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Mobile Nurse Practitioner

A Pilot Program to Address Service Gaps Experienced by Homeless Individuals

Joan Alviar Fraino, DNP(c), RN-BC, CNL

ABSTRACT

An estimated 2.3 to 3.5 million individuals are homeless in the United States, many of whom have chronic medical and mental illnesses. Underserved individuals who are homeless experience gaps in services, resulting in poor health care outcomes and readmission to the hospital setting, often presenting in crisis through the emergency department. The financial state of hospitals is negatively impacted by the burden of patients returning to the hospital due to unresolved issues. The current article presents the role of a psychiatric–mental health nurse practitioner as part of a pilot program, Opportunity Village Mobile Health, that provides a comprehensive approach to meet the physical and mental health challenges of homeless individuals who are discharged from inpatient to outpatient services. Continuity of health care services are made available to this unique patient population to reduce hospital readmission rates and provide much needed transitional care.
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In the United States, the number of homeless individuals is estimated to range between 2.3 to 3.5 million, with many of these individuals experiencing chronic medical and mental illnesses (Buck, Brown, Mortensen, Riggs, & Franzini, 2012). American health care continues to be one of the most expensive commodities in the United States, accounting for 17.9% of its gross domestic product in 2011 (Ferrier, Leleu, Moises, & Valdmanis, 2013).

Patients returning to the hospital setting due to unresolved issues upon discharge negatively affect the financial state of hospitals. Doran et al. (2013)

found that individuals who are homeless approximately tripled the 30-day hospital readmission rates compared to individuals who are not homeless. In 2011, the costs for all hospital stays averaged approximately $10,000 per stay (Pfuntner, Wier, & Steiner, 2013). Factors associated with frequent readmissions include untreated or ongoing health conditions, poor compliance with discharge recommendations, misunderstanding of follow-up care, and lack of services available to individuals upon discharge. Outreach programs implemented as preventive strategies in the community can help reduce frequency of hospital visits for individuals who are homeless.

The current article presents Opportunity Village Mobile Health (OVMH), a pilot program that aims to provide comprehensive care to homeless individuals who are transitioning from the inpatient to the outpatient setting in an effort to reduce rehospitalization.

HISTORY AND NEED FOR EVIDENCE-BASED INTERVENTIONS

A retrospective chart review by Doran et al. (2013) showed a 50.8% readmission rate in one urban hospital from May through August 2012 among individuals who are homeless. Homeless individuals are identified as a vulnerable group of individuals using extensive health care services, contributing to a significant burden to the health care system. Patients with unstable housing situations and limited resources have an increased likelihood of rehospitalization. The disparities of services available to these individuals contribute to feelings of helplessness, hopelessness, and dehumanization. They are often stigmatized and viewed as unproductive members of society, relying on the system for care. High-risk users of the health care system, those who give rise to what is known as the *revolving door phenomenon*, frequently present in emergency departments due to lack of support systems in their communities (Buck et al., 2012).

In addition to limited housing resources, homeless individuals are often living with chronic physical and mental health conditions and poor family support systems. They have a higher rate of dual diagnosis, living with coexisting mental illness and substance abuse, which further complicates their treatment needs (Buck et al., 2012). Poor discharge planning, lack of coordinated inpatient and outpatient services, and mental illness are all risk factors that increase the probability of hospital readmission. The lack of infrastructure and limited available programs increases homeless individuals' lengths of stay, contributes to higher mortality rates, and imposes higher costs to health care organizations compared to the general population (Buck et al., 2012).

Transitional care models that offer an integrative care process that includes a range of services can be incorporated as part of the patient's plan with an emphasis on timely and safe transitions from one setting to another (Noseworthy, Sevigny, Laizner, Houle, & La Riccia, 2014). Individuals who are homeless find it challenging to navigate their way through the fragmented health care system, contributing to susceptibility to relapse and lack of trust in care providers. It is essential to explore the reasons why this vulnerable population is not being managed effectively on an outpatient basis.

REVIEW OF THE EVIDENCE

A review of the literature supports programs that extend beyond the hospital setting to the community setting where these individuals can access continuity of care while transitioning to a more stable living situation with services in place. The literature identifies several programs that help support individuals transitioning from institutional settings, such as hospitals, to outpatient settings. According to O'Connell et al. (2010), the framework of the Boston Health Care for the Homeless Program (BHCHP) serves as an innovative model for today's health care delivery. This program approaches health care from a social justice perspective and ensures quality health care is available to the underserved, especially individuals who are homeless. The guiding principles of the BHCHP program focus on the necessity of bridging the gap of services between hospitals and health care centers within the community of shelters and homeless service providers (O'Connell et al., 2010). The importance of these partnerships is emphasized as part of a community effort where mobilized programs fill the gaps in services while exploring long-term solutions for continuity of care for this disenfranchised group.

