

## **CARING FOR THE HOMELESS IN OUR COMMUNITIES: POST-HOSPITAL TRANSITION OF HOMELESS PATIENTS**

*A Summary of Regional Meetings Convened by the  
Hospital Council of Northern and Central California  
In Fulfillment of AB 2745 (Jones) of the California Legislature  
December 2007*

### **BACKGROUND**

In an effort to encourage community dialogue regarding the post-hospital transition of homeless patients, AB 2745 (Jones) was introduced in 2006 and subsequently signed into law by Governor Schwarzenegger. The legislation called for the California's regional hospital associations to convene local meetings of key stakeholders to identify 'best practices' and opportunities for improvement surrounding the hospital discharge of homeless patients. Twenty-five meetings with 898 participants were held throughout 2007 covering nearly every county served by the Hospital Council of Northern and Central California. The meetings were held in hospitals, Veteran's Halls, community rooms, and County Health Departments...some in collaboration with existing community groups already well-engaged with the homeless population and others in places with little local 'infrastructure' to deal with the needs of the homeless. Hospital Council staff also attended two meetings of the Northern California Homeless Roundtable (in Sacramento and in Redding) to extend the discussions further into the communities we serve.

As called out in the legislation, this report summarizes our findings, lessons learned and opportunities for continued community collaboration and fulfills the requirements as set forth in AB 2745 to provide a summary report of the regional meetings.

### **METHODOLOGY**

The Hospital Council of Northern and Central California created an organizational plan to carry out the provisions of AB 2745. Each Regional Vice President implemented the plan in their respective territories, tailoring each meeting to the local needs and circumstances. Among Hospital Council staff, a common meeting agenda was drafted so that all of the discussions would generate similar input in order for us to better assess trends, gaps and future opportunities across the region.

In communities with existing local 'infrastructure' serving homeless residents, these meetings were often done in conjunction with those service providers. In communities with no real organized network of service providers, hospitals directly convened the discussion. The invitation list for each local meeting included all local hospitals and those individuals and agencies as outlined in the legislation, including but not limited to: County Board of Supervisors; law enforcement; county social service agencies; County health care service providers; continuum of care coordinators (HUD); nonprofit social service providers; and regional advocates for the homeless. The actual participation of those invited to each meeting varied but, overall, the meetings were well-attended and included a good representation of local stakeholders.

## OVERVIEW

There is little doubt that the regional meetings as envisioned by Assemblymember Jones and called for in this legislation provided an important opportunity for hospitals, communities, California...and, ultimately, for the homeless patients in our cities. There are several striking ‘themes’ that resonated in all of our local discussions:

- There is clearly a shared belief in all communities and among all stakeholders that **the current situation facing California’s homeless population is a complex, long-standing, deep-rooted, under-funded problem. It is bigger than any single institution and it is one where solutions will require engagement of all sectors.** Each stakeholder held a shared interest in improving the care and services for homeless residents...how each were able to contribute to that differed but there was clearly a shared commitment to that outcome.
- It is important to recognize that **each organization or nonprofit providing services to the homeless, including hospitals, operates within a larger community context** and is not an ‘island’ unto itself. It follows then that **the solution to the homeless problems facing our cities must also be solved in that larger context and through the efforts of multiple stakeholder groups.** Communication between stakeholders ...and learning how the parts of a community work together on this issue...are essential.
- It also follows that **the problems that homeless individuals deal with also occur in a larger context and they rarely are just a single issue of health care *or* housing *or* transportation.** Rather, in most cases, California’s homeless deal with all of those issues and more...substance abuse, mental illness, domestic violence, limited job skills, children to care for, lack of finances...the list goes on. Their issues are not one-dimensional...nor can our solutions be one-dimensional.
- **In the absence of a larger State or community homeless plan, it often falls to every organization or institution involved to work outside their ‘highest and best’ use...**moving into areas where they have inadequate staff, training and/or resources...in order to meet the homeless patient’s needs. For example, it is common to find hospitals involved in every aspect of caring for the homeless...clothing, transportation, meals, family, health insurance programs, and public assistance...housing agencies searching for healthcare, food, and insurance...or homeless shelters attempting to provide medical care.
- **There are many passionate and deeply committed community members who work on the homeless issues every day...and often with very limited resources.**
- **Local infrastructure to deal with homeless issues varies greatly from place to place...and ranges from extremely well-developed to virtually none at all.**

## PRINCIPLES DRIVING THE COMMUNITY CONVERSATIONS

In meetings all across the Hospital Council’s Northern and Central California region, a common set of principles seemed to emerge from these community conversations. Every community is committed to find the most effective strategies and solutions to serve their homeless residents driven by the following shared principles:

- **Permanent and sustainable solutions** that result in life changes vs. ‘temporary fixes’
- **Collaborative work across all sectors:** healthcare, social service and other government agencies, law enforcement, nonprofit community-based organizations, faith-based groups, housing agencies, elected officials, and schools
- **A network of services for homeless residents** that is centralized, integrated, seamless and easy to access and that spans the full continuum of care
- **Reliable funding from a variety of sources** (to decrease dependence for funding from a single source) and a **commitment to *expand* rather than simply *shift* resources** for this population
- **Ensuring the ‘highest and best use’ of all community resources** in meeting the needs of this population

## CURRENT CHALLENGES, RESOURCES AND SERVICE GAPS

Each regional meeting began with the identification of local resources currently available. As expected, those community resources varied from region to region and from the urban to the more rural communities. This discussion led to the identification of ‘gaps’ in services as viewed through the lens of each community. Those ‘gaps’ are summarized here.

