. Second Chance Center (justice-involved clients)

25. Atlantis Community, Inc.

26. The Reciprocity Collective

27. Senior Support Services

28. Recovery Works Today (respite beds in Lakewood/Jefferson County)

29. Colorado Village Collaborative

30. Colorado Access

31. Colorado Health Network

32. Colorado Immigrant Rights Coalition (CIRC)

33. Colorado Community Health Alliance (CCHA)

34. Family Tree

35. HUD Colorado Field Office

*UCHealth's HTT continues work to develop deep community partnerships that will take-over community care (e.g., long term case management). *At its core, UCHealth's HTT is a hospital-based program intended to provide transitions of care into the community.*

Community Sites

Denver Rescue Mission
Lawrence Street Shelter
Downtown


A Loft Hotel (City of Denver/Salvation Army)
Protective Action Respite Site


CCH's Beacon Place Respite Program


Catholic
Charities 48th
Ave Shelter


Catholic Charities'
Samaritan House
Downtown

Salvation Army's Aurora
Safe Outdoor
Space (Peoria)


Denver Rescue Mission's 48th Ave Shelter

Volunteers of
America Family
Motel
(Aristocrat)

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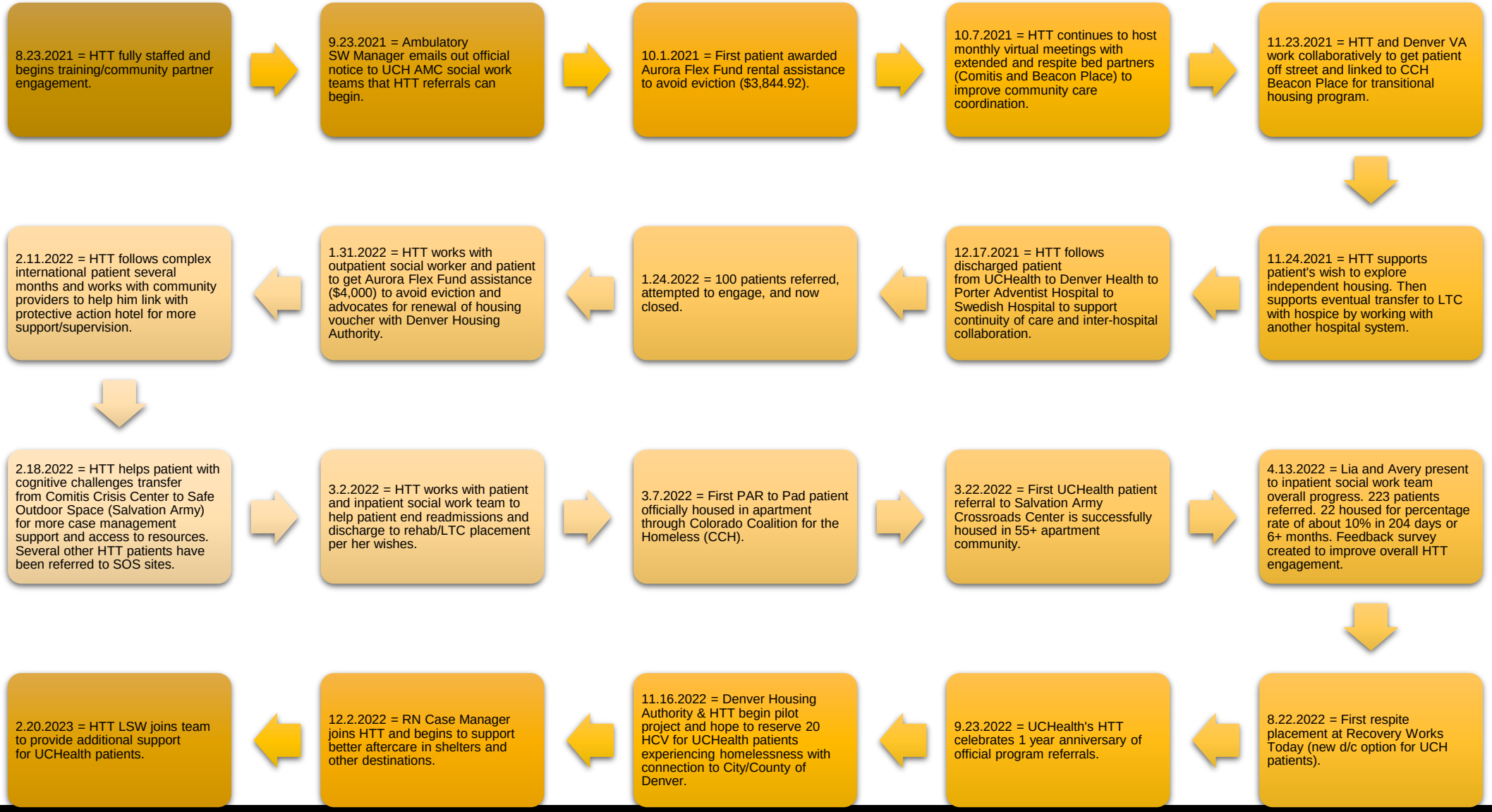
Photo Sources: Original onsite photos, Google Images, DRM, & Denverite.