Respite programs and home health models have drawn attention away from focusing on infrastructures and directed energy to the community settings where integrated primary and behavioral care can be provided to individuals who are homeless (Buck et al., 2012). Home health models focus on bringing services to individuals in their community settings. Doran et al. (2013) found that patients discharged to a motel or rehabilitative placement had lower 30-day readmission rates compared to those discharged to the streets. Ensuring patients have a place to go upon discharge gives them an opportunity to connect with services that help stabilize them in the community.

Formulating a plan that not only takes into account patients' medical conditions but also their socioeconomic, social, and psychological factors is imperative to their successful integration into the community (Rooney & Arbaje, 2012-2013). This

comprehensive approach to health care delivery considers the entire spectrum of health care needs. Jordow (2014) explored the patient-centered medical model as a foundation to increase access to health care. This model explores innovative and cost-effective strategies that enable health care teams to provide care to the underserved, focusing on delivering care to individuals in the community rather than focusing on limited infrastructures.

Another novel approach that has been explored is the implementation of *critical time intervention* (CTI). The benefits of CTI versus usual care were well-recognized in reducing rehospitalization among individuals who were homeless in a randomized control trial after discharge from an inpatient psychiatric hospital (Herman et al., 2011). This trial focused on strengthening individuals' long-term ties to the community, promoting self-sufficiency, and establishing invaluable support networks in the community (Herman et al., 2011). The study aimed at prevention of recurrent homelessness and relapse through supportive treatment programs delivered in a time-sensitive manner. Although the study by Herman et al. (2011) supports the benefits in paving the way to connect patients with community services, there is also emphasis placed on CTI workers helping patients navigate through community programs. Chen (2013) explained the importance of the role of CTI workers in connecting individuals to community programs using existing services aimed at preventing rehospitalization. Emphasis is placed on the significance of these time-limited strategies being implemented shortly after discharge. During this window of opportunity, CTI workers can assist patients in staying motivated for treatment because opportunities for services are brought forward during the transitional period from inpatient hospitalization to outpatient care.

A recent evidence-based project showed promise using innovative approaches in managing patients with mental health conditions in the community setting while these patients waited for clinic appointments with their health care providers (Schaumberg, Narayan, & Wright, 2013). This psychiatric bridging program involved a psychiatric advanced practice nurse (APN) who provided short-term psychoeducational counseling and prescription medication support to patients with depression as a cost-effective measure while patients waited to be seen for initial psychiatric evaluations (Schaumberg et al., 2013). This approach supports interventions by health care providers reaching out to community settings where the underserved are often overlooked. Implementing strategies that generate creativity and new initiatives supporting homeless individuals in their transitions from hospitalization to community-based programs reduces the chances of these patients going into crisis that make hospitalization inevitable.

PILOT PROGRAM

Background and Premise

Vulnerable patients, such as homeless individuals, who are discharged from the hospital setting will likely experience gaps in services. A collaborative effort increases success of patients moving through the health care system effectively.

Understanding Maslow's hierarchy of needs provides a foundation of meeting the particular needs of this population. Maslow's pyramid is a five-stage model that includes (a) biological and physiological, (b) safety, (c) love and belongingness, (d) esteem, and (e) self-actualization needs (McLeod, 2007). The needs at each stage are meant to build upon one another to meet the highest level of needs (i.e., self-actualization). The most basic physiological needs, such as food and shelter, must be addressed before one can move up the pyramid to have other needs met.

When individuals who are homeless are unable to have their most basic needs met, they are prevented from moving to the next level of need, such as safety and belongingness (McLeod, 2007). Improvements in transitional care from inpatient to outpatient settings are vital components to successful outcomes for this population. The development of outreach services and community mental health services has demonstrated effectiveness in meeting the specialized needs of this population, thus reducing hospital readmission rates (Hwang, Weaver, Aubry, & Hoch, 2011). Programs that assist in meeting the most basic needs can help individuals who are homeless attain higher needs on the pyramid, paving the way to patients experiencing a sense of belonging in their communities.

Organizations and providers must take initiatives to improve patient outcomes by identifying and reinforcing their place within their communities and assisting patients in navigating the health care system. Along with the multifaceted approach to meeting the unique needs of homeless individuals, a specialized program that assists these individuals in exploring and connecting with housing options for long-term shelter security should also be included. Community-based case management homeless services will help ensure individuals who are homeless have appropriate referrals for housing, incorporating a patient-centered approach emphasizing values and preferences. The implementation of such an integrative program is designed to address the gaps that exist between hospitalization and community with a focus on strengthening partnerships.

