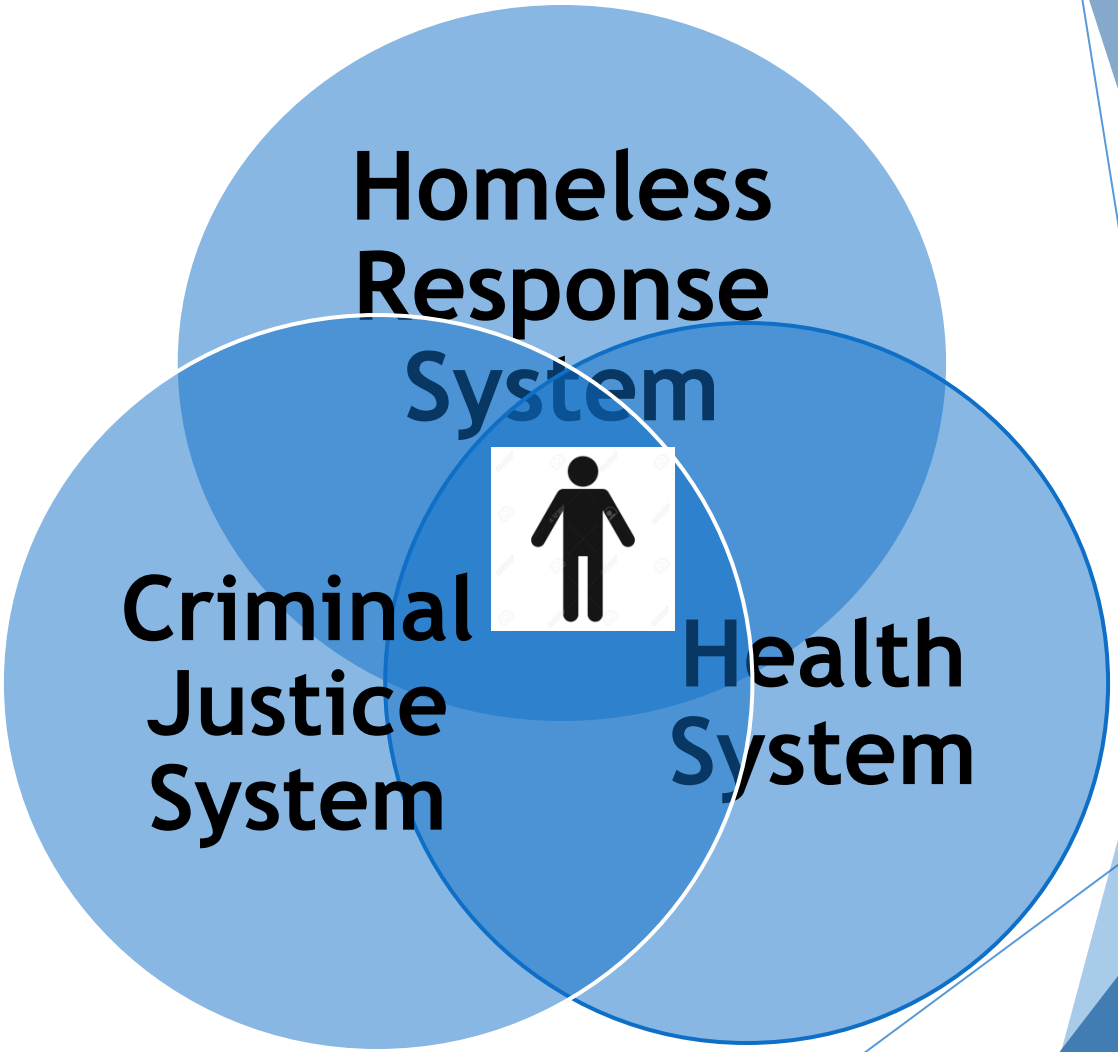
November 26, 2019

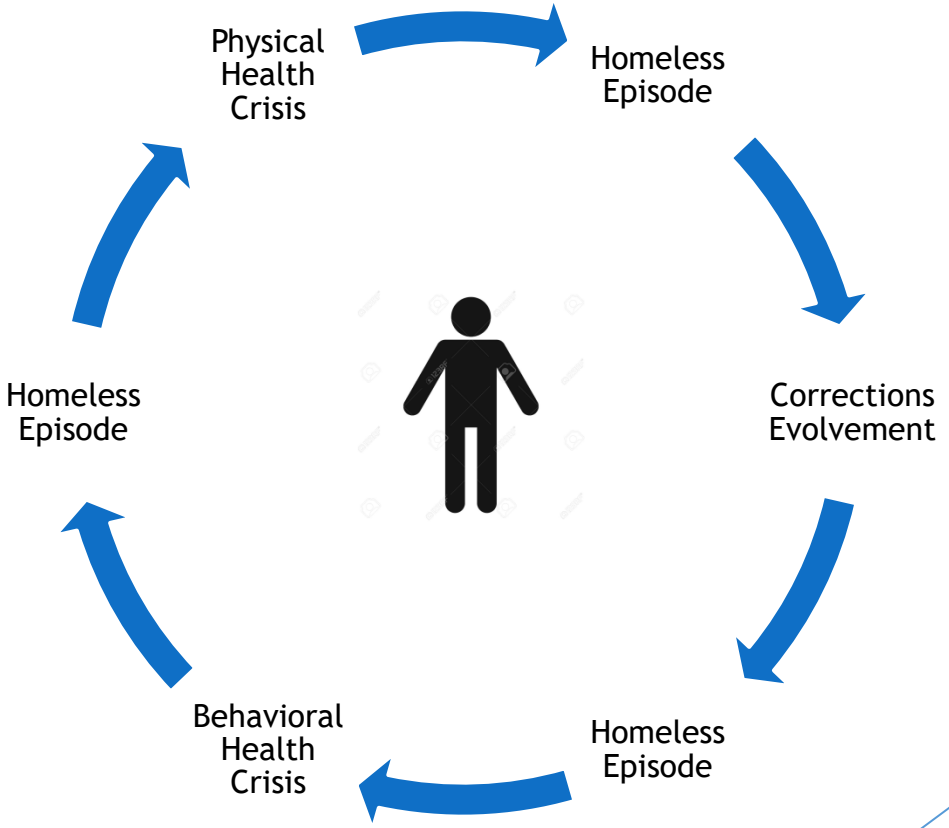
CENTRAL FLORIDA COMMISSION ON HOMELESSNESS

HOMELESS SERVICES NETWORK of Central Florida

Inaugural Discharge Planning Committee Meeting

Health/Homeless System Collaboration

