Healthcare 3 (2015) 238–244

Contents lists available at ScienceDirect

Healthcare

journal homepage: www.elsevier.com/locate/hjdsi

The Leading Edge

Improving post-hospital care for people who are homeless: Community-based participatory research to community-based action

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ARTICLE INFO

Article history:
Received 4 February 2015
Received in revised form
20 July 2015
Accepted 21 July 2015
Available online 25 August 2015

Keywords:
Homelessness
Community-based participatory research
Hospital readmissions

ABSTRACT

This article discusses how community-based participatory research (CBPR) on hospital care transitions in New Haven, Connecticut led to the development of a new medical respite program to better serve patients who are homeless. Key insights include:

- Homelessness is an important driver of hospital utilization and must be addressed in efforts to decrease hospital readmissions.
- Hospitals and community organizations often serve a shared patient/client base and can work together to develop innovative programs that are beneficial to all parties.
- Community-based participatory research methods are particularly conducive to producing research that is translatable to policy and new programs.
- Targeted dissemination of research results played a pivotal role in securing resources and funding for the new program.

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1. Background

More than 1.5 million people experience homelessness each year in the United States[1,2]. People who are homeless face numerous health risks, strikingly illustrated by mortality rates more than double those of the general population[3–7]. While overall life expectancy in the United States has been steadily increasing, the chance that a person who is homeless will live to age 75 more closely resembles that of a person living in a developing country [4]. These mortality rates stand despite high levels of health care spending for people who are homeless, often in the form of emergency department visits and costly inpatient hospitalizations[8–12]. Prior research has found that people who are homeless are hospitalized more frequently than other people, and may have longer lengths of stay and higher hospital costs[9,10,13].

Amidst increasing pressures to both reduce hospital lengths of stay and decrease hospital readmission rates, hospitals struggle with discharging patients who are homeless[14]. On the one hand, homeless patients may remain hospitalized for days after their acute medical needs have been met as hospital providers attempt to arrange suitable discharge locations and plans. On the other hand, hospital providers may simply discharge patients to the streets or emergency shelters, due to lack of knowledge that patients were homeless, lack of alternative discharge settings, poor understanding of how homelessness may affect discharge plans, or pressure to quickly discharge patients once their acute medical needs have been addressed. In these settings patients may not be able to adequately recuperate or follow complex medication regimens and other post-hospital discharge instructions. Such struggles have been highlighted dramatically in news stories of "hospital dumping," in which patients, sometimes still in hospital gowns, are dropped off at homeless shelters without prior communication and despite the fact that the shelters have little ability to provide needed care for medically fragile clients[15–17].

Despite these challenges, little published research has examined how hospitals can work together with community organizations and others to develop solutions for improved hospital discharge of patients who are homeless. In this manuscript we discuss how a community-based participatory research (CBPR)

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http://dx.doi.org/10.1016/j.hjdsi.2015.07.006
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approach to understanding hospital care transitions among people who are homeless in New Haven, Connecticut led to the development of a new program to better serve them while reducing health care costs.

2. Organizational context

2.1. New Haven, Connecticut

New Haven has a population of approximately 130,000. Though a relatively small city, New Haven struggles with urban problems including unemployment, crime, and homelessness. The 2013 homelessness point-in-time count (conducted on a single winter night) found 767 homeless people in shelters or on the streets[18]. There are two main shelters for single adults in New Haven with approximately 150 total beds year-round and additional winter overflow beds, and two shelters for homeless families.

2.2. Columbus House, Inc.

Columbus House, Inc. is a non-profit organization that has provided services to people who are homeless in New Haven since 1982. It is the largest homeless services agency in New Haven and its programs include both a year-round and seasonal emergency shelter for homeless adults, as well as multiple transitional and permanent supportive housing sites. Additionally, Columbus House provides case management, employment assistance, street outreach, and other services to people who are homeless.

2.3. Yale-New Haven Hospital (YNHH)

Located only one mile from the Columbus House emergency shelter, YNHH is the largest hospital in New Haven. At the time this CBPR was conducted, YNHH had approximately 1000 inpatient beds; it has since merged with a nearby hospital and now consists of two New Haven campuses with more than 1500 beds.

