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Case Manager Discharge Planning for Safe Discharge of Homeless Patients

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Case Manager Discharge Planning for Safe Discharge of Homeless Patients

by

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Abstract

Acute care case managers are continually challenged with the task of identifying discharge barriers and preparing a discharge plan that facilitates successful recovery and healing. Planning a discharge for a patient that is homeless can be extremely challenging. This MSN Nursing project addresses the complex discharge barriers involved in planning a safe discharge for homeless patients. The project goal was to create a Case Management Resource Algorithm that will organize available community resources to meet the social determinants of health deficits to prevent the progression of disease processes, prevent repeat visits to the emergency room, decrease inpatient admissions, as well as shorten the overall patient length of stay.

Keywords: discharge planning, homeless, Social Determinants of Health, case manager

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A heartfelt thank you to my mother who always encourages me to follow my heart (I miss you so much), my father who is my example of true love and compassion for humanity, and my precious husband-cheerleader who has prayed over me every single day and helped me to stay focused on the finish line, to my children and grandchildren who surrounded me with their love and encouragement, and to my project chair, Erin Montgomery, DNP, and her amazing guidance and encouragement through this incredible journey. God bless you each and every one. We did it!!

Table of Contents

Appendices

List of Figures

List of Tables

CHAPTER I

Introduction

Case managers are increasingly faced with the difficult task of navigating safe discharge plans for the homeless population. The homeless population faces many challenges directly related to frequent visits to the emergency room or requiring inpatient admissions including a lack of a primary care provider, insurance coverage, resources to obtain needed medication, and many times are suffering from mental illness and other debilitating health challenges.

Case managers have the task of ensuring patients have a safe discharge plan. But what constitutes a safe discharge plan for those who have no home, no insurance, no money, and many times no support system? Case managers would benefit from a systematic algorithm that would assist in navigating a safe discharge plan for homeless individuals and utilize community resources to meet the homeless population as well as identify opportunities for grant proposals or community efforts to obtain emergency resources to assist in meeting the basic needs and ensure a safe discharge plan.

Problem Statement

The primary responsibility of acute care and inpatient case managers is to provide a safe discharge plan for patients to ensure the post-acute needs of the patient are met and the patient is discharged to a level of care congruent with optimal recovery to avoid injury or readmissions. The limited resources, lack of support, and the lack of appropriate shelter are only a few of the barriers that make discharge planning for the homeless an extremely difficult task. The proposed intervention is to design a discharge algorithm that

provides a care pathway that will maximize the available community, state, and federal resources to meet the basic needs of the homeless patient.

Significance

The United States Interagency Council on Homelessness (2022) reported 9,280 homeless cases in North Carolina in 2020. Homelessness is not, by any means, a new problem. Homelessness has been a part of human existence since the beginning of time and will continue to be a part of our societies. The homeless population is at greater risk of poor health outcomes. The National Health Care for the Homeless Council (2019) reported the homeless population has higher rates of illness and dies 12 years sooner than the general United States population. Many times, a homeless patient is ready to discharge from the hospital but not well enough to return to the shelter or the streets.

Case managers have the responsibility of planning and executing a safe discharge plan for the homeless. Some of the barriers to a safe discharge of the homeless include: no longer being able to live independently due to a debilitating health event, no family or friend support, no health insurance, no return address or appropriate personal documents needed to complete forms or applications for assistance, lack of resources for medication, no transportation to follow up appointment, lack of communication for follow-ups calls, no resources to obtain durable medical equipment, no electricity source to operate durable medical equipment such as a nebulizer or oxygen concentrator, nowhere to rest and recuperate properly. Most homeless shelters require the patient to be completely independent to be admitted to the facility.

Purpose

The purpose of this Master of Science in Nursing project was to identify available resources in North Carolina for the purpose of creating a resource algorithm for case

manager utilization. The desired outcome was to minimize or eliminate deficits and provide resources needed for post-acute respite care and facilitate sufficient recovery of the homeless patient.

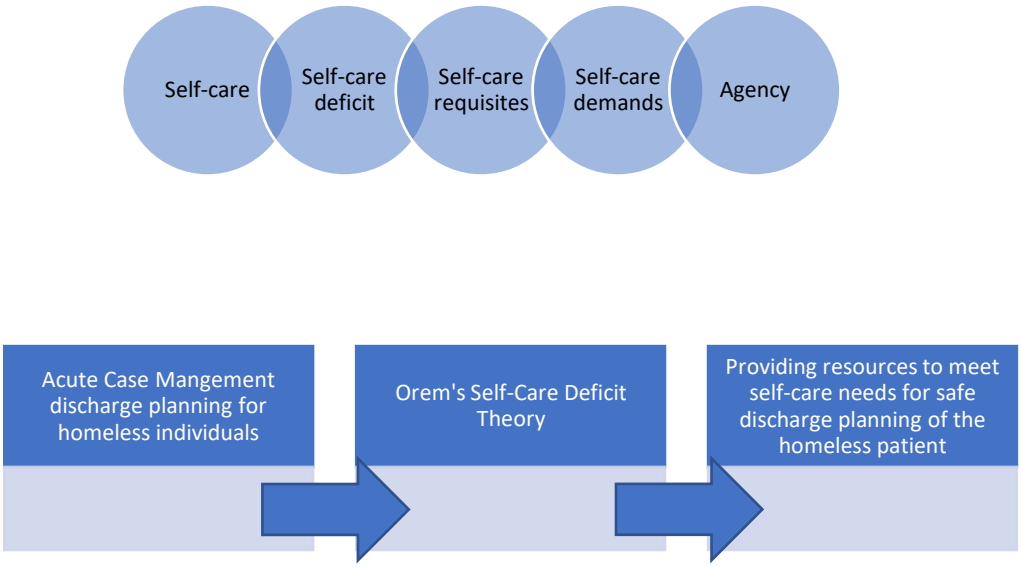
Theoretical or Conceptual Framework

The conceptual framework for this project was based on Dorothea Orem's Self-Care Deficit Nursing Theory (Orem et al., 2001). The basis of Orem's theory describes the need for persons to have the means and ability to care for themselves. Orem's theory explains that when the self-care needs are greater than self-care abilities, then someone else must provide that care (George, 2011). Orem's theory is a holistic approach to health promotion and maintenance by providing the basic needs of food, water, air, and an environment free of hazards. The role of the nurse within Orem's theory is to assist patients in meeting their self-care needs. Hood (2014) listed five key concepts of the Orem theory: (1) self-care (learned behaviors contributing to individual health), (2) self-care deficit (self-care needs that are beyond the patient's current ability to meet), (3) self-care requisites (essential needs), (4) self-care demand (actions required), and (5) agency (capacity to engage and participate).

Orem's nursing theory (Figure 1) is relevant to this project because the expectations of acute care case managers are to provide a safe discharge plan for all patients that will promote continued healing and prevent readmissions. Patients are assessed for social determinants of health to identify social deficits that could have a direct impact on the overall recovery of the patient. Deficits are identified and resources can be provided to the patient by the case manager to meet those needs, eliminate the identified self-care deficits, and promote better health outcomes.

Figure 1

Orem's Self-Care Deficit Theory



Discharge planning for the homeless individual is extremely complicated. The self-care deficits are complex, and resources are extremely limited. For example, if a homeless shelter is closed during the day, where does the patient recovering from a stroke find a place to rest until the shelter reopens? If a homeless patient has no insurance and no source of income and needs durable medical equipment, how will that need be met? How does an acute care case manager provide the resources needed to ensure the homeless patient receives adequate resources to promote healing and the highest possible level of recovery while conscientiously preserving facility resources and minimizing the length of stay?

Summary

The goal of the acute care case manager was to provide a safe discharge plan for all patients to promote continued healing and prevent readmissions. The Orem's Self

Care Deficit Theory is the conceptual framework chosen as the foundation of this project with the sole purpose of identifying the self-care deficits of the homeless patient and providing community resources and contact information to assist the homeless patient in meeting those self-care deficits and needs. Discharge planning for the homeless patient must identify the barriers to discharge and self-care deficits. Once these deficits are identified, the case manager needs to find resources to meet those needs. By creating an algorithm, resources could be quickly accessed.

The U.S. Department of Health and Human Services (2021) published an assessment tool identifying risk factors that have a major impact on the health and well-being of humans. The Social Determinants of Health (SDOH) screens for the deficits in several aspects, but the determinants that will be the concentration of this project will be housing, transportation, food, access to medical and psychiatric services, and access to medications.

By providing case managers with an algorithm that organizes available resources that address deficits in social determinates of health (SDOH), it is expected that the outcome will be a decrease in the patient's length of stay (LOS), prevention of readmissions, improve the patient health outcomes, and provide community resources that decrease or alleviate the identified self-care deficits. For example, a homeless patient presents to the emergency room and has no insurance or income. During the interview with case management, the patient mentions veteran status. The case manager follows the Case Management Resources Algorithm and is directed to contact Veterans Services to identify service benefits eligibility. As a result, the veteran was found to be eligible for monetary compensation, housing assistance, medical services, and psychiatric services.