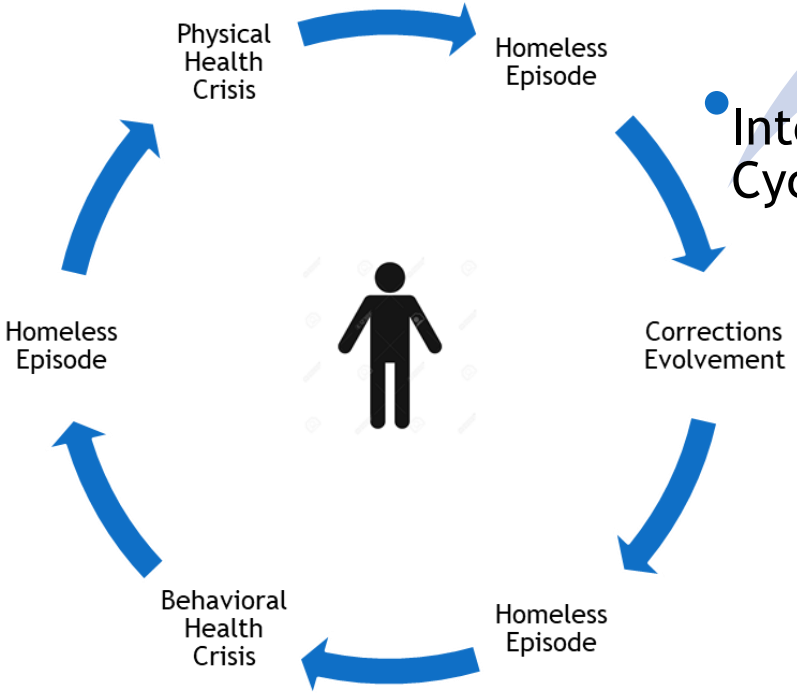

Homeless Response System
Criminal Justice System
Health System


Physical Health Crisis
Homeless Episode
Corrections Evolvement
Homeless Episode
Behavioral Health Crisis
Homeless Episode

Do you recognize this cycle?