### ***Inconsistency in Overall Community Plans / Infrastructure to Serve the Homeless***

- The absence of comprehensive community plans creates a lack of clarity on roles, accountability, and scope of services available leading to fragmented, duplicative or, in some cases, totally ‘absent’ services for this population.
- In most cases, the centralized function, if one existed at all, was carried out through a collaboration of non-profit agencies and was not ‘institutionalized’ in the County or City systems.

### ***Inadequate Capacity to Serve the Needs of the Homeless Population***

- Every community reported that the local shelter capacity fell short of the daily basic needs. Compounding the problem, shelter staff reported that they are not trained or equipped to manage individuals with medical needs.

### ***Complexity of the Problems Facing the Homeless***

- Lack of permanent, affordable housing...a ‘housing first’ view was shared by many participants in these community meetings.
- Services for the homeless are made more challenging due to the complexity and multi-dimensional nature of the problems they face (e.g. shelter, substance abuse, mental illness, domestic violence, and the like).
- Specifically, services for homeless residents with substance abuse issues are a huge unmet need in every community (detoxification facilities, sobering centers, or long-term recovery locations are few and far between).
- The ability to secure legal guardian status and/or conservatorships for the homeless is difficult.

### ***Healthcare Challenges***

- The single biggest gap in the health-related ‘continuum of care’ is the lack of medical respite care facilities. We found communities that have no respite care options or, if they did, the capacity is inadequate, under-funded, or too restrictive in its use (e.g. San Francisco has a 60-bed medical respite facility but that capacity is far below the City’s needs). *This was universally reported in all regions of Northern and Central California.*
- Facility protocol for the discharge and transfer of homeless patients varies among hospitals, community service providers, shelters and others involved with this population.
- Intensive case management services for patient follow-up have proven effective in some communities but are not widely available (this links to continuing challenges with affordable pharmaceutical services, medical equipment, and the like for homeless patients).
- Underutilization of community clinics (especially for weekend care) was noted.
- All communities suffer from a severe shortage of inpatient psychiatric beds/services as well as a shortage of long-term care options for the homeless
- Overuse of emergency departments by homeless patients burdens an already over-taxed system within hospitals and does not necessarily promote the long-term health of the homeless patient.

### ***Lack of Data and Information Sharing***

- Hospitals vary in their data collection re: homeless patients, length of stay, recurrence of hospital stays, etc, making it more challenging to clearly define the scope of the problem. It is difficult to correctly collect data identifying a patient as ‘homeless’ upon admission or arrival in the Emergency Department, due to inaccurate reporting by the patient, data entry system limitations and other constraints.
- HIPAA regulations make the sharing of homeless patient information from hospital to hospital or from hospital to community agency more challenging.

### ***Funding and Resources***

- The inadequacy of, constraints on, and reliability for funding of homeless services in general, and homeless healthcare services specifically, is a continuing struggle.
- Not all stakeholders in a given community had a good understanding of the resources available to serve the homeless population...agency lists were outdated, not available in a centralized location or incomplete.

### ***Services for Homeless Children***

- This population presents unique challenges and there was a sense that the resources, services, and needs of homeless children elevated the problem to a higher level.

### ***Additional Challenges***

- Parolees recently released from County jails or State prisons add complexity to the local challenges as many shelters and homeless centers will not provide services to individuals with a criminal record.
- Homeless individuals with behavioral or mental health problems, especially those who have been barred from previous shelters as a result, are difficult to place.
- Some existing State legislation actually is counter-productive to serving homeless (e.g. 5150 holds).
- Not all community resources are ‘at the table’ in these discussions (e.g. long-term care facilities and ‘board and care’ residences) and must be included.
- The bureaucratic delays to qualify a homeless individual for assistance programs (SSI, Medi-Cal, etc) take months and delay funds to pay for permanent housing solutions and/or their medical needs.

- Regardless of any single community's resources, shelters, plans or services, it is the fundamental right of any competent adult to choose to accept medical care or social service assistance...or not. Every meeting included real-life stories about homeless individuals who simply declined to participate in any of the help offered.

## BEST PRACTICES AND LESSONS LEARNED

The community meetings afforded the opportunity to learn more about successful practices and resources that were available in each region. Northern and Central California communities are resourceful, innovative and always searching for new ways to do more with less. Throughout the twenty community conversations, several 'best practice' trends emerged and are summarized with examples given below. The chance to replicate these practices throughout the region holds great promise to accelerate the region's ability to care for the homeless.

### ***Medical Respite Care***

- San Francisco's Department of Public Health operates 60 medical respite beds.
- Contra Costa County's 24-bed respite care center is expected to open in mid-2008.
- The Interim Care Project (Sacramento) is an 18-bed respite care facility operated as a collaboration between four area hospitals, Sacramento County and the Salvation Army.<sup>1</sup>
- East Oakland Community Project's 12-bed respite care center is planned to open in January 2008.
- Kern, Marin, Fresno and Santa Clara Counties are actively exploring the establishment of respite centers.
- Solano County, through the Solano Coalition for Better Health, contracts with two homeless shelters to provide respite beds.

### ***Frequent Emergency Room Users Programs***

- The *BRIDGE* program at Kaweah Delta District Hospital (Tulare County), *New Directions* (Santa Clara County), *Project Respect* (Alameda County), and *ED Action Plan* (San Francisco) have all demonstrated success in caring for homeless patients and getting them access to follow-up care outside of frequent, costly, return visits to hospital emergency rooms as well as access to other community services (e.g. interim and permanent housing options in Santa Clara County).

### ***Hospital Discharge Policies and Protocol***

- Hospital discharge planners, working in conjunction with local homeless service agencies, are developing shared discharge protocol (Contra Costa and Santa Clara Counties).

### ***Strong Community Infrastructure***

- Homeless Services Coordinating Council (San Luis Obispo County) is an example of a strong, coordinated community collaborative.
- HUD/Continuum of Care groups exist in nearly every community.

<sup>1</sup> For more information, see "No Place to Go: Addressing the Challenge of Homeless Patients in Sacramento," California Healthcare Foundation Issue Brief, July 2006 ([www.chcf.org](http://www.chcf.org))

### ***“One Stop” Community Resources and Services***

- Several programs exist that provide a ‘one stop’ service center for homeless individuals, such as the *“Healthy Connections”* program (San Joaquin County).
- Communities with well-developed 211 systems (Alameda and Contra Costa Counties, for example) have found them to be a tremendous resource.
- Tri-City Homeless Coalition (Alameda County) is opening one-stop center and case management services for the homeless mentally ill in 2008.
- Specialized transportation systems for homeless patients leaving hospitals in San Francisco have been very helpful in connecting these patients to appropriate community resources.
- The Santa Clara Board of Supervisors has recently endorsed the development of a one-stop service center for homeless individuals.

### ***Mobile Units***

- Mobile units of service providers, mental health staff, and home health nurses reach out to the homeless populations in Tulare, Kern, Santa Clara, San Francisco, and San Mateo Counties.

### ***Substance Abuse Services***

- These ‘best practices’ are very limited in California but in other states and a few Northern California communities where they exist, they have been a valuable piece of the continuum of care for homeless individuals (examples include the San Francisco’s McMillan Sobering Center and Alameda County’s Detoxification Services Center (set to open in early 2008).

### ***Funding***

- Some communities have been successful in using Proposition 63 funds to increase services for the mentally ill homeless.

## **MOVING FORWARD: FUTURE OPPORTUNITIES**

- **Medical respite care** emerged as both the most significant gap *and* the most promising opportunity to improve services for the homeless population. Continued efforts, legislation, funding and technical assistance in creating these centers throughout Northern and Central California would add great value to the healthcare needs of our homeless residents.
- In communities with **case management services for the homeless**, all reported that this ‘individualized’ care plan was highly successful. Efforts to support more case management work within each region will continue.
- **Regional and local collaboratives are essential** to advancing the larger issue of homeless services in any community. Hospitals will continue to be engaged and active participants in these local efforts to strengthen communication, coordination, referrals, and follow-up. When possible, **designation of a centralized community or County staff person/agency** to coordinate homeless services would greatly enhance local efforts.
- As one sector involved in the care of the homeless, hospitals will work together to identify, **collect and monitor relevant data** regarding hospital care of homeless patients (within the constraints of federal legislation); **shared and streamlined discharge protocol, policies, and referral processes** where applicable; and **shared resource lists** to better meet the patients needs. Hospitals will also continue with their **internal staff training** regarding their individual community’s homeless needs and practices in caring for this special patient population.

- A focus on **leveraging existing funding sources** (e.g. Prop 63) and **identifying additional revenue streams** will continue. In addition, linkages and alignment with existing community resources will continue to be an essential element of every community plan (e.g. expanding the role of community ombudsmen to include acute care hospitals).

## ATTACHMENTS

- Assembly Bill 2745 (Jones)
- List of community meetings held (location, date, number of participants)
- Hospital Council of Northern and Central California regional map