Ready for Discharge – Now What?

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What are Rooted Life, Independent Living Homes?

Rooted Life formed in San Diego in October 2015 as the answer to inadequate housing choices for individuals with disabilities, substance use disorder, behavioral health and mental health issues. Commonly called Independent Living homes or Supportive Housing, these homes provide low cost solutions to homelessness and recidivism in the hospital setting.

Supportive Housing and Independent Living Homes (such as Rooted Life), are an integral part of low-income housing for vulnerable populations. But connecting individuals with the correct housing model upon discharge from institutions has been a challenge throughout the advent of the “Housing First” initiative. Individuals need secure housing in order to thrive, advance and be connected back to the community but with stringent regulations and less providers willing to take the risk; How do we connect individuals to the correct housing and what resources can be utilized to achieve a modicum of success to stop the revolving door in the institutional setting?

Rooted Life Housing

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During discharge, connecting patients to the appropriate level of care will vastly reduce recidivism in hospital institutions. Repetitive homeless ER visits account for a vast majority of wasteful healthcare spending.

**Common housing options:**
- **Assisted Living:** 24/7/365 Care and Supervision; Centrally stored medication and medication management; Assistance with Activities of Daily Living; More often that not, cost prohibitive. This is the option that most patients coming directly out of a hospital setting need but is unavailable.
- **Independent Living:** Oversight and monitoring; Staff member available 24/7/365; residents must be independent with Activities of Daily Living; No medication management; Affordable shared housing option usually under amount received for SSI.
- **Supportive Housing:** Combination of housing and services such as mental health, limited medical services, case management and in some instances job readiness.
- **Recovering Care Facilities:** Addresses the critical need of homeless men and women newly released from the hospital but still requiring medical attention.

Reducing dependency on hospital services is of utmost importance to lower healthcare spending. The most effective solution is providing housing and wraparound services that follow the patient months after discharge.

Hospital Discharge planners, Case Managers etc. have limited resources as well as incomplete knowledge of housing options and services for the homeless, mental health and substance use population.

Connection between different departments in hospital setting is essential to create a clear picture of patients needs and limitations upon discharge. Good practice can be achieved when there is a clear understanding between hospitals and service providers on how appropriate and timely referral and joint working between agencies can be established.
Patients can be incorrectly referred to various housing modalities due to a lack of information shared between different hospital departments, discharge and service providers. Implementation of a simple questionnaire/assessment for individuals who are homeless or at risk for homelessness due to mental health or substance abuse issues can guide discharge planning. To increase the likelihood of successfully housing patients after discharge, upon admittance to hospital those who fit the aforementioned criteria could answer a simple questionnaire to the best of their ability with follow-up by case manager during the patient’s tenure at the hospital.

Assessment/Questionnaire examples

Example assessment for housing placement to be filled out by patient:

- What events lead up to you being hospitalized?
- If you were in a home or facility prior to admittance
  - Name of Facility/Home
  - Will you be going back to the same Facility/Home upon discharge?
  - Reason you will not go back to Facility/Home, if applicable.

Example assessment for housing placement:

- Is patient able to take care of all ADLs?
- Is patient ambulatory?
- Is the patient incontinent?
- Does patient have a source of income?
- Does patient have a history of drug or alcohol abuse?
- Is the patient connected to any services, such as mental health, behavioral health, or case management?
- How is this person going to receive their meds upon discharge?
- Does the patient have a primary care physician or psychiatrist/psychologist?
## San Diego Housing Resources

### Recuperative Care Facilities

- San Diego Rescue Mission [www.sdrescue.org](http://www.sdrescue.org) (619.687.3720)
- Interfaith Community Services [www.interfaithservices.org](http://www.interfaithservices.org) (760.721.2117)

