HOSPITAL CASE MANAGEMENT

THE ESSENTIAL GUIDE TO HOSPITAL-BASED CARE PLANNING

INSIDE

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Roles and Functions of Community Health Workers

Lay educators can address health disparities, reduce readmissions

How can healthcare entities give patients necessary services that would prevent rehospitalization? Community health workers (CHWs) have the potential to enhance primary care access and benefit patients — but remain a largely untapped resource.

According to the American Public Health Association (APHA), there are seven key roles among CHWs:

- bridging and providing cultural mediation between communities and health and social service systems;
- providing culturally appropriate health education and information;
- ensuring people obtain services they need;
- providing informal counseling and social support;
- advocating for individual and community needs;
- providing direct services, such as basic first aid and health screening tests;
- building individual and community capacity.

> COMMUNITY HEALTH WORKERS ARE LIAISONS WHO HELP TO INCREASE ACCESS TO CARE, IMPROVE QUALITY, AND LOWER HEALTHCARE COSTS.

Community health workers, according to the APHA, are liaisons who help mitigate health disparities, increase access to care, improve quality of care, and lower healthcare costs. CHWs are nonclinical, nonmedical advisors and patient

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educators, also sometimes called lay health educators. They have a similar focus to patient navigators (PNs), who address health disparities across many chronic diseases.

Decisions about how to best use these workers depend on needs of patients and care teams, clinical workflows, financial viability, and addressing practice burdens while facilitating performance and cost savings.

A recent study in the *Annals of Family Medicine*[2] says increasing the presence of CHWs also requires training and clinical integration necessary to build this new workforce, including certification, health information technology, and clinical oversight.

One of the study's lead authors, **Andrea Hartzler**, PhD, of the Department of Biomedical Informatics and Medical Education at the University of Washington in Seattle, characterizes CHW roles and functions in primary care through 12 functions:

- care coordination;
- health coaching;
- social support;
- health assessment;
- resource linking;
- case management;
- medication management;
- remote care;
- follow-up;
- administration;
- health education;
- literacy support.

It's an "interesting idea" for RN case managers to work alongside CHWs, Hartzler says. She points to a different study[3] that took a similar approach.

"The goal was for a CHW to meet with high-risk hospitalized patients at discharge, then follow up with them via weekly phone calls post-discharge to identify and address barriers through community-based services and support for transition tasks. The CHW coordinated directly with nursing and front desk staff as patients returned to primary care," she explains.

Due to poor protocol completion rates, she says, the study showed no statistically significant improvement over usual care. However, post-hoc interviews with the CHWs revealed a number of addressable barriers, including inadequate information and communication systems.

For instance, CHWs often lacked information on patients' discharge timing, and thus missed 40% of discharge appointments, she notes. The missed opportunities to establish personal connections may have affected subsequent follow-ups.[3]

Hartzler says CHWs in that study also lacked logistical tools for tracking and monitoring follow-up

EXECUTIVE SUMMARY

Community health workers (CHWs) are lay health advocates who help to mitigate health disparities while building trusted patient–provider relationships. Decisions about how to best use community health workers depend on:

- needs of patients and care teams;
- clinical workflows and financial viability;
- addressing practice burdens while facilitating performance and cost-savings.

when it did occur. Some system-level strategies to combat this and to better support CHWs include:

- using contact management tools;
- implementing appointment notifications;
- coordinating with nursing staff;
- providing additional training and support for CHWs.

One important role of the RN case manager would be to coordinate with the CHW to review patient information such as symptoms, concerns, and barriers to care, and provide the CHW with up-to-date logistical information on follow-up appointment schedules.

"Building empathy is important for building trusted patient–provider relationships, and CHWs can certainly facilitate information sharing and connection to that end," Hartzler says.

In addition, regular contact to coordinate case management for individual patients may be needed to ensure the CHW shares concerns that require nurse intervention.

"One model for how that meeting could work is a routine huddle, perhaps weekly or daily, to monitor patient status during the discharge and post-discharge period as patients transition from hospital to primary care — approximately two to four weeks," Hartzler says.