CHAPTER II

Literature Review

A review of literature was performed utilizing various databases including and not limited to PubMed.gov, PubMed Central, and Bulldog One Search. Keywords used to search for material included *discharge planning for homeless, case management, social determinants of health, and United States homelessness, community resources.* Relevant articles were sorted and organized to support the significance of this project. The homeless population is at higher risk for poor health outcomes compared to the general population. The lack of basic resources such as housing, food, medicine, durable medical equipment, insurance, a primary care provider, and transportation place the homeless patient at high risk of multiple admissions. There is a desperate need for discharge policies that address the needs of the homeless patient. Deficits in resources and policies set the stage for discharge failures and increase the likelihood of poor outcomes and repeated admissions (Jenkinson et al., 2020).

Social Determinants of Health

The United States Department of Health and Human Services (USDHHS) and Healthy People 2030 categorize Social Determinants of Health (SDOH) into five domains that assess the quality-of-life outcomes and risks based on current environmental conditions. According to USDHHS, one out of 10 Americans suffers from poverty. The SDOH focuses on five domains: economic stability, education access, health care access, neighborhood-environment, and social-community resources.

These SDOH domains have a direct impact on the patient's health, well-being, and their quality of life. Screening tools designed to identify SDOH deficits can be

utilized in discharge planning to optimize recovery, recognize discharge barriers, and minimize poor post-discharge outcomes by providing available community resources to alleviate those deficits and facilitate a successful discharge. For example, the case manager may ask the patient, do you have transportation to your appointments? Are you currently homeless? Do you have running water and electricity? Have you been unable to purchase food? Are you currently employed? Do you have family or friends who are willing and available to help you if you have a need? Do you have a primary care provider? Do you have medical insurance? (U.S Department of Health and Human Services, 2021).

Homeless Discharge

Miyawaki, et al. (2020) performed a statistical analysis comparing homeless patient discharges and readmissions to non-homeless patients, and found the readmission rate significantly higher for the homeless population directly related to common disparities of homelessness including lack of adequate shelter, absence of a primary care provider, lack of food source to promote healing, lack of access to medication, lack of resources to support the use of durable medical equipment including nebulizers, oxygen concentrators, and the inability to properly store medications such as insulin, and the lack of transportation to ensure access to follow up appointments.

Forchuk (2020) discusses the findings of a study that identified a need to assess housing during hospital admissions. The study revealed incidences in which patients became homeless during admission due to a variety of reasons including loss of income, relationship changes, evictions, and abandonment. Forchuk (2020) references studies that argue that discharging a patient only to have that patient return for readmission and

requiring a higher level of treatment due to an inadequate discharge plan, is illogical. Overall, it would be more reasonable and less costly to seek and provide resources at discharge that facilitate optimal recovery.

Models of Discharge Planning for Homeless Patients

Homeless serving hospitals (HSH) had lower readmission rates and emergency room visits compared to other hospitals. These HSH facilities were found to have community healthcare workers and patient advocates who were familiar with available community resources. These professionals were able to facilitate a discharge plan connecting the homeless patient with adequate resources to promote optimal recovery (Miyawaki et al., 2020).

Canham et al. (2019) discuss the need for collaboration and the development of partnerships between hospitals and shelters to provide respite support for homeless patients in need of short-term shelter and allow the opportunity to continue to recover in a safe environment. Shared accountability with community resources in medical respite models focused on aftercare assistance to the homeless population at discharge report reduced hospital readmissions which have resulted in significant savings to the healthcare system (Basu et al., 2012). Research results included six thematic findings: (1) unique vulnerabilities of disabled or elderly homeless, (2) inappropriate accommodations for disabled or elderly in the shelter setting, (3) limited shelter options for patients suffering from complex health or psychiatric needs, (4) limited convalescent options for optimal recovery, (5) Lack of need specific shelter or housing options, and (6) lack of community support and resources (Canham et al., 2019).

Recuperative Care Center (RCC) is an example of a medical respite program in California. Tan et al. (2013) published a PowerPoint that explains the program and guides case managers through the process of discharging patients to the program as well as outlines the care provided to the homeless patient. Recuperative care referrals for hospital case managers provide the homeless patient the opportunity to obtain medical stability, resources, and housing solutions. The addition of respite-type programs to the case manager discharge planning regimen has resulted in a significant reduction in lost revenue for participating facilities. Tan et al. (2013) included a bar graph demonstrating a savings in California of $11.7 million in 15 months compared to the potential hospital loss of an estimated $16 million. The actual cost of the program during these 15 months was $4.2 million. The average length of stay at the RCC was 11 days. Services included medical and psychiatric care, physical therapy, nursing services, assistance in seeking Medicare, Medicaid, or other insurance coverage solutions such as sliding scale and charity clinics, connecting veterans with services, housing referrals, food resources, community resources, job training and applications (National Health Care for the Homeless Council, 2021).

Hog-Graham et al. (2020) discuss the importance of coordination of care between hospitals and community-based organizations (CBOs). Discharge planning by case managers requires an understanding of the referral requirements and the organization's limitations. Developing a stronger relationship between hospitals and CBOs will optimize the success in meeting the social determinant deficits of the discharging patient as well as prevent unnecessary utilization of limited resources. It is important that CBOs and clinical case managers build and maintain a close relationship through collaborative

efforts to create screening and referral processes that will best utilize resources to improve population health and provide needed assistance to meet patient needs (Hog-Graham et al., 2020).

CHAPTER III

Needs Assessment

Discharge planning for the homeless population is very challenging. Patients with the social determinant of health deficits (SDOH) are at a greater risk for poor health outcomes. Without the needed resources such as required durable medical equipment (DME), healthy food, medication, housing, and transportation to follow-up appointments, it should be expected that this population of patients will return repeatedly to the emergency room for treatment. It should also be expected that the disease processes will progressively grow worse creating more discharge challenges, longer, lengths of stay, and resulting in increased financial losses for the medical facility. The Case Management Resource Algorithm is intended to provide a pathway guiding case management in utilizing community, state, and federal resources to prepare a discharge plan for homeless patients. The algorithm will assist in preparing a discharge plan for homeless patients by connecting the patient to shelter and housing resources, access to transportation to primary care follow-up visits, discharge medications, and assuring appropriate DME is provided to promote healing and safety.

Target Population

The target population for this project was case managers performing discharge planning for homeless patients being discharged from a rural acute hospital in Western North Carolina. The responsibility of the case manager in the acute setting is to assess patients as they are being admitted to the facility to identify needs the patient may have that would hinder an appropriate discharge and recovery. The goal of a successful discharge is to prevent unnecessary readmissions related to deficits defined in the social

determinants of health assessment. To further clarify, the homeless is defined as a patient that does not have an adequate discharge destination as a nighttime residence (U.S. Department of Health and Human Services, 2021). The United States Interagency Council on Homelessness (2022) reported 9,280 homeless cases in the state of North Carolina in 2020. According to the United States Census Bureau Report (2020), the home county of this project had an estimated population of 80,463. Thirteen percent were reportedly living in poverty, 14% of persons under the age of 65 were disabled, 15.3% did not have health insurance, and 4,793 citizens in this county were Veterans.

Setting

The setting for this project was an estimated 80-bed community hospital in a rural area in the North Carolina foothills serving 4-5 surrounding counties in the region. The emergency department providers and inpatient case managers often encounter patients who are currently homeless, patients that become homeless during admission, or patients that have been abandoned by family or their previous facilities and are now faced with homelessness at discharge. Local resources include the Department of Social Services, the County Housing Authority, several nonprofit food banks, clothing banks, two shelters, a nonprofit substance abuse ministry, a nonprofit medical clinic, and a local soup kitchen.

Sponsors and Stakeholders

Sponsors would include the facility Director of Case Management, Facility Social Worker, Chief Nursing Officer, Director of Nursing, Director of Case Management, Department of Health and Human Services, Department of Social Services, and Hospice-Palliative Care Services. Internal stakeholders include acute care case managers and

discharge planners, hospital administration and providers, clinic directors, and unit managers. External stakeholders include CBOs involved in homeless ministries, homeless shelters, the Department of Social Services, the housing authority, nonprofit health clinics, local assisted living facilities, local skilled nursing facilities, local respite care homes, local group homes, Veterans Services (VA), and persons currently experiencing homelessness.

