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Advancing the Care Continuum for the Homeless: A Shelter-based Care Coordination Project Focused on Mental Health

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Advancing the Care Continuum for the Homeless: A Shelter-based Care Coordination Project Focused on Mental Health

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Abstract

The future implications of this project include

Prior to this project, there was no coordination process for shelter guests with SMI following hospitalizations or ED visits. Stakeholders included the shelter’s care coordination manager, shelter employees, and mental health professionals to coordinate care upon discharge. All 20 were monitored throughout implementation for outgoing 911 calls recorded by the facility. Each 911 call by a participant was followed up with by the designated shelter coordinator.

Case examples from discharge follow-ups:

- Guest was at the local hospital for two weeks and was dropped off here on 3/12. Guest had an alcohol addiction and was diagnosed and bipolar. Guest is confined and needs things to be explained to him. He was given an appointment with his representative to explain his medication. Has outpatient appointment at the clinic on 5/18. Guest has been doing well. Will continue to work with guest as he gets acclimated here.
- For guest, she overtooked on narcotic medication. Guest’s been addicted to drugs and alcohol for 21 years. She has asked for help with her addiction (prescription grandi). Guest has not been using anything she can get her hands on. She has been clean a few days and took alcohol, alcohol. Guest has mental health diagnoses, but has not been doing anything for her mental health for a long time. Guest has been the subject of 911 calls for the past 12 months. Guest stated she’s been addicted to drugs since she was 18 years old. The guest radios England. Guest has not been in and out of jail since that time. Guest has not had much help for her mental health also the cause of being homeless. Resources given to guest, including shelter’s residence.

Conclusion

The shelter facility now has a seamless process of following up with all behavioral health/hospital discharges. The designated coordinator that provides the contact explains that these meetings have been crucial for most guests and their future care.

The project started with 20 participants that were identified as shelter guests with SMI and frequent healthcare services. Follow-up after the shelter identification of their high risk guests with serious mental illness.

Objectives

The goals of this project are:

1) To improve communication and information sharing between the local hospital shelter and behavioral health hospital.
2) Increase the shelter’s identification of their high-risk guests.
3) Increase the number of hospitalizations and emergency service users by specified groups.
4) Increase the percentage of community cost savings and reduce mental health outcomes.

The aim of the project is to increase in care coordination contacts by shelter staff high-risk individuals by the end of 3 months.

References

4. Spradley’s (1980) change theory: