Transitional Care Program

An Innovative Post-Discharge Respite Program

Solano Coalition for Better Health

Thank you for Attending

- Who is the Solano Coalition for Better Health
- What is the TCP Program and why was it developed?
- Goals of the program
- Program components
- Admission criteria
- Life in a TCP House
- Client responsibilities
- How referrals are made
- Results
- Client success stories

Solano Coalition for Better Health

Who We Are

From Partnership comes Progress

- Founded in 1988 to improve the health and quality of life of Solano communities by providing leadership, focusing resources and developing partnerships.
- Partners include:
  - + Kaiser Permanente
  - + NorthBay Healthcare
  - + Sutter Health
  - + Solano County Health and Human Services
  - + United Way
  - + Solano Office of Education
  - + Touro University
  - + Solano Community College
  - + Community Clinics

What we Do

Increasing Access. Improving Health

- Solano Kids Insurance Program (SKIP)
- **Transitional Care Program**
- Oral Health Program
- Faith-Based Committee
- Covered California and other programs
- Solano Health Improvement Council
- Health Access Committee

About Solano County

- One of the most challenged communities in the Bay Area.
- Highest rate of unemployment in Bay Area
- 15% live below FPL
- Estimated homeless population of 1,200 (425,000 total population)

Why TCP?

- High rate of hospital readmissions among homeless population
- Long inpatient lengths of stay
- Few shelters and other resources for homeless
- Most are permanent residents of our community
- Hospitals were willing to invest in a solution

Goals

- Reduce readmission by providing:
  - Appropriate recovery setting
  - Intervention for psycho-social issues that lead to homelessness
  - Assistance in securing permanent source of income, health care services and housing
  - Follow-up services
- Provide clients with resources to end their cycle of homelessness

What we Do
Transitional Care Program

- Up to six-weeks of residential respite care for homeless patients, post hospital discharge.
- Homes in Vallejo and Fairfield – five beds each.
- Coordinate post-discharge medical care, mental health services, referrals to drug/alcohol counseling, housing assistance and other services.
- Up to 50 clients served annually, each site.

Program Components

- Up to six-week program
- Counseling services required (at least three sessions)
- Assistance in applying for SSI, public assistance or job search
- Secure permanent housing if income is established
- Assistance in budgeting
- Home nursing visits supported
- Follow-up services (six months)

TCP Admission criteria

- Ready for hospital discharge
- Require respite care for continued recovery
- No other appropriate respite options
- Able to perform activities of daily living
  - Mobile
  - Continent
  - Good cognition
- Willing to follow house rules
- No violent felonies or known violent behaviors

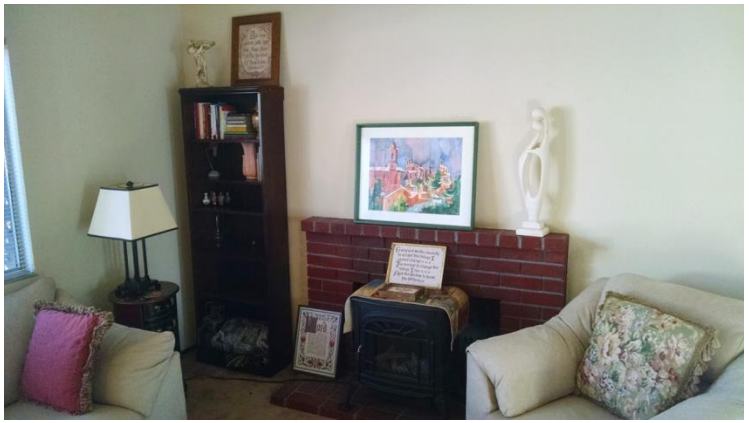
How TCP Referrals are made

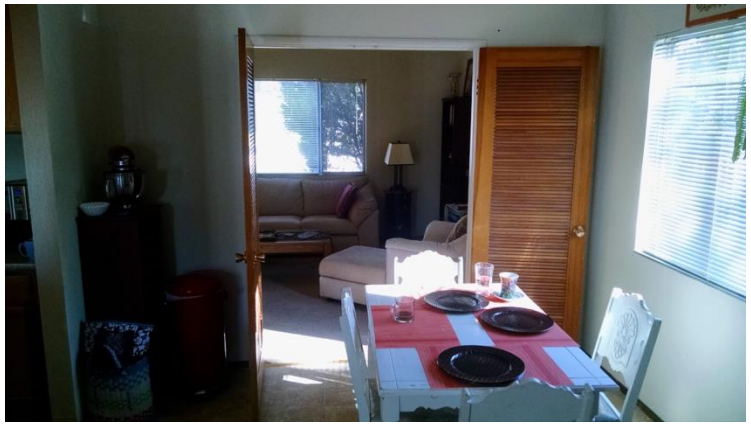
- Call from discharge planner or social services in participating hospital
- TCP team meets with client in hospital
  - Ensure client meets criteria
  - Ensure client is willing to participate in the program
- Conduct general background check on client

