THRIVING BEYOND RECUPERATIVE CARE: NAVIGATION & SUPPORT FOR GRADUATES

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Cottage Center for Population Health

Overview

- Cottage Recuperative Care Program at PATH
- Graduate Support
- Patient Story
- Questions

COTTAGE RECUPERATIVE CARE PROGRAM AT PATH

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 Rehabilitation Hospital

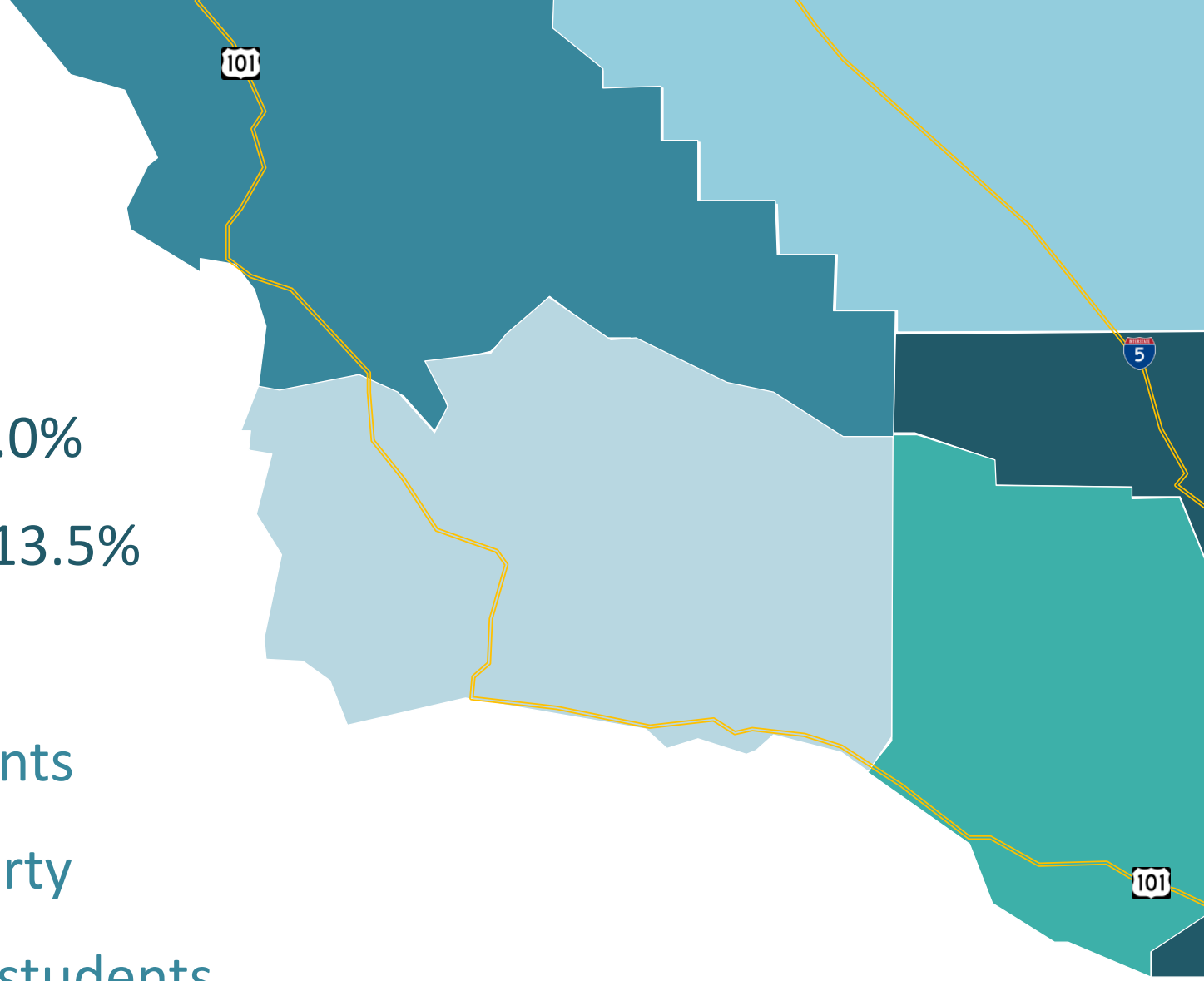
Cottage Residential Center
for chemical dependency treatment

