

Hospital Discharge Protocols for the Homeless Population

By: Oscar Cerrito-Mendoza,
Housing Services Program Manager



History

- AIDS Response Effort, Inc. (ARE) is a nonprofit AIDS Service Organization that has been providing HIV/AIDS Services within the Lord Fairfax Health District since the 1991.
- ARE started providing housing services for those with a HIV positive diagnosis with the help of Housing Opportunities for Persons with HIV/AIDS or HOPWA.
- ARE has been a very active and committed agency within our CoC for the last 13 years.
- On March 2014 ARE expanded its housing services to serve the homeless population within our community.



Valley Health Systems

- Valley Health System first opened its doors in 1903 as Winchester Memorial Hospital and was committed to provide superior quality healthcare services to residents throughout the region. More than a century later, Valley Health continues to uphold and expand this vision throughout West Virginia, Virginia, and even parts of Maryland.



ARE and Valley Health Systems

- AIDS Response Effort, Inc. (ARE) and Valley Health Systems have been partners in providing services to the HIV/AIDS positive community for over 20 years.
- ARE is an affiliate under the umbrella of Valley Health Systems.
 - Benefit from Employment Benefits
 - Provide us with payroll management
 - In-kind donations



Valley Health Systems

- VHS is comprised of 6 hospitals which expand from North Western Virginia into West Virginia. 4 of which are located within the Lord Fairfax District.
 - Winchester Medical Center
 - Warren Memorial Hospital
 - Shenandoah Memorial Hospital
 - Page Memorial Hospital



Western Virginia 513 Continuum of Care

- ARE belongs to the Western Virginia CoC which covers the counties of Clarke, Frederick, Page, Rockingham, Shenandoah, and Warren, and the cities of Winchester and Harrisonburg. The official HUD-designated name of this CoC is VA-513.
- The VA-513 works to identify and implement a comprehensive strategies to prevent and end homelessness in the region.(VA-513 Website)

Western Virginia 513 Continuum of Care

- Housing First Philosophy as a Continuum of Care.
- ARE as an agency representing the VA 513 CoC extended the invitation at the beginning of 2015 to Valley Health systems to join the efforts on addressing the issue of homelessness within our community by providing access to permanent housing resources.

Coverage Area

- ARE and Valley Health Provides services to the Lord Fairfax Health District.



AIDS Response Effort, Inc. and Quality Improvement Plans

- As an agency ARE has been focusing on enhancing our services. ARE has developed a Quality management role to help the organization with this transition.
- Housing Quality Improvement Plan
 - Improve the delivery of housing services to the homeless population to ensure permanent housing access.
 - In March 2015, ARE and Valley Health met to discuss the use of the hospital as shelter by homeless individuals.



Identified Need

- Based on recorded data from Valley Health Systems, there was a total of 193 homeless admissions to the hospital, 56 unduplicated individual identified as homeless. An average of 3-4 admissions per individual within a given year.
- **** Only homeless individuals admitted to the hospital are included on this list**



Why is this a need?

- According to Becker's Hospital Review, the average cost per unfunded inpatient day across 50 states in 2013, the national average cost is \$2,289. (Becker's Hospital Review)
- The estimated average daily cost for non-profit hospital in the state of Virginia is about \$1,753.
- The cost to care for an unfunded patient (many of whom are homeless) is about \$1,820.41/day based on 2015 data from Valley Health-Winchester Medical Center and data from the Lord Fairfax Health District.



Identified Issue

- Valley Health Systems (VHS) had no written protocols in place to address what would be an effective way to refer individuals who are homeless to housing resources, therefore the Lord Fairfax Health District hospitals experience high numbers of recidivism of homeless individuals into Valley Health Sites.



Why did we want protocols?

- **Goal:** Record data around homeless persons admitted by the hospital.
- **Goal:** Have seamless and effective homeless discharge referrals to VA-513 Continuum of Care (CoC) Centralized Intake by establishing discharge protocols in collaboration with VHS's social workers by November 2015.