Desired Outcomes

The desired overall goal of this Master of Science in Nursing project was to create a Case Management Resource Algorithm for acute care facility case managers and discharge planners providing pathways for referrals to utilize appropriate CBO resources (Hog-Graham et al., 2021). The project leader will contact CBOs to obtain referral information. The project leader will interview current case managers at the participating medical facility to identify the discharge barriers they have experienced during discharge planning for patients that identified as homeless. The project leader will organize information according to available resources. The algorithm will focus on the patient deficits identified during an assessment interview utilizing the Social Determinants of Health Assessment (U.S. Department of Health and Human Services, 2021). The SDOH assessment will guide the case manager to the appropriate path on the algorithm to meet those needs. The Case Management Resource Algorithm will address the social determinants of health regarding housing, food, finances, and transportation. The algorithm will direct the nurse case manager or discharge planner to the appropriate resources available for the patient. The case manager/discharge planner will submit referrals and provide patients with a discharge plan that offers solutions and resources to

promote healing and decreases the probability of repeat emergency room visits and admissions related to inadequate patient resources (Forchuk 2020). The success of this project is expected to translate into a measurable decrease in repeat admissions and emergency room visits, as well as facilitate a decrease in the patient length of stay. The following steps describe the process for creating the Case Management Resources Algorithm:

1. Week 1: Arrange an interview with the case manager director at the participating medical facility to discuss the project plan and timeframe.
2. Week 2: Contact CBOs.
    - Call and discuss the services provided.
        - What is the referral process?
        - What are the requirements to receive services?
        - Are there any restrictions that would disqualify a person?
    - Obtain contact information:
        - for admissions during business hours
        - after-hours contact if available
3. Week 3: Organize CBO information according to service provided related to SDOH needs with a projected goal of completion by week 2.
    - Housing/Shelter
        - Emergency housing
        - Walk-in shelter
            1. Men
            2. Women

- Family Shelter
- Homeless Ministry Housing
- Substance abuse ministries
- Prison recovery ministries

- Food
  - Food bank locations and contact information
  - Local soup kitchen information
- Transportation Resources:
  - Medicaid transportation program
  - Medicare transportation
  - Public transportation
- Financial
  - Social services
    1. Medicaid
    2. Emergency assistance
    3. Guardianship
    4. Department of Health and Human Services Food and Nutrition Services Program
  - VA services
    1. Service connection status of Veteran
    2. Available services
  - Social Security
    1. Medicare status or eligibility

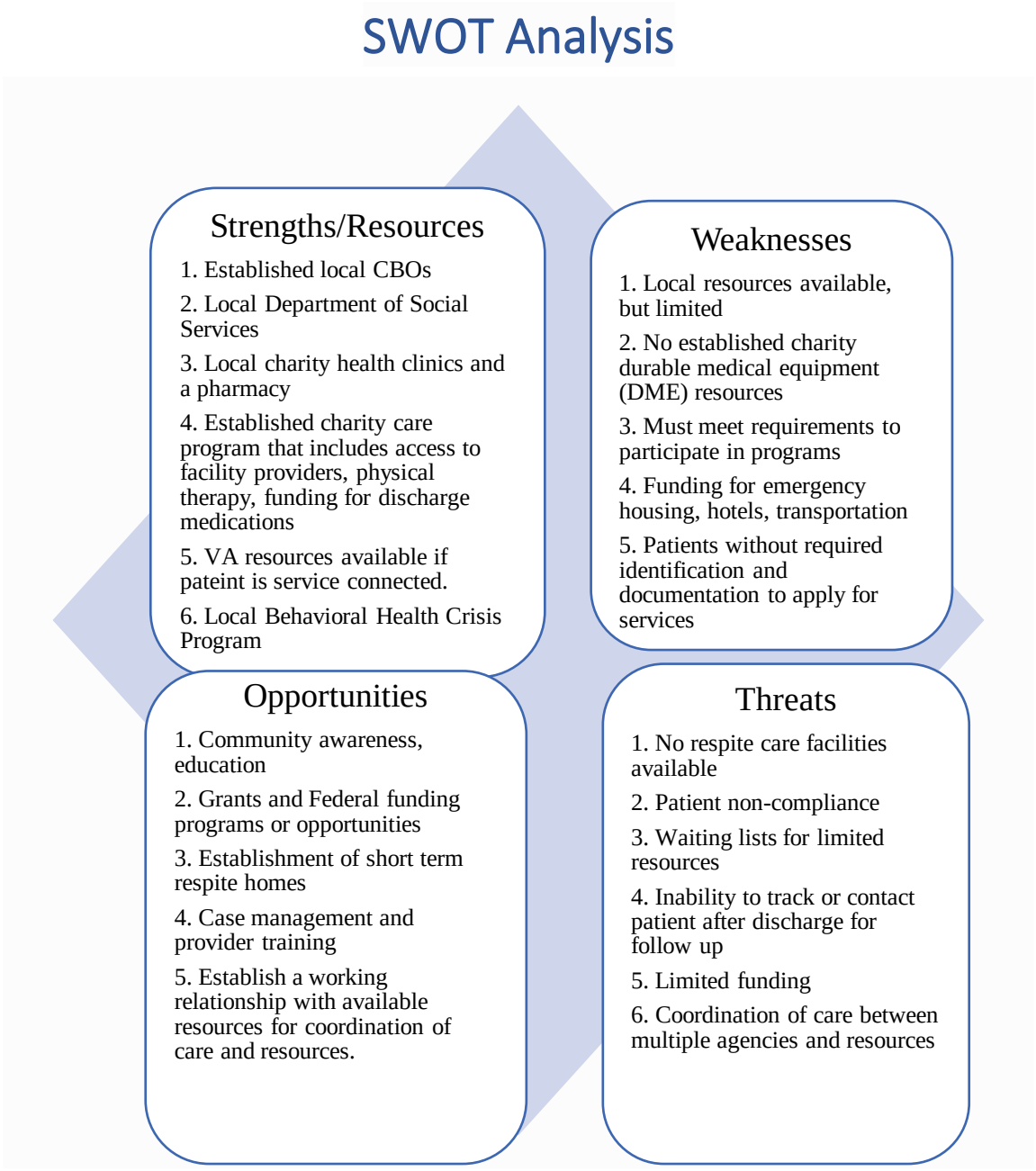
        2. Disability application information
    - Medication assistance program
        1. Foundation assistance for discharge medications
        2. Local income-based health clinic and pharmacy

4. Week 3: Create an algorithm using the SDOH categories and available CBO services.
5. Week 4: Present the Case Management Resource Algorithm to the facility Director of Case Management.
    - Schedule a meeting with the Director of Case Management to present the algorithm and request 1-month trial utilization of the algorithm with the case management department.
    - Create a survey for case managers to complete following the trial utilization for feedback and suggestions.

SWOT Analysis

Figure 2

SWOT Analysis



Strengths and Resources

Strengths

1. Established community-based organizations are available to utilize for meeting some of the discharge needs of the homeless patient. These resources are limited, and the individual must meet certain criteria to be eligible to utilize or participate in these programs. There are resources outside the county as well, but some are limited to county residents only. Walk-in shelters in neighboring counties can be utilized but transportation would need to be provided. Admission to walk-in shelters is first come first serve and there is no guarantee of admission.
2. Shelter-work ministry provides housing, meals, and necessities for the resident. The program provides a work program in which the residents work at a community thrift store. The outreach program is designed to transition the homeless individual back to an independent life. The profits from the thrift store and community donations provide funding for the shelter, as well as a minimal income while the residents are staying at the shelter. Appropriate candidates for this program require them to be independent and therefore is not an option for a patient requiring assistance.
3. Local Department of Social Services and the Department of Health and Human Services screen patients for eligibility for local, state, and federal assistance programs including Food and Nutrition Services, Medicaid, Disability, and access to medical services through the health department's primary care clinic. Patients may be required to provide documentation to confirm identification, citizenship, income, and address of residence.

4. Health clinics and pharmacy services are available. Patients must meet certain criteria to be eligible for these services. Service rates are on an income-based sliding scale. The clinic and pharmacy are funded through a combination of grants, private donations, and community fundraisers, and are primarily staffed by volunteer health care providers and nurses. This program also provides primary care providers, patient education, medications to the patients, and access to specialized care services for required surgical interventions and specialist consultations.
5. The United States Census Bureau Report (2021), 4,793 citizens in this county were recorded as Veterans. Patients who report they are United States Veterans may be eligible for additional assistance. The case manager would contact the United States Veterans Affairs Department (VA) to determine the service connection percentage of the Veterans which determines the services the Veteran/patient qualifies for.
6. Behavioral health crisis programs are available for substance abuse interventions and resources. These services are primarily outpatient counseling services. A 24-hour crisis line is available. A substance abuse counselor receives the referral from the facility. The counselor comes to the facility and performs a needs assessment. Services are provided based on the need. This group assists in referrals to substance abuse recovery facilities. The patient must voluntarily agree to participate in the interview and admission process. Services are dependent on facility availability to accept new patients.

Weaknesses

1. Resources may be limited compared to larger cities. Referrals may require being placed on a waiting list for services. Resources may need to be considered outside the county.
2. Patients may require durable medical equipment at discharge such as oxygen, walkers, canes, nebulizers, etc. It would be beneficial to seek DME donations of walkers, canes, etc. The local DME company does offer a discounted cash price for oxygen, but the patient must have an address and the ability to use an oxygen concentrator that requires electricity to run.
3. Some of the established programs may have specific requirements for participation such as being unemployed, uninsured, a resident of the county, and void of financial resources to obtain the services on their own.
4. Occasionally, funding for emergency housing, hotels, and transportation has been provided for patients under extenuating circumstances. It is rare and approved case-by-case by administration. It would be beneficial to establish intervention programs providing respite services for homeless patients medically ready for discharge but require a higher level of care than a walk-in shelter can provide.
5. Patients that have misplaced or cannot gain access to identification documentation may not be eligible to apply for services. It would be beneficial for case managers to have the ability to assist in obtaining proper documentation such as copies of birth certificates, state-issued identification cards, and social security cards.