Authorization for the current project was granted through the University of San Francisco. The University of San Francisco health care team led by Dr. Jo Loomis focuses its efforts on identifying and implementing transitional care and services for individuals who are homeless.

Opportunity Village Mobile Health

OVMH is a pilot program providing mobile health services to individuals who are homeless in Marin County, California, as they transition from the hospital to the community. This nurse-

led team includes nurse practitioner faculty, student family nurse practitioners, student psychiatric–mental health nurse practitioners (PMHNPs), and student clinical nurse leaders. OVMH partners with Marin county agencies, such as Opportunity Village (OV), Project Independence, county clinics, county hospitals, and Sutter Health, to address gaps in services among individuals who are homeless.

OV is a program for qualified individuals to receive the following free services as they transition from the hospital setting to the community: free room and board for an average of 21 days; three meals per day; lifeline emergency response system during their stay; links to medical, social, and housing services; and volunteer transportation services. Project Independence provides care transitions for individuals going from the hospital to home. They help patients follow hospital discharge recommendations as well as provide volunteer transportation services. Sutter Health focuses on provisions of home health nursing services as part of their community partnership with the current project. In partnership with these Marin county agencies, OVMH assists patients in exploring and navigating through resources and bridging the gap of services as they transition back to the community setting.

The OVMH team receives referrals from OV and works closely with this agency to provide comprehensive care to individuals who are homeless. High-risk patients with a potential for relapse are identified through a trigger system on admission to the hospital setting. The hospital case manager refers eligible patients admitted to the hospital for evaluation and enrollment to OVMH. Eligible participants must be: (a) at least 18 years old, (b) lack a system of care at hospital discharge, (c) independently mobile, and (d) able to manage activities of daily living and medications with minimal support from county agency programs. Individuals with acute medical conditions are eligible provided they have an identifiable endpoint for transitional care. OV screens these patients and assesses whether they meet eligibility criteria to participate. Once a patient is approved and accepted, OV contacts the OVMH team for mobile health services for the patient upon discharge. Ideally, the OVMH team meets with patients while they are still hospitalized. If the team is unable to meet with a patient during hospitalization, the meeting occurs shortly after the patient is discharged. During the initial meeting, a needs assessment is conducted and discharge recommendations for outpatient care are reviewed with the patient. It is then the OVMH team's responsibility to navigate the patient through the health care system where gaps have been identified. During this transitional phase, the OVMH team applies a patient-centered approach when discussing the care and goals of the patient. Patient-centered care uses an approach where a partnership occurs between the patient and health care provider that encompasses the patient's values, preferences, and needs (Boykins, 2014). This is an important aspect of transitional care, as the patient must agree with the recommendations so his or her preferences can be integrated to the plan of care.

The goal of implementing a mobile health team is to provide continuity and extension of services upon discharge from the hospital setting to improve patients' chances of living independently and successfully in their community.

The goal of implementing a mobile health team is to provide continuity and extension of services upon discharge from the hospital setting to improve patients' chances of living independently and successfully in their community. This approach results in savings to the hospital and improved health outcomes for patients as they receive supportive measures through community programs. Through a collaborative effort that supports the transitional needs of patients from the hospital setting to their community setting, a reduction in hospital readmission rates are expected, ultimately reducing financial burden on hospitals.

The Role of the Psychiatric–Mental Health Nurse Practitioner in the Community

PMHNPs are in a key position to help patients navigate effectively through the health care system from hospitalization to the community setting. Moczygemba, Osborn, and Lapane (2014) found that the critical component to positive and ongoing mental health care is longitudinal treatment in the outpatient setting. In addition, patients are more likely to comply with treatment on an outpatient basis if services are established during transition. As part of the mobile health team, PMHNPs are APNs skilled in delivering psychotherapeutic modalities instituted during the period of transitional care. PMHNPs have advanced knowledge and clinical expertise to identify signs and symptoms of potential relapse and can intervene with specialized crisis management techniques in an effort to reduce rehospitalization (Jordow, 2014). Responsibilities of PMHNPs include mental health and educational support to increase adherence to treatment while simultaneously connecting patients to community services.

KEYPOINTS

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1. Mobile health teams serve to meet the needs of the community by providing creative and integrative approaches in helping individuals such as those who are homeless connect with community partners for continuity of care.
2. Vulnerable individuals, such as those who are homeless, often live with chronic medical and mental health conditions that can be managed by nurse practitioners while they transition from inpatient to outpatient care.
3. By strategically placing psychiatric–mental health nurse practitioners in community settings through mobilized care teams, they can help screen, identify, and implement services that can reduce the likelihood of patients returning to the hospital setting through lateralized services of care with community partners.