Toni Cesta, RN, PhD, FAAN, partner and consultant in North Bellmore, NY-based Case Management Concepts, points to the proposed rule for discharge planning for ambulatory surgery patients, EDs, and all other outpatient procedures. "Because someone has an outpatient procedure, it doesn't mean they don't need follow-up," she says.

"CMS has proposed that hospitals may have to assess all patients for continuing care services, not just inpatients, and that would be a big shift. I think it's the right thing to do," adds Cesta. "As more patients are treated in outpatient settings, they may need continuing care after ambulatory surgery or other invasive outpatient procedures. We don't want these patients to have a poor recovery at home. In addition, these patients are at risk for returns to emergency departments or readmissions."

> "MANY STRUGGLE WITH MULTIPLE ILLNESSES COMBINED WITH SOCIAL ISSUES [RELATED TO] MENTAL HEALTH, SUBSTANCE ABUSE, EXTREME MEDICAL FRAILTY, AND SOCIAL NEEDS. IT IS VERY DIFFICULT FOR THESE PATIENTS TO NAVIGATE THE HEALTHCARE SYSTEM."

Examples of Common Functions

Community health workers' roles vary, but core functions cluster into the following areas:

- **Clinical services.** This role focuses on health assessment and remote care more than other clusters. Examples include assessment of vital signs, lifestyle, health knowledge, psychosocial factors, and care through routine exams aided by remote communication with physicians. These services provide for patient dialogue, helping care teams understand patients' health, backgrounds, and preferences.

  One example would be a community health aid who provides clinical services in remote Alaskan villages using scripted questions and directed exams for common health problems.

- **Community resource connections.** These connections link patients with community-based services, such as referrals for transportation or food assistance. Ongoing social support and follow-up phone calls are common, yet remote care, education, and literacy support are less common.

  Example: "Promotoras" who screen patients for depression by interviewing them about contextual factors (e.g., unemployment) and help resolve those barriers with community referrals (e.g., vocational training).

- **Health education and coaching.** Health coaching generally involves motivational interviewing and action planning to help patients achieve health goals.

  Example: Peer health coaches who counsel, teach, and support self-management.

Guidance on Community Support

There's a growing demand in the United States for transition-of-care navigators and more CHWs due to increased healthcare spending, regulatory demands and penalties, and patients with complex conditions who require high levels of services and account for a high percentage of costs.

"Many struggle with multiple illnesses combined with social issues such as mental health and substance abuse, extreme medical frailty, and social needs. It is very difficult for these patients to navigate the healthcare system," says **Terri Marshall**, RN, MS, CCM, senior managing consultant at Berkeley Research Group.

There is a need for healthcare systems and ambulatory providers to focus on high-risk patients, such as those who are in the early stages of chronic diseases, and to provide education and understanding of disease processes.

"Both the acute care and outpatient providers work collaboratively to manage and assist the patients in every aspect of their care. Starting with handoff from acute care to ambulatory care, this is critical in ensuring patient safety and quality of care," says Marshall.

Some of the key duties for community health workers include the following:

• helping the patient and family understand the importance of self-care and being able to advocate what they want from the healthcare team;

• working collaboratively in the acute care setting with the patient and family, providing education regarding the disease process and building the relationship to be a resource and support contact;

• developing an individual care plan that includes a call at 24 hours post-discharge to verify the patient understands the discharge instructions, follow up on any barriers to care (e.g., lack of transportation), and ensure a follow-up office visit is scheduled and any prescriptions are filled;

• making follow-up calls at 30-45 days post-discharge to screen for symptoms that suggest a worsening condition and knowing what to do in case of a problem.

Top Risk Factors

With ever-evolving models of care, the collaborative case management model can better serve high-risk patients. Community health managers can work to minimize some of the top risk factors affecting outcomes, according to Marshall. These risk factors include:

• **Poor handoff from acute to ambulatory providers.**

• **Poor healthcare literacy.** Make sure there is a caregiver who understands the plan of care and can assist the patient. "Provide low literacy instructions and educational materials to facilitate patient understanding. Reduce the complexity of self-care instructions provided to patients," says Marshall. *(For more on health literacy, see related article on page 109.)*

• **Language barriers.** Limited English proficiency is associated with lower rates of outpatient follow-up, use of preventive services, medication adherence, understanding diagnoses, and other factors, she explains.

