Beyond the Hospital Walls: A Partnership to Improve Hospital Care and Care Transitions for Persons Experiencing Homelessness

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Objectives

• Background
• Methods
• Key Findings
• Implications
• Applying Shared Vision
Funding and Disclosures

• No conflicts of interest
• All photos and data shared with permission
Snapshot of Homelessness

Metro Denver 2019

Source: Metro Denver Homeless Initiative, 2019 Point in Time Report
Background: Partner Organizations

- Safety-net hospital and vertically integrated healthcare system in
- Mission to provide high quality healthcare to all people

- Integrated housing, healthcare and supportive services provider
- Mission to create lasting solutions to homelessness
# 2018 Denver Health Hospital Encounters

Adult discharges from Medicine, Surgery and Psychiatry, excluding emergency dialysis

<table>
<thead>
<tr>
<th></th>
<th>Homeless, n= 1717</th>
<th>Not Homeless, n = 10,243</th>
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</thead>
<tbody>
<tr>
<td>Mean age, years</td>
<td>48</td>
<td>51</td>
</tr>
<tr>
<td>Female</td>
<td>377 (21.9%)</td>
<td>4377 (42.7%)</td>
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<tr>
<td>Payor</td>
<td></td>
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</tr>
<tr>
<td>Medicare</td>
<td>365 (21.3%)</td>
<td>3150 (29.9%)</td>
</tr>
<tr>
<td>Medicaid</td>
<td>1243 (72.4%)</td>
<td>4828 (45.8%)</td>
</tr>
<tr>
<td>Substance Use</td>
<td>1394 (81.2%)</td>
<td>4037 (39.4%)</td>
</tr>
<tr>
<td>Mental Health Condition</td>
<td>1034 (60.2%)</td>
<td>4767 (46.5%)</td>
</tr>
<tr>
<td>Average LOS, days</td>
<td>7.69</td>
<td>6.44</td>
</tr>
<tr>
<td>30-day readmissions,%</td>
<td>17.6</td>
<td>12.6</td>
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Large Shared Homeless Population

Primary Care Medical Home for Adult Inpatient Encounters for Homeless Individuals on Medicine, Surgery and Psychiatry, 2018 Denver Health data

Excluding emergent dialysis encounters
Homelessness and Health Inequities

- Large burden of acute and chronic disease
- High rates of mental health and substance use disorders
- Higher ED and hospital utilization
  - Longer Length of Stay
  - More 30-day readmissions
- Increased risk of death

Wadhera RK, et al. Med Care, 2019
Rinehart DJ, et al. Med Care, 2018
Morrison DS, Intern Journ Epid, 2009

Photo credit: Colorado Coalition for the Homeless
Thinking Beyond the Hospital Walls

• Hospitalized patients experiencing homelessness are a vulnerable group

• A better understanding of the perceptions of people with lived experience and frontline community stakeholders is needed to improve care

Photo credit: Colorado Coalition for the Homeless Street Outreach
Partnership Goals

1. Develop a new academic-community research partnership with Colorado Coalition for the Homeless

2. Convene a Community Advisory Panel (CAP) to:
   - Better understand community perceptions, needs and priorities related to hospital care and care transitions
   - Develop a shared vision for meaningful improvement through future research, programs and services
Methods

• Setting: Stout Street Health Center, Denver, CO

• Participants: Adults with lived experience of homelessness or community care providers, English-speaking, able to participate in meetings and provide consent

• Structure: 6 meetings planned/facilitated by lead partners, refined through shared decision-making with participants. Meals and $25 gift cards provided

• Data Collection/Analysis: meetings audio-recorded and transcribed, coded in Atlas.ti utilizing codes derived *a priori* from theory and inductively, major themes and sub-themes identified
Hospital Care and Care Transitions CAP

6 Patients with Lived Experience:

- 5 men and 1 woman
  - 2 dropped out due to work conflict
  - Remainder each attended between 3-5 meetings
  - 3 participants hospitalized and/or incarcerated but remained engaged

6 Community Stakeholders:

- Street Outreach worker
- Respite Case Manager
- Mental Health Professional
- Housing Program RN
- Health Center RN
- Hospital Social worker

*All attended 5-6 meetings
# CAP Challenges

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Strategies</th>
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<tr>
<td>Precarious health and housing status</td>
<td>Convenient location, call in-in option, contacting patients through respite</td>
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<tr>
<td>Lack of transportation</td>
<td>Arranging transportation to and from meetings</td>
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<tr>
<td>Facilitation of interdisciplinary panel</td>
<td>Facilitation to ensure all voices heard</td>
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<tr>
<td>Difficult topics</td>
<td>Ground rules, trauma-informed approach, support during/after meetings</td>
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<tr>
<td>Sustained engagement</td>
<td>Shared decision-making, communication between meetings</td>
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“Everybody sitting around this table is broken in some way. Some of us just live it more broken. But everybody is broken in some way. Some people handle it better than others”.
The Power of Patient Voice