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The role of the PMHNP encompasses the importance of the therapeutic nurse–patient relationship. The PMHNP takes a holistic approach to health care, emphasizing the patient-centered model where importance is placed on mutual treatment goals and supportive measures that assist the patient to live as independently as possible in the community. As a member of the OVMH team, the PMHNP strengthens patient rapport and establishes trust by increasing the frequency of visits and spending the time necessary to instill health-promoting behaviors.

The PMHNP provides an alternative approach to meeting the needs of this population in community settings that is cost-efficient and just as effective as other providers in the clinical setting (Schaumberg et al., 2013). With the new era of health care emphasizing cost-effective measures, integrating PMHNPs in community settings reduces cost. Patients discharged from the hospital setting with limited resources and minimal access to health care services can be strategically placed in the care of PMHNPs. Using the blended model for integrative health care, PMHNPs emphasize collaboration of care with the patient, community partners, and point-of-care providers to improve outcomes of care within this unique population (Jordow, 2014). Integrative care through collaborative partnerships brings a comprehensive treatment approach to patient care. This collaborative approach examines the individual needs of patients and incorporates specialized care and lateralizing services that improve their outcomes. Emphasis is placed on continuity of care through community services and support programs once the patient graduates from the transitional program. Bridging the gap of services through community partnerships and therapeutic alliances helps reduce patients' chances of relapsing into psychiatric crisis and using emergency services.

The PMHNP acts as a surrogate and advocate for the patient, ensuring the necessary resources are connected with the patient. The PMHNP also takes the role of a leader by helping patients take initiative and personal responsibility for their care in this process. This approach helps patients navigate identified gaps and established resources. These resources include establishing care with other health care providers, establishing a pharmacy where medications will be filled, participating in community services that will support the patient toward independent living, and any other community services incorporated into the patient's plan of care. The PMHNP takes the role of a resource nurse and helps patients incorporate the needs identified as necessary components to their success, optimizing their sense of acceptance and belonging in the community.

The ultimate role of the PMHNP is to provide continuity and comprehensive mental and behavioral health services to remedy gaps, ensuring necessary services are available to individuals who are homeless to improve their care as they transition from inpatient to outpatient care. This service reduces the likelihood of readmissions to the hospital setting and reduces the costs associated with readmissions.

The PMHNP assesses the psychiatric needs of the patient after discharge, using the identified discharge recommendations from the hospital. The PMHNP assesses and implements strategies that ensure patients' success in the community using a patient-centered and holistic approach to health care delivery. These objectives are discussed with patients and included as part of the transitional plan of care to increase adherence to the program.

During their participation in the OVMH program, patients are provided with a lifeline emergency response system to ensure they have access to emergency care, if warranted. County clinic services consist of health care professionals, such as primary care providers, psychiatrists, and psychologists, who will follow the patient upon discharge from the hospital. The PMHNP ensures that access to providers is in place through timely appointments.

The PMHNP works directly with the patient to ensure gaps in services are addressed. As a designated agent for the patient, the PMHNP is responsible for performing mental health screenings, reviews of records, psychotherapy, medication management, and community service referrals. Collaborative partners identified through Marin County services are accessible to the PMHNP as resources for the patient during his or her transitional phase from the hospital setting.

DISCUSSION AND CONCLUSION

The enactment of the Patient Protection and Affordable Care Act (PPACA) in 2010 presented an opportunity to improve the current health care delivery system that exists today (Jordow, 2014). As health care reform acknowledges the necessity of essential programs to meet the challenges of individuals with mental illness, it paves the way to improve psychiatric care implemented in current health care systems. The PPACA is a platform for evidence-based practice to be instituted as part of the patient care delivery model that moves away from a fragmented system to a patient-centered care system. Individuals who are homeless can benefit from such a model where they become active partners in their care (Jordow, 2014).

Integrating mobile health services is a creative and innovative approach to meeting the specialized needs of chronic users of the health care system. It is important that hospitals and community organizations participate in a joint effort with mobilized services to improve the outcomes of vulnerable patients (Doran et al., 2013). Providers, health care organizations, and patients alike are witnessing the benefits that early intervention programs, such as mobile health units, provide in transitioning patients from acute inpatient settings to independent living in the community. Mobile health programs that incorporate PMHNPs as part of their team provide cutting edge approaches to health care delivery. A PMHNP in the community setting is a cost-effective measure that cannot be overlooked. As a clinician serving the needs of individuals who are homeless, strategically placing a PMHNP in the community setting offers cost reduction measures and reduction of burdens to the health care system. PMHNPs have the specialized skills and expertise to address the mental health challenges of this vulnerable population and ensure a well-rounded approach is instituted as part of their transitional care toward wellness, thus giving individuals who are homeless a sense of purpose and belonging to their community.

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