



Homeless Care Navigation Project







Presented By:

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Background






- Providence Saint John's Health Center is located in Santa Monica, CA
- The area has a high rate of homelessness
 - Estimate of over 3,000 homeless persons in the immediate area (Homeless Count 2016)
- The hospital serves approximately 150 homeless patients per month in the E.D.

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Responding to the Need



- Living our Mission, "As people of Providence, we reveal God's love for all, especially the poor and vulnerable, through our compassionate service.
- The Providence Promise, "Together, we answer the call of every person we serve: Know me, care for me, ease my way."®
- Part of our Catholic heritage and social teaching
 - "Whatever concerns the poor is always our affair" Mother Joseph of the Sacred Heart, S.P.

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The Pilot



- Pilot project initiated in 2014 in partnership with OPCC and Providence Saint John's Health Center
- Focus was to assist homeless patients using the emergency department and to provide better discharge/follow-up care
- Pilot was intended to last 3 months but concluded after 2 months based on the results
- OPCC provided a case manager to work in the emergency department

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Pilot Components



- Case manager placed in the E.D. from 4:00 p.m. to midnight, 5 days/week
- 135 patients seen during the pilot
- Case manager worked with patients to assess needs and link them with appropriate resources upon discharge
 - Shelter/Food/Clothing
 - Medical Care
 - Counseling
 - Social Services
 - Benefits
- Education of E.D. staff regarding resources and services available to these patients

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Findings From Pilot



- Many of the homeless coming to the E.D. were dealing with mental illness and/or substance abuse issues
- The homeless patients tend to come to the E.D. for medical conditions that are secondary to their mental illness/substance addiction
- Many of the patients in the pilot study were not repeat visitors
- Many patients had health coverage (Medicaid or Veterans benefits)

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Findings (continued)



- Most of the homeless patients treated in the E.D. (prior to the pilot) were being discharged to the place/facility requested by the patient
- Approximately 46% of the patients seen had received services in the community in the past
- E.D. staff needed better training in how to work with this population and in the resources and services available in the community

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From Pilot to Implementation



- Based on the success of the pilot, PSJHC approved a full-time Community Care Coordinator for the E.D.
- A person with experience in working with the homeless was hired
- The Homeless Care Navigation Program was started in December 2015
- Homeless patients being discharged from the E.D. would be referred to the Care Coordinator to assist the patients
- Coordinated referrals with area agencies and shelters

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Key Learnings



- Knowing the patients' circumstances is key to successful discharge and placement
 - Case Example: Homeless patients with pets
- Many patients have benefits (e.g. Medicaid) and are either unaware or confused on how to access services/benefits
- Some patients fit priority categories for housing but need help with the paperwork
- Social Work, Case Management, Security and Spiritual Care are key collaborators
- Working closely with the homeless serving agencies is key to successful placement
- Need for good tracking across agencies

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Outcome/Impact



- To date (through April 30th) 200 patients have been seen in the program
- 33% have been linked with shelter/housing
- 23 patients declined immediate help with shelter placement, but asked for information on shelter and housing in the area
- 18% of the patients have returned to the E.D.
- A project team is in place with physicians, nursing, social work, the community care coordinator, and case mgt. to try and work with 4 very high utilizing patients
- Patient, employee, and MD satisfaction

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Observations



- Program staff needs to be experienced in working with this population
 - Person does not need to be a Nurse/Clinician but should be someone with professional training
- Training of E.D. staff and physicians is key
 - Ask the right questions up front
- Communication with community partners is important to ensure appropriate follow-up and tracking
- Connection with mental health resources
- Develop partnerships within the community
- Work closely with Security, EMS and Police

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Next Steps



- Development of a quiet space within the hospital for homeless patients being discharged late at night/early morning
- Work with our local homeless serving agencies to have a warm patient hand off
- Better identification of homeless patients in the electronic health record
- Ongoing training of staff
- Continue to fund care for the homeless through the Venice Family Clinic
 - Medical Home Model
- Development of a hospice for the homeless

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Discussion



- What are the barriers and challenges that you find within your community in caring for homeless patients?
- What are some of the best practices in caring for this population?

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Questions



Thank you for your participation

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