Patient & Provider Barriers

Before the ER

- Do I know where the facility is? How do I get there? Is there a language barrier?
- My friends have gone to the ER/hospital and don't come back
- Low medical literacy - should I go?
    - So used to poor physical health that threshold is very high
    - So desperate to get shelter that threshold is very low
- Who will watch my pet/dependent friend/relative?
- What will happen to my possessions?
- I know something is wrong, but I am terrified and would rather not know
- What's the point - they won't/can't listen/help
- Fear of repercussions/being ignored for substance use or being unsheltered
    - Will the ER manage my withdrawal symptoms?

In the ER/hospital

- Do I understand what is being asked of me?
- Am I able to effectively communicate information about my condition?
    - Did my PCP provide paperwork to relay information?
    - If my PCP attempted to do a provider sign out, were they able to connect with an ER provider?
    - Did my misunderstanding or lack of comprehension of the situation lead to the wrong workup?
    - Did the ER providers have the time to walk me through my symptoms for a more accurate understanding?
        - Was the ER overwhelmed with patients?
        - Were there critical situations being appropriately prioritized?
        - Am I a frequent visitor with difficulty communicating, so my symptoms are considered part of normal presentation instead of something new and serious?
        - Is the need to communicate my emotions taking priority over the medical questions the provider is asking me?
- Am I willing/able to comply with the recommended workup?
    - Fight or flight trauma response
    - Chronic complex PTSD/borderline personality disorder
- Do I meet admission criteria but I'm too scared to stay?
- Do I not meet admission criteria but am at severe risk of decompensation if instructions are not followed?
- Did anyone talk with me about my housing status?
    - Was I informed of local shelters?
    - Did a hospital/ER employee contact the shelter to ensure availability?

After the ER/hospital

- Did my unsheltered status alter my discharge plans?
    - Did I need to go to a SNF but could not?
    - Did I need medical equipment but have nowhere to store it or no electricity?
    - Was I discharged in the middle of the night when navigation and connection to resources are far more difficult?
    - Was I kept in the hospital for weeks or months because I could not be placed?
        - Prevents use of very needed hospital beds
        - Contributes to ER overload
- Did I need an adult care facility, rehab center, or respite care but there was no availability?
- Do I understand my discharge instructions?
    - Did I leave AMA and not get any instructions?
    - Do I have the capacity to understand?
        - Altered mentation from dementia, panic, frustration, organic psychosis, substances
        - Low medical literacy level
- Was I able to pick up medications?
    - Did I know how to get to the pharmacy the meds were sent to?
    - Was the pharmacy closed?
    - Could my transportation only get me to one place and I elected to go to my desired location/camp?
    - Were the meds stolen or misplaced rapidly after I got them?
- How did I get back to my desired location?
    - Did I get displaced simply by visiting the ER?
    - Was there availability at and transportation to a warming shelter?
    - Was my camp swept in my absence?
    - Were all of my possessions stolen?
- Did my pre-existing PCP get notification that I was seen?
    - Did I forget their name/location?
    - Was I assigned to a new clinic?
    - Did the chart note get sent and reviewed?
    - Do I have access to a phone to schedule an appointment?
    - Do I have transportation to the appointment?
    - Is my PCP booked out for weeks when I'm supposed to be seen in 1-3 days?
- Did I get in touch with any recommended specialists?
    - Did my PCP get the notes?
    - Am I able to relay any of the information from a specialist appointment to my PCP to prevent repeat testing, medication interactions, etc?
    - Repeat most barriers encountered during ER/hospitalization evaluation and in previous bullet point

Provider Specific Barriers:

- EMRs do not speak to each other
- Lack of communication with/notification from ER/hospitals
    - Our attempts can be spurned or our requests ignored due to high volume
    - We may not find out until the patient is in the office that they had been hospitalized or seen in the ER
- Outreach frequently finds people on the street who need urgent medical care who were recently discharged and we have to begin with no information
- Patient buy-in and compliance diminishes when needs are repeatedly unmet
- No pharmacy notifications as to whether discharge meds are obtained
- Patients frequently challenging historians and cannot relay any medically relevant information that would help direct care
    - Lack of compliance due to this low medical literacy is very frequent
- Very limited appointment and time availability - we are also short staffed
- Decompensation to the point that return to the ER is appropriate
    - Often patients outright refuse this regardless of potential consequences
- Death or severe morbidity due to lack of appropriate follow up

Cases That Went Wrong Despite Best Efforts

Cases That Went Right Despite Barriers

Things That Can Help Us All

- Data - we need more
    - Lack of communicating EMRs is a large barrier
    - Providers could guide data mining, but addressing patient need appropriately takes priority over tracking numbers
- Reducing poor outcomes with better care everywhere
    - Reducing ER load by reducing repeat visits
    - Reducing PCP load by better communication and teamwork resulting in faster interventions and less decompensation in patient health
- Community Health Workers
    - Would need to work for the hospital and be present on every shift
    - Enormous asset to good patient outcomes and improved communication
- Respite care with trained medical professional oversight
    - Arches Inn is a shining example of a community asset that could easily be modified into a true respite center - imagine how much more benefit we could get with a trained nurse and social services on site
- More shelters/adult care facilities/rehab centers with low barriers
- More FQHCs
- No discharges after 7 pm
    - There are currently medical systems that have this in place with good effect

    - A true respite center to temporarily house these patients until they can be handed off to services the following day would be a good way to keep the ER from becoming overwhelmed
- Better primary care reimbursement for increased patient complexity
    - More primary care offices would be willing to see these patients for longer periods of time to more comprehensively address needs
        - More primary care intervention capacity means fewer inappropriate ER visits and less health decompensation leading to appropriate ER visits
        - Financial and time "burden" furthers systemic discrimination against unsheltered patients in the entire healthcare system
- **COMMUNICATION AND TEAMWORK**

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