Opportunities

1. Community awareness and education are key to gaining needed support, resources, donations, and funding. Goals to seek additional funding, resources, and support would require reaching out to local businesses, churches, and community-based organizations to raise public awareness of the need and to collaborate efforts to meet the financial demand.
2. Seeking out available grants and federal funding programs could potentially provide additional funding and resources. An experienced grant researcher-writer should be considered to perform research and prepare proposals that clearly identify the need and draft an official request for assistance.
3. The project location lacks an established short-term respite home. Establishing a short-term respite home for homeless patients appropriate to discharge from the acute setting, but not well enough to return to a shelter would assist in continuing recovery in a supervised, temporary setting. The expected time frame would be 1-4 weeks with services available to continue the healing process including a physical therapist, registered nurse, and a health care assistant. Examples of appropriate patients include those patients without an appropriate discharge destination, insured, or requiring additional, minimal assistance or supervision beyond acute care discharge, such as a hip replacement patient needing continued physical therapy and minimal supervision.

4. Case management and provider training would be required to assure appropriate resources are utilized, especially for the emergency room setting when case managers are not available after hours.
5. It would be important to establish a working relationship with available resources for coordination of care and resources. For example, a quarterly meeting with leaders of community-based organizations and case managers would be beneficial to review the utilization of resources, discuss the need to program revisions, collaborate on any problems that need to be addressed, and set goals for improvement.
6. Coordination of care between multiple agencies and resources will assure the resources are appropriately utilized. It is important that a strong working relationship is established between the facility and the community resources for the purpose of coordinating goods and services in an efficient manner. It is important that each participant understand the availability, referral guidelines, and limitations of available resources and programs.

Threats

1. This project location does not currently have a respite care facility available. Without a respite care facility, uninsured, homeless patients with needs that cannot be sustained in a walk-in shelter and do not have a discharge address to go to will have to remain in the hospital until the discharge is considered safe and appropriate. This drastically increases the length of stay and increases facility cost/losses.

2. Patient non-compliance is considered a threat because the goal is to plan a discharge that meets the patient's needs to facilitate a successful discharge. Patient non-compliance leads to repeated admissions and an exacerbation of symptoms and accelerated progression of disabilities and disease processes.
3. This project setting is a small rural city with limited resources. Though resources are available, there may be waiting lists that may prevent the utilization of these resources in a timely manner.
4. Homeless patients often do not have a method of communication, such as a cell phone. The inability to track or contact patients after discharge for follow-up appointments leads to repeat visits to the emergency department. Follow-up appointments are required for obtaining necessary medication refills, required lab work, and medical examinations to monitor medication responses and the healing process.
5. Limited funding translates into limited resources. Resources can be donated while others must be purchased. Without financial assistance, resources are very limited.

Team Members

Team members for this project include the Project Leader, Director of Case Management, Director of Nursing, Facility Nurse Educator, Facility Social Worker, and the Emergency Room Director.

Cost-Benefit Analysis

The cost of developing a Case Management Resources Algorithm for acute care facility case managers and discharge planners is minimal because this project involves

organizing available resources. Cost considerations would include temporary office space to use a computer, phone with faxing capability, internet access, office materials such as paper, folders, printer, ink, and basic office supplies for creating, publishing, and distributing the algorithm.

The expense incurred by medical facilities due to repeated admissions, multiple emergency room visits, and extended lengths of stay for the homeless population are astronomical. Schappert et al. (2020) conducted a study of emergency room rates for the homeless in the United States during 2015-2018 and reported 203 emergency room visits per 100 homeless patients. Sun et al. (2017) reported that 40% of United States emergency room visits are uninsured, homeless individuals. The average cost of an emergency room visit is $800-$1,100. Taking this into consideration, the cost for the statistics described would equal $223,300.00 per 100 homeless patients.

CHAPTER IV

Project Design

Goals

The project design for creating a Case Management Resource Algorithm will include gathering available resources, contact information, referral requirements, and guidelines. Once information is gathered, resources will be organized to create a Case Management Resource Algorithm based on the Social Determinants of Health (SDOH) needs assessment for financial, housing, transportation, and food deficits. As previously stated, the success of this project is expected to translate into a measurable decrease in repeat admissions and emergency room visits, as well as facilitate a decrease in the patient length of stay.

Objectives

I. Weeks 1-2:

Gather available resources and organize them according to SDOH categories for easy access to important information such as contact names, phone numbers, fax numbers, emails if needed, referral instructions, preferred route of referral submission, program restrictions, and information regarding obtaining referral forms or various program applications.

II. Week 3:

Create an algorithm pathway from admission to discharge based on case management initial assessment results. For example, the patient reports

they have an established residence (discharge address) vs homeless, insured vs uninsured, Employed vs unemployed, and so on.

III. Week 3:

From the SDOH categories, continue to create a path based on needs and resources available to meet those needs until an acceptable discharge plan has been achieved.

IV. Weeks 4-8:

Utilization of the completed Case Management Resource Algorithm is expected to provide the case manager with all available resources to complete a discharge plan that meets the patients' needs for a safe and acceptable discharge.

Plan and Material Development

The case management initial patient assessment includes the following questions: Where do you live? In the last 12 months have you had to stay in a homeless shelter, sleep in your car or stay at a friend or family member's home because you did not have housing? Does your home have power and running water? Do you have food in the house? Are you able to meet your basic needs? Do you have transportation to your appointments? Do you walk independently, or do you require using a walker, cane, wheelchair, etc.? What additional durable medical equipment do you have? Are you a dialysis patient?

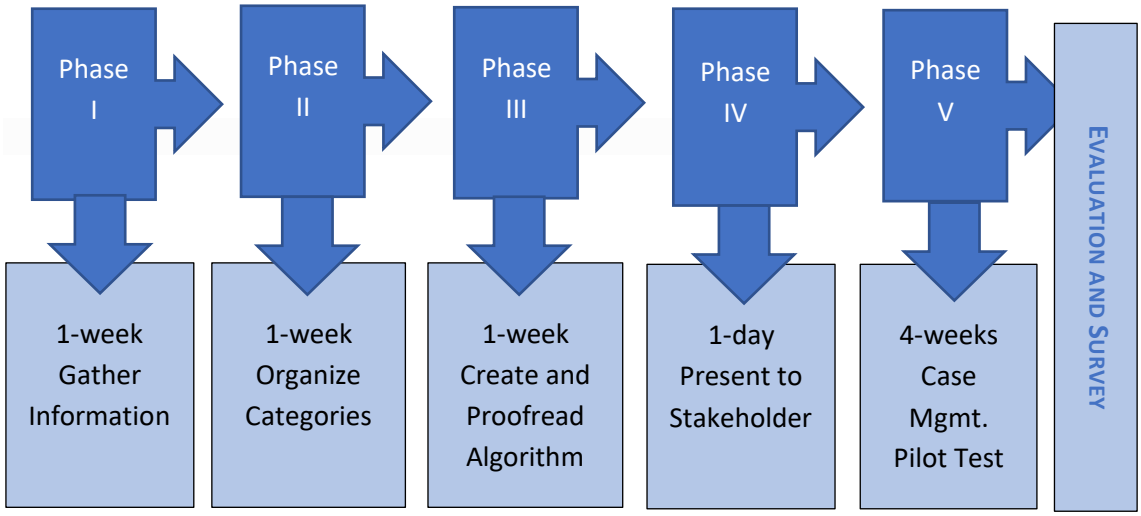
Based on these answers, the case manager will follow the Case Management Resources Algorithm to appropriately develop a discharge plan to meet the need deficits of the patient by providing the patient with access to available community resources. Plan

and material development will involve organizing available community resources to allow case managers to follow a care path along the algorithm.

Timeline

Figure 3

Timeline



Phase I: (1 week)

Community resources will be gathered and should include the following information: name of resource or organization, services provided, contact name and phone number, fax number, contact person's email address, hours of operation, referral procedure information, and any restrictions.

Phase II: (1 week)

Once information is gathered, confirmed, and organized according to the resource category. The information will then be added to the appropriate Case Management Resources Algorithm draft.

Phase III: (1 week)

Completed Case Management Resources Algorithm (Appendix A) will be reviewed, and any corrections completed.

Phase IV: (1 day)

The Case Management Resources Algorithm draft will be presented to and reviewed by the case management director and case manager department for approval or revision suggestions.

Phase V: (4 weeks)

The Case Management Resources Algorithm will be provided to the case management department to be utilized as a trial run for 1 month. Case managers will be given an anonymous survey to rate the usefulness of the Case Management Resources Algorithm. Case managers will have the opportunity to offer suggestions for improvement and to rate the usefulness of the project.

Budget

Table 1

Budget

Project Estimated Costs	
Office Space ($100 day* x 12 days) *(*Donation to a local church for temporary use of available office space)*	$1,200.00 (includes the use of facility Wi-Fi, phone, fax, copier)
Office Supplies	$500.00
Laptops (2)	$1,500.00
Payroll $15.00/hr. x 8/hr. x12 days *(2 temporary contract employees)*	$2,800.00
Project Leader Salary	$1,400.00
TOTAL	$7,400.00

Evaluation Plan

Outcomes will be measured by comparing the following statistics:

- Total hours a homeless patient is in the emergency room as compared to patients with no SDOH deficits.
- Total inpatient length of stays for homeless patients as compared to patients with no SDOH deficits that share similar a diagnosis. For example: compare the length of stays for hip fracture repairs or chronic obstructive pulmonary disease exacerbation.

A survey will be provided to the participating case managers to provide an opportunity for feedback and for suggestions to make improvements to the algorithm design or content.