• **Cultural beliefs and customs.** Unique personal customs may influence patients' health behaviors, perceptions of care, and interpretation of medical information or advice, explains Marshall.

• **Lack of support.** Absence of family or caregivers may lead to social isolation. To prevent that, community health workers can make follow-up phone calls at 72 hours, verify appointments with a primary care provider, and arrange for home care services.

• **Prior hospitalization.** The collaborative care team must understand the reasons for hospitalization and whether it could have been prevented.

• **Physical limitations.** Engage family/caregivers to assist with post-discharge needs. Marshall recommends that community health workers follow up with a phone call at 72 hours to assess any care needs and adherence to the discharge plan.

• **Polypharmacy.** Patients may have difficulty understanding all of the prescribed medication instructions, or may need medication reconciliation to ensure they are not taking old or contraindicated prescriptions.

• **Psychological issues.** Positive depression screening and history of depression diagnosis also are risk factors.

Promoting Collaborative Care

Another issue is making sure team members are working toward the same goals. Everyone on the team must understand their shared purpose on both the community side and within hospital settings, Marshall stresses.

"It comes down to education, communication, and collaboration," she says.

Develop a care transition work group to include home healthcare agencies, skilled nursing facilities, long-term acute care hospitals, and rehabilitation facilities, explains Marshall.

"Standardize education tools so that the hospital, physician, home health agency, and skilled nursing homes are all using the same language and documents to educate and instruct the patient," she adds. "Consider sharing access to medical

records to improve clinical data-sharing."

Cesta adds that case managers often don't include the family during discharge planning educational episodes.

"When people are sedated or tired, a family member should also be present. We don't always take the time to focus in on the family or family caregivers," she says.

Indeed, poor communication among healthcare providers and the lack of shared information about patients are common causes of undertreatment, suboptimal therapy, adverse drug events, and hospital admissions or readmissions.

Looking Toward the Future

Going forward, what should healthcare teams focus on?

"In a nutshell, we have bundled payments and other payment modalities that require that we consider the patient's needs at all points across the continuum of care," says Cesta. "Most hospitals need to create case management departments that incorporate case management in the community setting with inpatient case management staff, thereby creating one case management department. We propose having a senior leader who has responsibility for the division of acute care case management and community-based case management."

In a perfect world the two teams would meet monthly, with hospital case managers seeing what happens to certain high-risk patients out in the community setting, and for the community health workers to see what happens when they come back to the hospital.

"What failed on the community side, perhaps? It's kind of like 'walk a mile in someone else's shoes' because there's typically not a good understanding of what happens to patients after they leave the hospital and risk factors that can affect outcomes," she adds. ■

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Limited Health Literacy a Barrier to Achieving Good Outcomes

How can RN case managers ensure that patients truly comprehend what they need to know?

A patient's literacy level refers to the number of years of education required to understand oral and written materials. According to the National Institutes of Health (NIH), it's best to aim for a level that is two to five grades lower than the highest average grade level of an intended audience. The NIH says this method accounts for a probable decline in reading skills over time.

For patients who have acknowledged low literacy, it's best to keep discharge materials and other communication on a third- to fifth-grade level. *(For more on health communication goals, visit: https://bit.ly/2MoMS3Y.)*

Communication Failures and Heart Disease

Currently, only 12% of Americans have the health literacy skills to successfully navigate the healthcare system, according to a new report by the American Heart Association.[1]

Patients with limited health literacy may not understand that a "positive" stress test is not a good result, or may have difficulty sticking to a low-sodium diet if they do not understand nutrition labels.

Those are two scenarios analyzed in the AHA report, which suggests that limited healthy literacy is a major barrier to achieving good cardiovascular health or benefiting from effective treatment for heart attacks, heart failure, strokes, and other cardiovascular diseases.

"Many patients do not understand the written materials they receive as part of healthcare, or do not have the numeric skills to understand quantitative information. Also, medical care uses a considerable

amount of specialized terminology, which some call jargon," said **Jared W. Magnani**, MD, MSc, co-author of the AHA report and associate professor of medicine at the University of Pittsburgh School of Medicine.