Hospital Discharge Protocols

- ARE's housing staff, in collaboration with VHS's Social Work Clinical Manager, developed discharge protocols



Hospital Protocols for the Homeless-Housing/Shelter needs

Step 1 – Check for the patient’s housing situation on admission to the hospital, verify their address and whether this is the address they expect to return to. Check if the patient comes from the Lord Fairfax Health District - LFHD (Clarke, Frederick, Winchester, Page, Shenandoah and Warren Counties) and why they may be homeless.

- Is the patient staying with a friend, in a hotel, own apartment, in a car, shelter?
- How long will the patient be able to stay in the temporary situation and what is their long term plan for housing, if known.
- Does the patient come from LFHD (Lord Fairfax Health District) or wish to be in the LFHD?
- If they had a home before coming into the hospital, why are they not able to go back there?
- If the patient is known to be staying at a **shelter or other temporary accommodation** (see the **If You Are Homeless Resource Manual**) for further information about temporary accommodation in the LFHD)

Step 2 – During office hours (8:30am – 12pm, 1pm-4:30pm)

- If the patient is homeless and needs help to find temporary housing in LFHD, **contact the Centralized Intake at 540-271-1701. Leave a message, no one will answer the phone but someone will return a call within 48 hours.** The Centralized Intake provides LFHD homelessness information about prevention services, housing advice, including referrals to the providers that most closely match the consumers’ service needs.
- **People from outside LFHD:** for people who do not come from LFHD, and do not wish to stay in the city, contact the Centralized Intake.



Referrals to the Centralized Intake may be made by social workers or nurse case managers. There is no need to contact shelters directly. The Centralized intake prioritizes based on the consumer's needs.

Once a referral is received by the homelessness prevention case manager, will either take a homeless application over the phone, or arrange to visit if there are complex need, and a longer interview is needed. This will take place within 48 hours on working days (or sooner if this is possible), and particularly if it is known that the person was admitted for a stay of less than 24 hours.

To help facilitate the process the social worker or case manager should gather the following information:

- Full name and date of birth
- Previous address and type of housing
- Names and ages of dependents
- How long the person has been living in the LFHD (Lord Fairfax Health District)
- Any other agencies involved with the patient
- Details of any risks posed by the patient or linked to their health
- Any particular needs which should be taken into account

The Community Assistance Fund will have time to assess how to find accommodation for the patient, if they receive clear information well before the patient is going to be discharged. If the decision to discharge is made late on a working day, it is unlikely that accommodation will be found that night.

VHS's Social Work Clinical Manager will send a weekly report of people identified as homeless through social workers and nurse case manager's assessments, this will ensure tracking individuals throughout the process. Housing Program manager will be review the report and match it against HMIS (Homeless Management Information System) report for referrals being made to the Centralized Intake.



Hospital Discharge Protocols

- Identify a point person for each Valley Health site responsible for referring homeless individuals to the VA-513 Continuum of Care Centralized.
- ARE's housing staff, obtained information from VHS's Social Work Clinical Manager on how EPIC could be used to gather housing baseline data. This will be done by the end of July 2015.
- Using EPIC and HMIS.



Hospital Discharge Protocols

- Train identified point persons responsible for referring to the VA-513 Continuum of Care Centralized Intake at each Valley Health.
- Implementation of the established hospital protocols for the homeless and data collection for that project began on January 1, 2016