Summary

The purpose of this project was to provide acute care case managers with a tool that will make resources readily available for planning a safe and efficient discharge for a homeless patient. Repeated use of the emergency department and inpatient admissions related to the homeless population places a financial strain on the facility and community. Failing to provide an adequate discharge plan offers little benefit to the patient because the basic needs are not available to promote adequate healing and recovery. The desired outcomes would include the utilization of a resource algorithm that provides:

- Efficient assessment of patient needs based on SDOH.
- Identifies appropriate community resources that meet the homeless patient's SDOH deficits.

- Provides a safe discharge for the homeless patient that promotes healing and recovery.
- Reduces repeated visits to the emergency room, reduces inpatient admissions, and shortens overall inpatient lengths of stay.

CHAPTER V

Dissemination

Dissemination Activity

The project leader will arrange a meeting with the facility's Director of Case Management. The purpose of the meeting was to present the project proposal and material for recommendations. The project presentation includes copies of the Case Management Resources Algorithm (Appendix A) and a PowerPoint presentation (Appendix B) that provides the project proposal, purpose, research, goals, objectives, project timeframe, expected project outcomes, project estimated budget, and explanation of the project evaluation plan. This project will also be presented via poster at the Gardner-Webb University Hunt School of Nursing Scholar's Day.

Limitations

The project limitations identified or anticipated are a lack of respite care facilities in the project area, local homeless shelters being small, and admissions to the shelters being limited with a waiting list. There are admission protocols disqualifying individuals from receiving or participating in some community resources if there is a history of drug or recent alcohol abuse. Another common barrier often seen with homeless individuals is trust issues which inhibit the patient's willingness to participate and can result in refusing needed assistance.

Implications for Nursing

Returning to the conceptual framework of this project, Dorothea Orem's Self Care Deficit Nursing Theory (Orem et al., 2001), when a patient does not have the means to provide the necessities to care for themselves and promote healing and recovery, then the

patient needs someone to provide those resources (George, 2011). Holistic nursing according to Orem promotes health by providing the basic needs of food, water, air, and an environment free of hazards.

The utilization of the Case Management Resource Algorithm is intended to provide acute care nurse case managers with local community resources to assist homeless patients in obtaining the means to reduce, improve, or eliminate resource deficits. The desired result of providing these resources is to promote healing and recovery, empower the patient to prevent the progression of the disease processes, and reduce the number of repeat visits to the emergency room and inpatient admissions.

Recommendations

The project manager presented the project to the facility's Director of Case Management. The Director of Case Management recommended adding the statistics from the California respite house model and to add pictures of the facility and patient rooms. The Director found the scenario included in the PowerPoint to be impactful and gave the audience a greater understanding of the struggles of a homeless patient without resources. The Director requested permission to obtain a copy of the Case Management Resource Algorithm to use in the Case Management Department, especially to use during the orientation and training of case managers and to establish a standard of work for the department. A copy of the algorithm and presentation PowerPoint will be provided to the Director as requested.

Conclusion

Identifying SDOH deficits during the initial case management assessment and providing resources to meet those needs will likely reduce the number of repeat

emergency room visits, reduce inpatient admissions, decrease the length of stay for the facility, and slow the progression of disease processes. Based on the California model for respite housing, it would be beneficial for this community to consider the establishment of a small respite house. This house could provide post-discharge care and maximize the recovery of the homeless patient needing continued assistance and resources such as physical therapy for a short time.

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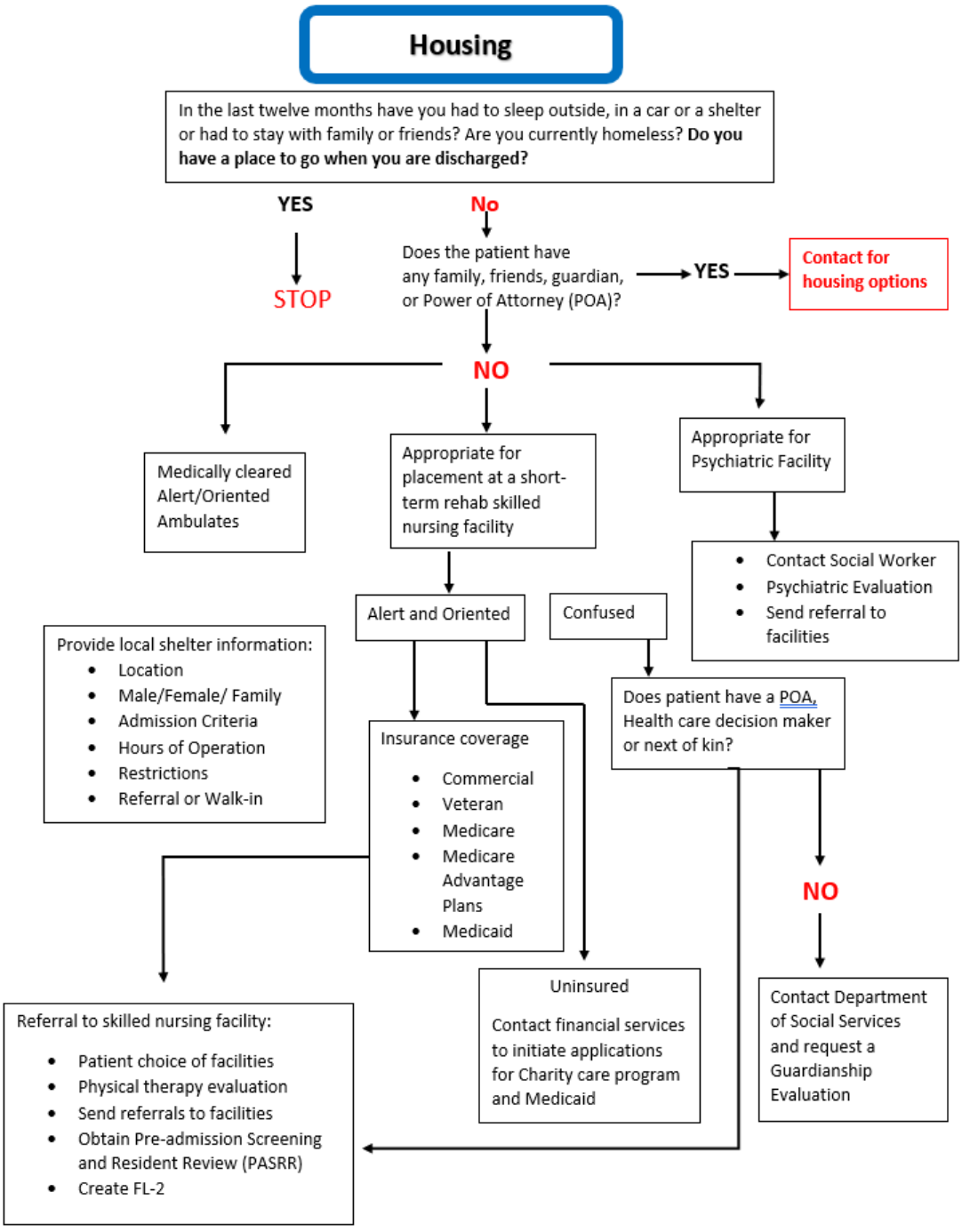
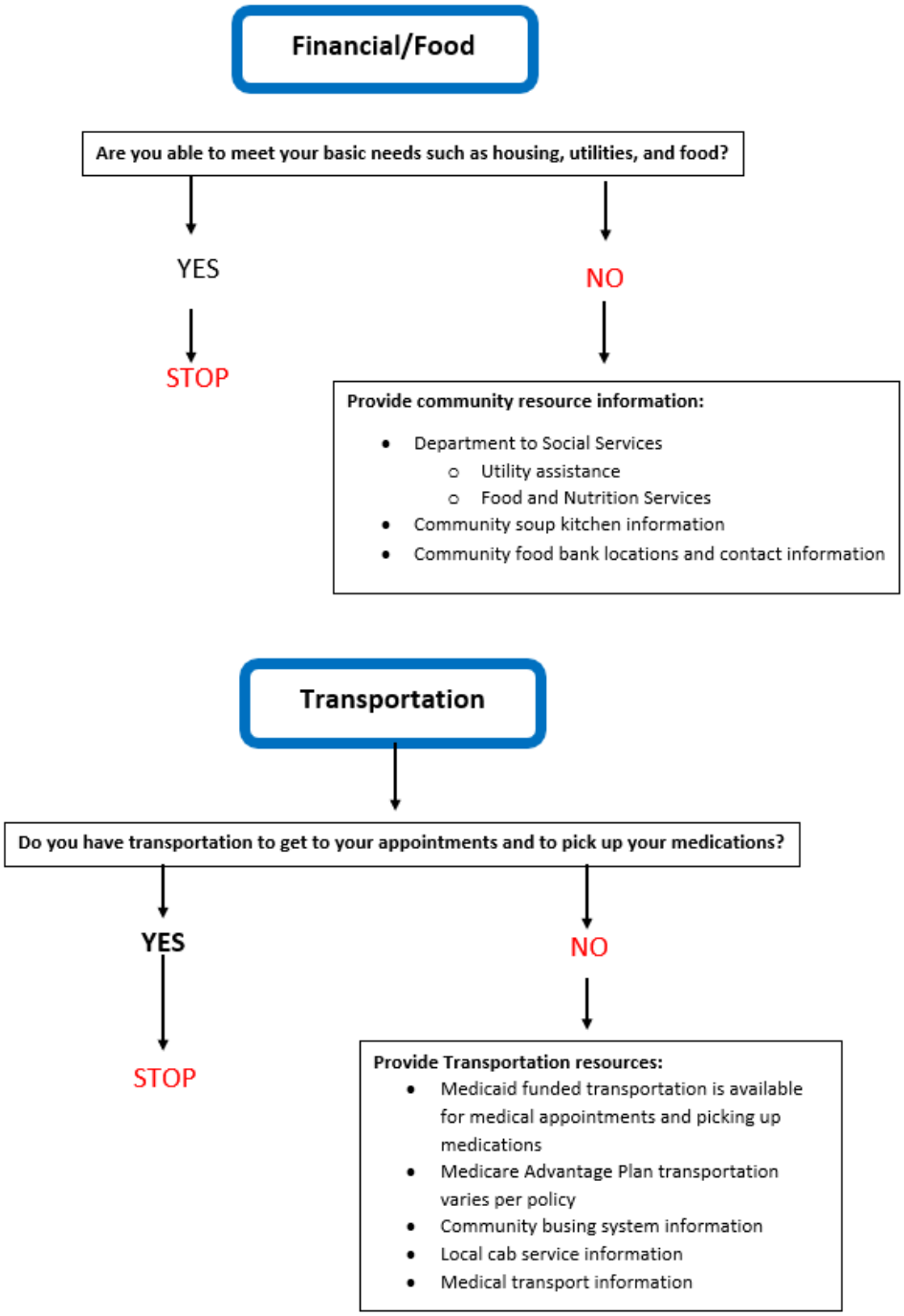
Appendix A