2.4. Robert Wood Johnson Foundation Clinical Scholars Program (RWJF CSP)

The RWJF CSP is a two-year fellowship program for physicians from any field who have completed residency. It operates at four medical school sites throughout the country: Yale University, University of Michigan, University of Pennsylvania, and University of California, Los Angeles. Fellows learn skills in health services research, health policy, and leadership. CBPR is a required training component at all four sites[19]. CBPR is a "collaborative research approach that is designed to ensure and establish structures for participation by communities affected by the issue being studied, representatives of organizations, and researchers in all aspects of the research process to improve health and well-being through taking action, including social change"[20]. Financial support for CBPR at Yale is provided by the RWJF, Yale Center for Clinical Investigation, Yale School of Medicine, and U.S. Department of Veterans Affairs. Because the RWJF CSP program is only two years long, continuity in CBPR can be a challenge; the CBPR described in this paper was started by one RWJF Clinical Scholar (S.R.G.), who introduced a new incoming Scholar (K.M.D.) to the project team prior to completing his fellowship to facilitate a smooth transition and continued collaboration[21].

3. Problem

Transitions of care from the hospital to the community at the time of hospital discharge can be challenging for all patients, but are particularly challenging when patients are homeless. Despite providing services for a shared group of homeless clients, Columbus House and YNHH had not previously collaborated to improve services for their shared population since—like in most communities throughout the U.S.—health care and social services generally operate in separate silos[22]. Using CBPR principles, researchers from the Yale RWJF CSP created a new partnership with staff from Columbus House and YNHH to identify issues in transitions in care between the hospital and homeless shelter. The partnership was initiated by a researcher in the RWJF CSP who was interested in health care for people who are homeless. This researcher initially reached out to the New Haven City Council, who shared the New Haven Ten Year Plan to End Chronic Homelessness Implementation Plan (2007). The Plan noted the need for improvements in the hospital discharge process for people who are homeless, and suggested interdisciplinary collaborations to address this problem. Little work had yet been pursued toward this specific goal, so the RWJF CSP researcher sought community partners to begin more coordinated research and work around hospital care transitions. After meeting with leaders from several New Haven shelters, Columbus House was identified as an ideal partner because of its large size, strong leadership, and interest in its clients' health. YNHH was also a natural fit as the largest hospital in New Haven and because several key staff members had experience with homelessness-related work. This team also engaged with local government, federally qualified health centers and other community organizations, and homeless clients themselves in all elements of identifying study questions, defining research goals, and determining study design.

The CBPR process and study results have been previously described[21,23,24]. In brief, the CBPR team, with input from the multiple stakeholders described above, developed a mixed-methods survey on hospital care transitions. Between April and May 2010, researchers administered the survey to 98 homeless clients at Columbus House who had an acute care hospital visit (emergency department visit or inpatient hospitalization) in the past year. The study found that only 44% of homeless clients reported that their housing status was discussed at their last hospital visit[23]. The majority (67%) spent their first night after hospital discharge in a shelter, 21% spent it with friends or family, and 11% spent it on the street[23]. Qualitative data revealed that study participants delayed seeking health care because of an expectation of suboptimal hospital discharge coordination[23]. An additional CBPR study combining YNHH chart review data with the Columbus House client surveys found that client self-report of having had their housing status addressed during their hospitalization was independently associated with higher performance in key discharge quality domains[24].

These findings demonstrated objectively what community providers already suspected: that there was much room for improvement in transitions of care out of the hospital for patients who are homeless. Of particular concern was the finding that 11% of patients spent their first night after hospital discharge on the streets, which both hospital and community providers agreed should never occur. The findings also demonstrated potential actionable steps to improve hospital care transitions for homeless patients.

4. Solution

In direct response to findings from the CBPR, representatives from YNHH, Columbus House, and the RWJF CSP began meeting regularly to discuss potential solutions to improve hospital discharge for patients who are homeless. Though various hospital-level interventions such as improving identification of and social

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