HTT Timeline Service Highlights



Patient Success Stories

Patient Story (Tim)

- Tim had been living on the streets and cycling in and out of the ED for over a year after being denied housing voucher due to daily health and functionality needs; Tim identified no supports in the community. HTT coordinated with Aurora Mental Health and inpatient SW to discuss options; Tim initially declining any facility placement, but eventually ARG/LTC Medicaid approved and agreeable to SNF in lieu of housing; Tim now thriving at LTC.

Patient Story (Paul)

- Paul was evicted in context of COVID- and health-related disruptions in Paul's ability to access income; Paul resided in emergency shelter beginning in July of 2021, and experienced prohibitive barriers in navigating traditional housing resources. HTT coordinated with community agencies with access to housing vouchers, and Paul moved to respite motel in December, with confirmed pathway to permanent housing in the coming months.

Patient Story (Sarah)

- A refugee, Sarah was 6 weeks out from giving birth while caring for her 2-year-old daughter. She was non-weightbearing on one leg due to an incident of intimate partner violence with the father of her unborn child. Sarah shared an e-mail from Denver Housing Authority reporting she had been taken off waitlist due to failure to respond to a letter sent. [The letter was sent while Sarah was inpatient, recovering from her surgery and attempting to heal from the traumatic event.] HTT SW spent several weeks calling and e-mailing Denver Housing Authority (DHA) in attempts to advocate for DHA to reconsider their decision. Ultimately, DHA granted a hearing for Sarah. HTT SW and Sarah's Social Worker in OB/GYN clinic gathered documentation to send to DHA and attended the hearing to advocate for patient, young children, and elderly aunt to be reconsidered for permanent, supportive housing. Sarah was re-instated and is back on the waitlist. HTT SW also submitted a referral to Aurora Flex Fund which ultimately awarded Sarah $4,000 of rental assistance which will allow Sarah and her family to remain in their current apartment until the end of April. **Patients' names changed to protect confidentiality*

Program Successes

Improved discharge planning for patients

- More dedicated time building rapport with patients and co-developing discharge plans to promote community stability/avoi d readmissions.
- Continued advocacy for patients after discharge to help them connect and maintain links with housing, medical/mental health care, and other important services.
- Helped patients apply for benefits when needed to support their overall stability post-discharge (e.g., identification to qualify for housing).

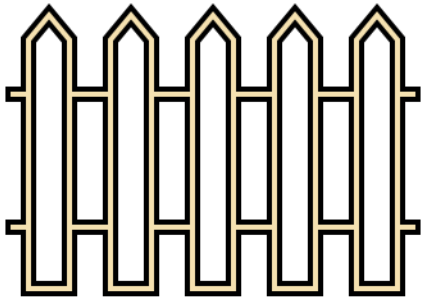
Increased community partnerships & new resource pathways

- Built new relationships with community agencies. This has opened new resources and shortened typical wait times for patients accessing services.
- Successfully applied with patients and received eviction prevention assistance that helped keep them in their housing (City of Aurora's Flex Fund).
- Outreached patient in community with Denver VA homeless coordinator and helped patient link to transitional housing opportunity (promoting their stability and safety).

Increased patient choice, trust, & participation

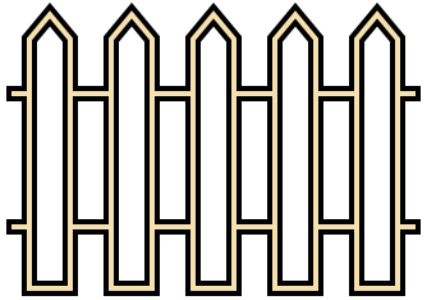
- Built collaborative relationships with patients to help determine best fit for their housing needs and helped them link to alternative to congregate shelters when needed (e.g., Safe Outdoor Space sites, extended respite stays, etc.).
- HTT was able build therapeutic alliances with patients to provide mental health support and triage in the community when needed.
- One consistent staff-advocate contact through the medical system (ED, inpatient, outpatient, and into the community).

Program Barriers



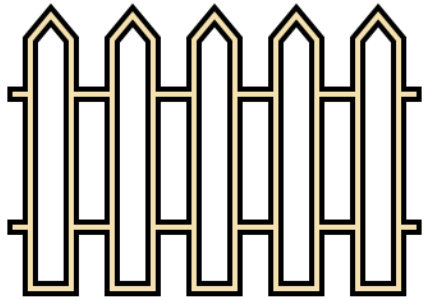
Gaps in established resources that effectively exclude some populations or create prohibitive obstacles to access

- Resources are limited for those with legal history, documentation status, gender identity, and/or families with children.
- Gaps in immediate and long-term access to needed services exacerbating their physical and mental health challenges.



Lack of options for individuals who do not have a "safe discharge plan" and have prolonged hospital stays

- Need a higher level of care than a shelter can provide but do not have appropriate insurance coverage.
- Need a higher level of care but have known behavi ors to placement.



Resource silos

- When resources function in silos this causes individuals that lack financial/ material resources, access to transportation, and sufficient technology to communicate with several institutions at once to access services.
- This is occurring at a time when staffing shortag es are common and in-person engagement is complicated due to COVID-19.

Thank you!

For additional questions or info, email us at:
housingtransitionsteam@uchealth.org