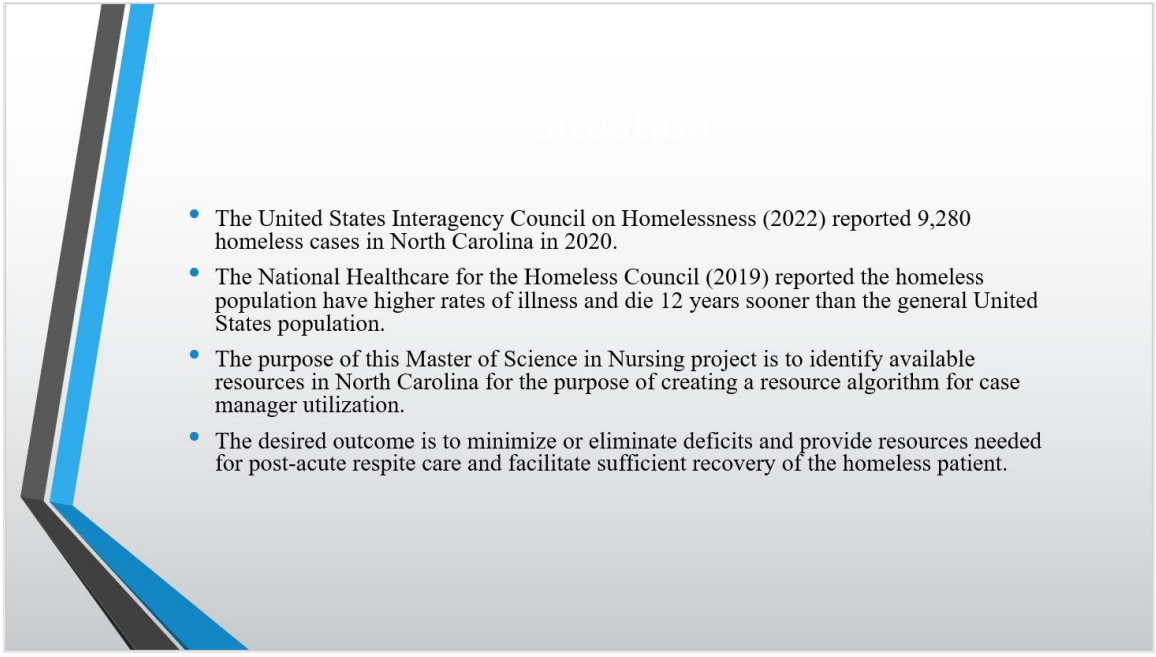
Case Management Resource Algorithm




Financial/Food
Are you able to meet your basic needs such as housing, utilities, and food?
YES
STOP
NO
Provide community resource information:
Department to Social Services
Utility assistance
Food and Nutrition Services
Community soup kitchen information
Community food bank locations and contact information
Transportation
Do you have transportation to get to your appointments and to pick up your medications?
YES
STOP
NO
Provide Transportation resources:
Medicaid funded transportation is available for medical appointments and picking up medications
Medicare Advantage Plan transportation varies per policy
Community busing system information
Local cab service information
Medical transport information

Appendix B

Case Management Resource Algorithm PowerPoint Presentation



The homeless patient

Imagine coming to the emergency room. You are homeless, tired, hungry, and now you are sick. You had a miserable night . You walk to the nearest hospital emergency room.

You are triaged, go thru patient registration, and then wait for your name to be called.

You hope you can get some relief. It is a very long wait, but it is comforting just to have a chair to sit in and to have the luxury of air conditioning as you sit in the waiting room.

You are called to the treatment area. The provider makes his diagnosis, you are given a prescription, you are discharged.

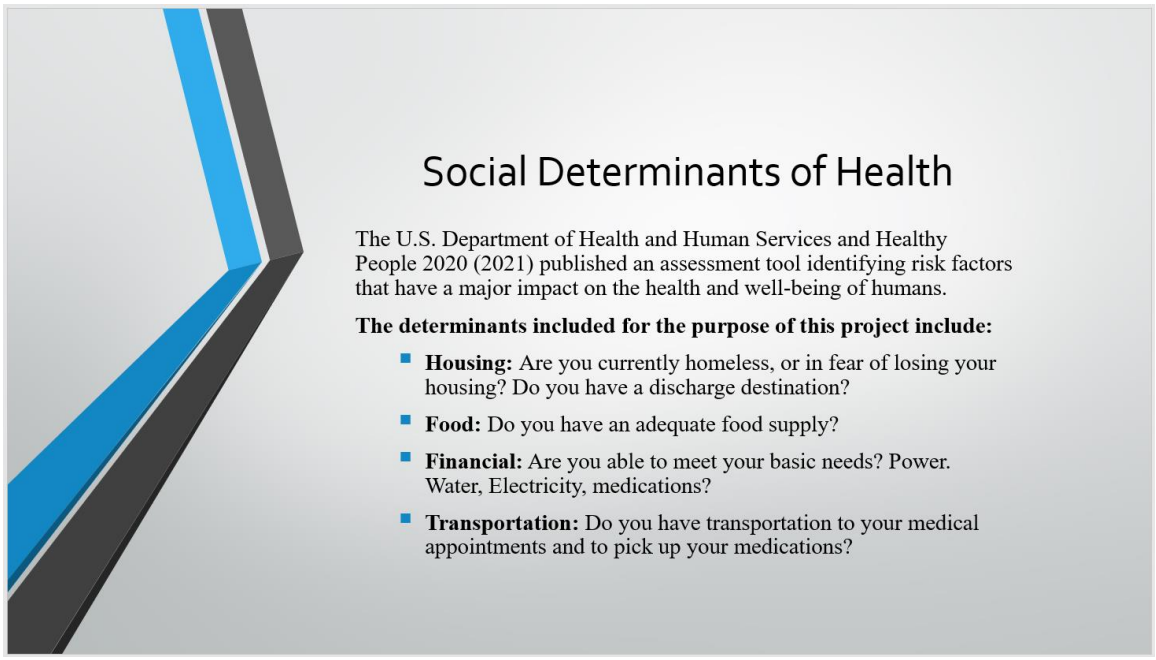
You walk out the door with discharge instructions and a prescription in hand. You have no insurance, you have no money, you have no where to go. You are still sick.

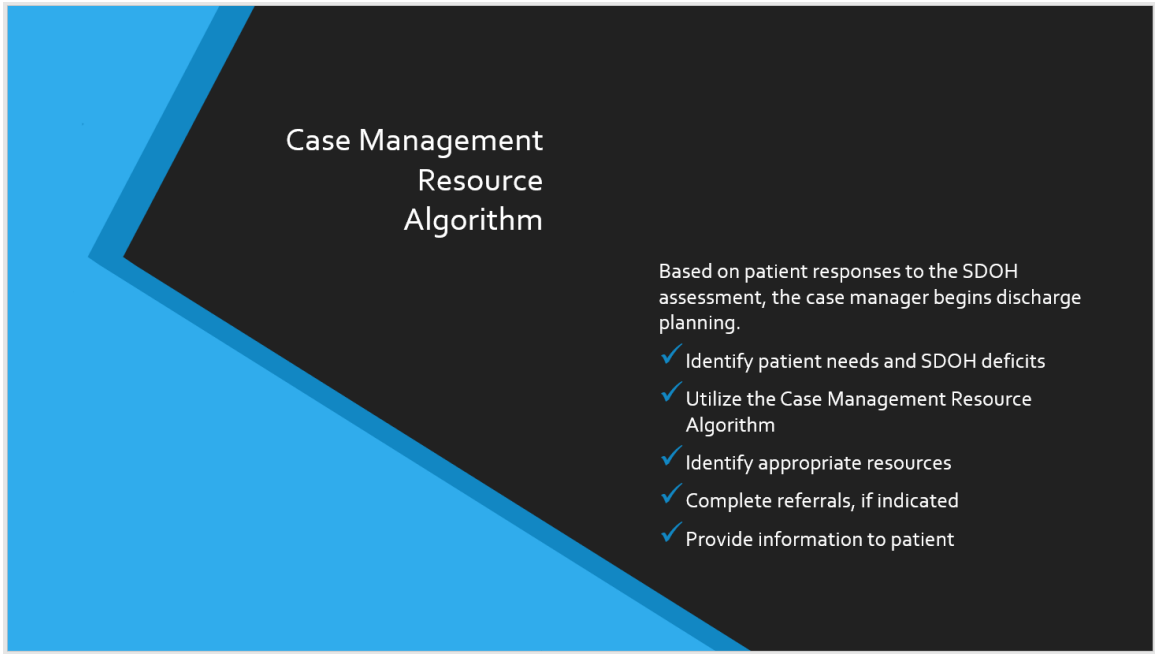
The only benefit you carried away from this Emergency room visit was that you were able to sit in a chair in the air conditioning for a couple of hours.

