Connect 2 Care: Evaluation of a care coordination and community outreach program for socially vulnerable patients

Hasham Kamran[1], Alicia Polachek [2], Gabe Fabreau [2], Kerry McBrien [2]

1 MPH Candidate, Simon Fraser University
2 Cumming School of Medicine, University of Calgary

INTRODUCTION

- Socially vulnerable individuals face barriers to care and have higher acute care use than the general population. Following discharge, they are 2-4 times more likely than the general population to have a repeat emergency department visit within 7 days
- Connect 2 Care (C2C) is a unique and innovative program in Calgary serving socially and medically complex clients who are vulnerably housed or homeless and who often have substance use and/or mental health concerns.
- C2C provides mobile intensive case management that is client-centered, trauma-informed and rooted in harm-reduction principles.
- Researchers at the University of Calgary are evaluating the program to determine if C2C reduces acute care use, improves health and social outcomes, and meets the needs and expectations of patients, staff, and partners.

METHODS

- A mixed-methods evaluation of the C2C program according to the Donabedian framework of structure, process, and outcome is underway.
- Data sources include: (a) administrative health data; (b) longitudinal participant surveys at 6- and 12-month post enrollment; (c) housing look-back timeline incorporated with the surveys; (d) qualitative interviews; (e) field observations.

RESULTS

- C2C successfully engaged with 436 individuals between September 2017 and May 2019.
- Reasons for referral included: Primary care attachment, Housing, and Discharge coordination.
- Thematic analysis from qualitative interviews suggest C2C is the bridge between hospital, community and clients, which helps to fill existing gaps, improve communication, and enhance continuity of care across contexts.
- Housing stability increases after enrollment in the C2C program, while the number of housing transitions decreases.
- Analyses also show improved connection to healthcare, supported housing stability, and increased capacity for independence and self-empowerment.

DISCUSSION

- C2C effectively engages socially vulnerable patients and coordinates needed resources.
- Housing Stability for C2C clients improved after enrollment into the program.
- The C2C intervention may provide insight into how similar interventions could be deployed in other jurisdictions to meet the unique needs of socially vulnerable individuals.

Emergency presentations, in-patient stays, and cumulative bed days are lower following enrollment in the Connect 2 Care program, a mobile community outreach program for socially vulnerable individuals.

SCAN ME

Take a picture to learn more

SINCE BEING REFERRED TO C2C:

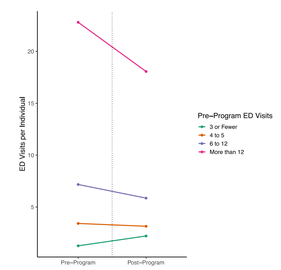
49% of clients without housing, became housed

58% of clients without a primary care physician, were connected to primary care

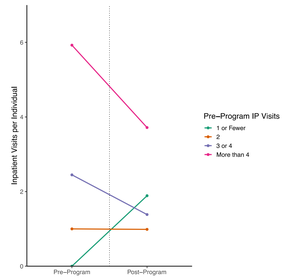
62% of clients without medication coverage, obtained coverage

ACUTE CARE ANALYSIS

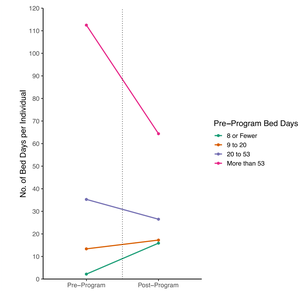
ED Visits



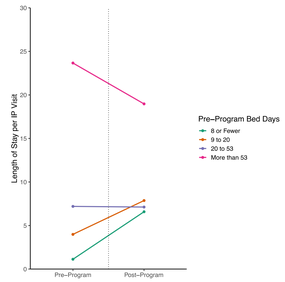
Admissions



Total Bed Days



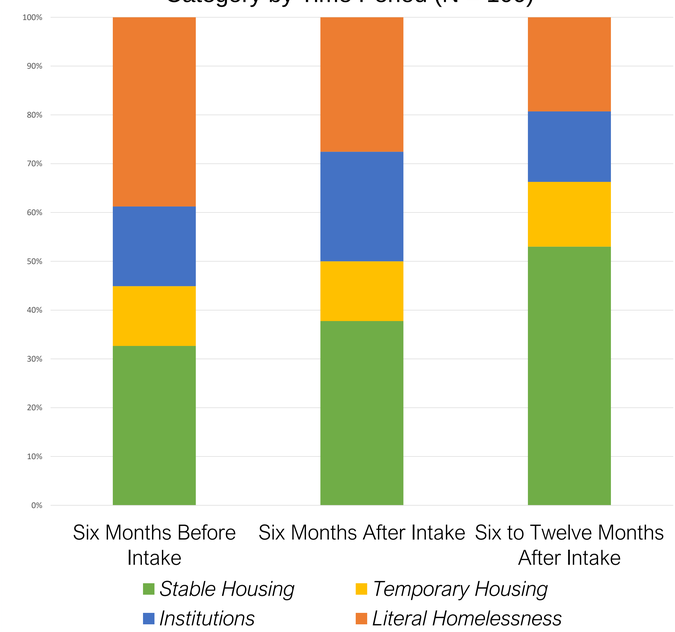
Length of Stay



HOUSING LOOK-BACK TIMELINE

A significant reduction in both the mean proportion of time spent in literal homelessness (from 0.38 to 0.16) and the median number of housing changes made in six months (from 2 to 1) was observed between the six months preceding intake and the six-to-twelve months after intake.

Mean Proportion of Time Spent in Housing Category by Time Period (N = 100)



Alberta Health Services · CUPS · ALPHAHOUSE · UNIVERSITY OF CALGARY O'Brien Institute for Public Health · W21C · ALBERTA INNOVATES