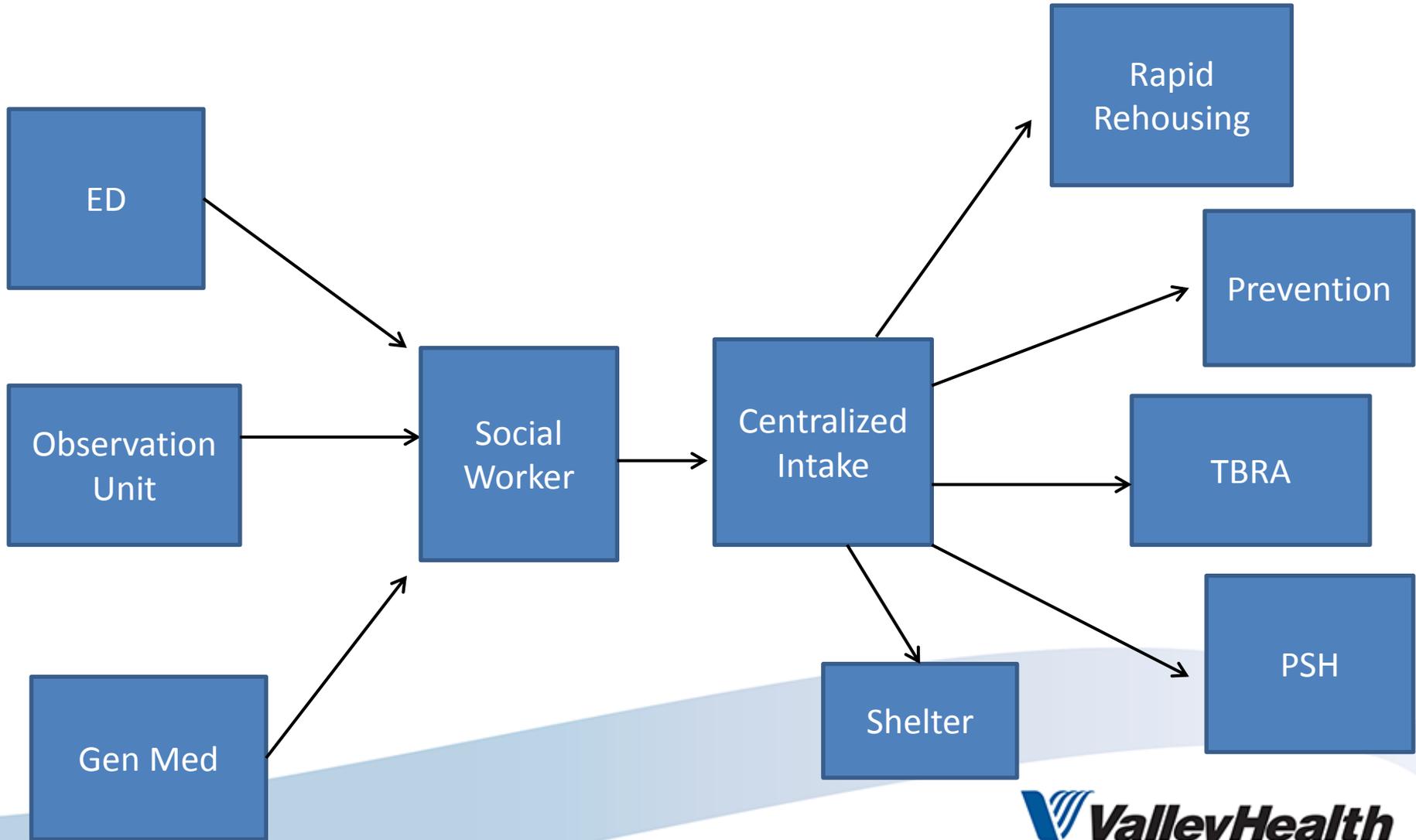


Hospital Discharge Protocols

- ARE's housing staff provides ongoing monitoring by retrieving data from the identified point person at Valley Health site on a weekly basis; tracking successful referrals through Centralized Intake.