Patient returns to emergency room in 48 hours and now requires admission.

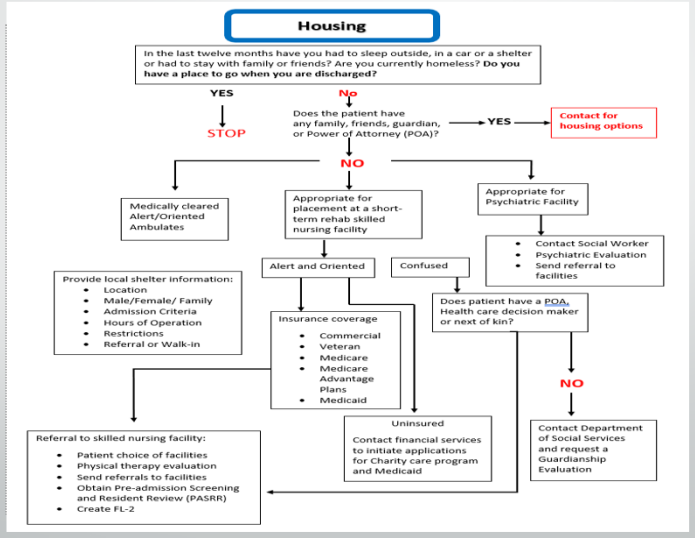
Was this admission avoidable?

Though we can never guarantee a discharge to be successful, there are measures that can help facilitate a discharge plan that provides basic needs associated with healing and recovery.

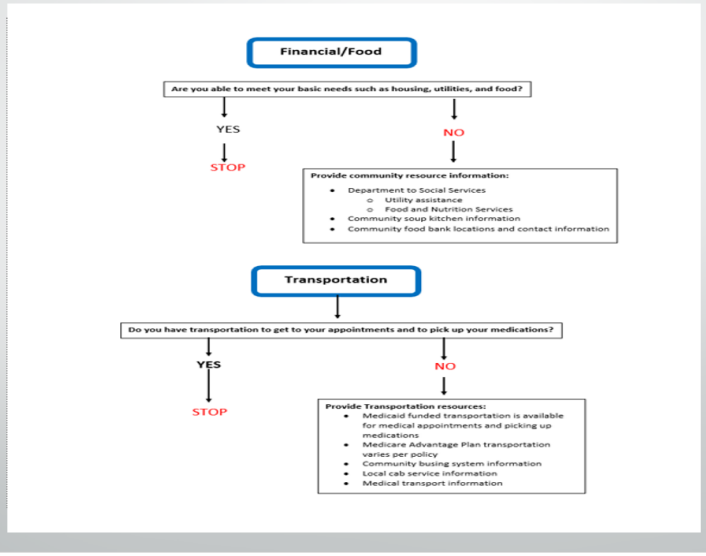

Social Determinants of Health
The U.S. Department of Health and Human Services and Healthy People 2020 (2021) published an assessment tool identifying risk factors that have a major impact on the health and well-being of humans.
The determinants included for the purpose of this project include:
Housing: Are you currently homeless, or in fear of losing your housing? Do you have a discharge destination?
Food: Do you have an adequate food supply?
Financial: Are you able to meet your basic needs? Power. Water, Electricity, medications?
Transportation: Do you have transportation to your medical appointments and to pick up your medications?

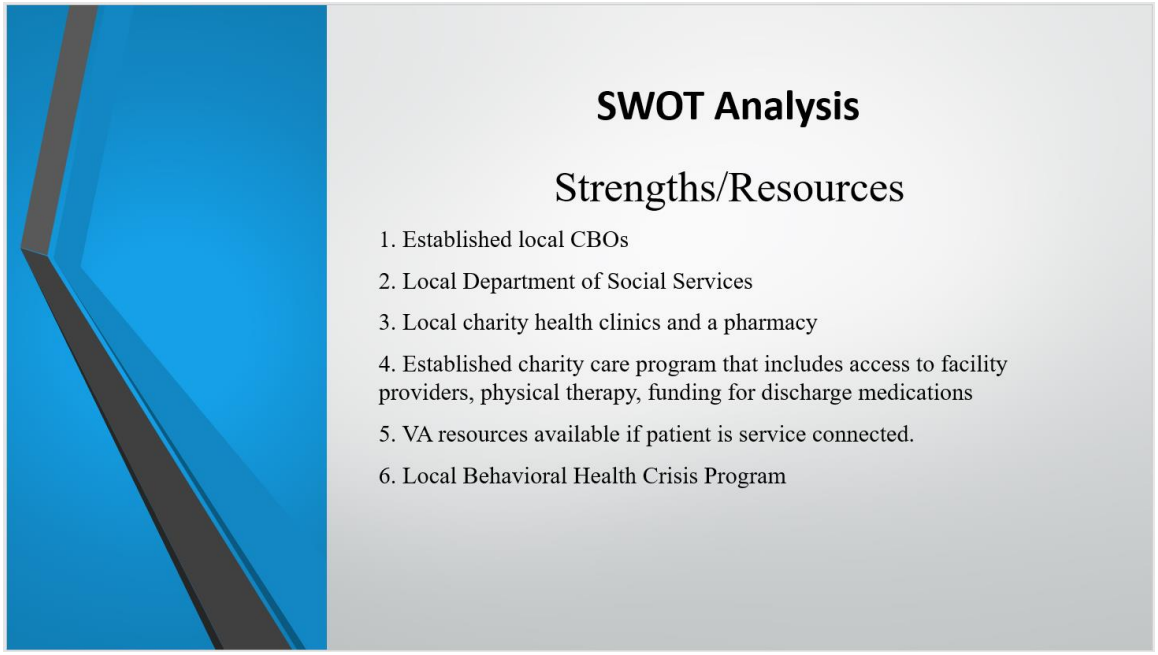

Case Management Resource Algorithm
Based on patient responses to the SDOH assessment, the case manager begins discharge planning.
Identify patient needs and SDOH deficits
Utilize the Case Management Resource Algorithm
Identify appropriate resources
Complete referrals, if indicated
Provide information to patient