**Researcher**
- Meaning and connection
- Perspective on the problem

**Community**
- Engagement and shared purpose
- More meaningful interventions to address disparities

**Audience**
- People remember the story **NOT** the data
Major Themes

1. Trauma experienced through homelessness and through healthcare interactions
2. Perceptions regarding the patient-provider relationship and communication
3. Support and recovery during hospitalization and after discharge
4. Interagency communication and care coordination, access to post-discharge services
5. Moral distress and burnout in those caring for homeless population
Theme 1: Trauma encountered through healthcare and homelessness

➢ The experience of trauma is pervasive, individualized and impacts care experience

“Clean and sober we have a lot of emotions that you have to deal with now. And when you are high you don't do emotions. So once you come off, you get bombarded. And it is overwhelming. And that makes you realize how you now can feel now. But that also causes more trauma.”
Theme 2: Patient-Provider Relationship

Need for Empathy in Healthcare Interactions

“I start with first responders... And a lot of times medical personnel, they act really messed up with the people they encounter on the street. So there has to be a complete shift in an entire population of first responders as to how you deal with somebody who... is obviously suffering from some trauma, some loss that obviously they require some kind of revolutionary love instead of being treated like in a stack of firewood to be transported and pawned off to somebody.”

“It just seems like when you are in the hospital you are dealing with Problem Solvers, not people that want to sit around and talk about your feelings... it just seemed like with my options, they are very matter of fact... You can go here. You can't go there... it kind of seemed like they weren't really engaged at all. They were just kind of checking boxes... Just the fact that they were even there it just seemed perfunctory.”
And I wouldn't have had a cardioversion if it hadn't been that I trusted him. And when he said you need to get to the ER or you are going to be dead. It actually impacted me, not because of the threat, that wasn't it... but because it came from somebody who basically, I felt listened to me.”

“We are a very complicated and diverse population of people... And I think that is the more critical point. Is that the system isn't being really respectful and responsive or sensitive to our diversity.”

“And yet it really requires - if you are dealing with somebody who is already damaged by something - that you really start from the beginning that there is no wrong person or person who is less, you know, worth to be able to be treated.”
Theme 3: Support and Recovery

➢ Social isolation is a major contributor to poor health outcomes

“What we need more than anything else, more than a system—is support, a support network. For many of us, because of our fragile condition, we have to have someone to talk to.”

➢ Peer support is a promising intervention

“Since most of us are isolated due to addiction and rejection, abandonment, neglect and self-afflicted issues... without a positive inspiring influence. [We need] someone who knows how to navigate life... This person doesn't have to have a degree. Can be a church member. Someone to just go somewhere with that knows Denver. That has phone numbers. They don't even have to know all the resources...”
Theme 4: Interagency communication and care coordination, post-discharge services

Hospitalization is a missed opportunity for communication and interventions to address vulnerability.

“We wish there were some kind of alert system. When someone comes into the ER who really needs to be flagged, we keep missing an opportunity to have that communication taking place. Or be admitted long enough to be sober to then take the exam. So even if you don't present as needing a Social Work consult, maybe that is a person we have been trying to capture to get into the health system... We talk about that all the time.”
Theme 4: Availability, Integration and Coordination of Post-Discharge Services

- There are substantial gaps in existing post-discharge services and a lack of integration and coordination.

“It is frustrating when the hospital tells us... they can do their ADLs and then we would get them and they can't get their ADLs. And they need a bed pan. We need this. We need that. And on the referral it says they can do their ADLs. And then we have them like in the situation yesterday, he couldn't do his ADLs. So I was constantly in the dorm...”
“So I mean a part of it is getting the patient, my client, to understand about their illness and maybe take their medicines or do their follow up appointments and be invested in their health, because they have other major priorities, right? Whether it is housing or food or a million things that are more important to them than a pill that doesn't make them feel any different than they did yesterday. But then I'm fighting the battle with the health system, right? Or that person is a no-show and they are not going to come. So it's like the fine line before an enabler or an advocate. I think ...sometimes I might sound like an enabler through the health system because I have to fight to get them to reschedule that appointment with a person who has missed 4 times because they don't know the trauma that they've experienced in health centers.”
Implications

- Community partnered research has many benefits to both researcher and community, and results in a better understanding of community needs and priorities.

- First Responders, healthcare providers/organizations should adopt a trauma informed approach that seeks to understand behaviors through a trauma response lens and resist re-traumatizing people.

- Hospitals and community organizations should work in partnership to improve communication and more effectively coordinate existing services.

- Policy leaders should expand post-discharge care options to better meet the needs of vulnerable persons experiencing homelessness in our community.

- Researchers should partner with community to develop and evaluate interventions to address trauma/stigmatization, provide meaningful tailored support, and bridge care from hospital to community.
Applying Shared Vision

• Initiatives to improve care for hospitalized patients experiencing homelessness
  – Data sharing, improvements to care coordination and medical respite

• Curriculum development in medical education
  – Health Equity Pathway curriculum development (trauma informed care training, community immersion)

• Community-partnered research
  – Joint Pilot Proposals

• Conversations with policy stakeholders
  – Denver’s Behavioral Health Crisis Response Task Force
Thank You

• Members of the Hospital Care and Care Transitions Community Advisory Panel
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• Mentors: Ed Havranek, MD, Bill Burman, MD, Lilia Cervantes, MD, Georgina Lucas, MSW

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