Hospital Discharge Protocols

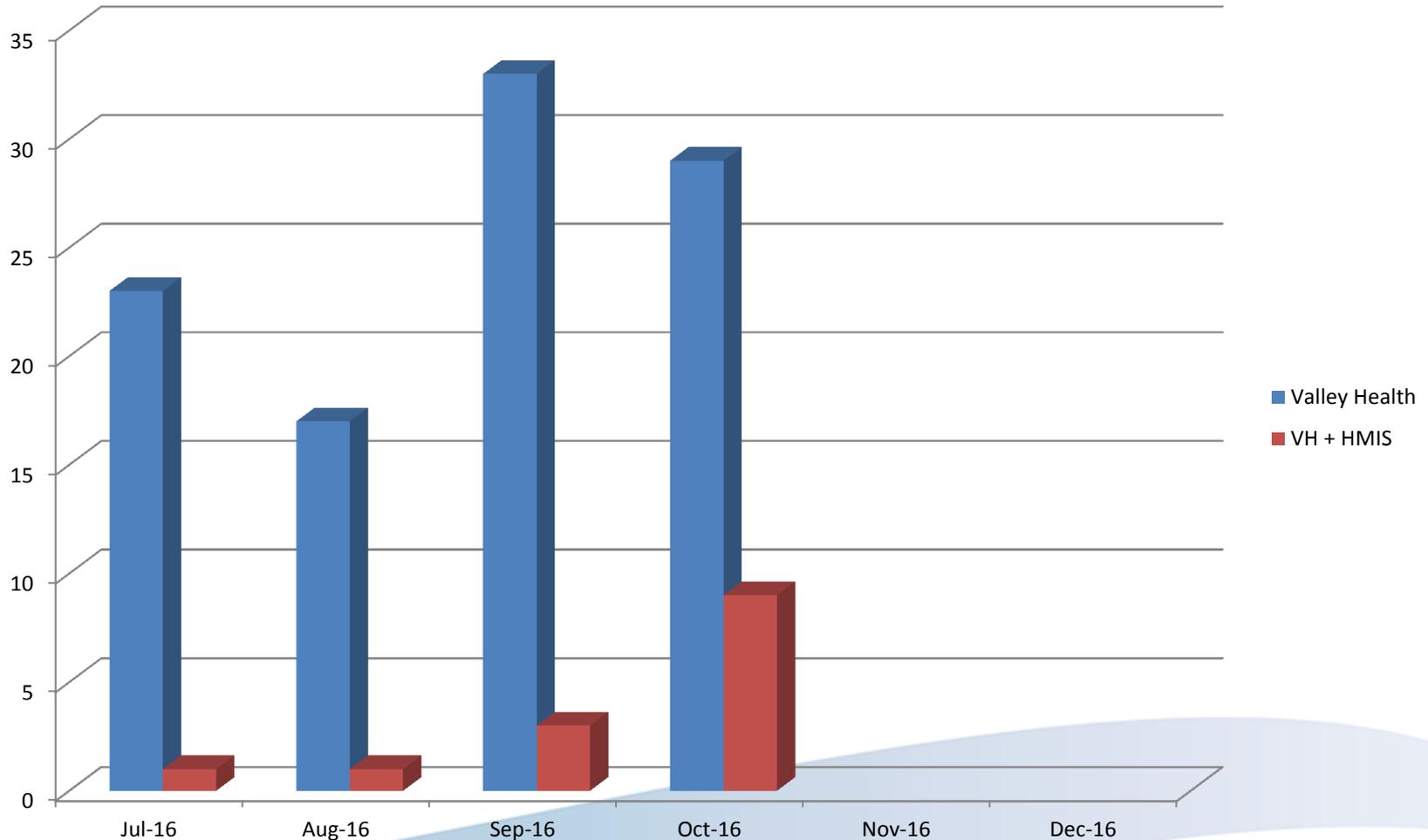


Barriers

- Change in Social Worker's responsibility roles.
- Reports structure from HMIS and EPIC.
 - HMIS and EPIC not compatible with each other.
 - Reports needed to be formatted specifically for this purpose.



Data Collected to date



Case Study

- Mr. Ranger, an individual in his mid 50s. He was homeless for 13 years and used the hospital as means of shelter specially during the winter months.
- First case who had access to housing after being referred from the hospital to the Centralized intake.
- Mr. Ranger has been permanently housed for a year and was able to access mainstream resources like SSI, Medicare and SNAP benefits.
- Mr. Ranger has been admitted to the hospital since then a few times but this time due to appropriate medical issues.



Questions

Oscar Cerrito-Mendoza

Housing Services Program Manager

AIDS Response Effort, Inc.

124 West Piccadilly Street

Winchester, VA 22601

ocerrito@valleyhealthlink.com