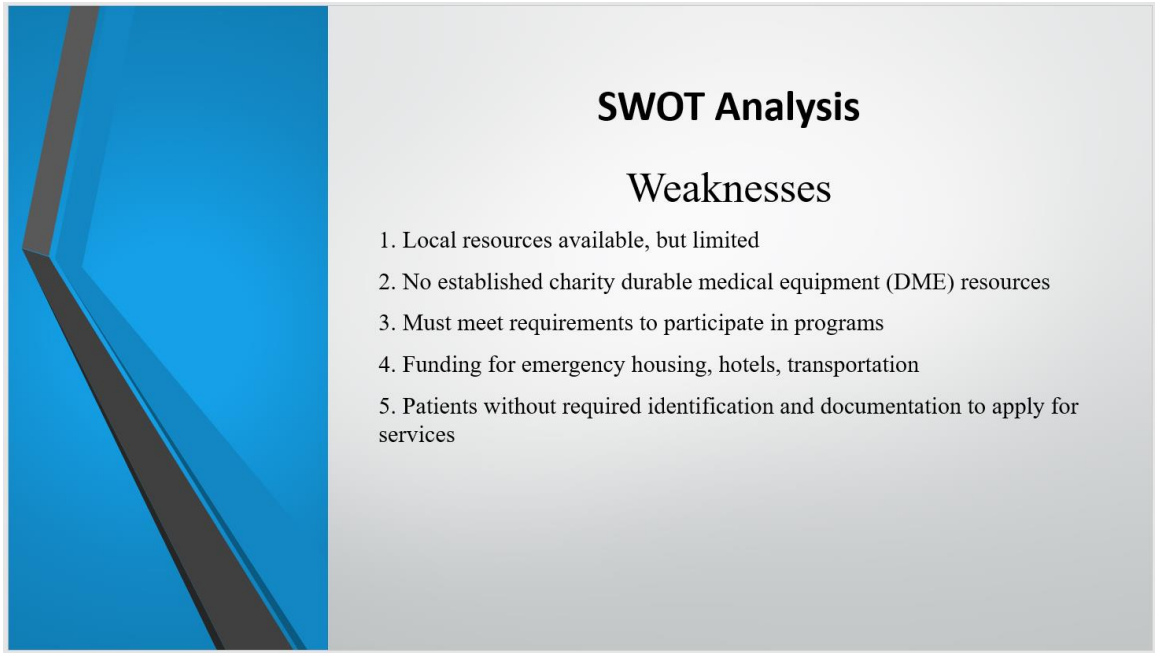
Case Management Resource Algorithm

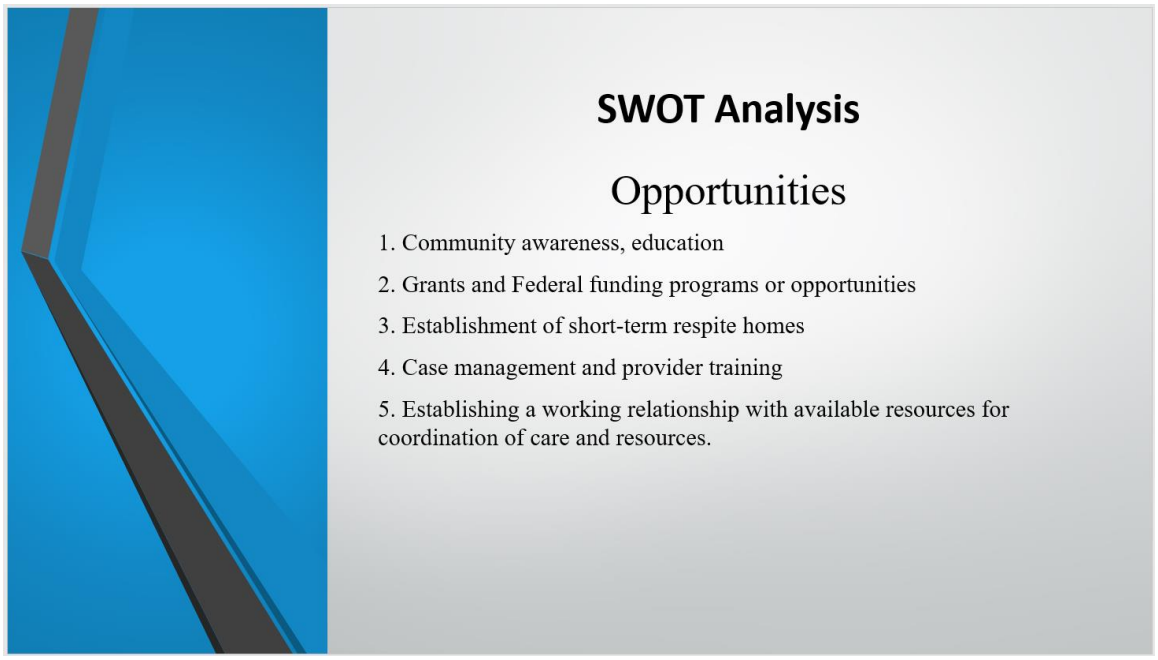


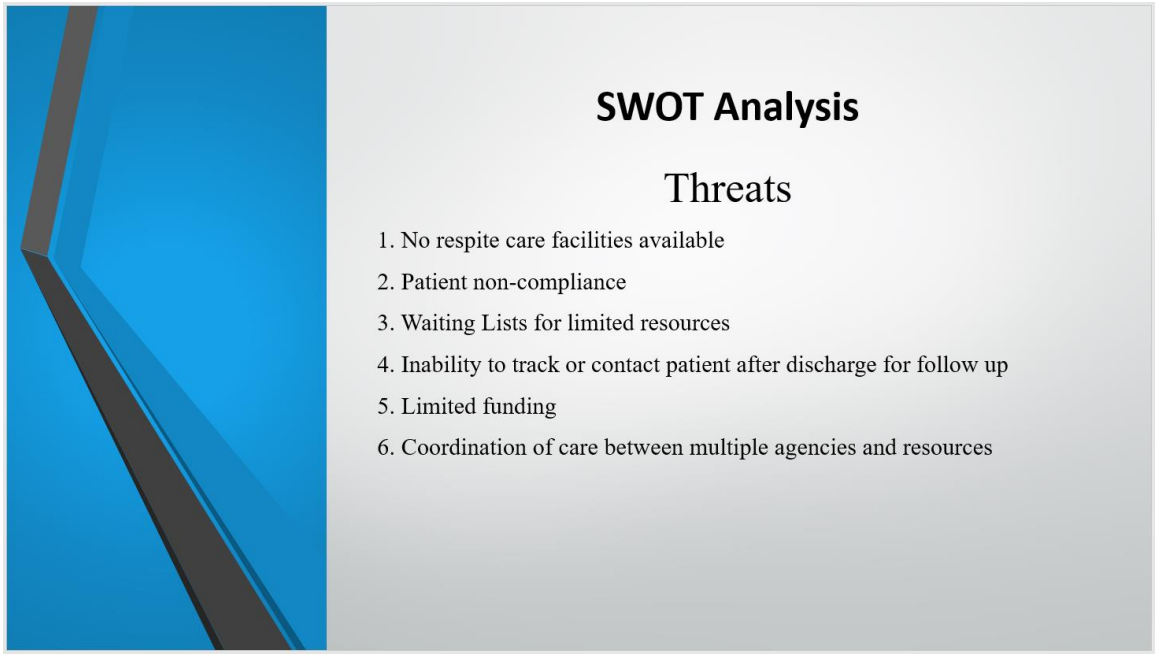
Case Management Resource Algorithm




SWOT Analysis
Strengths/Resources
1. Established local CBOs
2. Local Department of Social Services
3. Local charity health clinics and a pharmacy
4. Established charity care program that includes access to facility providers, physical therapy, funding for discharge medications
5. VA resources available if patient is service connected.
6. Local Behavioral Health Crisis Program


SWOT Analysis
Weaknesses
1. Local resources available, but limited
2. No established charity durable medical equipment (DME) resources
3. Must meet requirements to participate in programs
4. Funding for emergency housing, hotels, transportation
5. Patients without required identification and documentation to apply for services


SWOT Analysis
Opportunities
1. Community awareness, education
2. Grants and Federal funding programs or opportunities
3. Establishment of short-term respite homes
4. Case management and provider training
5. Establishing a working relationship with available resources for coordination of care and resources.


SWOT Analysis
Threats
1. No respite care facilities available
2. Patient non-compliance
3. Waiting Lists for limited resources
4. Inability to track or contact patient after discharge for follow up
5. Limited funding
6. Coordination of care between multiple agencies and resources

Benefits

The expense incurred by medical facilities due to repeated admission, multiple emergency room visits, and extended length of stays for the homeless population is astronomical.

Schappert, et al. (2020) conducted a study of emergency room rates for the homeless in the United States during 2015-2018 and reported 203 emergency room visits per 100 homeless patients.

Sun, et al. (2017) reported 40% of United States emergency room visits are uninsured, homeless individuals.

The average cost of an emergency room visit is $800-$1100.

Example: 203 visits x $1100.00= 223300.00 per 100 homeless patients

Budget

Case Manager Discharge Planning
for Safe Discharge of Homeless Patients
MSN Project Budget: Summer 2022
Gardner-Webb University Master of Science in Nursing
Melody Jenkins, Project Leader

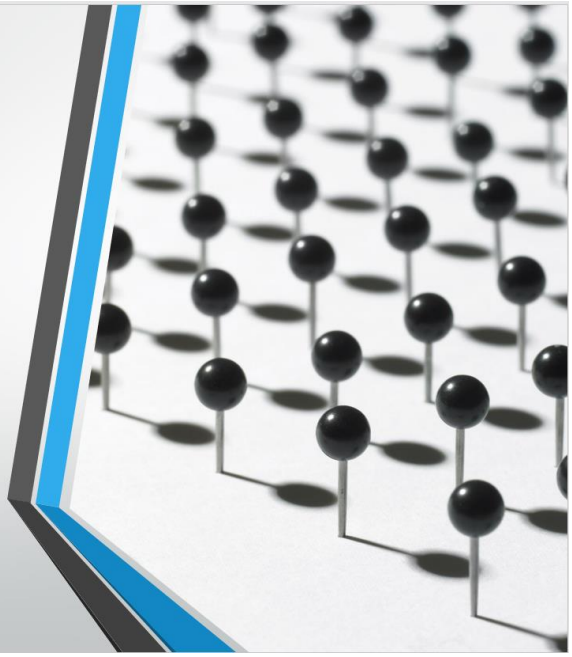
Project Estimated Costs

Office Space ($100 day x 12 days)	$1200.00 (includes use of facility Wi-Fi, phone, fax, copier)
Office Supplies	$500.00
Laptops (2)	$1500.00
Payroll $15.00/hr. x 8/hr. x12 days (2 temporary contract employees)	$2800.00
Project Leader Salary	$1400.00
TOTAL	**$7400.00**

Desired Outcomes

The Case Management Resource Algorithm

- Efficient assessment of patient needs based on SDOH
- Identifies appropriate community resources that meet the homeless patient's SDOH deficits
- Provides a safe discharge for the homeless patient that promotes healing and recovery
- Reduces repeated visits to the emergency room, reduces inpatient admissions, and shortens over all inpatient lengths of stay



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