What frustrates you most about this cycle?

Rate your motivation to interrupt this cycle if the resources were available today—1 meaning your lowest priority, 10 being your highest priority.



Interrupt Cycle

Discharge Planning & Diversion Mediation

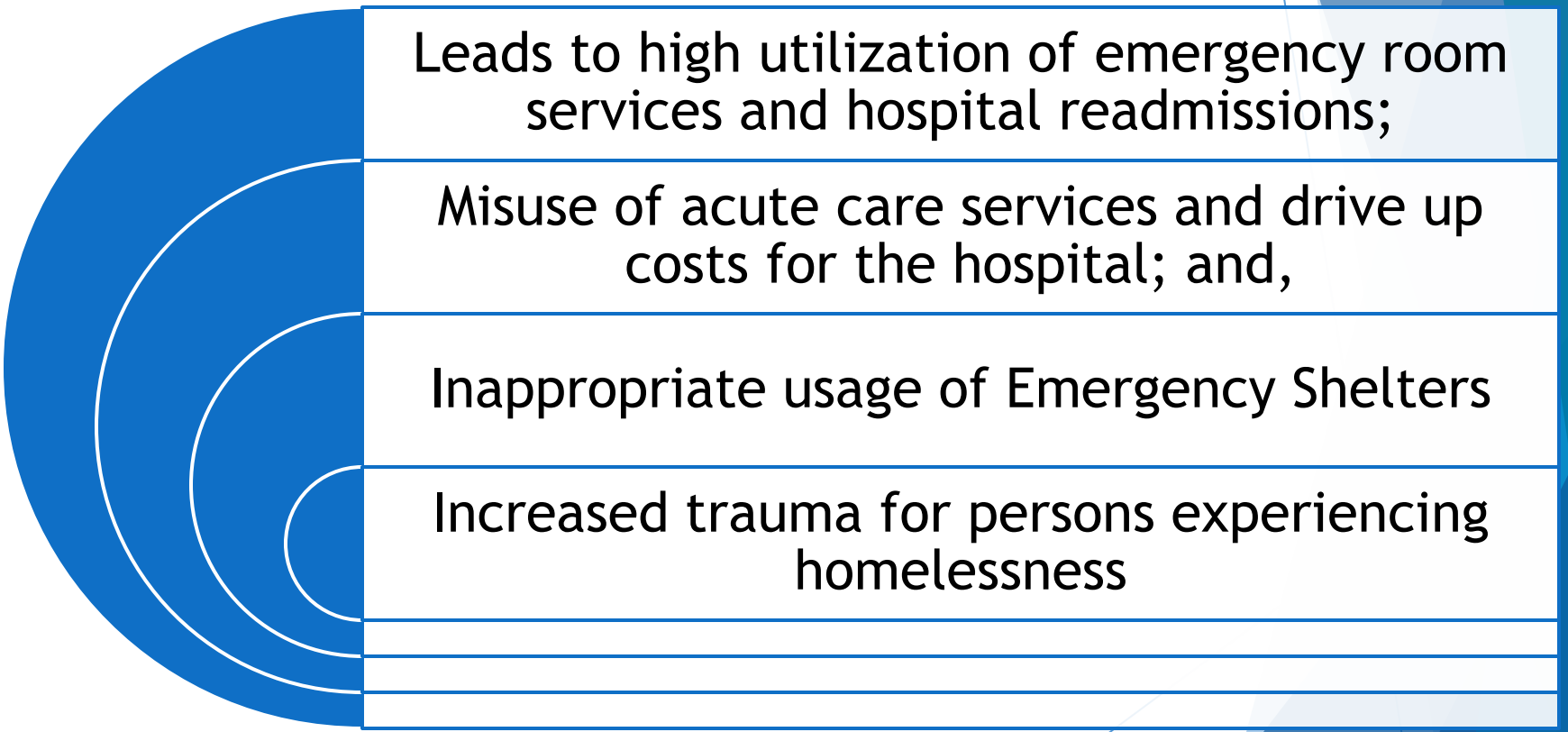
Housing

Institutional Discharge & Diversion Mediation

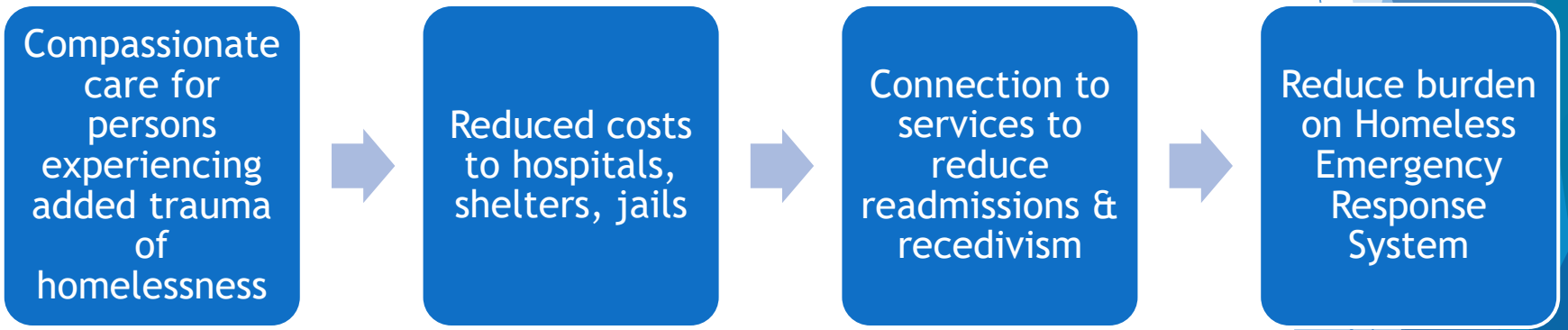
- Ideally Discharge Planning—begins at admission to prepare a person in an institution for return into the community--linked essential housing, community services, & supports.

- Housing Focused Diversion Mediation—creative conversation to identify housing opportunities to divert individuals at-risk or literally homeless from the Homeless Response System. Diversion conversations are for everyone and begin before other emergency response services are offered.