Diabetic patients with low health literacy are more likely to develop disease complications such as diabetic retinopathy, according to the report. They also are 1.7 times less likely to use an online patient portal — a fast-growing technology for patient communication and disease management.

The authors emphasized that even patients with higher education may have poor or limited health literacy if they are not familiar with health terminology and face situations beyond their normal experience.

SMOG: Simple Measure of Gobbledygook

It's important to communicate clearly and keep discharge planning as simple as possible to increase comprehension.

But how can case managers communicate effectively if even highly educated patients face health literacy stumbling blocks?

One idea is to assess the "readability" level of patient materials with a commonly used formula called SMOG (Simple Measure of Gobbledygook). This readability formula was developed more than 40 years ago and is appropriate for fourth- grade to college-level readers.[2]

POTENTIAL RED FLAGS COULD INCLUDE PATIENTS WHO SAY "I FORGOT MY GLASSES," OR "I'LL HAVE SOMEONE READ THIS TO ME AT HOME."

The SMOG formula calculates a patient's reading level using the following four steps:

1. Count off 30 sentences — 10 near the beginning, 10 near the middle, and 10 near the end of the text.

2. From this sample, circle all words containing three or more syllables (polysyllabic), including repetitions of the same word, and total the number of words circled.

3. Estimate the square root of the total number of polysyllabic words counted (find the nearest perfect square and take its square root).

4. Add a constant of three to the square root. The resulting number is the SMOG grade, or the reading grade level, that a person needs to fully understand the text being assessed.

An Eye Toward Optimal Outcomes

The Agency for Healthcare Research and Quality's Health Literacy Universal Precautions Toolkit recommends implementation of "health literacy universal precautions by making systematic, practicewide changes to simplify communication and reduce the complexity of healthcare for all patients."[3]

For example, the "Design Easy-to-Read Material" tool offers several recommendations for evaluating and creating appropriate patient materials, such as avoiding jargon, integrating pictures as teaching tools, and encouraging patient feedback.

When it comes to patient feedback, be alert for red flags or responses to receiving written information.

Potential red flags could include patients who say "I forgot my glasses," or "I'll have someone read this to me at home."

Likewise, if a patient has trouble completing forms or makes frequent errors, it may indicate limited health literacy.

To obtain the best health outcomes, it's critical that team members create understandable forms and informed consents, and always take into account that patients come from a wide variety of literacy backgrounds.

EXECUTIVE SUMMARY

To ensure optimal outcomes for patients from all backgrounds, review your materials and communications to ensure they include all literacy levels.

- For patients with low health literacy, it's advised to keep communication materials on a third- to fifth-grade level.
- Studies have found that patients with higher education levels also can have poor or limited health literacy when faced with unfamiliar medical situations or terminology.
- The Agency for Healthcare Research and Quality recommends keeping all materials for all patients at or below the sixth-grade level.

The toolkit also gives the following advice:

• avoid jargon;

• integrate pictures as teaching tools;

• create understandable forms, informed consents, and brochures;

• improve patient follow-up and phone access;

• ask patients to bring in all of their medications so that the healthcare provider can assess medication adherence and safety;

• consider the patient's culture, customs, and beliefs in their care. ■

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Post-discharge Communication: Preprogrammed Phones May Lower Readmissions

Texas home health agency reduced readmissions through phone calls, texts

When patients are hospitalized, they rely on the dependable nurse call button. But once home, that familiar helper is gone. And while effective communication between the nurse and patient before and during discharge is critical, what percentage of 30-day readmissions could be avoided — and how many thousands of dollars could be saved — if patient symptoms were addressed immediately post-discharge?

Reducing unplanned hospital readmissions is obviously a high priority for hospital case managers as Medicare penalties grow each year. The problem is that no two patients are alike. Often, one patient may require more than one type of service — and the more complicated the case, the more challenging it can be to coordinate post-discharge care.

But now, discharge planners can include preprogrammed phones for calls and texting options for patients at high risk of readmission. If patients communicate with their home care provider or visiting nurses at the onset of symptoms or complications, readmissions could be avoided by prompt in-home treatment.

