A Health System-Led Recuperative Care Program: Enhancing Cross-Organizational Collaboration for Seamless Care

2024 CALIFORNIA Recuperative Care SYMPOSIUM

SEPTEMBER 12-13 ★ SACRAMENTO

PRESENTED BY KAISER PERMANENTE®

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NATIONAL INSTITUTE for MEDICAL RESPITE CARE

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

Overview

1. Health System Leadership
2. Shelter Partnership
3. Program Design
4. Program Overview
5. Evaluation
6. Discussion and Questions


HEALTH SYSTEM 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 Rehabilitation Hospital

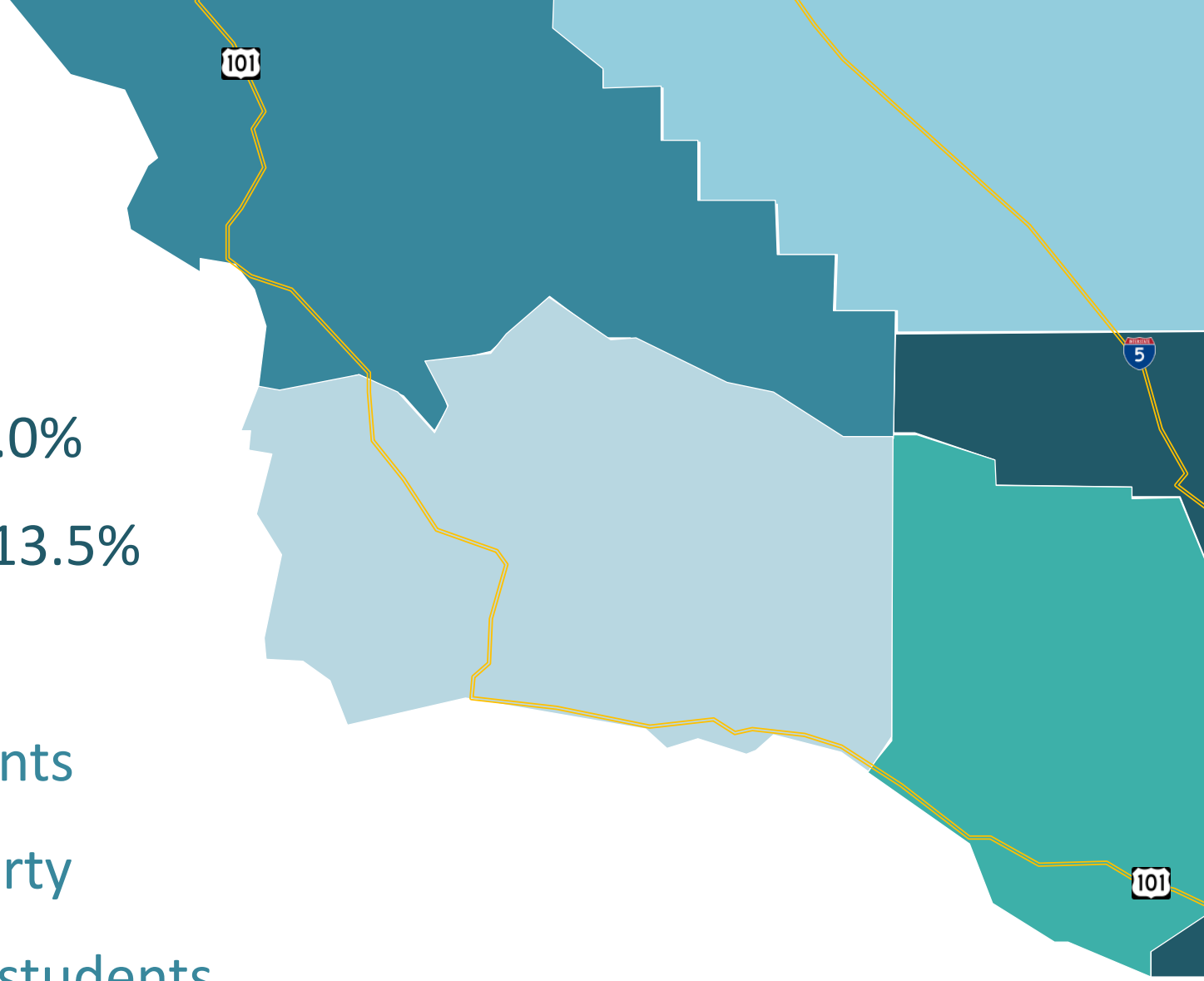
Cottage Residential Center
for chemical dependency treatment