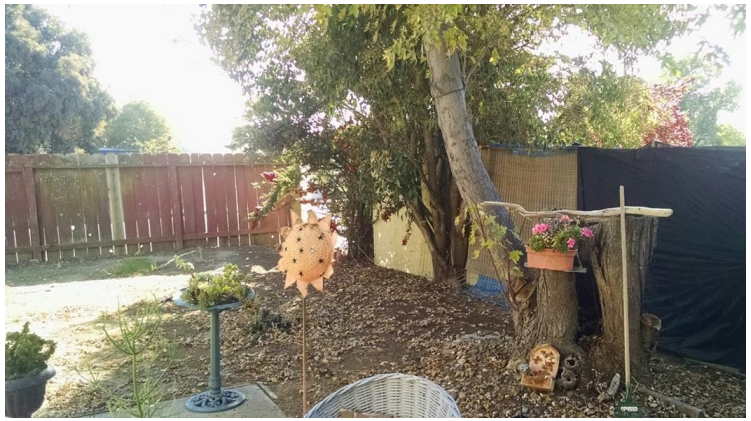
Reconnecting with a Home Environment

- Respite homes are “homes” to help reconnect clients with the security of permanent housing

A Place to Call Home







A Place to Call Home

Life in a TCP House

- Live-in house managers
- Private home setting
- Shared room (same gender)
- Shared meals
- Shared responsibility

Client responsibilities

- Keep personal space clean and common areas clean
- Make own breakfast and lunch
- Assist with dinner preparation
- Follow house rules
  - Curfew
  - No drugs or alcohol
  - Respectful behavior
- Commit to program

Why Placements Can't be Made

- Acceptance Rate is 70%.
- Who are the 30% not appropriate for TCP?
  - Needed higher level of care
  - Client did not want assistance
  - Client could not be reached or left AMA
  - Failed background check
  - Unstable behavioral or mental health issues
- Many are appropriate for the At-Large Program

What we Do
Transitional Care Program

At Large Services – TCP "in the field"

- At Large Services Clients
  - Don't meet admission criteria
  - Won't or can't follow house rules
  - Prefer current living situation
- Regular client contact (six months)
  - Follow up on medical care
  - Link to services

Solano Coalition for Better Health

Management & Governance

- Governance: Transitional Care Collaborative
  - All funders represented
  - Strategy
  - Program development
  - Annual planning and budgeting
- Program Management/Administration: Solano Coalition
  - Fiscal sponsor
  - Contractor management
  - Convene stakeholders
  - Reporting
- House management and service coordination: Community Action Council
  - Day-to-day house management
  - Coordinate client services
- Mental Health: Anka Behavioral Health

Funding

- Annual budget of $250,000
  - Costs shared by County Health & Social Services, and three hospital partners
  - House food provided by Food Bank

- Expenses

  Contractors: 60%

  Coalition staff – 20%

  Program expenses – 20%

Results: By the Numbers

Goal: *The number of emergency department visits by Transitional Care Program (TCP) clients will decrease by 40%, before program entry vs. six months post exit.*

- Actual reduction: 47%
- Services provided by the TCP program resulted in a $2 million savings in community health resources in 2014.

Results – FY 2014-2015

- 78 clients served by the program
  - 58 in house
  - 20 at-large
- 71 of 78 clients completed the program
- 71 of 71 exited program with health insurance and primary care physician
- 58 of 71 exited with permanent source of income
- 42 of 71 exited with permanent housing

Results – One Hospital's ROI

- Total annual investment -- $60,000
  - Number of TCP placements – 29
  - Cost per TCP placement -- $2,070

Pre-TCP hospitalization costs	**$1,700,000**
Post-TCP hospitalization costs	$900,000
TCP investment	$60,000
Estimated savings	$860,000

Roger's Story

- 56-year old male veteran with acute renal failure
- Living out of car
- Secured identification
- Re-established with Veteran's Affairs
- Linked to SSI, Cal Fresh and General Assistance
- Linked to health insurance and PCP
- Linked to permanent house
- Provided household basics and budgeting assistance

Linda's Story

- 60-year-old woman with COPD and pneumonia
- Been living in shelters and motels
- Secured income (SSI)
- Secured health insurance and PCP
- Accepted into section 8 housing
- Provided household basics and budgeting assistance

Louis's story

- 84-year-old man
- Apartment burned down, admitted with smoke inhalation
- Secured additional benefits
- Re-established relationship with family
- Linked with Primary care physician
- Secured housing
- Secured discounted transportation
- Still in healthier living situation one-year post discharge.

The Future

We're still exploring

- Third TCP home
  - Developing criteria
- Expansion of at-large services
- Harm reduction program
- Homeless advocacy

Contact Information

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