### Housing First/Rapid Re-Housing

- PATH [www.epath.org](http://www.epath.org) (619-810-8600)
- Independent Living Association (Listing of Independent Living Homes in San Diego and soon Alameda County) [www.ilasd.org](http://www.ilasd.org)
- Alpha Project [www.alphaproject.org](http://www.alphaproject.org) (619.542.1877)
- Center for Family Solutions [www.womenhaven.org](http://www.womenhaven.org) (760.353.6922)- Imperial County
- Veterans Community Services [www.ccvcs.net](http://www.ccvcs.net) (800.974.9909)- San Diego and Imperial County
- San Diego Housing Commission [www.sdhc.org](http://www.sdhc.org) (619.578.7768)

## San Diego Housing Resources

### Assisted Living/Adult Residential Facilities

- Community Care Licensing Division (Adult Residential Facilities, RCFE) [www.cdss.ca.gov/inforesources/Community-Care-Licensing](http://www.cdss.ca.gov/inforesources/Community-Care-Licensing)
- Choose Well San Diego (Compares and rates assisted living facilities) [www.choosewellsandiego.org](http://www.choosewellsandiego.org)

### Assertive Community Treatment – Provides intensive case management to people with severe and persistent mental health issues who are at a high risk of hospitalization.

- Community Research Foundation [www.comresearch.org](http://www.comresearch.org) (619.275.0822)
- Telecare [www.telecarecorp.com](http://www.telecarecorp.com) (510.337.7950)
- Pathways (Molina) [www.pathways.com](http://www.pathways.com) (562.467.5440)
The links between housing and health are clear: Individuals struggling with unsafe or unstable housing experience worse health outcomes and higher health care costs. Evidence is equally strong for the benefits of interventions to promote housing stability. Spending more time in more stable housing and eliminating housing-related stressors lead to improved health and fewer, shorter hospitalizations. Since the broad consensus is that individuals’ social needs are central to health and well-being, hospital and health system leaders are getting involved in these types of interventions, either alone or in partnership with community organizations.

The economic benefits for hospitals can be significant, because homeless or unstably housed individuals are more likely to be uninsured, be hospitalized more frequently, have longer lengths of stay, be readmitted within 30 days and use more high-cost services. Reducing homelessness and other forms of housing instability — through case management, supportive housing (supportive services combined with housing), housing subsidies or neighborhood revitalization — improves health outcomes, connects individuals with primary care and reduces utilization. When hospital and health system executives focus their resources on housing supports and case management, the cost savings can offset the expenditures by between $9,000 and $30,000 per person per year. Reducing readmissions by improving care transitions also matters more as health care providers move toward value-based models of care.

~American Hospital Association, Trustee Archives (Executive Briefing) Housing and Hospitals; March 12, 2018
Consumers with SMI need stable housing to engage in treatment and reach self-determined goals for recovery. Respects the recovery process, consumer self-determination, and provides an innovative approach to care management.
THE SCATTERED-SITE MODEL

- Progressive Housing Program sites are scattered across San Joaquin county.
- Widely dispersed sites allow the utilization of single family homes in residential neighborhoods.
- Each site has a House Leader that maintains a safe environment in the house and reports directly to the SSHH Operations Supervisor.

HOUSING PROGRAMMING

- Provides a Housing First approach coupled with Radical Hospitality for consumers with SMI.
- Low barriers to entry do not initially require consumer sobriety.
- Consumers are provided individualized treatment from behavioral health services.
Housing Levels

| Level 1: Pre-contemplation Pre/Post Assessment Process | Consumers are sheltered as a guest (not tenant) while they complete the assessment process and are able to self-determine program participation. |
| Level 2: Contemplation & Treatment Sober Living & Treatment | Consumers are placed in a shared housing that is monitored by a house leader who lives on site. There are expectations that consumers maintain medication compliance, adhere to house rules, attend house meetings and perform household chores. |
| Level 3: Recovery & Treatment | Consumers are assigned a housing case manager that will assist with identifying tangible and permanent housing options. |
| Level 4: Graduation Independent, permanent housing | Consumers opt-in to residency in a shared housing environment where a small portion of their income is used to cover monthly household expenses. Consumers work collaboratively with housing case managers to develop permanent housing plans, increase positive rental history, increase or obtain income, and obtain documentation for housing voucher/rental application. |