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

Homelessness in Santa Barbara County 2024

Santa Barbara County:
2,119 individuals experiencing homelessness

South Santa Barbara County:
1,418

Cottage Health hospital averages for patients experiencing homelessness:

- 453.5 patient visits/month
- Daily census:
  - 13.7 patients in Emergency Department
  - 13.0 inpatients

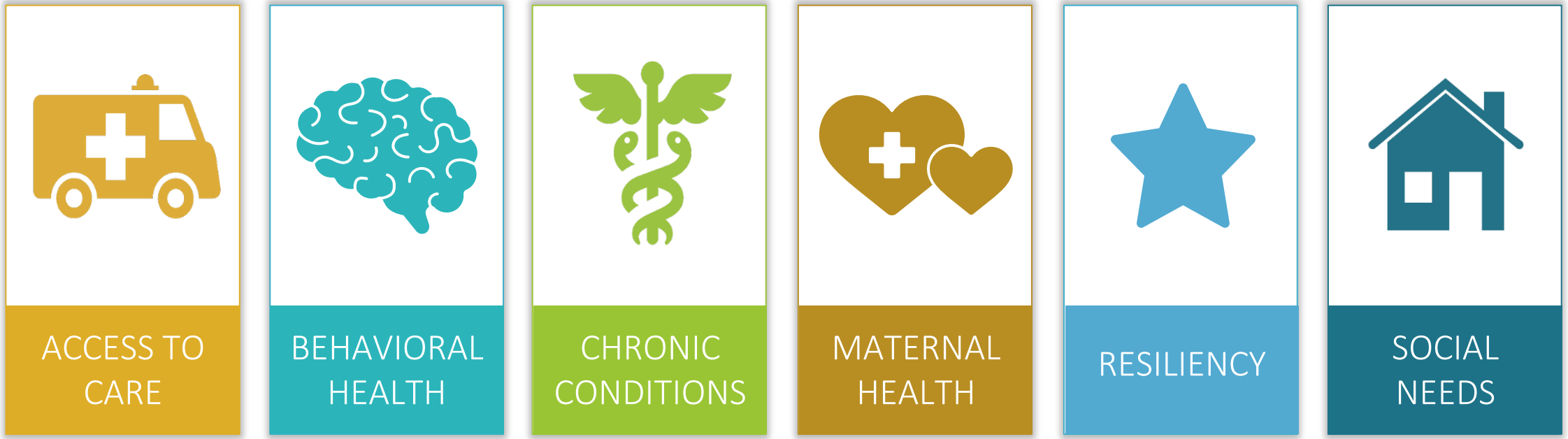
Community Health Needs Assessment

2016-2022 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

2022 Community Health Needs Assessment:
Priority Areas




SHELTER
PARTNERSHIP

INTRO TO PATH

For the **last 40 years**, PATH has worked to end homelessness for individuals, families, and communities. **Founded in 1983**, PATH's mission is to end homelessness for individuals, families, and communities. PATH does this by providing supportive services and building affordable and supportive housing across the state.

With staff in **150 cities** across California, PATH provides supportive services to over 25,000 individuals each year. **Last year, PATH served nearly 534 individuals and helped over 119 make it home in Santa Barbara**.