The cost of poor discharge planning



Discharge Collaboration Goals



Homelessness in Central Florida

7,000+

…unique individuals experience homelessness every year in Central Florida

2000+

…on any given night are sleeping in a place not fit for human habitation

Central Florida Chronic Homelessness

410

Persons are known by name, are Chronically Homeless, and need housing

Unsheltered

300+

On any given night are without are unsheltered

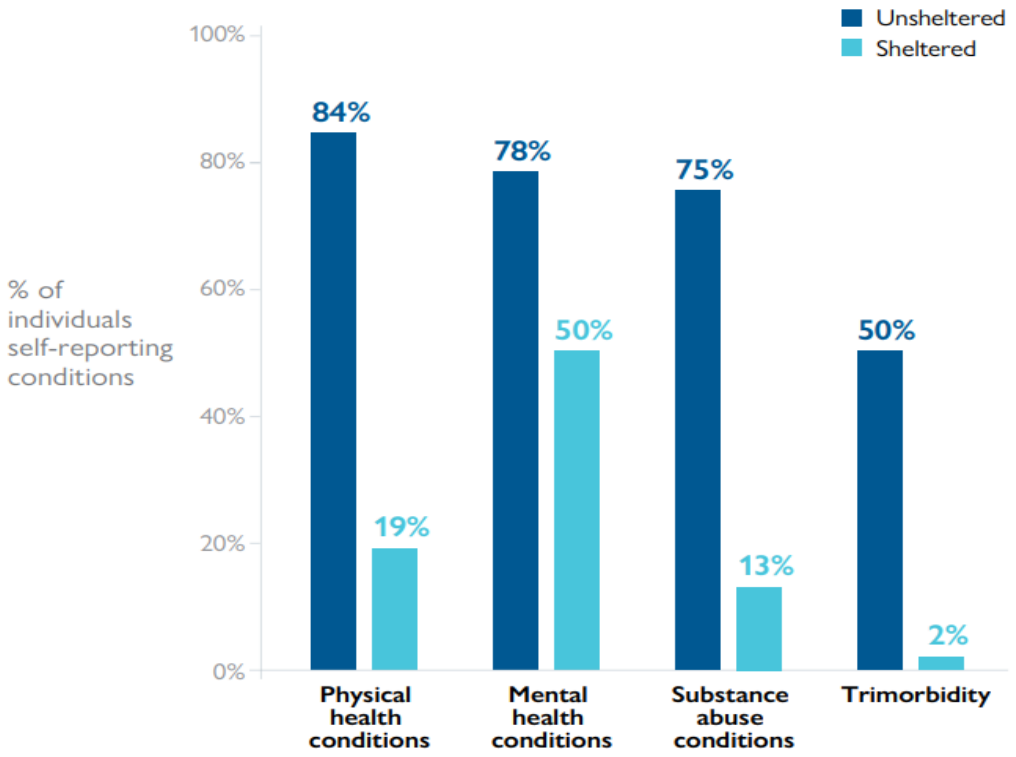
(we know this is an undercount)

These persons are the highest utilizers of hospitals and jails

Unsheltered High Utilizer Snap-Shot

- Unsheltered individuals were four (4) times as likely to report that physical health conditions had contributed to a loss of housing as unsheltered people
- Unsheltered individuals were three (3) times as likely to report mental health conditions contributed to loss of housing
- Those individuals unsheltered were more than eight (8) times as likely to report that the use of drugs or alcohol had contributed to a loss of housing
- 50% of unsheltered individuals report that they have difficulty taking care of basic needs vs. 3% of sheltered individuals who report to share the same difficulty.

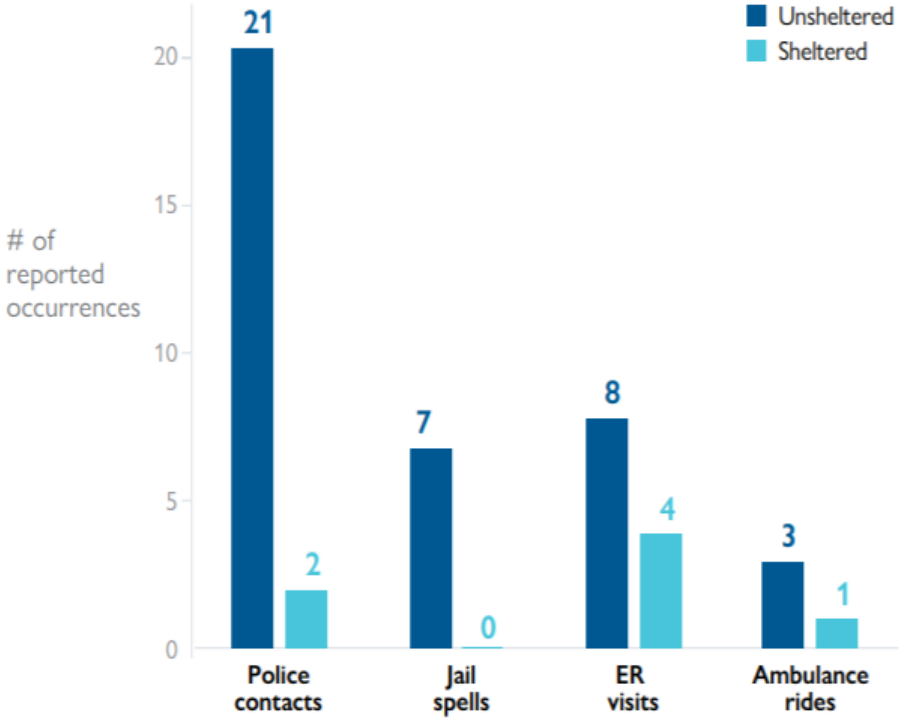
FIGURE 4. Physical health, mental health, substance abuse, and trimorbidity by shelter status[11]



