REDUCING HIGH ED UTILIZATION BY PATIENTS EXPERIENCING HOMELESSNESS

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Background

Who are ED high utilizers?[1]

- Psychiatric diagnoses
- Substance use
- Patients with chronic conditions
- Persons experiencing homelessness

What has been tried?[2,3]

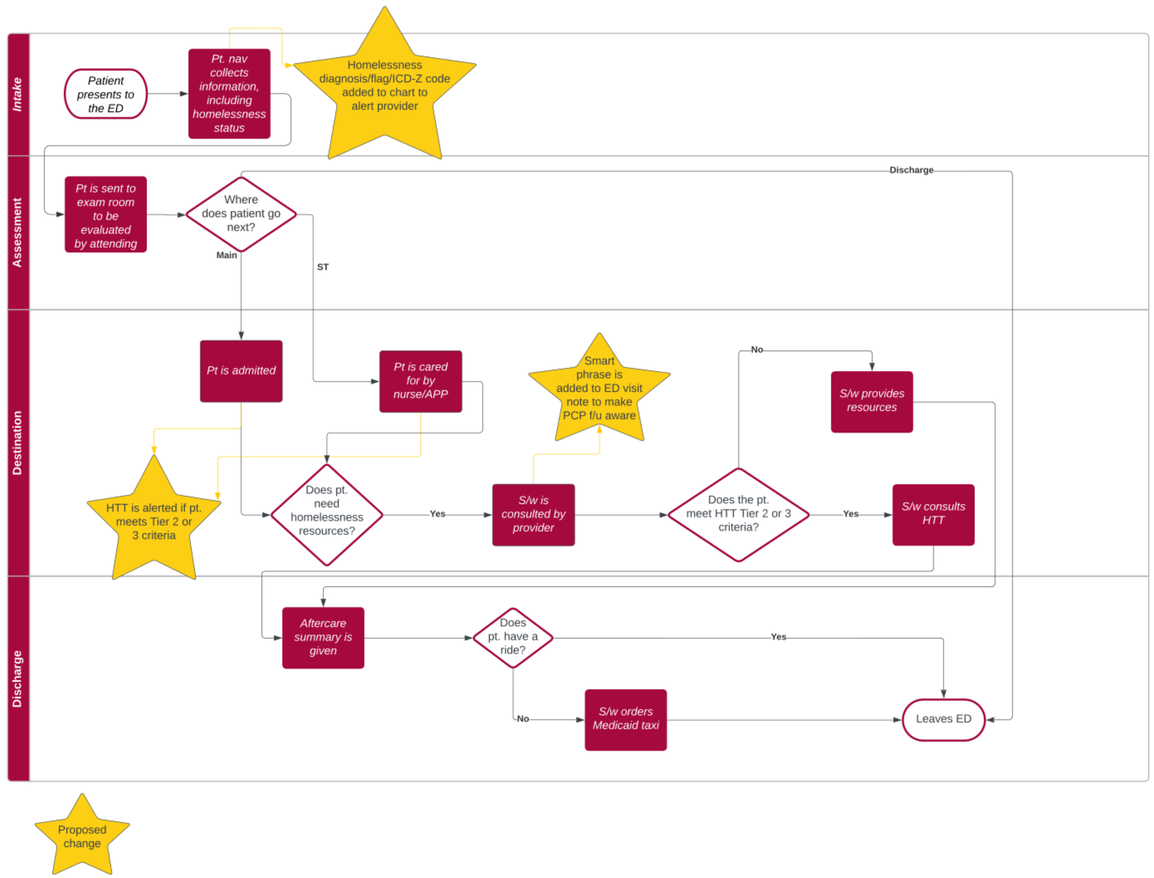
- Case management
- Self-administered computer-based risk assessment
- Patient education
- Financial incentives
- Help lines
- Appointment scheduling at discharge
- Rapid primary care

Methods

- Chart review
- Needs assessment of employees and patients in the ED
- Process map

PEH High Utilizers at UCH

- American Indian/Alaska Native: 1% of CO population, 3% of PEH encounters (3X)
- Black: 4% of CO, 16% of Aurora, 25% of PEH encounters **(>6x)**
- **23%** of PEH return to the ED within 30 days
- Average length of stay by PEH: 13 days (UCH Goal = 5 days)



Findings

- "It's a revolving door; they come back because they have nowhere to go" - *CDU social worker*
- "Unless it's part of the chief complaint, SDOH are not discussed in the ED." - *HTT member*
- I wish I was more knowledgeable about the resources (shelters, food banks, etc.) - *MD resident*

Recommendations

Low Impact, Low Investment

- Clinician education
- Updated resources
- Improved HTT branding

Medium Impact, Medium Investment

- Amend clinical workflow
- Education for trainees
- Additional data tracking

High Impact, High Investment

- Targeted homelessness care
- Funding for additional programs
- Focus on grants and novel interventions

References

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