Northwest Michigan Coalition to End Homelessness

Policy and Procedure: Discharge from Munson Hospital Cadillac to Homeless Response System

Background: Ending Homelessness

In order to end homelessness in our communities we must have a comprehensive response system in place that ensures homelessness is prevented whenever possible, and if it cannot be prevented, it is **a rare, brief and non-recurring experience.** These goals are consistent with goals outlined by the United States Interagency Council on Homelessness: https://www.usich.gov/goals/

The Northwest Michigan Coalition to End Homelessness (NWCEH), through its Coordinated Entry Policy and Procedures, has the capacity to:

1. Quickly identify and engage people at risk of and experiencing homelessness.
2. Intervene to prevent people from losing their housing and divert people from entering the homelessness services system.
3. Provide people with immediate access to shelter and crisis services without barriers to entry if homelessness does occur.
4. Quickly connect people experiencing homelessness to housing assistance and services tailored to their unique needs and strengths to help them achieve and maintain stable housing.

The work of the NWCEH and the Coordinated Entry Policy and Procedures alone is not enough to end homelessness in any community. An effective end to homelessness includes a community that has resources, plans, and system capacity in place to prevent and quickly end experiences of homelessness for any identified individual or family. Coordinated efforts among all service delivery systems within a community are critical to ending homelessness. Service systems that have been identified as critical partners in the work to end homelessness include but are not limited to the healthcare system, the justice system, substance use treatment providers as well as the Department of Health and Human Services.

Identifying Themes and System Leverage Points

Critical to ending homelessness is the work to prevent the experience of homelessness from ever occurring. Although not a possible solution for every person or family who is at risk of facing homelessness, prevention and diversion services have been proven effective as a response to diverting people from the homeless response system through a targeted approach of creative problem-solving interventions. Prevention and Diversion services are a leverage point in the intersections between healthcare and homelessness that can be addressed using procedural modifications and adjustments within the health care system as well as the homeless response system.

Source: https://endhomelessness.org/resource/homelessness-prevention-creating-programs-that-work/

Another area significant to the work to end homelessness is the work to quickly identify and respond to the individual experiencing homelessness or a housing crisis. Although the NWCEH Coordinated Entry system has 24-7 Call Center services to quickly connect people experiencing homelessness to services and supports, a call center is not an effective intervention for everyone. Capacity of staff throughout the NWCEH who are responsible for covering a large geographic area (10 county coverage area for the call center) often results in the call center needing to return calls rather than answering them live. The call center additionally lacks mobility to do face to face assessment and triage throughout the 10 county coverage region. Quick identification among hospital staff and in turn, a more urgent face to face response time in hospital by NWCEH street outreach staff is another potential point of leverage to improve the discharge process between hospital and NWCEH staff.

Best Practices

The work to improve discharge planning between the homeless response system and the healthcare system is not unique to the communities we serve. Across the country service systems are at their breaking point and are being faced with identifying innovative solutions to increase capacity and meet the need of the vulnerable individuals requiring service.

Hospital system across the state of California have been leading the way at identifying new solutions to assisting their patients navigate the health care AND housing systems.

Examples:

i. **Hospital Patient Navigator Model in Los Angeles, CA (2019):**
   a. Hospital in-reach through a new "Patient Navigator" position based in hospitals with high volumes of patients experiencing homelessness. Navigators bridge health care and housing and can better engage patients experiencing homelessness, and some have lived experience. Navigators are seen as valued members of healthcare teams for their expertise, knowledge and resources.

ii. **Hospital Liaison: Bridging Hospitals & Coordinated Entry System through the South Bay Coalition to End Homelessness, Los Angeles, CA:**
   a. Hospital Liaison primary duties: Works with private hospital discharge planners, and clinical and social worker staff to link patients to appropriate homeless, health and housing services through CES. Works with County Harbor/UCLA staff to connect persons to other resources who are not eligible for its own housing programs. This expedites the referral process since the Hospital Liaison understands the client eligibility and access doorways to the resources, relieving hospital

staff from understanding the complicated and evolving world
of homeless services.

iii. **Community Health Worker-Homeless Services: John Wesley County Hospital Institute (JWCH), Los Angeles, CA:**

a. The Community Health Worker will primarily be stationed at California Hospital Medical Center (CHMC). This position will also require working with JWCH and in the community to increase linkages and access to health services. Assist homeless clients referred by CHMC in accessing and navigating a health care medical home, including as needed, scheduling appointments, enrollment and eligibility assessments, and broken appointment follow-up.

iv. **Community Health Navigator: Care 1st Health Plan (an affiliate of Blue Shield of California):**

a. Community Health Navigator helps Care1st members who are at risk of and/or are experiencing homelessness. The Community Health Navigator will establish relationships with community partners and providers to assist members with linkage to housing and other community resources. Facilitate placement to recuperative care centers, homeless shelters, and other housing resources as appropriate to meet the member's needs. Support member through placement into permanent and stable housing through providing intensive case management services or collaborating with other community agencies who may be providing intensive case management services to support members with their transition into permanent or supportive housing.

The staffing support and solutions noted above are just a few solutions to bridging the gap between the healthcare and homeless response systems that exist across the country. Although implemented in an urban hospital system, many of these roles share the common experience of our rural community, and can be replicated at a smaller scale within the existing systems in Northwest Michigan.

According to "A Systemic Review on the Intersection of Homelessness and Healthcare in Canada", published by the Journal of Nursing and Care in 2012, themes that emerged from interviews of individuals experiencing homelessness when they met with health care professionals include the following:

i. Chronic physical and mental health conditions
ii. Inability to obtain health care services
iii. Fragmentation of supports
iv. Discrimination and stigmatization
v. Lack of health insurance
vi. Increased needs among women experiencing homelessness
vii. Being considered “unfixable” and experiencing abandonment
viii. Moral worth

Source: Darkwah V, Yamane H, Richter S, Caine V, Maina G, et al. (2012) A Systematic Review on the Intersection of Homelessness and Healthcare in Canada. J Nurs Care 1:115. doi:10.4172/2167-1168.1000115

These themes are consistent with the findings of the work of the NWCEH CHIR project on discharges from Munson Hospital of Cadillac. The work to identify gaps, system linkage points and continued points of system failure were identified through a series of story telling sessions and meetings among Munson staff and staff of the NWCEH in Wexford County. Key findings and leverage points of the system identified through this work include the following, with some areas primed and ready for procedural change that can make significant impact in the work to improve the discharge planning between Munson Cadillac and the Homeless Response System of the NWCEH.

Procedural Themes:

i. Decreased fragmentation of services:
   a. Ensuring that Munson Emergency Department, In-patient and Out-patient intake processes include questioning associated with housing status in order to quickly identify those who are currently experiencing homelessness or who are at risk of homelessness. Ex. “What is your current housing status?” “Where did you stay last night?” “Do you own or rent your own home?” etc.
   b. Munson social worker staff conducting “diversion services” with patients who are identified through the above-mentioned intake questions to be at-risk of experiencing homelessness, or who could potentially enter homelessness without further problem solving and light-tough intervention.
   c. On-site/in hospital support from a Street Outreach worker to conduct triage/diversion services when hospital staff has identified an individual or family experiencing homelessness. This on-site support would be coordinated through hospital social work staff and street outreach staff through either an email or texting referral.