Unsheltered individuals lack access to ES but not Police/Jails/ER

- Individuals who have experienced homelessness the longest are not accessing emergency shelters
- Unsheltered individuals reported lengths of time since last stably housed that were on average more than six (6) times longer than sheltered individuals (2,632 days vs. 410 days)—and unsheltered women reported an average of 5,855 days since they last had stable housing.
- Unsheltered homeless report 10x the number of Police contacts

FIGURE 6. Police contacts, jail spells, emergency room visits, and ambulance rides in previous six months by shelter status[13]



Central Florida's "First 100" Pilot Program to House Chronically Homeless

Sandi Vidal,

Vice President

Central Florida Foundation

Feedback from Summer Health/Homeless System Consultation

What are the gaps?

- We simply do not know the other's system well enough
- We don't know how to define success for the other's system (What does success look like?)
- Both systems struggle to navigate mainstream and mental health issues

What are the gaps?

- Disconnect between nutrition and lifestyle and reality post –discharge presents;
- Lack of follow-up care (accessibility, affordability)
- Genuine need for lived-experience feedback

What are the gaps?

- Hospital case managers are not equipped to navigate homeless service system
- Homeless service providers are not equipped to deal with patients that have acute medical needs
- Not maximizing our current pool of resources, or Unaware of all available resources.
- Lack consistency in our communication

What are the gaps?

- Technical unknowns around discharge orders
- We are not prioritizing institutional high utilizers for housing resources
- **No current system or agreement** in place that satisfies privacy concerns, but allows **for sharing of necessary patient information** for the purpose of continuing post-discharge care.

How to bridge the gaps

Some best practices from around the nation

Best practices

- Community Discharge Standards and Coordination
- Cross System Data Sharing
- Medical Respite; Step-down Recuperative Care

Community Discharge Standards and Coordination

- Care coordination and case management to link homeless patients to community resources such as mental health care, housing, and drug treatment
- Training for social workers and discharge planners related to the special needs of the homeless
- Discharge planning that begins at the time of admission
- Identification at the time of admission of homeless patients
- Mental status assessment to determine the patient's ability to understand treatment options, necessary follow up, and discharge plans.
- Patient participation
- A commitment to creating relationships within the community to maximize resource availability

Cross System Data Sharing

- Matched/shared data can help
  - Identify those who frequently use multiple services/systems and target appropriate housing and social service interventions
  - Engage in data-driven decision-making around service provision at both provider and system level.
  - Improve collaboration and coordination of housing, health care, and supportive services for individuals with health conditions who are experiencing homelessness
  - Facilitate better understanding of system-level operations, effectiveness, and efficiency of current resources in addressing the comprehensive needs of individuals experiencing homelessness

Medical Respite; Step-down Recuperative Care

- Step down beds (recuperative care) for the homeless who still require hospital care but at a lower level
  - Medical respite care shelters reduced utilization of emergency department, reduced inpatient days, and reduced clinic visits.
  - Medical respite programs can provide an effective place for homeless patients to recover, while reducing hospital re-admission due to insufficient recovery

ONE MORE THING!

- We have learned that the challenges can be found in the **FACTS**
  - **F**inancing
  - **A**ccountability
  - **C**onsensus on standard practice
  - **T**ime
  - **S**haring

Discussion/Feedback
Goal: Improve Health/Homeless System Collaboration—and Discharge Planning

In Groups of 5-7

1. What are some short-term actions(30 Days)?
2. What are some intermediate-term actions(12 months)?
3. What are some long-term actions(1 – 3 years)?

- Name the barriers to accomplishing these actions.
- Name the opportunities these actions create.

Next Steps

Create a small ad hoc working group to tackle actions towards goal of improving Health/Homeless System Collaboration and Discharge Planning

- Meet Monthly (next 4-6 months)
- Supported by HSN Staff
- Report back to Commission on Homelessness (CoC)

Email: L.Rashad.Haynes@hsncfl.org to participate