Housing Progression

- Consumers move progressively through various housing levels based on their progress and recovery goals.
- Mental health, medical, and other treatment providers make routine home visits (no on-site clinical or therapeutic services).
- A Housing Case Manager works with consumers to self-determine a housing case plan and related goals. Additionally, they provide assistance documenting positive rental history, obtaining identification (ID and social), and financial planning.
A Collaborative Approach to Meeting Patients’ Needs

Ernell De Vera, RN, MBA
Chief Nurse Executive, Mental Health

Topics

• Sutter Health and System Mental Health
• A Successful Patient Story
• Organizational-level care coordination
• Care coordination with the broader community
Sutter Health

Who We Are

Our Not-For-Profit Philosophy at Sutter Health leads the transformation of health care to achieve the highest levels of quality, access and affordability.

- **54,000** Employees
- **12,000** Physicians
- **24** Hospitals
- **2** Free Standing Psychiatric Hospitals

Rated Top 15 Health System by Truven Analytics – 2016
Serving Over 100 Communities

Mental Health & Addiction Care Centers

Serving California, Oregon, Nevada, Hawaii, & Pacific Rim

Inpatient Facilities including Hospital Based Outpatient Services

- **3** Mental Health Inpatient Units
  - California Pacific Medical Center (16 beds)
  - Mills Peninsula (64 beds)
  - Alta Bates (89 beds)

- **3** Outpatient Care Centers (Ambulatory)
  - California Pacific Medical Center
  - Palo Alto Medical Foundation
  - Sutter Gould Medical Foundation - Modesto

- **2** Freestanding Facilities
  - Sutter Center for Psychiatry - Sacramento (71 beds)
  - Kahi Mohala - Oahu (88 beds)

Total of 328 Licensed Inpatient Beds
# Outpatient

## Hospital-based Outpatient
Outpatient Services Under the Hospital’s General Acute-care License

<table>
<thead>
<tr>
<th>PHP</th>
<th>IOP</th>
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</thead>
<tbody>
<tr>
<td><strong>Partial Hospitalization Program</strong></td>
<td><strong>Intensive Outpatient Program</strong></td>
</tr>
<tr>
<td>- Program May Include: DBT, CBT, and Groups for Individuals with Co-occurring Disorders and Eating Disorders</td>
<td>- Step-down Program from PHP and may include Groups for Individuals with Chemical Dependency and Eating Disorders</td>
</tr>
<tr>
<td>Mills-Peninsula Health Services</td>
<td>Sutter Center for Psychiatry</td>
</tr>
<tr>
<td>Alta Bates Summit Medical Center</td>
<td>Kahi Mohala</td>
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## Ambulatory
Traditional Outpatient Programs

<table>
<thead>
<tr>
<th>Traditional Outpatient Psychiatry</th>
<th>Traditional Group Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>California Pacific Medical Center</td>
<td>Sutter Gould Medical Foundation - Modesto</td>
</tr>
<tr>
<td>Palo Alto Medical Foundation</td>
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</tbody>
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Patient Story...
### Organizational-Level Care Coordination

#### Whole-person Approach
- Interdisciplinary team approach
- Comprehensive needs assessment
- Connection and navigation
- Ongoing partnerships...

#### Partnerships
- Establishing relationships
  - With the patient
  - Within your organization
  - Within the community

### A Collaborative Approach

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<tr>
<th>Strategy</th>
<th>Partners</th>
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<tbody>
<tr>
<td>Peer Support</td>
<td>Crisis Residential</td>
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<tr>
<td>Proposition 63</td>
<td>Shelters</td>
</tr>
<tr>
<td>Technology</td>
<td>TLCS Navigators</td>
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Key Partnerships

Questions

Go to www.menti.com and use the code 28 26 94

Questions?

Waiting for questions

Once questions are accepted by the moderator, they will show up here so that you can answer them one by one.
Thank You

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