The problem is that some patients are less likely to be technologically savvy, explains **Randy Paramore**, chief executive officer of Accessible Home Health Care in Houston.

That's one reason he took part in a pilot program to test preprogrammed phones that encourage patients to call or text their home health providers before they involve EMS dispatches and EDs.

Six months after the implementation of the pilot program, Paramore says the number of missed visits plunged by 50% while their CMS rating increased 20% to 4.5 stars. This improvement put them in the top 5% of home healthcare agencies in Texas and the top 10% in the nation. Readmission rates are significantly lower, and patient satisfaction has improved dramatically.

"By far, the biggest operational challenge is communication and missed visits. Too often, clients wouldn't answer their phones when clinicians called to confirm appointments, even 15 minutes before the scheduled time," says Paramore.

The May 2018 issue of *Hospital Case Management* shared a different program that saw an 80% participation rate in post-discharge phone calls

EXECUTIVE SUMMARY

Six months after the implementation of a pilot program using preprogrammed phones to encourage patients to call or text their home care provider or visiting nurse at the onset of worsening conditions, readmission rates at Accessible Home Health Care decreased significantly.

• The number of missed visits decreased by 50%.

• The company's CMS rating increased 20% to 4.5 stars.

to patients. In that case, when the phone rang, the caller ID cited the healthcare facility as the source of the call. Inpatient case managers worked with participating patients to expect the automated phone calls, explaining why it's important to participate and how the nurses would be following them to make sure they are doing well. *(The article is available at: https://bit.ly/2yQqVc7.)*

Now, it's about educating patients to be proactive and reach out about any worsening symptoms or worries.

Paramore says the device also played a role in how his team members communicate with each other as well as with patients. Staff can call into the device, allowing direct contact to patients without giving out nurse cellphone numbers.

Accessible Home Health Care professionals can easily reach patients to confirm appointments, which is the biggest contributor to lowering missed visit rates. Certified nursing assistants visiting patients use the device to speak directly with their supervising RNs. The staff are able to communicate potential issues as indicated by changes in vital signs or other indicators, often mitigating the potential for immediate readmission.

Paramore wanted a solution that would improve the three most critical metrics he tracks:

- communication between Accessible Home Health Care staff, clients, and their families;
- the agency's CMS star rating;
- unnecessary hospital readmissions.

Paramore estimates his home health agency has wasted more than 300 personnel hours per year due to missed appointments caused by miscommunication among team members and patients. His home health agency serves the entire Houston metropolitan area and employs 30 clinicians in a variety of disciplines, including registered nurses, certified nurse assistants, social workers, and physical, occupational, and speech therapists.

Not only did this take a toll on the agency's costs of doing business, but it also frustrated staff and patients.

While the average CMS rating for agencies like Accessible Home Health Care is 3.0, Paramore wanted his team to deliver better-than-average quality care. "Our CMS star rating moved from 3.5 at the start of the pilot program to 4.5 in January 2018," he says. ■

Providers Address Homelessness to Reduce ED, Hospital Use

How does one ensure that a homeless patient takes his or her medicine or receives adequate follow-up for his or her chronic diseases following an ED visit? It's a challenging problem, to say the least, and it is one that emergency providers in the United States confront on a daily basis. Now, some hospitals are stepping up their game in this area, adopting a "housing first" philosophy — or, the idea that having a roof over one's head is inextricably linked with better health, and is a critical first step to any effective treatment plan.

Taking aim at what policymakers refer to as the "social determinants of health," some of these programs are tiny compared to the scope of the homelessness problem in their communities. However, policymakers are giving frontline providers new options, drastically reducing use among formerly homeless participants. Further, in some cases, these new options are winning over new community partners willing to share the risk.

Assess Community Needs

The University of Illinois Hospital in Chicago initiated its "Better Health Through Housing" (BHH) program in 2015 following a community health needs assessment that revealed a high rate of chronic disease in the area.

"We were left to ponder what we were going to do about this," explains **Stephen Brown**, MSW, LCSW, director of preventive emergency medicine at the University of Illinois Hospital and Health Sciences System in Chicago.

Brown has long been interested in how homelessness, serious mental illness, and substance use contribute to ED use.

