HealthInfoNet

PCHC
Penobscot Community Health Care

Use Case Report

Connecting Homeless individuals with Health Care and Community services to prevent Readmissions

In 2018, Penobscot Community Health Care (PCHC), a Federally Qualified Health Center and The Hope House Health and Living Center in Bangor began a unique collaboration between health care and homelessness services utilizing HealthInfoNet's Analytics and Reporting Platform (HARP). This tool identifies patients at high-risk for readmissions and connecting them to appropriate community and health services to prevent readmissions.

Workflow

1. PCHC Care Manager accesses HARP weekly – as part of PCHC High Utilizer Group (HUG) - to identify all PCHC patients:
    - ❖ Discharged from the Emergency Department (ED)
    - ❖ Discharged from any hospital in Maine
    - ❖ Currently in the hospital

"This partnership between PCHC and Hope House is innovative and unique in our field. You don't see this type of collaboration often between the healthcare providers and the homelessness services. We are using predictive analytics to inform comprehensive care for our most vulnerable population, and its making a real difference."

– **Joshua B. D'Alessio, Manager of Homeless Initiatives**

2. This list is presented at the weekly 'Services Connect' meeting at Hope House. This meeting consists of a group of over a dozen, including a health coach, peer navigators, peer support service providers, social workers, housing navigators, and peer recovery coaches. The team reviews the list, identifies patients who have been guests at Hope House to answer the following:
    - ❖ Is this patient assigned to an Outreach Worker at Hope House?
    - ❖ Does this patient have a Community Plan in place?
    - ❖ What services does this patient need - Case Management, assistance with Medicaid applications, food stamps, etc.
    - ❖ If this patient is currently in the hospital, should the Outreach Worker visit them in real-time to access and plan for their discharge?

This multidisciplinary group also uses the list to dispatch staff into the community to find the patients and connect them with the most appropriate community and health resources to prevent future readmissions.

"With this collaborative process, we are able to gain a more holistic picture of our patients, understanding all of their needs – from their health complications to their housing status. This allows us the opportunity to provide the most appropriate care and also connect patients to support services that may help to assist them with becoming more stable."

– Cher Randall, Care Management Health Coach, PCHC

Documentation

Hope House staff document the patient's risk score in their Homeless Access Data Information Management (HADIM) system. This system also tracks the number of outreach workers assigned to a participant, the number of treatment services post discharge, frequency of case management and other aftercare utilization to determine the correlation between the services and the readmission risk score.

PCHC's Care management team tracks their high-risk patients over time in their EHR to monitor change in risk of readmission and document interventions.

"Use of the analytics report also helps us intervene with clients when they need us. We normally see our clients once a month, now we know if they have been hospitalized and can go see them right in the hospital and ensure they have the right social services when they are discharged."

– Abby Smith, Hope House Housing Navigator

Impact

Since February 2018, Hope House staff intervened with over 80 patients from the HIN Analytics connecting them to community and health resources to prevent readmissions.

Pictured L-R: Cher Randall, Joshua D'Alessio and Abby Smith