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

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

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

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EMERGENCY EXIT ONLY
ALARM WILL SOUND

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

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

Electronic Medical Record Documentation

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

Hospital-led
Recuperative Care

- Improved continuum of care
- Workforce development program
- Buy-in from community partners, including funders
- Funding support
  - Leverage community benefit
  - Bring Medicaid expertise
  - Connect with broader philanthropic support

Recuperative Care Patient Advisory Committee

Overview

- Quarterly meetings
- Housed and unhoused groups
- 3-4 residents per group
- Incentive gift bags

Goals

- Gather feedback on quality improvement opportunities
- Receive stakeholder guidance on future direction

Theme:

Recuperative Care helps patients meet their medical goals

I went from being in a wheelchair 90% of the time to be able to take a shower mostly by myself, and now I can take a shower with a little supervision.

Theme:

Patients' perceived medical status has improved

My cancer is in remission. My doctor says I am doing much better with my thyroid numbers…I'm doing better all the way around the block.

Document-ready for Housing

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

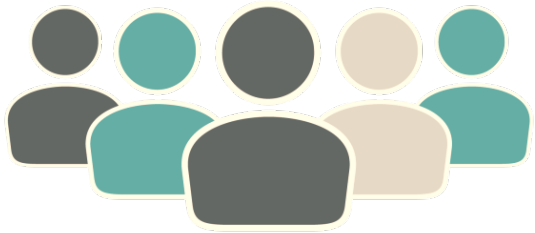
72% document-ready for housing at exit

90%

personal documents secured

81%

completed housing applications



118 unique patients from October 2018 – March 2023

Recuperative Care Evaluation

October 2018 – March 2023

PATIENT OUTCOMES:

156

Patients total

38

Repeating patients

7

Current patients

78%

Visited medical home during stay

3.31

Average # of PCP visits/patient stay

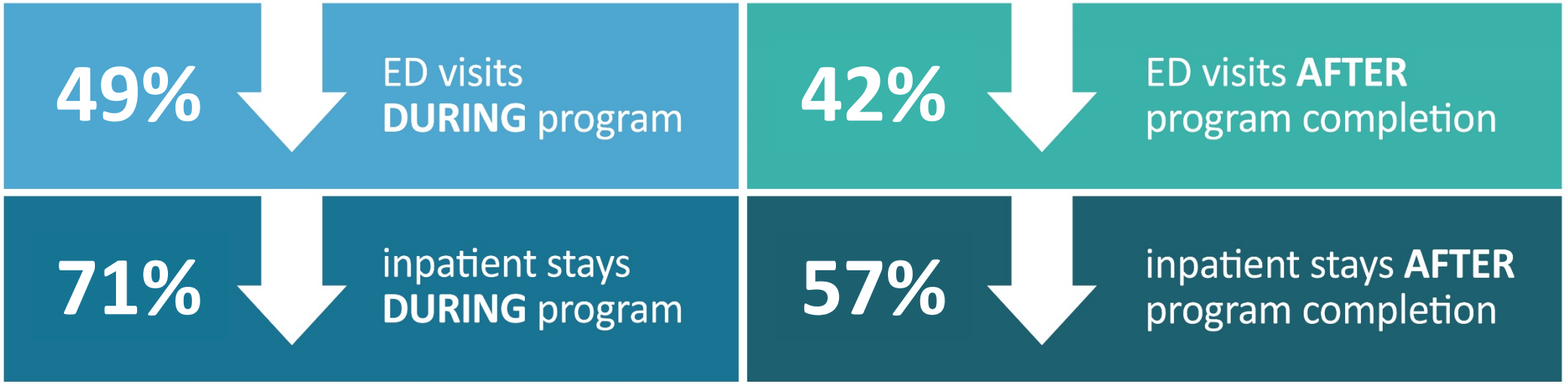
3.39

PCP to ED visits during program ratio

Hospital Utilization

October 2018 – March 2023

PROGRAM OUTCOMES:



Compared to the 90 days before entering the program


GRADUATE SUPPORT

Cottage Recuperative Care Program
Graduate Support

25 average case load

365 days or longer of follow-up care

0.5 FTE social worker

0.5 FTE registered nurse

0.2 FTE social needs navigator

- All graduates of Recuperative Care Program
- Continue with housed and unhoused patients
- Support patients with varying levels of need

Recuperative Care Nurses

- Create and update Medical Needs Care Plans
- Provide basic medical care and education
- Connect to a medical home
- Navigate to appointments and liaison with physician
- Assist with medication management

Community Health Navigator

- Creates and updates Social Needs Care Plans
- Connects with resources and support services for social or basic needs
- Helps become document-ready for housing
- Coordinates with Cottage case managers and social work

Medical Social Worker

- Connects patients with necessary resources
- Liaisons and advocates with housing property and other partners
- Counsels those in crisis or experiencing distress
- Conducts psychosocial assessments to identify mental or emotional distress

Graduate Follow-up Approach

- Flexible to meet patients' needs
- Patients' needs guide:
  - Intensity of follow-up
  - Length of services
- Small actions build trust
- Leverage other community resources as much as possible

Graduate Support: Patient Goals

- Reach individual medical goals
- Connect to permanent supportive housing
- Maintain permanent housing
- Develop independence in supporting basic needs

Types of Medical Goals

- Independent in medication management
- Maintain relationship with primary care provider
- Tracking vitals and nutrition
- Continuing to engage in treatment plan

Graduate Support
& Continuum of Care

- Hospital employs follow-up care team
- Increased continuity of care
- Communication with hospital care teams

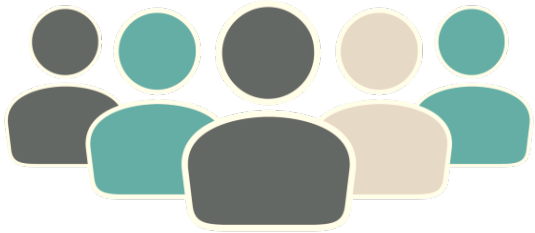
Graduate Housing Placement

- Most housing placements happen post-Recuperative Care Program
- Majority of patients retain transitional/temporary housing

56% ever entered permanent housing

49% currently housed

88% housing retention rate



114 unique patients from October 2018 – March 2023

Location if Ever Entered Permanent Housing

October 2018 – March 2023

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%


PATIENT STORY

Recuperative Care Graduate: Patient Story

Recuperative Care Graduate:
Patient History

- 57-year-old male
- Living in his truck and couch surfing
- Medical needs:
  - Diabetes
  - Stroke
  - Hypertensive heart disease with CHF
  - Sleep apnea
- Polysubstance use and depression
- Challenges adhering to treatment plan
- Multiple ED visits and inpatient stays

Progress During Program

- One full and one partial stay in Recuperative Care (90+23 days)
- Established new primary care provider due to bias
- Started engagement in treatment plan
- Initial recognition of substance use challenges
- Trust built with care team

Patient Story:
Addressing Medical Needs

- Assisted with wound care
- Helped him fill his pill box weekly
- Set-up pharmacy pick-up near his home
- Assisted with establishing routine to take his insulin
- Set-up advance directive
- Navigated to medical appointments
- Coordinated with his providers to arrange care

Housing Placement:
Housing Authority Property

- Project-based voucher
- Name came up on the waitlist
- Studio apartment with a kitchenette

Patient Story: Building Trust

- Warm handoff to introduce follow-up care team
- Started by addressing his top priorities in new home:
  - Setting up cable
  - Ordering shoes and tablet
  - IT questions
  - Continuous glucose monitor
  - Transportation to appointments

Patient Story:
Addressing Mental Health and Substance Use Needs

- Provided grief counseling and support during family loss
- Offered education on impacts of substance use with health conditions
- Supported his access to spiritual care
- Reported he became sober to maintain housing and has been sober for 6+ months

Patient Story: Addressing Basic Needs

- Signed up for SNAP and utility rebates
- Enrolled in EasyLift transportation and In Home Supportive Services (IHSS)
- Connected to existing community resources
- Served as liaison and advocate with Housing Authority to prevent eviction

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