HEALTH CARE FOR THE HOMELESS

LINKAGE TO PRIMARY AND BEHAVIORAL HEALTH CARE

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Health Care for the Homeless

HEALTH CARE for the HOMELESS INC.

ER DIVERSION PROGRAM MODEL

Two Staff

- Registered Nurse
- Community Health Worker

Three Hospitals

- Mercy Medical Center
- University of Maryland
- John Hopkins Hospital

Target: 75 Clients by June 2015

- Homeless, high frequency ER utilizers
- Estimated 25 per hospital

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PARTICIPANT NUMBERS
(MAY 15 – DECEMBER 31, 2014)

Referrals: 87

- Mercy Medical Center: 30
- University of Maryland: 31
- Johns Hopkins Hospital: 26

Engaged in Care*: 48

* Accepted into the program and seen more than twice

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DIVERSION TO CARE AT HEALTH CARE FOR THE HOMELESS

- Engaged with any HCH service: **78%**
- Engaged in more than one HCH service: **57%**
- Total number of HCH visits as of December 2014: **572**

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DECREASED ER USE AFTER SIX MONTHS

76%

(16 out of 21 patients)

Parameters

- Comparing ER usage six-months prior to intervention vs. six-months post intervention
- In program for at least six months
- Mercy Medical Center and University of Maryland ER usage data only

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CLIENT EXAMPLE #1

63 visits 6 months before ER Diversion

25 visits 6 months after ER Diversion

- Chronic alcoholic
- No ER use while sober (especially when in treatment)
- Struggles to maintain sobriety

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CLIENT EXAMPLE #2

14 visits 6 months before ER Diversion

3 visits 6 months after ER Diversion

- Street homeless for 20 years, severely mentally ill
- Helped to link to ACT team
- Housed through Downtown Partnership for one year, working on long-term housing plan

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CLIENT EXAMPLE #3

13 visits 6 months before ER Diversion

71 visits 6 months after ER Diversion*

Zero visits in months 4-6

- Developmentally disabled, lost family support, living in ERs
- Connected with Adult Protective Services and Psychiatric Rehabilitation Program
- Reconnected with family

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HEALTH CARE FOR THE HOMELESS CONVALESCENT CARE PROGRAM

- Safe place for people experiencing homelessness to recover from an acute medical condition
- 12 hours/day, 7days/week nursing care coordination
- Full-time licensed clinical social worker
- Mercy Medical Center is one of largest referral sources

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HCH CONVALESCENT CARE PROGRAM
QUALITY & ACCESS

Connected to PCP post-discharge:

- HCH provider: 56%
- Any provider: 79%

Connected to any HCH service:

- Any HCH service post discharge: 60%
- More than one service: 28%

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NEXT STEPS

- Improved coordination of referrals from ER
- Advocate for supportive housing, increased intensive mental health and addictions services

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