"We felt [a housing program] could have a huge impact for the relatively small investment in dollars, and it has," he says.

While the hospital pays $1,000 a month toward housing for each patient in the BHH program, that is significantly less than the per-day hospital expenditures for some of the homeless patients seen in the ED. Subsidies from the Department of Housing and Urban Development (HUD) also help cover housing for program clients, and case management services are provided

through the Chicago Center for Housing and Health.

In a pilot of the BHH program, healthcare costs for program clients were reduced by a collective 18%, but in some cases the cost-savings were quite dramatic. Brown notes that one client's average monthly costs dropped from $132,000 before program participation to $55,000 after enrolling in the program.

Eleven of the original 26 patients referred into the program in 2015 still reside in housing provided through BHH, and the University of Illinois Hospital recently announced that it will provide an additional $250,000 to the program — enough to provide permanent housing to an additional 25 chronically homeless ED patients.

Generally, potential candidates for the BHH program are identified by the number of times they have visited the ED in the past year. Patients who present to the ED more than eight times in a year are considered superusers.

"We start with that, and we begin to look at particular characteristics of these individuals," Brown explains. "One of the key characteristics is they have to be chronically homeless," meaning that the person has been homeless for at least one year or has experienced homelessness four times in the previous three years. The chronically homeless make up just 10% of the homeless population in the United States, but these individuals consume more than 50% of government dollars, Brown observes. A substantial portion of these dollars goes toward ED and hospital inpatient costs.

Cases that meet baseline criteria for the BHH program go before a chronically homeless referral panel (CHRP), a group that meets every two to three weeks to evaluate and select appropriate candidates for the housing program.

"We have a representative from our housing partner, The Center for Housing and Health, on the panel to make sure [candidates] meet criteria for the HUD subsidies that pay for part of [the housing]," Brown explains. Also on the panel are emergency and psychiatric physicians and social workers.

One of the critical factors the CHRP panel considers is the Level of Care Utilization System (LOCUS) score, a number derived from a tool designed to assess the care needed by individuals with psychiatric problems who present to EDs and other hospital settings. The LOCUS tool breaks down a person's care needs into six levels, with persons at the highest level of need scoring 28 or higher.

"We have discovered that there are people who are so acutely psychotic that they are not appropriate for the type of housing we have because we don't have the level of support necessary to keep them successfully retained," Brown notes. "We have a cut off [LOCUS] score of 22, [which is the top score for level 4]. Anything below that is appropriate for referral into the BHH program."

Other factors go into the evaluation process as well. For example, people who are undocumented are not excluded from the program, but entry is more challenging, Brown notes. Also, some people screened for the program have been sexual predators, which also is very challenging. "We need to also make sure that someone is not so acutely ill that they really need to be in a nursing home," he says.

Once all the factors are assessed for an individual, the CHRP panel members will take a vote on whether the person is appropriate for the BHH program. If he or she is accepted, the hospital will begin an intake process, Brown explains.

Establish Trust

At this point, an outreach worker who is skilled at finding and connecting with the homeless will be charged with locating the individual.

"He knows areas in the city where the homeless congregate — under bridges, in overgrown fields," Brown says. "He knows the resources around those areas, so, for example, he will go to a soup kitchen that is open for a limited number of hours per week."

In some cases, it takes time for the outreach worker to establish trust with an individual who has been deemed appropriate for the program.

"The most reluctant have serious mental illness and are withdrawn due to their symptoms," Brown says. Some patients experience paranoia, auditory hallucinations, or have other issues that make social interaction difficult. "Also, those with the most serious substance abuse disorders have difficulty following through because of their frequent intoxication," Brown adds.

While it can take one or even two months before some of these individuals accept the housing program, once they have given their consent, they are temporarily placed in a single occupancy hotel unit where they will be stabilized while the housing search takes place, a process that can generally be completed within a month.

"We have 125 to 150 units scattered around the city, and we work with our collective 28 area supportive housing agencies," Brown shares. "Every one of the units comes with a permanent supportive case manager."

While the program links patients

with appropriate care resources, it is a misconception to think that simply connecting these patients with a primary care provider (PCP) will take care of their needs.