STATEWIDE IMPACT

PATH By The Numbers 2023

AT A GLANCE TOTALS

26,221
people served

4,104
housing placements

LOS ANGELES
15,852 people served
2,698 housing placements

SAN DIEGO
6,594 people served
884 housing placements

SANTA CLARA COUNTY
1,188 people served
221 housing placements

SANTA BARBARA
534 people served
119 housing placements

ORANGE COUNTY
2,053 people served
182 housing placements

* Data represents approximate totals from July 2022 - June 2023

SANTA BARBARA

On July 1, 2015, PATH merged with Casa Esperanza Homeless Shelter to become PATH Santa Barbara. In Santa Barbara, PATH provides a variety of life-saving services for our neighbors experiencing homelessness that include street outreach, housing navigation, interim housing, inclement weather shelter, rapid re-housing, intensive case management services, landlord engagement, and permanent housing solutions.

Our facility also serves as an access point for the county's coordinated entry system (CES), which allows PATH to help unhoused Santa Barbarians navigate the resources and services they need to move into and retain their own homes.

SANTA BARBARA PROGRAMS

Key Programs:

- Interim Housing
- Rapid Re-Housing (RRH)
- Permanent Supportive Housing
- Housing Search & Navigation
- Health and Wellness
- Coordinated Entry System Physical Access Point
- Community Food Program


PROGRAM DESIGN

Recuperative Care Program History

Prior to 2016:

Offered Transitional Care Program at PATH

2016-2017:

Initiated Recuperative Care planning and Steering Committee based on community needs assessment

2018-2019:

Piloted and launched Cottage Recuperative Care at PATH

2020:

Transitioned to documenting in medical records

2021-Present:

Process improvements:

- Advisory Committee
- Graduate program expansion
- Enhanced hospital coordination

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

Cottage
Center for
Population Health

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

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

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

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

Electronic Medical Record Documentation

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

Patient Story: Building Trust

- Medical Hx: diabetes, stroke, substance use, and depression
- Began engaging in treatment plan during Recuperative Care
- Project-based voucher and housed in Housing Authority studio apartment
- Built trust by addressing his top priorities in new home


PROGRAM EVALUATION

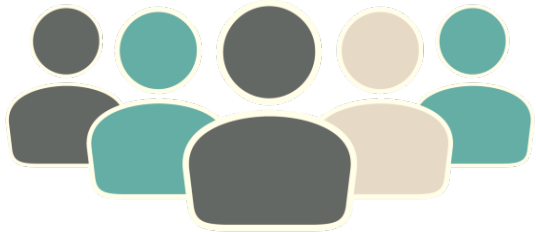
Recuperative Care Evaluation

- Patients document-ready for housing at exit
- Improved patient health and self-efficacy
- Personal documents secured

84% have entered permanent housing

51%
decrease in Emergency Department visits

58%
decrease in inpatient stays



137 unique patients
from October 2018 – December 2023

Recuperative Care Patient Advisory Committee

Overview

- 3 meetings/year
- 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.

What We've Learned: Document-ready for Housing

- Support during the program helps patients enter housing in the future
- Continued support after program allows time to become document-ready
- More permanent, supportive housing options are needed

What We've Learned: Continuum of Care

No matter where Cottage patients go, they have had support. This provides the continuum of care that is critical.

-- Service provider at Housing Authority properties

What We've Learned:
ED and Inpatient Use

- Connection to primary care provider is a top goal
  - 1.34 ratio of PCP to ED visits
- Social work and case manager connections in hospital are critical
- Accompany patients to the ED when necessary

What We've Learned: Funding

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

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Center for
Population Health

PATH
MAKING IT HOME

DISCUSSION: EXPERIENCES IN THE FIELD

WHAT HAVE YOU LEARNED

in advocating to hospital leadership for those experiencing homelessness?

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WHAT SHOULD BE THE ROLE

of a hospital after the patient transitions to recuperative care?

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WHAT OUTCOMES COULD
hospitals and shelters achieve together?

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