"By the time these people come to us, some of them have been chronically homeless for more than 10 years," he says. "They generally have a lot of complex medical needs."

The level of care required would overwhelm most PCPs, Brown notes. However, the supportive case manager will transition each patient's care to centers or specialists that make the most sense, given their needs and the location of their permanent housing.

"The most important thing out of all of this is that ED utilization drops because [these individuals] no longer need to be in the ED anymore. They are not desperate to get out of the cold," Brown says.

For example, one of the program's success stories is a man with asthma and some mental illness who used to visit the ED 35 to 45 times per year.

"Sometimes, his asthma would be triggered because he was outside all the time," Brown recalls. "We found him a place to live, and now he has great pride in his apartment."

This patient's use has dropped almost to zero, although he still comes into the ED once or twice a month just to see the nurses because they are his friends, Brown notes.

Secure ED Staff Buy-in

Now that the BHH program is well-established, ED personnel have become adept at making referrals.

"This has become a huge satisfier for our nurses, social workers, and doctors because they have been so frustrated with these individuals because they are so prevalent in our ED," Brown says. "About half of our top 100 [users] are homeless, and a third of our top 300 [users] are homeless, so there is a great deal of frustration among our staff that these people keep coming in repeatedly."

However, if one studies the behavior of these individuals, they are simply doing what anyone would in such dire circumstances, Brown observes. "Some of the people know how to gin up their symptoms and things like that because they have no other options."

In fact, some people who wind up in the BHH program don't even register when they come into the ED.

"They come in, and they sleep in our ED because we have a gap in the continuum of care here," Brown notes. "The city has downsized the number of shelter beds for people with mental illness or substance use, and they haven't offered up a plan to provide shelter for these vulnerable patients."

The ED now employs an overnight social worker who makes connections with these individuals, and will present appropriate candidates to the CHRP panel. While social workers handle most of the presenting, psychiatrists, attending physicians, and hospitalists will present patients to the panel on occasion, too.

Share Risk

Given the impact of homelessness, food insecurity, and similar issues on health, it is curious that such factors are rarely mentioned in patient medical records, Brown observes. This is a reality that he and his staff are trying to change.

"You rarely see [these issues] documented at all, but our social workers are beginning to add [these items] to the problem list, and I am beginning to track compliance with doing [such] documentation," Brown shares.

When it comes to homelessness, Brown is on a quest to convince healthcare providers that it is, in fact, a dangerous health condition.

"If someone comes in and has symptoms of a certain type of cancer, we will do everything we can, and it will be very expensive care for that individual," he explains. "The irony of this is that we will discharge [a homeless] person back to the street, and the risk of mortality is comparable [to the person with cancer.]"

Armed with such statistics, Brown is hoping to convince other hospitals to address homelessness as a matter of health, and he is getting some traction. Indeed, three hospitals in the region already have replicated the BHH program.

"If you think about it from a collective standpoint, if every hospital here in the city of Chicago decided to pay for housing for 10 chronically homeless individuals, we could reduce the number of chronically homeless people here in the city by 20% to 25%, and that is major impact," he says. "And, it wouldn't cost that much to do it."

Brown also is working to engage managed care organizations on the issue, noting that they derive the greatest financial benefit from programs like BHH. He is proposing that they rebate some of the costs when the BHH program finds and houses chronically homeless individuals.

"A lot of these companies are open to the idea, so it is a way to do shared risk ... and we are making it painfully easy for them to do," he explains.

To push forward on the housing issue, Brown and the University of Illinois Hospital are taking steps to better identify the number of

homeless people living in the region. They're working with All Chicago, a group that maintains a database of all of the homeless people in Chicago. Using a grant from Academy Health, the University of Illinois Hospital and All Chicago have developed a tool that will let ED staff know when a homeless patient has registered to be seen. Using this approach, Brown is hopeful that homeless patients can be identified and linked with care resources at an earlier stage, thereby improving the odds for better health outcomes.

"There is this emerging recognition that homelessness is a very dangerous health condition, and healthcare is trying to figure out how to respond," Brown adds.

Dignity Health in Sacramento, CA, has partnered with Lutheran Social Services (LSS) of Northern California to offer a similar program, dubbed Housing with Dignity. In this case, most patients referred to the program are identified upon admission to one of Dignity Health's hospitals in Sacramento.

"Our care coordination team starts working with them, and the patients are identified as being chronically homeless with a chronic disability," explains **Ashley Brand**, the director of community health and outreach at Dignity Health. "Then, LSS will come to the hospital, meet with the patients, and make sure they are open to the services because the program is voluntary."

Patients who consent to the program are discharged into what Brand refers to as stabilization apartments.

"It gets them [housed] with a roof over their heads with intensive wraparound services while LSS works to get them permanent, supportive housing," Brand explains. "Sometimes, the units the patients are in for stabilization will actually become their permanent, supportive housing, but, technically, they move to a different program at that point. This provides some consistency for them, and enables them to build trust and build a home. That is ideal."

Essentially, there are 12 stabilization units, but they move around based on what is available, Brand notes. "We really focus on the intensive, wraparound services that LSS has the expertise to provide so that patients are ready for the next step when the time comes," Brand says. This includes getting the patients established with a medical home and plugged into behavioral health services. There also is a focus on equipping the patients with an ID and getting all of their documentation in place so that they can take advantage of more opportunities for stability as they move into permanent supportive housing.

Many different types of patients have come through the Housing with Dignity program, Brand says.

"We have had people who have been homeless for several years who have substance use disorders, and they may have been offered the program multiple times before they are ready," she says. "By having that transition from the hospital to the stabilization unit, they are slowly able to [make a change]."

Some patients have been on the streets for so long that they may initially sleep on the porch or in the kitchen.

"They may put up their tent so that they feel some consistency with what they are used to," she says. "One of the things that is great about the partnership with LSS is [their professionals] will move with the patient and meet them where they are at, and then work together to create goals as they move through the program." The aim of the program is to help individuals feel empowered so that they can be their own self-advocates while there is someone to support their chosen direction, Brand notes.

"When we talk about the overall health and well-being of the community we serve, stable housing and supportive services are critical elements," she says.

While Dignity Health has not yet conducted a full cost-benefit analysis of the program, administrators have studied the impact on use, and the results are impressive. In fiscal year 2017, the total number of days spent in the hospital by patients in the program decreased by 52%, and there was a 55% decrease in ED use. Brand stresses that the patients in the program tend to be very sick, but the program builds a relationship between LSS and the care coordinators at Dignity Health so that patients can be followed closely and kept on track with their care plan.

Brand's advice to other hospitals that are just getting involved with addressing the housing component of health is to find a trusted partner who can work with them on the issue. "We worked very closely with LSS to build a program that is collaborative and impactful," she says. "A lot of it is learning as you go, and being able to have iterations that respond to needs as they change."

Knowing how your program works with the system in place in your region is critical because you don't want clients to lose access to social services because their homeless status has changed, Brand notes.

"It is just one piece of a larger puzzle," she says. "Work to understand the barriers that this population experiences, and really address the whole person." ■

HOSPITAL
CASE MANAGEMENT

CE INSTRUCTIONS

To earn credit for this activity, please follow these instructions:

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CE QUESTIONS

1. **Which of the following is *not* a typical role among community health workers?**

   a. Financial assistance
   b. Clinical services
   c. Community resource connections
   d. Health education and coaching

2. **Community health workers typically are nurses, rather than lay persons.**

   a. True
   b. False

3. **Six months after the implementation of a pilot program at Accessible Home Health to test preprogrammed phones that allow staff to easily reach patients to confirm appointments, the number of missed visits decreased by what percentage?**

   a. 25%
   b. 35%
   c. 40%
   d. 50%

4. **Only which percentage of Americans have the health literacy skills to successfully navigate the healthcare system?**

   a. 9%
   b. 12%
   c. 15%
   d. 18%

CE OBJECTIVES

After reading each issue of *Hospital Case Management*, the nurse will be able to do the following:

1. identify the particular clinical, administrative or regulatory issues related to the profession of case management
2. describe how the clinical, administrative or regulatory issues particular to the profession of case management affect patients, case managers, hospitals or the healthcare industry at large
3. discuss solutions to the problems facing case managers based on independent recommendations from clinicians at individual institutions or other authorities.